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

VOLUME 23 **NUMBER 3** **AUGUST 2014**

♦ SUPPORTING Us TOO INTERNATIONAL ♦

You know the statistics! Each month more than 2,400 men will die from prostate cancer, and another 230,000 men will be diagnosed with the disease this year. The effective diagnosis and potential treatment of prostate cancer requires a series of informed decisions that are specific to each man--from when to begin testing for the disease, to treatment options and the potential impact of side effects on the man and his family, as well as his overall quality of life.

US TOO is a non-profit organization under Section 501(c)3 of the Internal Revenue Code with a network of 325 support groups and chapters throughout the United States and in numerous cities worldwide. For nearly 25 years, US TOO International and its chapters have empowered the prostate cancer community with hope by providing opportunities to gain the knowledge necessary to take control of managing the disease. It does this by serving as a resource for peer-to-peer prostate cancer support and for educational materials to help men and caregivers make informed decisions about prostate cancer detection, treatment options and related side effects. It also pursues effective advocacy and awareness initiatives. I urge you to visit the Us TOO web site at www.ustoo.org to learn about the extent of US TOO programs and activities that make it the premier organization within the greater prostate cancer community.

Us TOO International renders its services without charge, relying on contributions from both corporations and individuals to sustain its operation. Previous financial support from the pharmaceutical industry has decreased while the need for Us TOO services and programs has increased. Our Walter Reed Prostate Cancer Support Group has been an Us TOO chapter for almost 19 years, so we understand and appreciate the leadership role that Us TOO has provided within the prostate cancer community. Now it needs our financial support to sustain its essential purpose. To that end, I ask that you consider a tax-deductible gift to Us TOO. Visit pages 3 and 4 to see how you can help.

Jim Thompson
President
WRNMMC Prostate Cancer Support Group

♦ *INSIDE THIS ISSUE* ♦

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♦ FROM THE EDITOR ♦

Our support group is a chapter of Us TOO, International, the largest prostate cancer education and advocacy organization. Have you visited the Us TOO website yet? Go there at www.ustoo.org to see the extent of the Us TOO programs that benefit the prostate cancer community nationwide**. Then go to pages 3 and 4 to lend your support to help continue the Us TOO mission.**

♦ SPEAKER'S REMARKS - MAY 29, 2014 ♦

Our program featured a joint presentation by Dr. James R. David, a board certified psychotherapist now in private practice, and Dr. Peter Fagan, Associate Professor of Medical Psychology in the Department of Psychiatry and Behavior Sciences, The Johns Hopkins University School of Medicine. Their topic was: "Life with Cancer: Practical Tools for Living with Uncertainty." A summary of their presentations begins on page 16.

♦ MEETING SCHEDULE FOR AUGUST 7, 2014 ♦

Our quarterly Guest Speaker Program for Thursday, August 7, 2014, has a topic that should have wide appeal. **The topic is "Recent Advancements in Prostate Cancer Detection, Prognosis and Therapy."** The speaker is Dr. Albert Dobi, Associate Director, Basic Science Program, at our Center for Prostate Disease Research and Assistant Professor of Surgery, Uniformed Services University of the Health Sciences.

Join us at 7 PM, Thursday, August 7, 2014. Your family members and friends are always welcome. There is no charge and no registration is required. (The presentation also may be viewed via video teleconference at the Fort Belvoir Community Hospital. Go to the Oaks Pavilion, 1st floor, Room 332 to participate.)

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

♦ HELP Us TOO TO HELP THOSE BATTLING PROSTATE CANCER ♦

Since 1990 Us TOO International chapters and support groups have facilitated survivors sharing valuable information and advice with each other; and the nonprofit has developed and distributed free resources, comprehensive information for prostate cancer, as well as advocacy and awareness initiatives.

The effective diagnosis and potential treatment of prostate cancer require a series of informed decisions that are specific to each man—from when to begin testing for the disease, to choices about active surveillance, treatment options and the potential impact of side effects on a man and his spouse or partner, and his overall quality of life.

For nearly 25 years, Us TOO has empowered the prostate cancer community with hope by providing opportunities to gain the knowledge that's necessary to take control of managing the disease.

Providing resources for informed choices requires funding. Previous financial support for Us TOO from the pharmaceutical industry has decreased while the need for our services in the prostate cancer community has increased.

Although Us TOO operated at a deficit last year, we're committed to the continuation of our mission of providing prostate cancer support, education and advocacy. **But we need your help—now more than ever.**

Please print and use the **Donation Form on page 4** to make a contribution that will sustain us in our mission of education and support to the prostate cancer community.

On behalf of the board, staff and volunteers at Us TOO International, those we have helped in their battle with prostate cancer, and those we will help -- Thank You!

