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A PROSTATE CANCER SUPPORT GROUP
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NEWSLETTER

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♦ BREAKTHROUGH AT THE CENTER FOR PROSTATE DISEASE RESEARCH ♦

Researchers at the Uniformed Services University of the Health Sciences (USU) Center for Prostate Disease Research (CPDR), in collaboration with investigators at the Armed Forces Institute of Pathology (AFIP) and Walter Reed Army Medical Center, have developed a highly specific assay for the detection of ERG, a protein associated with tumor formations which is present in more than half of all prostate cancers. This reagent has an unprecedented specificity (99.99%) for detecting prostate tumor cells in pathologic specimens with great potential in diagnosis.

The study, co-led by Dr. Shiv Srivastava, CPDR scientific director, and Dr. Isabell Sesterhenn, from the Department of Genitourinary Pathology at AFIP, provides first insights into how and where ERG is present by developing a comprehensive map of ERG in whole-mount prostate sections of more than 130 patients. The team established the selective presence of ERG in malignant cells and the virtual absence of ERG in normal cells. Researchers at CPDR have been actively studying biology, biomarker and therapeutic utility of ERG alterations in prostate cancer since their original discovery of the frequent ERG overexpression in 60-70% of all prostate cancer patients more than five years ago. Activation of the ERG gene, by combining with other genes, is one of the key genetic defects in prostate cancer.

“We are excited about the potential of streamlining the detection of ERG oncoprotein in clinical specimens,” said Srivastava. “This notable advance in the field has been possible only because of the amazing specificity of the ERG monoclonal antibody. Since this type of assay is routinely used in pathology settings, we anticipate that this strategy will open new opportunities in clinical evaluation of prostate cancer worldwide,” said Albert Dobi, Ph.D., assistant director of CPDR’s basic science research program and a co-author of the paper.

The Uniformed Services University of the Health Sciences (www.usuhs.mil) is the nation’s federal health sciences university. USU students are primarily active duty uniformed officers in the Army, Navy, Air Force and Public Health Service who are being educated to deal with wartime casualties, emerging infectious diseases and other public health emergencies. Of the university’s more than 4,500 physician alumni, the vast majority are supporting operations in Iraq, Afghanistan and elsewhere, offering their leadership and expertise. (Source: The Uniformed Services University of the Health Sciences, June 29, 2010)

♦ *INSIDE THIS ISSUE* ♦

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♦ FROM THE EDITOR'S DESK ♦

We did not publish the Newsletter for May 2010 for two reasons. We cancelled our February meeting due to inclement weather conditions. Consequently, we had no summary remarks from the scheduled speaker to include in the May issue. It was our intent to publish an abbreviated newsletter, but unexpected personal considerations made it impossible for us to do so. It was the first time in eleven years that we failed to publish the quarterly newsletter.

♦ MAY SPEAKER'S REMARKS ♦

Our May program featured Dr. Nancy Dawson, Director, Clinical Research and Attending Oncologist, Georgetown University Medical Center. Dr. Dawson's topic was "Recurrent Prostate Cancer: Treating a Complex Disease." We regret that we are unable to provide a summary of Dr. Dawson's presentation due to technical difficulties associated with her presentation.

♦ SUPPORT FROM FERRING PHARMACEUTICALS ♦

We are pleased to announce that Ferring Pharmaceuticals has supported the publication of the Newsletter by making a generous grant that ensures its continued production. We are very grateful to Ferring for its interest and support.

♦ MEETING SCHEDULE FOR AUGUST 4, 2010 ♦

Our August program will feature two speakers on related topics of importance and interest to you. The speakers are Dr. James R. Jezior, Chief of Urology, WRAMC, and Dr. Robert C. Dean, Director of Andrology, WRAMC. Their joint topic is "Current Trends in Continence Care and Sexual Health after Prostate Cancer Therapy." Dr. Jezior will discuss continence and Dr. Dean will discuss sexual health. Join us on Wednesday, August 4, 2010, at 7:00 pm in Joel Auditorium. Family members and friends are always welcome.

