

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

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◆ PROSTATE CANCER AWARENESS ◆

You don't have to be a communications expert to be aware of the large disparity in public awareness and media attention regarding breast cancer and prostate cancer. The reasons for this disparity are several and varied. The fact is that public awareness and media attention translate into research funding for these worthy causes. The breast cancer community does a magnificent job in mobilizing the sympathy and concern of the American public in the fight against breast cancer. The number of nationwide events for prostate cancer awareness is increasing, but the effort is miniscule compared to those for breast cancer. Nevertheless, prostate cancer organizations are working hard to enhance public awareness of the disease. One of the more promising efforts is ***Sneakers@Work Day***.

***Sneakers@Work Day*** is a nationwide workplace-based education, awareness and fund-raising event to focus attention on prostate cancer. Last year 647 companies participated in the event involving almost a quarter million men and women who are now well informed about the disease. The goal for 2008 is 2,000 companies. Here's how it works. Companies agree to participate and encourage their employees to wear sneakers with blue shoelaces to work on the designated day. Each participating employee donates \$5.00 and receives a pair of symbolic blue shoelaces. Promotional and educational materials provide useful information about prostate cancer to the participants. Us TOO chapter members can help by enlisting participating companies and by facilitating local events where possible. Us TOO members should contact their chapter leadership to get involved. Us TOO International is collaborating with the American Prostate Initiative, Inc., and the Dean and Betty Gallo Prostate Cancer Center, to conduct ***Sneakers@Work Day***. For more information, visit the Us TOO web site at [www.ustoo.org](http://www.ustoo.org) or call at (630) 795-1002.

**SNEAKERS@WORK DAY, 2008, IS SCHEDULED FOR FRIDAY, SEPTEMBER 19, 2008.**



**NATIONAL PROSTATE CANCER COALITION RUNNING FOR AWARENESS**

The National Prostate Cancer Coalition (NPCC) is racing for the cure with two new initiatives to raise awareness and funds for prostate cancer research. First, the NPCC is sponsoring a "Fight Prostate Cancer Team" to participate in the high-visibility Marine Corps Marathon on Sunday, October 26, 2008. Next, the NPCC spotlights Prostate Cancer Awareness Month with its inaugural ***Dash for Dads***, a 10K race on Sunday, September 28, 2008 in Alexandria, VA. The NPCC plans to replicate the ***Dash for Dads*** event nationwide. Both events reflect the NPCC's mission to eradicate prostate cancer through awareness, outreach, advocacy and research. If you are interested in participating in these significant events, visit the NPCC website at [www.fightprostatecancer.org](http://www.fightprostatecancer.org) or call toll free at 888-245-9455.

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◆ **FROM THE EDITOR'S DESK** ◆

First person accounts are very useful to our readership. Not only are they interesting, but more importantly, they provide personal insights to men who faced or are facing similar circumstances. First person accounts need not be unique or dramatic. A straightforward description of your prostate cancer experience is more important. And you need not be an English major to tell your story. We will work with you to present a worthy product. Interested? Good! Contact the newsletter editor as shown at the left to get the ball rolling.



We have discontinued our February evening speaker program. Accordingly, there is no speaker's summary in this issue of the newsletter.



◆ **MEETING SCHEDULE FOR MAY 7, 2008** ◆

Colonel Robert C. Dean, M.D., is our speaker for Wednesday, May 7, 2008 at 7 pm. He is the Director of Andrology (Male Sexual Health), WRAMC. Dr. Dean is a graduate of the University of Rochester and the Uniformed Services University of the Health Sciences. After an internship at Tripler Army Medical Center, Honolulu, he served his Urology Residency at WRAMC. Next, he completed a fellowship in Andrology at the University of California, San Francisco, before becoming the Director of Andrology at WRAMC. His interests include erectile dysfunction, medical management for erectile preservation, Peyronie's disease, and male infertility. Dr. Dean's topic will be "Life after Prostate Cancer: Effective Treatments for Erectile Dysfunction." Join us on Wednesday, May 7, 2008, at 7 pm in Joel Auditorium. Plan now to attend and bring your spouse or a friend. They are always welcome.

