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◆ **PROSTATE CANCER TREATMENT—THEN AND NOW** ◆

by

William P. Snyder, Colonel, USA (Ret.)

My 1975 Army retirement physical examination included the cryptic remark: “Digital rectal examination reveals enlarged prostate, both lobes, with no nodules; not-tender.” That observation failed to attract my attention in the years that followed. The condition of my prostate was also not noted by any of the several physicians performing physical exams during those years. Beginning in 1990, however, I underwent annual physicals; all included, at my request, a digital rectal exam and a PSA test. PSA tests were always in the 2.0-3.0 range, and none of the examinations recorded any enlargement or hardening of the prostate.

Following my retirement from a civil service position in May 1995, my wife and I moved from Alabama to North Carolina. I delayed my annual physical until after the move, hoping thereby to establish a medical relationship in our new location. The physical took place late in July, and the young doctor who performed the DRE told me that the prostate felt unusually hard. She then arranged an appointment with an urologist at the University of North Carolina Hospital. Although the PSA remained under 3.0, this second exam confirmed a hardened and enlarged prostate. A biopsy was ordered. The young resident who performed the biopsy, apparently aware of the low PSA reading, confidently announced that I had nothing to worry about—“your prostate is fine!”

Just over a week later I received a call from the Chief of Urology at the UNC Hospital. He got straight to the point: “You have prostate cancer; I’ve made an appointment for you to see one of our urologists about treatment.” He did not tell me how fast the cancer was progressing.

The appointment took place a few days later. The urologist—a surgeon—described the biopsy results. He then tore off a large piece of paper from the patient table and sketched a diagram showing the location of the prostate and its relationship to the bladder and other organs. There were two basic options: surgery or radiation. Surgery was the gold standard, he explained, and I sensed that was the approach he recommended. (He mentioned Patrick Walsh’s book, but I was unable to find a copy!) **(Continued on page 10)**

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**◆ FROM THE EDITOR'S
DESK ◆**

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The National Prostate Cancer Coalition (NPCC) recently released two reports of great interest to the prostate cancer community.

The first is the NPCC's annual "Report Card" grading the states and the District of Columbia for their efforts in the fight against prostate cancer. The NPCC's report, "*The Prostate Cancer Gap: Crisis in Men's Health*," is a powerful analysis of disparities in public awareness of prostate cancer. Both these NPCC documents are treated in this issue. Be sure to read about these topics.



The Department of Defense Prostate Cancer Research Program (PCRP) relies on prostate cancer survivors to serve on peer review panels to evaluate research proposals that will help eradicate the disease. The PCRP convened during July 2007, to begin the process of awarding \$80 million to the most promising proposals. Our WRAMC Support Group has always responded to the need for participants, and this year three of our members will serve on the panels. Many thanks to Paul Finneran, Colin McKinley, and Ray Walsh for their contributions of time and talent to this worthy cause. This fall we will be seeking volunteers for the 2008 PCRP.



◆ PROGRAM FOR WEDNESDAY, AUGUST 1, 2007 ◆

Dr. James R. Jezior, Department of Urology, WRAMC, is our speaker for Wednesday, August 1, 2007. A 1985 graduate of the United States Military Academy, he received his medical degree from the Uniformed Services University of the Health Sciences in 1989. His topic is "Quest for Continence: Evaluation and Treatment of Post-Prostatectomy Incontinence." Incontinence is a major concern for many men following surgery for prostate cancer. Dr. Jezior will provide us an update on the various methods of treating incontinence. Join us at 7 PM on Wednesday, August 1, 2007, in Joel Auditorium. Plan now to attend and bring your spouse or a friend. They are always welcome.

Veterans, Agent Orange, and Prostate Cancer Recurrence.

Vietnam veterans exposed to Agent Orange have a 48 percent increased risk of prostate cancer recurrence following surgery than their unexposed peers, and when the disease comes back, it seems more aggressive, according to Terris, et al., at the Veterans Affairs Medical Center, Augusta, GA, and the Medical College of Georgia. The study involved 1,653 veterans who had prostate cancer surgery at Department of Veterans Affairs Medical Centers in five cities between 1990 and 2006; 199 had been exposed to Agent Orange during the Vietnam War.

The disease appeared to be caught earlier in the exposed veterans. However, when the disease recurred, exposed veterans experienced a more rapid biochemical progression of their disease. In blacks, the PSA doubled in almost half the time of their unexposed peers.

As a population in general, veterans exposed to Agent Orange were more likely to have a recurrence. If they were black and exposed, they were more likely to recur than if they were black and unexposed. The researchers concluded that these Agent Orange-related patients need to be screened earlier, their cancer treated aggressively, and be followed closely afterward because they are at higher risk for recurrence. (Source: *Science Daily* adapted from a news release issued by Medical College of Georgia)

Intermittent Hormonal Therapy and Advanced Prostate Cancer.

Intermittent androgen suppression therapy for prostate cancer does not diminish survival nor hasten tumor progression compared with continuous therapy, and it may confer a small advantage in quality of life, according to a study presented at the annual meeting of the

American Urological Association. The patients were 335 men with stage D1 or D2 prostate cancer randomized to receive

continuous or intermittent treatment with goserelin and bicalutamide.

The men treated intermittently were taken off therapy when their PSA levels decreased by 90%, or to less than 4 mg/dL. Therapy was resumed when PSA rose by 10 mg/dL or more. Of those patients, 88% were off therapy more than 50 percent of the time. Ultimately, 65% of the patients receiving intermittent therapy and 66 percent of those receiving continuous treatment experienced disease progression. There was a trend toward a longer median time to disease progression for patients in the intermittent-therapy group - 17 months, compared to 12 months for men on continuous therapy, but the difference was not statistically significant. Median survival times were 51.4 months and 53.8 months with intermittent and continuous therapy, respectively.

On quality-of-life measures such as pain, vitality, emotional well-being, and social functioning, there were no differences between the groups. Starting at about 1 year, measures of general well-being were slightly higher among men receiving intermittent treatment, but the difference was not significant. Men in this group also experienced a higher rate of adverse events, but here too the difference was not significant.

Miller, et al., Benjamin Franklin Medical Center, Berlin, Germany, say their findings suggest that intermittent therapy is a safe and viable option for patients with stage D1 or D2 prostate cancer. They recognize that intermittent hormonal blockade is not now the standard of care, but they believe it can be offered safely to patients with advanced prostate cancer. An observer commented that many urologists already use intermittent therapy in the hopes of sparing patients the adverse effects and quality-of-life reductions associated with continuous androgen suppression. He said these findings will help practicing urologists feel more comfortable with using intermittent androgen suppression. The study was funded by AstraZeneca.

