WRAMC US TOO, Inc.

A PROSTATE CANCER SUPPORT GROUP
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NEWSLETTER

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♦ DR. MOUL DEPARTS WRAMC ♦

Colonel Judd W. Moul, MC, retired from the United States Army on June 30, 2004, after twenty-six years of active duty. A distinguished scientist, administrator, urologic oncologist, and surgeon, he leaves an indelible mark in the annals of modern military medicine. His achievements are remarkable. As Director of the Department of Defense's Center for Prostate Disease Research, he recruited and led a scientific team responsible for $45 million in research funding that produced an array of peer-respected scientific studies regarding prostate cancer. As Professor of Surgery at the Uniformed Services University of the Health Sciences, he helped train the next generation of military medical professionals. Dr. Moul authored or co-authored over 250 scientific publications, often appearing in the prominent medical professional journals. A renowned prostate cancer authority, he has made numerous scientific presentations at national and international meetings; he appears regularly on the national news media on the subject of prostate cancer; and he is on the editorial boards for several major medical journals.

Yes, his professional achievements are legend, but men here with prostate cancer will remember him as a caring physician whose personal concern for patients and their families was palpable as he helped them cope with the disease. In 1991, he co-founded the US TOO Chapter at Walter Reed Army Medical Center and served as its president for thirteen years. He provided us with facilities, spoke to our group regularly, obtained distinguished guest speakers for our program, and wrote an article for every edition of this newsletter. Under his enthusiastic leadership, our regular meetings increased from four to twenty-eight per year, attracting a total annual attendance of 700; the newsletter grew from a readership of 100 to 2,100. Dr. Moul's concern for patient education and welfare was not limited to WRAMC. He serves as medical advisor to US TOO International and the National Association for Continence. And if there is a prostate cancer support group he has not spoken to, it is because it never asked him.

So we will miss him sorely. We are consoled by the fact that he will continue his dedicated service to our cause as Professor of Surgery and Chairman of the Department of Urology at the Duke University Medical Center.

♦ *INSIDE THIS ISSUE* ♦

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♦ FROM THE EDITOR'S DESK ♦

Dr. Moul Departs

Words fail when considering the recent retirement of Colonel Judd W. Moul, MC, US Army, who has done so much for the WRAMC US TOO Prostate Cancer Support Group for the past thirteen years. Our cofounder and patron, Dr. Moul's contribution of time and talent was an important element of this newsletter. I know that his regular articles and his ***The Doctor Is In*** column are the first items many of you turn to upon receiving each edition of the newsletter. His promptness and enthusiasm in beating every deadline made the editor's job so easy. But he didn't stop there! No–he personally reviewed every word of every edition, not only for scientific accuracy, but for spelling and grammar! What a guy!

Our speaker for the May meeting was Dr. Paul Y. Song, Department of Radiation Oncology, WRAMC. He spoke on the topic ***Prostate Seed Brachytherapy and Radiation Oncology.*** Unfortunately, we are unable to record and transcribe his remarks due to technical difficulty with the recording system. We hope to provide a summary of his presentation in a subsequent issue.

♦ PROGRAM FOR AUGUST 4, 2004 ♦

Is your prostate cancer cured or under control? Good! But as many have learned, there are no guarantees. That is why our August 4 meeting is so important. ***When Cancer Returns - Therapeutic Options*** will be presented by **Dr. Nancy Dawson**, a graduate of Georgetown University School of Medicine, who had a distinguished career in military medicine. She retired from military service in 1999 as Chief, Hematology-Oncology Service at WRAMC. She is now Director, Genito-Urinary Medical Oncology and Professor of Medicine at the Greenebaum Cancer Center, University of Maryland. **Join us at 7 PM on Wednesday, August 4, 2004, in Joel Auditorium at WRAMC**. Plan now to attend and bring your spouse or a friend. They are always welcome.

♦ **You Pay Your Money, and You Make Your Choice!** Newly diagnosed men with early stage prostate cancer are likely to have good outcomes regardless of the primary therapy they select according to recent research at the New York Prostate Institute. Accordingly, quality of life issues assume greater importance in choosing among radical prostatectomy, external beam radiation, and permanent seed implantation. The researchers compared freedom from biochemical recurrence as measured by PSA levels in 1,819 men with early stage (T1 or T2) prostate cancer. After a median follow-up of 58 months, estimated freedom from recurrence at seven years was 79% in the surgery group, 77% in the external beam group, and 74% in those who selected brachytherapy. Treatment outcomes were not significantly associated with age, race, clinical stage, or selected treatment. The study did not consider combination therapy (e.g., hormonal therapy and surgery). The study suggests that selection of a primary therapy by men with early stage prostate cancer can be based on considerations of potential side effects such as erectile dysfunction, urinary incontinence, and rectal problems. (Source: *Radiotherapy and Oncology*: February 2004;71:29-33 via Reuters Health Information, April 21, 2004)