**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.

**Cryotherapy Said to be Effective.** Cryotherapy, freezing the prostate to kill cancer, may be as effective as more common treatments such as surgery and radiation, according to a follow-up study spanning 10 years. But the method remains controversial, and is currently the least-used method for treating prostate cancer in the United States. More than 60,000 prostate surgeries are performed in the U.S. each year; some 50,000 men receive brachytherapy; and about 30,000 men undergo external radiation for prostate cancer. It is estimated that there are probably 10 to 15,000 cryotherapy procedures performed annually in the United States. Miller, et al., Allegheny General Hospital, Pittsburgh, acknowledge that cryotherapy is controversial because the long-term results have been uncertain. Their 10-year follow-up study is the first of its kind and it found that clinical outcomes are basically the same as seed implant radiation and external radiation therapy, according to the researchers.



The researchers reviewed the cases of 370 men who underwent cryotherapy as their first-line treatment for various stages of prostate cancer. During an average of 12.5 years of follow-up, the researchers found that men with low-risk prostate cancer had a nearly 81 percent disease-free survival rate after undergoing cryotherapy. In addition, more than 74 percent of men with moderate-risk prostate cancer and almost 46 percent of men with high-risk malignancies experienced disease-free survival over the long follow-up period. The researchers say that men facing primary treatment decisions may want to consider cryotherapy, knowing that the results will be similar to other choices. Furthermore, cryotherapy is a salvage option after failing radiation therapy. In addition, patients with advanced prostate cancer may also benefit from cryotherapy in lieu of radiation. They

also note that the risks associated with cryotherapy, including incontinence, impo-

tence and treatment failure, are the same as those of other prostate cancer treatments.

On the other hand, the report was greeted by skepticism by one expert observer who notes that the study was not based on a randomized trial, so it is impossible to compare the results with the standard treatments of surgery and radiation. In his opinion, cryotherapy is still experimental and should not be viewed as equivalent to the conventional primary therapies. (Source: *Urology*, March 2008, via *HealthDay* News, March 18, 2008)



**Salvage Cryotherapy After Radiation Failure.** Researchers at St. Luke's Cancer Center, Guildford, Surrey, UK, say targeted cryoablation of the prostate (TCAP) is safe and effective for localized prostate cancer recurrence after radiotherapy. Salvage TCAP has previously been shown to increase disease-free survival in men with recurrent prostate cancer after radiotherapy, but its impact on quality of life and long-term survival remained uncertain. The researchers evaluated the biochemical outcome and complications after salvage TCAP in 100 men whose prostate cancer recurred after radiotherapy. The biochemical recurrence-free survival (BRFS) was 83% at 12 months, 72% at 24 months, and 59% at 36 months. When the patients were categorized into risk groups based on PSA level, Gleason score, and clinical stage before radiotherapy, the 5-year actuarial BRFS was 73% for the low-risk group, 45% for the intermediate-risk group, and 11% for the high-risk group.

Regarding side effects, perineal discomfort was common after the procedure, but only 4% of patients had prolonged perineal pain, and that was treated successfully with oral analgesia. A significant proportion of men had urinary urgency and frequency, and 13 men developed persistent incontinence after TCAP. Among the 14 men who reported adequate erectile function before cryotherapy, 6

regained the same activity, 6 had reduced erectile function, and 2 had complete loss of erectile function after TCAP. The overall rate of erectile dysfunction after TCAP was 86%. The researchers concluded that TCAP is safe, well tolerated, and effective for the salvage treatment of prostate cancer; it is minimally invasive, can be repeated, and is associated with low morbidity (except for erectile dysfunction); and for patients in whom radiotherapy has failed, it offers an additional hope of cure. They also recommend further research into long-term survival and quality of life. (Source: *Reuters Health Information*, November 5, 2007)



**Dendron Completes Enrollment for Provenge Trial.** Dendreon Corporation said it completed enrollment of more than 500 patients in a late-stage clinical study of its vaccine Provenge for advanced prostate cancer. The vaccine stimulates the immune system to fight existing tumors. Earlier, the drug had failed to show that it slowed the progress of advanced prostate cancer -- the main goal in two key trials conducted by the company. However, one analysis found patients receiving Provenge lived about 4.5 months longer. This new study, called IMPACT, is designed to test whether men with prostate cancer who are treated with Provenge live significantly longer than those treated with a placebo. It is a response to a U.S. Food and Drug Administration (FDA) request last May for survival data that would support approval of Provenge. The FDA action at that time was a source of great concern to the prostate cancer community. Cancer patients and citizen groups staged a protest at the FDA headquarters in Washington, D.C., demanding it to approve Provenge for men with advanced prostate cancer who had no other alternative treatment. Dendreon expects interim results from the IMPACT trial in the second half of 2008, a year earlier than previously expected. The company said the FDA will accept either a positive interim or positive final analysis of

overall survival from the study. (Source: *Reuters Health*, October 23, 2007)