My best to you all,

Thomas Kirk
President & CEO

US TOO DONATION FORM

**(Mail to: Us Too International Prostate Cancer Education & Support Network
2720 S. River Road, Suite 112, Des Plaines, Il 60018-4106)**

CONTRIBUTION DATE: _____/_____ /_____

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METHOD OF PAYMENT: ( ) Check or Money Order (payable to Us TOO International)

( ) Master Card ( ) VISA ( ) American Express ( ) Discover

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Expiration Date _____

CW Code (3 digits on back of card; 4 for AMEX) _____

We recognize contributions in our annual report. ( ) Check here to remain anonymous

Are you affiliated with an Us TOO chapter or support group? If so, please indicate the name of the chapter or support group: _____

Signature: _____

PROSTATE-SPECIFIC ISSUES

Six Months Hormone Therapy Plus Radiation Therapy Improves Prostate Cancer Survival. A pill that blocks male hormone activity can improve survival and delay the need for chemotherapy in men with advanced prostate cancer, a new clinical trial has found. The trial involved more than 1,700 men located across the globe. Researchers randomly assigned 872 to receive enzalutamide, and the other 845 to take a placebo. Men who took a daily dose of the drug enzalutamide started chemotherapy nearly a year and a half later than men who received a placebo, even though their prostate cancer had spread to other parts of their bodies, researchers said.

The oral drug also improved survival by nearly a third compared with placebo. The benefits of enzalutamide were so great that the independent committee overseeing the clinical trial ended it early so the men receiving placebo could be offered the drug, Beer said.

Enzalutamide blocks the ability of male hormones, also called androgens, to bind with prostate cancer cells and fuel their growth. The drug is already approved by the U.S. Food and Drug Administration for prostate cancer patients who have had chemotherapy, based on its ability to prolong their survival. Researchers decided to see if enzalutamide could help men prior to chemotherapy, since it is an easy-to-take pill with fewer side effects than standard chemo. One year into the study, two-thirds of enzalutamide patients showed no progression in their prostate cancer, compared with just 14 percent of patients in the placebo group.

Overall, the pill reduced the risk of death by 29 percent, researchers reported. Seventy- two percent of patients in the enzalutamide group were alive when the trial was halted. In the placebo group, 63 percent were alive at the end of the trial.

The medication also caused prostate-specific antigen levels to decline by at least half in 78 percent of the men assigned enzalutamide, compared with 3 percent of placebo patients. Doctors use high PSA levels to diagnose prostate cancer.

One observer said enzalutamide is an incredibly well-tolerated drug that has some minor side effects. Side effects included high blood pressure, fatigue, back pain, constipation and joint pain. He also noted anything that can delay the onset of chemotherapy is a plus for patients. A number of patients are just not ready to pull the trigger on something as toxic as chemotherapy, if you can put it off.

It reportedly is at least as good as and possibly has a greater magnitude in reduction of risk of death than abiraterone. Both drugs are expensive, costing $8,000 to $9,000 a month. FDA approval for using enzalutamide prior to chemotherapy could come fairly quickly. (Source: HealthDay News, June 2, 2014, via MedlinePlus)

Prostate Cancer Tests Underestimate Disease Severity in Half of Cases. This study in the United Kingdom involved 847 men with prostate cancer: 209 out of the 415 who were initially told their cancer was slow-growing were found to have a more aggressive form of the disease. And for almost a third of the 415 men, it had spread beyond the prostate. Scientists are calling for better tests to define the nature of the cancer. Prostate cancer is the most common male cancer in the UK. There are 41,700 new cases diagnosed and 10,800 deaths each

year.

For this study, scientists at the University of Cambridge graded the men's cancer before and after they had surgery, between 2007 and 2011. Shaw, et al., the University of Cambridge, found there were a "surprising" number of men who were not diagnosed appropriately the first time around. The researchers said the study was "very important" for British men as cohorts abroad were not always comparable to the type of prostate cancer in the UK.

At the moment, men with low-grade, early stage cancers are offered the choice of an operation, to remove the prostate, or active surveillance, where doctors perform regular blood tests and examinations. Dr. Shaw said if men opted for active surveillance, 30% of them would be likely to need "radical treatment", such as surgery and radiotherapy, five years later. But he added there was potential for bias in the study, as there might have been a subtlety in the advice given to men in the clinic that hinted their cancer was more severe, which could have been why they opted for surgery. So the study was not necessarily representative of those men who opted for active surveillance, he said.

Shaw said a template biopsy, which looks at more tissue samples than the usual prostate biopsy, should be included. More samples may give a clearer picture of the extent of the disease. He also said MRI scans should be improved to identify how aggressive the prostate cancer was from the outset. An observer agreed that this was a very good and thoughtful study, but he said the study had limitations as the definitions of "significant" cancer were uncertain.

Dr Iain Frame, director of research at Prostate Cancer UK said: "Accurate prostate cancer diagnosis continues to be one of the biggest challenges facing the disease today. "The results of this study highlight yet again that existing tests cannot provide a precise picture of the aggressiveness of a man's cancer, often leaving men and their doctors to make difficult decisions about treatment without all the facts." He said until tests improved, it was important men talked to their doctors about the pros and cons of each treatment. (Source: BBC Health News, April 10, 2014)

MRI FOR PROSTATE BIOPSIES INCREASES ODDS OF FINDING AGGRESSIVE TUMORS. Prostate biopsies performed using magnetic resonance imaging (MRI) are more likely to find aggressive tumors than those that rely on ultrasound, suggests a new study at Washington University School of Medicine in St. Louis.

