

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

**VOLUME 22**

**NUMBER 4**

**NOVEMBER 2013**

◆ **NUTRITION FOR CANCER PREVENTION** ◆

(Dr. Neal Barnard, president of the Physicians Committee for Responsible Medicine, a nationwide group of physicians promoting preventive medicine, spoke recently to our support group. He is widely published, especially in the area of nutrition and dietary influences on health. His presentation was reported in *The Journal*, a publication of the Naval Support Activity, Bethesda. The author was Bernard Little, WRNMMC Editor.)

"I grew up with the world's worst diet" said Dr. Neal Barnard. "Every day of my life in Fargo, ND, was roast beef, baked potatoes and corn, except for special occasions when it was roast beef, baked potatoes and peas," said the son of cattle ranchers and physicians. About the time I finished my residency, I quit smoking and changed my diet, trying to make up for lost time," Barnard said.

Barnard, a clinical researcher, author, and adjunct professor of medicine at George Washington School of Medicine and founding president of the Physicians Committee for Responsible Medicine, was guest speaker at the Walter Reed Bethesda's Us Too Prostate Cancer Support Group's quarterly meeting on August 1.

The physician and health advocate has discussed health issues on documentaries, national news and talk programs, in addition to hosting three PBS programs about healthy eating. During his presentation, Dr. Barnard addressed nutrition for cancer prevention and survival. "When we look at how foods can affect cancer, one of the first tools we use is population studies, he explained, We don't ask people to do anything, we just track what people are eating, choices they are making, and see what patterns emerge."

Dr. Barnard discussed a Physician Health Study (Harvard, 2001) which showed high calcium intakes, mainly from milk and other dairy products, may increase prostate cancer risk by increasing the insulin-like growth factor -1(IGF-1). He explained IGF-1 in the blood promotes growth and while the rise in IGF-1 level is an important reason for the bone-building effects of cow's milk, it may also promote undesirable growth of cancers. "The second thing that happens, and this is peculiar, is milk suppresses the actions of Vitamin D," Dr. Barnard said. "There is a cancer-preventive effect of Vitamin D that milk interferes with. Vitamin D's natural source is sunlight on the skin, he continued. "The prostate is going to benefit from a higher level of Vitamin D which suppresses prostate cancer."

Vegetarians have lower levels of IGF-1, and people who are on a plant-based diet have slightly lower rates of IGF-1," Dr. Barnard added. He said Asian and African countries and other regions where traditional staples of diets are various kinds of legumes and grains tend to have lower cancer rates. **(Continued on page 10)**

◆ **INSIDE THIS ISSUE** ◆

**Next Speaker . . . . . Page 2**  
**Prostate-Specific Issues . . . . Page 3**

**Nutrition . . . . . Page 1**  
**Counselors Listing . . . . .Page 13**

**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**

**James Thompson  
(President)**

**Raymond Walsh  
(Vice President)**

**James Collins  
(Treasurer)**

**David Bertrand**

**Robert Butterworth**

**Ben Hawley**

**Vincent McDonald**

**Jim Padgett**

**Michael Pausic**

**Don Williford**

**◆ FROM THE EDITOR ◆**

Our support group is a chapter of Us TOO, International, the largest prostate cancer advocacy organization. Have you visited the Us TOO website yet? Try it, you will like it! It contains a wealth of information such as current developments in prostate cancer therapies. And it's monthly *Hot Sheet* is a must-read publication. Go to [www.ustoo.org](http://www.ustoo.org) to see what you have been missing.

**◆ AUGUST 1, 2013, SPEAKER'S REMARKS ◆**

Our August program featured Dr. Neal Barnard, president of the Physicians Committee for Responsible Medicine. The topic of his presentation was "Nutrition for Cancer Prevention and Survival." A summary of his presentation begins on page 1.

**◆ MEETING SCHEDULE FOR NOVEMBER 7, 2013 ◆**

Our speaker is Dr. Edmond L. Paquette, Dominion Urological Consultants. A graduate of the Brown University School of Medicine, his military career included service at Madigan Army Medical Center, Fort Lewis; Chief of the Urology Service, Womack Army Medical Center, Fort Bragg; as well as service in Germany, Bosnia, and Iraq. His special interests include laparoscopy, urologic cancers, erectile dysfunction, and incontinence. Dr. Paquette is a Diplomat, American Board of Urology and a Fellow, American College of Surgeons. His topic is "The PSA Controversy - What Patients Should Understand."

