

**WRNMMC Us TOO, Inc.**  
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**◆ The Link Between Prostate Cancer and Osteoporosis ◆**

Osteoporosis is a condition in which bones become weaker, less dense, and more likely to break. Many people—even some doctors—think of osteoporosis as a women’s disease, but millions of men develop it, too. Men who break bones are less likely than women to be treated for bone disease, even though treatment can help prevent broken bones in the future.

**The Link Between Prostate Cancer and Osteoporosis.** Studies show that men who receive hormone deprivation therapy for prostate cancer have an increased risk of developing osteoporosis and broken bones. Hormones such as testosterone protect against bone loss. Once these hormones are blocked, bone becomes less dense and breaks. Vitamin D plays an important role in calcium absorption and bone health. Some individuals may require vitamin D supplements to achieve the recommended intake of 600 to 800 IU (International Units) each day.

Hormone deprivation therapy is one of several treatment options available to men with prostate cancer. Traditionally, it has been used mainly to treat prostate cancer that has spread to other parts of the body. But because men are more likely today to be diagnosed in the early stages of prostate cancer, more of them are opting to be treated with hormone deprivation therapy earlier in the course of the disease.

**Osteoporosis Management Strategies.** Several strategies can reduce a man’s risk for osteoporosis, or lessen its effects if he already has it.

**A. Nutrition.** Some studies have suggested a link between a high-fat diet and prostate cancer. However, it is not yet clear which foods or supplements may play a role in reducing the risk of prostate cancer. As far as bone health is concerned, a well-balanced diet rich in calcium and vitamin D is important. Good sources of calcium include low-fat dairy products; dark green, leafy vegetables; and calcium-fortified foods and beverages. Taking dietary supplements or multivitamins also can help ensure that you meet your body’s daily calcium requirement.

However, some evidence suggests that high calcium intake might be associated with the development of prostate cancer. But the studies that produced these findings are not definitive. In fact, other studies have shown a weak relationship, no relationship at all, or the opposite relationship between calcium and prostate cancer. **(CONTINUED ON PAGE 8)**

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◆ FROM THE EDITOR ◆

Do you know persons who would benefit from receiving this newsletter? Put them in contact with the editor as shown at the top, left, of this page. Also, we solicit your recommendations for topics for our quarterly meetings. Contact the editor with your suggestions.

◆ SPEAKER'S REMARKS - FEBRUARY 4, 2016 ◆

Our February program featured a presentation by Nancy Tschiltz, Registered Dietician, within WRNMMC's Integrative Cardiac Health Project. Her timely topic was "Nutrition and Cancer." A summary of her remarks begins on page 10.

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◆ MEETING SCHEDULE FOR MAY 5, 2016 ◆

Our speaker for Thursday, May 5, 2016, is Dr. Philip M. Arlen, Medical Oncologist, National Cancer Institute, whose topic is "**Prostate Cancer: An Overview and Update of Novel Treatment Modalities**." Please join us at 7:00 PM in the America Building (Bldg 19), 2nd floor, Room 2525. Remember, your family and friends are also welcome.

(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.)

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

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## ◆ PROSTATE-SPECIFIC ISSUES ◆

**Early Salvage Radiation Extends Prostate Cancer Survival.** Researchers suggested that even when very low levels of prostate specific antigen (PSA) appear following definitive surgical treatment for prostate cancer, clinicians should consider beginning salvage radiation therapy—and the earlier the better.

Danielle Rodin, MD, et al., Princess Margaret Hospital/University of Toronto, found worse outcomes with each increment of 0.1 ng/mL in PSA. They looked at a number of possible risk factors for prostate cancer progression, and at how low one should go before initiating salvage therapy in regard to PSA values. They thought that the lower, the better!

When PSA reached a threshold of 0.3 ng/mL, each 0.1 ng/mL higher resulted in higher rates of progression. PSA values greater than 1.0 ng/mL at time of salvage radiotherapy were associated with 3.5 times the risk of the rate of progression. They also found that when the PSA was less than 1 ng/mL, PSA doubling time was actually a more significant predictor of disease progression than the actual PSA value itself.

Rodin and her colleagues examined the histories of 726 consecutive prostate cancer patients receiving post-operative radiotherapy between 1992 and 2013 at Massachusetts General Hospital. The researchers excluded patients who had undergone adjuvant radiation, were diagnosed with metastatic disease at the time of salvage radiation therapy, or those patients who had received salvage radiation therapy prior to the year 2000.

Salvage radiotherapy is used to treat recurrent prostate cancer following surgery, but treatment failure occurs in up to 40 percent of cases. Optimal PSA levels at which to initiate salvage radiotherapy and prevent subsequent progression have not been firmly established, particularly compared to other risk factors. In addition to doubling time as a risk factor, Rodin observed that Gleason score, extracapsular extension, and pre-salvage PSA levels were also significant influences in progression of recurrent disease.