**Follow the Money!** The National Cancer Institute (NCI) spends about \$6 billion a year in the war on cancer, allocating some funds for general cancer research and some for studies of specific cancers. But a review of the NCI 2006 funding for five of the biggest cancers (lung, prostate, breast, colon, pancreatic) showed a wide disparity in the amounts of money spent relative to each cancer death and each new case of cancer. The data offer an important but partial snapshot of public cancer spending in this country, as other government offices, such as the Department of Defense, also fund cancer research. The big loser in the cancer funding race is lung cancer. It is the biggest cancer killer in the country, yet on a per-death basis receives the least NCI funding among major cancers. In 2006, the NCI spent \$1,518 for each new case of lung cancer and \$1,630 for each lung cancer death.

Among the major cancers, breast cancer receives the most funding per new case, \$2,596, and by far the most money relative to each death, \$13,452. Notably, prostate cancer receives the least funding per new case at just \$1,318. But on a per-death basis, it ranks second with \$11,298 in NCI funds. (Source: *The New York Times*, March 6, 2008)



**Blood Test Indicates Spread of Prostate Cancer.** Testing men with prostate cancer for a substance called endoglin in their blood may help doctors know if the cancer has spread outside the gland to the lymph nodes, according to Roehrborn, et al., University of Texas Southwestern Medical Center, Dallas. They note it is known that removing the pelvic lymph nodes can provide important information about the prognosis of prostate cancer,

but it is still not clear in whom this procedure should be done. Previous research identified elevated levels of endoglin in patients with breast cancer and colon cancer that has spread, but whether endoglin levels are increased in prostate cancer patients had never been studied. The team studied 425 men who underwent surgical removal of the prostate and removal of the pelvic lymph nodes. The investigators found that men with elevated endoglin levels were more likely to have cancer that had spread to the lymph nodes, as well as other signs of more aggressive cancer. With existing standard factors, the researchers could predict with 89 percent accuracy whether the cancer had spread to the lymph nodes. When the endoglin measurement was included, the accuracy rose to 98 percent. If these results are confirmed in other studies, it might be possible to identify men whose prostate cancer has not spread with more certainty, and so spare them from having their lymph nodes removed. (Source: *Clinical Research*, March 1, 2008, via Reuters Health, March 5, 2008)



**Routine Prostate Cancer Screening.** The American College of Preventive Medicine (ACPM) says there is insufficient evidence to recommend for or against routine population prostate screening with the digital rectal exam (DRE) or measurement of PSA. Instead, ACPM advises that clinicians caring for men, especially African-American men and those with a family history, should provide information about the potential benefits and harms of screening and the limits of current evidence to allow for them to make an informed decision about screening. Prostate cancer is the leading type of cancer among U.S. men, and

the second leading cause of cancer deaths. While prostate cancer incidence increases with age, and men with a family history of prostate cancer and African-American men are at higher risk of both developing and dying from prostate cancer, there are both risks

and benefits associated with prostate screening. Further studies are needed to establish the efficacy and optimal age at which prostate cancer screening should be initiated in these high-risk population groups.

The ACPM's recommendation emphasizes that "Patient and clinician discussion about screening is important; however, a man should ultimately be allowed to make his own decision about screening while taking into consideration personal preferences and life expectancy. If the patient prefers to defer to the clinician or is unable to make a decision regarding screening, then testing should not be offered as long as the patient understands the associated benefits, potential limitations, and adverse effects." According to Dr. Michael Parkinson, President of ACPM, "Prostate cancer remains a significant concern among U.S. men today. ACPM will continue to review emerging evidence to determine and communicate the most effective methods to detect and prevent the disease." (Source: *Science Daily*, January 28, 2008)



