WRAMC Us TOO, Inc.

A PROSTATE CANCER SUPPORT GROUP
SPONSORED BY
WALTER REED ARMY MEDICAL CENTER

NEWSLETTER

VOLUME 18 **NUMBER 4** **NOVEMBER 2009**

♦ YOU CAN HELP DIRECT RESEARCH F0R PROSTATE CANCER! ♦

The Prostate Cancer Research Program (PCRP) funded by the Department of Defense has approximately $80 million to distribute among worthy research proposals during 2010. The PCRP is part of a larger medical research effort termed the Congressionally Directed Medical Research Programs (CDMRP) managed by the U.S. Army Medical Research and Materiel Command at Fort Detrick, MD. During 1997-2007, the PCRP received 8,401 research proposals and funded 1,837 proposals with a total of $710 million.

The PCRP relies on panels composed of scientists and consumer reviewers to recommend the most promising prostate cancer research proposals for funding. Consumer reviewers are prostate cancer survivors who represent the collective views of their communities. This unique partnership between scientists and consumer reviewers provides the participants with useful insights into the funding decisions; the scientists benefit by understanding the consumers perspectives on innovative research, and the consumer reviewers are enriched by participating in the discussion of the merits of the research proposals.

Us TOO International chapters and individual members have traditionally supported this unique research effort by volunteering to serve as consumer reviewers. You need not be a rocket scientist to participate! Past consumer reviewers agree that a well-read person who is concerned about prostate cancer issues will be comfortable in addressing the various research proposals. The review panels usually meet during the summer in a hotel in the Greater Washington, DC, area. Participating consumer reviewers receive an honorarium and their travel and hotel expenses are paid.

Are you interested? If so, let the leader of your local prostate cancer support group know that you want to get involved. He should be aware of the PCRP and be able to assist you with the application and nomination process. To get more information and obtain a nomination packet, contact:

Congressionally Directed Medical Research Programs
ATTN: Consumer Recruitment
1077 Patchel Street
Fort Detrick, MD 21702-5025
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♦ *INSIDE THIS ISSUE* ♦

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♦ FROM THE EDITOR'S DESK ♦

Our August newsletter described the nature of the newsletter, the effect of the national economic situation on our traditional corporate support, and the need for your financial support. We are pleased to report that the readership has responded. By September 23, 2009, 127 readers had contributed $7,285.00 to our appeal. The individual gifts ranged from $5.00 to $200.00 and the average gift was $57.36. We are very grateful!

We were also pleased to receive many notes accompanying the checks. Some told in personal terms how much they appreciate the newsletter; others fondly recalled their relationships with the WRAMC medical staff; and some were surprised to learn that the newsletter is not a free government publication.

Approximately 7.1% of the readership responded to our appeal. If you are among the 92.9% that has not responded, but intended to do so, IT IS NOT TOO LATE! Use the form at the bottom of page 3 to make your contribution. Your gift is tax-deductible; all gifts will be acknowledged promptly.

♦ MAY SPEAKER'S REMARKS ♦

Our August program featured Leslie Cooper, Ph.D., a consulting psychologist to the Center for Prostate Cancer Research and other cancer centers within WRAMC. Her topic was "Why Talking is Important, or Why 'Sucking It Up' Doesn't Work." A summary of Dr. Cooper's presentation begins on page 7.

♦ MEETING SCHEDULE FOR NOVEMBER 4, 2009 ♦

Dr. Myron Murdock is our speaker for Wednesday, November 4, 2009. Dr. Murdock is a urologic surgeon, educator, author, clinical trial expert, and Medical Director for Vibrance Associates. His special interests are male sexual health, urinary incontinence, and erectile dysfunction. He has appeared often in the national media, including CNN and the Fox Television Network. His topic is "Prostate Cancer, Male Sexual Health, and Incontinence." Join us in Joel Auditorium at 7:00 pm, Wednesday, November 4, 2009, as Dr. Murdock addresses important issues affecting men with prostate cancer and their families. Family members and friends are always welcome.