(Source: AUA 2007 Annual Meeting: Abstract LBA 1723; May 19-24, 2007. *J Urol*. 2007;117 (via Medscape Medical News)

Robotic Prostatectomy and Continence.

Terari, et al., Weill Medical College, Cornell University, say an anatomic restoration technique used during robotic prostatectomy can hasten the recovery of urinary continence. The pubo-prostatic ligaments, puboperinealis muscle, and arcus tendineus are important for urinary continence. The researchers developed reconstructive strategies to reconnect these elements and evaluated the effectiveness of the modifications in 50 men undergoing robotic prostatectomy for clinically localized prostate cancer.

Within the first week after surgery, 12 patients (29%) became continent; twenty-six patients (62%) were continent within 4 to 6 weeks; 37 (88%) within 12 weeks; and 40 (95%) within 16 weeks. This compares with continence rates of 42% at 6 weeks and 54% at 12 weeks in 50 previous consecutive patients not treated with the new technique. Compared with the earlier robotic approach, the new technique required an additional 7 to 10 minutes. The researchers conclude that the new technique is safe, easy to learn, time efficient, and effective. It results in an early recovery of continence with corresponding quality-of-life benefits, they say (Source: *Urology* 2007; 69:726-73, via Reuters Health, May 25, 2007)

Treatment for Early Prostate Cancer Associated with Type of Specialist Seen.

A new study analyzing men with localized prostate cancer shows that the specialty of the physician they see can influence the type of therapy they ultimately receive. The study at Memorial Sloan-Kettering Cancer Center found that patients aged 65 to 69 years old who consult a urologist are more likely to undergo surgery to remove the prostate, while those who consult a radiation oncologist and a urologist, regardless of age, usually receive radiation therapy. These practice patterns are

no surprise because prostate cancer specialists tend to favor the treatment they themselves deliver, despite the fact that no one has shown one treatment for early stage prostate cancer to be better than another, according to the researchers.

The study reviewed the records of 85,088 men aged 65 and older who were diagnosed with prostate cancer between 1994 and 2002 to determine the type of specialist they saw and the therapy they received. The treatments included radical prostatectomy, radiation therapy, primary hormonal therapy, and watchful waiting. A high correlation was observed between the specialist patients saw and the treatment they received. This was especially true in the younger men aged 65 to 69 year old where 70 percent of men who saw only a urologist had a radical prostatectomy. However, if men in this group saw a radiation oncologist and a urologist, 78 percent had radiation therapy. If the men saw a medical oncologist and urologist, 53 percent had a prostatectomy and an almost equivalent number had radiation therapy (17 percent), expectant management (16 percent), or primary androgen deprivation therapy (14 percent). The researchers say that the treatments for early stage prostate cancer have different side effects, different recovery profiles, and involve a different commitment of time, so it is imperative that men be advised about the details of all options so that they can make an informed decision that is right for them. (Source: Cancerfocus.net, June 6, 2007)

Vitamins and Prostate Cancer. Want more confusing news? Here it is! Taking too many vitamins may increase men's risk of dying from prostate cancer. The recent study doesn't settle the issue. But it is the biggest yet to suggest that high-dose multivitamins may harm the prostate. It is also the latest chapter in the confusing quest to tell whether taking various vitamins really helps a variety of conditions, is a waste of money, or worse. The

study tracked the diet and health of almost 300,000 men. About a third reported taking a daily multivitamin, and 5 percent were heavy users, taking the pills more than seven times a week. After five years, 10,241 men had been diagnosed with prostate cancer. Some 1,476 had advanced cancer; and 179 died. Heavy multivitamin users were almost twice as likely to get fatal prostate cancer as a man who never took the pills, concludes the study in the *Journal of the National Cancer Institute*. Overall, researchers found no link between multivitamin use and early-stage prostate cancer.

They speculate that perhaps high-dose vitamins had little effect until a tumor appeared, and then could spur its growth. Scientists at the National Cancer Institute note that similar but smaller studies also have suggested a link between multivitamin use and prostate cancer, but say that more rigorous research is needed. (Source: Associated Press, May 15, 2007)

Tomatoes are Outta Here! Beta-Carotene Too! Lycopene, the much-touted cancer fighting antioxidant found in tomatoes and tomato products, is ineffective in preventing prostate cancer, according to a new study. And beta-carotene is no Silver Bullet either. Peters, et al., Hutchinson Cancer Research Center, studied over 28,000 men, all of whom had no prior history of prostate cancer. They were screened for the disease at the start of the trial in 1993, and then followed with regular screening until 2001. During the course of the trial, 1,320 prostate cancer cases were diagnosed. The study found no significant difference in blood levels of lycopene between men who had prostate cancer and those who didn't. Tomatoes, and tomato found in ketchup and pizza, don't reduce the risk for prostate cancer, say the researchers.

Similarly, the study found an association between increased risk of aggressive prostate cancer -- disease that has spread beyond the

prostate -- and higher intake of beta-carotene, another popular antioxidant commonly used as a dietary supplement. The researchers warn that consumers should be very cautious about taking high doses of supplemental beta-carotene. Another expert agreed that men should not be taking lycopene or beta-carotene to prevent prostate cancer. The best strategy for preventing cancer in general is to not place one's faith in a particular food, but to live an active, healthy lifestyle. The report appears in the May issue of the journal *Cancer Epidemiology, Biomarkers & Prevention*. (Source: HealthDay News, May 17, 2007)

Prostate Cancer Hospitalizations Declining.

Men were less likely to be hospitalized for prostate cancer treatment in 2004 than in 1997, according to the latest News and Numbers from the Agency for Healthcare Research and Quality (AHRQ). Hospitalizations for treatment of the disease fell nearly 30 percent in those eight years. Prostate cancer is the second most common cancer in men. Currently, an estimated two million men in the United States are living with the disease. According to the AHRQ:

- Approximately half of men hospitalized for prostate cancer treatment were 45 to 64 years old, and men age 65 to 84 accounted for 44 percent of those hospitalized. About five percent were older than age 85, and less than one percent were age 18 to 44;
- Nearly 73 percent of these men underwent open prostatectomy -- the most common procedure for the disease;
- Hospitals charged \$1.7 billion for the stays of patients admitted for prostate cancer treatment, of which nearly half was billed to private insurers. Forty-three percent was billed to Medicare; four percent to Medicaid; 1.5 percent

to uninsured patients, and the remainder were charged to other payers such as the Department of Veterans Affairs, the military, or other state programs.

