WRAMC US TOO, Inc.

A PROSTATE CANCER SUPPORT GROUP
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NEWSLETTER

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♦ VIRGINIA PROSTATE CANCER COALITION FORMED ♦

A group of concerned prostate cancer activists has organized to form the Virginia Prostate Cancer Coalition (VPCC). Its purpose is to make prostate cancer an urgent priority for the medical, patient, and legislative communities and the people of Virginia through education, outreach, advocacy, and fundraising programs. The VPCC organizers note these facts regarding Virginia: 4,900 new cases of prostate cancer are diagnosed annually; 800 men will die of prostate cancer in Virginia this year; two-thirds of the states have lower cancer mortality rates than Virginia. In response to these challenges, the VPCC will focus on increased public awareness of prostate cancer, improved access to early diagnosis and treatment, and increased funding for prostate cancer research. Interested persons can obtain additional information by visiting the VPCC websites at **www.vapcacoalition.org** and **eduslate@vapcacoalition.org**.

♦ NEWLY DIAGNOSED? HELP OTHERS WHILE YOU HELP YOURSELF! ♦

Researchers at Georgetown University Hospital and the Lombardi Cancer Center invite men who have been recently diagnosed with early-stage prostate cancer and not yet made a treatment decision to participate in a study to evaluate a computer-based health education program. The educational tool is a computer disk that contains up-to-date information on prostate anatomy, diagnostic tests, and treatment options. It is designed to help men make informed decisions about treatment for prostate cancer. The study involves participation in four telephone interviews and using the computer disk to obtain treatment information about prostate cancer. All contacts are by telephone or mail, and participants need not receive their treatment at Georgetown University. A modest stipend is paid to participants. If you are interested or have any questions, contact Tara Lamond, the project coordinator, at **(202) 687-0435**, or Kathryn Taylor, the principal investigator, at **(202) 687-0649**.

♦ *INSIDE THIS ISSUE* ♦

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♦ FROM THE EDITOR'S DESK ♦

Coming Soon to a Computer Near You!

The WRAMC US TOO newsletter is available on the website of the Center for Prostate Disease Research. The current issue and back issues are accessible at **www.cpdr.org**. Planned enhancements to the website will soon allow us to send the newsletter directly to your computer screen. The CPDR website will provide an online subscription capability to an e-mail ver- sion of the newsletter. Readers will be able to request, receive, or terminate their subscriptions electronically. When the capability is in place, we will be asking you to choose between electronic delivery or continued delivery via the US Postal Service.

Dr. Neal D. Barnard, president of the Physicians Committee for Responsible Medicine, was the speaker at our February meeting. He emphasized the connection between diet and prostate cancer with special attention to dairy products. A summary of Dr. Barnard's presentation begins at page 7.

♦ PROGRAM FOR AUGUST 6, 2003 ♦

WRAMC US TOO meets next at 7 PM on **Wednesday, August 6, 2003,** at Joel Auditorium at WRAMC. Our speaker is Colonel Judd W. Moul, MC, USA, director of the DOD Center For Prostate Disease Research. Each year at our August meeting Dr. Moul presents the latest developments across a broad spectrum of prostate disease-related issues as reported at the annual conference of the American Urological Association. Don't miss it. Plan now to attend and bring your spouse or a friend. They are always welcome.

♦ **Prostate Cancer Research is Going to the Dogs!** Researchers at Cambridge University in England are seeking funds for a trial to train dogs to help detect prostate cancer. The idea is to train the dogs to identify men with prostate cancer by the odor of the men's urine. (**Editor's Note:** I am not making this up! What next, trained monkeys to perform DREs?) (Source: CNN.com via Reuters, April 27, 2003)

♦ **Nightly Sildenafil for Erectile Function After Radical Prostatectomy.** Padma-Nathan, et al., followed 76 men with normal preoperative erectile function who underwent bilateral nerve-sparing radical prostatectomy. Four weeks after surgery, the men received nightly sildenafil or a placebo. After 48 weeks, 27 percent of the patients receiving sildenafil had a return of spontaneous erectile function compared to only 4 percent of the men taking the placebo. The intent of the treatment was not to produce erections suitable for intercourse. Rather, it was intended to help the earlier, more complete return of erectile function after surgery. The researchers hypothesize that nightly sidenafil for nine months shortly after surgery influences the preservation of tissue damaged during nerve-sparing prostatectomy and may even improve the rate of repair. (Source:Emma Hitt, PhD, Medscape Medical News, April 30, 2003)

♦ **Lower PSA Cut-Point May be Indicated.** Two related major studies indicate that the traditional PSA cut-point of 4.0 ng/ml may need to be revised downward. Lowe, et al., at St. Luke's/Roosevelt Hospital in New York, studied more than 36,000 prostate biopsies. They found an incidence of malignancy of 27.48% for men with PSAs ranging from 2.5 ng/ml to 4.0 ng/ml. This compared with an incidence of malignancy of 30.08% for men with PSAs ranging from 4.0 ng/ml to 10.0 ng/ml. The relative closeness of these rates of malignancy indicate the need to consider prostate biopsy for men with PSAs over 2.5 ng/ml, particularly for men with such risk factors as family history and African American ethnicity. Catalona, et al., Northwestern University, followed almost 21,000 men who had initial PSA values of less than 2.6 ng/ml. Eventually, 523 men had a PSA above 2.6 ng/ml. The researchers found that 81% of men with PSAs between 2.5 ng/ml and 4.0 ng/ml had organ-contained prostate cancer; seventy-one percent of men whose PSAs were over 4 ng/ml did not. The researchers concluded that performing biopsies at a lower PSA level may be associated with better clinical outcomes. (Source: Reuters Health Information, April 29, 2003, via Medscape)

♦ **Pretreatment PSA and Survival in Prostate Cancer Patients Receiving Radiation.** The pretreatment PSA (pPSA) was shown to be an independent predictor of survival after external beam radiation. Roach, et al., assessed the survival predictive value of the pPSA in 927 men with localized prostate cancer treated with radiotherapy. The researchers found that pPSA was linked to a lower risk of PSA failure and better progression-free and overall survival than a higher pPSA level. For example, pPSA level of less than 20 ng/ml was linked to a lower risk of PSA failure than a higher pPSA level. The results should be helpful to patients and physicians in assessing the progress of newly diagnosed men. (Source: *Urology* 2003; 61:730-735 via Reuters Health Information May 2, 2003)

♦ **Dean Ornish Study on Lifestyle and Prostate Cancer.** A low-fat diet, exercise, and stress-reduction activities may halt or even reverse the progression of prostate cancer in men undergoing watchful waiting, according to Dr. Dean Ornish, the well-known diet guru. Ornish and his team random-

ized 87 men with prostate cancer into an experimental group and a control group. The men had PSA levels of 4.0 ng/ml to 10 ng/ml and Gleason scores of less than 7. The experimental group ate a plant-based diet using unprocessed foods, and also engaged in moderate exercise, stress management, and support group activity. After one year, the mean PSA of the experimental group decreased by 3%, and the mean PSA increased by 7% in the control group. Ornish concluded that urologists may wish to consider having patients make major changes in diet and lifestyle regardless of whether the patient remains on watchful waiting or selects a definitive therapy such as surgery or radiation. (Source: Medscape Medical News, April 28, 2003)

