

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

VOLUME 21

NUMBER 3

AUGUST 2012

◆ **WRNMMC PROSTATE CANCER SUPPORT GROUP SCHEDULE** ◆

PROGRAM AT THE WALTER REED NATIONAL MILITARY MEDICAL CENTER, BETHESDA

Monthly Meetings. We meet on the third Thursday of every month in two sessions. The day session is from 1:00-2:00 PM, and the evening session is 6:30-7:30 PM. Both sessions meet in the River Conference Room on the third floor of the America Building, adjacent to the Center for Prostate Disease Research (CPDR). Please join us for open and frank discussion about all aspects of prostate cancer. Your spouses, partners, and friends are always welcome!

Quarterly Meetings. The quarterly meetings have guest speakers on topics of importance to you. We meet on the first Thursday of February, May, August, and November at 7:00 PM in the River Conference Room, third floor of the America Building, adjacent to the Center for Prostate Disease Research (CPDR). This speaker program is available at Fort Belvoir via video teleconference. (See Fort Belvoir program, below).

Parking. Ample parking for the monthly and quarterly meetings is available in the America Garage behind the America Building. **Note:** The America Garage is reserved for patients, persons with appointments and visitors. Occasionally a security guard may inquire if you have an appointment. The answer is **YES**, you do have an appointment at the Center for Prostate Disease Research.

Security. A military ID card is required to enter the installation. Persons without a military ID card should call the CPDR front desk (301-319-2900) no later than noon of the day prior the meeting, so we can notify the Security Office to obtain access for you. Have some form of picture ID readily available (e.g., a driver's license).

PROGRAM AT FORT BELVOIR COMMUNITY HOSPITAL

Monthly Meetings. The Fort Belvoir Support Group meets on the second Thursday of every month in two sessions. The day session is from 11:00 AM-12:00 noon, and the evening session is from 6:30-7:30 PM. Both sessions meet in the Urology Clinic on the second floor in the Sunrise Pavilion. Please join us for open and frank discussion about all aspects of prostate cancer. Your spouses, partners, and friends are always welcome!

Quarterly Meetings. The quarterly guest speaker program at WRNMMC, Bethesda, is available at 7:00 PM via video teleconference on the first Thursday of February, May, August, and November. Go to the Oaks Pavilion Conference Room (first floor, Room 332/333).

Parking. Parking is available in the Meadows Garage near the Sunrise Pavilion or in front of the hospital.

Security. There is no need for prior entry arrangements. Have a picture ID card ready, and advise the security guard that you are attending a program at the Urology Clinic.

◆ **INSIDE THIS ISSUE** ◆

Next Speaker Page 2
Prostate-Specific Issues Page 3

Active Surveillance Page 6
Counselors Listing Page 14

**WRNMMC Us TOO
NEWSLETTER EDITOR**

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

MEDICAL ADVISORY STAFF

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

Jane Hudak, RN, PhD

Ginger Lew-Zampieri, PA-C

Kimberly Peay, RN, NP

BOARD OF DIRECTORS

**Vincent P. McDonald
(President)**

**Raymond Walsh
(Vice President)**

Robert Butterworth

James Collins

Ben Hawley

Jim Padgett

Michael Pausic

Ken Simmons

Edward T. Watling

Don Williford

◆ FROM THE EDITOR'S DESK ◆

If you have been tracking prostate cancer items on the Internet lately, you are likely aware that the latest hot topic is the emergence of Active Surveillance as a significant alternative to the definitive treatments of radical prostatectomy and radiation for newly diagnosed men who are in the low risk category. This is all part and parcel of the prostate cancer screening controversy wherein some studies have shown that screening in many cases results in overtreatment of men who might otherwise not require immediate curative therapy. So our May speaker's remarks are very apropos. See Dr. George K. Philips remarks in this edition of the newsletter.

◆ MAY SPEAKER'S REMARKS ◆

Our May program featured Dr. George K. Philips, a genitourinary cancer expert at the Lombardi Comprehensive Cancer Center, Georgetown University Hospital. Dr. Philips' main interest is in clinical trials with special interest in prostate cancer screening, prevention, and active surveillance. His topic was "The Role of Active Surveillance in Dealing with Prostate Cancer." A summary of his presentation begins on page 6.

◆ MEETING SCHEDULE FOR AUGUST 2, 2012 ◆

Our speaker for Thursday, August 2, 2012, is Nancy Dawson, MD, an internationally-recognized genitourinary cancer expert who is director of clinical research and attending oncologist at the Lombardi Comprehensive Cancer Center, Georgetown University Hospital. Dr. Dawson is a graduate of the Georgetown University School of Medicine, and served as a military physician for 20 years at the Walter Reed Army Medical Center. Following her retirement from the Army, she joined the University of Maryland Greenebaum Cancer Center, where she was professor of medicine and director of the genitourinary medical oncology program. She is board-certified in internal medicine, hematology, and oncology. **DR. DAWSON'S TOPIC IS "DEALING WITH ADVANCED PROSTATE CANCER."** Come join us at 7:00 PM, Thursday, August 2, 2012. Your family members and friends are always welcome.