(Source: National Prostate Cancer Coalition's *AWARE*, May 30, 2007)

Robotic Surgery May Improve Survival Rate For Prostate Cancer Patient.

Performing less invasive laparoscopic surgery using robotic technology may improve survival rates for prostate cancer patients, according to a study by urologic oncologists at Thomas Jefferson University Hospital. In a study presented May 21, 2007, at the annual American Urological Society meeting, Lallas, et al., reported that the laparoscopic radical prostatectomy (LRP) using robot technology can reduce positive surgical margins. The researchers said the study demonstrates that even in a high volume center with an established laparoscopic radical prostatectomy program, the addition of robotic technology leads to a lower positive surgical margin rate. The Jefferson urologists reviewed the cases of 247 men with clinically localized prostate cancer treated at Thomas Jefferson University Hospital with either LRP or robotic assisted laparoscopic prostatectomy (RALP) from March 2000 to August 2006. Of the 247 cases, 197 patients underwent LRP and 50 patients underwent robotic-assisted laparoscopic pros-

tatectomy. The overall positive surgical margin rate for patients who had LRP was 18 percent, as compared to six percent for those who had RALP. (Source: [Thomas Jefferson University Hospital Release, May 24, 2007](#))

Fast PSA Rise Implies Bad Prostate Cancer.

Men whose PSA count goes up 2 ng/mL or more in one year are at high risk of dying of prostate cancer despite treatment.

The finding by D'Amico, et al., Dana-Farber Cancer Institute, is derived from a study of 948 men who underwent surgery or external beam radiation therapy for prostate cancer. At the time of treatment, all of the men had localized prostate cancer. Among the 660 men who chose radical prostatectomy there were 89 deaths within a median 5.4 years. Prostate cancer caused 29 of these deaths. In 44 percent of these prostate-cancer deaths, the only sign of high-risk disease was a PSA rise of at least 2 ng/mL in the year before treatment.

Among the 288 men who chose external-beam radiation treatment, there were 75 deaths within a median four years. Prostate cancer caused 32 of these deaths. In 28 percent of these prostate cancer deaths, the only sign of high-risk disease was a PSA rise of at least 2 ng/mL in the year before treatment. Other clues that a man is at increased risk of dying from prostate cancer are tumors with a score of 7 or more on the Gleason score; clinical disease that has advanced to the T2b stage; and a PSA level of greater than 10 ng/mL. But none of these signs was as powerful as what D'Amico and colleagues call PSA velocity. When the men had just one sign of severe cancer, that sign was PSA velocity for 88 percent of patients treated with surgery and in 80 percent of patients treated with external-beam radiation therapy.

There is some evidence that taking testosterone-blocking drugs in addition to surgery or radiation can improve prostate cancer survival in these men. There is also evidence that adding chemotherapy to surgery or radiation can prolong prostate cancer survival. The findings appear in the July 1 issue of the American Cancer Society journal *Cancer*. (Source: WebMD, May 5, 2007)

High-Dose Radiotherapy and Prostate Cancer.

Conformal radiation (CFRT) techniques focus the radiation beam more accurately onto the prostate gland, thus allowing delivery of

higher doses of radiation than standard radiation techniques. The largest trial of CFRT to date suggests that delivering a higher radiation dose improves efficacy but increases the incidence of longer-term adverse effects.

Dearnaley, et al., Royal Marsden Hospital, Sutton, United Kingdom, studied 843 men with localized prostate cancer and compared a standard dose of radiation (64 Gy) with a higher dose of radiation (74Gy), both delivered by CFRT and followed by androgen-suppression therapy. After 5 years of follow-up, the group that received the higher dose of radiation had substantially improved biochemical progression-free survival (BPFS), the researchers note. The BPFS was 71 percent in the higher-dose group versus 60 percent in the standard-dose group. The men receiving the higher dose of radiation also showed better local control and metastases-free survival and used less androgen-suppression therapy. However, this group also had an increased incidence of bowel toxicity, but not bladder toxicity. A third of the men (33%) who received the higher dose of radiation reported late bowel toxicity within 5 years of starting treatment, compared with 24% of the standard group.

The researchers conclude that the advantages and disadvantages of dose-escalated CFRT need to be fully explained to patients so that they can make fully informed decisions about their treatment options. They say the disadvantages of increased toxicity may not be acceptable, even in the context of improved biochemical control of disease, lessened need for salvage androgen suppression, and improved metastases-free and prostate cancer-specific survival. (Source: *Lancet Oncol* published online May 4, 2007, via Medscape Medical News, May 4, 2007)

Spike in PSA Predicts Recurrence. The doubling time for prostate-specific antigen (PSA) can predict disease recurrence and

mortality after radical prostatectomy, a new study shows. PSA testing has been called into question by a number of research teams looking for new biomarkers for prostate cancer. Despite the limitations of PSA, a new report shows that it is a reliable tool and can help clinicians identify at-risk patients.

Tollefson, et al., Department of Urology, Mayo Clinic, Rochester, Minnesota, studied more than 5,000 men and 1,521 of them had biochemical recurrence after radical prostatectomy. They say their analysis confirms that PSA doubling time is an excellent indicator of clinical disease recurrence. Doubling time is defined as the duration for PSA levels in the blood to increase by 100%. It remains the only significant factor that predicts clinical progression. Patients with a more rapid PSA doubling time experience more local recurrence and systemic progression and higher rates of cancer-specific death. In contrast, patients with a slow PSA doubling time experience low rates of clinical progression, and only patients with multiple PSA levels greater than 0.4ng/mL experience any clinical progression

Men with a PSA doubling time of less than 3 months after therapy are at imminent risk for death from prostate cancer. And patients with a doubling time of 3 to 12 months are at significant risk of developing systemic disease and dying. These new findings should prompt physicians of patients with doubling times of less than 1 year to initiate systemic therapies like hormonal therapy and chemotherapy.

Patients with PSA doubling times of 1 to 10 years are more likely to have a local rather than systemic recurrence. Patients with a PSA doubling time of greater than 10 years are at low risk for recurrence. (Source: *Mayo Clin Proc.* 2007;82:422-427, via Medscape Medical News, April 30, 2007)

Prostate Cancer Treatments and Quality of Life.

