

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

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◆ **Aggressive Prostate Cancer Declining in U.S.** ◆

High Gleason score prostate cancer (PCa) in the United States is declining in incidence among all races, according to study findings presented at the Society of Urologic Oncology 17<sup>th</sup> annual meeting in San Antonio, Texas.

Siddiqui et al., Saint Louis University, Missouri, examined the effect of the 2008 and 2012 guidelines issued by the U.S. Preventive Services Task Force (USPSTF) stating there was insufficient evidence to support PCa screening.

The study included 337,504 men diagnosed with PCa from 2008 to 2013 who had a mean age range of 65 to 74 years. The investigators categorized Gleason score (GS) as low (GS 2–6), intermediate (GS 7), and high (GS 8–10). Low, intermediate, and high GS were recorded for 42%, 36%, and 16% of the men, respectively. The GS was unknown for 6% of the patients.

From 2008 to 2013, the incidence of GS 8–10 disease (per 100,000 men) decreased from 21.7 to 19.4 among white men, 39.5 to 33.7 among black men, 22.8 to 19.0 for Hispanic men, and 17.7 to 13.8 among Asian/Pacific islanders

Over the 6-year study period, black men had the highest cumulative incidence of low Gleason score cancer (76.2 per 100,000), followed by white men (52.9 per 100,000). The cumulative incidence of high Gleason score cancer was 37.5 and 21.0 per 100,000 for black and white men, respectively.

The annual percentage change (APC) declined significantly among all races for low GS cancer (-8.9% for whites, -8.6% for blacks, -8.6% for Hispanics, and -8.7% for Asian/Pacific Islanders) and intermediate GS cancer (-8.6%, -6.5%, -9.2%, and -9.9% respectively). The APC for high GS cancer declined significantly for blacks and Hispanics (-3.5% and -4.4%, respectively), but did not change significantly among whites and Asian/Pacific islanders.

The investigators say the trends suggest decreased diagnosis of aggressive PCa following issuance of the USPSTF guidelines. (Source: *Renal and Urology News*, December 12, 2016)

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**WRNMMC Us TOO  
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◆ FROM THE EDITOR ◆

**Inclement Weather.** If the federal government is closed the day of the presentation, the speaker program is cancelled. If the federal government has a delayed opening that day, the show will go on! Call the Prostate Center at 301-319-2900 if you have any questions.

◆ SPEAKER'S REMARKS - AUGUST 4, 2016 ◆

Our speaker on Thursday, November 3, 2016, was Dr. Camille McCann Williams, a radiation oncologist at WRNMMC. Her topic was "**Radiation Therapy Treatment Options for Prostate Cancer: Understanding the Basics.**" A summary of her remarks is at page 8.

**MEDICAL ADVISORY STAFF**

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USA

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◆ MEETING SCHEDULE FOR FEBRUARY 2, 2017 ◆

Our speaker for Thursday, February 2, 2017, is **Dr. Jim David**, a board certified psychotherapist in private practice treating individuals, couples and families. His topic is **The ABCs of Self-Care** (Get tips, tools and techniques to enhance self-care skills and coping abilities to remain calm and peaceful during stressful times). 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 ◆

**Socioeconomic Position and Mortality among Patients with Prostate Cancer.** Men with low socioeconomic position experience higher mortality after a prostate cancer diagnosis compared to men with a higher socioeconomic position, however, the specific mediators of this association are unclear. Researchers associated with the Danish Cancer Society, Copenhagen, evaluated the influence of potential mediators on the association between socioeconomic position, and prostate cancer-specific and all-cause death in prostate cancer patients.

They conducted a cohort study of prostate cancer patients in the Danish Diet, Cancer and Health Study. All patients completed questionnaires and anthropometric measurements at enrollment. Information on educational level, income, comorbidity and vital status was obtained by linkage to Danish nationwide registries. Clinical data and anthropometric measures were collected from medical records at diagnosis.

The study included 953 prostate cancer patients identified among 27,179 male participants in the Diet, Cancer and Health Study who were followed for a median of 6.5 years. Patients with low socioeconomic position were more often overweight or obese at baseline. Low socioeconomic position was associated with increased prostate cancer-specific and all-cause death. The increased mortality could largely be explained by tumor aggressiveness, comorbidity, treatment and metabolic indicators, except for patients in the lowest income group.