SEE THE BACK PAGE OF THIS NEWSLETTER FOR IMPORTANT INFORMATION ABOUT THIS MEETING.

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

Prostate Cancer Screening - The Beat Goes On! Screening asymptomatic men for prostate cancer with the prostate-specific antigen (PSA) test is worth doing, according to the American Society of Clinical Oncology (ASCO).

In contrast to the blanket statement issued by the United States Preventive Services Task Force (USPSTF), which did not recommend routine PSA testing for any asymptomatic man, regardless of age, the new guidance issued by ASCO is more nuanced. It concludes that PSA testing can be recommended for asymptomatic men with a life expectancy of more than 10 years, but not less. However, the new guidance stops short of actually recommending PSA testing for asymptomatic men with a life expectancy of more than 10 years. Instead, it recommends that physicians and such men "discuss" whether PSA testing is appropriate. ASCO has published a decision aid to facilitate these discussions.

The ASCO panel of experts and the USPSTF used the same body of evidence — a review carried out the Agency for Healthcare Research and Quality. However, they came to different conclusions. ASCO did agree that for men with a shorter life expectancy, the risk of harms associated with PSA-based screening and subsequent unnecessary treatment likely outweigh the benefits. But for men with a longer life expectancy, ASCO holds that the balance of risks and benefits is less clear, and that well-informed conversations between men and their physicians remain worthwhile about harms, potential benefits, and appropriate management strategies after a diagnosis of prostate cancer.

As a result, the ASCO experts concluded that PSA testing might reduce the risk for death from prostate cancer in men with longer life expectancies. (Source: *J Clin Oncol*. Published online July 16, 2012)

Wait! There's More! Most men with localized prostate cancer, especially those with either

low-risk disease or prostate-specific antigen (PSA) levels lower than 10 ng/mL, should be monitored initially rather than treated with surgery, according to the authors of a major randomized trial. Overall, radical prostatectomy did not significantly reduce either all-cause or prostate-specific cancer mortality when compared with observation among men with localized disease, according to investigators from the Prostate Cancer Intervention Versus Observation Trial (PIVOT).

Specifically, 47.0% of the surgery group died from all causes vs 49.9% of the observation group. In addition, 5.8% of the surgery group died from prostate cancer or treatment vs 8.4% of the observation group. The researchers concluded that men with early-stage prostate cancer treated with observation had similar length of life and deaths from prostate cancer. Accordingly, physicians can now confidently recommend observation as the preferred treatment approach for most of their patients diagnosed with early prostate cancer.

PIVOT subset analysis also indicated that surgery provided no mortality benefit at all in men with early-stage (localized) disease that was low risk. Additional analysis showed that surgery did not provide a significant mortality (all-cause and disease-specific) benefit for men with PSA levels lower than 10 ng/mL.

Some commentators felt that the design of the study was underpowered. The original design called for 2000 men to be randomly assigned to either surgery or observation. Unable to recruit enough patients, the investigators modified the design, which subsequently called for 740 patients, but only enrolled and randomized 731. Nevertheless, the commentators agreed that the PIVOT study combined with Canadian research strongly support the notion that active surveillance should be offered to men with low-risk cancer. (Source: *J Clin Oncol*. 2010;28:126-131).

Urinary and Sexual Dysfunction May Linger.

Dr. Gerald Chodak notes that much has been written about the long-term side effects that men face after surgery or radiation for localized prostate cancer. He cites a recent study by Taylor, et al., in a recent edition of the *Journal of Clinical Oncology* which looked at men who were in the PLCO screening trial. The researchers identified more than 500 men with prostate cancer who underwent treatment and compared them with the same number of men who were not diagnosed with prostate cancer. They conducted follow-up phone calls to these men 5-10 years after their diagnosis and treatment.

The study had several findings: Compared with men without cancer, men who had been treated with surgery or radiation had significantly worse urinary control, sexual function, and bowel function. Of importance, when patients who had surgery were compared with patients who had radiation, urinary and sexual function were significantly worse in the surgery group, and bowel function was significantly worse in the radiation group.

These patients were treated at major medical centers participating in the PLCO trial. So, it might be assumed that across the board, among general urologists in the United States, we would not expect to see better outcomes than those reported in these patients. Furthermore, these may be long-term side effects. When a man has impotence at 1-2 years after treatment, many people have thought that this would improve with time. This study shows that this might not be the case and that the observed side effects are longstanding.