**Cancer Death Rates Still Declining.** U.S. death rates from cancer have declined by 18.4 percent among men and by 10.5 percent among women since mortality rates first started going down in the early 1990s. This occurred for almost all of the major cancer sites for men and women, which include colon and rectum in both men and women, breast cancer in women, and prostate cancer in men. Death rates from cancer continue to decrease because of prevention, early detection and treatment. Still, more than a half a million Americans can be anticipated to die of cancer this year, the equivalent to nearly the

entire population of Washington, D.C. The decrease in smoking is a big part of the decline. Smoking rates have been decreasing for the last 30 to 40 years, when the Surgeon General issued his landmark report. In men, cancers of the prostate, lung, colon and rec-

tum represented about half of all newly diagnosed cancers. Prostate cancer alone accounted for one-quarter of the total cancer cases in men. (Source: *HealthDay News*, February 20, 2008)



### **Cholesterol-Lowering Drugs and Anti-Inflammatory Drugs and Prostate Cancer.**

A new study suggests that men with prostate cancer who take cholesterol-lowering statin drugs or anti-inflammatory drugs live longer than those who don't. Katz, et al., Saints Medical Center, Lowell, MA, say they found an association between both statin and NSAID use and the risk of dying of any cause. NSAIDs or nonsteroidal anti-inflammatory drugs, include aspirin, ibuprofen (sold as Motrin, Advil, and others) and naproxen (Aleve and others). Examples of statins include Zocor, Lipitor, Pravachol, Crestor, Lescol, and Mevacor.

The researchers studied more than 7,000 men who were diagnosed with localized prostate cancer between 1990 and 2003. About two-thirds underwent surgery to remove the prostate, while the rest selected radiation therapy. A total of 1,824 men reported they had taken statins, and about 1,830 reported NSAID use. The men were followed for an average of three and 1/2 years.

Results showed that men who reported ever taking statins were 41% to 65% less likely to die during the course of the study than men who didn't. Men who took NSAIDs were 53% to 61% less likely to die than those who did not. Taking statins or NSAIDs within 12 months after prostate cancer treatment did not extend lives.

While the study was not designed to explain how statins might protect cancer patients, other research has suggested that statin drugs keep prostate cancer cells from growing in the test tube. As for NSAIDs, some be-

lieve that anti-inflammatory drugs may attack prostate cancer at its biological roots. (Source: *WebMD*, February 18, 2008)



**Prostate Cancer's Effect on Caregivers.** An estimated 44 million Americans care for an adult family member, and that number is expected to grow. Yet little is known about how many of these caregivers suffer from their own psychological and physical symptoms. A recent study suggests that wives and other caregivers of men with prostate cancer may be at risk of anxiety, fatigue and other symptoms that exact a toll on the quality of their lives. Miaskowski, et al., University of California San Francisco, studied 60 female caregivers and found 40 percent had significant anxiety symptoms; 12 percent were suffering from depression; and about one-third reported substantial fatigue or sleep disturbances. Another 15 percent complained of bodily pain, according to the findings published in the *Journal of Clinical Oncology*.

The women, mostly wives, were 64 years old, on average, and their rates of each of these conditions surpassed the average for U.S. women their age, the researchers point out. Those symptoms often took a toll on the women's daily lives. Those with higher levels of depression, anxiety and fatigue also had the lowest scores on a standard measure of quality of life. The findings, based on a small sample, suggest that many family caregivers of cancer patients have health problems that need attention. (Source: Reuters Health Information, February 14, 2008)

**Nerve-Sparing Prostatectomy and Incontinence.** New research indicates that a nerve-sparing approach to radical prostatectomy shortens the period until continence is regained and improves long-term continence rates. Previous studies demonstrated that preservation of the neurovascular bundle can improve post-operative potency rates, but whether nerve-sparing surgery improves in-

continence was unclear, according to Zippe, et al., Cleveland Clinic Foundation. The researchers assessed incontinence rates in 152 patients who underwent radical prostatectomy with unilateral or bilateral nerve sparing or with no nerve sparing. During an average follow-up period of 7.8 years, 27 patients (17.7%) were incontinent. Eighteen of 61 patients treated with non-nerve sparing surgery were incontinent compared with just 6 of 66 treated with bilateral nerve-sparing surgery. By contrast, unilateral nerve sparing offered no benefit over non-nerve sparing. In addition to the type of surgery, patient age also affected incontinence rates; subjects older than 65 years were significantly more likely to become incontinent than were younger patients. The researchers concluded that all patients, irrespective of potency status and age, would benefit from nerve-sparing procedures when this is clinically feasible. (Source: *Urology* 2007; 70:1127-1130, via Reuters Health Information, January 31, 2008)