Join us at 7 PM, Thursday, November 7, 2013. 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-SPECIFIC ISSUES

**Radiation Guidelines for Prostate Cancer.** The American Society for Radiation Oncology (ASTRO) and the American Urological Association (AUA) have set forth several recommendations and clinical principles on the topic of radiation therapy after prostatectomy for patients with and without evidence of prostate cancer recurrence

Based on a review of 324 research articles published between 1990-2012, the authors recommend that candidates for radical prostatectomy as a treatment for localized prostate cancer be informed of the potential for adverse pathologic findings that portend a higher risk for cancer recurrence. Patients with adverse pathologic findings at prostatectomy (seminal vesicle invasion, positive surgical margins, extraprostatic extension) should be offered adjuvant radiotherapy and should be informed that, compared with radical prostatectomy alone, adjuvant radiation therapy reduces the risk for biochemical recurrence (prostate-specific antigen, or PSA), local recurrence, and clinical progression of cancer. Salvage radiotherapy should be offered to patients with PSA or local recurrence after prostatectomy in whom there is no evidence of distant metastatic disease.

The guideline states that clinicians should define biochemical recurrence as a detectable or rising PSA value after surgery that is at least 0.2 ng/mL, with a second confirmatory level of at least 0.2 ng/mL. Patients should be told that a PSA recurrence after surgery is associated with a higher risk for metastatic prostate cancer or death from the disease. These men should also be made aware that radiation therapy for PSA recurrence is most effective when administered for lower levels of PSA. A restaging evaluation in patients with a PSA recurrence may be considered.

The decision to administer radiotherapy should be made by the patient and the multidisciplinary treatment team. The patient's history, values, preferences, quality of life, and functional status should all be factors in the decision-making process. Men who are considering undergoing this treatment should be informed of its possible short-term and long-term urinary, bowel, and sexual side effects as well as the potential benefits of preventing cancer recurrence. (Source: Oncology Nurse Advisor: September 25, 2013)

**Not All Prostate Cancer Needs Treatment.** In a study of older men who had died from causes other than prostate cancer, almost half were found to have prostate tumors. And up to half of those tumors detected on autopsy would have qualified for treatment had doctors known about them while the men lived, though none had been the cause of death. This adds to a growing body of evidence that a wait-and-see approach might be better than immediate treatment for many prostate cancers.

Zlotta, et al., Mount Sinai Hospital, New York, say their study suggests that the progression of early prostate cancer, including some more aggressive forms of the disease, is far from inevitable within a man's lifetime as many such tumors are found in men who died from other causes when their prostate is analyzed on autopsy.

The researchers examined the prostate glands of more than 300 men over 60 who had died from a variety of causes, but not prostate cancer. They autopsied 220 men in Russia and 100 in Japan, both countries where the prostate-specific antigen (PSA) screening test is not as commonly used as in the United States. They selected a Caucasian population of Russian men similar in lifestyle and risk factors for

prostate cancer to U.S. men in order to look at how common the cancer is in older men who have not been routinely screened.

In the U.S., the number of tumors they found would have been much lower because many would have been identified by screening and treated or removed before death. For comparison, they chose an Asian population in Japan because clinically detected prostate cancer and mortality are much lower among Asian men compared with Caucasian men, and their lifestyles/diet are dramatically different.

Though many fewer Japanese men are diagnosed with or die from prostate cancer than men in the U.S., the new study found that the disease is present in the same proportion of men, and serious tumors are even more common in Japan, based on posthumous prostate examinations. Almost 40 percent of the Russian men, had tumors of the prostate, compared to 35 percent of the Japanese men.

One in four tumors in the Russian men were deemed serious and would likely have been treated with surgery or radiation in the U.S., compared to one in two tumors in the Japanese men. But one observer noted there are still many differences between Russian and American men, so it is difficult to generalize the results. He cautioned about trying to apply the results to Americans where we have a very heterogeneous population including very high risk groups such as African Americans.

In the United States, about 239,000 men are expected to be diagnosed with prostate cancer in 2013, but far fewer - less than 30,000 - will die of it, according to the American Cancer Society.

That's still more than will die of the disease in Japan, despite the American men getting more screenings and treatments - a curious inconsistency that could not be explained.