What is the bottom line? Patients who are counseled about the options for treating prostate cancer need to be aware that not only do these side effects occur, but they can last for a very long time. Of greatest importance: Although this was not a randomized study, it demonstrated that sexual and urinary function are significantly worse in men treated with surgery compared with radiation, but bowel function is worse in men who have had radiation therapy. This is information that patients should have. Surgeons are not likely to find these out-

comes desirable or satisfactory, but these are the results of this trial. (Source: Dr. Gerald Chodak via Medscape, July 11, 2012)

Nerve Sparing Boosts Continence After Prostatectomy.

Italian researchers say that a nerve-sparing approach to radical prostatectomy seems to improve the odds of urinary continence afterward. The study wasn't randomized, and so the journal *BJU International* says their evidence is only "level 4." Still, the researchers say that a nerve-sparing approach should always be planned in order to increase the probability of achieving full continence after radical prostatectomy.

Suardi, et al., University Vita-Salute San Raffaele, Milan, noted that although a nerve-sparing approach significantly improves post-operative erectile function, the impact on urinary continence is controversial. Their new conclusions are drawn from 1,249 men who had radical prostatectomy between 2003 and 2010, including 900 who had bilateral nerve-sparing, 49 who had unilateral nerve-sparing, and 300 whose surgeons used a non-nerve-sparing approach. At a mean follow-up of 42.2 months, 933 patients (79.5%) had recovered urinary continence. Overall rates were 76% at one year and 79% at two years.

Stratified by procedure type, one- and two-year rates of urinary continence were 79.5% and 84.0% after bilateral nerve-sparing surgeries; 62.8% and 75.9% after unilateral nerve-sparing; and 44.6% at both points when nerves weren't spared.

After accounting for all variables, men who had bilateral nerve sparing still had a 1.81-fold higher probability of completely recovering urinary continence compared to those who had non-nerve sparing surgery. The researchers concluded that when technically and oncologically feasible, a nerve-sparing radical prostatectomy should be considered. (Source: Reuters Health, July 6, 2012)

Prostate Surgery and Bladder Cancer. New research from Canada suggests that one in 20 men who have their prostate gland removed may need a second surgery for severe loss of

bladder control, new research from Canada suggests. Based on more than 25,000 men who had prostate surgery, the study also found that rates of subsequent surgery for urinary incontinence doubled between five and 15 years after the first operation.

Tam, et al., University of Toronto, concluded that urinary incontinence may be a long-term problem for men many years after their prostate surgery. They say that physicians should be more aware that that bladder issues can persist even 15 years after prostate surgery.

According to the Prostate Cancer Foundation, about a quarter of men report frequent leakage or no bladder control and the need to use absorbent pads at six months after prostatectomy. But by three years, fewer than 10 percent report using pads at all. However, the new study's finding that the long-term likelihood of having a surgical procedure to treat incontinence went up with the passage of time suggests that bladder issues persist.

The researchers tracked hospital and cancer data for 25,346 men who underwent radical prostatectomy between 1993 and 2006. Overall, nearly five percent of these men had follow-up operations for bladder issues. If the prostatectomy was done after age 60, a man's risk of needing a subsequent surgery for incontinence doubled.

Among the 15 percent of study subjects who needed radiation treatment after prostate removal, chances of needing incontinence surgery were 50 percent greater than those who didn't get radiation.

The experience level of the surgeon who performed the original prostatectomy also influenced a man's chances of needing bladder surgery. Men whose surgeons did more than 48 prostatectomies a year were half as likely to need incontinence surgery than men whose surgeons did a lower volume.

The researchers note that there are large costs associated with dealing with incontinence after radical prostatectomy. These include the cost of daily pads, drug therapy and, if needed, major

surgery performed under general anesthesia to insert a prosthetic device and the implant alone costs 8,000 Canadian dollars. (Source: *J of Urol*, online June 15, 2012, via Reuters Health)

Intermittent Androgen-Deprivation Therapy.

Many men take a break from hormone therapy - - aka androgen-deprivation therapy or ADT -- to lessen its often debilitating side effects. But preliminary research shows that taking a break from hormone therapy can shorten the lives of some men with metastatic prostate cancer

ADT is a first line of treatment for metastatic disease, but because hormone therapy blocks male hormones, it can lead to loss of sexual function, severe hot flashes, osteoporosis and heart problems.

In a new study of more than 1,500 men tracked for nearly a decade, patients with minimal cancer spread given continuous ADT lived an average of about two years longer than those given intermittent ADT. Maha et al., University of Michigan Comprehensive Cancer Center, Ann Arbor, say that interrupted ADT should no longer be recommended as an initial treatment-continuous therapy continues to be the standard of care.