Men with prostate cancer considering surgery, external beam radiation therapy, and brachytherapy for early-stage prostate cancer must consider that they yield different quality of life outcomes. Litwin, et al., UCLA, evaluated general and disease-specific health-related quality of life (HRQOL) in 580 men after treatment for localized prostate cancer with radical prostatectomy, external beam radiation therapy, or brachytherapy. Treatment type did not influence general HRQOL, but there were several differences in disease-specific HRQOL. Urinary control and sexual function were worst after radical prostatectomy, followed by brachytherapy and external beam radiation therapy. Bilateral nerve-sparing surgery diminished the differences between surgery and radiation therapy. On the other hand, bowel dysfunction was significantly more common among radiation therapy patients.

Among men who were potent prior to their treatment, those who underwent bilateral nerve-sparing surgery showed a greater initial loss of sexual function but better long-term improvement than did men who underwent external beam radiation therapy or brachytherapy. External beam radiation therapy recipients were more likely than the others to return to baseline sexual function. Over the long term, similar proportions of men in the three groups reported severe urinary bother and severe sexual bother, but bowel bother was more pronounced in external beam radiation therapy and brachytherapy recipients.

The researchers conclude that men facing the array of treatment options for early or advanced prostate cancer are best served by thoughtfully considering both cure rates and quality-of-life implications into their decision-making; their physicians should provide advice that incorporates quality-of-life and survival outcomes. (Source: *Cancer* 2007;109:2239-2247, via Reuters Health, June 7, 2007)

MRI in Predicting Insignificant Prostate Cancer.

Magnetic resonance imaging (MRI) and spectroscopy findings, in combination with clinical variables and biopsy data, may be useful for predicting insignificant prostate cancer, according to a study reported in the April issue of *BJU International*. According to the researchers, the increasing incidence of small-volume, low-grade cancers on pathology in PSA-screened populations and the slow natural history of prostate cancer have raised concerns that some patients with clinically insignificant cancers are being over-treated. Shukla-Dave, et al., Memorial Sloan-Kettering Cancer Center, New York, recorded the probability of insignificant cancer retrospectively and separately for MRI and combined MRI/MRSI.

The study involved 220 prostate cancer patients who underwent magnetic resonance imaging (MRI) and MR spectroscopy imaging (MRSI) before radical prostatectomy. They had clinical stage T1c or T2a prostate cancer, PSA levels < 20 ng/mL and Gleason scores of 6. At pathology, 41 percent of patients had insignificant cancer defined as organ-confined

cancer measuring 0.5 cubic centimeters or less with no poorly differentiated elements. Both MRI and combined MRI/MRSI models developed by the team incorporating clinical data, biopsy results, and MR data, performed significantly better than existing clinical models in predicting insignificant cancer.

The researchers are optimistic that the new MRI and MRI/MRSI models might improve the overall accuracy of clinical models in predicting the likelihood of insignificant prostate cancer and help in counseling patients who are considering deferred therapy. (Source: *BJU Int* 2007;99:786-793, via Reuters Health, April 23, 2007)

Annual Prostate Cancer Report Cards.
The National Prostate Cancer Coalition (NPCC)

recently issued its Prostate Cancer Report Cards for the various states. The report assesses each of the 50 states and the District of Columbia, and assigns a grade based on critical areas like mortality and screening rates, support for prostate cancer-related legislation, and accessibility to urologists and clinical trial sites. Connecticut, New Jersey, and Rhode Island scored at the head of the

class with the highest grades this year, but Arkansas, Kentucky Mississippi, New Mexico, and Wisconsin received failing grades. So how did your state do this year? To see the NPCC report card for your state and all the other states and DC, go to www.fightprostatecancer.org/2007ReportCards. (Source: NPCC's *AWARE*, June 16, 2007)



KNOW SOMEONE NEWLY DIAGNOSED WITH PROSTATE CANCER? DIRECT HIM TO THE WEB SITE OF THE CENTER FOR PROSTATE DISEASE RESEARCH AT WWW.CPDR.ORG. IT HAS MUCH USEFUL INFORMATION. HE CAN FIND THE CURRENT ISSUE AND BACK ISSUES OF THE WRAMC NEWSLETTER ON LINE AT WWW.CPDR.ORG/PATIENT/NEWSLETTER.HTML.

**(Prostate Cancer Treatment – Then and Now
– Continued from page 1)**

There are two major risks associated with the surgery, he explained, incontinence and impotence. Since I was then just 67, the surgeon believed I would have no problem handling the operation. I agreed with his suggestion, and I was scheduled for surgery about a week later.

On Tuesday, September 5, 1995, my wife drove me to the hospital, and the surgery was performed that morning. An irregular heartbeat was detected after the surgery, and hordes of heart specialists and residents descended on me. Nothing of any consequence developed, although the hospital lost my location and my wife spent the day frantically trying to find me! The surgeon visited me in late afternoon, and said he was confident that the cancer had not spread outside the prostate. That evening a young

hospital attendant came to my bed and insisted I get up and walk. I protested but complied—and promptly collapsed on the floor amid a tangle of tubes and wires!

Five days in the hospital were followed by three weeks wearing a catheter. There were two subsequent visits with my surgeon, the second some six months later. He was pleased that I was continent but disappointed that I was impotent. He ruled out Viagra, then under fire for suspected heart problems, and referred me to a technician who provided prescriptions for the Osbon pump and Caverject. That was my last visit to the surgeon, although some months later he invited me to join a support group.

In recounting my experience with prostate cancer, I don't wish to deprecate the relatively spartan treatment I received in 1995 or even before. Indeed, I remain cancer-free after twelve years, and I'm quite grateful to my physician and the hospital. The point, rather, is to highlight the progress that has been made in the treatment of the disease over the past decade or so. Equally important, my experience highlights the remarkable improvements in the information available to patients about prostate cancer and its treatment.

First, it is difficult to imagine a primary care physician treating a mid-60s male who is not now sensitive to the possibility of prostate cancer, even one with a relatively low PSA. Indeed, most are now well aware of the predictive inadequacy of PSA.

Second, there were then few sources of information on symptoms or possible treatments. Indeed, except for the Walsh book, there were no accessible sources of information on prostate cancer or mention of a support group I might consult. Now there are a wide variety of web sites that provide quite specific information: visit www.prostatecancerfoundation.org, or try some of 100 or so sites listed on Google at "Prostate Cancer." As for publications, none is more useful than this WRAMC newsletter.

Third, patients now have a much greater range of potentially effective treatment options: seeds, external-beam radiation, laparoscopic surgery, and the newest approach, the Da Vinci procedure, among others. While research continues on the efficacy of these options, several seem to be approaching surgery in effectiveness. Treatment options for those whose cancer has spread are also more promising. Finally, patients can now expect more informed and timely advice on dealing with post-procedure difficulties, whether incontinence or impotence.