Prostate Cancer Deaths to Rise. Prostate cancer deaths are expected to rise by 17 percent during 2010, according to estimates based on National Cancer Institute data and reported in ZERO - The Project to End Prostate Cancer. ZERO Chief Operating Officer Jamie Bearse recognizes the current PSA controversy, but emphasizes that early detection of prostate cancer can be achieved only by annual testing. He also added that a better biomarker for the disease is necessary to distinguish slow-growing tumors from deadly ones, but in the meantime we need to continue testing. The 2010 prediction of a 17 percent jump in deaths is accompanied by a 13 percent rise in diagnosed cases. These are the greatest percentage increases since the mid-1990s. (Source: ZERO - The Project to End Prostate Cancer, June 15, 2010)

Study Says Radiation Boosts Prostate Cancer Survival. A new study shows that adding radiation to standard hormone treatments for men with cancer starting to spread beyond the capsule significantly boosts survival. Even though these treatments have long been used, few studies have been done to establish their value alone or in combination. In this new study, Warde, et al., Princess Margaret Hospital, Toronto, assigned 1,200 men to get hormones plus radiation or hormones alone. After seven years, 74 percent of those receiving the combined treatment were still alive compared to 66 percent for men on the single therapy. Also, men on the combined treatment lived on average six months longer than the other men. Serious side effects occurred in less than 2 percent of men in either group. The study was sponsored by the National Cancer Institute of Canada. One observer said that the study shows that radiation is an indispensable element in the treatment of patients with high-risk prostate cancer. A spokesman for the American Cancer Society also praised the survival advantage. (Source: The Associated Press, June 6, 2010, via ZERO)

Positive Surgical Margins and PCa-Specific Mortality. A recent study suggests there is a definitive link between positive surgical margins post-surgery and prostate cancer-specific mortality. There has long been evidence that such was the case; however, there is also case-specific evidence that surgical margins are not necessarily associated with prostate cancer recurrence or progression.

This study by Wright, et al., is apparently the first to clearly suggest that positive surgical margins following prostatectomy are associated with prostate cancer- specific mortality. A review of data from 1998 to 2006 identified 65,633 men who had a radical prostatectomy as their primary therapy and who otherwise met the study criteria. The cumulative prostate cancer-specific mortality was nearly three times higher in men with positive surgical margins than it was in patients who had negative surgical margins at a median follow-up of four years. On the other hand, less than one percent of the patients had died at the four-year follow-up. The study authors acknowledge limitations in their study, among them are the relatively short-term of the follow-up and the lack of consistent centralized pathological review of the surgical specimens. (Source: ProstateCancerinfo Link.net, May 14, 2010)

FDA Approves New Chemotherapy Drug. The Food and Drug Administration recently approved the first prostate cancer chemotherapy drug found to extend the survival of men who are no longer being helped by other treatments. The drug Jevtana is made by Sanofi-Aventis of France. The FDA approved Jevtana to treat prostate cancer that does not respond to hormone-deprivation treatments or to docetaxel, the cancer drug most commonly used to fight prostate tumors. Earlier this year, a study showed Jevtana prolonged survival for those patients by 10 weeks.

Jevtana was approved for use in combination with the steroid prednisone which is often used in cancer treatment. In the study, patients who received a treatment regimen including Jevtana lived for about a year and three months after starting treatment. Those

who received standard treatment lived for about a year and three weeks. There is hope the drug will have a stronger effect on patients who are not as sick. Sanofi-Aventis expects the drug to be available this summer.

Jevtana is given by injection. In the study, patients on Jevtana were more likely to have their tumors shrink than those who were on standard chemotherapy. However, no patients in the study experienced a complete remission, or disappearance of all signs of the disease.

Jevtana's side effects include decreased levels of infection-fighting white blood cells and lower white blood cell count, anemia, lower levels of blood platelets, diarrhea, fatigue, nausea, vomiting, constipation, weakness and kidney failure. The drug was developed under the name cabazitaxel. (Source: The Associated Press, June 17, 2010)

HIFU Shows Promise as a Prostate Cancer Therapy. High-intensity focused ultrasound (HIFU) shows promise as a treatment for early-stage prostate cancer, according to interim study results presented at a meeting of the European Association of Urology. The study included 20 men with stage T1c-T2b, N0, and M0 unilateral prostate cancer. All subjects had a PSA of 15 ng/mL or lower, a Gleason score of 7 or less, and a prostate size of 40 cc or less.