♦ **PSA Velocity Study Breaks New Ground**. Catalona, et al., Northwestern University, studied 1,095 men who had radical prostatectomies for prostate cancer. Men whose PSA levels had risen rapidly in the year before the cancer was diagnosed were much more likely to die from their disease. Men whose PSA scores had jumped by more than two points were ten times as likely to die as those whose PSAs increased by less than that. A rapidly rising PSA velocity predicted a bad outcome even if the PSA score never exceeded 4.0 ng/ml, which is often considered a normal level. The new findings indicate the rate of change in PSA is more important than the result of a single reading. Previous research had suggested that this was the case, but this new research is the most definitive to date, and the first to show a clear link to survival. The rate of PSA rise can be useful in making decisions between watchful waiting and more aggressive therapy. Some observers likened PSA tests to mammograms which women typically start having at age 40, followed by regular monitoring thereafter. Men should get a baseline PSA as early as age 35, especially those at increased risk, such as men with a family history of prostate cancer and African Americans. The study is reported in the July 8, 2004, issue of the *New England Journal of Medicine*. (Source: *The Washington Post*, July 8, 2004, pages A1-6)

♦ **Newly Diagnosed Men Poorly Served**. Existing patient education materials are not adequate to serve the needs of men facing treatment decisions according to researchers at the Department of Internal Medicine, University of Michigan Health System. Most existing literature promotes active treatment with little comment about side effects. Early stage prostate cancer is usually treated with watchful waiting, surgery, radiation therapy, or hormone therapy. Yet no clinical trials have shown a difference in 10- to 15-year mortality among these treatments. Accordingly, the side effects associated with each treatment

modality assume greater importance in making the treatment decision. For example, the researchers note that only about half the educational materials surveyed discuss the need for hospitalization and catheterization after radical prostatectomy. Incontinence and impotence are frequently listed as potential side effects, but bowel disorders and the risk of death are seldom acknowledged. (Source: *Annals of Internal Medicine* 2004 via United Press International, May 4, 2004)

♦ **Salvage Therapy After Failed External Beam Radiation**. Prostate cancer patients who relapse after external beam radiation (EBRT) have limited therapeutic options. Recent research indicates that high-intensity focused ultrasonography (HIFU) may be helpful for men with local recurrence after EBRT. In the study, seventy-one men were treated by HIFU after failed EBRT, and after a median follow-up of 14.8 months, 80% of the patients had negative biopsies. At the most recent follow-up, 44% of the patients had no evidence of disease progression. The researchers see HIFU as a promising treatment option with curative potential for patients with local recurrence after EBRT. The related morbidity, (e.g., rectourethral fistula, severe incontinence, and bladder neck blockage) was lower than that reported for other types of salvage therapy. It was noted that some of the researchers have economic interest in ultrasound therapy apparatus. (Source: *Urology* 2004;63:625-629 via Medscape Medical News, April 16, 2004)

♦ **Many Men Take Dietary Supplements to Prevent Prostate Cancer**. A significant percentage of men take dietary supplements such as vitamins, minerals and herbs to prevent prostate cancer despite a lack of evidence that they work, according to a recent study by researchers at the Fox Chase Cancer Center. More than half of the men in the study say they take natural products believed to reduce their chances of developing prostate cancer. Although the preventative effectiveness of many of these supplements is not established, they are widely perceived by the public to lower the risk of developing prostate cancer. Most commonly used are vitamins such as A, B, C, D, and E, minerals such as zinc, calcium and selenium, and fruit/seed extracts such as saw-palmetto, soy isoflavones and flax seed. One in four men took three or more agents. Claims of effectiveness are often based on theories outside of Western medical science. Users of nutritional supplements generally believe the products to be "natural" and therefore, have no side effects when many actually do. Other studies suggest that many patients do not inform their physicians about their use of supplements, but it is important that they do so. (Source: *British J of Urol*: 2004 via Fox Chase Cancer Center)

♦ **Low-PSA Prostate Cancers May Be Clinically Significant.** There is ongoing debate about the clinical significance of prostate cancer in men with low PSA levels (less than 4.0 ng/ml). Recent research at the University of Chicago indicates that most low PSA tumors do have clinical significance. The researchers studied the clinical and pathological specimens of 79 men with PSAs less than 4.0 ng/ml who had radical prostatectomies. They then compared them with prostatectomy specimens from 30 men with high PSA prostate cancer. The analysis showed that 52% of the low-PSA tumors were clinically significant (e.g., Gleason score of 7 or greater; evidence of spread beyond the prostate; and high tumor volume). The researchers conclude that PSA increases

alone are inadequate to diagnose clinically significant tumors, and that low-PSA prostate cancers may not be low-volume, clinically insignificant disease. They will now seek to explain why PSAs were low in those men found to have clinically significant prostate cancer. (Source: *British J Urol Intern'l,* 2004;93:499-502 via Reuters Health Information, April 7, 2004)

