WRNMMC Us TOO, Inc.
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NEWSLETTER

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♦ Annual Report Shows Cancer Death Rates Continue to Drop ♦

According to results from the Annual Report to the Nation on the Status of Cancer, cancer incidence rates have declined in men while remaining stable in women. Additionally, there have been significant declines in cancer death rates, but differences between race and ethnic groups remain.

The collaborative report looks at overall cancer incidence rates, which is defined as new cancers, and overall cancer death rates.

A companion study looks at incidences and mortality trends of prostate cancer in the United States. Prostate cancer trends were investigated further from data in US cancer registries between 2000 to 2014. Trends for mortality were determined based on data available from 1975 to 2015. The researchers said the decline in prostate cancer mortality has leveled out, and incidence of late-stage prostate cancer has increased.

Overall incidences decreased by 6.5% annually between 2007 to 2014. In 2007, there were 163 new cases of prostate cancer for every 100,000 men, but this decreased to 104 of every 100,000 men in 2014.

While these trends show a decline in prostate cancer, investigators found an increase between 2010 to 2014 for incidences of distant disease, where cancer spread beyond the original tumor to other parts of the body. According to national surveys from 2010 and 2013, there was a decline in prostate-specific antigen (PSA) screening among men between ages 50 and 74 years.

Serban Negoita, MD, DrPH, lead author of the prostate cancer study and chief of Data Quality, Analysis, and Interpretation Branch at NCI's Surveillance Research Program, says this increase in late-stage disease occurred simultaneously with a trend between 2013 to 2015 of cancer deaths leveling out. Prior to this stabilization, overall prostate cancer mortality was on a significant decline from 1993 to 2013. **(Continued on page 15)**

♦ *INSIDE THIS ISSUE* ♦

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FROM THE EDITOR'S DESK

Our charter and by-laws provide for a president, vice president, treasurer, and secretary as well as a ten-member board of directors. Jim Thompson, our president for the last four years, recently resigned the office upon his relocation to South Carolina. At our May 2, 2018 meeting Bill Mahr was elected to replace Jim Thompson as president, and Jim Padgett was elected to fill the vacant office of vice president. James Bohannon and Vin McDonald continue in the offices of treasurer and secretary respectively.

Thank you and best wishes to Jim Thompson on the occasion of his "second retirement" to South Carolina!

♦ MEETING SCHEDULE FOR AUGUST 2, 2018 ♦

Our speaker for Thursday, August 2, 2018, is Donna Horn-Hooks, LCSW, whose topic is **"Coping - Beyond the Diagnosis of Prostate Cancer for Patient and Caregiver."**

Please join us at the America Building (Bldg 19), 2nd floor, Room 2525, WRNMMC at 7:00 PM (video teleconferencing); or the Fort Belvoir Community Hospital, Oaks Pavilion, 1st floor, Library Lecture Room (S1.901). **See the back page for information about getting access.**

♦ PROSTATE-SPECIFIC ISSUES ♦

Preventive Benefit of Finasteride for Prostate Cancer. The Prostate Cancer Prevention Trial (PCPT) showed that the use of finasteride, a 5-alpha-reductase inhibitor, for 7 years reduced the risk for prostate cancer by about 25% compared with placebo. A new SWOG study published in the *Journal of the National Cancer Institute* indicates that the reduced risk for prostate cancer among men in the PCPT assigned to receive finasteride continued throughout 16 years of follow-up.

"After the Prostate Cancer Prevention Trial a lot of questions remained, including questions about the long-term survival patterns of these patients," explained Joseph Unger, PhD, a health services researcher at the Fred Hutchinson Cancer Research Center in Seattle, Washington. "We were interested in figuring out whether 7 years was sufficient to determine the maximum benefit of finasteride, and whether or not that benefit was maintained after 7 years."

Previously, Dr. Unger and colleagues had tried to investigate long-term survivorship of patients enrolled in a large breast cancer prevention trial by going back and trying to re-enroll women from the original investigation. However, this process was difficult and expensive, and the researchers were only able to enroll about 16% of the original patients, Dr Unger explained.