The researchers say their work adds to a lot of the literature supporting radiation salvage. "When you are looking at a patient and evaluating all the risk factors, if you see rapid doubling time in a patient with very low PSA I think that would support starting salvage therapy," they said.

A commentator said that the study supports a large body of evidence that has accumulated which implicates the role of PSA doubling time being predictive of radiotherapy outcomes. It also supports the fact that the higher the baseline PSA, the lesser the chance that radiation therapy will have a meaningful impact. All in all, this makes a compelling argument towards using radiotherapy earlier in this context, but perhaps the authors make the best point in suggesting that randomized clinical trials are really what is needed for this purpose of determining when to use salvage radiation."

The researchers also evaluated whether the type of surgery might have made a difference in outcomes. About 64 percent of the men underwent an open operation, 31 percent had a laparoscopic procedure, and 5 percent were treated using robot-assisted technology. The type of surgery appeared to have no impact on risk of progression. Among the study participants, the median time to disease progression was 6.03 years following salvage radiotherapy. Of 388 patients, 165 developed progression. There were 17 deaths among the men included in the trial; four of those deaths were due to prostate cancer. (Source: *On-*

### **Treatment at a High-Volume Facility and Improved Survival for Radiation-Treated Men With High-Risk Prostate Cancer.**

Although the association between higher hospital volume and improved outcomes has been well-documented in surgery, there is little data about whether this effect exists for radiation-treated patients. The researchers investigated whether treatment at a radiation facility that treats a high volume of prostate cancer patients is associated with improved survival for men with high-risk prostate cancer.

We used the National Cancer Database to identify patients diagnosed with prostate cancer from 2004 to 2006. A total of 19,565 radiation-treated high-risk patients were identified. Median follow-up was 81 months. The radiation case volume of each hospital was based on its number of radiation-treated prostate cancer patients. We used statistical techniques to compare the overall survival of high-risk prostate cancer patients in high versus low volume hospitals. The primary endpoint was overall survival.

The results suggest that treatment at centers with higher prostate cancer radiation case volume is associated with improved overall survival for radiation-treated men with high-risk prostate cancer. (Source: *International Journal of Radiation Oncology, Biology, Physics*, December 14, 2015 [Epub])

**Discontinue Erectile Dysfunction Drugs Before Surgery.** The American Association of Nurse Anesthetists (AANA) is recommending that men avoid erectile dysfunction medications before surgery. Men undergoing surgery should inform their anesthesiologist about any use of erectile dysfunction drugs. Erectile dysfunction medications that contain nitric oxide can cause a patient's blood pressure to become dangerously low when combined with anesthesia and other drugs used during surgery, according to the AANA, and are best avoided preoperatively.

The group advises men not to take Viagra or Cialis the day before surgery because the drugs take more than 24 hours to clear the body. It's also important for men to inform the person administering their anesthesia about their use of erectile dysfunction drugs. "Anesthesia professionals need to know this information to prepare the anesthesia plan, and to keep patients safe," Juan Quintana, RN, AANA president, said in a new release from the association. (Source: News Release, American Association of Nurse Anesthetists. Published March 22, 2016; via HealthDay News, March 23, 2016)

**Survivorship Information Is Scarce for Longer-term Survivors of Cancer.** Unmet health information needs, even nearly a decade after a cancer diagnosis, were a key finding of a study of the needs of cancer survivors who are at least 9 years beyond an initial diagnosis.

According to the researchers found that this group is especially interested in receiving information on cancer screening, the long-term side effects of cancer and treatment, and how to live a healthy lifestyle (e.g., diet and physical activity). They also found that information needs may differ depending on a person's age, race/ethnicity, education level, type of cancer, and even how they rate their own health," said authors Mary Playdon, Tara Sanft, MD, and Brenda Cartmel, PhD, in a question and answer session; all are affiliated with Yale

University in New Haven, CT.

They explained that a Survivorship Care Plan (SCP) covers all of the information needs they identified in this group. An SCP is a document provided to patients after completing cancer treatment. It summarizes their treatment and describes its long-term effects. It also describes screening for cancer recurrence or second cancers, advice on healthy living, and support in the community. However, SCPs were not common practice a decade ago, and so most of the study's participants did not receive them.

The researchers say that health care providers need to recognize that, even years later, cancer survivors may still need health information related to their cancer. A lot of this information can be provided through the current format of the SCP. Furthermore, printed material is currently the preferred format because the study population was an older generation of cancer survivors who are now approximately 65 to 70 years. (Source: The American Cancer Society's Study of Cancer Survivors [published online ahead of print January 7, 2016]. *J Cancer Surviv*. doi:10.1007/s11764-015-0513-4.)

