WRAMC Us TOO, Inc.
A PROSTATE CANCER SUPPORT GROUP
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NEWSLETTER

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♦ EVER HEARD OF CRYOSURGERY? ♦

by
GEORGE SYLVESTER

My guess is that men dealing with prostate cancer give little, if any, consideration to cryosurgery as a primary therapy. The newly diagnosed man is unlikely to encounter definitive information about cryotherapy in the sources readily available to the layman. Even avid internet searchers are more likely to become attracted to the new techniques of laparoscopic surgery and the Da Vinci robotic system, rather than to any meaningful comparisons of radical prostatectomy, radiation, and cryosurgery. As I read previous personal accounts in this newsletter, I became motivated to share my recent personal experience with cryosurgery in dealing with prostate cancer because it has been so apparently successful for me, and yet the layman seems to know so little about it.

My story begins in March 2004, when, as a result of a routine physical, my PSA showed a reading of 4.6. Over the next eighteen months it would shoot up to 9.8, with several intermediate readings along the way. My first stop after my physical examination was to a local urologist who took a very conservative approach to my situation. He recommended a "wait and see" routine. To him I was just another older patient (age 78) who, in his words, "was going to die of something else before the prostate cancer, if I had it, would kill me." I was not content with that approach and quickly decided I needed a second opinion.

It was my good fortune to tap into the expertise at the University of Virginia Medical Center in Charlottesville. UVA has become over the years my default medical treatment facility primarily because it is much closer to where I live in the Shenandoah Valley than is Walter Reed Army Medical Center. The urologist/oncologist at UVA was a Dr. Dan (first name). He gave me another, more sophisticated PSA test which was soon followed by a standard twelve sample biopsy of the prostate. By this time my PSA had risen from 4.6 to 6.7, but the biopsy was negative. In another six months my PSA had jumped to 9.8. Dr. Dan then performed a saturation biopsy of 36 samples. This procedure required a general anesthesia. As I had feared, the biopsy showed positive for cancer with a Gleason score of 7. All indications were that we were dealing with a potentially aggressive cancer, not the "wait and see" variety. In November 2005, my wife and I huddled with Dr. Dan to go over my options. Because of my age, he categorically ruled out radical prostatectomy. The remaining options were external beam radiation, brachytherapy, and cryosurgery. I was unfamiliar with cryosurgery so Dr. Dan explained it to me. **(Continued on page 8)**

♦ *INSIDE THIS ISSUE* ♦

♦ FROM THE EDITOR'S DESK ♦

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There are two items for your attention. The first is for readers in the Greater Washington Metropolitan Area who may have the opportunity to attend our regular meetings at WRAMC. They should refer to page 9 for our new schedule of meetings. Second, we are pleased to announce that Dr. Judd W. Moul, our co-founder and former Director, Center for Prostate Disease Research at WRAMC, returns as guest speaker at our regular quarterly meeting on Wednesday, August 2, 2006. Dr. Moul is well-known to many of you. Come welcome him back!

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Our program for the May 3, 2006, meeting featured a panel of five prostate cancer survivors who described their personal experiences in coping with the disease. We are very grateful to these men for sharing their diagnoses, selected therapies, and outcomes with us. A summary of their presentations, "Dealing with Prostate Cancer - Our Stories," begins on page 10.

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♦ PROGRAM FOR WEDNESDAY, AUGUST 2, 2006 ♦

As noted above, Dr. Judd W. Moul, Professor and Chief, Division of Urologic Surgery, Duke University Medical Center, is our speaker on Wednesday, August 2, 2006. While assigned at WRAMC, he annually made the feature presentation of our entire program, providing us with insights into topics of great interest to men with prostate cancer and their families. His topic is "Latest Developments in Prostate Cancer Research and Treatment." We are grateful to TAP Pharmaceuticals, Inc., and Novartis Oncology for their support in making the presentation possible. Join us at 7 PM on Wednesday, August 2, 2006, in Joel Auditorium. Plan now to attend and bring your spouse or a friend. They are always welcome.

Modern Cryosurgery Now an Option for Primary and Recurrent Prostate Cancer.
Third-generation cryotherapy is a safe alternative to surgery for primary and recurrent prostate cancer, according to a recent study of early outcomes of 51 men treated in the United Kingdom. At a follow-up of nine months, PSA levels fell to less than 0.05 ng/mL in 79 percent of patients who underwent cryotherapy for primary treatment of prostate cancer and in 67 percent of those undergoing salvage therapy after radiation or hormone ablation. Higher Gleason scores prior treatment were associated with poorer outcomes. No patient developed a fistula, often a
common complication of first-generation cryotherapy. Four percent of patients developed urinary retention requiring transurethral prostatectomy and 4 percent had persistent incontinence. Rates of erectile dysfunction were high - 86 percent. The researchers emphasized that patients must be carefully counseled about this possibility. Modern cryotherapy techniques now include transrectal ultrasound guidance, urethra warming catheters and temperature warming probes as well as small gas-based probes. Advantages of cryotherapy include a shorter hospital stay and lower morbidity than radical surgery, thereby allowing its employment for older and less fit patients who seek curative surgery. The researchers agree that longer follow-up is needed to determine the durability of response and the probability of cure. (Source: *BJU Int* 2006; 97:965-974. Via Reuters Health Information, May 31, 2006)