Prostate cancer screening does ultimately reduce the number of painful advanced

cancers and deaths from the disease, but it also picks up smaller cancers, and treating those aggressively could lead to unnecessary side effects. The study authors note that the lifetime risk of a man in the U.S. being diagnosed with prostate cancer is 17 percent, but his risk of dying from prostate cancer is 3.4 percent. That suggests many of those cancers would not advance quickly or at all, and something else would kill the man long before the prostate tumor. The problem is how to know which tumors will be harmless.

Experts said a new screening test may be needed that differentiates between more dangerous cancers and the many tumors that will not eventually kill, thereby avoiding the expense and risks of treatment and removal.

Another observer notes that the Prostate Health Index (phi) was recently approved by the FDA. It is a simple blood test that combines PSA with 2 other tests, and was shown to better predict the risk of aggressive cancer. The good news is that this is a very active area of research, and the whole process of screening and assessing continues to improve all the time. (Source: Journal of the National Cancer Institute online July 11, 2013 via Reuters Health, Thursday, July 18, 2013)

**Soy and Prostate Cancer Return.** Men who took soy supplements after having their prostate cancer removed were just as likely to see their cancer return as men who didn't take soy, in a new study by Bosland, et al., University of Illinois at Chicago.

Some doctors believed compounds found in soy - known as isoflavones - might help prevent prostate cancer, but more recent studies have found those and other nutritional supplements don't reduce the risk of developing the disease.

For the new study, Bosland and his colleagues randomly assigned 177 men who had their cancerous prostates surgically removed less than four months

earlier to drink either a soy or placebo beverage every day for up to two years between July 1997 and May 2010. Although the vast majority of the participants reported following the instructions, the study was stopped during an early evaluation because there was no benefit seen with soy, Bosland said.

The researchers found that 27 percent of the participants in the soy group ended up having their cancer return according to prostate-specific antigen (PSA) blood tests, which are used to check for evidence of cancer. That compared to about 30 percent for the placebo group.

One observer said this adds to the evidence that nutrition supplements really aren't beneficial. Other than undergoing regular PSA tests to check for a recurrence, he said patients who had their prostate cancer removed have no promising options to help prevent the cancer from coming back. On the other hand, there is some evidence to suggest people who eat soy starting early in life may be less likely to develop prostate cancer in the first place. (Source: The Journal of the American Medical Association, online July 9, 2013. via Reuters Health, Tuesday, July 9, 2013)

**Cryotherapy as a Salvage Therapy.** (Dr. Gerald Chodak, from Medscape, discusses the role of cryotherapy as a salvage therapy after men fail local primary cryotherapy or external radiation.)

"Wenske and colleagues reported the results from 328 men in Europe who had cryotherapy as a salvage therapy after their primary cryotherapy treatment or external beam radiation failed. They reported the 5- and 10-year disease-free survival and overall survival results.

Of concern is that the 10-year disease-free survival rate was only 35%. For men who received focal cryotherapy rather than total gland cryotherapy, the failure rate was 50%. This occurred despite a very low median prostate-specific antigen (PSA) value

after salvage therapy. It means that despite achieving a low PSA value, failure rates were still considerable at 10 years -- almost 65% of patients.

Another concern is that the group was very heterogeneous. There was wide variability in their intervals from primary therapy until cryotherapy, a wide range of PSA levels at the time of therapy, and not enough information about the PSA doubling time. The problem is that we know from other studies that the PSA doubling time from treatment until biochemical failure will help predict who will get into trouble over time. In fact, many men with slow PSA doubling times and a delay until recurrence are not going to get into trouble, even with long follow-up. They are going to die of something else without problems from their cancer. Having a rising PSA in and of itself is not lethal.

The problem is that many of the men who did well on the salvage therapy may not have needed it. On the other hand, a large number of men clearly do not do well with this therapy, and that may be either because the treatment fails to eradicate the disease or because they had microscopic metastases at the time that salvage therapy was initiated. In some ways, this is like looking at men who have had a radical prostatectomy and then were given salvage radiation. The overall benefit has been shown in a randomized study to be extremely small, only about 11% at more than 10 years.

At the end of the day, we struggle to help men who have recurrent disease after external radiation or primary cryotherapy. Salvage cryotherapy is an option, but it is an option for which we cannot predict whether a patient will benefit or how many men will suffer significant side effects. I don't know what we are going to do unless we perform randomized trials to evaluate this question. We will continue to see uncontrolled trials, and although they are well done, they still do not answer the question of whether this form of salvage therapy significantly affects

the disease." (Source: Medscape Urology, September 2, 2012)

**FDA Approves New Device for BPH.** The US Food and Drug Administration (FDA) recently authorized the marketing of the *UroLift* system, the first permanent implant to relieve low or blocked urine flow in men aged 50 years and older with an enlarged prostate. The UroLift system relieves the urine flow by pulling back the prostate tissue that is pressing on the urethra.