Instead, to investigate the long-term survivorship of the PCPT, SWOG designed and managed a study that obtained a data use agreement from the Centers for Medicare & Medicaid Services (CMS) to access records from Medicare and link patients enrolled in the PCPT to their Medicare claims from 1999 through 2011.

"We were able to link 75% of the patients, which is really excellent," Dr. Unger said. "We could use those Medicare claims to figure out what these men's long-term prostate cancer diagnoses patterns were through a median of 16 years of follow-up, adding 9 years to the 7 years on the trial."

Overall, men in the finasteride arm of the PCPT had a 21.1% decrease in the risk of prostate cancer. This effect was most was most pronounced in the first 7.5 years, which was consistent with findings from the PCPT. However, after 7.5 years, there was no increased risk for prostate cancer for men assigned to the finasteride arm.

"One concern with these kinds of interventions is that while people are taking the intervention that prostate cancer may be prevented, but then rates snap back once the intervention is discontinued," Dr. Unger said. "That did not happen here. The preventive benefit of finasteride was maintained over the 16 years.

Dr. Unger also mentioned that finasteride is a low-cost generic drug that has minimal side effects. In fact, in a previous analysis of the PCPT and linked Medicare claims, Dr. Unger and colleagues looked at long-term consequences of finasteride use. The study showed that patients assigned to receive finasteride had a 10% increased risk for new claims for depression, but a 6% lower risk for procedures for benign prostate hyperplasia (BPH)-related events. No other differences in long-term consequences were found between finasteride or placebo arms.

It is important to note that finasteride has not been approved by the U.S. Food and Drug

Administration (FDA) for prostate cancer prevention, and is most often used for treatment of hair loss or BPH. (Source: https://www.cancertherapyadvisor.com/prostate-cancer/finasteride-prostate-cancer-preventive-benefit-maintenance/article/756706)

Testosterone Replacement Therapy for Men with a History of Prostate Cancer.
Testosterone replacement therapy (TRT) does not increase recurrence rates following radical treatment or progression rate after placement on active surveillance, investigators reported at the American Urological Association 2018 annual meeting.

In a study examining the outcomes of 190 men with PCa (mean age 68 years) who received TRT after diagnosis and/or treatment for PCa over the previous 5 years, Abraham Morgentaler, MD, Associate Clinical Professor of Urology at Harvard Medical School , and colleagues found that biochemical recurrence rates after radical prostatectomy (RP) and radiation therapy, and the progression rate while on active surveillance (AS), were consistent with published rates from other studies.

After a mean follow-up of 47 months, the recurrence rates were 11.6% among the 86 men who underwent RP and 4.1% among the 49 men who had either external beam radiation therapy or brachytherapy. None of the 5 men treated with RP followed by salvage radiation had recurrence. The progression rate among the 47 men on AS was 10.6%.

“This is the largest series to date investigating the safety of testosterone therapy in men with prostate cancer,” Dr. Morgentaler told *Renal & Urology News*. “Recurrence rates following prostate cancer treatment with surgery or radiation were low for men treated with testosterone, and were quite similar to expected recurrence rates based on numerous published studies. This was also true for men on active surveillance.”

He added: “For decades, physicians have feared offering testosterone therapy to men with prostate cancer because we were taught that raising testosterone would be like ‘pouring gasoline on a fire.' From this study, and smaller studies before it, we know this concept can no longer be correct.”

Dr. Morgentaler stated that TRT can make an enormous difference in the lives of men who are testosterone-deficient. “I've had quite a few men tell me they wouldn't mind continuing with testosterone therapy even if it were certain to shorten their lives,” he related.

Eric A. Klein, MD, Chair of the Cleveland Clinic's Glickman Urological & Kidney Institute, who was not involved in the study, said the investigation by Dr. Morgentaler's team “adds to the existing data that TRT replacement in men with early stage low-grade prostate cancer or those treated for cancer is safe and does not appear to increase the risk of progression.”

Dr. Klein cautioned, however, that testosterone replacement should only be considered for men who have symptoms related to documented low testosterone levels.

In a separate study presented at the conference, Unwanaobong Nseyo, MD, and colleagues at the University of California, San Diego, looked at outcomes among 123 men who were on active surveillance for PCa—61 on TRT and a matched group of 62 patients not on TRT. The groups had similar proportions of men with a positive family history of PCa (15.7% vs 16.7%).