"Watchful Waiting" as a Viable Option for Low-Risk Prostate Cancer Patients. There is ample evidence that treating intermediate and high-risk cancers with either surgery, radiation, or hormone therapy can save lives; whether and how to care for low-risk cancers remains uncertain. Researchers at Beth Israel Deaconess Medical Center say appropriately selected prostate cancer patients, including older men and men with small, low-risk tumors, may safely defer treatment for many years without adverse consequences.

The researchers used the Health Professionals Follow-Up Study, a large cohort study comprising 51,529 men who have been followed since 1986. A total of 3,331 men reported receiving a diagnosis of prostate cancer between 1986 and 2007. Further analysis found that among this sub-group, 342 men (about 10 percent) had opted to defer treatment for one year or longer.

Ten to 15 years later, half of the men who had initially deferred treatment still had not undergone any treatment for prostate cancer. Deaths attributed to prostate cancer were very low among the men with low-risk tumors. The analysis showed that only two percent of the men who deferred treatment eventually died of the disease, compared with one percent of the men who began treatment immediately following their diagnosis--a statistically insignificant difference.

The researchers conclude that using PSA screening in this way allows more aggressive prostate cancers to be treated, while less aggressive tumors could initially be monitored. This would avoid problems due to treatment of overdiagnosed low-risk cancers, while preserving the lifesaving benefits of treating aggressive cancers that have been detected through PSA testing. (Source: Science Daily, September 14, 2009) **(Continued on page 4)**

♦ WRAMC Us TOO NEWSLETTER SUSTAINMENT ♦

Our August issue made an appeal to the readership for financial support to overcome deceased corporate support. The response was encouraging. 7.1% of our readers contributed. If you had intended to contribute, it is not too late. Please use the form below to do so. WRAMC Us TOO is a non-profit educational entity organized under Section 501(c)(3) of the Internal Revenue Code. Donations to it are tax-deductible. All contributions will be promptly acknowledged.

WRAMC Us TOO Board of Directors

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WRAMC Us TOO NEWSLETTER SUSTAINMENT

Enclosed is my tax-deductible contribution in the amount of $ ___________

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Make check payable to WRAMC Us TOO and mail to: WRAMC Us TOO, c/o Vincent P. McDonald 8661 Chase Glen Circle, Fairfax Station, VA 22039-3310

(Prostate-Specific Issues – Continued from page 3)

Prostate Size Does Not Affect Results of Surgery. Pettus, et al, Memorial Sloan-Kettering Cancer Center, New York, found that prostate size affects the technical difficulty of radical prostatectomy, but not the functional results. The researchers analyzed outcomes in 3,067 men treated by 5 surgeons at their hospital. Each man had a radical prostatectomy without chemotherapy, hormone treatment or radiation therapy. Reported prostate size was based on weight and ranged from 15 to 389 grams. With increasing prostate size there were increases in estimated blood loss and time required for the surgery. The authors noticed that with increasing size, surgeons were more likely to remove every trace of the cancer. But, the investigators found there was no significant association between specimen weight and the rate of side effects (e.g., erectile function and urinary continence) or relapse 1 year later.

They conclude that prostate size influences operative difficulty, but the increased difficulty does not seem to translate into worse functional results. (Source: J Urol 2009;182:949-955, via Reuters Health, September 11, 2009)

Is Brachytherapy the Superior Treatment for Prostate Cancer? The debate regarding the best treatment for prostate continues unabated. Already considered a good option for many prostate cancer patients, brachytherapy (radiation seed implants) now has the backing of research from the Prostate Cancer Foundation, Chicago, and the Taussig Cancer Center, the Cleveland Clinic. Studies there found brachytherapy had a superior disease-free survival rate for patients with early stage prostate cancer.