♦ **Follow-up PSA Tests Often Show PSA Levels Returning to Normal.** A large proportion of men receiving biopsies as a result of an elevated PSA were found to either have no cancer or cancer not severe enough to warrant treatment. A study followed 972 men who had annual PSA tests over four years. About 194 of these men had an elevated PSA, defined as above 4 ng/ml. In almost 50% of these cases, PSA levels returned to normal in subsequent tests. It was noted that the study did not identify men at higher risk for prostate cancer. Men who have a high PSA reading should consult their physicians about delaying biopsy or other procedures until the PSA test is repeated at least six weeks later. Such a delay is not likely to effect treatment decisions or outcomes. (Source: Health Section (F6), The Washington Post, June 3, 2003)

♦ **Transdermal Estrogen and Advanced Prostate Cancer.** The use of a patch to transmit estrogen to men with advanced prostate cancer has drawn renewed interest. Abel, et al., at Hammersmith Hospital, London, treated 20 men by using a transdermal patch to achieve satisfactory blood estrogen levels, resulting in an average reduction of PSA of 95%--comparable to traditional hormonal therapy. The researchers also commented that side effects were minimal. None of the men reported having hot flashes and other symptoms often associated with the traditional therapy, although 16 of the men reported mild to moderate distress resulting from gynecomastia. Overall, the study showed that patch therapy led to disease regression with fewer side effects and better quality of life. The use of the transdermal patch (at a tenth the cost of traditional therapy) would result in a substantial reduction in health care costs. Based on this research, larger clinical trials are indicated. (Source: *J of Urol* 2003;169:1735-1737 via Reuters Health Information, April 8, 2003)

♦ **PSA Testing and Men at High Risk.** There is evidence that 9% of men with total PSA levels below 4.0 ng/ml and a normal DRE will actually have prostate cancer, indicating that other tests might be needed. Uzzo, et al., at Fox Chase Cancer Center, Philadelphia, evaluated 310 men who had total PSA values below 4.0 ng/ml. The men were considered high risk for prostate cancer because they were African American or had a first-degree relative who was diagnosed with the disease. Thirty-seven of the men with total PSA values between 2 and 4 ng/ml and a normal DRE had a prostate biopsy if their percent free PSA was less than 27%. The cancer detection rate for the group was 52%, significantly higher than previously reported detection rates. All of the positive biopsies were early-stage, clinically significant malignancies. The researchers said their analysis demonstrates the benefits of percent free PSA testing in detecting significant prostatic disease in high-risk men. (Source: Urology 2003;61:754-759, via OncoLink, Abramson Cancer Center, University of Pennsylvania, April 22, 2003)

♦ **Hormonal Therapy and Elderly Men.** Withdrawing hormonal therapy appears to be safe for elderly patients with advanced prostate cancer who are asymptomatic and have achieved an undetectable PSA level after prolonged androgen blockade. Kwart and Pedraza, Washington Hospital Center, Washington, DC, followed the hormonal and biochemical responses of four men, ages 74-83 years, who withdrew from luteinizing hormone-releasing (LHRH) agonist therapy after an average

of 108 months of hormonal therapy. The men had undetectable PSAs after the prolonged treatment. After cessation of androgen blockade, their PSAs, testosterone levels and serum LH were regularly measured. After three years of follow-up, all four patients had castrate levels of testosterone, LH levels were in the normal range for three of the men, and all four were asymptomatic and had undetectable PSA levels. The researchers noted that the ages of the patients may have influenced the suppression of testosterone. Their observations suggest that prolonged androgen suppression may result in irreversible impairment of Leydig cell function. They also note the substantial economic advantage--withdrawal of hormonal therapy saves $10,000 per patient per year. (Source: *Urology* 2003;61:770-773 via OncoLink, Abramson Cancer Center, University of Pennsylvania, April 16, 2003)

♦ **Let's Hear It for the Rats!** The search for ways to prevent impotence in men undergoing surgery for prostate cancer goes on. One hope is that surgeons will eventually be able to administer gene therapy at the time of surgery to minimize nerve damage and preserve erectile function. Researchers at the University of Pittsburgh Medical Center injected rats with a harmless herpes virus to deliver proteins known as neurotrophic factors into the penis and the cavernous nerve, the nerve that stimulates erection. Neurotrophic factors protect the nerves and help damaged nerves to regrow. The cavernous nerves in the rats had been injured to mimic the damage that can occur during radical prostatectomy. Later, the researchers electrically stimulated the cavernous nerves in the rats. The rats that received the gene therapy had greater ability to achieve erections than those that did not receive the treatment. The researchers hope that this concept eventually will translate to humans. (Source: *NewsRx.com,* May 15, 2003)

♦ **More on Saw Palmetto--Read the Label.** Saw palmetto is widely used for its reported ability to reduce the frequency and urgency of urination in men with prostate enlargement. ConsumerLab.com evaluates herbal products through its Voluntary Certification Program. It found that only two-thirds of saw palmetto recently evaluated contained ingredients known to work in clinical studies. Several of the products had low levels of saw palmetto and other deficiencies. ConsumerLab.com advises consumers that herbal supplements are often designed by marketeers, and not clinicians. The company specifically recommends that a saw palmetto product provide a daily dose of either 320 mg of berry extract or one to two grams of berry powder. Berry extracts should be standardized to at least 85% fatty acids and 0.2% sterols; berry powders should be standardized to a minimum of 8.5% fatty acids and 0.02% sterols. Lesson learned-Read the Labels! (Source: *HealthNewsDigest.com*, May 26, 2003)

♦ **Factors Associated with Good Sexual Outcome in Prostate Cancer Survivors.** Researchers at the Cleveland Clinic Foundation sent surveys to 2,636 men on its prostate cancer registry in an effort to identify factors associated with good sexual outcome in a large group of survivors of localized prostate cancer. Overall, 1,236 men (49%) responded to the survey. The participants had been treated with definitive radiotherapy or radical prostatectomy. As demonstrated in other studies, there was a strong association between younger age and better sexual outcome. Improved sexual outcome was significantly associated with medical factors, such as not having had neoadjuvant or current antiandrogen therapy, and having had bilateral nerve-sparing prostatectomy or brachytherapy. Sexual factors associated with a better outcome were: ability to have normal erections prior to prostate cancer treatment; choosing a treatment based on the hope that it would preserve sexual function; having more sexual partners in the past year; and having a sexually functional partner. Also, the survey confirmed the researchers' impression that reports in the literature have been overestimating the success of both surgery and radiation in preserving sexual function. (Source: *Cancer* 2002; 95: 1773-1785 via FaxWatch, February)

"THE DOCTOR IS IN"

Colonel Judd W. Moul, MD

(Editor's Note: Readers should not act on the responses without prior consultation with their own physicians.)