Overall, 11 men experienced progression on repeat biopsy during active surveillance (5 in the TRT group and 6 in the non-TRT group). All 5 patients who progressed in the TRT arm and only 1 who progressed in the non-TRT arm underwent definitive treatment due to pathologic progression.

Men in the TRT group were diagnosed at lower PSA values than those in the non-TRT group (3.1 vs 5.3 ng/mL).

Dr. Nseyo's group concluded that their data suggest that aggressive screening or treatment is not indicated for men undergoing TRT, but TRT might alter patient choice of definitive treatment during AS. (Source: Poster presentations MP 17-03 and MP 17.09, AUA 2018 Annual Meeting, San Francisco, CA, May 18-21)

Managing Hormonal Therapy-Related Hot Flashes. Although hot flashes are most commonly associated with menopause, this uncomfortable feeling can also be a side effect that occurs in patients with cancer who are being treated with hormone therapy.

Because certain malignancies are dependent on sex hormones for growth, like subtypes with breast and prostate cancers, patients are treated with hormone therapies that deprive cancers of these sex hormones.

As a result, hot flashes – similar to that of menopause – can occur. Arjun Gupta, M.D., an oncologist at UT Southwestern's Simmons Cancer Center, defined these hot flashes as, "uncomfortable episodes of a sudden sensation of heat originating in the upper part of the body and spreading throughout."

Although hot flashes may only last a few minutes, they are typically accompanied with and followed by sweating and anxiety. These episodes can occur anywhere, anytime – sporadically or even several times a day – and worst yet, can even happen during sleep.

"They can be very troubling, and can disturb sleep and daily activities," Gupta said in an interview with *CURE*. "Recognizing and reporting them to your oncologist is the first step towards treating them."

The exact reasoning for hot flashes is unknown, because they can be a result of the cancer itself, or from infection or other medications, like steroids, that may also cause sweating.

Although they are similar to hot flashes that occur in women going through menopause, there are some differences. For example, both occurrences arise from a relative lack of sex hormones in the body. However, the main difference is in how they are treated.

“Patients with menopausal hot flashes can be treated by hormone replacement therapy (external sex hormones, such as estrogen and progesterone). Sex hormones cannot be used to treat hot flashes associated with anti-hormonal therapy used to treat cancer, since the goal of anti-hormonal therapy in these patients is to reduce levels of sex hormones,” explained Gupta.

Another big difference between the two: Hormone therapy-related hot flashes can also occur in men. To address this side effect, Gupta highly recommends for patients to let physicians know about the problem. They can be managed in a variety of ways, including through prevention, treatment, and even with nonmedication-based techniques that can be tried first and foremost.

First, Gupta urges patients to maintain a symptom diary that documents the number, intensity and duration of hot flashes.

“Patients may or may not have individual triggers for hot flashes and are in the best position to identify what sets these off,” he added. “Commonly, smoking, heavy alcohol use, a hot bath or a heavy meal can set them off. Maintaining a diary to document what set them off, how long they lasted, what improved it, can help your oncologist and you to come up with simple lifestyle changes that may prevent their onset.”

In conjunction with this, lifestyle changes may help patients offset this side effect without having to resort to medicine. “First line treatment for hot flashes is lifestyle changes, such as avoiding smoking, excess alcohol or coffee and performing relaxing exercise through yoga or exercise,” Gupta said. “A majority of these activities are 'in your own hands', and it is important to know what you can personally do to prevent their onset.”

If these strategies do not work, physicians can also prescribe medications. In this case, non-hormonal medications are used to treat hormone therapy–related hot flashes, including antidepressant medications. In addition, men can be treated with additional drugs, such as Megace (megestrol acetate). Lastly, herbal products, soy and acupuncture have been used, but the safety and efficacy of these interventions are unknown.