Radiation Therapy and Younger Men.
Common practice for treating younger men diagnosed with early-stage prostate cancer favors more aggressive therapy such as the radical prostatectomy. Many doctors felt that prostate disease in these men was more virulent, requiring aggressive treatment. A study by Konsi, et al., Fox Chase Cancer Center, suggests that younger men receive as much benefit from radiation as do older men. The researchers evaluated the outcomes of 84 men, 55 years old or younger, who were treated with radiation therapy (external beam radiation) for early-stage prostate cancer. These men were then compared with patients between 60 and 69 years old and patients 70 or older. The 5-year overall survival rate for the young group was 94 percent, comparable to the 95 percent rate in the 60-69 year-old group, and the 87 percent rate in the oldest group. Also, the percentage of patients whose cancer spread to other sites was about the same in the three age groups-approximately 3 percent. (Source: *CANCER*, June 15, 2006, via Reuters Health, May 8, 2006)

The Vacuum Pump and Penile Size. Men seeking a permanent increase in penile size are not likely to achieve it using a vacuum pump. In fact, prolonged use of the device risks complications such as numbness and hematoma. Vacuum devices do temporarily increase penis size by causing increased blood flow to the penis; however, it has been uncertain if such devices actually caause a permanent increase in penis size. Hosseini, et al., Tehran University of the Medical Sciences, Iran, recently assessed the long-term effects of vacuum treatment for penile elongation. The study involved 37 sexually active men said to be free from medical conditions that might affect penile length or erec-
tile function. The men used vacuum pumps three times a week for six months. They were instructed to keep it in place for 20 minutes after achieving an erection. The pump was considered to be 11.1 percent effective, defined as an increase in penis length of a least one centimeter. The researchers concluded that the vacuum device does not seem to be a useful method for penile elongation; however, it appeared to

provide a psychological benefit to some men. A spokesman for a vacuum pump manufacturer noted that the vacuum device was not intended for penile elongation, but rather as an aid for men with erectile dysfunction to achieve an erection sufficient for sexual intercourse. (Source: *BJU Int'l* 2006;97:777-778 via Reuters Health Information, April 18, 2006)

Getting Unbiased Treatment Advice. Choosing the best therapy for localized prostate cancer is a complicated task because there is no clear consensus about the optimal treatment strategy. A recent review of the literature indicates that men considering various therapies for their localized prostate cancer may get biased or incomplete advice from physicians and patient-education materials. Ramsey, et al., Fred Hutchinson Cancer Research Center, analyzed 69 peer-reviewed articles regarding the therapy decision-making process published between 1990 and 2004. Watchful waiting, radical prostatectomy, external beam radiation, and brachytherapy were the therapies under consideration. The researchers found that urologists nearly universally recommend surgery as the best therapy, while radiation oncologists do likewise for their specialty. Most patient education materials contain biases toward active treatment, minimizing the role of watchful waiting, and underestimating the likelihood and impact of side effects like incontinence and erectile dysfunction. The researchers say that the patient's treatment decision remains a process of carefully balancing uncertain outcomes. (Source: *MedPage Today*, March 27, 2006, via the National Prostate Cancer Coalition, March 28, 2006)

Improving Erectile Function After Radical Prostatectomy. There is evidence that early pharmacologic intervention after radical prostatectomy (RP) promotes the return of erectile function. A group of 132 men scheduled for RP were informed about the concept of penile rehabilitation after surgery. The group, ranging in age from 49 to 69 years, reported full sexual function prior to the surgery. It included men who then had non-nerve-sparing surgery or nerve-sparing procedures. The 58 men who accepted the rehabilitation option received oral sildenafil on four occasions soon after RP, then continued its use with the goal of obtaining three erections per week for at least 12 months. If they failed to respond to sildenafil, they received penile injection therapy. The other 74 men chose not to have the pharmacologic intervention, but agreed to participate in follow-up assessment of erectile function. Eighteen months after surgery, 52 percent of the rehabilitation group were able to achieve functional erections without medical assistance, compared with 19 percent of the non-rehabilitation group. The study concluded that early pharmacologic intervention soon after radical prostatectomy appears to maximize the return of erectile function. (Source: *Nat Clin Pract Urol* 2006;3(2):72-73 via Medscape, February 2, 2006)

Treating Prostate Cancer in Older Men. Prostate cancer can be a very slow-growing disease, so older men diagnosed with the condition are often considered to be candidates for watchful waiting instead of aggressive therapy. A new study by Wong, et al., Fox Chase Cancer Center, challenges that approach. It found that men over 65 with early prostate cancer live longer when treated than when they forego treatment. The study analyzed the data on more than 48,000 men, aged 65 to 80, who had survived at least one year after being diagnosed with localized prostate cancer. A total of 34,046 men received treatment with surgery or radiation. The remaining 14,560 men were placed under watchful waiting. The men who were treated had a median survival time of 13 years, compared to 10 years for men in the watchful waiting group. The study demonstrated a survival advantage for men choosing treatment compared to those in watchful waiting. (Source: *HealthDay News*, February 27, 2006, via