**Still Looking for Answers.** Last year, 218,000 men were diagnosed with prostate cancer, but nobody can tell them what type of treatment is most likely to save their lives. Those are the findings of a troubling new report from the Agency for Healthcare Research and Quality, which analyzed hundreds of studies in an effort to advise men about the best treatments for prostate cancer. The report compared the effectiveness and risks of eight prostate cancer treatments, ranging from prostate removal to radioactive implants to no treatment at all. None of the studies provided definitive answers. The agency review analyzed 592 published articles and studies of various primary treatments, including cryotherapy; minimally invasive surgery (laparoscopic or robotic-assisted radical prostatectomy); orchiectomy (testicle removal); hormone therapy; high-intensity ultrasound; radiation therapy; and watchful waiting. No one treatment emerged as the best option for prolonging life. And it

was impossible to determine whether one treatment had fewer or less severe side effects. Many of the treatments now in widespread use have never been evaluated in randomized controlled trials. In the research that is available, the characteristics of the men studied varied widely. And investigators used different definitions and methods, making reliable comparisons across studies impossible.

The agency highlighted these findings:

- All active treatments cause health problems, primarily urinary incontinence, bowel problems and erectile dysfunction. The chances of bowel problems or sexual dysfunction are similar for surgery and external radiation. Leaking of urine is at least six times more likely among surgery patients than those treated by external radiation.
- Urinary leakage that occurs daily or more often was more common in men undergoing radical prostatectomy (35 percent) than external-beam radiation therapy (12 percent) or androgen deprivation (11 percent).
- External beam radiation and androgen deprivation were each associated with a higher frequency of bowel urgency (3 percent) compared with radical prostatectomy (one percent).
- Inability to attain an erection was higher in men undergoing active intervention, especially androgen deprivation (86 percent) or radical prostatectomy (58 percent) than in men receiving watchful waiting (33 percent).
- One study showed that men who choose surgery over watchful waiting are less likely to die or have their cancer spread, but another study found no difference in survival

between surgery and watchful waiting. The benefit, if any, appears to be limited to men under 65.

- Adding hormone therapy prior to prostate removal does not improve survival or decrease recurrence rates, but it does increase the chance of adverse events.
- Combining radiation with hormone therapy may decrease mortality. But compared with radiation treatment alone, the combination increases the chances of impotence and abnormal breast development.

The agency noted that studies comparing brachytherapy, radical prostatectomy, external-beam radiation therapy or cryotherapy were discontinued because of poor recruitment. Two ongoing trials, one in the United States and one in Britain, are evaluating surgery and radiation treatments compared with watchful waiting in men with early cancer. Other studies in progress or development include cryotherapy versus external beam radiation, and a trial evaluating radical prostatectomy versus watchful waiting. An accurate assessment of the comparative effectiveness and harms of therapies for localized prostate cancers awaits the outcomes of these studies. (Source: *Ann Intern Medicine*, online February 4, 2008, via *The New York Times*, February 5, 2007)



**Older Men, Hormone Therapy, and Cardiovascular Factors.** D'Amico, et al., Brigham and Women's Hospital, Boston, MA, report that adding hormone therapy to radiation treatment for aggressive prostate cancer can save lives, but the benefit often doesn't apply to men who have other serious medical problems. An earlier study effort said that treatment to suppress male hormones (androgens) improved survival of older men with aggressive prostate cancer. This recent study says the benefit was limited to men without other serious medical problems, especially cardiovascular considerations. Adding hormone therapy to radiation treatment in the 206-man study decreased the rate of death significantly, but the benefit was confined to men without other health issues. The

researchers said that if a man is 75 and otherwise healthy, adding hormone therapy is likely to help. If the same man has had a heart attack or stroke, or if he is a smoker or diabetic, adding hormone therapy makes things worse. They also note that such a precaution is common practice, i.e., any surgical procedure must take into consideration the patient's other health issues before proceeding. The average age of men in the study was over 70. An observer said the study is relatively small and requires further confirmation, but it does provide useful information to the patient and his doctor in considering hormone therapy. Until now, only general advice about hormone treatment could be given to such men, he said. "Now we can be a little more specific and say, 'If you don't have underlying cardiac disease or other major comorbid conditions, the chance of having a good response to the treatment is better.' But many men with heart disease or other problems may decide they do not want to deal with the side effects of hormone treatment." (Source: *Healthday News*, January 22, 2008)