“There is currently insufficient data to support the routine use of some medications, including plant-based products such as black cohosh and soya, and techniques such as acupuncture,” said Gupta. “Speak to your doctor if you would like to incorporate these therapies in your care. It is important to speak to your oncologist if you are using any over-the-counter medications/ herbal-products to treat hot flashes- these may have significant side effects or reactions with your other medications.” (Source: https://www.curetoday.com/June 17, 2018)

Erectile Dysfunction Strongly Predicts Cardiovascular Events. Men with erectile dysfunction are almost twice as likely to experience a cardiovascular event as those without sexual dysfunction.

Erectile dysfunction (ED) independently predicts higher risk for cardiovascular events including heart attacks, cardiac arrests, sudden cardiac death and strokes, beyond other risk factors. Researchers reported the strongest evidence to date in the latest issue of *Circulation.*

Of 1,914 participants (mean age 69) in MESA (Multi-ethnic Study of Atherosclerosis), half (45.8%) reported ED symptoms. Of participants, 42% were white, 24% black, 11% Chinese, and 23% Hispanic.

Over nearly 4 years of follow up, the cohort experienced 40 coronary heart disease (CHD) events and 74 cardiovascular (CVD) events. Significantly greater proportions of men with ED than those without suffered an event: 3.4% vs 1.4% CHD events and 6.3% vs 2.6% CVD events. Men with ED had 1.9 times greater risk for CVD events. Investigators adjusted for major risk factors such as smoking, diabetes, family history of CHD, cholesterol levels, and systolic blood pressure, as well as use of lipid-lowering and antihypertensive medication, beta blockers, and even depression.

"Our results reveal that erectile dysfunction is, in and of itself, a potent predictor of cardiovascular risk," says study senior investigator Michael Blaha, MD, MPH, associate professor of medicine at the Johns Hopkins School of Medicine in Baltimore, Maryland, according to a release. "Our findings suggest that clinicians should perform further targeted screening in men with erectile dysfunction, regardless of other cardiac risk factors and should consider managing any other risk factors -- such as high blood pressure or cholesterol -- that much more aggressively." Source: https://www.renalandurologynews.com/erectile-dysfunction-ed/erectile-dysfunction-strongly-predicts-cardiovascular-events/article/772613/June 11, 2018)

Androgen Deprivation Therapy (ADT) Affects Sexual Function, Intimacy in Early Prostate Cancer Treatment. In this study, researchers evaluated the outcomes of 72 men with prostate cancer on ADT and their partners. Sexual and relational intimacy was found to be reduced throughout the first 6 months among patients with prostate cancer (PCa) undergoing androgen deprivation therapy (ADT), according to a study published in *Supportive Care in Cancer*.

Some of the most common side effects of ADT — a frequently used treatment for prostate cancer that lowers testosterone to castration levels — include mood depression and sexual dysfunction. Although the impact on individual patients has been well-established, the impact on the patient-partner sexual relationship and intimacy has not been fully explored.

For this study, researchers evaluated the outcomes of 72 men on ADT and their partners. Couples completed questionnaires evaluating prostate cancer health-related quali-

ty of life, sexual function (e.g., desire, erection, orgasm, overall function), sexual bother (bother associated with aspects of sexual function), and mood (e.g., tension, depression, anger, vigor, fatigue, confusion). Measures were assessed over time, starting at baseline, then 3 months and 6 months after initiating ADT.

Results showed that there were declines in sexual function, frequency, and relational intimacy during the first 6 months of ADT; 37.5% of couples were sexually active at baseline, 15.3% at 3 months, and 6.9% at 6 months. Sexual bother significantly increased between baseline and 3 months only.

No significant changes in mood were observed, but couples reported that emotional intimacy was higher when partners understood the other's mood state. Patient and partners rated sexual intimacy as being higher when they were more sexually active.

The authors concluded that “this study confirms declined sexual function and activity and increased sexual bother for patients, as well as declined relational intimacy for both patients and partners. Better understanding of these changes, and their impact within the couple, may assist in identification of interventions to preserve patient and partner QOL and relationship quality." (Source: Mood, sexuality, and relational intimacy after starting androgen deprivation therapy: implications for couples [published online May 18, 2018]. *Support Care Cancer*. doi: 10.1007/s00520-018-4251-9)

USPSTF Backtracks, Now Says PSA Test Is 'Individual Decision' Men aged 55 to 69 years should make an informed, individual decision on prostate cancer screening with prostate-specific antigen (PSA) testing after discussing the potential benefits and harms with their clinician, says the US Preventive Services Task Force (USPSTF) in the final version of its recommendation statement.