The bottom line: Prospective prostate cancer patients now enjoy better diagnostic procedures, a number of improved and less difficult treatment options, more and more informative sources of information for deciding how best to treat the cancer, and improved counseling on post-treatment problems.

Join me in congratulating the medical community on its remarkable progress over the past decade in identifying and treating prostate cancer.

◆ A Just Technology or Just Technology ◆

Dr. Stephen A. Brassell

Center for Prostate Research, Walter Reed Army Medical Center

(A summary of a presentation to the WRAMC Us TOO Chapter on May 2, 2007)

INTRODUCTION

What I'd like to talk about tonight is the robotic prostatectomy and how this new technology is changing the face of prostate

cancer treatment, emphasizing what it affords the surgeon and the patient. I'll also discuss its relationship to the conventional open prostatectomy that we have relied on for so many years.

At the outset, let me emphasize the importance of prostate cancer screening. It is the most commonly diagnosed cancer in men; a third of men will develop prostate cancer in their lifetime. This likely will result in over 210,000 cases being diagnosed in 2007. That is one case every 15 minutes! When we analyze autopsy studies done for a variety of reasons, we find that at eighty years of age, 80 percent of men will have prostate cancer to some degree. So the ubiquity of the disease is evident, requiring the availability of effective treatment options that also help maintain the patient's quality of life. When we look at the epidemiology of prostate cancer compared to other diseases, we see that prostate cancer has a higher incidence than any other cancer affecting men. In fact, it is double the rate of lung cancer, its closest competitor. That's the bad news! The good news is that we are noticing a marked decline in the instances of metastatic disease at the time of diagnosis. For example, 17 percent of men that presented between 1980 and 1990 had metastatic disease at the time of diagnosis. This rate has decreased to 4 percent in the last decade. Similarly, the incidence of extracapsular disease at initial diagnosis decreased from 15 percent to 6 percent. Thanks to greater aware-

ness and the PSA test, we have made great strides in earlier detection of prostate cancer when it is still organ-confined. Despite the prevalence of prostate cancer noted above, early detection and more aggressive treatment results in men having only a 3% overall risk of dying from the disease. This is truly good news for all of us.

THE DA VINCI ROBOTIC SYSTEM

The traditional treatment options are surgery, radiation, hormonal therapy, and watchful waiting. But now you as patients and we as clinicians have a multitude of treatments available such as a combination of brachytherapy and external beam radiation therapy, cryosurgery, proton beam radiation therapy, to name a few. Tonight we will talk about a relatively new technique – the robotic prostatectomy.

Turning to the surgical option, there are two main choices, the robotic prostatectomy and the conventional retropubic prostatectomy. More men are inquiring about the robotic prostatectomy. Let's take a look at the operative schematics. This is how the room looks to us. The patient is right there on the table and the robot actually sits over the patient as shown. The surgeon's assistant sits by the bedside and helps change out the instruments for the robotic arms as necessary, and the surgeon sits across the room at a console controlling the robotic arms. This is what the robot looks like up close. The equipment has gone through several upgrades. The one you see here is the Da Vinci S model, the latest available. Notice that it has four arms. Earlier versions had only three. So we have the advantage of one camera arm and three working arms. The robot does not provide any tactile feedback to the surgeon. So he must depend on visual cues to know how the tissue is responding to him. The robot makes up for this by allowing the instruments to be scaled anywhere from a 1-1 motion to a 1-5 motion. What does that mean? It means that we can manipulate the robotic arms very precisely and as finely as the procedure may require. In addition, the robot incorporates a motion filter to eliminate the normal tremor that exists in even the steadiest of hands.

This is what the surgeon sees through these lenses. And this is how the surgeon operates. He places his fingers in the two finger cuffs and these are "velcroed" together. Notice that

he has a 360° motion capability in a clockwise fashion. He can go forward and backward and side to side as necessary. So there is an unlimited range of motion with the robot which gives it advantages over the open prostatectomy or the pure laparoscopic technique. To add to the benefits of the robot, it permits the surgeon to actually see in 3D through lenses that focus just like your eyes, and it can magnify things up to ten times. This visual capability is another advantage over traditional laparoscopy which is two-dimensional and has minimal magnification.

Look at this cartoon regarding port sites. When we get you in the operating room we mark you for the placement of the robotic ports. This is the typical scheme to accommodate the camera and the robotic arms. We may vary the locations depending on the circumstances as you can see in the diagram to the left. Notice the size of the ports. These are very small incisions. The one at the navel is the largest port at about 12mm in size through which we eventually remove the prostate. At that time, we may have to extend it slightly.

How did this technology develop? In the 1980s, the US Army developed a concept for remote surgery for battlefield casualties. For example, a surgeon at a hospital in Europe or even the United States could operate on a soldier in Iraq. We actually have done successful transcontinental surgery using just a standard internet line. There is very minimal delay between the motions of the surgeon and those of the robot arms. The eventual goal is to transform the capability to a battlefield application. The medical community at large quickly saw the potential for remote surgery. The equipment, surgical techniques, and supporting technology were quickly developed and the FDA approved them in 2001. (At this point, Dr. Brassell showed and commented on a film clip of an actual robotic prostatectomy.)

THE CONVENTIONAL RADICAL PROSTATECTOMY

Now let's talk about the conventional radical prostatectomy that is familiar to many of you. The surgery was originally described in 1947 by an Irishman named Terrence Millen who published his results in *Lancet*, the highly regarded medical journal. He was received with skepticism, but he is now regarded as the founder of the radical retropubic prostatectomy. The techniques and technology have improved dramatically over time such that the procedure is still considered the "gold standard" for the primary treatment of prostate cancer. The surgeon has the advantage of tactile sensation, i.e., he can feel the prostate and the surrounding structures, even the tumor. Special glasses provide magnification anywhere from 2.5 to 5x which is more than adequate for the task at hand. The procedure has undergone several revisions over the decades to include the most important ones - Meyer's work in the 1980s describing the anatomy of the external sphincter to preserve continence; and Walsh's contribution of the nerve-sparing technique to preserve potency. As you know, the open approach is done through about a ten centimeter incision through the midline just below the navel. (Dr. Brassell showed and commented on several vugraphs depicting the technique for the open prostatectomy.)

COMPARING THE PROCEDURES

Now let's compare these two surgical procedures in terms of several key factors:

Incision Length. The total incision length concerns some patients. If we add up the incisions for the Da Vinci, they amount to about 7.5 cm; and the open prostatectomy incision is about 10 cm, a 2.5 cm or about a one inch difference – not a big deal.