The study confirmed the a priori assumption that socioeconomic position is associated with increased mortality after prostate cancer. The increased mortality could largely be explained by lifestyle and clinical parameters. (Source: Acta Oncol. 2016 Dec 2:1-6. [Epub ahead of print] via UroToday, December 13, 2016)

**The Effect of Prostate Cancer Treatment on Patient Reported Urinary and Sexual Function Varies by Disease Severity.** Patient-reported outcomes (PROs) are critical to a patient-centered treatment approach. In prostate cancer, PROs such as erectile dysfunction and urinary incontinence have a large impact on health-related quality of life. Yet, little is known regarding how these outcomes may vary by disease severity.

The authors at Vanderbilt University used data which prospectively enrolled men with localized prostate cancer in 2011 and 2012. PROs were measured at baseline, 6, 12, and 36 months after treatment. A model was developed to assess the effect of treatment by disease severity. Variables included in the model were time since treatment, pre-treatment function, age, race, comorbidity, educational attainment, insurance type employment, marital status, physical function score, social support, depression score, participatory decision-making score, and study site.

More than 2,500 patients who underwent treatment for prostate cancer were included: 1,155 (45%) had low risk, 983 (39%) had intermediate, and 417 (16%) had high risk disease. For patients with low risk disease, radical prostatectomy (RP) was associated with more severe decreases in sexual function compared to external beam radiation therapy (EBRT) at 3 years. However, these differences were tempered and insignificant in the high risk cohort.

In the urinary incontinence domain, both patients with low risk and high risk disease demonstrated worse functional outcomes with RP relative to EBRT at 3 years.

These data suggest that the effect of treatment on urinary and sexual function may differ by disease severity. In the high risk population, sexual function domains are similar; however larger declines in urinary function domains are noted.

One potential limitation to this study is that it is unclear whether patients who received adjuvant or salvage radiation post-prostatectomy were removed from the study cohort. If these patients were included, urinary function post-prostatectomy may be worse. In addition, a breakdown of robotic versus open prostatectomies would be helpful. Overall, however, PROs are critical in reducing information asymmetry regarding treatment options. Only when they are included in the discussion alongside the oft-included oncologic outcome data is shared decision-making optimized. (UroAlert, January 3, 2017)

### **Do men with prostate cancer and their partners receive the information they need for optimal illness self-management in the immediate post-diagnostic phase?**

An international consortium of researchers sought to determine (a) whether the information provided to men with prostate cancer and their partners in the immediate post-diagnostic phase met their needs; and (b) examine patient and partner satisfaction with the information received.

Pre-intervention survey data from a randomized controlled trial involving 42 patients with prostate cancer, and their partners were collected to examine their psychosocial concerns/needs.

The main concerns for patients and partners were psychosocial in nature such as managing emotions, concern about the future, and losing control. Overall, patients and partners received most information about tests and treatment options. Partners reported receiving significantly less information about support services and self-care strategies compared to patients. Partners also reported being significantly less satisfied with the information they received.

The researchers concluded that whereas medical information is routinely given, patients and partners may benefit from greater information about psychosocial issues arising from cancer. Despite increased recognition of partner's information needs, these still remain unmet. (Source: Asia-Pacific journal of oncology nursing. 0000 Jan [Epub] via PubMed <http://www.ncbi.nlm.nih.gov/pubmed/27981111>)

### **Relationship Determines Physician Influence on Treatment Recommendation Adherence.**

The researchers sought to determine whether quality of physician-patient relationships influences acceptance of physician treatment recommendations in men with clinically localized prostate cancer (PCa). Data were collected via survey and medical record abstraction between July 2010 to August 2014 at two cancer centers and three community facilities. Analyses were prospective and relied on modeled associations between quality of the patient- physician relationship and influence of physician recommendations on treatment choice. The participants (N = 1,166) were 14.7 percent minority; 37.1 percent had low-, 47.5 percent had intermediate-, and 15.4 percent had high-risk PCa. Those reporting a better

physician-patient relationship perceived that their physician's treatment recommendation was more influential and were more likely to choose the recommended treatment. A pattern of interactions emerged indicating that quality of the physician-patient relationship was more strongly associated with the influence of recommendations for more aggressive treatment, versus less aggressive treatment, in those with low-risk, but not intermediate-risk disease.