I had a rising PSA after radical prostatectomy and went on continuous hormonal therapy for three years. Now I have been on intermittent hormonal therapy for eleven months. My PSA remains undetectable, but aside from "feeling good" about that, I have not noticed any quality-of-life differences. What quality-of-life differences, if any, should I reasonably expect under the circumstances?

Answer. It is known that traditional hormonal therapy (HT), such as LH-RH agonists or orchiectomy, may cause hot flashes, loss of libido, impairment of erection, weight gain, loss of muscle mass and strength, anemia, and fatigue. Some men are bothered by some or all of these side effects, while other men tolerate the treatments extremely well. When a man changes from HT to intermittent hormonal therapy (IHT), the side effects do not generally go away until he has been off HT long enough for his testosterone level to return to normal. Since the cited side effects are largely due to the effects of low testosterone levels, their decrease or disappearance is dependent on the hormone levels. There is quite a bit of individual variation in time to the return of normal testosterone levels in men on IHT. In your case, as in all individuals, there is also a lot of individual variation in "feeling good" and quality of life. The concept of quality of life is very important, but extremely variable. How many side effects you had from HT, your current level of testosterone, and your individual tolerance of side effects will all factor into your individual quality of life while you are on IHT.

In a recent issue, you compared the male urethral sling and the artificial urinary sphincter in response to a question about incontinence. Many members of my support group are unfamiliar with the male urethral sling. Could you provide a brief description of the device, how it is "installed," and how it functions?

Answer: The male urethral sling is a relatively new operation, and there is quite a bit of variation in the subtle aspects of the technique among surgeons. In simple terms, the operation involves a small incision in the perineal area to place a piece of tissue against the urethra to create pressure. Given the notable current variation in technique employed by various urologic surgeons, it is best for patients interested in the procedure to discuss it in detail with their urologists. At Walter Reed Army Medical Center, the operation is being performed by Dr. James Jezior (LTC, MC, USA), and Dr. Burkhardt Zorn (COL, MC, USAR).

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"TOPICS IN PROSTATE CANCER AND DIET: THE ROLE OF DAIRY; STUDIES ON DIET AND SURVIVAL"

Neal D. Barnard, MD

Physicians Committee for Responsible Medicine

(A summary of a presentation to WRAMC US TOO on May 7, 2003)

Introduction

Thank you for the kind invitation to speak with you tonight. As Jim mentioned in his introduction, I have had a major career change. I grew up in Fargo, North Dakota, where the pasture landscape stretches for as far as the eye can see. My entire extended family is in the cattle business. Our normal menu was either roast beef, potatoes, and green beans, or roast beef, potatoes, and corn! I grew up convinced that was what everyone ate. My father left the cattle business, went to medical school, and spent his life dealing with diabetes. I followed in his medical footsteps and eventually became a psychiatrist at George Washington University. My first job after residency was at St. Vincent's Hospital in downtown Manhattan. I was seeing patients who also were diagnosed with such conditions as heart disease, cancer, and diabetes, and I was struck by the fact that medical practitioners did little to help prevent these conditions. We waited until the patient arrived via the Emergency Room with a heart attack, or until the cancer showed up on a test before we sat down with the patient and asked, "What are you eating, what are your smoking habits, what are your exercise habits, etc.?" We tended to let these issues percolate until the disease became full-blown. We may not be too late, but it's a more difficult situation than if we had intervened much earlier in the patient's life. So, I left psychiatry to pursue research and advocacy, and I am now in the Department of Medicine at G.W. We are starting an NIH-funded study this fall in diabetes. Yes, it was quite a career shift, but in my opinion, I am now in a position to make a bigger difference in my patients' lives. Along the way, I've come upon some findings that are relevant to cancer that I'd like to present to you tonight.

Applicable Studies

I want to focus on two things. I'll talk about recent studies regarding survival based on diet used as therapy after diagnosis. These studies are preliminary in nature, but the results are very intriguing. Then I want to focus on dairy products. Dairy products appear to play a very peculiar and completely unexpected role in prostate disease.

Let's address dairy products first. As we look around the globe, we note that different kinds of food are related to the risk of cancer. You're probably already familiar with the data on lycopene—the red pigment in tomatoes and watermelons. People who consume more of it may have a lower risk of prostate cancer. Men on lower fat and higher fiber diets also tend to be protected as well. But there's a peculiar association with milk. Ganmaa, et al., reported data in the International Journal of Cancer showing the more milk men drink in the course of the day, the higher their risk of prostate cancer. This doesn't tell us anything about the "why"—no cause and effect—it just says the more milk men drink, the more cancer.

Studies are just now helping us to understand what is going on. Dr. Edward Giovannucci, a

noted researcher into the relationship between

diet and health, produced a landmark study in 1998. He followed almost 48,000 health professionals (other than doctors) as part of a major research effort at Harvard. Giovannucci found that persons consuming two servings or more per day of milk had about a 60% increased risk of prostate cancer compared to the other participants. Let me repeat that. The milk-drinking men ended up with a 60% increased risk of prostate cancer compared to the other men. Particularly striking was the fact that fat content was not the culprit. Eighty-three percent of the milk consumed during the test was skim or low fat milk. These health professionals knew that whole milk should be avoided and they did just that. In a related study, Dr. J. M. Chan followed about 21,000 physicians. Those consuming at least 2.5 servings of dairy products per day had about a 34% increased risk of prostate cancer, a statistically significant result.

The Role of Milk

There are now about 16 studies in different countries showing similar results. Milk drinkers have more prostate cancer. Why? Well, that prompts another question, "What is the biological role of milk?" Is milk produced because it tastes great with Oreos? I think not! Is it there to help you sleep? No. Then what is the role of milk? Who is it for? Milk is for babies, that's who--a baby calf if it's cow's milk, a baby human if it's human breast milk, a baby horse if it's horse milk. Milk is species-specific and exists for the infant of the species. It is designed to provide all the nutrients to help babies grow rapidly. And once the calf is big enough to graze, it's weaned. Weaning is universal, but humans are creative -- we don't like being controlled by things like biological processes, so we've found ways to avoid being weaned from milk. This is worrisome because milk has protein in a simple form. It is in the form of casein molecules which break up and allow the body to get the nutrients it needs. Milk has lactose sugar and fat, lots of fat; about 49% of the calories in whole milk are nothing but fat, mostly saturated fat.