**On the Other Hand, ADT Has Some Advantages!** Roach, et al., University of California, San Francisco, say that just four months of hormonal therapy before and with standard external beam radiation therapy slowed cancer growth by as much as eight years, especially the development of bone metastases, and it increased survival in older men with potentially aggressive prostate cancer. This neoadjuvant hormonal therapy may allow men most at risk of developing bone metastases to avoid long-term hormonal therapy later on. Importantly, the short-term hormonal therapy did not increase the risk of cardiovascular disease which is a potential side effect of long-term hormonal therapy. The researchers studied 224 men with high-risk prostate cancer who received ADT (goserelin and flutamide) before and concurrent with external beam radiation therapy, and 232 men with the disease who received radiation ther-

apy alone. After 13 years of follow up, they found better 10-year disease-specific death rates for men who received ADT plus radiation (23 percent versus 36 percent of the radiation-only group); better disease metastasis rates (35 percent versus 47 percent); better disease-free survival at 10 years (11 percent versus 3 percent); and better biochemical failure rates (65 percent versus 80 percent). Among men who received neoadjuvant hormonal therapy, there was up to an eight-year delay in the time it took 40 percent of patients to develop bone metastases compared with men receiving radiation alone. Fatal cardiac events occurred in 12 percent of patients in the ADT group compared with 9 percent of the radiation-only group--a difference that was not statistically significant.

The researchers said the study demonstrates that the benefits of short-term hormonal therapy for men receiving radiation therapy for prostate cancer far outweigh the risks; four months of hormonal therapy isn't enough to cause significant side effects; and it can delay the development of bone metastasis by as many as eight years. (Source: *Journal of Clinical Oncology*, January 2, 2008, via *ScienceDaily*, January 2, 2008)

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### **Wait, There's More! Another ADT ITEM.**

Androgen deprivation therapy (ADT) may increase the risk of subsequent diabetes in men with prostate cancer. Lage, et al., HealthMetrics Outcomes Research, Groton, CT, conducted a retrospective study using a claims database to compare 1,231 prostate cancer patients treated with ADT with 7,250 prostate cancer patients who did not undergo hormone treatment. They found that comorbidities including hypertension and cardiovascular disease, demographic characteristics, prior statin use, and treatment with ADT all affected the probability of incident diabetes within one year. After controlling for other factors, the estimated relative risk of incident diabetes associated with ADT was a signifi-

cant 1.36. The researchers note that ADT is the hallmark strategy for prostate cancer patients with high risk of progressive disease or with advanced cancer, and more needs to be learned about the metabolic consequences associated with this treatment. They conclude that the metabolic effects, including increased risk of diabetes and metabolic syndrome should be considered when treating men with prostate cancer, as well as with the other more commonly recognized effects such as hot flashes, decreased libido, and physiologic effects such as increased bone loss and muscle wasting. (Source: *Urology* 2007;70:1104-1108, via Reuters Health Information, January 22, 2008)

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### **The Role of the DRE in Prostate Cancer Screening.**

Recent research argues that the digital rectal examination (DRE) should not be excluded from prostate cancer screening protocols. Catalona, et al., Northwestern University Feinberg School of Medicine, Chicago, IL, compared clinical variables and survival outcomes between patients diagnosed with prostate cancer by DRE alone versus those diagnosed by PSA level, regardless of DRE findings. They studied 2,233 men who were diagnosed with prostate cancer and underwent radical prostatectomy; 303 (14%) were diagnosed on the basis of DRE alone, 1,426 (64%) on the basis of PSA alone, and 504 (22%) based on abnormalities of both tests. Eighteen percent of men who underwent a prostate biopsy because of abnormal DRE findings alone were diagnosed with prostate cancer. Twenty percent of cancers detected by DRE alone were non-organ confined, 20% had a Gleason score of 7 or higher, 16% had positive surgical margins, 3% had seminal vesicle invasion, and 1.3% had lymph node metastases. Adverse pathology was significantly more likely in men with abnormalities in both DRE and PSA than in those detected by either test alone. Ten-year progression-free survival was similar for cancers detected by DRE only (83%) or PSA only (82%), but sig-

nificantly lower for cancers detected by abnormalities in both DRE and PSA (63%), the investigators note. Similar results were seen for overall survival and cancer-specific survival. The researchers concluded that: performing both the DRE and the PSA test provides a better evaluation of the prostate; eliminating the DRE would miss a significant proportion of patients with a clinically important and potentially curable prostate cancer; it may be reasonable to avoid DRE in men with a PSA level less than 1 ng/mL; and PSA testing and the DRE must be continued on a regular (annual) basis to be most effective because persistent changes over time are as important as the absolute findings at any one point in time. (Source: *Urology* 2007;70:1117-1120 via Reuters Health Information, January 24, 2008)