The researchers concluded that quality of the physician-patient relationship would benefit through physician training, practice change, and patient feedback to increase adherence to physician treatment recommendation. However, strategies need to align with efforts to reduce physician recommendations for inefficacious treatments to prevent overtreatment. Source: Health Services Research, 2016 Dec 15 [Epub ahead of print] via PubMed <http://www.ncbi.nlm.nih.gov/pubmed/27981559>)

### **Active Surveillance for Low-risk Localized Prostate Cancer: What do Men and their Partners Think?**

The aim of this study was to better understand conceptualizations, experiences and reasons why men with low-risk localized prostate cancer and their partners adopt active surveillance (AS). We conducted five focus groups (FGs), three among men with low-risk localized prostate cancer who had chosen AS and two with their partners. The groups were video/audio recorded, transcribed and analyzed using qualitative thematic analysis. A total of 12 men and 6 partners (all women) participated in the discussions. The most common reasons for choosing AS were seeing the localized prostate cancer as 'small' or 'low grade' without need for immediate treatment and trusting their physician's AS recommendation. The most common concerns about AS were the perceived unreliability of prostate specific antigen, pain associated with repetitive prostate biopsies and potential risk of cancer progression. Partners saw themselves as very involved in their husbands' treatment decision-making process, more than men acknowledged them to be. Multiple terms including 'watchful waiting' were used interchangeably with AS.

There appeared to be a lack of understanding that AS is not simply 'doing nothing' but is actually a recognized management option for low-risk localized prostate cancer. The researchers concluded that emphasizing the low risk of a man's localized prostate cancer and enhancing physician trust may increase acceptability of AS. Standardizing terminology and presenting AS as a reasonable and recognized management option may also help increase its adoption. (Source: Family Practice. 2016 Dec 29 [Epub ahead of print] via UroAlert January 2, 2017)

### **Laparoscopic Radical Prostatectomy with A Remote Controlled Robot.**

Robotics in surgery is a recent innovation. This study investigated the applicability of remote controlled robotic surgery to laparoscopic radical prostatectomy. The technology offers a number of attractive features in laparoscopy. It overcomes the difficulties with fixed port sites by restoring all six degrees of freedom at the instrument tips, provides new possibilities for miniaturization of surgical tasks, and allows remote controlled surgery

Previous experience with laparoscopic prostatectomy served as a basis for adapting robotic surgery to this procedure. A surgeon at a different location who activated the tele-manipulators of the Da Vinci robotic system performed all steps of the intervention. A scrub nurse and a second surgeon who stood at patient-side had limited roles in port and instrument placement,

exposure of the operative field, assistance in homeostasis and removal of the operative specimen. Our patient was a 63-year-old man presenting with a T1c tumor discovered on 1 positive sextant biopsy with a 3+3 Gleason score and 7 ng./ml. preoperative serum prostate specific antigen.

The robot provided an ergonomic surgical environment and remarkable dexterity enhancement. Operating time was 420 minutes, and the hospital stay lasted 4 days. The bladder catheter was removed 3 days postoperatively, and 1 week later the patient was fully continent. Pathological examination showed a pT3a tumor with negative margins. Robotically assisted laparoscopic radical prostatectomy is feasible. This new technology enhances surgical dexterity. Further developments in this field may have new applications in laparoscopic tele-surgery. (Source: *The Journal of Urology*. 2016 Dec 21 [Epub ahead of print] via PubMed <http://www.ncbi.nlm.nih.gov/pubmed/28012768>) and *UroAlert*, January 3, 2017)

**Risk of Second Cancer following Radiotherapy for Prostate Cancer.** The researchers investigated the risk of second cancer and radiation-induced second cancer following prostate cancer radiotherapy. They compared men who had radiotherapy only with those treated with radical prostatectomy only, and those with radiotherapy after radical prostatectomy. Cumulative incidences of second cancers were calculated. Cox analyses were performed to identify determinants influencing second cancer incidence.

Nineteen thousand five hundred thirty eight (19,538) patients were analyzed. Age and median follow-up differed significantly with radiotherapy only patients having the highest median age (70.3 years) and radical prostatectomy only patients the longest median follow-up (10.2 years).