National Prostate Cancer Coalition, March 7, 2006)

Treating Prostate Cancer in Older Men - A Second Opinion! A new study suggests that men older than 75 years may have adverse consequences due to aggressive treatment of localized prostate cancer, supporting the notion that screening may be of limited benefit in that population. Hoffman, et al., New Mexico VA Health Care System, compared survival and quality-of-life outcomes in men aged 75 to 84 years diagnosed with localized prostate cancer who were treated with aggressive versus conservative approaches. A total of 465 men were studied. Of the participants, 175 had a radical prostatectomy or radiation therapy, and 290 received hormone therapy or no treatment. Medical records and patient surveys were used at diagnosis and after two years of follow-up. Aggressively treated men had significantly lower quality-of-life measures. They were more likely to report daily urinary leakage, other urinary problems, and sexual dysfunction compared to the conservatively treated group. The hazard ratio for death favored aggressive treatment; however, the difference in 5-year disease-related survival was low - only 6 percent (98% versus 92%) - and overall, more than 80 percent of deaths were from other causes. The researchers say the study supports guidelines suggesting that men 75 years and older may not benefit from prostate cancer screening. Furthermore, they say that decisions about aggressive treatment must balance possible increases in life expectancy with the more certain, immediate, and persistent treatment complications that adversely affect quality-of-life. (Source: *Medscape Medical News*, May 2, 2006)

To Screen or Not To Screen? The debate about the pros and cons of screening for prostate cancer remains unsettled. A major issue is whether PSA-based screening detects many malignancies that would never impact the life of an individual or require treatment. A new study by Catalona, et al., Northwestern University, provides more ammunition for the pro-screening medical community. Of 35,661 men in a screening study between 1989 and 2001, a total of 3,568 (10%) were diagnosed with prostate cancer. Radical prostatectomy (RP) was performed on 2,254 of these men. The researchers found that 99.8 percent of the screen-detected tumors were clinically localized. About 70 percent of the cancers treated by RP were subsequently determined to be organ-confined by the postoperative pathologic analysis. More than 90 percent of the cancers identified would have been considered clinically significant. The authors conclude that screen-detected prostate cancers are usually clinically significant, but curable. (Source: *J Urol* 2006: 175:902-906 via Reuters Health Information, March 15, 2006)

Washington State Passes Prostate Cancer Screening Law. Washington State recently passed legislation requiring health insurers and state health plans to cover the cost of prostate cancer screenings ordered by a medical professional. The law is effective in 2007. Only 45.6 percent of men over the age of 50 in Washington have been screened for the disease, the third lowest rate in the nation. Oregon passed similar legislation last year. Twenty-one states still lack required insurance coverage for prostate cancer screening. On the other hand, 49 states have laws requiring insurance coverage for breast cancer screening. (Source: National Prostate Cancer Coalition, March 23, 2006)

Androgen Deprivation Therapy and Comorbidities. Although some direct health effects of androgen deprivation therapy are recognized, e.g., sexual dysfunction, there is another set of less specific, more vague symptoms such as changes in mood and memory, feeling unwell, and fatigue. This latter grouping has been termed “androgen deprivation syndrome.” A new study shows that androgen deprivation syndrome is likely due to the fact that patients are older, sicker and have more advanced disease, rather than the therapy itself.

Shahinian, et al., University of Texas, Galveston, investigated the role of androgen deprivation therapy in causing these symptoms. They assessed the rate of depression, cognitive impairment and constitutional symptoms in 50,476 men with prostate cancer compared to 50,476 men without the disease. Among men who survived for at least five years after diagnosis and who were receiving androgen deprivation therapy, 31.3 percent had at least one diagnosis of depression, cognitive problems or constitutional symptoms. That compared to 23.7 percent of prostate cancer patients who did not get androgen deprivation therapy, and 22.9 percent of the non-cancer cohort. However, after statistical adjustment for age, disease stage and other relevant variables, the differences between the two prostate cancer groups either disappeared or were greatly reduced. After the adjustment, men receiving androgen deprivation therapy were 8 percent more likely to have a depression diagnosis, one percent less likely to have cognitive impairment, and 17 percent more likely to have constitutional symptoms. The researchers concluded that androgen deprivation therapy is probably not playing a major role in causing androgen deprivation syndrome. Accordingly, they say that androgen deprivation therapy should not be avoided for patients for whom it is otherwise indicated based on concerns that the patients will develop androgen deprivation syndrome. (Source: *Archives Intern Med* 2006; 166:465-471, via Urology Today, March 13, 2006)

New Screening Guidelines for Prostate Cancer. The National Comprehensive Cancer Network (NCCN) has released the 2006 version of its professional practice guidelines for Prostate Cancer Early Detection. The NCCN guidelines are a standard for medical practice and generally achieve a high degree of consensus. The NCCN recommends: (1) annual screening starting at age 40 for men with a family history of prostate cancer or men of African American descent; (2) consideration for a biopsy for men with a PSA level lower than 4.0 ng/m/L if the rate of increase in PSA level is greater than or equal to 0.5 in one year. NCCN generally recommends a biopsy for all men with a PSA over 2.5 ng/mL; (3) recommends a TRUS-guided biopsy for all men with an abnormal or positive DRE result, regardless of PSA level; (4) includes a "percent free PSA" as an option for follow-up for men with a PSA between 4-10 ng/mL who may want to avoid biopsy or treatment due to other medical conditions and expected life-span. (Source: Nat'l Prostate Cancer Coalition, May 31, 2006)