Six months after treatment with HIFU, 95% of men were able to achieve erections and had pad-free urinary continence. Also six months post-procedure, 55% of men had wet ejaculations and no patient had rectal toxicity.

Of the 19 men who underwent biopsy, two (10.5%) had cancer recurrence. One patient was switched to active surveillance and the other underwent another HIFU treatment. Six months later, magnetic resonance imaging and biopsy revealed no evidence of disease among the participants.

Emberton, et al., University College London Hospital, London, remarked that treating the disease using focal therapy avoided the morbidity associated with radical therapy, while restoring men to a position where they can have access to active surveillance.

The researchers know that HIFU is controversial, but said it is the only currently available strategy that might lead to reductions in treatment-related side effects. (Source: www.RenalandUrologyNews.com, June 6, 2010)

Active Monitoring Versus Immediate Treatment. New data from the Swedish national prostate cancer registry suggest that the 10-year prostate cancer-specific mortality rate is less than 2.5 percent for men who opt for careful disease monitoring as opposed to immediate invasive treatment.

According to a new study by Stattin et al., the use of active monitoring, along with deferred treatment when necessary, was associated with only a 2.4 percent mortality rate after 10 years of follow-up compared to an 0.7 percent 10-year mortality rate among men who selected immediate radical prostatectomy or radiation. Stattin and his colleagues identified 6,849 patients of 70 years of age or younger. The patients had to have been diagnosed with clinical stage T1–2 prostate cancer, a Gleason score of 7 or less, a serum PSA level of less than 20 ng/mL, and managed with some form of active monitoring or immediate curative intent.

There are several cautions about interpreting these data. For example, this is a retrospective analysis of data that reflect the biases of the patients and their physicians. It is not a randomized, controlled clinical trial. In addition, the design of the study inevitably had a strong “selection bias,” meaning that a higher proportion of healthy patients with prostate cancer with adverse factors were inevitably assigned to receive a radical prostatectomy as opposed to active monitoring. In addition, a longer follow-up is needed because most patients currently diagnosed with localized prostate cancer are in their 60s and have a life expectancy of more than 15 years.

The bottom line is that there are increasing amounts of data to suggest the value of active monitoring for patients with low-risk disease who are 70 years of age and younger. The problem is still that of how to best distinguish between the patients who can be effectively and safely managed with active surveillance and other forms of monitoring and

those who need early invasive treatment to prevent progression to advanced disease. (Source: www.ProstateCancerInfoLink.net, June 21, 2010)

Anejaculation After Radiation for Prostate Cancer. Anejaculation is defined as the inability to ejaculate semen. With this condition, a man can produce sperm but cannot expel them during normal ejaculation even though anejaculation often is accompanied with normal orgasmic sensation. According to Mulhall, et al., Memorial Sloan-Kettering Cancer Center, nearly 90% of men who undergo radiation therapy (RT) for prostate cancer will eventually develop anejaculation. Radical prostatectomy is more commonly associated with loss of ability to ejaculate, but the researchers have shown that, with time, RT also causes anejaculation in a majority of patients. Although anejaculation after RT has not been widely discussed in the medical literature, clinical experience has shown that it is a common complaint after pelvic RT.

The study involved 364 men who provided information regarding their ejaculatory function and orgasm as a routine part of their sexual health evaluation for post-radiation sexual problems. Of the study cohort, 252 men underwent external-beam radiation therapy and 112 underwent brachytherapy. The mean age of the study population was about 65 years, and the mean length of follow-up after RT was about 6.5 years. Overall, 72% of men lost their ability to ejaculate in an antegrade fashion after prostate RT by their last visit. A total of 16% reported anejaculation at one year, 69% at three years, and 89% at five years. The proportion of men experiencing this side effect increases over time, and men do not recover their ability to ejaculate. Risk factors for anejaculation at three years included higher RT doses, older age, exposure to androgen-deprivation therapy, and smaller prostates at the time of RT.