♦ **Prostate Cancer Therapy and Colorectal Cancer Risk Appear Unrelated.** Pelvic irradiation has been implicated in increased risk for subsequent diagnosis for colorectal cancer. Researchers at Wayne State University studied colonic samples from twelve prostate cancer patients treated by radiation, twelve treated with surgery and hormonal therapy, and ten patients in a control group at high risk for colon cancer, but who lacked any identifiable colon cancer or prostate cancer. The analysis revealed that there does not appear to be any significantly increased risk of colorectal cancer after prostate cancer regardless of the what therapy was used to combat the prostate cancer. The researchers noted the need for large prospective epidemiological studies to confirm their findings. (Source: Medscape via Reuters Health Information, March 29, 2004)

♦ **Dealing With Refractory Prostate Cancer.** The FDA recently approved Taxotere®(docetaxel) for use in combination with prednisone for the treatment of metastatic, hormone refractory prostate cancer. Safety and efficacy were demonstrated during two studies involving 1,776 patients. The primary efficacy endpoint was survival. A statistic- ally significant survival advantage was demonstrated compared to the standard chemotherapy. The Taxotere® regimens were associated with a 24% increase in survival, confirming for the first time that prostate cancer, like breast cancer, is an appropriate target for chemotherapy. Experts say that the findings will change the standard of care for metastatic prostate cancer. Although the increased survival represented an average difference of only about three months, this is the first time that the survival line has moved–an important fact. The survival advantage was accompanied by more severe adverse effects that were dose-dependent. Possible adverse effects include anemia, neutropenia, infection, nausea, vomiting, anorexia and fatigue. The next step will be to evaluate Taxotere® in men with early stage disease. Taxotere® is manufactured by Aventis Pharmaceuticals. (Source: ASCO Press Release, May 19, 2004, and Medscape Medical News, June 9, 2004))

♦ **Group Urges Earlier Prostate Cancer Testing.** The National Comprehensive Cancer Network (NCCN), a consortium of 19 major hospitals that develops cancer management and screening strategies, is advising that prostate cancer screening be offered to men at age 40 in order to establish a baseline PSA level. This is ten years earlier than called for by others. The NCCN also suggests that biopsies be considered for men with PSA readings over 2.5 ng/ml because recent research shows that more than 20% of men with PSA scores between 2.5 and 4.0 ng/ml have the disease. The 2.5 ng/ml benchmark is much lower than the more conservative PSA level of 4.0 ng/ml heretofore employed. Other experts caution that too many men already have unnecessary biopsies–as many as two out of three men with suspicious PSA levels do not have cancer–and undergo treatment that exposes them to serious side effects. Deaths from prostate cancer have declined by about 20%

among whites and 16% among blacks since the mid-1990s with the advent of widespread PSA testing. Some experts doubt that that the PSA test should get all the credit. The U.S. Preventive Services Task Force takes a more conservative approach to PSA testing, noting the absence of definitive scientific proof that PSA testing actually saves lives. The Task Force maintains there is insufficient evidence either to recommend or oppose routine prostate cancer screening. (Source: USA Today, April 14, 2004)

♦ **Figures Don't Lie, but Liars Figure!** It has been hypothesized that frequency of sexual activity plays a role in the onset of prostate cancer. A new study sponsored by the National Institutes of Health and the National Cancer Institute found that high ejaculatory frequency is not associated with increased risk of prostate cancer, and may actually be protective. Over 23,000 men completed a self-administered questionnaire on frequency of ejaculation, including sexual intercourse, nocturnal emission, and masturbation. The group ranged in age from 46 to 81 years. The survey has been updated bi-annually through 2002. The researchers relied on a questionnaire that asked participants to estimate the average number of ejaculations per month during ages 20 to 29 years and 40 to 49 years, as well as the most current year (2000). Compared with men who reported an average of four to seven ejaculations per month over a lifetime, men who reported 21 or more ejaculations per month had a lower risk of prostate cancer. In this study of predomi-nantly white men, higher ejaculation fre-quency was not related to increased prostate cancer risk. In fact, there was the suggestion that high ejaculation frequency possibly may be associated with a lower risk of total and organ-confined prostate cancer. (**Editor's comment - How lucky can you get! That is, of course, if the study participants accurately reported their ejaculatory frequency, which is entirely another matter!)** (Source: *JAMA* 2004;291:1578-1586 via Medscape Medical News, April 6, 2004)