The TURP and Erectile Dysfunction. A recent study by Mishriki, et al., Royal Infirmary of Aberdeen, Scotland, indicates that the transurethral resection of the prostate (TURP) does not adversely affect sexual function and that erectile problems often preceded rather than followed the procedure. The study involved 280 patients with lower urinary-tract symptoms (LUTS) who had a TURP. It included a 12-year follow-up period of pre- and postoperative sexual activity. The patients ranged in age from 49-88 years and the mean age was 68 years. There has always been concern that the TURP might cause erectile dysfunction, so the study sought to evaluate the long-term effects of the TURP. The patients and their partners completed periodic questionnaires about their sexual activity during the 12-year follow-up. Noting that 31 percent of patients who were sexually active before TURP were still sexually active after 12 years, the researchers said the common concern that the TURP impairs sexual function is not the case. A commentator on the study observed that the results were encouraging, but noted that orgasmic function was not measured and would likely be impaired after TURP. (Source: AUA 206 Annual Meeting: Abstracts 1514 and 1427, presented May 24, 2006, via Medscape Medical News, May 26, 2006)

Improved Nomogram Predicts Prostate Cancer Recurrence Up to Ten Years. Kattan, et al., at the Cleveland Clinic, report they have upgraded their existing nomogram to accurately predict the 10-year probability of prostate cancer

recurrence after radical prostatectomy (RP). The nomogram uses PSA, clinical stage, primary and secondary Gleason grade, year of surgery, and the number of positive and negative biopsy cores. In addition to the long-range prediction, the model is able to estimate the probability of recurrence at any point in time from one to ten years after RP. This ability to predict risk of early recurrence may be helpful in designing neo-
adjuvant strategies because disease recurrence within 2-3 years after RP is associated with an increased risk of metastasis and cancer-specific mortality. (Source: J Natl Cancer Inst 2006; 98:715-717)

Treatment Information Often Lacking. A recent study says that men with prostate cancer often make emotionally driven treatment decisions influenced by anecdote or misconception rather than consideration of clinical trial evidence. Fear and uncertainty affect initial treatment decisions seeking rapid results without consideration of getting second opinions. Patient decision were also influenced by misunderstanding about disease management options and reliance on the anecdotal evidence provided by other men with prostate cancer, even when the severity of their own disease and available treatment options were significantly different. (Source: *CANCER*: American Cancer Society; August, 2006)

DEVELOPMENTS IN PROSTATE CANCER

Data from the National Prostate Cancer Coalition's annual Men's Health Survey as well as data from the National Cancer Institute and the American Cancer Society show that progress is being made in the fight against prostate cancer, although much remains to be done. Here are selected items from the cited sources:

- Prostate cancer deaths in the U.S. will be 10 percent lower in 2006 than in 2005.
- An estimated 27,350 men will die from prostate cancer in 2006, down from 30,350 in 2005.
- When prostate cancer is detected and treated early, the 15-year survival rate is 77 percent, up from 61 percent in 2005; the 10-year rate is up one percent to 93 percent; the five-year rate is unchanged at virtually 100 percent.
- The United States now ranks 28th worldwide in prostate cancer deaths, having improved from 13th in 2005.
- Uganda, Norway and Sweden have the highest prostate cancer death rates, and China has the lowest.
- Hawaii has the lowest prostate cancer death rate in the nation, and Washington, DC, the highest.
- The federal government spends annually $495 million on prostate cancer research, compared to $850 million for breast cancer.
- More than twice as many states have legislation mandating insurance coverage for breast cancer than for prostate cancer.
- Surgery is the most common treatment choice for prostate cancer, followed by hormone therapy and external beam radiation. Watchful waiting as a treatment strategy declined by 10 percent since 2004.
- Seventy-one percent of men treated for prostate cancer report having erectile dysfunction.
- Only about half of the men over 50 get screened for prostate cancer.
- Prostate cancer mortality rates in the U.S. per 100,000 by race: African American-68.1; Caucasian-27.7; Hispanic-23.0; American and Alaska Native-18.3; Asian American-12.1.

(Cryosurgery - Con't from page 1)

The more I heard, the better I liked it. Cryosurgery for prostate cancer dates back to the 1960s, but back then it was rather primitive and the long term results were not encouraging. It fell from favor for several decades, but was then reintroduced in the early 1990s as the result of much improved technology and techniques. I also liked the idea that cryotherapy can be repeated, if necessary, and that it is a salvage technique after failed radiation therapy.