So what is in milk? It is a watery base with fat, lots of sugar, protein (casein and whey), some minerals, some hormones, and a whole raft of biologically active compounds. As I mentioned, the fat content of whole milk is about 49% of its calories. Sugar is about 30% of its calories. Many people will say, "I don't drink soda and I only have nonfat milk." But look at the sugar content of nonfat milk. Nonfat milk is 56% sugar. There are a number of hormones in milk. Keep in mind, milk is all that baby calf is getting. So in effect, the cow directs the growth and maturation of her calf by the many hormones and related chemicals that are part of her milk.

Milk and Prostate Cancer

The first explanation for why milk might be associated with higher risk of prostate cancer is that the more fat you consume, the more your body is likely to make testosterone. Generally speaking, a higher fat diet promotes testosterone production, and so that would tend to increase the risk of prostate cancer. But that may not be the issue at all, because, as I noted earlier, fat content didn't necessarily play into it. What I think is more likely to play a role is a hormone called IGF-I (Insulin-Like Growth Factor I). Its name comes from the fact that if I take cancer cells, put them in a test tube, and add IGF-I to them, they grow—they start multiplying. "Insulin-like" means it acts like insulin, moving sugar from the blood stream into the cells. We all have IGF-I, although the serum concentration in adults varies dramatically from one person to another. The key is that IGF-I accelerates cancer cell growth in-vitro (in the test tube).

Let's return to the Harvard Physicians' Health Study that I cited earlier. The researchers didn't just track whether or not the participants drank milk. They also measured IGF-I levels at the

outset. They followed the participants for the next ten years to see who developed cancer and who didn't, and they compared later IGF-I blood levels with the baseline levels. The participants who eventually developed cancer had IGF-I blood concentrations of 269.4 ng/ml. The participants who stayed healthy had IGF-I levels of 248.8 ng/ml—not a huge difference, but a distinct and significant one.

It just so happens there is IGF-I in cow's milk. Several surveys have measured the amount, and I have to tell you, it's probably small. It is there and it is presumably important that the calf gets this small amount of IGF-I. But for humans, just drinking that glass of milk—the protein and the sugar in it, perhaps the fat-- causes your body to make IGF-I. In other words, it's not the amount of IGF-I in the milk; it's that the protein and sugar in milk and other dairy products trigger your body to make extra IGF-I. Why do we care? Because IGF-I is a growth factor for cancer cells.

Robert P. Heaney is a capable scientist within the dairy industry. He did a remarkable study. He took men and women, middle-aged and older, and asked them to drink three eight-ounce glasses of milk per day. He measured their IGF-I levels at the beginning and at the end of a twelve-week period, and he found that their IGF-I levels went up about 10%.

We know that milk-drinking men have more prostate cancer, and we're trying to figure out why. There are three smoking guns. We suspect that milk increases testosterone. Milk seems to increase IGF-I. And milk tends to disrupt vitamin D balance. The vitamin D phenomenon is particularly interesting. As you may know, when the sun hits your skin it makes vitamin D. It's made right in your skin, but it's not active yet. It's a preliminary form of vitamin D. The vitamin D goes to the liver where the first step of activation occurs and a hydroxl group (-OH) is added. Then it goes to the kidney where another one is added in the second step of activation. You now have the active form of vitamin D which goes to the digestive tract to help your body absorb calcium. That is vitamin D's job. But vitamin D has another function important to you--vitamin D protects the prostate. People don't think much about that, but it's true. Vitamin D helps protect the maturity of prostate cells.

If you have too much calcium in your diet, from milk or other source, your body stops activating all that vitamin D. The Vitamin D activation pathway is blocked. In effect, your body says " I don't need any more vitamin D." The problem is, the prostate loses out. The prostate was depending on that vitamin D to maintain its maturity. Now it's lost it because the body has too much calcium in the blood.

Paradoxically enough, even though you drink vitamin D-fortified milk, the increased calcium intake reduces the amount of active vitamin D in the bloodstream. This is due to the fact that vitamin D in milk is a precursor. It is not yet the active form. For example, the men in the Harvard study who subsequently got prostate cancer had a higher IGF-I level and a lower vitamin D level. The more calcium they consumed, the more trouble they were in. These are the things we learn as we seek to explain the effects of milk consumption.

"Beans and Greens"

I don't mean to suggest that limiting milk consumption is the only weapon in confronting cancer. It obviously isn't. High vegetable and fruit diets are protective. Low-fat diets seem to be protective, as are high-fiber diets. When I say we shouldn't be consuming milk, I recognize the need for calcium. We actually don't need a lot of it. The World Health Organization just came out with a report saying that if you are getting about 400 or 500 mg a day, it's probably enough. Others (our government and the dairy industry) recommend more than that. There really isn't much evidence that

more is better. We know that post-menopausal women are vulnerable to hip fractures. Is milk consumption the answer? Well, no. Harvard had another cohort study of nurses, and after a follow-up of eighteen years, the conclusion was that milk drinkers have absolutely no protection from fractures at any anatomical site. Milk as a defense against fractures appears to be a marketing tool. It does not work. If any of you want to know what does work to prevent osteoporosis, I'd be glad to go into that, but the idea of drinking milk for strengthening the bones is a waste of effort.

You do need some calcium in your diet and the healthful sources are what I call "the beans and the greens"—beans being the legumes, such as black beans, chick peas, and Great Northern beans. Greens—green leafy vegetables—have a fair amount of calcium, except for spinach which is a very selfish vegetable. It has a lot of calcium in it, but it's not easily absorbed. It's in there, but you won't be able to get it all. Well, how much calcium is absorbed? From brussels sprouts, mustard greens, broccoli -- somewhere over 50%, a pretty good absorption rate. Calcium in milk has a 32% absorption rate. Although there is less calcium in the greens than in milk, the absorption rates of the greens are higher. If you compare the different sources of calcium, you notice that there are extra things in greens that milk does not give you. For example, beta-carotene—there's a lot of it in broccoli, but none in whole milk. If you look at vitamin C, iron, and the other nutrients, green leafy vegetables are really nutrient-packed. The reason I am emphasizing this is to encourage your shifting diet toward the healthier kinds of food while providing assurance that when you do, you are not losing out on any essential nutrients.

Healthy Diet

So what constitutes a healthy diet? A healthy diet is based on four food groups -- no, not the four we all grew up with -- hamburgers, french fries, catsup, and ice cream! Healthful foods are whole grains, legumes (meaning beans, peas, and lentils), vegetables, and fruits. If you regularly consume these foods, you get plenty of protein, you get plenty of calcium--from what?-- “beans and greens!” Be sure to add a daily multiple vitamin because you need it for vitamin D and vitamin B_{12}. If you are out in the sun every day, you'll get plenty of vitamin D. But a lot of us are inside working on our computers or watching television, and may not get the sunlight our bodies need. So take a multiple vitamin. Vitamin B_{12} is something that is made naturally by microorganisms, but modern hygiene has largely eliminated that source. Any multiple vitamin that supplies complete nutrition will work.