Prostate biopsies often are recommended when blood levels of prostate-specific antigen (PSA) rise above 4.0 ng/ml. Typically, the procedures are performed using ultrasound to guide the placement of biopsy needles into the prostate. But ultrasound is not sensitive enough to visualize suspicious areas that might indicate cancer. So, urologists randomly distribute needles into the prostate to withdraw tissue samples for analysis.

“Biopsies performed under ultrasound guidance are very much hit or miss,” said prostate cancer expert Gerald Andriole, MD, chief of urology at Washington University School of Medicine and Barnes-Jewish Hospital. “If a biopsy is negative, there’s a significant chance that it missed a cancer, and if it’s positive, there’s a tendency to treat the cancer aggressively due to con-

cerns that the biopsy missed an aggressive component of the cancer. This leads to many men receiving excessive treatment."

Each year in the United States, about 1 million men undergo prostate biopsies, but only about 20 to 25 percent are positive. The procedure can be painful and comes with a risk of bleeding and infection.

In recent years leading urologists have been investigating whether targeted biopsies performed using MRI to visualize suspicious areas of the prostate are more likely to be accurate. Washington University is the only center in the St. Louis region where targeted prostate biopsies are performed using MRI guidance.

In the new study, Andriole evaluated his experience with MRI-guided prostate biopsies in 70 men who had the procedure at some point from December 2010 to July 2013. Their average age was 65, and their PSA scores averaged just above 8.0 ng/ml.

The biopsies were performed after results of MRI scans of the prostate were available. For each biopsy, he took multiple tissue samples in areas of the prostate that looked suspicious for cancer as well as in non-suspicious areas where cancers may have been too small to visualize with MRI.

The analysis showed that biopsies targeted to suspicious areas of the prostate were nearly three times more likely to find cancer than those targeted to non-suspicious areas. Further, biopsies targeted to suspicious areas were four times more likely to detect aggressive tumors that warranted treatment. Such tumors have a Gleason score of 7 or more. The Gleason scoring system measures tumor aggressiveness based on biopsy results and can range from 1-10, with 10 being the most aggressive.

MRI is not perfect, Andriole noted. In this study, it accurately predicted a positive biopsy 62 percent of the time. For men with elevated PSAs, biopsies targeted to suspicious areas with MRIs missed about 7 percent of aggressive tumors. By comparison, ultrasound biopsies typically miss up to 20 percent of aggressive cancers.

But as MRI technology improves, Andriole thinks prostate cancer screening eventually could be like mammography screening for breast cancer. If a mammogram is negative, there's no need for a biopsy, but if it's positive, a targeted biopsy is performed to confirm or rule out cancer. "We hope to get there with prostate cancer," said Andriole, the Robert Killian Royce, MD, Distinguished Professor of Urologic Surgery. "In the future, if a man has an elevated PSA, we'd like to do an MRI and be so confident in the technology that we'd only do a targeted biopsy if the MRI were positive. We're not there yet, but that's the goal." (Source: Siteman Cancer Center, Washington University School of Medicine, May 20, 2014)

Some Prostate Cancer Patients Might Safely Delay Hormonal Therapy. In this new study, researchers found that it was safe to delay hormone-depleting therapy in men with rising PSA levels who did not experience symptoms nor have evidence of a tumor. Hormone-depletion therapy is a common treatment for prostate cancer, but one that also carries side effects for men such as sexual dysfunction and fatigue. How-

ever, this new study suggests that in certain cases the treatment can be delayed -- boosting the patient's quality of life. One expert applauded the study. "In view of the cost and potential side effects that are associated with hormonal therapy, this is an important study that supports the notion that we don't have to jump on early hormonal therapy if PSA is showing signs of recurrence," said Dr. Ash Tewari, chair of urology at the Icahn School of Medicine at Mount Sinai, in New York City. "This study is also a great example of how less-aggressive treatment can sometimes offer patients optimal outcomes while sparing them from side effects that impair their quality of life," he added.

Natural hormones such as testosterone are known to be associated with the growth of prostate tumors. So, one common treatment, called androgen deprivation therapy, involves reducing a patient's levels of these hormones. However, experts note that the therapy also has side effects, including sexual dysfunction, weakening bones, hot flashes, fatigue, decreased mental sharpness, depression and loss of muscle mass, among others.

But what if the therapy could be at least delayed, even if a patient's PSA levels are rising? The new study found that, in certain cases, delaying hormonal therapy in this scenario is possible.

In the study, the researchers looked at data on more than 14,000 patients. Of these, just over 2,000 saw their PSA levels begin to climb again after prostate surgery or radiation therapy. These "PSA relapse" patients were divided into two groups: those who received hormone therapy immediately and those who deferred their hormone therapy until later.

The "immediate" group received hormone-depleting therapy within three months of their PSA relapse. The "deferred" group did not receive it until they developed a tumor or symptoms. Men in the "deferred" group also received hormonal therapy if their PSA level doubled in a short period of time.

Overall, the average time from initial treatment to PSA relapse was a little more than 2 years, the researchers said. After experiencing a relapse, the men were followed for an average of almost 3.5 years.