♦ **Does Viagra Decrease Fertility? Pfizer Says No.** Pfizer, Inc., maker of Viagra, disputed a recent study at Queen's University, Belfast, that found that Viagra may reduce the fertility of users. The researchers were especially concerned about fertility in men who use Viagra as a sexual enhancement as opposed to its use in treating erectile dysfunction. A Pfizer spokesman cited many clinical trials and over six years of use by 23 million men to dispute the finding. He said it was more likely that Viagra actually helped men with severe erectile dysfunction father children. The Belfast study did not include Viagra's competitors, Levitra and Cialis, but both those drugs work in a manner similar to Viagra. (Source*:* Medscape via Reuters Health Information, April 2, 2004)

♦ **Predicting Urinary Problems After Brachytherapy.** Radioactive seed implantation (brachytherapy) is becoming a more popular therapy for men with locally confined prostate cancer. For men with treatment options, the incidence of side effects is assuming greater importance in their selection of a primary therapy. Researchers at the Mayo Clinic College of Medicine in Jacksonville, Florida, report on a technique that predicts the likelihood of urinary problems from brachytherapy before the procedure is actually performed. Using simple pre-operative testing such as a urinary flow test and post-void residual measurement, combined with prostate size

as measured by a transrectal ultrasound, the researchers reviewed the records of 105 men who had brachytherapy. Patients with a slow urinary flow and an elevated American Urinary Association score were likely at greater risk for urinary complications after brachytherapy. In the Mayo Clinic study, significant urinary side effects were observed in 37% of men classified as "high risk" in the preoperative evaluation, compared to 15% in the "low risk" group. The study's value resides in its ability to allow newly diagnosed men to make more informed choices of their primary therapy options. (Source: *Mayo Clinic Proceedings*, March 2004 via Yahoo! News, April 12, 2004)

♦ **Prostate Cancer More Lethal After 15 Years.** One of the longest studies of early prostate cancer suggests that untreated, slow-growing tumors can become more lethal after 15 years–findings that argue for more aggressive treatment for newly diagnosed younger men. The Swedish study looked at "watchful waiting" in which doctors forego definitive treatment such as surgery or radiation in favor of observing tumor development. Doctors often choose this option for many patients with slow-growing tumors, particularly in older men who might die of other causes before the prostate cancer becomes life-threatening. The study involved 223 men, average age 72, with untreated, early-stage prostate cancer. They were followed for an average of 21 years. The death rates from prostate cancer were fairly constant during the first three five-year periods after diagnosis (about 5-7 percent). But after 15 years, 16.7 percent of the remaining participants died of prostate cancer. The researchers said their study suggests that doctors should consider more aggressive treatment in men who have more than 15 years of life expectancy at time of diagnosis. (Source*: The Washing - ton Post*, page A8, June 9, 2004)

♦ **Continued Support for PSA Screening.** A recent study of 977 patients found that continued screening for prostate cancer with the PSA test is warranted. The patients, whose nonpalpable (T1c) prostate cancer was diagnosed by PSA screening, were risk-stratified according to their pretreatment PSA, Gleason score, percent positive biopsy findings, and age. A substantial portion (61.5%) were found to be at risk for clinically significant tumors. The researchers at the University of Pennsylvania said their analysis supports continued reliance on the PSA test in the diagnosis of prostate cancer. (Source: *Archives of Internal Medicine*, 2004; 1227-1230 via Medscape Medical News, June 17, 2004)

♦ **Cancer Rates Down, Survival Up!** The 2004 annual report on cancer issued by the American Cancer Society, the National Cancer Institute, and the Centers for Disease Control and Prevention had much good news, albeit tempered by less favorable outcomes for minorities**.** Americans' risk of getting and dying from cancer continues to inch down. Lung cancer remains the nation's top-killing malignancy for both sexes, as well as the second most common cancer, but it slowly declined among men since the early 1990s. Now it appears that women's lung cancer experience has turned a favorable corner. Another major finding is that more people are living at least five years after an initial diagnosis for most types of cancer. Five-year survival is a major milestone for cancer patients. For men, survival rates improved the most, more than 10 percent, for cancers of the prostate, colon, kidney, and for melanoma and

leukemia. The biggest survival improvements in women came in colon, kidney and breast cancers. How does this improvement translate for men? It means that 99.3 percent of men diagnosed with prostate cancer will live at least 5 years, up from 70 percent in the 1970s–a dramatic improvement. Not surprisingly, survival from all cancers is strongly connected with how early the cancer is detected. Nevertheless, the racial gap is disconcerting. When all cancers are combined, black men are 26 percent more likely to die of a malignancy than white men, and Hispanic men are 16 percent more likely than white men. Black women and Hispanic women have even worse ratios compared to white women. According to the report, these disparities reflect poorer access to cancer prevention and detection services, as may additional illnesses minority patients have that could complicate cancer treatment. (Source: *CNN.com*, June 3, 2004)

♦ **Fake Viagra Reported**. Fake versions of Pfizer's Viagra have appeared in retail pharmacies in Glendale and Fresno, California, according to the Food and Drug Administration. Although no adverse effects have been reported to date, only genuine Viagra is FDA-approved as safe and effective. The fake tablets differ slightly in appearance from the real thing–the fake tablets have more pronounced edges and are lighter blue in color. Pfizer recommends that consumers concerned about the authenticity of their Viagra tablets should consult with their pharmacists. Pfizer plans to introduce new packaging designed to make the Viagra label harder to copy. (Source: *Reuters Health Information*, July 1, 2004, via Medscape.)