Earlier published data on post-RT ejaculatory function are inconsistent They tended to show that while anejaculation was associated with RT, the condition stabilized to some degree over time. This study used a different questionnaire.

The researchers emphasized that men who are selecting a treatment for prostate cancer should be made aware of the high likelihood of anejaculation with RT. Since radical prostatectomy always causes anejaculation, some men may choose RT with the false expectation that they will retain their ejaculatory function. (Source: Medscape.com, June 10, 2010)

New PSA Test May Predict Prostate Cancer Recurrence. Men who have just had their cancerous prostate gland removed are naturally concerned about recurrence. But conventional tests are not sensitive enough to provide a concrete answer. Subsequent tests often detect no PSA, only to have cancer return in up to 40 percent of the cases.

Research by Mirkin, et al., Northwestern University Feinberg School of Medicine and the University International Institute for Nanotechnology, shows that an ultrasensitive PSA test using nanoparticle-based technology may be able to definitively predict after surgery if the cancer is cured long-term or if it will recur. The new test is based upon assays invented at Northwestern, and is reportedly 300 times more sensitive than currently available commercial tests. It reportedly can detect a very low level of PSA that indicates the cancer has spread beyond the prostate. The test also may pick up cancer recurrence at a much earlier stage when secondary treatment is most effective for a patient's survival. It also gives an early indication of whether secondary treatments, such as radiation and hormone therapy, are working. The study was presented at the American Urological Association's 2010 Annual Meeting.

William Catalona, M.D., professor of urology at Feinberg, was a senior investigator on the study. Dr. Catalona was the first to demonstrate that the PSA test could be used as a screening test for prostate cancer.

The researchers said the next step for scientists is a prospective clinical trial to compare the nanoparticle-enhanced PSA assay to traditional PSA assays and determine if earlier detection and treatment can save lives. (Source: BeforeItsNews.com, June 2, 2010)

Sexual Decline After Radiation. Sexual function declines in the first two years after external beam radiation therapy for prostate cancer but stabilizes thereafter, according to data from a prospective cohort study. Valicenti, et al., University of California Davis, found that all parameters of sexual function declined significantly in the first two years after external-beam radiation therapy (EBRT). But for years two through six of follow-up, none of the evaluated parameters of sexual function changed significantly.

Pretreatment sexual function was the strongest predictor of sexual function at any time after EBRT. These findings challenge the perception that sexual function declines continually after radiation therapy for prostate cancer.

Reported rates of impotency after EBRT for prostate cancer have ranged from 8% to 85%, a variation the authors attributed to the different instruments used to assess sexual function. Moreover, many studies included men who received androgen deprivation therapy in addition to EBRT, possibly masking the contributions of radiation therapy to changes in sexual function.

The investigators prospectively followed 143 men who completed a sexual function questionnaire prior to EBRT for prostate cancer and at each follow-up visit. The questionnaire assessed four domains of sexual function: sexual drive, erectile function, ejaculatory function, and overall satisfaction. The mean age of the patients was 69, median Gleason score was 6, and median total radiation dose was 73.8 Gy. During a median four-years of follow-up, the study participants completed a total of 1,187 questionnaires. Some patients were followed for as long as eight years after EBRT.

Baseline scores for sexual drive and erectile function were significantly associated with patient age. Ejaculatory function was significantly associated with age, race, and marital status. Scores on all four domains of sexual function, as well as the total score, declined significantly in the first two years after EBRT compared with baseline values.

A separate analysis of scores from years two through six showed no significant changes in any of the domains: sexual drive, erectile function, ejaculatory function, and overall satisfaction.