Diet and Prostate Cancer

Now let’s talk about some of the studies affecting men who have already been diagnosed with prostate cancer. The research is still in its early phases, but we do have some intriguing findings, starting with observational studies looking at different diet patterns to see how they are linked to survival. A study done in Quebec City followed 384 prostate cancer patients for five years. The men who got the most saturated fat—men in the highest third of saturated fat intake--had three times the mortality risk compared to the other two-thirds (Fradet, et al., *Eur Urol* 1999;388:91). (A personal aside: When I was growing up in North Dakota, I'd get out of bed in the morning and Mom would be frying bacon. She'd take the hot bacon strips out of the pan and put them on paper towels to drain. We'd gather around and eat. She didn't throw away the grease. Oh no, she carefully poured it into a jar and saved it. What happened to that hot grease? As it cooled down, it hardened into a kind of waxy substance, the sign that it was very high in saturated fat. She kept that grease on a shelf.

She didn't even have to refrigerate it. The next day Mom would take it off the shelf and spoon it into the frying pan and fry food again. It's amazing that any of us lived to adulthood! I'll bet many of your moms did exactly the same thing!) Anyway, saturated fat has been indicted, not only in heart disease, but it also seems to be associated with a higher risk, not only of developing prostate cancer, but a higher risk of succumbing to it after diagnosis and therapy.

In the Quebec City study, total fat and monounsaturated fat, such as olive oil, were also associated with increased risk, but not in a statistically significant manner. Oddly enough, researchers in a Toronto/Vancouver observational study reached somewhat different conclusions, mainly that monounsaturated fat (olive oil and canola oil) actually seemed to be helpful. Of the 263 prostate cancer patients followed for three to seven years, the men who had the most monounsaturated fat intake seemed to do better. Also, animal fat and saturated fat increased mortality, but the effect was not statistically significant (Kim, et al., Cancer Causes and Control 2000;11:65-77).

Researchers began to say, "Let's make big changes in the diets of men who've already been diagnosed and see what happens." These are the so-called intervention studies. Many of you know about the Dean Ornish research. Dean Ornish is a great researcher, a young Harvard-trained physician who began doing studies to reverse heart disease. He used a vegetarian diet because vegetarian diets have no cholesterol. In addition to diet, he emphasized regular exercise, no smoking, and reduced stress (perhaps one reason why he didn't do the study here in Washington, DC!) Ornish found he could actually reverse heart disease with this kind of regimen. He then turned his attention to prostate cancer and reported some exciting findings. He took 84 men with untreated prostate cancer and assigned them to two groups. The vegan group of 42 men was asked to follow a total vegan diet—no meat, no dairy, no eggs, no animal products at all, and keep the oils very low. The control group was asked to follow the approach recommended by their regular doctor. The men were all in the "watchful waiting mode," so their PSAs were being followed regularly. After three months without any diet change, the average PSAs of the control group rose, which is what you might expect. Seven of the 42 could no longer wait and had to have treatment. In the vegan group, the average PSA dropped from 6.3 to 5.8 ng/ml—not a huge amount, but we'll take it—and no one needed any treatment in the initial three-month period. These results must be considered very preliminary, and Ornish continues to follow these men, but you get the idea. Diet changes seem to be a promising approach to dealing with prostate cancer (Dean Ornish, Urology 2001;57 (4 Suppl):200-201).

In a small study at the University of Massachusetts, 10 men were put on a vegan diet, each acted as his own control and calculated his PSA doubling time. From a baseline established at the outset, the median PSA doubling time was about 6.5 months. After the men were on the vegan diet for four months, the median PSA doubling time slowed down to almost 18 months. In three men, their PSA levels actually dropped (G. A. Saxe, J of Urol 2001;266:2202-7).

Now what about a macrobiotic diet? I like to describe a macrobiotic diet as Chinese medical principles distilled through Japanese cuisine; lots of rice, lots of vegetables, no dairy products at all, little or no meat, and rules about how to eat, too. It's hard to argue with the results. In this small study, nine men with prostate cancer were assigned to a macrobiotic diet. Their mean survival time was relatively long —228 months. The mean survival time of the nine matched individuals in the control

group was 72 months (J.P. Carter, J Am Coll Nutr 1993;12:209-26).

The cited studies are intriguing. They are by no means definitive, but they suggest to me that while we should pursue pharmacological treatments and improvements in surgery, radiation, hormonal therapy, and every other weapon we can muster in the fight against prostate cancer, we must never neglect powerful nutritional interventions. Tomorrow you are going to have breakfast, lunch, and dinner; and every time you choose what to put on your plate, you choose whether or not your diet is likely to drive cancer cell growth or improve your defenses against cancer.

Getting with the Program

While researchers continue efforts to effect cures for human maladies, we do not have to wait to begin a nutritional program because we already have some ideas about what are healthful foods and what are not. Grains are very high in fiber, helping to moderate the testosterone level, and very low in fat; legumes are also high in fiber, very low in fat; vegetables and fruits, same story. You notice I didn't include a dairy group. Let's say you want to use diet to prevent or restrain prostate cancer. What should you do? First, use these four food groups (grains, legumes, vegetables, fruits) as your basis and, before you actually change your diet, test different recipes to see which ones you like. For dinner, do you like spaghetti with marinara sauce? Do you like bean burritos? Try them out. You don't have to be a gourmet. You just need to choose six or eight meals that you like. That's your homework. We have many books and recipes listed on our website. So, using the four food groups, try out some recipes, and then do the diet 100%. If you do it just a little, your body doesn't really get much better. Do it all the way, but resolve to follow your new diet for three weeks. That makes it manageable. Don't just dip your toe in the swimming pool saying, "Well, maybe once in a while I'll eat something healthful." Jump right in - the water's fine! And stick to the diet for three weeks. If you have high cholesterol, it will start to come down. It's not going to come all the way down in three weeks, but it will get started. Three years ago we published an article in the *American Journal of Cardiology* reporting the strongest cholesterol lowering ever recorded in any diet trial in women over fifty. The dramatic results were achieved in five weeks, just using this total low fat, cancer survival diet. If you have hypertension or diabetes, this vegan diet tends to ameliorate those conditions. If you find you don't like it, you can stop. If you do like the diet and what it is doing for you, extend for another week, and another, and another.