♦ **Limitations of the Gleason Score and the Implications for Counseling Patients.** Patients and providers make important treatment decisions based on information from the prostate needle biopsy. Very often, the amount of tissue recovered is rather limited, and may be difficult for the pathologist to interpret. A recent study reported in the July 2004 issue of the *Journal of Urology* considered Gleason grade 6 prostate cancers seen on biopsy in order to assess the degree of misclassification that occurs. The study looked at the 10-year radical prostatectomy experience of a single surgeon, focusing on 451 men who had a Gleason score of 6 after biopsy and who then underwent an RP. The researchers then compared the assessment of the pre-surgery biopsy with the final pathology evaluation post-surgery. They found that 51% of patients who had a Gleason score 6 pre-surgery also had a Gleason score 6 post-surgery. Forty-one percent of the patients had higher Gleason scores in the final surgical specimen, and 8% had lower Gleason scores. As expected, the patients with the highest Gleason scores after surgery had the worse oncologic outcomes. The study shows that the Gleason grading of the prostate needle biopsy is an inexact science. Although doctors typically rely on the biopsy Gleason score to counsel patients regarding therapy, it is sobering to note that the pathology grade of cancer from the biopsy is incorrect nearly half the time. It is simply very difficult to differentiate low-grade from high-grade cancers with all that means for subsequent treatment for the patient. (Source: *NEJM*: 350; Number 22, May 27, 2004, via Medscape Journal Scan (Urology, June 30, 2004)

♦ **Adjuvant and Salvage Radiotherapy Comparable After Prostate Cancer Surgery.** Researchers at the Medical

College of Virginia suggest that adjuvant and salvage radiotherapy after radical prostatectomy have similar biochemical recurrence-free survival rates. The key to favorable outcomes depends on beginning early treatment before the PSA level reaches 1.0 ng/ml after surgery. Regarding adjuvant radiotherapy, the urologist typically decides on treatment soon after radical prostatectomy based on histologic features of the tumor specimen and if the PSA level is detectable. Regarding salvage radiotherapy,

treatment is not begun after surgery until there is clinical evidence of recurrence, such as a rising PSA. The researchers say the evidence gives some assurance that salvage radiotherapy is a safe alternative to adjuvant radiotherapy. In the study, 157 men were placed into an adjuvant group and a salvage group. The median time from surgery to radiotherapy in the adjuvant group was 2.9 months, compared to 40.3 months for the salvage group. When either adjuvant and salvage radiotherapy was used when PSA levels were less that 1.0 ng/ml, the five-year biochemical recurrence-free survival rate was about 75%. When patient PSA exceeded that threshold at the time of treatment, the rate was only 33%. The researchers felt that, despite their findings, many clinicians will likely continue to opt for adjuvant radiotherapy. (Source: *Int J Radiat Oncol Bio Phys*:2004:59:329-340 via Reuters Health,
June 10, 2004)

New Prostate Cancer Support Groups in Northern Virginia Area

Readers residing in Northern Virginia will be interested to learn about the availability of new local prostate cancer support groups.

Dewitt Army Community Hospital, Fort Belvoir, VA. Meets the second Thursday of every month from 11:00 AM - 1:00 PM at the Wellness Center (4th Floor, Room B406). For more information, contact Paul Finneran at (703) 321-8481 or pjfinneran@yahoo.com.

Westminster-Potomac Hospital Chapter, US Too International. The chapter covers the greater Woodbridge-Dale city area. Meetings are held every other month on Saturday from 10:00 AM to noon in the multipurpose room at the Westminster Retirement Community, 12191 Clipper Drive, Lake Ridge, VA. For additional information and the next meeting date, contact Dick Gillespie at (703) 497-0628 or chesterii@aol.com.

"THE DOCTOR IS IN"

Colonel Judd W. Moul, MD

(Editor's Note: Readers should not act on the responses without prior consultation with their own physicians.)

QUESTION. I am a very strong believer in donating blood to the Red Cross and I do so regularly. However, my physician recently placed me on Proscar (finasteride) for an enlarged prostate. When I last attempted to give blood, the nurse told me that I could not do so until I had been off finasteride for at least a month. I really wish to continue giving blood, even to the extent of skipping finasteride for a month or so.