Dr. Dan, who holds the prestigious chair in urology/oncology chair at UVA, has been performing cryosurgery for the past seven years. Almost tongue in cheek, he said that he didn't have a track record on any patient beyond seven years! By the way, his record during the first seven years has been outstanding. The success rate (free of cancer following surgery) is on the order of 85%, and the incontinence rate is less than 5%. He warned, however, that impotence would likely be a problem although not a certainty. When we left his office I was leaning toward the cryosurgery option, but needed more time for research and to think about it. I guess I was surprised that the available literature, including the internet, is pretty thin. However, there was one internet item that caught my eye. A European study of over 200 cryosurgery patients reported that 95% of them said that if they had to do it all over again, they would select cryotherapy. That was very compelling and convincing to me. Cryosurgery it would be!

So on December 29, 2005, I reported to UVA for the cryosurgery procedure. It's an outpatient process, but it does require general anesthesia. The actual time in the operating room was about two hours, but with the pre-op and post-op activities, it seemed like it took all day. The object of cryotherapy is to freeze the prostate into oblivion. The medium is liquid argon, an inert gas, and the method involves inserting some 14 argon-carrying needles between the scrotum and the rectum, penetrating into the prostate. An instrument called a transrectal sonogram allows the surgeon to see what he is doing. Warm water is pumped through the urethra to keep it from freezing during the process. Mild pain medication was discontinued 12 hours after the operation. The only downside in the immediate aftermath was the necessity to have a suprapubic catheter for the first five weeks. It consisted of a plastic tube connected directly to the bladder exiting the lower abdomen about two inches below the belly button, and emptying into a bag strapped to the thigh. It was inconvenient but painless and posed only minimal limitations on my daily activities. During this time my normal plumbing was inactive. After four weeks I started clamping the catheter tube for three hours at a time and letting my normal plumbing take over. In less than a week the catheter was removed during an office visit by an entirely painless procedure. Since then, my urinary functions have been entirely normal. The doctor says my prostate is like a steel ball – no tissues and no function.

At week seven I had my first post-op PSA reading. It was down from 9.8 to 0.25 and descending. There has been no pain and no incontinence - none. And there is nothing like a dosage of Cialis to overcome erectile dysfunction! The doctor tells me that I am among the very lucky minority in that respect. As is the case with all prostate cancer therapies, I know that I am not out of the woods yet, but based on the results so far, I am very optimistic.

What continues to mystify me, however, is why we hear so little about cryosurgery and why it is not performed more widely. It works for me!

(**Editor's note:** Readers interested in a detailed, technical treatment of cryosurgery should visit a review article by Cooperberg, et al., University of California, San Francisco, dated June 15, 2005, by going to www.emedicine.com/med/topic3539.htm. Also, visit the National Cancer Institute at www.cancer.gov/cancertopics/factsheet/therapy/cryosurgery. Finally, see the first item under "Prostate-Specific Issues" on page 3 of this newsletter.)

NEW MEETING SCHEDULE *
WRAMC Us TOO PROSTATE CANCER SUPPORT GROUP

The WRAMC Us TOO meets 28 times a year. It conducts both quarterly and monthly meetings.

QUARTERLY MEETINGS: These meetings are held on the first Wednesday of February, May, August, and November from 7 PM - 8:30 PM in Joel Auditorium, WRAMC. The quarterly meetings feature a presentation by a medical professional and a Question & Answer period.

MONTHLY MEETINGS: These meetings are held on the second Wednesday of every month. There is a daytime session and an evening session. The daytime session is from 1:30 PM - 3 PM; the evening session is from 6:30 PM - 8 PM.***** Both sessions meet in the conference room, Center for Prostate Disease Research (Ward 56), WRAMC. The monthly sessions feature informal discussions on prostate cancer-related topics of interest to the attendees.

Meetings of WRAMC Us TOO are open to the public and interested persons need not have any military affiliation in order to attend. Spouses and partners are always welcome.

(***** This is a new schedule effective July, 2006. The monthly evening meeting previously held on the second Thursday of every month has been moved to the second Wednesday of every month. In effect, both monthly meetings are now held the same day with daytime and evening sessions.)

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DEALING WITH PROSTATE CANCER - OUR STORIES
Five Prostate Cancer Survivors Relate Their Personal Experiences

(A summary of a panel presentation to the WRAMC Us TOO on May 3, 2006)

RADICAL PROSTATECTOMY
by
Bob Grafton

I am Bob Grafton and I had a radical prostatectomy after I was diagnosed at age 69. My PSA had been rising over the course of five or six years. My rising PSA led me to have two biopsies that were both negative for prostate cancer. Finally, a third biopsy proved positive - five percent of one core. So it was a small amount. But as I learned later from being in the prostate support group, biopsies are hit and miss propositions because the cancer can be spread unevenly throughout the prostate. So I feel I was lucky that it was finally detected. My Gleason score at the time of diagnosis was a 6 and my PSA was 11.

Now what to do? My wife and I met with my urologist, and he explained the situation and the various options available in my case. What I did not realize until then was that I was the one to select among the options! I guess I'm too "old school." My expectation was that the doctor would fully inform me, but he would make the decision as to treatment! Now I had to spend a lot of time learning to ask the right questions, searching the internet websites, and seeking second and third opinions. It was a very intense time for me, although I suppose I should have been happy that I had options! I had the same experience that many men in my support group encountered - the surgeon advised surgery and the radiation oncologist recommended radiation therapy. In fact, when I met with a urologist who was doing a study in watchful waiting, he said I was a candidate for that approach, too!