Waiting longer to begin hormone therapy did not have a significant effect on men's long-term survival, the researchers reported. The estimated five-year survival for the "immediate" treatment group was about 85 percent, compared to just over 87 percent for the "deferred" group -- not a significant difference. The researchers concluded there was no significant benefit to starting hormone therapy right away after a PSA relapse.

Postponing treatment could, however, reduce the side effects and costs linked with hormone therapy. Waiting to begin treatment could give men two or more years of life without some of the common and distressing symptoms tied to the therapy, the researchers suggested.

According to the researchers, rising PSA levels trigger a lot of anxiety, and many men want to start treatment as soon as possible. These findings suggest that there may be no need to rush to androgen deprivation therapy. If the results are confirmed in randomized trials, patients

could feel more comfortable waiting until they develop symptoms or signs of cancer that are seen on a scan, before initiating therapy.

However, research presented at medical meetings is typically considered preliminary until published in a peer-reviewed journal, and the researchers agreed that more research will be necessary. (Source: American Society of Clinical Oncologists news release, May 14, 2014, and HealthDay News, May 14, 2014)

New Approach May Boost Survival From Advanced Prostate Cancer. Adding generic docetaxel to standard hormonal treatment seems to have benefit. Adding the chemotherapy drug docetaxel to standard hormone-depleting therapy may extend the lives of men with advanced prostate cancer, a new study finds.

Hormone therapy has been a standard treatment for prostate cancer since the 1950s. According to the researchers, this is the first study to identify a strategy that prolongs survival in newly diagnosed metastatic prostate cancer. The benefit is substantial and warrants this being a new standard treatment for men who have extensive disease and are fit for chemotherapy.

One expert not connected to the new trial agreed that these data are practice-changing and help us further improve the care we give to patients with prostate cancer. He further believes the study will also help to better understand the biology of the most aggressive and lethal prostate cancers so we can design new clinical trials to further improve the outcomes of men with this devastating disease.

Prostate cancer is often spurred on by hormones such as testosterone, so hormone-depleting therapy is the standard initial treatment for these "hormone-sensitive" tumors. The treatment is initially effective, but the disease eventually becomes resistant to the therapy in most patients. Chemotherapy is typically started only after the disease progresses despite hormone therapy, experts note.

In this U.S. National Cancer Institute-led study, 790 men newly diagnosed with advanced hormone-sensitive prostate cancer were divided into two groups. One group received hormone therapy alone, while the other group got hormone therapy plus docetaxel for 18 weeks.

After a median follow-up of more than two years, there were 136 deaths in the hormone therapy-only group, and 101 deaths in the hormone therapy-plus-docetaxel group. Median survival was 44 months in the hormone therapy group and 57.6 months in the hormone therapy/docetaxel group, the researchers reported.

Among men whose prostate cancer had spread to major organs or bones, median survival was 32.2 months in the hormone therapy group and 49.2 months in the hormone therapy/docetaxel group.

The use of docetaxel also delayed cancer progression, the study found. Median time to progression after treatment was 19.8 months in the hormone therapy group and 32.7 months in the hormone therapy/docetaxel group.

"These results demonstrate how we can use 'old tools' in new, more powerful ways to improve and extend patients' lives," ASCO President Dr. Clifford Hudis said in the ASCO news release.

"This study is also a powerful testimony to the importance of National Cancer Institute-led research, as both of these drugs are available in generic form today and this research might have otherwise not been pursued," he added.

Experts caution that studies presented at medical meetings should be considered preliminary until published in a peer-reviewed journal. (Source: American Society of Clinical Oncology, news release, June 1, 2014; and HealthDay News, June 1, 2014)

Varying Cost of Prostate Cancer Surgery. For an uninsured man with prostate cancer, the price of surgery could range from $10,000 to $135,000, depending on the hospital, a U.S. study finds. What's more, that wide range in charges -- a 13-fold difference -- has nothing to do with quality, researchers said. "Consumers are used to higher prices meaning higher quality. But that's not true in medicine," said Dr. Bradley Erickson, the senior researcher on the study. "Prices are not attached to any kind of quality information."

What does determine hospital charges for prostate cancer surgery? "We really don't know," said Erickson, an assistant professor of urology at the University of Iowa in Iowa City.

What's clear, Erickson said, is that a man with no health insurance -- or insurance with high copays -- would have a tough time "shopping" for the best hospital for prostate cancer surgery.

For the study, recently published in the journal *Urology*, one of Erickson's colleagues pretended to be an uninsured man in need of prostate cancer surgery. He called 100 American hospitals, following the same "script" each time: He was an otherwise healthy man with the means to pay out-of-pocket, and he wanted an estimate of the total charge for surgery -- hospital and surgeon fees included.

Thirty percent of hospitals said they couldn't offer an estimate. Among the rest, the price ranged from $10,100 to $135,000 -- though only three hospitals were willing to put a quote in writing. The average price was almost $35,000, more than twice the Medicare reimbursement, the researchers said. Geography mattered. Hospitals in the Northeast quoted higher prices, on average, than hospitals in the South -- about $40,800 versus $30,300.

But in other ways, there was little rhyme or reason. Big-city hospitals, for example, charged no more than those in small cities, on average. And there was no relationship between hospital charges and their ranking by *U.S. News and World Report*, which publishes a list of the nation's "best" hospitals.