Surgical Approach. The robotic prostatec-

tomy must be done using an intra-peritoneal approach, meaning that the surgeon must enter the bowel cavity to proceed. This gives him the working space he needs to do the surgery. On the other hand, the open prostatectomy procedure actually pushes the bowels aside and never enters the bowel cavity. This is known as an extra-peritoneal approach. The point here is that the robotic procedure does have a very slight potential for damage to the bowels. I have never seen this happen, but it is a theoretical risk.

Post-operative Pain. Every patient is concerned about post-operative pain. Studies show no difference in patient post-operative pain between the robotic and the open prostatectomy. A Vanderbilt study had patients measure pain on a scale of one to ten, and it is interesting to note that the patients in both groups reported minimal post-operative pain – three or less on the ten-point scale. This is consistent with our experience here at Walter Reed.

Duration and Blood Loss. The duration of the surgery is a bit longer with the robotic prostatectomy. On the other hand, the robotic approach has a lower blood loss. At the national level, the average blood loss is about 200cc during the robotic procedure and 600cc during the open procedure. There is no statistically significant difference in transfusion rate. The difference is largely due to the carbon dioxide gas used to inflate the belly during the robotic procedure. It provides pressure against the blood vessels, stopping the venous bleeding. Catheter time and time to continence are about the same between the two.

Learning Curve. There certainly is a learning curve for the surgeon performing the robot procedure; however, a surgeon experienced in the open procedure overcomes it very quickly. For example, one report on 2,500 cases involving both procedures at various institutions found that urinary continence can be achieved at the very outset

of the learning curve, i.e., surgeons performing their first robotic procedure achieved the urinary continence rate of the open procedure. Achieving comparable rates regarding margin status and sexual function takes more time. They thought it took about 100 to 150 cases, and about 200 cases before the surgeons themselves felt comfortable enough to choose the robotic procedure over the open procedure. When we look at positive margin rates for robotic surgery, it appears that the surgeon needs about 50 cases under his belt to actually get an adequate margin rate. Once you get those 50 cases, you actually achieve a very good margin rate. In the study shown here, Group One is the first 50 cases and Group Two is the next 50 cases. We can see the positive margin rate decrease from 27% to 4-5% after those 50 cases. By way of comparison, the positive margin rate for the open procedure on average is about 10-15%. So, they are all in the same ballpark, but it looks like the margin rate for the robotic procedure may be a bit better as the surgeon gains more experience. Now this is due to several operating techniques using a stapling device and taking down some of the ligaments that hold the prostate in place. All those different techniques are in evolution, so this is a work in progress, so to speak.

Cost. Now for those concerned about comparative cost and stewardship of healthcare dollars, the robotic prostatectomy is clearly more expensive. Some civilian institutions are reluctant to start Da Vinci programs because of high start-up and operating costs. The robot itself costs about a million dollars and the annual machine maintenance is about \$100,000. The cost of disposables is about \$1,500 dollars per case. This totals \$11,000 per case for institutions if they do one case a day or 365 cases a year. No one does that, so \$15,000 a case is probably a better estimate. In comparison, the open prostatectomy costs about \$5,000 per case. Theoretically, this would result in an annual cost difference of \$1.4 billion. This

may lead some health policy analysts to question the economics of the robotic procedure when the relatively inexpensive, tried-and-true open procedure is available.

Hospital Stay. We find that there is no difference in hospital stay between the two procedures. The average time to discharge from Walter Reed is about 48 hours. Some hospitals in the civilian sector discharge prostate cancer patients on post-operative day one, especially after the robotic procedure. The most common reason for an extended hospital stay after surgery is ileus, the temporary disruption of the digestive process. Theoretically, bowel activity should return faster with the open procedure because there is less disturbance to the bowels, but our experience at Walter Reed shows there is no difference in hospital stay between the two procedures.

Rectal Injury and Incontinence. Some observers have voiced concern that there is a higher instance of rectal injury associated with the robotic procedure. The robotic rate for rectal injury is between 4-5 percent, compared with 1-2 percent for the open approach. I have been performing the prostatectomy using both procedures for ten years and I have never seen a rectal injury from either approach.

Urine leakage requires special attention during the robotic procedure. One major medical center reports leakage in about 6.5 percent of their cases. The surgeon must be very precise in doing the anastomosis (reconnection of the urethra and bladder). The open technique relies on six separate sutures. The robot uses one running continuous suture all the way around. If it becomes slack, then leaks may occur. There are techniques to overcome this problem, such as an absorbable clip placed on the suture to keep tension necessary to prevent leaks. As the surgeon gains experience, there is no need to use the clip.

The post-operative incontinence rates for both the robotic and open procedures vary considerably among the published studies. In general, they range from 2.5 - 85 percent. Our data at Walter Reed put us at the lower end of that range at about 10 percent. Our experience with the Da Vinci system is that about 76 percent of patients are pad-free. This is consistent with our open prostatectomy experience of 80-90 percent pad-free. Only 1-2 percent of patients undergoing either of these procedures need a follow-up procedure for incontinence. I should note that the data do not include men who have stress incontinence associated with coughing or sneezing.

Post-operative Potency. No doubt you are very interested in the preservation of post-operative potency! We are finding that there is no real difference between the two techniques. The potency rate for both is about 50% in men whose erections were normal prior to surgery. When we provide medications such as Viagra, Levitra, or Cialis, we find that those post-operative potency rates can reach 60-70 percent. You may hear some hype that the robotic technique is more effective in preserving potency. Several studies show that this is simply not the case. That is something each patient should be aware of before deciding on a surgical procedure

CONCLUSION

The surgeon strives for the “trifecta,” i.e., cancer control, maintenance of continence and preservation of potency. About 60 percent of all patients achieve all three, but we need to do better by developing technology and raising skill levels. The Da Vinci system is one example of what we are trying to achieve. Regarding margin rates (cancer control), I think we can say that it is similar for both

procedures. The incontinence and potency rates for the two procedures are also similar; likewise for pain, hospital stay, and catheter time. Duration of surgery is lower with the open procedure while blood loss is less with the robotic procedure. At this point that is about all we can say. We need to continue improving both procedures and analyzing the benefits/risks between them.

OTHER DEVELOPMENTS

Before I entertain any questions I want to talk about other technology that we are introducing at Walter Reed to help achieve the “trifecta” I mentioned.