Yes, indeed, the decision was mine to make and I chose surgery for several reasons. For one thing, I wasn't very comfortable with watching and waiting. An acquaintance of mine had died from prostate cancer that had metastasized to his bones, and I knew I didn't want any part of that. In my mind I saw surgery as the more definitive therapy. Once the excised prostate was analyzed, I would know exactly where I stood regarding the disease. I certainly considered the possible side effects of incontinence and impotence, but all the primary therapies can produce them. Finally, my wife's experience in dealing with breast cancer affected my decision. Her doctors said survival rates in her case were similar whether she chose surgery or did nothing. But she chose surgery and has never looked back. She wanted the definitive therapy, and so did I.

I had a radical prostatectomy in October, 2004. There was a complication in the operation because my prostate was very large - 94 grams - the size of a small orange. I experienced more post-operative pain than I expected, and I was kept an extra day. After I got home and rested, things slowly began to get better. Now 18 months later, my PSA is undetectable. I feel very satisfied that I selected surgery. All indications are that the cancer was removed, although I realize that only time will tell.

I admit that I am left with some of the side effects. The initial incontinence was very severe at the outset, but it is mitigated to the point that it is very tolerable. I travel frequently for both business and pleasure without concern. And yes, erectile dysfunction is an issue, but it is one that my caring wife and I are dealing with very well. One unexpected bonus has been the disappearance (along with my prostate) of the benign prostatic hyperplasia (BPH) that had plagued me for almost fifteen years. I am free from the urinary urgency and frequency that

BPH caused. Overall, I have reasonable peace of mind that the cancer is gone, and my quality of life is acceptable.

BRACHYTHERAPY
by
Jim Cassidy

I have organized my remarks in terms of disease detection, selection of treatment, selection of doctor, the operation and the side effects. First the detection. During the period from 1997 to 2000 my PSA bounced up and down in the range between 1.5 and 2.6. When it jumped to 3.6, my doctor recommended a biopsy and cancer was detected. My Gleason score was 6, and I was staged as a T1c. Now I had to decide on a primary therapy. When I first became "prostate cancer aware," I started following developments in brachytherapy. I was very impressed with the improvement in technology and technique that permitted more precise placement of the radioactive seeds.

Brachytherapy had emerged as a real alternative to surgery and to other forms of radiation therapy. It became my therapy of choice, but I had strong feelings about who should perform the procedure. I preferred a team that had considerable experience, yet was young enough to be employing the latest in technology and technique. Also, I wanted to have a team of two skilled doctors who would be checking on each other, not just one doctor assisted by technicians. The first urologist I visited was not receptive to my concerns and even discouraged second opinions. I got out of there fast! Over time, I had three different consultations at reputable institutions. The team I chose, a radiologist and a urologist, were in their late thirties and early forties. They had excellent references and they were cited in the local *Washingtonian Magazine* as leading physicians in their specialties. If I make only one point with you, it's this - do your own homework and seek second opinions!

Having made my treatment choice and selected my doctors, I was ready to face the brachytherapy procedure. But there was a complication. The shape and size of my prostate required three months of hormonal therapy (Lupron) to shrink the prostate in order to maximize the effectiveness of the procedure. Now let's talk about the effects of the operation. I tolerated it very well and was back on my feet very quickly. But for about two months I had to deal with frequent and urgent urination as well as diarrhea. By the third month, these problems were much, much better. My physician said, "You're doing fabulous." Now it has been over four years since my brachytherapy and my most recent PSA was 0.01, so I feel confident that the cancer has been taken care of. One lingering problem has been constipation. My physician tells me constipation occurs in only about 5% of all cases; diarrhea is the much more common post-operative complaint, but it has not been a problem for me. So I must be very careful of my diet - not only what I eat, but when I eat. At this point, brachytherapy has worked for me, and I have no regrets whatsoever.

Before ending, I'd like to echo the remarks of the previous panelist regarding individual responsibility for your treatment decisions. Simply put, it is YOUR decision. The doctors order and analyze the various tests, present the clinical data to you, and describe the range of treatment options available to you. Then you must decide. So do your homework, seek the best available medical practitioners, make your decision, and don't look back.

DA VINCI ROBOTIC SURGERY
by
Mike Gelb

A funny thing happened to me on the way to the auditorium tonight! I was eating a Subway sandwich and a glob of dressing fell out and landed in my lap. I ducked into the men's room to get it off and in the process left several rather prominent wet spots on my light-colored slacks.

Now I must stand before you to tell you how effective the Da Vinci robotic system is and that I am completely continent, knowing that you won't believe a word I say! Well, you'll just have to take my word for it!

I was first diagnosed just before my 50th birthday. I had no symptoms at all. In fact, the only reason I got checked was that two of my colleagues at work recently had been diagnosed. So I was sensitized to the idea of getting checked regularly. I went to George Washington University Hospital and was seen by a Dr. Michael Manyak. My PSA was normal, but he discovered an irregularity in my prostate during the digital rectal examination. The overall size of the prostate was normal. There were no other symptoms.