Ten-year cumulative incidence of second cancer was 15.9%, 13.2% and 10.5% for patients with radiotherapy only, radiotherapy after radical prostatectomy, and radical prostatectomy only. Increasing age and belonging to the radiotherapy only group were associated with a higher risk of second cancer. No significant increase was seen in radiotherapy after radical prostatectomy patients. A significantly higher rate of smoking-related malignancies, like lung, bladder and non-melanoma skin cancer, was seen in radiotherapy only patients.

No clear increase in radiation-induced second cancer was found in patients after radiotherapy for prostate cancer. Whereas the rate of second cancer was increased in radiotherapy only patients, no such increase was seen in patients with radiotherapy after radical prostatectomy. The increase of second cancer following radiotherapy only is highly likely to reflect advanced age and lifestyle habits and comorbidities. (Source: *Radiation Oncology*, London, January 3, 2017, via *UroToday*)

**Powerful Drug for Advanced Cancers May Need Less Frequent Dosing.** Patients whose disease has spread to bone can cut side effects tied to zoledronic acid, researchers report. Use of the bone cancer drug once every three months, instead of monthly, does not boost the risk of bone problems over two years, a new study finds. That could reduce side effects from the drug, also known as Zometa, and increase cost savings, the researchers said. The drug is used to treat the spread of breast cancer, prostate cancer and multiple myeloma to the bone.

Current guidelines suggest that zoledronic acid be given intravenously every three to four weeks to reduce cancer-linked pain, as well as the risk of bone problems, such as broken bones. However, the drug comes with its own, often serious, side effects. "It can cause flu-like symptoms and bone pain in the short term," noted Dr. Jane Carleton, associate chief of clinical affairs at Northwell Health Cancer Institute, Lake Success, NY. According to Carleton, zoledronic acid also "increases the risk of osteonecrosis of the jaw," a severe bone disease. The condition "can be very painful, and is a complication for which there is no good treatment."

Himmelstein, MD, et al., Helen F. Graham Cancer Center & Research Institute in Newark, DEL, speculated that the drug might be administered less often. His team randomly gave the drug on different schedules to more than 1,800 patients with breast cancer, prostate cancer, or multiple myeloma that had spread to the bone. Half of the patients received the drug just once every three months, while the other half received it once per month, all over a two-year period.

After the two years, 795 patients were left in the study. Bone-related problems appeared in 30 percent of those who took the drug once per month and 29 percent of those who took it once every three months. The levels of side effects weren't significantly different in the two groups, the findings showed.

So, outcomes being roughly equal, "this longer [dosing] interval may be an acceptable treatment option," the study authors concluded. That could be good news for cancer patients, said Dr. Carleton, who reviewed the new findings but wasn't involved in the study. "In cancer care, we are always looking to see when we should do more and be more aggressive in our treatment, and when we can do less and possibly decrease complications from treatment," she said.

The new findings may mean that clinicians can consider decreasing the frequency of giving this medication. That should mean fewer treatment visits for the patient and lower costs for cancer treatment. (Source: *Journal of the American Medical Association*, news release, January 3, 2017 via HealthDay, January 4, 2017))

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# **Radiation Therapy for Prostate Cancer: *The Healing Beam***

by

**Camille M. Williams, MD, Department of Radiation Oncology**

**Walter Reed National Military Medical Center**

(A summary of a presentation to the WRNMMC Prostate Cancer Support Group, November 3, 2016)

**Introduction.** I am pleased to be with you tonight to present information on radiation therapy as a primary treatment modality for prostate cancer.

**Prostate Cancer Detection, Diagnosis and Staging.** The primary detection techniques for prostate cancer are the digital rectal exam (DRE) in conjunction with the blood test for Prostate Specific Antigen (PSA). Even in the absence of a suspicious finding on the DRE, PSA values may call attention to the need for further clinical evaluation. With each successive decade of aging, PSA tends to rise. Although there are no precise PSA values that preclude, or confirm the existence of prostate cancer, a PSA above 4.5 nanograms per milliliter (ng/mL) is always considered suspect. Of course, a rapidly rising (e.g., doubling time) of PSA may be especially concerning. Remember, the circulating level of PSA is a reflection of only the past few days or so of production and entry into the blood stream; the half-life of PSA is about 2.5 days.