As previously reported by *Medscape Medical News*, the USPSTF had previously caused controversy by recommending against PSA-based prostate cancer screening.

However, the USPSTF has since changed its stance, and in a new draft recommendation published in spring 2017 emphasized shared decision making. The final version of that new recommendation has now been published. In it, the USPSTF concludes that the decision as to whether to undergo PSA-based screening should be made individually for each man aged 55 to 69 years, taking into account the man's values and clinical circumstances.

This is a C recommendation, meaning that "there is at least moderate certainty that the net benefit is small."

The task force also made a D recommendation that men aged at least 70 years not be routinely screened for prostate cancer. The D recommendation indicates that "there is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. Clinicians should also inform men at increased risk of developing

prostate cancer, such as African men or those with a family history of the disease, about their increased risks and the potential benefits and harms of screening.

Consequently, the USPSTF concludes that men aged 55 to 69 years should be offered PSA-based screening, but that "the decision to be screened for prostate cancer should be an individual one," and that men aged 70 years and older should not undergo screening.

The recommendations highlight that the "most important" prostate cancer risk factors are "older age, African American race, and family history of prostate cancer."

They note that men aged 55 to 69 years "should have an opportunity to discuss the potential benefits and harms of screening with their clinician" before making the decision, and that their "values and preferences" should be taken into account.

"Clinicians should not screen men who do not express a preference for screening and should not routinely screen men 70 years and older," it warns.

The publication of the USPSTF final recommendation for prostate cancer screening is accompanied by numerous editorials in the various *JAMA* journals.

In an editorial in *JAMA Internal Medicine*, Richard M. Hoffman, MD, MPH, from the Holden Comprehensive Cancer Center, University of Iowa Carver College of Medicine, Iowa City, describes the introduction of PSA testing as "a disruptive event in US healthcare."

He says that it dramatically increased the incidence of early-stage prostate cancer "at a time when there was scant evidence to inform decisions about whether or how to treat these cancers.

"The PSA era has also provided an edifying message, effectively promulgated by the USPSTF, that cancer-screening decisions can be complex, controversial, and consequential," he writes. "We now better appreciate that prostate cancer screening is associated with benefits and harms at both the population and individual levels."

In an editorial in *JAMA Surgery,* Peter R. Carroll, MD, MPH, from the University of California, San Francisco–Helen Diller Family Comprehensive Cancer Center, takes issue with some of the calculations used by the task force.

He argues that the USPSTF assertion that screening would prevent only 1.3 deaths and two metastatic cancers per 1000 men screened over 13 years "underestimates the effect of screening for many.

"The benefits might be greater over a 20- to 30-year follow-up," he argues, and states that this may be of more relevance to younger men or those in "excellent health."

Moreover, he believes that the USPSTF does not "address contemporary early detection strategies, which preserve the benefits of early detection and minimize the risks."

As an example, Carroll points to the National Comprehensive Network panel on early prostate cancer detection, which offers "a refined strategy for screening" in which an early baseline PSA measurement is performed at age 45 years. This measurement can then guide later testing.

Nevertheless, Carroll concludes that the USPSTF recommendation for screening "has restarted a national discussion on prostate cancer early detection.

"The Task Force deserves credit for this more balanced, fairer approach. The message now is not 'no screening,' but 'smarter screening,' preserving benefits and reducing harms," he concludes. (Source: *JAMA.* 2018;319:1901-1913 via Medscape at https://www.medscape.com/viewarticle/899111)

Screening All Men Age 85 and Older for Osteoporosis. All men 85 years and older should be screened for osteoporosis, and men as young as 65 years should be tested if they have certain risk factors for fracture, according to a new study.

"Osteoporosis is often considered a disease of women, but it actually has a major impact on men," said Cathleen Colon-Emeric, MD, from the Duke University School of Medicine in Durham, North Carolina.

"Men are the forgotten population for this particular condition," she said here at the American Geriatrics Society 2018 Annual Scientific Meeting.