We decided a biopsy was in order and it was positive for prostate cancer. My Gleason score was 3+3 or 6. Now there were choices to be made. Given my relatively young age, I felt surgery was the only realistic alternative for me. But I still had choices to make. I had to choose among three kinds of surgery: the conventional radical prostatectomy; the laparoscopic procedure; and the Da Vinci robotic system. Dr. Manyak was a strong advocate of the Da Vinci system, and I myself was intrigued by it from the outset. In the meantime, friends acquainted me with the prostate cancer expertise at Johns Hopkins so I visited there twice. On one occasion, I discussed laparoscopic surgery, but I found the technique comparatively primitive compared to the Da Vinci robotic system. On a second visit, I discussed the virtues of the conventional radical prostatectomy and the Da Vinci system. The Johns Hopkins staff clearly saw the conventional RP as the gold standard for patients like me. No doubt, there is a definite professional rivalry at work here. The Da Vinci system is relatively new, so it lacks the long-term statistics regarding survivability and side effects. In the decision process I also talked to a Dr. Mani Menon, who is sort of the grandfather of the robotic procedure. At any rate, I had the Da Vinci robotic surgery on October 29, 2004, shortly after my 50th birthday. It was performed by Dr. Jason Engel, a colleague of Dr. Manyak, who has considerable experience with the procedure.

The surgery went without any complications. The immediate post-operative experience was uneventful. I had to walk up and down the hall a few times to find my sea legs, so to speak. I do not remember much pain. Having a catheter was bothersome, but tolerable; in any case, that was the worst of it. Before being discharged, I inquired about antibiotics and was told they were unnecessary. I did get a prescription for extra strength Tylenol with codeine. I never bothered to fill it. I was a little tender walking around with the catheter, but it was removed after about four days. I was back to work about a week after the surgery for half-days at first. I was back full time in 10 days or so.

Now for the ultimate outcome. I was 100% continent right from the beginning. I did the Kegel exercises, but I doubt they made much difference. One of my hobbies is weight lifting and I can lift as much as I want and not have any kind of leakage. That is about as good as it gets. So I consider myself completely continent. Regarding erectile dysfunction, I was able to get my first erection within a week of the surgery. They are not the same as they were before, and I need to use one of the "miracle pills," Levitra. But here I am, ready, willing, and able. All I lack is a significant other! As for my PSA, it is still zero a year and a half after surgery. Dr. Engel says I've hit a home run - cancer-free, continent, and potent - a lucky guy!

RADICAL PROSTATECTOMY AND HORMONE THERAPY
by
Bob Faure

After retirement from my two careers - military service and civil service - I was considering returning to the workforce. All the while, I was

under pressure from my better half to get a good physical examination. I resisted until the pressure got less subtle, so I finally followed her "advice." I came through with flying colors, or so I thought, until I got that dreaded call saying "the doctor would like to see you again." So I went back and he said "Your PSA is elevated. I think we should schedule a biopsy." Now I was thinking that I should have listened to my wife much sooner! They took ten core samples - three were 3+3, and one was a 3+4, so in effect, I had a Gleason score of 7. My PSA was 6.7.

I came here to Walter Reed and met Jane Hudak, the patient educator and counselor, who told me more about prostate cancer than I had ever wanted to know! My situation was such that all the primary therapies were available to me. After discussions with Jane and Dr. Judd Moul, it didn't take me long to make up my mind about treatment options. I wanted the cancer out, and soon. That is just my personal style. So I signed up for the radical prostatectomy. I came in here
and Dr. Moul did my surgery. I was up and walking the day of surgery. Soon I was walking all over the hospital. In fact, I was discharged a day earlier than anticipated. My biggest gripe about the entire procedure was enduring the Foley catheter. When I eventually returned to have the catheter removed, the staff could not locate my name on that day's catheter-removal schedule. I told them I didn't care if the janitor did it, but someone was taking it out TODAY! Well, they finally saw things my way!

Now I thought I was all set - the surgery was over and to everyone's surprise, I was continent from the outset. I felt like some sort of poster child for the radical prostatectomy. Then came another call! The post-operative pathology analysis on my prostate showed positive margins and a Gleason score of 8. Now all of a sudden, I'm in the high-risk category. What do we do now? I declined a radiation approach - I just wasn't comfortable with it. Then I learned about a clinical trial involving chemotherapy, Casodex and Zoladex. The trial had two arms - one had patients taking chemotherapy and hormones, and in the other arm patients received hormones only. I was randomized to the hormones-only arm of the trial.

With hormonal therapy, you instantaneously become more sympathetic to your wife's experience in dealing with menopause! Crying jags, hot flashes, all the rest! I was somewhat depressed by the clinical trial arrangements because I wanted to attack the disease with everything I could. At any rate, the trial was a two-year program that I completed last October. I thought everything was going well, when all of a sudden a follow-up PSA test showed .017. A month later it was 0.02 - it's going up! Another PSA test showed it back down to less than or equal to .003. So the bottom line for me is that you really should not panic over every little blip in PSA. When you have a steady increase, then it is time to be concerned.