ANSWER. First and foremost, Proscar (finasteride) was prescribed for you to treat specific prostate and urinary symptoms, so you should not discontinue or interrupt its use without prior consultation with your physician. It is true that a person taking finasteride cannot be accepted as a blood donor. The Food and Drug Administration and the American Society of Blood Banks require that a blood donor not donate until a month after ceasing to take the medication. These agencies have this requirement because finasteride, even in small amounts, can cause harm to a developing fetus if a unit of blood is transferred to a pregnant female. Your commitment to the blood donor program is admirable, but it should not jeopardize your own health in the process.

QUESTION. I am reading more and more about laparoscopic radical prostatectomy, and I am considering it in my own case. Is it being done at the Walter Reed Army Medical Center?

ANSWER. At this point, laparoscopic radical prostatectomy is still considered an investigational form of the operation. We simply do not know yet if it is as good as open surgery. For example, it may not be as effective in nerve sparing to preserve sexual function. The procedure takes about two-to-three times as long as the conventional procedure (2-2.5 hours for open surgery versus 5-8 hours for laparoscopic surgery). It is available here at Walter Reed. The best candidates for it are younger, slim men with very early stage prostate cancer who are capable of being under anesthesia for longer periods of time. We also have the DeVinci robotic system available for prostate surgery. It is experimental, and it takes about eight hours for an RP. In ***very*** experienced hands, laparoscopic or DeVinci robotic prostatectomy may be comparable to open prostatectomy. However, in experienced hands, the conventional "open" RP can be performed through a very small, very low midline incision with outstanding pain control and cosmesis. At present in 2004, my own surgical choice would be for an open, nerve-sparing radical prostatectomy done by a very experienced urologic cancer specialist.

QUESTION. I understand that the Food and Drug Administration recently has approved Taxotere® for treatment of metastatic, hormone refractory prostate cancer. What are the implications of this approval for men facing cancer recurrence?

ANSWER. Taxotere®, generic name docetaxel, is a taxane-based chemotherapy that is clearly active in prostate cancer. At the recent American Society of Clinical Oncology convention, two landmark clinical trials were presented showing that docetaxel-estramusine and docetaxel-prednisone combinations improved survival rates for men with hormone refractory prostate cancer compared to the standard regimen of mitoxantrone plus steroids. The differences in median survival rate were modest, but significant. For men at earlier stages of prostate cancer, such as those with cancer recurrence after prior surgery or radiation, the use of Taxotere® will now be studied. The clinical trials are just now getting started. In this setting, Taxotere® will be tried alone and with other drugs such as hormonal therapy. At present, Taxotere® must be considered investigational in the setting of earlier non-hormone refractory prostate cancer.

♦ Using Our Volunteer Counselors ♦

The penultimate page of each WRAMC US TOO newsletter lists persons who are willing to share their experiences in coping with prostate cancer. We are very grateful for their service. The listing is primarily intended for newly diagnosed men and for prostate cancer survivors who face new treatment decisions due to changes in their prostate cancer conditions. We encourage readers to contact these volunteers. From time to time, some volunteers find it necessary to end their involvement. Accordingly, we ask that callers ensure they are using the current list of volunteers. The effective date of the current list is shown at the top of the listing.

♦ Helping Direct Prostate Cancer Research Funds ♦
Prostate Cancer Survivors Making a Difference

Prostate cancer advocate Philip Brach recently joined with other prostate cancer survivors in the evaluation of over 800 research proposals submitted to the Prostate Cancer Research Program (PCRP) sponsored by the Department of Defense. Philip was nominated for participation in the program by the prostate cancer support group at Walter Reed Army Medical Center, a chapter of US TOO International. As a consumer reviewer, he was a full voting member, joining with prominent scientists to determine how a congressional appropriation of $85 million will be spent on future prostate cancer research. The unique Congressionally Directed Medical Research Programs at Fort Detrick, MD, is under the overall management of the U.S. Army Medical Research and Materiel Command. Since 1977, congressional appropriations for prostate cancer research have totaled $565 million.

During three days of deliberations, Brach and other consumer advocates represented the collective view of prostate cancer survivors, their families, and persons at risk for the disease. Consumer advocates and their scientific colleagues assessed the research proposals for their relevance to such key issues as disease prevention, screening, diagnosis, treatment, and quality of life. Reflecting on his role as a consumer reviewer, Philip remarked that "the opportunity to represent the prostate cancer community was very satisfying, and I was especially impressed by the manner in which my scientific colleagues on the panel were receptive to the survivors' viewpoints." Philip added that the experience enhanced his optimism that the war on prostate cancer was being won.

This unique partnership of consumer reviewers and scientists in the evaluation of prostate cancer research proposals has been working since 1997. This year, 43 consumer reviewers and 260 scientists shared the experience. The process provided the scientists with knowledgeable consumers' perspectives on innovative research at the same time it encouraged the consumers that progress was being made for a cure to the disease.