**Radical Prostatectomies Mostly Performed Robotically.** A recent study finds that 85% of all radical prostatectomies performed by urologists in 2013 were robot-assisted procedures, compared with just 22% in 2003. Robot-assisted laparoscopic prostatectomy (RALP) is performed 5 times more than open radical prostatectomy (RP) and accounts for 85% of all RPs performed by urologists in 2013.

Oberlin, MD, and colleagues from Northwestern University Feinberg School of Medicine in Chicago examined 6-month case logs from 6,563 urologists, or 2/3 of urologists in the United States certified by the American Board of Urology from 2003–2013. Of these, 68% had performed at least 1 RP in 6 months.

Relatively few surgeons performed a high volume of procedures, however. Overall, 39% of surgeons performed 2 or fewer open RPs within 6 months and 19% performed 2 or fewer RALPs. The median number of open RPs was 2 and RALPs, 8. The highest volume robotic surgeons performed 41% of RALPs. Open RP was more likely to be performed by lower volume surgeons. Oncologists represented just 4.1% of surgeons but performed 15.1% of RP. General urologists performed the majority (57.8%) of RPs.

The researchers noted that influence of surgeon volume on patient outcomes is a hotly debated topic in surgery today, with studies showing that surgeons who perform a low volume of specialized procedures per year have increased mortality, postoperative infections, and revision rates. They also noted that the literature describes significant improvement in potency and continence when patients have procedures at high-volume centers. A minimal surgical volume for proficiency has yet to be established.

The study's findings corroborate trends found in previous research. (Source: *Urol Oncol*, doi:10.1016/j.urolonc.2016.01.008, via Renal and Urology News, March 2, 2016)

**PSA Testing Differs Among Primary Care Doctors, Urologists.** Urologists are far more likely than primary care doctors to do prostate cancer screenings known as prostate-specific antigen (PSA) testing, a new study reports. For the test, a blood sample is taken and sent to a laboratory to check for levels of a protein produced by cells of the prostate gland.

PSA testing declined overall after the U.S. Preventive Services Task Force in 2011 recommended against routinely screening all men. But the new research finds the falloff was sharper among primary care doctors than urologists. Between 2010 and 2012, PSA testing decreased from about 36 percent to 16 percent at primary care physician visits, but only from about 39 percent to 34 percent at urologist visits, the researchers found.

This discrepancy may reflect different perceptions of the benefits of the test among doctors. The greater decline in PSA testing among primary care doctors could also stem from conflicting prostate cancer screening guidelines and differences in patients' demographics or expectations, the study authors suggested.

This finding emphasizes the need to continue interdisciplinary dialogue to achieve a broader consensus on prostate cancer screening," the researchers concluded. The study involved nearly 1,200 preventive office visits made by men aged 50 to 74 who were not diagnosed with cancer or any other prostate condition. Primary care doctors were seen in 1,100 of these visits. The others were examined by a urologist, a doctor who specializes in the urinary tract. (Source: *JAMA Internal Medicine*, news release, February 8, 2016 via HealthDay News, February 8, 2016)

### **Penile Rehabilitation after Radical Prostatectomy: an Attracting Illusion or a Standard Reality?**

Erectile dysfunction following radical prostatectomy represents a major concern for patients and physicians and generates much of the controversy associated with the treatment of low risk disease. Spontaneous return of erectile function after the procedure is awaited during the first 4 years and is affected by several factors. Some of these factors are patient dependent and others are the results of the surgeon expertise and the surgical technique applied.

As such, younger and healthier patients with no cardiovascular morbidities have better sexual outcome than their older and sicker counterparts. Preoperative erectile function is another important variable affecting postoperative erectile recovery. Motivated patients with sexually functional partner and a preoperative IIEF-EF score  $\geq 26$  have the best results in terms of postoperative satisfactory sexual activity. Bilateral high anterior release nerve sparing procedure performed by experienced surgeons in order to avoid stretching, heating and/or crushing the neurovascular bundles as well as to preserve any accessory cavernosal artery yields the highest erectile function recovery rates. However, these rates are unsatisfactory as only one third of potent patients will recover their preoperative status. The substantial burden on the quality of life of the remaining patients had urged the scientific community to understand the pathophysiology of surgically induced erectile dysfunction.