"For example, a man has a higher risk of having a major osteoporotic fracture than getting prostate cancer, but nobody really thinks of screening men for osteoporosis. We're trying to address that," she told *Medscape Medical News*.

Clinical practice guidelines are clear on when women should be screened but not when men should be tested. "There are multiple conflicting recommendations around the world on whether to screen men for osteoporosis at all and, if so, when, which men, and at what age," she explained.

Colon-Emeric and her colleagues wanted to determine whether there is a benefit to screening men for primary osteoporosis. The team assessed data on 2,539,812 men 65 to 99 years of age with no history of fracture from the Centers of Medicare and Medicaid Services and Veterans Administration.

They used propensity scores to match men who had undergone osteoporosis screening with dual energy x-ray absorptiometry during routine care with men who had similar risk factors for fracture and a similar probability of being screened but who had not undergone any screening.

Of the 183,943 men who had undergone screening, 33,224 (18%) were older than 80 years.

Fracture rates were 15% lower in the screened population than in the overall population

Slightly more men older than 80 years than younger men met the threshold to receive at least one prescription for an osteoporosis medication (16.3% vs 13.4%).

For men with no known risk factors for fracture, the age at which screening becomes more effective than not screening is approximately 85 years.

"Our findings not only support universal osteoporosis screenings for all men over age 85, but also suggest that men as young as 65 may benefit from diagnostic evaluation when certain risk factors are present," Colon-Emeric reported. "In the younger men with risk factors, there is a 10% reduction in hazard with screening."

Certain medications, such as steroids and those for prostate cancer, are risk factors, as are certain chronic conditions, such as chronic lung disease, chronic liver disease, rheumatoid arthritis, diabetes, thyroid disease, and Parkinson's disease.

"Any man age 85 and older, as long as we think he is going to have a 2-year life expectancy and live long enough to benefit from osteoporosis treatment, should be considered for screening," she added.

There is actually "a real crisis in the treatment of osteoporosis," said Colon-Emeric. "Treatment and adherence rates started going down around the time we started to see some news stories coming out in the *New York Times* and other places reporting serious but very rare side effects of those medications. It scared a lot of people."

Educating patients about the risks and benefits of osteoporosis medication requires a careful discussion, she explained.

"In general, if you're at high risk for fracture, the benefits of these medications far outweigh the very small risk. The National Bone Health Alliance, the National Osteoporosis Foundation, and the American Society of Bone and Mineral Research are doing media and educational campaigns to help patients understand that, certainly, there are risks for any medication, but there are also substantial benefits," she pointed out.

This "landmark study" adds "significant evidence" for the benefit of osteoporosis screening for men 85 years and older, said Alayne Markland, DO, from the University of Alabama at Birmingham, who is associate director of the Birmingham/Atlanta Geriatrics Research Education and Clinical Center.

The findings "affect clinical care and guidelines for community-dwelling men," she told *Medscape Medical News*.

Although 85 years might seem old, "the data show that 85 years is the inflection point at which screening made a difference. We are seeing our population live longer and, even at 85, at least that's a starting point for screening with some evidence behind it," she said.

"A hip fracture can take someone 85 years or older who is fully functional and who has a 5-year life expectancy to being nonfunctional with a life expectancy of perhaps 1 year

or less, so screening can have a profound impact if osteoporosis is found and treated appropriately," Markland said. (Source: American Geriatrics Society (AGS) 2018 Annual Scientific Meeting: Abstract P2. Presented May 3, 2018)

What Might Make Prostate Cancer's Return More Likely? Obesity and other health problems may boost the chances of cancer returning after a man has his prostate removed, a new study finds.

"Prostate cancer is the most common cancer in men, and up to 30 percent of patients will develop recurrence after [prostate removal]," said study author Dr. Arash Samiei, of Allegheny Health Network's urology department in Pittsburgh.

Samiei's team analyzed data from 1,100 prostate cancer patients who had their prostates removed (radical prostatectomy) at a Pittsburgh hospital between 2003 and 2013. The patients were an average of age 60 when diagnosed.