### **Moderate Exercise and Bone Density.**

Walking exercise programs appear to slow and might even reverse bone loss from androgen deprivation therapy and radiation for prostate cancer, a surprise finding shows. The investigators were actually exploring the effects of exercise on other quality-of-life measures, such as fatigue, the ability to sleep, nausea, and cardiac fitness, but their efforts directed their attention to the relationship of exercise to bone density in certain prostate cancer treatments. The analysis included 70 sedentary men with stage 1, 2, or 3 prostate cancers who were randomly assigned to either a walking program or no exercise during radiation treatment. More than half of these patients were also receiving hormone therapy. The researchers collected

data before and after radiation therapy, including DEXA scans and self-reported physical activity.

It is estimated that men undergoing androgen deprivation therapy lose between 4% and 13% of their bone mass each year — a rate that is much higher than the average healthy middle-aged man, who is said to lose no more than 1% of his bone mass per year. Chiplis, et al., Johns Hopkins University, Baltimore, found that prostate cancer patients who did not exercise lost more than 2% of their bone density in just 8 to 9 weeks. The researchers said that patients who walked about 5 times a week for 30 minutes at a moderate pace maintained or gained bone density. Men are not typically considered to be at risk for osteoporosis and bone fractures, yet their rate of bone loss has been reported to be often greater than that of the average postmenopausal woman.

The researchers acknowledge that the study sample was small, but suggest that the statistically significant finding in such a small group of patients only serves to strengthen the result. They conclude that exercise has important and demonstrable positive effects in preserving bone mass. (Source: *Medscape Medical News*, October 29, 2007)



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Ray Walsh	Annandale, VA	(703) 425-1474	
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### **HORMONAL**

"Mac" Showers	Arlington, VA	(703) 524-4857	
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### **WATCHFUL WAITING**

Tom Baxter	Haymarket, VA	(703) 753-8583	
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### **CLINICAL TRIALS**

Philip Brach	Washington, DC	(202) 966-8924	
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### **SPOUSE SUPPORT**

Kay Gottesman	North Bethesda, MD	(301)530-5504	
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### **OTHER THERAPIES/MULTIPLE THERAPIES**

Howard Bubel	Fairfax, VA	(703) 280-5765	(Cryosurgery, Hormonal, Sexual Function)
Arthur E. Clough	Kerryville, TX	(210) 896-8826	(Surgery and Radiation)
S.L. Guille	Sumerduck, VA	(540) 439-8066	(Surgery, Radiation, Hormonal)
Richard Leber	Chapel Hill, NC	(919) 942-3181	(Surgery, Radiation, Hormonal)
Charles Preble	Annandale, VA	(703) 560-8852	(Cryosurgery, Hormonal, Intermittent Hormonal)
Emerson Price	Absecon, NJ	(609) 652-7315	(Hormonal, Radiation, Cryosurgery)
S.L. Ross	Alexandria, VA	(703) 360-3310	(Brachytherapy, Radiation, Hormonal)
Ken Simmons	Alexandria, VA	(703) 823-9378	(Radiation and Hormonal)
Bill Stierman	Vienna, VA	(703) 573-0705	(Surgery and Hormonal)
Ray Walsh	Annandale, VA	(703) 425-1474	(Surgery and Hormonal)

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**OFFICIAL BUSINESS**

**◆ MEETING ANNOUNCEMENT ◆**

**WEDNESDAY, MAY 7, 2008  
7 PM**

**JOEL AUDITORIUM (SECOND FLOOR)  
MAIN HOSPITAL BUILDING, WRAMC**

**◆ SPEAKER ◆**

**COLONEL ROBERT C. DEAN, M.D.  
DIRECTORY OF ANDROLOGY  
WALTER REED ARMY MEDICAL CENTER**

**◆ TOPIC ◆**

**“LIFE AFTER PROSTATE CANCER: EFFECTIVE TREATMENTS  
FOR ERECTILE DYSFUNCTION”**