Side effects. There is a fairly lengthy list of side effects. Sleeplessness for one. Sleeping pills didn't agree with me at all, so I rarely took them. Then there was the weight gain. For more than twenty-five years, I stayed between 198 and 203 pounds, and now I stay between 220 to 228 pounds attributable to the hormones. But wait - it gets worse! I was advised there could be some testicle shrinkage. OK, I could live with that, but I hadn't bargained for the diminished penile size! And that still frustrates me. Hormones also affect libido and that is exactly what happened to me. My libido simply disappeared. The two-year trial is over and it still hasn't returned. Erectile function is back, but I am not optimistic that the prior penile size will return which is disappointing. Talk about watchful waiting!

Now for the positive side. Believe it or not, I've got more hair than I had before. But so much more important on the positive side, I'm still here alive and kicking! Would I do it again? Yes, certainly. If my PSA rises again I will seek some other clinical trial because I don't believe in sitting back and doing nothing. When I wake up each morning I try to look at the positive side of my situation.

TAKING A NEW APPROACH - A VACCINE TRIAL AND EXTERNAL BEAM RADIATION
by
Philip Brach

My diagnosis of prostate cancer came right after Memorial Day, 2001. I had been feeling severe pain in my hands, especially at night so I had difficulty sleeping. I encountered a young man at a career fair who was probably in the fifth grade. He said, "Mister, you are sick." He said he could see it in my eyes! At that point I knew I should see a doctor. So I made an appointment with the intention of getting relief for my hands. The doctor hadn't seen me in more than ten years so he was reluctant to treat my hands without a complete physical examination. The examination included a PSA test. For all I knew then, a PSA was a "public service announcement" and a DRE was the "director of religious education" at church! I soon learned better - my PSA was 14.7! Next came a biopsy showing a T1c cancer and a Gleason score of 8. Like a previous panelist tonight, I fully expected the doctor to select the appropriate therapy and get on with the job. Not so. I learned it was my job to select my treatment! I am an engineer and when I design a bridge, I don't ask the client to decide how big it should be! Well, live and learn! I was soon talking with a radiation oncologist because surgery was ruled out under my circumstances. We were discussing a combined radiation approach - external beam radiation to reduce the size of my prostate followed by brachytherapy. I just happened to blurt out, "Is that all there is? Isn't there anything on the cutting edge? The radiation oncologist was associated with the National Institutes of Health (NIH) and he was aware of a treatment protocol that might be applicable to me. Now I am off to the NIH where I am enrolled in a Phase II clinical study entitled "Combining a Recombinant Cancer Vaccine with Standard Definitive Radiotherapy in Patients with Localized Prostate Cancer." That's me! Lo and behold, I was in a vaccine protocol. Now I had 16 medical professionals working with me. The next ten months involved eight cycles of vaccination (a total of about 80 injections, most of them self-injected). I developed a wonderful relationship with the NIH staff, as dedicated and concerned a group as I could ever hope to meet! I captured my experience with photography. Look at these pictures. I used photography as therapy to compensate for the stress, and to avoid feeling sorry for myself. It works!

Three times during the protocol I would go to visit the "vampires," as I called them. These were the nurses at NIH who performed the required Lukapherses procedure. While I watched TV or a movie, it filters the blood to collect white blood cells. The removed white cells were used for the related experimental research. Then I had conformal three-dimensional external beam radiation midway through the trial. It's been five years now. I am regularly followed at the NIH and I still have an undetectable PSA, not to mention a number of wonderful friends at NIH.

Let me go back to say that at the outset of my treatment, I was placed on hormonal therapy. It was planned for two years, but I had a bizarre reaction that led me to discontinue the hormonal therapy after one year.

The idea behind the entire vaccine protocol is to develop a natural immunity. It doesn't cure me of cancer. But should the prostate cancer recur, as it often does in many men, hopefully I will have developed a natural immunity to resist the cancer better. In retrospect, I am more than satisfied with the choice that I made, even if the results had not turned out as well as they have (so far). I have an undetectable PSA. I lost not one day of work in this entire process. The satisfaction of dealing with cancer in an environment that is filled with hope for all men challenged by prostate cancer is very comforting to me. After all, life is a rollercoaster and this is just one of the loops. You can't change what has happened to yourself, but there is nothing more satisfying then being involved in an adventure that eventually might help someone else.

♦ WRAMC US TOO COUNSELORS ♦ (AS OF JULY 1, 2006)

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

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Gil Cohen	Baltimore, MD	(410) 367-9141	
Richard Dorwaldt	Burke, VA	(703) 455-8657	(Laparoscopic Surgery)
John Fellows	Annandale, VA	(703) 503-4944	
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Harvey Kramer	Silver Spring, MD	(301) 585-8080	(Brachytherapy)
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7 PM

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♦ SPEAKER ♦

JUDD W. MOUL, M.D., F.A.C.S.
Professor and Chief
Division of Urologic Surgery
Duke University Medical Center

♦ TOPIC ♦

"LATEST DEVELOPMENTS IN PROSTATE CANCER RESEARCH AND TREATMENT"