In an 11-year study, the Prostate Cancer Foundation, Chicago, analyzed 9,137 patients between 1997 and 2008 who were treated for prostate cancer with brachytherapy. 67.5% of the patients were regarded as low risk, 29.36% as intermediate, and 1.01% as high. Of those patients, overall cure rates were 96%, 84%, and 75% for low, intermediate, and high risk patients, respectively. When combined with external beam radiation therapy in intermediate and high risk patients, the brachytherapy results far exceed those of surgery. The Taussig Cancer Center, Cleveland Clinic, demonstrated brachytherapy to be superior to surgery in all cases. For low risk patients, the study found a 95% survival rate after five years, 89% for intermediate risk, and 71% for high risk patients. This research concluded that, for low risk patients, brachytherapy was equally successful as external beam radiation, but more successful than a radical prostatectomy. (Source: News-Medical.Net, September 2, 2009)

Heavy Drinking and Prostate Cancer Risk. Regular, heavy consumption of alcohol increases the risk of high-grade prostate cancer and blunts the chemopreventive effect of finasteride, according to data from the Prostate Cancer Prevention Trial. The trial looked at 19,000 healthy, middle-aged men who were randomly selected to either take finasteride or a placebo for seven years. Researchers found men who consumed at least four drinks daily doubled their risk of high-grade prostate cancer while lower consumption levels did not influence their risk. Additionally, men who took finasteride and drank four or more drinks a day did not see positive effects of the drug like those seen in less heavy drinkers. Prior to this analysis, researchers were uncertain about alcohol's effect on prostate risk, though two previous meta-analyses showed an increased risk of 20 percent among heavy drinkers. The researchers conclude that it would be prudent for physicians who are recommending finasteride for prostate cancer prevention to assess their patients' alcohol consumption and recommend drinking no more than two or three drinks per day. (Source: AWARE, Newsletter of ZERO, Volume 5, No. 5, July 14, 2009)

Race Disparities Gap in Cancer Deaths. According to a recent study, African-Americans were more likely than other patients to die from three gender-related cancers--breast, prostate and ovarian--even when they received the same advanced care from the same doctor. The survival disparity for the three cancers persisted after researchers controlled for socioeconomic factors such as education and income. The research did not find a statistically significant as-

sociation between race and survival for lung cancer, colon cancer, lymphoma, leukemia or myeloma. The study analyzed records of more than 19,000 adult cancer patients across the country who participated in 35 randomized phase III clinical trials and were followed for at least 10 years. The trials were conducted by the Southwest Oncology Group, and funded by the National Cancer Institute.

African-Americans' risk of dying during the study period was found to be 61 percent higher for advanced ovarian cancer, 49 percent higher for early post-menopausal breast cancer, 41 percent higher for early breast cancer before menopause, and 21 percent higher for advanced prostate cancer. The findings suggest that African-Americans' lower survival rates for certain cancers are not entirely due to factors such as poverty and poor access to quality health care. Instead, the study suggests that an interaction of hormones, tumor biology and inherited gene variations likely plays a significant role in the survival gap for breast, prostate and ovarian cancers by controlling the body's metabolism of drugs, toxins and hormones.

This new study has not gone unchallenged because the prevailing view in health disparities research is that socioeconomic factors play the dominant role. Some researchers were critical of the study's methodology and its conclusions about biological causes for racial disparities. (Source: Chicago Tribune, July 7, 2009)

Prostate Drug Appears Safer Than Thought. A new study suggests that the drug finasteride does not cause more aggressive cancer, so doctors don't have to be so cautious in prescribing finasteride to men at risk for prostate cancer. The drug has been shown to prevent prostate cancer in about one in five men who take it. However, findings from the 2003 Prostate Cancer Prevention Trial (PCPT) had concluded that men who developed prostate cancer while taking finasteride were 25 percent more likely to develop an aggressive form of the disease. But a new study from the Stanford University School of Medicine suggests that the drug does not increase the risk for aggressive prostate cancer, but simply makes it easier to diagnose.

The Stanford team suspected a flaw in the analysis of data in the 2003 PCPT study, rather than a problem with the drug. To test this theory, they analyzed data on 1,304 men who had an abnormal digital rectal exam or high PSA test results and had been referred to Stanford. None of the men was taking finasteride. Prostate cancer was eventually diagnosed in nearly 500 of the men, including 247 who had aggressive, high-grade cancer.