Mother Knows Best

Use transition foods to help manage the adjustment. My mom taught me this. My mother had a very high cholesterol level. She wouldn't listen to a word that I said, and the reason is, I'm her third-born child. Those of you who have kids, you know what I'm talking about. The first kid is absolutely amazing. When that child utters any nonsense syllable, you call Gramma and let her know about it. You write these things down, and you have a photo album full of pictures. Then the second kid comes along. Now, you've been there, done that! No big deal. When you get your third child, you couldn't care less! I said, "Mom, you have atherosclerosis. You've got hypercholesterolemia." She wouldn't listen to my advice. Finally, she went to a clinic, and the doctor said, "Mrs. Barnard, sit down. You have a dangerously high cholesterol level, and you have to be on cholesterol-lowering drugs. If you don't—." He really scared her. Then she

said, "Wait a minute. Before you write me a prescription for drugs, let me just think about it." She came home and picked up one of my books, called *Food for Life*, and she said, "Neal's been telling me I should do this vegetarian Dean Ornishy thing." She was reluctant to try it, but she thought, "All right. I'll give it six weeks." And she did. She did it all the way--no cheating. She went back to her doctor, and the doctor drew her lipid level. He thought he had a lab error. Her cholesterol had dropped about 70 points within six weeks. There was absolutely no cholesterol in her diet. There was virtually no saturated fat. Her cholesterol level dropped dramatically. She came home and called me to say, "Neal! Why didn't you tell me about this before?"

So then Mom decided my father ought to do a vegan diet, too. Well, my father grew up on a cattle ranch, but the nice thing is, my dad's been sitting at the same dinner table for fifty-one years, and he can't find his way around the kitchen! He's been relying on Mom for fifty-one years to put the plate in front of him. So Mom went to the local health food store and bought hot dogs that are called "Not Dogs," and veggie burgers -- which used to taste like cardboard, but now they're really good. She can get Canadian bacon made of a wheat derivative. It's all vegetarian. Instead of cow's milk, it's soy milk, rice milk, fake eggs—all that stuff! Dad just keeps cleaning his plate. Now I've got two vegetarian parents, and only one of them knows it! I tell you all this to encourage you to start on the road to better health. Use the transition foods to help you make the dietary change, then go for it.

Conclusion

It has been my pleasure to be with you tonight. I realize that most, if not all, the men here have prostate cancer. Don't think it is too late to make a major diet shift. A healthy diet such as I have described may be just what you need to help control your cancer. At the same time, the diet will surely result in improvements in your overall health. Think about it for yourself and those you love.

In closing, I want to mention that I do advocacy and research through the Physicians Committee for Responsible Medicine. We handle all kinds of medical issues related to diet. We also offer classes for cancer survivors offered free of charge. Bring your spouse or significant other or anyone who is likely to balk at your diet change. Visit our website at **www.pcrm.org**; we have a quarterly called ***Good Medicine***, and we also have an electronic newsletter called *Breaking Medical News*. Go to our website and click on "*Breaking Medical News*" to sign up. You will not get spammed, you will not get advertisements; what you get is an electronic alert when new developments occur affecting diet and health. Now we have time for questions.

Questions and Answers

Q: Can you give us some general comments about milk with breakfast cereals?

A: I have two thoughts. If it's a hot cereal, like oatmeal, you don't really need any kind of milk on it, and you're better off getting what I call "old-fashioned oatmeal" rather than instant or even one-minute variety. In order to make it "instant," they have disrupted the fiber; they've chopped it up into powdery flakes. Then prepare oatmeal the old-fashioned way. Don't follow the instructions on the box. The instructions say, "Heat water to a boil and then pour the oatmeal in." I guarantee it will come out like little rocks! Instead, start with cold water. One part oatmeal, two parts cold water. Heat it while stirring. It will be quite soft, creamy, and delightful—very high in fiber. You don't need anything on it, although I prefer

to put some cinnamon or raisins on it. Second, if you prefer a cold cereal, choose the high fiber kinds and try soy milk or rice milk. There are at least forty different flavors of nondairy milks and if you don't like the first one, try another.

Q: Isn't lactose-free milk easier to digest?

A: Yes, it goes down easier, but remember, lactose intolerance is not a disease. If anyone is telling you, "You have an illness," that person is wrong. Lactose intolerance is a completely normal condition. It's the absolute norm for humans and for every other animal on earth to be lactose-intolerant. However, lactose-free milk is just as likely to contribute to prostate cancer as unmodified milk, so far as we know.

Q: What's been the response of the dairy industry to this kind of information ?

A: In my view, the dairy industry has not been as helpful as it could be. The dairy industry plays a peculiar role. It works with the US Government in many ways to make sure that milk is front and center at all stages of life. The federal school lunch program is a good example. Many kids rely on it as their main source of nutrition. The government will not pay for that lunch if milk is not on the tray. Substitute lactose-intolerant soy milk and calcium-fortified O.J.?—forget about it! I am now doing a test of the acceptability of soy milk in a school in Florida to learn if the kids will drink it. I think the kids ought to have the chance to make informed choices about their lunch beverage.

The dairy industry works aggressively with the federal government to promote consumption of dairy products. There is a program called the "Check-off Program." It mandates that dairy producers contribute to a fund administered by the Department of Agriculture to promote dairy products. The department works actively with such companies as Wendy's and Subway to get cheese as an ingredient in their burgers and sandwiches. Go to the drive-through window at Taco Bell and you will hear, "Would you like Monterey Jack on your chicken sandwich?" Cheese is included in most fast-food sandwiches. Domestic cheese consumption has increased from fifteen pounds per person per year in the mid-seventies to over thirty pounds per person per year today. We regularly read about obese Americans. I strongly suspect that increased cheese consumption is part of the problem.

Q: Are there any substantial differences in nutritional effect between raw and pasteurized milk?

A: I'm not aware of any study assessing differential effects on prostate cancer risk., but I suspect that you wouldn't be able to detect any differences because the natural nutrients are about the same.

Q: Can you give us a quick comparison about the fat content of some of the most common foods? How easy is it to adjust to the vegan diet?

A: Yes. The leanest beef is about 29% fat. The leanest chicken—I'm talking about skinless chicken breasts after you throw away all the fat and the skin—is about 23% fat. Fish vary; some are lower, some are higher, some are a lot higher such as Chinook salmon which is about 50% fat. Venison—I guessing here—maybe 15- 18% fat. Beans are 4% fat. Rice is between 1-5. Virtually all vegetables are under 10% fat, and they all have fiber. No animal product has any fiber.

The question about adjusting to the vegan diet always intrigues me. When I made the change, it took me four or five weeks before I was used to it. Some people are a bit resistant, though. If I say to you, "No more raspberries for the rest

of your life." Who cares! Or, "You can't have a banana all week." You don't care about that, either. But if I say, "No meat," about one in four people in surveys refuses to give it up, even if you paid them $1,000. No cheese? That's too tough. No sugar, no chocolate? Wow! For some people it doesn't mean much to avoid these foods, but for many others, it is asking a lot.