**The Biopsy.** With a rising or elevated PSA, further evaluation of the prostate is recommended with a prostate biopsy. A pathologist then evaluates the biopsy samples under the microscope for any abnormal cells. If abnormal cells are seen in various areas under review, the pathologist will determine a Gleason score. The score reflects the degree of abnormality (on a scale of 1-5). The most common and the second most common numbers are then added for the total Gleason score. The scoring system can be complex, but generally the lowest total number is usually 6 and the highest is 10. These are then grouped into Low Risk (Gleason 6), Intermediate Risk (Gleason 7) or High Risk (Gleason 8-10). Examples include 3+3=6 (low risk), 3+4=7 (intermediate risk), 4+3=7 (intermediate risk that is more aggressive), 4+5=9 (high risk). Scores in the high-risk range will likely prompt a computerized tomogram (CT) or other additional imaging studies to make sure that the cancer did not leave the prostate and spread elsewhere (such as the bone, brain, liver, etc.). These imaging techniques help the urologist and oncologist to stage the cancer properly and recommend appropriate treatment.

The urologist and radiation oncologist will review with the patient the risk group which is determined using a combination of PSA levels, Gleason Scores and prostate cancer staging. Other factors that may be considered when recommending treatment are other illnesses, age, general health and anticipated lifespan. There are several non-radiation therapy approaches to treat the prostate cancer that may be focal, or comprehensive any may include surgery, high-intensity focused ultrasound (HIFU), and hormonal therapy. The consideration of various and ever-expanding options integrates technical availability, outcomes research, the preferences (benefits and risks) of the patient and treating physician expertise. The international guidelines are continually evolving.

**Radiation Therapy.** Radiation therapy is all around us. Life on earth is exposed at all times to multiple sources of radiation. Some wavelengths are familiar to us – such as visible light, microwave and cell phones, most of which are not harmful. We cannot perceive, without

scientific detectors, the wavelengths associated with “low energy” (non-ionizing radiation) nor the wavelengths of incoming, high energy wavelengths without possible dangerous exposure (e.g., x-rays, gamma rays).

When treating cancer, there are different forms of radiation therapy that can be used – internal radioactive source that is within the body for a short period of time or external beam radiation therapy that is similar to getting an x-ray. Whatever the source of the medically delivered radiation, without special shielding or other directional and technical implementation, a radiation beam powerful enough to reach the abnormal cancer cells will also be affecting normal cells close by, not only the cancer. For example, parts of the rectal wall and bladder wall will be in the beam path when treating prostate cancer. One way to decrease the side effects while treating the prostate is to use Intensity Modulated Radiation Therapy (IMRT) which uses multiple, small carefully angled beams – each of different intensity – that are calculated to intersect/converge at the prostate depth. Treating prostate cancer using IMRT assist in minimizing/decreasing the exposure of the surrounding normal tissues – such as the bladder and rectum.

### **Achieving Efficacy and Minimizing Side Effects While Expanding Treatment Options.**

External Beam Radiation Therapy (EBRT) introduced the medical profession to uses of radiation for cancer treatment. In prostate cancer, radiation therapy can be integrated with other therapies (for example, after surgery, or combined with hormone therapy, or permanent seed implant). Conventional radiation therapy is a process of that introduces patients and clinicians alike to the concept of the "Healing Beams" of Radiation Therapy." At present, Intensity Modulated Radiation Therapy (IMRT) is the “standard of care” in 2016 in the USA .

One approach to efficacy while minimizing side effects is to fractionate the dosage by giving a small amount radiation dose daily, so that the total dose to be administered is spread over time; this will to allow normal cells/tissues time to recover and repair from the radiation dose. Radiation dose is measured in an internationally accepted unit know as a Gray (Gy). Once the radiation oncologist has selected the desired total dose, it is given over a few weeks (example; 79Gy in 39 fractions over 9 weeks).