The researchers found that the earlier connection between finasteride and more aggressive cancer was related to the size of the prostate. Finasteride shrinks the prostate, making malignancies easier to detect. And the smaller the prostate, the more likely a biopsy would yield a diagnosis of high-grade cancer, and the more likely a high PSA level would predict the disease. The researchers associated with the 2003 PCPT study reportedly support the conclusions of this new study. (Source: Health Day News, July 8, 2009, via Forbes.com, July 8, 2009)

Prostate Cancer Hormone Drug Risk. Hormone therapy suppresses the amount of testosterone produced, in turn causing prostate tumors to shrink or grow more slowly. The treatment can help men with more advanced disease when used with surgery or radiation. But the side effects are several: impotence, bone loss, hot flashes, memory problems, fatigue and an increased risk for diabetes and heart disease.

A recent study links hormone therapy for prostate cancer with a higher risk of death in older men who have had serious heart problems. Nanda, et al., Harvard Radiation Oncology Program, Boston, followed more than 5,000 men with prostate cancer that had not spread. The men, most in their 60s and 70s, were followed for an average of five years. All the patients had brachytherapy at the same treatment center. Thirty percent of them also took hormone therapy for an average of four months.

Five percent of the men in the study had a history of heart failure or heart attack and 43 of those men died. Among those with heart problems, the hormone treatment was linked with a 96 percent higher risk of death after adjusting for other risk factors. In raw numbers, of the 95 men on hormone therapy who also had a history of serious heart problems, 25 died; and of the 161

men not on hormone therapy who also had a history of heart problems, 18 died.

Observers noted that the study was observational, meaning the men chose their treatment with their doctors, rather than being randomly assigned to get one treatment or another. This is a less rigorous approach and means the deaths could have been caused by factors other than the hormone therapy. The small number of deaths also calls for additional research. Nevertheless, the findings agree with prior studies that have found that sicker men don't benefit from hormone therapy when it's added to radiation. And hormone therapy used alone in older men has been linked to a slightly heightened risk of death. In the study, the drugs given were leuprolide or goserelin injections combined with oral bicalutamide or flutamide. (Source: Associated Press, August 25, 2009)

Men Selecting Surgery Do Well. A major study has good news for men who have prostate cancer surgery, but leaves unanswered the complicated question of whether a man should have that operation, another treatment or just watchful waiting. The study of almost 13,000 American men who had a radical prostatectomy between 1987 and 2005 found that only 12 percent of them died of the disease.

The choice of surgery, radiation therapy or watchful waiting must be made each year for more than 190,000 American men, most middle-aged or older, who are diagnosed with prostate cancer. From 40 percent to 50 percent choose surgery, about 10 percent choose watchful waiting, and the rest choose some form of radiation therapy. Overall, there was a greater chance that a man in the study would die of a cause other than prostate cancer. The rate of death from other causes was 38 percent, compared to 12 percent attributed to prostate cancer.

The study will result in a new predictive model so that physicians and patients can learn about their anticipated survival after surgery. The new predictive tool is an improvement over the existing method, which relies essentially on readings of prostate-specific antigen levels. But no such predictive method exists for newly diagnosed men who must choose between treatment and watchful waiting, and so a predicament remains for those men and their physicians, i.e., does the diagnosed cancer pose enough threat to warrant definitive therapy. (Source: Health Day News, July 27, 2009)

♦ DEALING WITH INCONTINENCE - MY EXPERIENCE ♦

I had a radical prostatectomy in January, 2001. After 7 years of leakage and countless rounds of Kegels, to little or no effect, I learned about a surgical device called the AdVance Sling. It involves the passage of a thin strip of mesh between pinpoint incisions on the inner thighs which is then passed deep beneath the urethra to provide increased support in the area where the tissues are weakened. I consulted with the local military hospital, and by sheer chance, there was a reservist reporting for duty who had experience in the surgical implantation of the AdVance Sling. It turned out that I was an ideal candidate for the procedure. The surgery was performed through my perineum on March 19th, 2008. After removal of the catheter, I have been essentially leak-free ever since.