Let me give you a preview of what we are observing. There is a drug called naloxone--the brand name is Narcan. It's an opiate blocker. Give it to a person with a heroin overdose—they wake up. Naloxone blocks opiate effects. It has a similar effect on a chocolate addict; sit him down in front of a tray of chocolates. He'll eat a large amount. Bring him back in the next week—same tray, but give him naloxone, the opiate blocker. He'll eat a small amount if he's hungry, but then he stops. Give him cheese—same story; he's not overdoing it any more. We know that meat and sugar stimulate an opiate release in the brain. Researchers have studied the opiate effect of sugar in infants. You start with a 9- to 12-week old baby, putting the baby about fifteen inches away from you, face-to-face. Then mix a cup of water and a teaspoon of sugar, place a pacifier in the sugar water, then in the baby's mouth, maintaining eye contact for three-and-a-half minutes, then stop. That's all it takes. Walk out of the room. Come back in with other persons. The baby will not look at any of them—only you. The baby will gurgle, smile, and coo, because what you did was to stimulate his/her taste buds causing a neurological phenomenon in the brain whereby opiates are released in the pleasure center. You've linked the sensation with the memory of your face. What I'm saying is, foods act like opiates in certain cases.

Let me conclude this long-winded answer by facetiously admitting there is one safe way to enjoy a little bit of meat. Here's what you do. Take a small portion, no more than about four ounces. Broil it, adding no extra fat, until the juice is running through. Then let it cool on a small plate. Put the plate on the floor and call your dog! Your dog is a natural carnivore, while you are a primate.

Q: My mother ate whatever she wanted, or rather what was available, lived to age 86 and died from Alzheimer's. What do you make of that?

A: If she outlived everybody else and lived long enough to get Alzheimer's, maybe that's a good thing. Have you been looking at the data on Alzheimer's lately? It's really very, very encouraging, because this was something for which we had no dietary interventions at all, and now we are starting to have some. The results follow the established pattern. People with lower fat intakes have lower risk of Alzheimer's. There was a good study in Chicago that came out earlier this year. If I'm remembering correctly, there were about 800 people involved. Those who were in the upper levels of a saturated fat intake had about double the risk of Alzheimer's compared to those in the lower level. One other comment on this topic. Get your homocysteine levels measured. Doctors who measure cholesterol are now measuring homocysteine. High levels of homocysteine are associated with heart disease and Alzheimer's disease. What reduces the risk? A low animal diet, but more importantly, diets loaded with vegetables for folic acid (or a folic acid pill), vitamin B_6, vitamin B_{12}. Those are things that lower the homocysteine level.

Q: Can you comment on the suggested relationship between calcium and osteoporosis?

A: Vegetarians seem to have somewhat less osteoporosis than meat eaters. Osteoporosis isn't a condition of inadequate calcium intake. It's a condition of rapid calcium loss. The calcium is in the body; it's just coming out too fast. Why is it doing that? Part of it is due to

physical inactivity. When your bones have no reason to live, they give up their calcium. Animal protein contributes to calcium losses. There was a study of people on the Atkins diet, which is dangerously high in protein. It was done at the University of Texas' Southwestern Medical Center in Dallas. When persons were put on the Atkins diet, the high animal protein intake leached calcium from the bones and excreted it through the kidneys. Even in the maintenance phase of the diet, the permanent stage, the calcium losses were about 55% higher than normal, and Americans already have high calcium losses to start with. High sodium intake also causes calcium loss, as does a lack of vitamin D. These are the conditions that really contribute to bone loss. So, if you get your exercise, eat your beans and greens, avoid animal protein and excess sodium, and get out into the sun regularly, your bones have a better chance of staying healthy.

Q: Please comment on breast feeding.

A: It should be strongly encouraged for all mothers. It improves the baby's health, immunity, and even intelligence. It's a challenge for some new mothers. It can be uncomfortable, awkward, and inconvenient. A lot of new mothers get no coaching or help. A relative, a friend, and an understanding employer can really help with that. For human babies who drink human breast milk, there is never any need for cow's milk, and at the age of weaning, somewhere between twelve and twenty-four months, there is no reason for any more milk at all. If for any reason breast milk cannot be provided, all hospitals have soy milk. Babies are less likely to be allergic to soy milk than to cow's milk as a substitute for breast milk.

Q: Please comment on dietary considerations for Parkinson's Disease.

A: The Department of Neurology at George-town University has some interesting studies on Parkinson's. They are focusing on the role of protein. They have found that after a diet high in protein, the Parkinson's symptoms tend to worsen. So as an experiment, the patients have carefully planned, very-low-protein meals throughout the day, and if patients are going to have any higher protein food, it is served late in the day so symptoms occur when the patients are asleep. Then the cycle is repeated. The details of the study are available from the Neurology Department at Georgetown University.

Q: I read that using aspartane causes headaches.

A: This is an interesting topic. When Richard Wurtman at MIT was working with a company to market aspartane, he became so concerned that he tried to get the FDA to disapprove it. There have been hundreds of cases of people who have seizures from using aspartane—I'm not talking about small amounts of aspertane, I'm talking about a hot summer day when persons ingest a large quantity of it. The manufacturers will say, "It's pure chance." Toxicologists are not so sure.

Q: What about the heavy advertising for drugs to control problems arising from diet?

A: The sad thing is that when we hear about unhealthy dietary patterns, our immediate solution is a drug. Have you been watching the evening national news? Almost every commercial is for a drug to deal with diabetes, high cholesterol, etc. Of course, there is always a role for medication, as well there should be. We clearly need more drug research and we need better drugs to rely on, but if we're not using right foods with the medication, we really have one arm tied behind our backs. Unfortunately, the nutrition message is being drowned out by all the drug commercials.

Q: What can you tell us about the relationship between diet and diabetes?

A: We broke a few dietary rules for diabetics. If you have diabetes, you have sugar in your blood. The level of sugar is so high that it is leaking through the kidneys into the urine. That is how we measure it. The old idea was that diabetics should not consume sugar or anything that can produce it, e.g., starches, grains, beans. But if you look at it epidemiologically, the individuals with the lowest prevalence of diabetes are from Asian countries. I don't mean people in downtown Tokyo, but those in the rural areas. When Japanese individuals "westernize" their diet, the rate of diabetes goes up about 400%. Their genes haven't changed, but their food consumption has. This is my simplified analogy about diabetes -- the insulin hormone produced in your pancreas gets in your blood, it goes to the cells of your body, and when sugar is produced, insulin, the doorman, turns the knob, opens the door of a cell, lets sugar inside, and closes the door. And then insulin goes to the next cell and repeats the process. By now you have a lot of grease in your diet—beef fat, cheese fat, chicken fat. Insulin's hands slip on that greasy doorknob. It can't open the door. The grease you have been eating causes insulin resistance. The cells are not responding to insulin, so sugar builds up in the blood and your body has to make more and more insulin to get that cell door to open. That's how your body builds up insulin resistance.

We did a pilot study at Georgetown several years ago. We put seven people on a diet that was exactly the opposite of the one being used. It was a high-carb, very-low-fat, totally vegan diet because we wanted to mimic the Japanese diet with lots of rice and vegetables. Six of the participants were on oral medications, and four of them either came off their medicines completely or reduced their doses within twelve weeks. NIH liked our findings. We just did a study on insulin sensitivity, so we will now do a definitive study this fall with many more participants.

Q: Describe a typical menu you would use if you were newly involved with the vegan diet.