High Intensity Focused Ultrasound. First, we are trying to acquire a High Intensity Focused Ultrasound (HIFU) capability. This is a non-invasive mechanism using a probe placed in the rectum. The probe resembles that used for the prostate biopsy. It permits us to visualize the prostate on this machine and target it with high-intensity, focused ultrasound waves that melt the prostate. You don’t have any incisions, but you do need a catheter afterwards. Here is an actual image of a prostate being treated. As you can see here, this is our target zone. When we target it with the ultrasound we can see a cavitory lesion that means we had adequate treatment of that area of the prostate. We have a temperature probe and some power adjustments to tailor our therapy so that most of the therapy goes in the prostate and the least amount to the side of the prostate to avoid damage to the nerves affecting erections. HIFU isn’t ready for prime time. It is not yet FDA-approved, but it is available in Canada and some European countries. It offers promise, so we hope to acquire one for Walter Reed to assess its potential.

MRI Spectroscopy. Next, we are working with industry to obtain a better diagnosis of prostate cancer. I have done research in

imaging of prostate cancer. We have been approached by a company to do MRI spectroscopy. This entails doing an MRI then overlaying it with a metabolic image of the cancer. Take a look at this slide. You see the MRI of the prostate right here. This small, darker area is the prostate cancer. Prostate cancer processes certain chemicals differently than does normal tissue, specifically choline. When we look at the metabolic image using the spectroscopy portion of it we can see the prostate cancer is lighting up with the choline showing it extending into the seminal vesicle. So this man has locally advanced disease. This helps us to make the diagnosis, plan treatment and also counsel the patient about the most appropriate treatment for him. MRI spectroscopy is now undergoing institutional review and we hope to bring it here soon.

Studies. There are several studies going on at our Center for Prostate Disease Research. Our Watchful Waiting Dutasteride study has just closed. We took a medication for benign prostatic growth and gave it to patients undergoing watchful waiting to see how it affects their PSA levels. Next, we also have a medication called Theralogix which is a super vitamin. This is used for treatment of recurrent prostate cancer after radiation or surgery. If the PSA rises after primary therapy, the patient is typically relegated to hormonal therapy which has some side effects. Theralogix does not have any of those side effects and is a good bridge to treat patients to see if we can get a PSA response for them. Finally, I want to mention our Genprobe study. It is looking at different molecular markers in the urine that can supplant PSA as biomarker. Many of you who have undergone a recent biopsy have enrolled in this study. What we are seeking is a more sensitive and specific biomarker than the PSA. We already have over 200 patients enrolled and we appreciate your support for the study.

QUESTIONS AND ANSWERS

Question: I am interested in the Theralogix trial you just described. If a PSA starts to rise after primary therapy, at what point do you begin to consider hormonal therapy or this Theralogix.

Dr. Brassell: For Theralogix therapy, we look at a parameter called PSA doubling time that many of you are familiar with. For example, if your PSA is one in January and the following January it's two, your PSA doubling time is 12 months. If it's one in January and then the next January it is four, then your PSA doubling time is about three months. To be in the Theralogix study your PSA doubling time has to be between three and twelve months. So that means in a year's time your PSA has to double.

Some men find after recurrence that their PSA doubling time is 18 or even 24 months, a very slow rise. Before someone in that category initiates hormonal treatment, there should be careful consideration about the benefits and risks of hormonal therapy. The options at that point are either hormones or continue to watch until the PSA dynamics change. The decision to begin hormonal therapy relies on the comfort level of the patient and his physician with the overall PSA level.

Question: The outcomes for the robotic and open procedures appear to be similar. And no doubt the robotic technique will eventually be widely available. Is this likely to result in the urologic medical community being fragmented into two separate communities – the robotic surgeons and the conventional surgeons?

Dr. Brassell: I think most of the newly trained surgeons will be more comfortable with the robotic and laparoscopic surgical techniques. I think it's important to be skilled in both procedures because different patients require different approaches. For example, for

a patient with a palpable tumor a surgeon may prefer to use the open procedure so that he can get the tactile feedback. Again, the open procedure may be indicated for heavier patients.

Question: That was going to be my next question. Are there any other personal characteristics in newly diagnosed men that would dictate their suitability for robotic surgery?

Dr. Brassell: Yes. For example, if a patient has locally advanced disease as indicated by a high PSA, a large palpable nodule, or a high Gleason score, then I would prefer to perform the open procedure. I think I can get a better margin that way.

Question: You compared the two procedures in terms of blood loss, pain and other factors. How about survivability? Is it too early to assess that?

Dr. Brassell: Regarding survivability, the efficacies of the primary therapies for prostate cancer are evaluated in terms of 15-year survivability. Since the robotic procedure only became available in 2001, we simply do not have the comparative data yet. Nevertheless, we find that most prostate cancer patients do well after the first five years regardless of the therapy selected.

Question: You mentioned that you would likely perform the open procedure for a patient with a palpable tumor. Why is that important in differentiating between the robotic and open procedures?

Dr. Brassell: Let me say that we do indeed perform the robotic procedure on patients with palpable nodules, but not a very large nodule. The tactile feedback associated with the open procedure allows the surgeon to keep a lot of extra tissue on the prostate itself without relying solely on visual cues.

Question: As telephone counselors we often deal with the element of fear on the part of the callers. The question is how reliable are the machines?

Dr. Brassell: How reliable is the robot as far as breaking down in the operating room during the procedure? That is a great question. I have never heard about that happening. We do have a redundancy of auxiliary equipment but here is only one robot because of the cost involved. However, the robot is very reliable. Still, your question makes the case for the surgeon to be proficient in both procedures in the unlikely event that the robot malfunctions.

Question: We are urged to be our own advocates and we often read about the number of times a surgeon should perform a specific procedure in order to obtain proficiency. Let's say the proficiency standard for the robotic procedure is 100. If I ask a doctor how many he has done and he says "ten," I'll be looking for another doctor! What is the procedure for building up your expertise numbers wise?

Dr. Brassell: This refers to the training of residents and training of physicians in new technology. I think that just goes to mentorship and the extent of specialty training. When you look at surgeons you must ask how much training do they have in prostate surgery; for example, did they do a fellowship in prostate surgery? How many cases do they do a year? Some could have done a thousand cases in their lifetime but none in the last five years. Similarly, a surgeon may have done only a hundred cases,

but they were done within the last year. In the final analysis, the patient must have a certain comfort level with his surgeon based on their relationship

Question: This question deals with age for surgery. I recall that age 70 seemed to be the cut-off for considering surgery. Does that still hold?