I was an ideal candidate because my leakage was relatively minor. I rarely used more than one pad per day; occasionally, when I was standing much of the day, I needed a second pad. There had been one "advantage" when I was leaking--I never had any hesitation when I wanted to urinate. Prior to my radical prostatectomy I would "dry up" occasionally while standing at a urinal if others were about, but after my radical prostatectomy, I could have urinated in front of a mixed audience! Now with the sling in place, I'm back with the "shy bladder," although I have no trouble urinating when I can relax with a little privacy.

Men with bothersome incontinence following prostate surgery should try the Kegel route first but, if it doesn't work for them, they should inquire about the AdVance Sling. It is a less invasive surgery for dealing with incontinence, and suitable for men with mild to moderate incontinence, defined as patients who require one to four pads daily to absorb leakage. It will not work for everyone, but it works for me!

DAVE KARPINSKI

♦ WHY TALKING IS IMPORTANT, OR WHY "SUCKING IT UP" DOESN'T WORK ♦

Leslie Cooper, Ph.D

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Clinical Psychologist, Department of Psychology, WRAMC

(A summary of a presentation to the WRAMC Prostate Cancer Support Group on August 5, 2009)

INTRODUCTION

Thank you very much for inviting me to be with you tonight. At the outset, let me say something about myself and how I came to be at WRAMC. I grew up in Chicago, then lived in LA for about thirty years before coming to Washington, D.C., in 2004 to become associated with the Breast Center here at WRAMC. In my private practice in LA I worked with what many consider the most challenging mental illnesses, substance abuse, and trauma within communities afflicted by poverty and violence. I was also a consultant to local government agencies. I came East because I missed the changing seasons and because when you hit sixty and you live in LA, you either get a lot of plastic surgery and dye your hair platinum blonde or you have to move to the east coast. I just thought it was easier to move to the east coast! And I am glad to say it was a wise choice. I am happy to be here.

"LET'S TALK!"

I hope the title of my presentation caught your attention. Some see the whole issue of "let's talk" as part of that "woo-woo stuff" they do out in LA; or as "that's what psychologists do." Of course, I think talking is important; it is my trade, after all. Still, I believe many persons downplay the importance of talking about feelings and personal thoughts. I hope tonight I can not only persuade you that talking is <u>really</u> important, but also generate discussion, opinions, and even dissent. I really welcome your comments and observations.

Did any of you see last Sunday's New York Times? Do you remember the lead front page article? It was a story entitled "After Combat – Victims of an Inner War" about post-traumatic stress disorder (PTSD) associated with service in Iraq and Afghanistan. It quoted researchers as saying that the way out for many of the afflicted often lies in talking it out. This is consistent with other studies regarding traumatic stress reactions, not just PTSD. Talking in a controlled fashion about the trauma, or exposure to it, gradually diffuses its emotional power. This is a very important statement for the military environment where there is a cultural reluctance to seek help because of the perceived effect on career progression, as well as the military's credo to "just suck it up."

No doubt you are aware of the dramatic increase in suicides within the military. The leadership is taking unprecedented action to confront the problem by installing suicide prevention programs at every level. The "just suck it up" credo is simply not working. Instead, our service members are being encouraged to seek help and start talking.

DEALING WITH CANCER

Now let's talk about cancer. Even today, talking about cancer is almost a taboo. Why? Every one has a set of beliefs, values, goals, and a self-image that is chal-

lenged when an unexpected or catastrophic event occurs. And a diagnosis of cancer certainly qualifies as such an event. Furthermore, cancer is a disease that has been feared beyond all others for centuries because it had neither a known cause nor a cure. So many cancer patients worry about being labeled, not only as a person with cancer, but as someone who might need psychological help in coping with the disease. Now think about the first time something unexpected or catastrophic happened to you and how it shook the whole foundation, even for a moment, of who you thought you were. Did you have an inclination to seek psychological help, but did not do so to avoid appearing weak, or even, well, a little crazy?