The 800 research proposals were solicited from all disciplines, including the basic, clinical, social, and psychosocial sciences, as well as public health, economics, occupational health, nursing research, and environmental concerns. After the evaluation of scientific merit by the consumer reviewers and scientists, the proposals are further evaluated by a senior advisory council which results in a priority list of research proposals recommended for funding. The entire process was completed by June 30, 2004.

This peer review process involving consumer reviewers is admired throughout the scientific community as a positive technique to guarantee that prostate cancer research dollars are targeted to the most crucial needs.

The Prostate Cancer Research Program will soon be seeking volunteers for the 2005 cycle. Watch for more information about getting involved in later editions of this newsletter, the publications of US TOO International, and those of other prostate cancer advocacy organizations. In the meantime, visit the website of the U.S. Army Medical Research and Materiel Command at cdmrp.army.mil.

♦ Screening for Prostate Cancer - A Second Opinion ♦

William Palos

(**Editor's Note**: Our February 2004 issue had an article by Stanley Klein–*Screening for Prostate Cancer - An Opinion.* Mr. Klein was concerned about recent research suggesting that the long-standing PSA cut-off score for diagnosing prostate cancer be lowered from 4.0 ng/ml to 2.5 ng/ml. Mr. Klein felt this would lead to treatment procedures having detrimental effects on patient quality of life without redeeming results. Now we have a second opinion from William Palos. Mr. Palos is a Regional Director (Western Illinois and Iowa) for US TOO International. He is also associated with one of US TOO's largest chapters. Here is his "second opinion.")

I read with interest Stanley Klein's article regarding the possible change in the PSA standard from 4.0 ng/ml to 2.5 ng/ml. I disagree with some of Mr. Klein's concerns.

I, too, counsel men about the need for early detection of prostate cancer and provide advice to those men who discover they have the disease. One of my main concerns with the current PSA standard of 4.0 ng/ml is that many primary care providers think that a man is OK if his PSA level is less than 4.0, regardless of his age or family history. Yet numerous articles relate examples of men with very low PSAs who were still diagnosed with the disease. One of my chapter members recently learned he had prostate cancer at age 55. He had been checked annually since age 50. His PSA jumped from 3.0 to 6.0 and a biopsy resulted in a Gleason score of 10. His doctor recommended immediate therapy and my friend had a radical prostatectomy. Unfortunately, it failed and he is now undergoing radiation therapy. The eventual outcome is uncertain. Obviously this man has had prostate cancer for some time. I am aware of several other cases of men in their mid to late forties who had surgery, but who almost immediately had to have radiation and/or hormonal therapy. Needless to say, if alarms had gone off before they exceeded the present 4.0 ng/ml standard, they may have had the opportunity for treatment options that would offer them a better quality of life than they now face.

I want to make two points. First, we need better standards regarding a rise in PSA and the speed at which it occurs before additional investigation or treatment is pursued. Second, there needs to be a more effective and economical method of cancer detection without having multiple biopsies. I am aware of men who have had four biopsies, but they are still in the dark about their status.

In our support group meetings, our presentations about early detection emphasize that a "good PSA" is one that remains relatively constant within a reasonable range, rather than a specific number. Doctors should not use the common standard of 4.0 ng/ml for all men. One PSA standard does not fit all! Age, race, overall prostate health–these are among the considerations affecting individual PSAs. A man in his early 50s with a PSA of 2.5 ng/ml could have a serious problem requiring regular follow-up.

I agree with Stanley Klein that many men are concerned about impotence and incontinence. Aren't we all? But his argument that changing PSA guidelines from 4.0 ng/ml to 2.5 ng/ml will result in high social and economic cost without any redeeming benefit is totally wrong. If a man's life is at risk, considerations of sex life, urinary continence, and cost become moot. The man at risk is the one to determine his course of action once he is armed with information about prostate cancer and the risks and benefits of the therapies available to him. This will be possible when he has established a PSA baseline compared from year to year with an annual PSA test and digital rectal examination (DRE). It cannot be overemphasized that the rate of change in PSA is more important than the absolute number.

The US TOO guidelines for prostate cancer screening are two-fold. Men should have an annual PSA and DRE beginning at age 45. Men at known risk, such as African Americans and men with a family history of the disease, should begin screening at age 40.

Although I disagree with my friend Stan on some aspects of PSA testing, I must mention how helpful he has been to me and our US TOO support group in planning our prostate cancer awareness events. When it comes to organizing and conducting prostate cancer awareness walk/run events, STAN IS THE MAN!

♦ WRAMC US TOO MEETING SCHEDULE ♦

Our support group conducts a series of regular meetings to provide information and counseling to men with prostate cancer and their families. Our regular quarterly meetings are held on the first Wednesday of the months of February, May, August, and November. We meet in Joel Auditorium, Walter Reed Army Medical Center from 7-8:30 PM. These quarterly meetings feature a medical professional presenting a topic of interest to the prostate cancer community followed by a question and answer period. This newsletter announces the speaker and topic for your information.