An FDA spokesman said UroLift provides a less invasive alternative to treating benign prostatic hyperplasia than surgery. It also may offer relief to men who cannot tolerate available drug therapies.

The FDA's review of the UroLift system included data from 2 clinical studies of 274 men with BPH implanted with 2 or more UroLift sutures. Both studies showed that physicians successfully inserted UroLift in 98% of participants. The studies also found a 30% increase in urine flow and a steady amount of residual urine in the bladder. Study participants answered validated questionnaires about their BPH-related symptoms and quality of life, reporting a decrease in symptoms and an increase in quality of life in the 2 years after treatment.

Minor adverse events reported included pain or burning during urination, blood in the urine, frequent or urgent need to urinate, incomplete emptying of the bladder, and decreased urine flow. Investigators did not report any serious device-related adverse events.

Severe BPH can lead to serious problems over time, such as strain on the bladder, urinary tract infections, bladder or kidney damage, bladder stones, and incontinence. Current treatment options to relieve symptoms associated with BPH include drug therapy or surgical procedures including removal of the enlarged part of the prostate.

The FDA reviewed the UroLift system through its de novo classification process, a

regulatory pathway for some novel low-to-moderate risk medical devices that are not substantially equivalent to an already legally marketed device. (Source: Medscape Urology, September 13, 2013)

**Younger Male Veterans and Incontinence.** In a U.S. national survey, men age 55 and younger with a history of military service were three times more likely than men who had never served to report urinary incontinence.

Conditions more common in combat veterans, including traumatic brain injuries and depression, are also linked with urinary incontinence, so screening even young male vets for urinary problems may be worthwhile, the researchers pointed out July 18th in *The Journal of Urology*.

Still, lead author Dr. Camille Vaughan of the Atlanta VA Medical Center in Decatur, Georgia, told Reuters Health, "We were surprised the association was only present in the younger age cohort."

Her team considered urge incontinence, as opposed to stress incontinence. Urge incontinence is the most common form of urinary incontinence among men, and is thought to affect more than 30 million U.S. adults, according to Brigham and Women's Hospital in Boston.

Previous research analyzing Veterans Administration medical records had found no extra risk for urinary incontinence among vets. But since men might not seek treatment for mild or moderate incontinence, Vaughan and her colleagues looked at an annual health survey covering a nationally representative sample of the population.

In the survey, men completed questionnaires and in-person interviews. Vaughan's team analyzed data on 4,700 men over the age of 20 gathered between 2005 and 2008. Nearly a quarter of the men had served in the military.

Overall, the researchers found that 10% of men with no military background reported urinary incontinence, compared to 18% of military veterans. In general, men with incontinence were more likely to be overweight, depressed and to have enlarged prostates, prostate cancer and multiple other chronic conditions such as diabetes, heart disease or chronic obstructive pulmonary disease.

And when the researchers separated the men into three age groups - 55 or less, 56 to 69 and 70 or above - they found no differences in incontinence rates based on military history in the two older groups. Among those 55 or younger, however, 9% of military men reported moderate to severe urinary incontinence, vs 3% of non-veterans.

There are two possible explanations for the link between urinary incontinence and military service: physical and psychological, according to urologist Dr. Christopher Amling of Oregon Health and Science University in Portland, who was not involved in the study. Blast forces like those suffered in combat might physically affect the bladder, he told Reuters Health.

Psychological stress is also linked to bladder irritation, which is tied to urinary incontinence, he said, adding that post-traumatic stress may have the same effect.

Brain health is closely linked to urinary function, he said. "We know that urinary incontinence can be associated with brain disorders of many kinds, including traumatic brain injury, depression or other psychiatric diagnosis."

More study is needed to further investigate the connection, Dr. Amling said, but perhaps the most curious finding was that the phenomenon was only seen among men under age 56.

**The study cannot prove that military service caused the incontinence. The younger veterans with urinary problems**

**may have been different from the civilians in other ways not accounted for by the analysis.** (Emphasis added)

The increased risk in the younger age group held, however, even after researchers adjusted for weight, depression, prostate conditions and other chronic diseases.