Thirty-four percent were obese, and 19 percent had metabolic syndrome -- a group of risk factors that increases the chances of heart disease, stroke and diabetes. Characteristics of metabolic syndrome include high blood sugar, obesity, abnormal cholesterol or triglyceride levels, and high blood pressure, according to the U.S. National Heart, Lung, and Blood Institute.

The patients were followed for an average of four years. Prostate cancer returned in more than 32 percent of obese patients, compared with about 17 percent of those who weren't obese, the researchers said. Patients with metabolic syndrome had a more than four times higher risk of prostate cancer return than those without the syndrome, according to the study.

The findings are scheduled for presentation at an American Association for Cancer Research meeting, in Austin, Texas.

"Obesity and metabolic syndrome have become increasingly widespread in our society," Samiei said in an association news release. This study indicates that "prostate cancer patients who are obese or have metabolic syndrome undergoing [prostate removal] may have a higher chance for recurrence of the disease, and these individuals should have more focused follow-up care," Samiei said.

Because the study is observational, it can't prove that obesity and metabolic syndrome are responsible for cancer returning. Still, "by preventing metabolic syndrome, men with prostate cancer may have a higher chance of a favorable oncological outcome following surgery," Samiei said.

Until published in a peer-reviewed medical journal, research presented at meetings is usually considered preliminary. (Source: HealthDay News, January 26, 20

New Guidelines on Testosterone Deficiency. The American Urological Association is now offering formal guidance on diagnosing, treating, and monitoring men with testosterone deficiency. The new guidelines focus on accurate assessment and proper monitoring.

Use of testosterone therapy has been an area of concern. Many men are receiving therapy who do not need it, hypogonadal men who need treatment do not receive it, and patients receiving treatment often fail to be monitored properly.

An expert panel conducted a systematic review of 546 articles published 1980 to February 2017 to support the new guideline statements. The strength of the evidence for each statement was graded A (high) to C (low). In the absence of sufficient evidence, the panel offered information as Clinical Principles and Expert Opinions.

Following is a selective list of statements from the new guidelines,.

Diagnosis of testosterone deficiency:

Clinicians should measure total testosterone more than once and obtain a symptom history before making a diagnosis. Validated questionnaires are not sufficient for either diagnosis or monitoring.

According to the guidelines:

- Clinicians should use a total testosterone level below 300 ng/dL as a reasonable cut-off in support of the diagnosis of low testosterone.
- The diagnosis of low testosterone should be made only after two total testosterone measurements are taken on separate occasions with both conducted in an early morning fashion.
- The clinical diagnosis of testosterone deficiency is only made when patients have low total testosterone levels combined with symptoms and/or signs.
- Clinicians should consider measuring total testosterone in patients with a history of unexplained anemia, bone density loss, diabetes, exposure to chemotherapy, exposure to testicular radiation, HIV/AIDS, chronic narcotic use, male infertility, pituitary dysfunction, and chronic corticosteroid use even in the absence of symptoms or signs associated with testosterone deficiency.
- Serum prolactin levels should be measured in patients with low testosterone levels combined with low or low/normal luteinizing hormone levels.
- Patients with persistently high prolactin levels of unknown etiology should undergo evaluation for endocrine disorders.
- Prior to offering testosterone therapy, clinicians should measure hemoglobin and hematocrit and inform patients regarding the increased risk for polycythemia.

- Clinicians should inform testosterone deficient patients that low testosterone is a risk factor for cardiovascular disease.
- Patients should be informed that testosterone therapy may result in improvements in erectile function, low sex drive, anemia, bone mineral density, lean body mass, and/or depressive symptoms.
- Patients should be informed that the evidence is inconclusive whether testosterone therapy improves cognitive function, measures of diabetes, energy, fatigue, lipid profiles, and quality of life measures.
- Clinicians should not prescribe alkylated oral testosterone.
- Clinicians should discuss the risk of transference with patients using testosterone gels/creams.

  Testosterone levels should be measured every 6 to 12 months while on testosterone therapy.
- Clinicians should discuss the cessation of testosterone therapy 3 to 6 months after commencement of treatment in patients who experience normalization of total testosterone levels but fail to achieve symptom or sign improvement.