Experts who reviewed the study weren't surprised. Other U.S. studies have shown wide-ranging prices for health care, said Dr. Ezekiel Emanuel, chair of medical ethics and health policy at the University of Pennsylvania in Philadelphia. He pointed to a study last year -- by the same researchers -- showing that the price of hip-replacement surgeries at U.S. hospitals ranged from roughly $11,000 to $126,000.

There are some reasons that hospital charges could legitimately vary. For example, their costs for equipment differ to some degree.

"But mostly, it's a mystery," Erickson said. "I don't think the hospitals even know why they charge what they charge."

The American Hospital Association declined a request to comment on the study. The "good news," Erickson said, is that 70 percent of hospitals did provide a price estimate, which is a larger response than some past studies have seen.

The not-so-good news: The "patient" here was a researcher who could ask savvy questions. Even so, a typical inquiry involved talking to four or five people, for up to 69 minutes, Erickson said. It's not clear how a real patient would fare on the phone, he added. And even if you get price information, "that's only half the story," Emanuel said. "You also need to know if you're getting a Yugo or a Mercedes."

Uwe Reinhardt, a health care economics expert at Princeton University in New Jersey, agreed. "Telling Americans to 'shop' for health care is like pushing someone into Macy's blindfolded, then saying, 'OK, go shopping,'" Reinhardt said. Not only does price have little relation to quality, he said, but the estimates hospitals give are just that. The actual charges could be greater.

The study did uncover one way for patients to get a financial break. One-third of hospitals said they would give a discount if the "patient" paid up front. On average, that meant one-third off the quoted price -- but some hospitals went as high as 80 percent.

For patients who can pay in advance, Erickson said, it might be worthwhile to call different hospitals and ask about a discount. To Reinhardt, the findings spotlight a convoluted system. "This study points up the sheer absurdity of our health care system, which most of the public isn't even aware of," he said. (Source: *Urology,* March 2014, via HealthDay News, June 19, 2014)

Diet and Lifestyle Affect Prostate Cancer Risk. Eating high-fiber carbs, drinking less milk, avoiding diabetes and heart risk factors may help cut prostate cancer risk, according to a trio of new studies.

A diet rich in complex carbohydrates and lower in protein and fat is associated with a 60 percent to 70 percent reduced risk of prostate cancer, according to Vidal, et al., a Duke University School of Medicine, Durham, N.C. In addition, a fiber-filled diet reduced the risk of aggressive prostate cancer by 70 percent to 80 percent, according to Vidal. "Good carbs, high-quality carbs, and high fiber are definitely protective against prostate cancer," Vidal said.

The two other studies found that:

- Drinking lots of milk could increase a man's risk of advanced prostate cancer.
- Men suffering from two or more health problems linked to metabolic syndrome also have an increased risk of aggressive prostate cancer.

Metabolic syndrome is a group of risk factors that increase a person's risk of heart disease, diabetes and stroke. They include obesity, high blood pressure, elevated blood sugar levels, elevated levels of triglycerides (blood fats) and reduced levels of "good" HDL cholesterol.

"When men have two metabolic syndrome components, their risk of high-grade prostate cancer goes up almost 35 percent," Vidal said. "With three to four components, their risk goes to almost 94 percent increased."

These studies shed more light on connections between diet, lifestyle and prostate cancer that up to now have been "tenuous," said Dr. Durado Brooks, director of prostate and colorectal cancers for the American Cancer Society. "We don't have as good evidence regarding a link between diet and prostate cancer as we do with colorectal cancer or breast cancer, and there has been some conflicting data in previous studies," Brooks said.

The first study focused on a group of 430 veterans at the VA Hospital in Durham, N.C., including 156 men with confirmed prostate cancer. Researchers had the men fill out questionnaires to track the amount of carbohydrates, protein and fat in their daily diets.

The researchers found that when men received more of their energy from carbohydrates rather than protein or fat, their risk of prostate cancer declined. High fiber intake also appeared to reduce prostate cancer risk.

Additionally, they found that foods like simple carbohydrates that cause blood sugar to spike appear to increase prostate cancer risk in black men.

That finding, along with the results of the metabolic syndrome study, seem to indicate there could be an as-yet-unknown connection between blood sugar levels and male hormones like testosterone that increase prostate cancer risk, Vidal said.

In the second study, doctors reviewed the consumption of dairy products among nearly 3,000 people, including almost 1,900 men with either localized or advanced prostate cancer.

The investigators found that drinking milk was associated with advanced prostate cancer. However, total dairy consumption was not related to prostate cancer risk, nor were consumption of yogurt, ice cream and cheese.

The analysis also found that men with low overall calcium intake were at greater risk of prostate cancer when they ate more dairy products, compared with men with average or high levels of calcium in their diet.

The findings suggest that although calcium intake likely contributes to an increased risk of prostate cancer, "additional components in dairy may contribute to prostate cancer development," the authors concluded.

The final study focused on the effects of metabolic syndrome on a man's chances of prostate cancer, with researchers reviewing data gathered for almost 6,500 men in an unrelated clinical

trial.

Researchers found that men with multiple metabolic syndrome risk factors had a progressively increased risk of prostate cancer.