We also offer two monthly meetings. These informal, friendly meetings permit the exchange of views and experiences among the participants. They offer camaraderie, frank discussion, information and support. The monthly sessions have a daytime and evening schedule. The daytime session meets on the second Wednesday of every month from 1:30-3:00 PM. The evening session meets on the second Thursday of every month from 6:30-8:00 PM. Both monthly sessions convene in the conference room at the Center for Prostate Disease Research (Ward 56), Walter Reed Army Medical Center.

EVERYONE IS WELCOME. BRING YOUR SPOUSE OR A FRIEND.

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♦ WRAMC US TOO COUNSELORS ♦ (AS AUGUST 1, 2004)

(These persons are willing to share their experiences with you. Feel free to call them.)

SURGERY

Jack Barnes	Oakton, VA	(703) 620-2818	
Jack Beaver	Falls Church, VA	(703) 533-0274	
Jerry Bussing	Laurel, MD	(301) 490-8512	
Gil Cohen	Baltimore, MD	(410) 367-9141	
Edward G. Courey	Silver Spring, MD	(301) 589-4092	
John Fellows	Annandale, VA	(703) 503-4944	
Tony French	Annandale, VA	(703) 750-9447	
Robert Gerard	Carlisle, PA	(717) 243-3331	
Harry B. Harris	Silver Spring, MD	(301) 384-5260	
Monroe Hatch	Clifton, VA	(703) 323-1038	
Bill Johnston	Berryville, VA	(540) 955-4169	
Dennis Kern	Reston, VA	(703) 391-9418	
Steve Laabs	Fayetteville, PA	(717) 352-8028	(Laparoscopic Surgery)
James Padgett	Silver Spring, MD	(301) 622-0869	
George Savitske	Alexandria, VA	(703) 671-5469	
Jay Tisserand	Carlisle, PA	(717) 243-3950	
Don Williford	Laurel, MD	(301) 317-6212	

RADIATION

John Barnes	Springfield, VA	(703) 354-0134	(Intensity-Modulated Radiation Therapy)
Leroy Beimel	Glen Burnie, MD	(410) 761-4476	(External Beam Radiation)
Philip Brach	Washington, DC	(202) 966-8924	(External Beam Radiation)
Ron Gabriel	Bethesda, MD	(301) 654-7155	(Brachytherapy)
Irv Hylton	Woodstock, VA	(540) 459-5561	(Brachytherapy)
Harvey Kramer	Silver Spring, MD	(301) 585-8080	(Brachytherapy)
Bill Melton	Rockville, MD	(301) 460-4677	(External Beam Radiation)
Oliver E. Vroom	Crofton, MD	(410) 721-2728	(Proton Radiation)
John Waller	Yorktown, VA	(757) 865-8732	(Brachytherapy)
Barry Walrath	McLean, VA	(703) 676-6405	(Brachytherapy)

INCONTINENCE

Larry Schindler	Silver Spring, MD	(301) 649-5946	
Ray Walsh	Annandale, VA	(703) 425-1474	

HORMONAL

"Mac" Showers	Arlington, VA	(703) 524-4857	
Tony Bicknell	Springfield, VA	(703) 451-7517	

SPOUSE SUPPORT

Faye Lohmann	Kensington, MD	(301) 933-3678	

MULTIPLE THERAPIES

Howard Bubel	Fairfax, VA	(703) 280-5765	(Cryosurgery, Hormonal, Sexual Function)
Arthur E. Clough	Kerryville, TX	(210) 896-8826	(Surgery and Radiation)
S.L. Guille	Sumerduck, VA	(540) 439-8066	(Surgery, Radiation, Hormonal)
Glenn A. Leister	Lynchburg, VA	(434) 384-1661	(Surgery, Hormonal, Chemotherapy)
Hank Lohmann	Kensington, MD	(301) 933-3678	(Surgery and Radiation)
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)
Ken Simmons	Alexandria, VA	(703) 823-9378	(Radiation and Hormonal)
Bill Stierman	Vienna, VA	(703) 573-0705	(Surgery and Hormonal)

WRAMC US TOO, Inc., NEWSLETTER
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WALTER REED ARMY MEDICAL CENTER
WASHINGTON, DC 20307-5001

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♦ MEETING ANNOUNCEMENT ♦

WEDNESDAY, AUGUST 4, 2004
7 PM

JOEL AUDITORIUM (SECOND FLOOR)
WALTER REED ARMY MEDICAL CENTER

♦ SPEAKER ♦

NANCY A. DAWSON, MD
DIRECTOR, GENITO-URINARY MEDICAL ONCOLOGY
GREENEBAUM CANCER CENTER, UNIVERSITY OF MARYLAND

♦ TOPIC ♦

"When Cancer Returns - Therapeutic Options"