Animal models reproducing cavernous nerve damage occurring during radical prostatectomy have demonstrated that temporary loss of erection results into decreased oxygenation. The temporary state of constant low oxygen supply leads to endothelial cell dysfunction, smooth muscle apoptosis and fibrotic changes in the corpora cavernosa as well as disrupts veno-occlusive mechanism. These irreversible structural and hemodynamic changes rendered uneventful spontaneous recovery of erectile function even after the disappearance of neurapraxia. The concept of cavernosal tissue oxygenation during this period raised hope by preserving endothelial and smooth muscle function while awaiting the return of cavernous neural transmission. As such, hyperbaric oxygen therapy after cavernous nerve crush in rats improved erectile function. Based on these rationales, several authors translated the concept of early oxygenation to humans applied marketed drugs

and/or devices used to treat erectile dysfunction. These authors found controversial results. Additionally, the largest study to date found no long term effect of PDE5I administration following radical prostatectomy compared to placebo and high quality studies for other available drugs or devices are lacking. However, despite the absence of proper data, penile rehabilitation is recommended by the majority of scientific societies and practitioners are divided according to the optimal rehabilitation program.

It is well known that oxygen tension in the flaccid penis is in the hypoxic range and that oxygenation occurs during the erect state. However, to date, no studies have proven an in vivo derangement of endothelial or smooth muscle cell metabolism secondary to a prolonged flaccid state. Recently, Martinez-Salamanca et al. have demonstrated that endothelial function and cavernosal sensitivity to PDE5I are preserved in erectile tissue of patients suffering from erectile dysfunction after radical prostatectomy. The content of fibrosis and the amount of smooth muscle apoptosis in their penile tissues were not significantly different from those in normal patients without erectile dysfunction. Their results do not support and even challenge the concept of penile rehabilitation to avoid hypoxia induced apoptosis and fibrosis using PDE5I. However, it suggests that if PDE5I are efficacious in penile rehabilitation programs following nerve sparing radical prostatectomy, another mechanism could be solicited.

Thus, practitioners must remain vigilant about flawed animal models and their limitations. Reversely, positive clinical bedside findings that were not predicted by animal testing-such as negative results of PDE5I in clinical studies- should backtracked the bridge of translational gap and be used to refine the preclinical models. By doing so, we can add some solid evidence to our current standards. (Source: ScientificWorldJournal. 2015;2015:876046. doi: 10.1155/2015/876046)

**Radiotherapy for Prostate Cancer and Risk of New Tumors.** Prostate cancer patients who undergo radiotherapy raise their risk of getting other cancers by nearly 70 per cent, a new study suggests. Health experts have warned that men who have low risk prostate cancer should not be given radiotherapy to avoid triggering future disease elsewhere.

Researchers in the US and Canada looked at 21 studies to determine if the treatment did cause secondary tumors to develop. They concluded that second malignancy should be added to the already long list of avoidable hazards associated with treatment for those men with low risk prostate cancer. The analysis suggests that the risk of developing bowel cancer within 10 years of radiotherapy rose by 68 per cent, while the odds of rectal cancer increased by 62 per cent and bladder cancer by 39 per cent.

Around 47,000 men are diagnosed with prostate cancer each year and many will be given radiotherapy, particularly as the first line of defense against low grade cancer. At least two thirds will have it at some point in their treatment. But many health experts now believe that small, slow growing tumors should be left alone and simply monitored rather than targeting them with aggressive treatments which can lead to debilitating side effects. The new study suggests that treatment could also have long term health implications, particularly for men who develop prostate cancer in middle age. The researchers say they identified an association between radiotherapy for prostate cancer and the development of secondary cancers of the bladder, colorectal tract, and rectum, compared with no radiotherapy or surgery.

The implications for clinical practice include use of these results in discussion with patients

for decision making. In particular, for patients with a long life expectancy of 20 years or more, the possibility of secondary malignancy related to radiation needs to be included in management discussion. This information could be particularly important to a large proportion of patients where treatment is recommended and according to treatment guidelines where surgery or radiation would be equal options for them to choose. The researchers point out the overall chance of developing secondary cancer is still low, but they say that radiotherapy is an "avoidable risk" that should be added to the already long list of avoidable hazards associated with treatment for those men with low risk prostate cancer who simply need no treatment at all.

Ultimately, clinicians and patients must decide together whether, for example, the roughly 1.4 -1.7 fold increase in relative risk of a second malignancy after a 10 year lag period justifies alternative treatments.

Previous studies have shown that radiotherapy caused new cancers in patients treated for Hodgkin's lymphoma. But it has been trickier to spot a link in prostate cancer because often men develop it when they are older and do not live long enough for a second tumor to develop.

The researchers acknowledge that despite an impressive relative risk, the absolute risk remains small, and the cancers discovered, although certainly requiring treatment, might not be lethal. It should not stand in the way of an effective and well-studied treatment being given to men with higher grade, lethal prostate cancer for whom the potential benefit simply dwarfs the risk. (Source: *The Telegraph*, News/Science 12181321, March 28, 2016)

### **(Osteoporosis - Continued from Page 1)**

At this point, researchers can only say that the relationship between calcium and prostate cancer risk remains unclear. Currently, it is recommended that men age 19 to 70 consume 1,000 mg (milligrams) of calcium per day, and those over age 70 consume 1,200 mg per day.