The researchers say the data indicate that the widely held opinion that sexual function has a slow, progressive decline after EBRT might be incorrect. Most sexual function decline in men undergoing EBRT for prostate cancer occurred in the first two years after treatment and all domains of sexual function, including erectile dysfunction, then appeared to stabilize. (Source: MedPage Today, (January 29, 2010)

Prostate Cancer Therapy and Quality of Life. A new study finds that the various forms of prostate cancer treatment -- from surgery to radiation to hormones -- can all have long-term effects on men's quality of life when it comes to sexual function and urinary problems. Yet the researchers found that none of the treatments seemed to have strong effects on men's overall quality of life - including energy levels, pain, emotional well-being and ability to perform day-to-day physical tasks, like walking, climbing stairs and carrying groceries. The findings, reported in the *Journal of Urology*, are based on 1,269 U.S. men who were followed for four years after treatment for earlier-stage prostate cancer. The majority -- 60 percent -- underwent radical prostatectomy. Another 17 percent had brachytherapy, and 12 percent had externally delivered radiation. Another six percent of patients had a combination of the two radiation therapies, and five percent received hormonal therapy.

These treatments can cause erectile dysfunction, and surgery and radiation often lead to urinary incontinence. But much less has been known about how these problems affect men's quality of life in the long run. Huang, et al., University of Pittsburgh School of Medicine, found that men who had surgery or any form of radiation saw their urinary symptoms worsen in the first year after treatment, based on their responses to standard quality-of-life questionnaires. As a group, surgery patients had the most problems.

In the second year after treatment, the surgery and radiation groups all showed a general improvement in urinary symptoms -- though they did not fully return to their pre-treatment quality-of-life ratings. The extent to which the men were "bothered" by their urinary problems also waned, moving close to their pre-treatment ratings. Men who underwent hormone therapy showed a different pattern: they tended to report a gradual, moderate worsening in their urinary function over four years. The researchers speculate that hormonal therapy may have effects on the pelvic muscles and urinary tract that, over time, can create urinary problems. Regarding sexual function, all of the treatment groups reported declines in the first year after treatment -- with the steepest drop seen among surgery patients. However, surgery patients also showed an improvement over the second year, whereas the other treatment groups did not -- such that men who had surgery were faring similarly to other men at the end of the study period. In addition, while men in all of the treatment groups tended to say they were more bothered by sexual problems after treatment than before, their "bother scores" declined less than their objective ratings of sexual function.

The researchers say that the study provides indirect evidence suggesting that while erectile dysfunction may be common, patients seem to adjust to these changes. And when it came to men's ratings of their overall quality of life, none of the prostate cancer treatments seemed to have a significant impact. All treatment types adversely affect urinary and sexual function, but do not appear to significantly impact the overall sense of well-being. (Source: Reuters Health, May 12, 2010)

Availability of Provenge, a New Prostate Cancer Vaccine. The cancer vaccine sipuleucel-T — now commercially branded as Provenge — will soon be available at a select group of medical centers nationwide, including the University of California, San Francisco (UCSF).

Provenge is a newly-approved, life-extending prostate cancer treatment for men with advanced disease. Medical centers that helped to carry out the clinical trials leading to approval by the U.S. Food and Drug Administration (FDA) will be the first to offer Provenge in standard practice. Within a few weeks, UCSF cancer specialists will become the first and only site in Northern California to make the treatment available to patients who are not participating in clinical trials.

Provenge is expected to be in short supply for a year or two. Dendreon, the company that developed Provenge, is still ramping up its manufacturing capability. The company announced that treatment would initially become available at about 50 sites nationwide.

The FDA approved the use of Provenge to treat only certain men with prostate cancer. A man must have cancer that has spread to other tissues. He must be experiencing no symptoms, or only minor symptoms. He must be taking hormonal therapy to block the cancer-stimulating effects of testosterone. In addition, his PSA score must be rising over time, despite hormonal therapy. A rising PSA score is an indication that hormonal treatment may no longer be effective.

Provenge is made from a patient's own immune cells. Certain immune cells are removed from the patient and trained to target a protein called PAP. PAP is found primarily on prostate tumor cells and on normal prostate cells. The patient receives three infusions of these immune cells, two weeks apart.

Compared to untargeted immune cells, Provenge extended patient survival by an average of four months in phase III clinical trials. Three times as many men treated with Provenge survived three years or more. Provenge does not appear to shrink tumors significantly. Nor does treatment cause a drop in PSA levels.