Men with minimal disease spread on continuous therapy lived an average of about seven years vs. five years for those treated intermittently -- a striking two-year difference. Among men with more extensive disease spread, the gap in survival narrowed: about four-and-a-half years for continuous therapy vs. five years for intermittent treatment.

Previous smaller studies suggested that intermittent hormonal therapy -- stopping and restarting treatment periodically -- was as effective as continuous therapy, but with a lower risk of these side effects, said one commentator. So interrupted ADT became widely used in the U.S. But this study for the first time indicates there may be a price to pay. Men need to ask themselves if they are willing to trade hot flashes for two years of their lives. (Source: WebMD Health News, June 4, 2012)

"Active Surveillance for Prostate Cancer"

by
George K. Philips, MBBS, MD, MPH, FACP

(Summary of a presentation to the WRNMMC Prostate Cancer Support Group on May 31, 2012)

INTRODUCTION

I am a medical oncologist by training. This specialty cares for patients with advanced cancer that has spread to other organs and it is typically incurable. We do not wield lasers, surgical instruments, radiation beams, or the like! What we do wield are prescription pads, pills, and injections and procedures such as chemotherapy and hormonal therapy for patients with incurable disease in the hope of maintaining quality of life and extending life itself by months or years. We don't work miracles, either, but there has been progress in some areas in the last few years.

So you may ask why would a medical oncologist be interested in something like active surveillance. I note that many of you are aware of the heightened interest in active surveillance among medical professionals and laymen alike. It has been discussed often of late, and not only in professional journals or conferences, but also the popular press. It is no longer a concept that rests solely in the urologist's province, but it is also gaining acceptance among other medical specialties. Similarly, active surveillance is a regular topic within prostate cancer support groups. Hence my presence here tonight!

I became interested in active surveillance for several reasons: a recent NIH conference; my involvement with the active surveillance program at Johns Hopkins; my interest in active surveillance stemming from the controversy surrounding screening for prostate cancer; and my involvement in a prostate cancer consortium here in DC.

ACTIVE SURVEILLANCE AND SCREENING

Active surveillance has a special role to play in addressing the screening controversy. The central issue is that screening may result in the over-diagnosis of prostate cancer and the sub-

sequent overtreatment. Whenever prostate cancer is diagnosed there is a tendency to resort to treatment about 90 percent of the time. Active surveillance helps to break that "automatic" link between diagnosis and treatment with its attendant anxieties, potential side effects, and complications. Resort to active surveillance in carefully selected men may help to reduce the potential harm associated with prostate cancer screening.

The Journal of the American Medical Association reported earlier this year on the recent NIH Active Surveillance Conference where some participants made interesting comments. A conference panel chairperson suggested that providers avoid the word "cancer" when talking to patients about their low grade, localized prostate cancer. Doing so may convince more men – at least 100,000 each year – to consider delaying immediate treatment in favor of active surveillance. Consider this analogy - if a provider told a patient that he had skin cancer, the patient's reaction would likely be less extreme than that of a patient who received a diagnosis of prostate cancer. Skin cancer doesn't convey the same fear and dread that prostate cancer does. Similarly, a renowned urologist has coined the term "IDLE" (Indolent Lesions of Epithelial Origin) in an attempt to soften the blow of a prostate cancer diagnosis and thereby limit an overreaction to it. Another conference participant suggested that primary care physicians in particular could set the stage for active surveillance as an alternative to curative treatment by explaining the ramifications of being screened in the absence of symptoms. This latter approach would sensitize the patient to the fact there is an alternative to seeking immediate definitive therapy after the patient receives a prostate cancer diagnosis which typically is delivered by a radiation oncologist or a urologist.

ACTIVE SURVEILLANCE VERSUS WATCHFUL WAITING

Watchful waiting was the term used in the past to describe a treatment alternative beyond the more aggressive therapies of radiation and surgery. But there is still confusion regarding the difference between watchful waiting and active surveillance even among those in the medical profession. Otherwise well-informed patients often make their treatment decisions more from a "gut feeling" even when they are intellectually aware of the full range of available therapies (including active surveillance). Another person, a urologist no less, said the whole idea of cancer evokes an emotional "combat" mentality, i.e., the cancer becomes the enemy that must be "fought" every step of the way! So active surveillance is unlikely to appeal to a man who responds with a combat mentality, no matter his education or status. On the other hand, I encountered an African American man in his fifties with intermediate risk prostate cancer. Most treating physicians would recommend that such a patient opt for definitive treatment by radiation or surgery. But for him, quality of life considerations, especially sexual potency, were paramount. He did not want treatment even though he knew he would be stressed about his decision in favor of active surveillance. He made his decision without having done any analysis of his health risk. So different types of men often make different treatment decisions even in the same framework of what that choice might mean.