If the problem is tied to military service, the finding could mean that urinary repercussions of military service wear off over time, Dr. Vaughan suggested. Or, Dr. Amling said, the results might indicate that combat itself may have changed over the past decades, and young men serving in the military now face different kinds of stress than those experienced by men who served 20 or 30 years ago.

The link may exist for military women as well, but more data is needed for that group, Dr. Vaughan said.

In the meantime, Dr. Vaughan said, "military men should be aware that treatments for urinary symptoms like incontinence are available." (Source: Reuters Health, August 9, 2013)

**ED in Younger Men.** Traditionally considered the bane of aging men, erectile dysfunction (ED) is surprisingly common in younger men as well, according to the authors of a new study. Capogrosso, et al., University Vita-Salute San Raffaele, Milan, reported that of 439 men visiting a sexual medicine outpatient clinic complaining of new-onset ED, 114 (26%) were 40 years old or younger.

Moreover, the rate of severe ED was similar in younger and older men, and scores on the International Index of Erectile Function (IIEF) also were similar between the age groups. "Therefore, the observation as a whole appeared to us as a worrisome picture from the everyday clinical practice," the authors write.

For this retrospective analysis, which included men visiting the clinic between

January 2010 and June 2012, the authors defined ED as "the persistent inability to achieve or maintain an erection sufficient for satisfactory sexual performance." In addition to undergoing a comprehensive medical evaluation, including a detailed medical and sexual history and measurement of circulating testosterone levels, the men completed the IIEF, a 5-item questionnaire covering various aspects of sexual performance and satisfaction.

Compared with men older than 40 years, younger men had fewer comorbidities, a lower mean body mass index, lower rates of hypertension and hypercholesterolemia, and higher mean levels of circulating testosterone. Premature ejaculation was more common in younger men, whereas older men had higher rates of Peyronie's disease. Low libido was reported by 10 younger patients (8.8%) and 23 (7.1%) older patients. Older patients were more likely to be taking medications such as antihypertensive or antidiabetic agents, drugs for uricosuria and lower urinary tract symptoms, and proton pump inhibitors. Younger men, however, were more likely to smoke cigarettes and to use marijuana or cocaine. There was no difference in the rates of alcohol use between the groups.

On the IIEF, 56 (48.8%) of the younger men and 132 (40.6%) of the older men had scores indicating severe ED.

Potential limitations of this research include the relatively small cohort of men studied and their presence at a sexual medicine clinic, suggesting a possible selection bias for patients with more serious cases of ED. "However, we consider that this methodological flaw would be equally present in both age groups, thus not undermining the value of these findings," the researchers write. In addition, they did not assess the patients for depression or anxiety, they did not delve into the men's adolescent sexual history, and they did not account for socioeconomic differences among the patients.

These findings underscore the importance of taking a comprehensive medical and sexual history and performing a thorough physical examination in all men with ED, regardless of age, the authors conclude. "Likewise, given the low rate of seeking medical help for disorders related to sexual health, these results express even more the need that healthcare providers may proactively ask about potential sexual complaints, once more even in men younger than 40 years of age." (Source: *J Sex Med*, published online May 7, 2013, via Medscape Medical News, June 10, 2013)

**Rise in High-end Treatment for Low-risk Prostate Cancer.** The proportion of U.S. men with early, slow-growing prostate cancer who received robotic surgery and other expensive treatments increased between 2004 and 2009, according to a new study. Researchers found that use of those therapies also rose among men who were unlikely to die from prostate cancer because they were sick with other chronic diseases when their cancer was diagnosed.

Evidence has been building that a wait-and-see approach might be most effective for men with low-risk prostate cancer that may or may not progress, rather than scheduling surgery or radiation right away. But both doctors and patients have been hesitant to adopt that strategy, also known as watchful waiting or active surveillance, researchers said.

One observer noted that there is no incentive for doctors to do it, because there is no real payment, and it is not easy to do active surveillance. Furthermore, some patients may prefer the most advanced technology and get rid of the cancer, making them feel more secure.

Hollenbeck, et al., University of Michigan, analyzed data on about 56,000 older men diagnosed with prostate cancer and covered by Medicare, the government's health insurance program for the elderly and disabled.

They found that among men with low-risk cancers, use of high-end treatment - including robotic surgery and high-precision radiation, known as intensity-modulated radiation therapy - increased from 32 percent in 2004 to 44 percent in 2009.