**Newer Approaches.** There are multiple ways to prescribe External Beam Radiation Therapy, including the newer approach of Proton Radiation Therapy. Here are a few examples of the external beam radiation technology used:

- Proton Therapy requires access to a large, complex cyclotron, from which electromagnets guide the beam to the gantry and then out of the “nozzle” directed at the area to be treated in the patient.
- The Linear Accelerator equipment includes a device (“gantry”) that arches above and moves around the patient as the beams are delivered in accordance with programming.
- The use of Gamma Stereotactic Radiosurgery (a general term referring to the use of multiple sighting angles to fix distant, targeted locations in 3-D) The powerful gamma rays are derived from a radioactive cobalt source. They are routed with exquisite precision to the targeted cancer tissue in the brain. The precision of targeting requires patient immobility during the therapy beam application with a fixed framed device.
- Cyberknife<sup>R</sup> is popularly known by one of its proprietary corporate names. It is a similar concept to Gamma Knife. It can deliver a shortened overall course of high daily

radiation dosage. It is frameless and can treat other areas of the body - not just the brain. The precision of targeting requires patient immobility during the therapy beam application. It also can include use of stereotactic placement and use of permanently inserted gold pellet markers (“fiducials”) to serve as 3-D reference points, angling and repositioning the incoming beams, and for overlapping the beams at the correct cancer tissue depth. Such markers enable frequent “pictures” throughout the shifting of the directional beams in order to maintain the desired radiation target on the cancer by keeping the desired spacing between cancer location and nearby fiducials. Even recurrent prostate cancer can be re-treated by Cyberknife<sup>R</sup>.

**Brachytherapy.** The word “Brachy” is derived from the Greek root for short or small. It is a term used when small radioactive pellets are placed directly in the prostate. The radiation from these small pellets only travel a short distance - about 3mm - into the prostate. The radioactive pellets may be either Iodine or Palladium which are then permanently inserted throughout the entire prostate. Generally speaking, a prostate with a volume 20-50 cc (small-/medium-size) is considered an optimal size for this type of therapy. The larger the prostate, the greater the number of radioactive pellets (“seeds”) that would be required for thorough treatment. Pretreatment ultrasound imaging is required to estimate the volume of prostate tissue to be treated and how many seeds to order in advance.

Because the half-life of the implanted seeds is about 60 days (for Iodine), the prescribed dose is generally 144 Grays (Gy). Therefore, some may consider precautionary measures of using a lead shield across their laps before holding young children. High-dose Rate (HDR) brachytherapy is administered using placement of about 15-20 “tubes.” These are inserted via a combination needle/catheter-like device through which the high dose radioactive source is passed at a prescribed rate to expose the area being treated. HDR brachytherapy can be used for any patient for whom low-dose brachytherapy is an indicated treatment. At present, high-dose brachytherapy is not yet available at WRNMMC-Bethesda.

**After Radiation Oncology Therapy.** The radiation oncologist’s choices for high-risk prostate cancer may include a combination of radiation therapy and two years of hormonal therapy. After treatment is completed, the PSA and testosterone levels are measured sequentially to monitor successful ablation/treatment. In the short-term, of course, the irradiation may cause a significant release of PSA into the bloodstream, which is referred to as the “bouncing” effect on PSA. After radiation, it may take up to 2 years before the PSA plateaus, generally less than 1ng/mL. Once a nadir or plateau is established after all treatment is completed, then a concerning level would be if the PSA rose a full 2 points above nadir. For example, if the nadir after all treatment is completed is established at 0.3, then only when the PSA rises to 2.3 would your radiation oncologist discuss the next level of treatment.

**Conclusion.** The increasing availability of therapeutic options for prostate cancer requires a joint decision-making process involving the patient, the urologist and radiation oncologists. My presentation tonight provides a brief and basic review of radiation therapy considerations -- whether monotherapy with radiation, combinations with other therapy modalities or re-treatments. The treatment decisions are framed by widely accepted but evolving guidelines that balance patient-specific considerations, treatment objectives and available resources.

◆ WRNMMC US TOO COUNSELORS ◆

(As of February 1, 2017)

(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, VA	(425) 883-4808	1998 (Robotic Surgery)
Bill Johnston	Berryville, VA	(540) 955-4169	
Dennis Kern	San Francisco, CA	(415) 215-3530	
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, FEBRUARY 2, 2017

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 ◆

JAMES DAVID, MD

(BOARD CERTIFIED PSYCHOTHERAPIST IN PRIVATE PRACTICE TREATING  
INDIVIDUALS, COUPLES AND FAMILIES)

◆ TOPIC ◆

"THE ABCs OF SELF-CARE"

(Tips, tools and techniques to enhance self-care skills and coping abilities to remain calm and peaceful during stressful times)

**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.