Now a question for you! How confident are you that you clearly understand the differences between watchful waiting and active surveillance? I see that some of you are not so sure! Well, you are not alone because many physicians find it difficult to distinguish between the two. So I will provide you with the definitions for these two processes drawn from the NCI conference I cited earlier. And I will admit that I myself find these definitions inadequate in some respects. Let me say at the outset that watchful waiting has gotten a bad name, that it means doing nothing; and some see active surveillance as somewhat fuzzy, but something like watchful waiting, because you are still doing nothing!

Active surveillance is defined as a disease management strategy that delays curative treatment until it is warranted based on defined indicators of disease progression. That is the

technical medical definition. In contrast, watchful waiting is a disease management strategy that foregoes curative treatment and initiates intervention only when symptoms arise.

Now does that help at all? The problem I have with these definitions is that they don't really get to the heart of the issue. The key to understanding the principle objective of these two strategies is provided by answering these questions: Is the objective to delay treatment or avoid treatment?; is the intent of the strategy curative or palliative?; is the motivation to preserve quality of life? Here is the essential difference between active surveillance and watchful waiting. With active surveillance the overall objective is to cure, but curative treatment is delayed and the disease closely monitored so that timely curative treatment can commence in the event that the disease worsens. In the meantime, the patient preserves his quality of life (e.g., sexual activity and urinary continence) free of the side effects associated with treatment, and it may be possible to avoid treatment altogether.

This slide depicts an experience with active surveillance. The patients who deferred treatment were categorized by prostate cancer risk (low, intermediate or high). You can see that at five years, that about 40 percent of low risk group had gotten treatment. By about ten years, 50-60 percent had resorted to therapy; and by 15-20 years 60 percent had gotten treated. What happened to the other forty percent? They may have died of other causes or the cancer may not have progressed to the extent that aggressive therapy was required. This outcome demonstrates that you can defer treatment for many patients, and for some patients the deferral avoids treatment and the associated side effects altogether.

ACTIVE SURVEILLANCE PROTOCOL

What does a general active surveillance protocol look like? Typically, the protocol starts with the original or baseline diagnosis of localized prostate cancer that could run a course of 15 to 20 years. The patient is closely followed based on such criteria as PSA velocity (PSA doubling time) and subsequent biopsy results. Typically, there would be periodic repeat biopsies, perhaps every two or three years, to de-

tect any changes in gleason scores and the extent of the disease. Concomitantly, there would be regular, periodic PSA tests, perhaps monthly or every six months at the latest, and of course, a digital rectal examination. Curative treatment would commence in the event of significant, predetermined changes in those criteria. Not to be overlooked is the patient's preference during the course of the protocol. He may reconsider his decision to participate in active surveillance, perhaps due to anxiety about missing a chance to be cured now.

THE SCREENING ISSUE

Back to screening. This slide shows global autopsy prevalence rates, i.e., the percentage of men by age who will be found to have prostate cancer at autopsy. For example, a white male between ages 61-70 has a 65 per cent chance of getting prostate cancer. Yet only 3 percent of all men die of prostate cancer. The problem with screening is that it detects disease in many men who are in the low risk category. Prostate cancer is widely prevalent, but we have not been able to distinguish the extent of the disease that really matters, i.e., the prostate cancer that is going to cause death in 3 percent of all men. So active surveillance is a way of looking at the behavior of prostate cancer over time to separate "must treat" disease from the "need not treat."

The face of prostate cancer has changed dramatically in the last thirty years or so. In 1989, about 37% of newly diagnosed men were in the high risk category; 34% in the intermediate risk category; and 30% in the low risk category. By 2002, the high risk category fell to 16%; the intermediate category was stable at about 39%; and the low risk category rose to almost 47% (it is currently about 60%). This remarkable shift to earlier detection has been attributed to the advent of aggressive screening in the United States. But this same phenomenon led to concern about over-diagnosis and overtreatment. This large low risk category is exactly the disease stage where there is uncertainty that immediate treatment makes a significant difference. We have good studies showing that for high risk prostate cancer, radiation, surgery and hormones in some combination, make a difference in survival. And for intermediate risk, we have good studies for radiation making a dif-

ference. For low risk, it's another story. Results of randomized PSA-based screening studies failed to show a major benefit from definitive therapy for low-risk prostate cancer, and there was also an absence of strong, reliable prognostic markers for low-risk disease. Then there are the quality of life issues associated with aggressive, curative therapy. These are the main reasons for the increased interest in an active surveillance option.

(As an aside, there is no consensus about whether one treatment is better than another for low risk, intermediate risk or even high risk prostate cancer. In previous position, I met with surgeons and radiation oncologists in the same room and at the same time for patients with all varieties of clinically localized prostate cancer. I never once heard any of them say that "in this case, my treatment is more effective than yours." Never heard that. But outside the room, it was a different story!)