A: I would start my day with something like oatmeal, perhaps with half a cantaloupe. If I chose toast, I would use whole grain toast or pumpernickel bread. There are certain advantages to them compared to other kinds of bread. I like some of the meat substitutes now available. Some people find that a little more protein in the morning keeps them more alert during the day. If I wanted something higher in protein, veggie sausages and veggie bacon are good choices. You might even try higher-protein foods like chick peas or some kind of beans early in the day. I enjoy having an international dish for lunch or dinner— a bean burrito with Spanish rice, a pasta with wild mushrooms and green peppers in a marinara sauce, or mushroom stroganoff. The idea is to experiment with various recipes to meet you own taste. There are plenty of choices.

(**Editor's note:** If you are interested in more information about the topics discussed by Dr. Barnard, you may wish to consult his most recent book, Breaking the Food Seduction (St. Martin's Press, 2003). It may be ordered on-line at the web sites shown below. Related topics are also available on the web site of the Physicians Committee for Responsible Medicine at **www.pcrm.org** and **www.cancerproject.org**.

Minutes of the WRAMC US TOO Board of Directors Meeting
May 7, 2003

The Board of Directors met on May 7, 2003, at the Center for Prostate Disease Research (Ward 56, WRAMC). A quorum was present.

Regular Reports

Secretary's Report: The minutes of the February 5, 2003, Board of Directors meeting were approved.

Treasurer's Report: Ken Simmons presented the report for the period January 1 - April 30, 2003. It showed income of $5,278.83 from member contributions, dividend and interest income, and a corporate grant. Expenses for the same period were $3,492.89. Net income for the four-month period was $1,785.94. Net worth on April 30, 2003, was $19,373.46.

Editor's Report: There was no Editor's Report.

Report on Support Groups and Volunteer Program: Jane Hudak reported that the monthly day group has been meeting for 30 months with an average attendance of 23. The monthly evening group has been meeting for 22 months with an average attendance of 5. There are 12 volunteers assisting regularly at the CPDR. The lending library now has 120 books and 50 videotapes.

President's Remarks: Dr. Moul noted the continuing financial assistance of AstraZeneca and the enthusiastic support we receive from Ron Kotulak. He will present a token of appreciation to Ron Kotulak at the general meeting this evening. Dr. Moul also mentioned the possibility of obtaining funds

from other companies in order to expand the WRAMC US TOO program.

Old Business: None

New Business:

a. Race for the Cure. Jim Padgett reported on the Race for the Cure. It will be held on June 7. WRAMC US TOO members who wish to participate are encouraged to do so. We would participate as a group, but in an informal manner. Jim will provide more information about a meeting place and time for members to assemble.

b. PC Awareness Walk/Run. Our February speaker, Dr. Lynch from Georgetown University, had announced that he was organizing a prostate cancer walk/run scheduled for September 7. Dr. Moul will contact Dr. Lynch to determine additional details so we can offer to assist and participate.

c. Duration of the Regular Board Meetings. The Board has been meeting at 6:00 PM, one hour prior to the general meeting at 7:00 PM. It has been observed that the Board is often rushed to conduct its business prior to attending the general meeting. Accordingly, it was agreed that future Board meetings would convene at 5:45 PM.

d. Speaker for the August Meeting. Dr. Moul will present his annual summary of important topics from the annual meeting of the American Urological Association.

WRAMC US TOO COUNSELORS (AS OF 8/1/2003)

(These persons are willing to share their experience with you. Feel free to call them.)

SURGERY

Jack Barnes	Oakton, VA	(703) 620-2818	
Jack Beaver	Falls Church, VA	(703) 533-0274	
Jerry Bussing	Laurel, MD	(301) 490-8512	
Gil Cohen	Baltimore, MD	(410) 367-9141	
Edward G. Courey	Silver Spring, MD	(301) 589-4092	
Tony French	Annandale, VA	(703) 750-9447	
Robert Gerard	Carlisle, PA	(717) 243-3331	
Harry B. Harris	Silver Spring, MD	(301) 384-5260	
Monroe Hatch	Clifton, VA	(703) 323-1038	
Bill Johnston	Berryville, VA	(540) 955-4169	
Dennis Kern	Reston, VA	(703) 391-9418	
James Padgett	Silver Spring, MD	(301) 622-0869	
George Savitske	Alexandria, VA	(703) 671-5469	
Don Williford	Laurel, MD	(301) 317-6212	

RADIATION

John Barnes	Springfield, VA	(703) 354-0134	Intensity-Modulated Radiation Therapy
Leroy Beimel	Glen Burnie, MD	(410) 761-4476	(External Beam Radiation)
Philip Brach	Washington, DC	(202) 966-8924	(External Beam Radiation)
Ron Gabriel	Bethesda, MD	(301) 654-7155	(Brachytherapy)
Irv Hylton	Woodstock, VA	(540) 459-5561	(Brachytherapy)
Harvey Kramer	Silver Spring, MD	(301) 585-8080	(Brachytherapy)
Bill Melton	Rockville, MD	(301) 460-4677	(External Beam Radiation)
Oliver E. Vroom	Crofton, MD	(410) 721-2728	(Proton Radiation)
John Waller	Yorktown, VA	(757) 865-8732	(Brachytherapy)
Barry Walrath	McLean, VA	(703) 676-6405	(Brachytherapy)

INCONTINENCE

Larry Schindler	Silver Spring, MD	(301) 649-5946	
Ray Walsh	Annandale, VA	(703) 425-1474	

HORMONAL

"Mac" Showers	Arlington,VA	(703) 524-4857	
Tony Bicknell	Springfield, VA	(703) 451-7517	

SPOUSE SUPPORT

Faye Lohmann	Kensington, MD	(301) 933-3678	
Catherine Williams	Brandywine, MD	(301) 372-8650	
Frances Porter	Bowie, MD	(301) 464-8721	

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)
Joseph C. Kiefe	Reston, VA	(703) 860-3697	(Surgery, Radiation, Hormonal)
Hank Lohmann	Kensington, MD	(301) 933-3678	(Surgery and Radiation)
Joe Porter	Bowie, MD	(301) 464-8721	(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)

David C. Williams Brandywine, MD (301) 372-8650 (Surgery, Radiation, and Hormonal)

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♦ MEETING ANNOUNCEMENT ♦

WEDNESDAY, AUGUST 6, 2003
7 PM

JOEL AUDITORIUM (SECOND FLOOR)
WALTER REED ARMY MEDICAL CENTER

♦ SPEAKER ♦

COLONEL JUDD W. MOUL, USA, MC

DIRECTOR, CENTER FOR PROSTATE DISEASE RESEARCH

♦ TOPIC ♦

"LATEST DEVELOPMENTS AFFECTING PROSTATE CANCER -- A REPORT FROM THE ANNUAL MEETING OF THE AMERICAN UROLOGICAL ASSOCIATION"