Ongoing studies aim to evaluate Provenge treatment at earlier stages of prostate cancer. Researchers also are initiating studies to combine Provenge with other treatments. (Source: UCSF.edu, May 21, 2010)

Prostate Cancer Can Get Hairy! This may be good news for balding men who are otherwise distressed by hair loss. A new study found that hair loss before age 30 is associated with a lower risk of prostate cancer later in life. This conclusion apparently contradicts

earlier research regarding baldness and prostate cancer risk. The study by Wright, et al., Fred Hutchinson Cancer Research Center, found that men with early-onset of male pattern baldness had a 29 per cent reduction in the risk of developing prostate cancer. The apparent protection applied to both aggressive and less aggressive forms of the disease.

Male pattern baldness affects about 25% of men by age 30, 50% by age 50, and nearly 80% by age 70. Testosterone is converted to dihydrotestosterone or DHT, and baldness occurs when hair follicles become exposed to too much DHT.

Commentators agree that more study is needed to replicate and clarify the link between male pattern baldness and prostate cancer risk. (Source: WebMD.com, March 19, 2010)

Few Differences in Outcome between Open and Laparoscopic Surgery. Open radical prostatectomy (ORP) is considered the standard treatment but the use of laparoscopic radical prostatectomy (LRP), with or without robotic assistance, is becoming more widespread. In the new study, researchers at Memorial Sloan-Kettering Cancer Center, New York, compared ORP and LRP outcomes in nearly 6,000 men, age 66 or older, with localized prostate cancer.

The researchers found no differences in the rates of general medical/surgical complications, genital/urinary/bowel complications, or in use of post-operative radiation and/or androgen deprivation. However, patients in the LRP group had a 35 percent shorter hospital stay and a lower rate of bladder neck/urethral obstruction. The study was published in the February 22, 2010, issue of the *Journal of Urology*.

The researchers concluded that men considering radical prostatectomy should be clearly informed about the differences between the two techniques and similarities in their expected outcomes, then make treatment decisions in collaboration with an experienced surgeon. (Source: HealthDay News, February 22, 2010)

Equivalent Outcomes for Young and Older Men After Brachytherapy. Researchers at Memorial Sloan-Kettering Cancer Center, New York, evaluated retrospectively the biochemical outcomes of young men treated with low-dose-rate brachytherapy for prostate cancer. From 1990 to 2005, 1,665 men with clinically localized prostate cancer were treated with low-dose-rate brachytherapy with two years of follow-up. Patients were stratified on the basis of age: younger or older than age 60. Biochemical failure was defined as a prostate-specific antigen (PSA) nadir plus 2 ng/mL. Median follow-up was approximately 68 months .

Young men achieved excellent 5- and 8-year biochemical control rates that are comparable to those of older men after prostate brachytherapy. The researchers concluded that younger age should not be a deterrent when considering brachytherapy as a primary treatment option for clinically localized prostate cancer. (Source: *Int J Radiat Oncol Biol Phys*, December 29, 2009, via UroToday.com, January 2010)

Obesity as a Risk Factor in Radical Prostatectomy. Obesity has been proposed as a risk factor for reduced disease-specific survival, increased positive surgical margins and biochemical recurrence after radical prostatectomy (RP) in patients with prostate cancer. Researchers at the Princess Margaret Hospital, University of Toronto, sought to clarify the relationship between obesity and surgical outcomes in patients undergoing RP.

Medical records of 491 patients who underwent RP from 2004 to 2007 were obtained and the patients were divided into three groups based on their body mass index (BMI). Outcomes after RP were compared between the groups in terms of length of stay, perioperative complications, biochemical recurrence and positive surgical margins, and Gleason scores.

Age, stage and preoperative prostate-specific antigen were similar between BMI categories. Operating time was prolonged in obese patients (146 vs 135 minutes) and blood loss was greater (640 vs 504 mL,), but did not

translate into higher transfusion rates. Early complication rates, positive surgical margin rates and Gleason scores were not statistically different between the groups. Significant differences in late outcomes, such as the need for adjunct procedures or biochemical recurrence were not noted.