ACTIVE SURVEILLANCE RESEARCH

There are six or seven major studies of active surveillance ongoing around the world. I want to avoid the technical details, but the majority of them had the same entry criteria for patients: gleason 6 or less and PSA less than 10. One exception is England where the study accepted patients with a gleason score of 3 plus 4 or less and patients with a PSA up to 15. Johns Hopkins has the most restrictive eligibility criteria; of patients who would have gone to radical prostatectomy at Hopkins, only four percent of them would have been eligible to be on active surveillance. This suggests an institutional preference for radical prostatectomy.

There are approximately 3,000 to 4,000 patients worldwide who have been involved in active surveillance studies for ten years or more. Researchers are finding overall that persons on an active surveillance protocol for over ten years have roughly a one or two percent chance of dying from prostate cancer, which is no different from the chance of dying from prostate cancer if you had immediate surgery or immediate radiation. You should remember that the several treatments for prostate cancer (e.g., radical prostatectomy, external beam radiation, brachytherapy) have never been compared for efficacy in any head-to-head, randomized manner. Some say that active surveil-

lance should be subject to the same rigorous analysis after 10, 15, or 20 years. At any rate, as I just noted, research to date shows that after 10 years the chance of dying from prostate cancer is the same (one or two percent after ten years) for active surveillance as it is for curative therapy.

THE DIGITAL RECTAL EXAMINATION AND ACTIVE SURVEILLANCE

I was asked earlier about the role of the digital rectal examination (DRE) when considering active surveillance. You may think that detecting a nodule (or not detecting one) is an important consideration in the active surveillance decision. But if you think the PSA test has its limitations, the DRE is even worse! There is often disagreement among doctors, even among urologists who are more adept at the task, as to what is a normal or abnormal DRE. After all, you can "score" a prostate biopsy and a PSA test, but the DRE is a personal judgment. Remember, the doctor actually feels only a relatively small area of the prostate. So we cannot rely on the DRE. It is even worse than relying on the "blind" biopsy.

But technology is helping to improve the biopsy procedure. This slide shows a magnetic resonance imaging (MRI) of the prostate. There new technology is called a functional MRI that allows the radiologist to add value to the image to detect which areas are likely cancerous. It makes it possible to actually pick out areas and have them colored automatically. So the biopsy needle is more likely to target areas where the cancer is located, thereby providing a more accurate evaluation.

CONCLUSIONS

a. Active surveillance as an alternative to immediate curative therapy is achieving greater awareness and acceptance within the primary care community because it is increasingly supported by expert consensus and the development of reasonable guidelines for participation.

b. Eligibility standards, diagnostic triggers and monitoring schedules are evolving. Who should be recommended for active surveillance? At what point would the physician recommend a change from active surveillance to curative

therapy? Different medical centers have different protocols for active surveillance and we need more uniformly accepted definitions. But there is an evolutionary movement in these directions.

c. Active surveillance is gaining credence as a curative strategy distinct from watchful waiting.

d. Additional psychological, economic, quality of life, and long term outcome data are gaining support for active surveillance.

e. New technologic advances and interventions will lend additional sophistication to active surveillance concepts and implementation. The MRI procedure I showed earlier is a good example of technological improvement.

f. There are several "Right Patients" and "Right Approaches" for active surveillance as there are for other prostate cancer treatments. At the moment there is no absolute "right patient" for active surveillance, nor is there a single "right approach." But there are generally accepted concepts about who should be enrolled in active surveillance and how they should be followed while enrolled.

ISSUES FOR THE FUTURE

As we gain confidence in active surveillance as a viable alternative to immediate curative therapy, there are issues for future consideration. They include: potential for expanded eligibility criteria; biomarkers and imaging; focal therapy; the role of 5 alpha reductase inhibitors; and minimal-risk interventions such as diet, lifestyle, and psychosocial factors.

CLOSING COMMENT

Finally, you may have seen a recent copy of the Washington Post that had an interesting article about the Genitourinary Multidisciplinary DC Regional Oncology Project which permits the strained but clever acronym "Gumdrop! Among others, it pictured Dr. Nancy Dawson, familiar to many of you from her long prior service at Walter Reed Army Medical Center. I started this group last year. It consists of seven regional institutions including the National Cancer Institute, Walter Reed, Howard University, Washington Hospital Center, Uni-

versity of Maryland, Johns Hopkins, organizations in Fairfax, and private practice groups. We meet every quarter to discuss clinical trials (prostate cancer and kidney cancer) of interest to us and otherwise share and exchange pertinent information. Patients benefit from the exchange because their physicians learn about helpful clinical trials involving local institutions that may be suitable for their participation. The consortium also allows a pleasant professional and social relationship to develop.

I have enjoyed being with you tonight. Now I will take your questions.