Likewise, the technologies' use among men with other serious health problems increased from 36 percent to 57 percent. Those high-end treatments largely replaced the use of older therapies, which became less common. Close to half of men diagnosed with low-risk cancer across the study period took a wait-and-see approach.

According to Healthcare Blue Book, prostate removal costs about \$13,000 - and robotic surgery usually adds to the price tag. In addition, treatment also comes with a risk of side effects including impotence and incontinence. However, one of the challenges of taking a more conservative approach such as active surveillance is that there are no standards for how often to check men to make sure their cancer hasn't grown, or on when to intervene. And it's not always clear which patients are the best candidates for watchful waiting or active surveillance. It can also be hard to tell which men have a limited life expectancy because of other diseases, and which ones can expect to live long enough to possibly benefit from treatment.

The researchers concluded that patients that are older and have low-risk disease or have a lot of other health problems should certainly have a frank discussion with their physicians about the perceived benefits of actively treating their cancer as compared to active surveillance. (Source: Journal of the American Medical Association, online June 25, 2013, via Reuters Health, June 25, 2013)

**FDA Approves Enlarged Prostate Urine Flow Device.** The UroLift system has been approved by the U.S. Food and Drug Administration to treat low or blocked urine flow in men aged 50 and older who have an enlarged prostate. The new device, which helps prevent the prostate from pressing on the urethra, was evaluated in clinical stud-

ies involving 274 men between the ages of 49 and 86. Participants given the device reported fewer symptoms of enlarged prostate and a better quality of life, the FDA said.

The most common adverse reactions included pain or burning during urination, blood in the urine, and incomplete emptying of the bladder.

The UroLift system is produced by NeoTract Inc., based in Pleasanton, CA. (Source: Renal&UrologyNews. September 17, 2013)

**Insurers and Proton Beam Radiation.** Several major health insurance companies recently decided either to stop covering proton beam radiation therapy for early stage prostate cancer, or are reviewing their policies, saying it is less cost-effective when compared to the price of other comparable treatments.

The federal Medicare program, the most influential insurer, reportedly pays more than \$32,000 for the procedure, compared to about \$19,000 for more conventional radiation options. Proton beam advocates say the therapy's precision spares healthy tissue from radiation therapy, thereby reducing the side effects associated with other radiation treatments.

There are eleven proton-beam facilities in the United States, and at least fifteen more are in development. The standard treatment for early-stage prostate cancer is intensity modulated radiation therapy (IMRT). Proton beam advocates claim that the proton-beam technique targets the tumor more precisely, reducing complications. The prevailing cancer treatment guidelines cite the lack of relevant clinical trial data to support the claims of proton-beam advocates. The therapy is also used for other rarer tumors, such as pediatric brain cancer and eye tumors., where its use is less controversial. (Source: Business Section, The Wall Street Journal, August 28, 2013)



**(Dr. Barnard's Remarks - Continued from page 1)**

As Westernization influences take away those dietary practices, cancer rates go up. He added that several heterocyclic amines are likely to be carcinogenic to people because of the way meats, including beef, pork, fish, and poultry are cooked, using high temperature methods such as pan frying or grilling directly over an open flame. He explained the American Institute of Cancer Research also expressed concern with processed meats such as bacon, sausage, ham, hot dogs, and deli meats linked to cancer. The strongest link is with colorectal cancer, but many other forms of cancer may also be linked to the consumption of processed meats.

Lycopene, which gives tomatoes, watermelon and grapefruit their reddish pigment and are "a cousin" of the beta carotene found in carrots, which gives them their orange color, is "a powerful antitoxin and cancer preventer." He cited another Harvard study which showed men who ate tomato sauce, "just two or three servings per week, cut their prostate cancer risk by about a quarter. If they got more than that, it could cut their risk by a third or even more."

In discussing women, breast cancer and nutrition, Dr. Barnard said a woman with a diet low in fiber and high in fat, and has more estrogen, is at a higher risk for developing cancer. But if she does "a little bit of a diet change, she will get a little bit of result." He also encouraged people to maintain a consistent exercise regime.

The nutrition researcher said a healthy diet should include fruits, grains, legumes and vegetables, saying that there are plenty of proteins in beans, grains and vegetables. He noted when people follow a plant-based diet, they can possibly benefit by losing weight, lowering their cholesterol levels, feeling better, and surviving cancer.