The researchers concluded that as surgical experience with high BMI patients has developed, RP appears to be a well-tolerated procedure irrespective of BMI. In particular, early outcome parameters, such as positive surgical margins and biochemical recurrence rates were similar. (Source: Int J Uro, June 9, 2010, via UroToday. com, June 29, 2010)

Use of PSA Testing Among Men Aged 75 and Older in the US. In 2008, the US Preventive Services Task Force (USPSTF) updated prostate cancer screening guidelines to recommend against screening for prostate cancer in men aged 75 years or older. An analysis by the Centers for Disease Control and Prevention (CDCP) described the prevalence of prostate-specific antigen (PSA) testing in this population and identified factors that may be correlated with the use of this test.

CDCP assessed the status of PSA testing in the past year among 9,033 US men aged 76 or older who had no history of prostate cancer to determine associations of PSA testing with certain sociodemographic and psychosocial factors.

Overall, 60% of men aged 76 or older reported having a PSA test in the past year. Men who had health insurance, were satisfied with life, or always had emotional support were significantly more likely to report having a PSA test in the past year. However, men who had no routine health checkup; were divorced, widowed, or separated; or had less than a high school education were significantly less likely to report having had a PSA test.

Clearly, PSA testing is common among men aged 75 or older in the United States. The identified sociodemographic and psychosocial factors may not only provide baseline data to evaluate acceptance and implementation of the USPSTF screening guidelines, but may also help physicians and public health providers better understand these sociodemographic and psychosocial factors in this population. (Source: Centers for Disease Control and Prevention, June 30, 2010)

Delayed Surgery and Prostate Cancer Risk. Men with low-risk prostate cancer had significantly worse outcomes if they delayed surgery for six months or more after their diagnosis, data from a large retrospective cohort showed. The study looked at the medical records of more than 1,100 men with low-risk prostate cancer and found that those who delayed surgery had almost double the likelihood of having high-grade disease at prostatectomy; twice as many men had biochemical progression compared with patients who had surgery less than six months after diagnosis. Carvalhal, et al., Northwestern University, Chicago, say that in a contemporary prospective radical prostatectomy cohort of low-risk prostate cancer patients, they found that a delay in surgery of six months or more after diagnosis was associated with worse outcomes, specifically, a significantly greater proportion of high-grade disease and higher rates of biochemical progression. Defining biochemical recurrence as a post-prostatectomy rise in serum PSA to ≥0.2 ng/mL, investigators compared pathologic features and biochemical recurrence rates in men who had surgery within six months of diagnosis or after six months. The study was presented at the recent meeting of the American Urological Association. Earlier studies of surgical delay's impact on outcomes have yielded conflicting results. As more men opt for active surveillance of low-risk prostate cancer, timing of surgery has emerged as a key consideration during follow-up. The researchers conclude that low-risk patients should be counseled about the possibility of worse pathological outcomes and an increased risk of biochemical progression with surgical delays of six months or more. (Source: MedPage Today, May 31, 2010)

♦ DEALING WITH INCONTINENCE - ANOTHER PERSPECTIVE ♦

The November 2009 WRAMC newsletter recounted a reader's favorable experience with the AdVance Sling to deal with his incontinence. My experience with the AdVance Sling has been very different. My radical prostatectomy in 2002 resulted in stress incontinence. Kegel exercises led to improvement, but by 2007 my condition began to worsen to the point that I was using an average of two pads a day. So in 2008 I agreed to have the AdVance Sling emplaced. My outcome was not good. In addition to being very sore and immobile for some 10 days - quite different from my earlier RP and by-pass experiences - I went abruptly from stress incontinence to urge incontinence. For me, this was a much worse type of incontinence. Not only must I answer those frequent "gotta-go" calls during the day , but also endure the multiple trips to the bathroom at night that interfere with my sleep.