Q & A

Question: How are they defining low, intermediate, and high risk?

Answer: In general, high risk is gleason 8, 9 10; intermediate risk is typically gleason 7; and low risk is gleason 6 or less. Regarding PSA, typically low risk is a PSA less than 10; intermediate risk is PSA 10-20; and high risk PSA is greater than 20.

Question: What about active surveillance for intermediate risk?

Answer: The University of California at San Francisco (UCSF) is at the forefront in offering active surveillance to men designated as intermediate risk. There may be a special situation here. The USFC protocol is essentially for patients with classic low-risk disease, but the intermediate-risk candidates are the type who just walk in the door and say, "Doc, put me on your active surveillance protocol. I want active surveillance and I made that decision for myself and I understand the risk fully." They tend to be highly educated men who have done their homework and know what they want. It's akin to the "old days" when that "combat type" I mentioned earlier would show up saying, "Get it out of my body; sign me up for a radical prostatectomy now! At the moment, few, if any conventional urologists would offer active surveillance to intermediate risk patients, but USCF does and its experience bears watching. Otherwise, some other preliminary evidence is that at four or five years, even intermediate risk patients may safely be on active surveillance, but this is not widely accepted.

Question: If I am in the intermediate risk category, is it fair to say that I should be signing up for curative therapy as opposed to considering active surveillance?

Answer: Yes, that is a fair statement. The preferred treatment options for men with intermediate risk prostate cancer are radical prostatectomy, radiation therapy, or combined radiation and hormonal therapy. I don't want to push active surveillance for intermediate risk men. That's jumping the gun when we have 10 to 15 years of solid evidence that surgery and radiation are the best treatment options for them.

Question: So it seems that there is no rush to make the decision for participation in active surveillance, or any other treatment decision, for that matter.

Answer: Absolutely. When I see patients for a second opinion, they think they have to make the decision yesterday! They often are already on schedule for some type of treatment. I let them know that it is okay to take time, even several months, to make a such decisions because it is better to spend adequate time evaluating alternatives instead of having a knee jerk reaction to the diagnosis of prostate cancer. If you are considering being on an active surveillance protocol for years, then what is the problem with waiting a few weeks or more to think it through?

Question: With all this talk about screening, I'm concerned about the usefulness of the PSA test. I'm aware of an instance wherein a man with declining PSA scores was found to have extensive metastasis.

Answer: The PSA is not that great a marker, but the situation you describe is very rare. Discovery of metastasis in men with otherwise declining PSA values means that their prostates are just not making PSA anymore. I have observed patients with widespread, fatal metastases whose PSA was close to zero. But in general, if a PSA is rising consecutively it means that the cancer is advancing at some pace, and if the PSA is coming down, it likely means that the cancer is responding to treatment.

Question: Speaking of incontinence, what degree of incontinence would deter a man from seeking definitive treatment? For example, if 70 percent of prostatectomy cases result in incontinence, it may make a person prefer to defer surgery, but if the incontinence rate was 10 percent or less, then more men may be more willing to take that risk.

Answer: General estimates of incontinence after radical prostatectomy can range from 10 percent to 90 percent. The question is why. Perhaps the cancer was more locally advanced requiring more extensive surgery. The more the extensive cancer, the more extensive the surgery, the more likely is incontinence. Some patients may be preoperatively incontinent to some degree and the surgery will likely exacerbate their condition. Much depends on the pa-

tient population. Finally, the definition of incontinence varies among urologists and one or two pads a day may be "continence" for the surgeon, but "severe incontinence" for his patient! Research has shown that surgeons report significantly lower rates of urinary continence than do patients. What I just said about incontinence also largely applies to erectile dysfunction. By the way, the disconnect between physician and patient reporting of outcomes and side effects has led to a new field called patient outcome reporting. It discounts the physician's description of what he thinks the patient told him. Instead, the patient independently and anonymously reports his situation which likely results in a more honest and complete account. There are a variety of surveys that are being used for this purpose. **(END)**

A STATEMENT BY ZERO - THE PROJECT TO END PROSTATE CANCER - REGARDING PSA TESTING

May 2, 2012 Washington, DC - The United States Preventive Services Task Force has issued its final recommendation for early detection of prostate cancer, effectively eliminating the PSA test and leaving American men without a defense in the fight against prostate cancer. "We are greatly disappointed by the decision to give the PSA test a "D" rating by United States Preventive Services Task Force," said Skip Lockwood, CEO of ZERO – The Project to End Prostate Cancer. "We believe that the decision, which eliminates men's access to potentially lifesaving information provided by a PSA test, should not be made by a government panel that doesn't include a medical oncologist or urologist."