**Exercise.** Like muscle, bone is living tissue that responds to exercise by becoming stronger. The best exercise for bones is weight-bearing exercise that forces you to work against gravity. Some examples include walking, climbing stairs, dancing, and weight more easily training. Regular exercise, such as walking, may help prevent bone loss and provide many other health benefits, such as reducing pain, relieving stress, and making cancer treatment easier to handle.

**Healthy lifestyle.** Smoking is toxic to bones as well as the heart and lungs. In addition, smokers may absorb less calcium from their diets. Studies also have found that heavy drinking hurts your overall health, weakens your bones, and increases your risk of broken bones. Moderate drinking—for most men, this means not more than two alcoholic drinks per day—has not been shown to hurt your bones.

**Bone mineral density test.** A bone mineral density (BMD) test is the best way to determine your bone health. BMD tests can identify osteoporosis, determine your risk for fractures (broken bones), and measure your response to osteoporosis treatment. The most widely recognized BMD test is called a dual-energy x-ray absorptiometry (DXA) test. The test is painless—a bit like having an x-ray, but with much less exposure to radiation—and

can measure bone density at your hip and spine.

Men being treated for prostate cancer with hormone deprivation therapy should discuss with their doctor whether BMD testing is a good idea. Don't wait for your doctor to bring up your bone health with you. A new study shows that many men on hormone deprivation therapy for prostate cancer are not being screened or treated for osteoporosis, even when they have other risk factors for the condition.

**Medication.** There is no cure for osteoporosis, but medications are approved by the Food and Drug Administration for men with the disease. Although no medications have been approved specifically to treat men with bone problems caused by hormone deprivation therapy for prostate cancer, studies of several medications are underway for this purpose. (Source: *Mayo Clinic Proceedings*, doi:10.1016/j.mayocp.2015.07.030)

**Clinician Attitudes Affecting PSA Screening of Older Men.** Older men whose clinician was a physician trainee had substantially lower PSA screening rates than those with an attending physician, nurse practitioner, or physician assistant as their clinician, a study published in *JAMA Internal Medicine* has shown.

Despite guideline recommendations advising against PSA screening in older men with a limited life expectancy, PSA screening remains common in this patient population. Therefore, researchers sought to identify clinician characteristics associated with PSA screening rates in older veterans according to life expectancy.

For this study, researchers analyzed data from 826,286 veterans aged 65 years or older who had laboratory tests performed in the VA health care system in 2011. Limited life expectancy was defined as age of at least 85 years with Charlson comorbidity score of 1 or greater or age of at least 65 years with Charlson comorbidity score of 4 or greater.

In 2011, 56% of the older veterans received PSA screening, including 39% of the 203,717 men with limited life expectancy. Researchers found that higher PSA screening rates in patients with limited life expectancy was associated with having a clinician who was an older male and was no longer receiving training.

Results showed that 27% of men with a physician trainee received PSA screening compared with 42% of men with an attending physician. A total of 22% of men with a geriatrician vs 82% of men with a urologist as their clinician underwent PSA screening, while 29% of those with a clinician 35 years or younger had screening vs 41% of those with a clinician 56 years or older. Also, the PSA screening rates ranged from 38% for men with a female clinician older than 55 years to 43% for men with a male clinician older than 55 years.

The findings ultimately suggest that interventions to reduce PSA screening rates in older men with limited life expectancy should be designed to target older male, non-trainee clinicians to achieve the greatest impact. (Source: *JAMA Intern Med.* doi: 10.1001/jamainternmed.2016.0695. : [published online ahead of print April 4, 2016].

◆ **EAT WELL - LIVE WELL!** ◆  
by  
**NANCY TSCHILTZ, REGISTERED DIETICIAN**  
**WRNMMC INTEGRATIVE CARDIAC HEALTH PROGRAM**

(A summary of a presentation to the WRNMMC Prostate Cancer Support Group, February 4, 2016)

**INTRODUCTION**

Good evening. I am pleased to be with you tonight. The theme of my presentation is "Eat Well - Live Well!" Let me say at the outset that there is no definitive prescription for "Cancer Prevention." Instead, there are a variety of prevention strategies that might lower the risk of developing cancer and the possibility of recurrence. And they are all linked to heart health! So eating well contributes to reduced cancer risk **AND** improved heart health.

**VITAMINS, MINERALS AND NUTRIENTS**

You are what you eat! When shopping for food, take time to read the nutrient content of what you buy. Get your nutrients from "real" foods, not processed foods. Here is a test: if your great-grandmother would not recognize the name of what you buy as "food," then it's probably full of processed ingredients!