"The more metabolic syndrome components, the more risk for high-grade prostate cancer," Vidal said.

The findings are in keeping with previous studies linking one of those risk factors, obesity, to a higher risk of aggressive prostate cancer, Brooks said.

"The question is whether because of their obesity these men are less likely to have their cancer identified and biopsied at an earlier stage," he said. "These researchers feel there's more than just delayed diagnosis, that there's something about these risk factors that contributes to prostate cancer."

Findings from these studies were scheduled for presentation at the American Urological Association's annual meeting in Orlando, Fla. Results from studies presented at meetings are generally considered preliminary until they've been published in a peer-reviewed journal. (Source: Presentations, American Urological Association annual meeting, Orlando, Fla., May 20, 2014, via HealthDay News and MedlinePlus, June 6, 2014)

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♦ Long-term Care Guidelines for Prostate Cancer Survivors ♦

An estimated 2.8 million men in the United States are living with prostate cancer or have had it at one time, and that number is growing. Prostate cancer is the most common cancer in American men after skin cancer – and long-term survival is common. But even long after diagnosis and treatment, survivors have continuing needs for follow-up care to manage treatment side effects, test to see if the cancer has come back, and treat other health conditions.

To help primary care doctors and prostate cancer survivors better manage prostate survivors' long-term care, the American Cancer Society has released its first ever Prostate Cancer Survivorship Care Guidelines, published June 10, 2014 in *CA: A Cancer Journal for Clinicians*. These newly developed guidelines provide detailed recommendations around nutrition and physical activity, cancer testing, management of side effects, and coordination of care among primary care doctors and specialists.

"We are hopeful that the hard work that went into the development of these much-needed guidelines will pay off in improved care for the approximately 240,000 men diagnosed with prostate cancer every year," said Rebecca Cowens-Alvarado, MPH, a co-author of the report. "The adoption of these guidelines will be a critical step forward to improve the delivery of prostate cancer survivorship care," she added. The Society is developing survivorship care guidelines for other cancer types as well, based on the number of survivors and the severity of health problems survivors face.

Healthy behaviors

The new prostate cancer survivorship guidelines recommend that primary care doctors talk to prostate cancer survivors about their lifestyle habits and give them advice on how to make changes. Increasingly, studies show that healthy eating and maintaining an active lifestyle after a prostate cancer diagnosis can lower the chances of the cancer coming back. Healthy behaviors include:

- Achieving and maintaining a healthy weight by limiting high-calorie foods and beverages, and getting more physical activity.
- Regardless of current weight, getting at least 150 minutes of physical activity every week, with a doctor's approval.
- Eating a diet rich in vegetables, fruits, and whole grains, and low in saturated fats, with adequate calcium and vitamin D. Men facing challenges to good nutrition should talk to their doctor or ask for a referral to a registered dietician.
- Limiting alcohol consumption to no more than 2 drinks per day.
- Avoiding tobacco.

Testing for prostate cancer

Depending on their treatment, survivors must have regular follow-up tests to check whether their prostate cancer has come back or worsened, and must also follow testing guidelines to check for any new cancer.

Men who've had radiation therapy may be at slightly higher risk for bladder or colon cancer, and may need different screening than people at average risk.

Most prostate cancer survivors should have a PSA test every 6 to 12 months for the first 5 years after active treatment ends, then every year after that. They should also have a digital rectal exam every year. Survivors on active surveillance may have a different schedule of tests.

Men should report any new symptoms, including blood in the urine, rectal bleeding, or pain to their doctor.

Side effects from treatment

Surgery, radiation, chemotherapy, and hormone treatments for prostate cancer can cause urinary, bowel, and sexual side effects. In addition, hormone therapy can cause anemia and hot flashes, and raise men's risk for heart problems and bone fractures. It is important to discuss these side effects with a doctor so they can be evaluated and if possible, treated.

It is not unusual for people who've had cancer to experience anxiety or depression. Feelings of sadness or distress should be discussed with a doctor, who can evaluate whether they are signs of clinical depression. Clinical depression can lower quality of life, and also make people less able to take care of their own health. There are many ways to treat clinical depression, including medicine, counseling, or a combination of both.

Coordinating care

When active cancer treatment ends, patients should ask their oncologist for a written follow-up care plan that they can share with their primary care doctor. It should include an explanation of which provider – oncologist, primary care doctor, or other specialist – should be in charge of cancer-related and other medical care.
A study from the National Cancer Institute found that primary care doctors who received a written plan from the patient's oncologist were 9 times more likely to discuss recommendations for survivorship with the patient than primary care doctors who received no written plan.

Beginning next year, the American College of Surgeons Commission on Cancer will require that every cancer patient receive a survivorship care plan from their oncologist when treatment ends, that includes written guidelines for monitoring and maintaining their health. (Source: American Cancer Society: Prostate Cancer Survivorship Care Guidelines. Published June 10, 2014)

"LIFE WITH CANCER: PRACTICAL TOOLS FOR LIVING WITH UNCERTAINTY"

by

JAMES R. DAVID, PhD

and

PETER FAGAN, PhD

JOHNS HOPKINS SCHOOL OF MEDICNE

(Summary of presentations to the WRNMMC Prostate Cancer Support Group, May 29, 2014)

(Dr. David and Dr. Fagan, psychotherapists, made separate presentations giving insights into dealing with cancer, particularly prostate cancer. Dr. Fagan spoke first.)