Three months later, September 2008, I saw another urologist and learned that my detursor dysfunction (bladder squeezing) was now made apparent by the fixed resistance sling. Indeed, as the previous writer put it, the sling doesn't work for everyone. Furthermore, the urologist informed me that the procedure is not easily reversible. Though incising the sling would reduce the resistance, such a surgical procedure would likely make things worse, particularly in terms of stress incontinence. Nevertheless, it is an option I would like to consider, but since practically all urologists hesitate to undertake a reversal unless the patient's detursor voiding pressure is greater than 40 cm (mine is much lower), I am holding back on that possibility until I find new, proven urological evidence to the contrary. I regret now that I agreed to the AdVance Sling, particularly now that I know that the sling is more appropriate for moderate to severe stress incontinence than for mild stress incontinence.

For almost two years now I have endured this annoying "gotta-go" call of urge incontinence along with loss of sleep at night due to nocturia. The latter keeps me from full potential physically and mentally, and I find myself falling behind on so many obligations and volunteer projects that I enjoy as a retired minister and Army chaplain. There is the possibility of another surgical procedure -- InterStim Therapy that neurostimulates the sacral nerves affecting urinary control to counteract the "gotta-go" sensation using an implanted device. Thus far I have not opted for that. Instead, for the past six months I have relied on intermittent self-catheterization, which has been somewhat helpful. If my AdVance Sling does not soon, on its own, lose some of its tightness, I may opt for the InterStim Therapy that is a reversible procedure.

I welcome suggestions from others, lay as well as professionals, who have had experiences with incontinence that may be useful to me. I may be contacted at williammacauley@bellsouth.net.

THIS NEWSLETTER IS MADE POSSIBLE BY A GRANT FROM FERRING PHARMACEUTICALS

♦ WRAMC US TOO COUNSELORS ♦ (As of August 1, 2010)

(THESE PERSONS ARE WILLING TO SHARE THEIR EXPERIENCES WITH YOU. FEEL FREE TO CALL THEM.)

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Oliver E. Vroom	Crofton, MD	(410) 721-2728	(Proton Beam Radiation)
John Waller	Yorktown, VA	(757) 865-8732	(Brachytherapy)
Barry Walrath	McLean, VA	(703) 442-9577	(Brachytherapy)

INCONTINENCE

Ray Walsh	Annandale, VA	(703) 425-1474	

HORMONAL

"Mac" Showers	Arlington, VA	(703) 524-4857	

WATCHFUL WAITING

Tom Baxter	Haymarket, VA	(703) 753-8583	

SPOUSE SUPPORT

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

OTHER THERAPIES/MULTIPLE THERAPIES

Howard Bubel	Fairfax, VA	(703) 280-5765	(Cryosurgery, Hormonal, Sexual Function)
Arthur E. Clough	Kerryville, TX	(210) 896-8826	(Surgery and Radiation)
Pete Collins	Mechanicsburg, PA	(717) 766-6464	(Surgery, Radiation, Hormonal)
S.L. Guille	Sumerduck, VA	(540) 439-8066	(Surgery, Radiation, Hormonal)
Richard Leber	Chapel Hill, NC	(919) 942-3181	(Surgery, Radiation, Hormonal)
Charles Preble	Annandale, VA	(703) 560-8852	(Cryosurgery, Hormonal, Intermittent Hormonal)
Emerson Price	Absecon, NJ	(609) 652-7315	(Hormonal, Radiation, Cryosurgery)
S.L. Ross	Alexandria, VA	(703) 360-3310	(Brachytherapy, Radiation, Hormonal)
Ken Simmons	Alexandria, VA	(703) 823-9378	(Radiation and Hormonal)
Bill Stierman	Vienna, VA	(703) 573-0705	(Surgery and 2nd Line Hormonal-Ketoconazole)
Ray Walsh	Annandale, VA	(703) 425-1474	(Surgery and Hormonal)

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♦ MEETING ANNOUNCEMENT ♦

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7 PM

JOEL AUDITORIUM (SECOND FLOOR)
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♦ SPEAKERS ♦

COLONEL JAMES R. JEZIOR, MC
Chief of Urology, WRAMC

COLONEL ROBERT C. DEAN, MC
Director of Andrology, WRAMC

♦ TOPIC ♦

"Current Trends in Continence Care and Sexual Health after Prostate Cancer Treatments"