Essential vitamins and minerals are especially high in fresh foods. Nutritional food supplements are not regulated by the Federal Drug Administration, and are likely to be unnecessary if you adhere to a healthy diet. Yet millions of dollars are spent annually on supplements in the mistaken belief that they are essential. Actually, some vitamins and minerals (e.g., Vitamin D, E or Selenium) can have negative health consequences. Overmedication with multi-vitamins may even enhance the prospects for certain cancers.

**CANCER AND HEART DISEASE – THE LINKAGE**

There is an important link between weight, stress, heart disease and cancer. The goal must be to maintain a healthy weight while reducing stress. We know that 2/3 of Americans adults are overweight, and 1/3 of those are in the obese category. Stress is caused by many factors, e.g., long work hours, commuting, financial worries, health concerns, and family issues. Both restful sleep and regular exercise help address the weight and stress issues. Try to find a way to work around the tendency to under-exercise and eliminate excuses such as bad weather. Sleep can be non-restful due to technology in the bedroom, overweight, sleep apnea, or even a snoring partner. Address sleep issues with your physician if you snore or have been told that you stop breathing while you sleep! Improving sleep can lead to decreased stress and weight loss.

Excess weight, increased stress, lack of sleep, and minimal exercise can lead to elevated levels of insulin, glucose, and insulin-like growth factors. This can result in insulin resistance and pre-diabetes, and eventually Type 2 diabetes, as well as increased risk for heart disease and cancer.

## **EATING PATTERNS - THE MEDITERRANEAN DIET**

I am sure that many of you are familiar with the Mediterranean Diet pyramid. It is not a fad diet, elimination diet or a quick weight-loss diet. It now has much scientific research to support it.

Its pyramid base includes fruits, vegetables, grains, beans, nuts, and legumes for daily consumption. The next pyramid step offers fish and seafood for consumption at least twice weekly, followed by poultry, eggs, cheese, and yogurt (moderate portions daily to weekly). And finally meats and sweets on a less often basis. Notice that no food category is excluded, but rather that thoughtful moderation is expected. Even wine is included, portion control!

Here is a useful hint to control portions. Measure your dinner plate and look for a plate that is nine inches in diameter, not the 13-inch plate found in restaurants! Visually divide the plate in half then fill half the plate with vegetables, then a one-quarter of the plate with lean protein, followed by another one-quarter with whole grains and legumes. Bon appétit!

### **ASPECTS OF THE MEDITERRANEAN DIET**

**A. Promotes intake of high amounts of fiber.** Fiber helps decrease cholesterol, fills the stomach (satiety), slows glucose absorption and moderates blood glucose surges. The fiber and sense of satiety lengthen the interval before sensing hunger and the urge to eat again soon. Fiber also enhances digestion and bowel function.

An easy way to increase fiber is to begin to look for sources of whole grain. Whole grains are rich in B vitamins and Vitamin E which can lead to increased metabolism. So, choose whole grain cereals such as brown rice, quinoa and whole grain breads to obtain all the nutrients possible. In contrast, white pasta, white bread/white bagels are stripped of beneficial fiber and nutrients. **Helpful Hint:** If you don't care for brown rice, start by adjusting your taste using mostly white rice and then transition gradually to a progressively larger percentage of brown rice.

**B. Consider the Mediterranean Diet Bread Sources.**

Pita contains whole wheat flour, water, soybean oil and yeast. These are the basic ingredients. When other bread labels are read, one is shocked by the multiple sources of sugars – up to 6 or more different kinds sugars – even if the name doesn't sound like “sugar.” Remember, molasses and high-fructose corn syrup added to bread are providing sugar.

**C. Fruit is essential to the Mediterranean Diet**

Fruits contain vitamins, minerals, fiber and antioxidants. Antioxidants help repair cells. Two-three servings per day provide sweetness through natural – not added sugars. Examples of one serving are: ½ banana, or one handful of grapes, or one handful of blueberries. Be mindful that the sizes of apples are varied in that one serving of apple may really represent four fruit servings. Visualize a handful!

In appropriate moderation, fresh fruit servings can help, even as a dessert, to attain better blood glucose levels. However, don't overdo the fruit and run the risk of compromising blood glucose levels. With respect to canned fruits or bottled fruit juices, be sure to read the label. Generally, whole natural fruit is the best source of fiber versus processed fruit or juice.