Dr. Fagan Tonight I would like to discuss the relational opportunities and challenges posed by the cancer diagnosis, the subsequent treatments, and the post-treatment periods as one deals with the disease. I will speak from personal experience because I myself have been through the three phases of diagnosis, treatment, and post-treatment. I am not used to speaking too personally about these matters, so bear with me. I don't want to burden you with one story, but I do think that, in a real sense, one person's story is every person's story.

My focus will be on what I have learned about the relational opportunities and challenges that confront each of us as well as our partners. Now what do I mean by "relational?" I mean that you the patient has a relationship with another person who likely does not have cancer, that is, a spouse, a domestic partner, or close friend. Of course, there may not be such an existing personal relationship. I am saying that the cancer journey is such a challenge that one should not try to go it alone.

I will never forget the call that evening. I picked up the phone; my wife is downstairs in her book club and I can hear the conversation and the laughter. My doctor told me that he has the test results and they are not good. I have multiple myeloma! I didn't know what it was, but I soon learned it is a form of bone marrow cancer. He seemed somewhat casual in telling me about it, but I was far from relaxed about hearing it. I was surprised because it wasn't one of the health issues that I thought I might be facing. The diagnosis arose from a kidney biopsy I had undergone. The family joke had been that I was a bit of a hypochondriac over the years, but I had missed the big one! Cancer came and was with me without my even worrying about it; and then we lived with it. So I speak to you tonight as a failed hypochondriac!

No, I didn't run down the stairs to interrupt Gail's book club! But I knew from the outset that I would want to include her in every step of the way in dealing with the disease. I knew her involvement would be essential to the process. I knew from my work as a clinical psychologist, as someone who had been in therapy with couples, that there can be no protective secrets. You cannot protect your partner by sharing only the good news, while protecting her from the bad news. It simply will not work! If you try to do that, before you know it, a curtain will come down between you and your partner and a distance begins to grow.

Look at it this way. Candid communication is really a kind of bridge between the two persons confronting a serious health condition. The information, good and bad, must flow freely, sharing love, anger, concern, and the other human emotions that affect their lives. The instincts of many of us, especially those of the male persuasion, are to keep the secrets and to "save" his partner from worry. In my practice I hear that refrain over and over again. He says "I don't want to tell her because I don't want her to worry, she is caring for me." Then she says "I don't want to upset him because he has cancer." But what happens is that this attempt at protective secrecy promotes distancing at precisely the time when more togetherness is what is needed.

Here is a practical example. Having Gail accompany me on appointments relieves the strain on me because she serves as another set of eyes and ears, relieving me of the total responsibility to hear and process what

the oncology staff is telling me. There is a lot of information being exchanged. So I can ask better questions than I would have had I been alone. This is especially important during the diagnosis stage. I may not be telling you something that you don't already know, but I am just saying it to make sure it is rooted in you, especially those of you who are in the early diagnostic stage of the disease.

Let's talk about the treatment stage. For most cancers there are a variety of treatment options, as is true of prostate cancer. This poses a challenge in assessing and selecting the right course. The new interest in the watchful waiting option is a welcome development at the same time that it could be an additional concern in making the right selection. I have a story about the non-treatment options. About a year and half into chemotherapy, my numbers were looking good, so it was suggested that I consider a stem cell transplant. I went to Johns Hopkins Hospital and had the protocol explained to me. It would require a a heavy dose of chemotherapy, my blood taken out and "magic" performed on the blood which is then reinfused. However, the study also required intensive follow-up at the hospital for several months with 24/7 monitoring. I would be very sick for several months and maybe by the end of the year I would be feeling well. The way my myeloma worked, it attacked my kidneys, and the additional chemotherapy would have put more strain on the kidneys. I didn't think I would get my sense of vitality back better than what I have right now. So why exchange maybe a year of life for a year of sickness? So this treatment versus non-treatment decision is very personal one, but we made it together. You have to realize that non-treatment is also an option. Some studies done on palliative care versus active therapy have shown that the life span in patients in palliative care and hospice is longer than a matched sample of patients who selected the active therapy option. So the jury is still out on many of those issues.

The side effects of treatment can, of course, have a profound effect on your relationships. Fatigue is one of the most difficult challenges to meet. It doesn't get much attention in the literature, but it is a pervasive issue between the couple. Listlessness and non-response to shared "around the house" tasks will surely weigh upon the healthy partner

Incontinence is a crucial factor, especially after radical prostatectomy for prostate cancer. It is one of the major problems that I encounter when working with couples in a post-prostatectomy situation. Many didn't necessarily see it coming. The urologist may not have prepared them for the eventuality, or they didn't appreciate how uncomfortable and embarrassing it could be, nor or how long it might take for the problem to resolve itself, or at least become manageable. Incontinence is surely a challenge to be faced together.

Sexual dysfunction is a very special case associated with prostate cancer treatment. It may involve not only the ability to gain an erection, but also a decline in desire for sex. Sexual dysfunction will require a very high degree of openness in communication. between the partners.