Dr. Brassell: Traditionally the cut-off point was 70. When evaluating an older candidate for surgery, we look at the benefit of surgery and the risk associated with longevity. Given general improvement in health conditions, we know that men at age 70 have a life expectancy into the late 80s, even 90. So the traditional age 70 cut-off is not ironclad; instead, each patient must be evaluated for several factors, age being only one of them. Here at Walter Reed we draw from a military culture where people tend to be healthier than the population at large. It is not unusual for us to consider men at age 75 who could be candidates for surgery. As a rule, I would recommend the open procedure for an otherwise eligible older patient because I can get him off the table quicker.

Question: Does the size of the prostate impact robotic surgery?

Dr. Brassell: Absolutely. If the prostate is 100 cm, even 90, then I think the open procedure is the way to go.



The Prostate Research Gap

Who can be unaware of the immense success of the breast cancer community in advancing national awareness of breast cancer and the need to achieve the cure? Breast cancer awareness events garner national attention in the media; full page advertisements regularly appear in the major newspapers and magazines; many manufacturers and retailers pledge a percentage of their sales revenue to

breast cancer-related organizations. As a result, there is a substantial difference in the resources available to breast cancer compared to other forms of cancer. Now the National Prostate Cancer Coalition (NPCC) recently made an important contribution to the prostate cancer community with publication of its startling report, *The Prostate Cancer Gap: A Crisis in Men's Health*.

The NPCC report identifies gaps in such areas as screening, insurance, media attention, research funding, and research results. For example, only 28 states and the District of Columbia currently mandate that insurance companies provide coverage for prostate cancer-related screening; this compares with 49 states that require insurance coverage for breast cancer-related screening. Federal funding for cancer research is another significant gap. The National Cancer Institute (NCI) funding for prostate cancer research grew from \$86 million in 1996 to \$376 million by 2006. During that same period, NCI funding for breast cancer grew from \$382 million to \$718 million. A similar pattern exists within the cancer research programs within the Department of Defense.

The NPCC report points no fingers. After all, in some respects the research efforts for breast cancer, prostate cancer, and other forms of cancer are complementary. Also, the prostate cancer community itself needs to organize to create awareness. In that regard, the NPCC presents a circular model emphasizing that Awareness leads to Advocacy to influence Policy; policy decisions generate additional resources for Research leading to new, effective Treatments which in turn generates national News Media Coverage, further enhancing public Awareness. We all have a role to play in making effective this circular relationship. You can read the entire NPCC report by going to [www.FightProstateCancer.org/ProstateCancer Gap](http://www.FightProstateCancer.org/ProstateCancerGap).

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◆ WRAMC US TOO COUNSELORS ◆ (As of August 1, 2007)

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

SURGERY

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| Tom Assenmacher | Kinsvale, VA | (804) 472-3853 | |
| 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 | |
| Richard Dorwaldt | Burke, VA | (703) 455-8657 | (Laparoscopic Surgery) |
| John Fellows | Annandale, VA | (703) 503-4944 | |
| Tony French | Annandale, VA | (703) 750-9447 | |
| Michael Gelb | Hyattsville, MD | (240)475-2825 | (Robotic Surgery) |
| Robert Gerard | Carlisle, PA | (717) 243-3331 | |
| Ray Glass | Rockville, MD | (301) 460-4208 | |
| Monroe Hatch | Clifton, VA | (703) 323-1038 | |
| Tom Hansen | Bellevue, WA | (425) 883-4808 | (Robotic Surgery) |
| Bill Johnston | Berryville, VA | (540) 955-4169 | |
| Dennis Kern | San Francisco, CA | (415) 876-0524 | |
| Steve Laabs | Fayetteville, PA | (717) 352-8028 | (Laparoscopic Surgery) |
| Don McFadyen | Pinehurst, NC | (910) 235-4633 | |
| James Padgett | Silver Spring, MD | (301) 622-0869 | |
| George Savitske | Alexandria, VA | (703) 671-5469 | |
| Artie Shelton, MD | Olney, MD | (301) 523-4312 | |
| Jay Tisserand | Carlisle, PA | (717) 243-3950 | |
| Don Williford | Laurel, MD | (301) 317-6212 | |

RADIATION

| | | | |
|-------------------------|-------------------|----------------|--------------------------------|
| John Barnes Therapy) | Springfield, VA | (703) 354-0134 | (Intensity-Modulated Radiation |
| Leroy Beimel | Glen Burnie, MD | (410) 761-4476 | (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) 442-9577 | (Brachytherapy) |

INCONTINENCE

| | | |
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HORMONAL

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

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

| | | |
|--------------|----------------|----------------|
| Philip Brach | Washington, DC | (202) 966-8924 |
|--------------|----------------|----------------|

SPOUSE SUPPORT

| | | |
|---------------|--------------------|---------------|
| Kay Gottesman | North Bethesda, MD | (301)530-5504 |
|---------------|--------------------|---------------|

OTHER THERAPIES/MULTIPLE THERAPIES

| | | | |
|-----------------------------|-----------------|----------------|--------------------------------------|
| Philip Brach | Washington, DC | (202) 966-8924 | (External Beam Radiation) |
| Howard Bubel Function) | Fairfax, VA | (703) 280-5765 | (Cryosurgery, Hormonal, Sexual |
| Arthur E. Clough | Kerryville, TX | (210) 896-8826 | (Surgery and Radiation) |
| S.L. Guille | Sumerduck, VA | (540) 439-8066 | (Surgery, Radiation, Hormonal) |
| Richard Leber | Chapel Hill, NC | (919) 942-3181 | (Surgery, Radiation, Hormonal) |
| Charles Preble Hormonal) | Annandale, VA | (703) 560-8852 | (Cryosurgery, Hormonal, Intermittent |
| Emerson Price | Absecon, NJ | (609) 652-7315 | (Hormonal, Radiation, Cryosurgery) |
| S.L. Ross | Alexandria, VA | (703) 360-3310 | (Brachytherapy, Radiation, Hormonal) |
| Ken Simmons | Alexandria, VA | (703) 823-9378 | (Radiation and Hormonal) |
| Bill Stierman | Vienna, VA | (703) 573-0705 | (Surgery and Hormonal) |
| Ray Walsh | Annandale, VA | (703) 425-1474 | (Surgery and Hormonal) |

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OFFICIAL BUSINESS

◆ **MEETING ANNOUNCEMENT** ◆

**WEDNESDAY, AUGUST 1, 2007
7 PM**

**JOEL AUDITORIUM (SECOND FLOOR)
WALTER REED ARMY MEDICAL CENTER**

◆ **SPEAKER** ◆

**COLONEL JAMES R. JEZIOR, MC
Department of Urology
Walter Reed Army Medical Center**

◆ **TOPIC** ◆

**Quest for Continence: Evaluation and Treatment of
Post-Prostatectomy Incontinence.**