The USPSTF rated PSA testing "D," saying there is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. This decision contradicts prostate cancer testing recommendations from medical and professional organizations, including the National Comprehensive Cancer Network and American Urological Association. Since the decision by the USPSTF in 2009 to change prostate cancer testing recommendations for men over the age of 75, no new research has been cited that would call for a drastic change in prostate cancer testing recommendations for all men.

Recent research confirms that the PSA test saves lives. The results of the Göteborg Randomized Population-based Prostate Cancer Screening Trial, released in July 2010, showed a 44 percent decline in prostate cancer deaths as a result of PSA testing. In this Swedish study, partially funded by the National Cancer Institute, an analysis of some 20,000 men was conducted during a 14-year period.

The PSA test and advances in treatment have led to a 40 percent reduction in prostate cancer deaths since the mid-1990s, and 90 percent of all prostate cancers are now discovered before they spread outside the gland. The five-year survival rate is nearly 100 percent when prostate cancer is detected early, while the tumor is still localized and hasn't spread. The decision on how best to test and treat for prostate cancer must be made between a man and his doctor and ZERO encourages men to continue to educate themselves and be active participants in their health care. In the absence of an improved test for the disease, ZERO believes that all men, especially those with risk factors, need to consider testing for prostate cancer in order to have the most information possible and make the best health decisions.

◆ WRAMC US TOO COUNSELORS ◆
(As of July 31, 2012)

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

SURGERY

Tom Assenmacher	Kinsvale, VA	(804) 472-3853	
Jack Beaver	Falls Church, VA	(703) 533-0274	
Gil Cohen	Baltimore, MD	(410) 367-9141	
Richard Dorwaldt	San Antonio, TX	(210) 310-3250	(Robotic Surgery)
Michael Gelb	Hyattsville, MD	(240) 475-2825	(Robotic Surgery)
Robert Gerard	Carlisle, PA	(717) 243-3331	
Ray Glass	Rockville, MD	(301) 460-4208	
Monroe Hatch	Clifton, VA	(703) 323-1038	
Tom Hansen	Bellevue, WA	(425) 883-4808	(Robotic Surgery)
Bill Johnston	Berryville, VA	(540) 955-4169	
Dennis Kern	San Francisco, CA	(415) 876-0524	
Steve Laabs	Fayetteville, PA	(717) 352-8028	(Laparoscopic Surgery)
Don McFadyen	Pinehurst, NC	(910) 235-4633	
Sergio Nino	Dale City, VA	(703) 590-7452	
George Savitske	Alexandria, VA	(703) 671-5469	
Artie Shelton, MD	Olney, MD	(301) 523-4312	
Jay Tisserand	Carlisle, PA	(717) 243-3950	
Don Williford	Laurel, MD	(301) 317-6212	

PROSTATE CANCER AND SEXUAL FUNCTION

James Padgett	Silver Spring, MD	(301) 622-0869	
---------------	-------------------	----------------	--

RADIATION

Leroy Beime	Glen Burnie, MD	(410) 761-4476	(External Beam Radiation)
Bob Bubel	Grand Junction, CO	(970) 263-4974	(Proton Beam Radiation)
Harvey Kramer	Silver Spring, MD	(301) 585-8080	(Brachytherapy)
Bill Melton	Rockville, MD	(301) 460-4677	(External Beam Radiation)
Joseph Rosenberg	Kensington, MD	(301) 495-9821	(Brachytherapy)
Oliver E. Vroom	Crofton, MD	(410) 721-2728	(Proton Beam Radiation)
John Waller	Yorktown, VA	(757) 865-8732	(Brachytherapy)
Barry Walrath	McLean, VA	(703) 442-9577	(Brachytherapy)

INCONTINENCE

Ray Walsh	Annandale, VA	(703) 425-1474	
-----------	---------------	----------------	--

HORMONAL

"Mac" Showers	Arlington, VA	(703) 524-4857	
---------------	---------------	----------------	--

WATCHFUL WAITING

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

SPOUSE SUPPORT

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

OTHER THERAPIES/MULTIPLE THERAPIES

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

◆ MEETING ANNOUNCEMENT ◆

THURSDAY, AUGUST 2, 2012
7 PM

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

◆ SPEAKER ◆

NANCY DAWSON MD

DIRECTOR OF CLINICAL RESEARCH AND ATTENDING ONCOLOGIST
LOMBARDI COMPREHENSIVE CANCER CENTER, GEORGETOWN UNIVERSITY
HOSPITAL.

◆ TOPIC ◆

"DEALING WITH ADVANCED PROSTATE CANCER"

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

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

Security: A military ID is required to get on base. Persons without a military-related ID card who are attending the meeting are required to register in advance in order to gain entry. To register, contact the CPDR front desk at 301-319-2900 **no later than noon on Wednesday, August 1 to arrange for entry.** Have a photo ID card ready when arriving at the gate.