Depression from dealing with or living with cancer shows itself in several ways . Perhaps it is the inability to make a decision, a failure to follow through on routine tasks, or even to starting them, as well as irritability when someone reminds you of these shortcomings. These are some of the depression-related side effects that may not be as important as some of the ones cited earlier, but they are all there to be wrestled with as a couple.

The essence of cancer raises the ultimate questions, such as, what meaning does my life have; what is it all about? What will I accomplish in the time that I have left? How do I want to spend the gift of time and health that I have because even though I may have cancer, I still have health. Of course, these fundamental questions pertain to every person to one degree or another. They are not questions that only persons with cancer must address. But persons with cancer will be able to address them successfully if they have direct and open communication with a spouse, partner, or friend.

Dr. David (Dr. David opened by likening a diagnosis of prostate cancer to smooth driving being interrupted by a large pothole in the road of life with all the resultant worry and stress. Then he offered techniques for coping with the disease.)

In an age when so many of us seem to be "captured" by our smart phones, the 4 x 4 x 4 stress management tool may seem out of step with the times. But I offer it to you as a substantive initial step in acquiring an authentic life where you are more self-regulating of the thoughts that come into your mind, the feelings that you feel in your body, and what you do and what you say. AWARENESS has a healing power you can acquire by practicing mindfulness, i.e., meditation. All types of meditation are essentially the same in that they bring us to the calming of the mind so that we experience deep inner peace, calm, and greater awareness. Without self-awareness, we are unable to identify and then resolve emotional issues, like a diagnosis of prostate cancer, that limit our ability to maximize ourselves.

The 4 x 4 x 4 formula works like this:

● Meditate **four times a day** before breakfast, lunch, dinner and bedtime. The central idea is to stay in touch with yourself (your thoughts, feelings, spirit, what you are inclined to say and do) so that you are stronger in managing yourself.

● The second "4" stands for meditating for **four minutes each time**. This brief amount of time is chosen because most everyone can carve out four minutes four times a day. Admittedly, four minutes may be insufficient in the beginning of your awareness journey, but the greater your adherence to this protocol, the more pronounced will be your benefit

● You know that the three most important aspects of real estate are (1) Location (2) Location (3) Location. Similarly, the three most important parts of being mentally healthy are (1) AWARENESS) (2) AWARENESS (3) AWARENESS!!

● The third "4" stands for four steps in mindfulness meditation. **(1)** The first step is BREATHING. Focus your mind's eye on your breath until you move from short, shallow, uptight breaths to deep, full, relaxed breaths. Inhale concepts of peace and relaxation and exhale stress and tightness. Notice that the deeper you relax, the more awareness that you gain of your thoughts, feelings and spirit. **(2)** The second step is to add to your breathing the practice of being OBSERVATIONAL. You observe the thoughts that come to your mind, the feelings that come into your body, and what you are inclined to say or do. The idea is to get these thoughts, feelings, and what you are inclined to say or do at arm's length, then have choice or freedom about these four parts of you, so that you control them instead of them controlling you. **(3)** Now as you continue your BREATHING and being OBSERVATIONAL, you ACCEPT whatever comes into your awareness and then let it float on by like a cloud in the sky. (Some of you might have to sit still long enough to realize and visually see that the clouds are moving!) **(4)** The fourth step is to LET GO of whatever comes into your awareness. So, in brief, the four steps are BREATHING, OBSERVING ACCEPTANCE, AND LETTING GO.

The benefits of the 4 x 4 x 4 technique are Relaxation (stress management); Greater Awareness (more observational); Being a friend to yourself; More "okayness" in just being; Emergence of new thought (fresh perspectives); and Connecting with the love, peace, and the joy already within you.

There is a related technique that I term the AUDIO. A is for awareness; U is for understanding; d is for deciding what you must do to heal or resolve the issue(s); I is for implementing the decision (s) you must make; O is for outcomes that must reevaluated to see if they are working in your life.

(Dr. David then engaged the audience in a brief meditation exercise, and also used a volunteer to illustrate the techniques he described. **Visit Dr. David's web site at www.askdrdavidnow.com and go to "Mental Health Articles" and "Handouts/Misc Forms" to get a wealth of information related to his presentation.)**

♦ WRAMC US TOO COUNSELORS ♦ (As of August 1, 2014)

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

SURGERY

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

PROSTATE CANCER AND SEXUAL FUNCTION

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

RADIATION

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

WATCHFUL WAITING

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

SPOUSE SUPPORT

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

OTHER THERAPIES/MULTIPLE THERAPIES

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

♦ MEETING ANNOUNCEMENT ♦

THURSDAY, AUGUST 7, 2014
7 - 8:30 PM

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

♦ SPEAKER ♦

ALBERT DOBI, MD

ASSOCIATE DIRECTOR, BASIC SCIENCE PROGRAM

CENTER FOR PROSTATE DISEASE RESEARCH

TOPIC

"RECENT ADVANCEMENTS IN PROSTATE CANCER DETECTION, DIAGNOSIS AND THERAPY"

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 two business days prior to Thursday, May 29, 2014 to arrange for entry**. Have a photo ID card ready when arriving at the gate