The panel also offered guidance for special populations. Whether testosterone therapy increases or decreases the risk for cardiovascular events is still unclear. The panel suggested not starting testosterone therapy in patients with a history of cardiovascular events.

PSA should be measured in men older than 40 years before starting testosterone therapy to exclude a prostate cancer (PCa) diagnosis. Currently, there is insufficient evidence to weigh the benefits and risks of testosterone therapy in men with PCa. Evidence has not confirmed a link between testosterone therapy and PCa development.

Men interested in preserving their fertility should have a reproductive health evaluation before considering testosterone treatment. Exogenous testosterone may affect spermatogenesis over the long term and should not be prescribed to men who are trying to conceive. Clinicians may use aromatase inhibitors, human chorionic gonadotropin, selective estrogen receptor modulators, or a combination in these men. (Source: Mulhall J, Trost LW, Brannigan RE, et al. Evaluation and management of testosterone deficiency at https://www.auanet.org/guidelines/evaluation-and-management-of-testosterone-deficiency)

Smoking and Prostate Cancer-Specific Mortality after Diagnosis in a Large Prospective Cohort. Prior studies of prostate cancer survivors suggest that smoking might be associated with higher prostate cancer-specific mortality (PCSM) after diagnosis with prostate cancer.

However, most of these studies were small and questions remain regarding this association's strength and whether it persists after adjustment for stage and Gleason score.

This analysis included men diagnosed with nonmetastatic prostate cancer between enrollment in the Cancer Prevention Study-II Nutrition Cohort in 1992-1993 and June 2013. Cigarette smoking was self-reported at enrollment and updated in 1997 and every 2 years thereafter. Analyses of pre-diagnosis and post-diagnosis smoking included 9,781 and 9,111 prostate cancer cases, respectively, with vital status follow-up through 2014.

There were 672 deaths from prostate cancer in analyses of pre-diagnosis smoking and 554 in analyses of post-diagnosis smoking. Both current smoking before diagnosis and current smoking after diagnosis were associated with higher PCSM compared to never smoking. Prostate cancer survivors who quit smoking more than20 years before diagnosis were also at significantly higher risk.

This large prospective study suggests that current smoking both before and after diagnosis of prostate cancer is associated with higher PCSM, even after accounting for stage and Gleason score. These results provide evidence that smoking is a relevant prognostic factor for prostate cancer patients and that prostate cancer may be among the causes of death attributable to smoking. (Source: Pub Med.gov at https://www.ncbi.nlm.nih.gov/pubmed/29700008 - June 27, 2018)

Cancer Death Rate Decline (continued from page one)

“Although suggestive, this observation does not demonstrate that one caused the other, as there are many factors that contribute to incidence and mortality, such as improvements in staging and treating cancer,” said Negoita. “Additional research is needed to get a more comprehensive understanding of the recent trends and the possible relationship with PSA screening, as well as the relationship with other factors that may be associated with these trends.”

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♦ MEETING ANNOUNCEMENT ♦

THURSDAY, AUGUST 2, 2018

7:00 - 8:30 PM

WRNMMC, AMERICA BUILDING (BLDG 19, 2D FLOOR) ROOM 2525
(VIA VIDEO TELECONFERENCE)

AND

FORT BELVOIR COMMUNITY HOSPITAL

OAKS PAVILION, 1ST FLOOR, ROOM S1.901
(LIBRARY LECTURE HALL)

♦ SPEAKER ♦

DONNA HORN-HICKS, LCSW

WALTER REED NATIONAL MILITARY MEDICAL CENTER

♦ TOPIC ♦

"COPING - BEYOND THE DIAGNOSIS OF PROSTATE CANCER FOR PATIENT AND CAREGIVER"

Security: A military ID card is required to get on base at Walter Reed. Persons without a military-related ID card who are attending the meeting are required to register in advance in order to gain entry. To register, contact the CPDR front desk at 301-319-2900 at least four business days prior to Thursday, August 2, 2018, to arrange entry. Have a photo ID card ready when arriving at the gate.

Fort Belvoir: Persons without a military ID card should arrive at the entrance one hour before the presentation to complete the entrance procedure. Have a picture ID with you.