Dr. Barnard's message was well-received by the audience. One attendee commented that the presentation was outstanding in every respect, finding the message clear, understandable, and convincing. He said it provided him with useful information about being a vegan. Another attendee said that Dr. Barnard made his case for alternative medicine by presenting evidence-based studies that he discussed convincingly. He was especially impressed by Dr. Barnard's conviction that a holistic approach to overall wellness, i.e., nutrition, exercise, and healthy lifestyle, is the "primary therapy," and that surgery, radiation, and the like, are the "actual alternative therapies."

Approximately 60 people attended from across the spectrum of the WRNMMC departments. The presentation was also video teleconferenced at Fort Belvoir Community Hospital.



**ADDITIONAL SELECTED ITEMS FROM DR. BARNARD'S PRESENTATION**

**Breast Cancer.** Dr. Barnard presented a series of slides that emphasized the relationship of food and cancer. In breast cancer, for example, the Shanghai Breast Cancer study showed a linkage between a "meat and sweet" diet and a 30% increased risk for breast cancer. A high fat, low fiber diet combined with excess body fat increases estrogen activity, leading to breast cancer promotion. Several other studies also show similar relationships between a high fat diet and cancer risk in women.

A meta-analysis of eight studies comparing Asian women (Asian diet with high soy consumption) and Asian-American women (western diet) found that the Asian women had a 29% decrease in breast cancer risk. Furthermore, Japanese women were less likely to develop breast cancer compared to U.S. women, and were more likely to survive, if cancer did develop. Also, 26 of 34 studies showed that excess weight increased the risk of breast cancer recurrence or a decrease in survival. In summary, breast cancer survival is enhanced by: reduction in body fat and dietary fat; consumption of fruits and vegetables combined with regular exercise; and soy consumption.

**Prostate Cancer.** The U.S. far exceeds other nations in the incidence of prostate cancer per 100,000 men, largely associated with high dairy product consumption. The well-known Physicians' Health Study found that 2.5 or more daily servings of dairy products led to a 34% increased risk of prostate cancer. Milk consumption affects hormones such as the Insulin-like Growth Factor I which moves sugar into cells and encourages cell proliferation. A follow-up study involving more than 47,000 medical professionals found that two servings of milk per day led to a 60% increased risk of prostate cancer.

Ornish, et al., studied how life style changes may affect the progression of prostate cancer. The control group maintained their normal dietary habits; the vegan group had an intensive vegan diet. After one year, the control group experienced a 6% increase in PSA and six of the its participants required cancer therapy; the vegan group saw a 4% decrease in PSA and none required cancer treatment.

A healthy diet "power plate" would include regular servings of fruits, vegetables, legumes and grains to provide the necessary protein, calcium and Vitamin B12. Processed meat products including bacon, sausage, ham, hot dogs, and deli meats should be avoided, if not eliminated. A healthy diet should have no artificial calorie limits, no portion sizes, no carbohydrate-counting, and provide benefits to encourage adherence.

**Visit the web site of the Physicians Committee for Responsible Medicine for more information about diet, exercise and health. Go to [www.pcrm.org](http://www.pcrm.org).**

**◆ WRAMC US TOO COUNSELORS ◆**  
**(As of November 1, 2013)**

**(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)
Bill Melton	Rockville, MD	(301) 460-4677	2001 ((External Beam Radiation)
Joseph Rosenberg	Kensington, MD	(301) 495-9821	2009 (Brachytherapy)
Barry Walrath	McLean, VA	(571) 969-8269	2001 (Brachytherapy)

**INCONTINENCE**

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

**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)
Charles Preble	Annandale, VA	(703) 560-8852	(Cryosurgery, Hormonal)
Ray Walsh	Annandale, VA	(703) 425-1474	1999, 2001 ((Surgery and Hormonal)

◆ MEETING ANNOUNCEMENT ◆

THURSDAY, NOVEMBER 7, 2013  
7 PM

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

◆ SPEAKER ◆

EDMOND L. PAQUETTE, MD  
DOMINION UROLOGICAL CONSULTANTS

◆ TOPIC ◆

"THE PSA CONTROVERSITY - WHAT PATIENTS SHOULD UNDERSTAND"

**We meet this month in River Conference Room (3d floor), America Building,** at the Walter Reed National Military Medical Center located at 8901 Wisconsin Avenue, Bethesda, MD 20889.

**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, November 6, 2013, to arrange for entry.** Have a photo ID card ready when arriving at the gate