**D. Vegetables:** "When in doubt, eat Vegetables." Vegetables are a key component of the Med Diet. They provide vitamins, minerals, fiber, antioxidants, and photochemicals. Vegetables can be enjoyed at meals and as snacks, and fresh and frozen vegetables are the best choices. Avoid canned vegetables because they have been processed at high heat so they are less nutritious and contain added sodium. Modern freezing techniques have led to improved nutritional intake when compared to canned varieties due to the capability to "flash" freeze vegetables near the point of their fresh harvesting. Choose organic or non-GMO (Gentrically Modified) products when/if possible. More importantly, aim for at least five daily servings of vegetables. A serving size is about a handful. Remember to fill about half of that 9-inch plate. They can be used as a low-calorie snack!

**E. Beans and Legumes.** Ideally, have a serving every day, but at least 3-4 times a week. Beans provide protein, iron, and fiber. There are many flavorful choices as a serving with the entrée or as a snack or salads. "Beans" include: black-eyed peas, navy beans, black beans, pinto beans, soy beans, lentils, and kidney beans. Canned beans and legumes are acceptable if the can's contents are drained through a strainer and rinsed in cold water to reduce the sodium. Ideally, when cooking dried beans, soak them overnight in cold water. In the morning, pour off the water, add fresh water and boil. This will reduce the overall sodium by about 30%. A slow cooker is a great way to have them ready. Freeze the excess cooked beans for a later use

**F. Nuts:** The nuts with the best nutritional profile include peanuts, almonds, pistachios and walnuts. They are good sources of monounsaturated fats. A portion size is about a handful. Portion control is the key! Resist the temptation of buy and then, when stressed or hungry, eat directly from a large container. Instead, either buy individual snack-size containers or set up single-serving bags to have available when you ready to eat nuts. Strive for up to five ounces of **unsalted** nuts per week. Remember that a handful is not a can-ful!

**G. Saturated Fats:** Think of them as "solid at room temperature." They extend the shelf life of processed food, but increase blood cholesterol and the risk of cancer! Saturated fats include meats, cheese, whole milk, and butter, as well as palm oil, palm kernel and coconut oil. Palm oil/coconut oil are high a saturated fats. The proprietary research (i.e., the manufacturers') touted earlier reports of the healthy aspects of coconut and palm oils. More recent, independent research doesn't support all the earlier claims of health benefits. So, a good rule of thumb is "Use them on your body and hair – but not to eat," and follow unbiased updated research.

Pay attention to food labels that state "Transat free" or "0 grams transfat." In reality, such a serving may have up to a half-gram of transfat. So multiple servings may be providing a substantial amount of transfat. And remember, transfats such as margarine, lard, and processed and fried foods are artery-clogging, leading to elevated cholesterol in a manner similar to saturated fats. They are being removed from food products, but may still be there – up to a half gram can be in a serving -- but not appearing on the product label. Watch for

the terms "Hydrogenated" or "Partially hydrogenated." The daily limit is 2 grams.

**H. Red Meat:** Solid research shows that people who reduced their usual weekly red meat consumption improved their cholesterol levels and cardiac blood flow. Reducing red meat consumption also aids cancer and prostate health. Think of meat as Mediterranean chefs do: as a condiment in the meal by quantity, rather than as a major meal component. Choose lean red meats. If you find it hard to immediately reduce consumption to four ounces of red meat, start with a gradual reduction from your typical, larger steak or burger size.

**I. Good Fats:** Yes, there are "good fats!" Mono- or polyunsaturated fats and Omega-3s. Monounsaturated fats are provided by vegetable oils such as canola oil or the distinctively flavored olive oil. They may lower LDL and improve HDL. Omega-3s are polyunsaturated fats that have anti-inflammatory properties. They are found in fatty fish: – mackerel, salmon, herring, sardines, and tuna. Plant sources are found in soybean, flax, canola and walnuts. Omega-3's may help to lower LDL.

The Bottom Line on Dietary Fats. Use **ALL** fats in moderation; use canola and olive oil as main oils; choose lean meats and skinless poultry; choose fish at least 2-3 times a week; choose less red meat.

## **OTHER DIETARY ISSUES**

**Salt in Food:** The American Heart Association recommends less than 1500 mg per day for most people. The average American is consuming over 3000 mg a day. Fast foods and processed foods are loaded with salt. One tsp of table salt is already over the daily limit! Sea salt has 200 mg less per tsp when compared to table salt. but it still exceeds the daily limit. What to do? Try Kosher salt, which has less sodium in its larger granules and a smaller amount can bring out taste. By all means, refrain from salting food before tasting to determine that it really needs the additional flavor. As an alternative, consider using Mrs. Dash as a condiment; it has no salt; it's a blend of many herbs. **And last but not least, leave the salt shaker in the kitchen – don't bring it in the dining room.**

**Sugars in Food:** There are approximately 46 different names for sugars! They include: high-fructose corn syrup, corn syrup, honey, agave, cane juice, dextrose, glucose, molasses, maple syrup, maltodextrin, fruit juice concentrate, malt syrup, barley malt and many others.

Sugar is addictive! A laboratory rat study showed that 98% of cocaine-addicted rats actually preferred sugar to cocaine when given the option. Did you know that 34 ounces of soda equates to 27 teaspoons of sugar? Sugar is an addictive substance! How can humans reduce vast consumption of sweetened soda drinks? Read labels for sugar content of foods, especially beverages and gradually reduce the portions. Begin to notice the feeling of less bloating and being more energetic. Artificial sweeteners will trigger the same taste and brain and chemical signals that result in an insulin output response from the pancreas.

**Hydration:** By the time you are "thirsty" you are under-hydrated. So don't wait to be thirsty. Instead, make it a habit to consume at least eight ounce glasses of water daily. Add citrus flavors or sparkling water to encourage consumption of water. Consider prod-

ucts such as caffeine-free herbal teas to flavor water to encourage hydration. For certain, eliminate or reduce consumption of soda, fruit juices, sports drinks, and energy drinks. They contain high amounts of sodium and potassium, and **lots of sugar!**

**Wine:** Wine may reduce heart disease risk, but it may increase the risk of cancer, stroke and bone loss. Ethanol is a toxin (reactive oxygen radicals are liberated) and can damage cells' DNA and, thus, can be a carcinogen. If you have elevated triglycerides, liver or pancreatic disease, high blood pressure, or a family history of cancer or alcoholism, exercise extreme caution!

Beneficial Behaviors: If you don't drink, don't start. Remember, the same beneficial polyphenols and antioxidants are in grape juice without the alcohol. If you choose to drink alcohol for cardio-protective effect (don't we all!) the rule is: one drink per day for women; two per day for men. "One drink" is 12 oz beer = 5 oz wine = 1-1/2 oz hard liquor.

**Mindful Eating:** Snacks aren't excluded totally from the Mediterranean diet. Portion control is the key! Here are some techniques to restrain from over-eating. For example, think back to your last meal: Where were you? What was it? Were you eating in the car while driving? Were you watching TV? How do you feel? Are you hungry? Were you using utensils to consume your food? Why are you reaching for food? Is it the brain (and a habit) you are feeding or is it the stomach?

If it helps, use a mental or visual "Hunger-Satiety Scale" (like the nurses' 1 to 10 pain scale)! What are you **really hungry for?** Sleep? Exercise? Stress reduction? Social interaction? Many times we are hungry for something other than food!

**Making Better Choices:** Yes, I know, the hectic schedules confronting families has transformed the mealtime routine and food choices. Still, there are some common sense tips that you should consider: When possible, try to eat together as a family; turn off the electronics and clear the table of other non-meal items; slow down, find out what's happening in one another's lives; don't encourage each family member to just grab a plate and disappear in a different direction; savor each bite of food; and take your time to enjoy!

The Mediterranean Diet is really a part of an entire change to a healthy lifestyle. Better eating has to be integrated into better living -- better sleep, less stress, more exercise. Pay attention to your body! Eat regular meals -- maybe at shorter intervals rather than trying to stretch out eating to 6 hours or more. Ideally, don't eat just before going to bed. If genuinely hungry at bedtime, consider what you ate at dinner some hours earlier. Are you "hungry" for sleep or is it boredom? Is it habit or is it hunger?

### **REMEMBER: YOU ARE WHAT YOU EAT!**

In closing, I invite you to participate in WRNMMC's Integrative Cardiac Health Project (IChP), a comprehensive cardiovascular risk reduction and overall health promotion program focusing on nutrition, exercise, sleep, and stress reduction. Our integrative formula

is: **EAT WELL, SLEEP WELL, MOVE WELL, RELAX WELL.** I'm aware that more than a few members of your support group have already participated in it. IChP is a self-referral

program, so you can come directly to us. Call us at 301-400-1111 for more information.

I enjoyed being with you this evening, and I hope to see you at ICHP soon!

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◆ WRNMMC US TOO COUNSELORS ◆ (As of May 1, 2016)

(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)
Rob Calhoun	Annapolis, MD	(410) 293-6635	2011 (Robotic Surgery)
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	2008 (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	

**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
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**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, MAY 5, 2016

7:00 - 8:30 PM

AMERICA BUILDING (BLDG 19, 2D FLOOR) ROOM 2525  
(DIRECTLY ABOVE THE LAB/PHARMACY)

WALTER REED NATIONAL MILITARY MEDICAL CENTER

◆ SPEAKER ◆

PHILIP M. ARLEN, MD

NATIONAL CANCER INSTITUTE

◆ TOPIC ◆

"RECURRENCE OF PROSTATE CANCER"

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

**Security:** A military ID card 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 at least four business days prior to Thursday, 2016, to arrange entry. Have a photo ID card ready when arriving at the gate.