Cancer therapies create a range of both psychological and physical effects, such as fatigue, incontinence, impotence, depression, anxiety, cognitive problems, mood swings, irritability, and concerns about body image. The management of the side effects of cancer treatment should include not only medication, but management of the psychological challenges they present. It seems so commonsensical, doesn't it? And yet until recently, the whole idea of providing psychosocial support to cancer patients wasn't clearly acknowledged as an essential component of cancer treatment. Even here at Walter Reed, it was only relatively recently that a psychologist was added to the multidisciplinary teams treating breast cancer, prostate cancer, and gynecology oncology. And in the civilian world, you won't find a psychologist or even a social worker on multidisciplinary teams except at the largest comprehensive cancer centers. Elsewhere, the patient is on his/her own in accessing psychological support.

DENIAL, DENIAL, DENIAL

Okay, so what can we do when we are feeling stressed out and overwhelmed? Very simple! We can just deny, deny, deny! We see no problem, hear no problem, and speak no problem! Not a bad way to deal with stress, is it? Denial is often seen as a negative response – "Oh, he's in denial." Denial in this negative sense stems from Freud's time, but denial has positive aspects as an avoidance strategy, an adaptive process, and a coping technique.

Denial used as an avoidance strategy can be a way to defend against the very painful or overwhelming aspects of a situation. Perhaps we just need time to assimilate our condition, so it's OK - really, it is - to use denial to avoid the issue for a time. Denial also can be an adaptive process, permitting oneself to come to terms with an unexpected, painful, or overwhelming life event. Why not slowly ease into it? Finally, denial as a coping strategy is a way to give oneself a plan to deal with a potentially painful or overwhelming event as reflected in the typical comment – "I am just not going to think about it."

But the question remains - does denial work? Well, there are all kinds of denials, and no doubt you have heard many of them. For example, there is the *denial of diagnosis* that I have heard myself – "The doctor didn't say it was cancer" or "Maybe the tests are wrong." Those persons are in denial because they prefer to doubt they have the disease. Then there is the *denial of impact* shown in the statement – "Right, I have cancer, but I am not worrying about it." Or how about the *denial of affect,* as in – "What is, is, so I take it as it comes." And lastly, there is something called behavioral escape – a resort to overindulgence in food, drinking, smoking, work, etc. In the final analysis, the use of denial is a phenomenon that allows patients to process what's happening to them. It can serve different purposes during the various phases of their illnesses from diagnosis through the various stages of treatment and recovery, and even end-of-life issues.

So denial can be positive when it allows patients the space to get used to their diagnoses. In that sense it is adaptive and a good way to cope. Three studies have shown that a patient's denial decreases significantly over time, although it may increase if, and when, the patient faces cancer recurrence, an advanced stage, or end-of-life issues.

What's the bottom line on denial based on the research to date? The truth is that the results are mixed as to be inconclusive, so the jury is really out. It didn't help that the studies varied in their definitions of the term denial. At best it can be said that denial works for some patients in a very positive way and for others it doesn't work so well.

DEPRESSION

Next, I want to talk about depression. As a psychologist listening to people talk about depression, I find oftentimes that they misunderstand what depression is. When I ask if they feel depressed, they often respond, "No, I'm not depressed; I am not suicidal; I am not preoccupied with thoughts of death; and I never contemplate hurting myself; so, no, I'm not depressed." But their response does not describe what depression is. Clinical depression is characterized by these conditions: feeling sad, empty, irritable or unable to enjoy oneself; having trouble making decisions; feeling fidgety and restless; being unable to concentrate or pay attention; overeating or conversely, lacking an appetite; low energy and lack of motivation; sleeping more, or less than usual; and feeling alone, yet seeking isolation and withdrawal from others. Did you know that these are all classic signs of depression? How many of them do you recognize in your own life?

What's wrong with "sucking it up?" When you do that, you are shutting yourself down, shutting down your thoughts and feelings, and thereby increasing your risk of danger, believe it or not. In other words, you are reducing your awareness of both the internal world and the external world and how they are affecting you. That is what depression is--a shutting down. Shutting down also increases the risk for "eruptions." Think of a pressure cooker reaching its limits. When you don't let the pressure escape, you are prone to eruption with the resulting irritability, snappishness, anxiety, isolation and withdrawal. We know from reputable studies that what you think and feel has a measurable effect on the immune system and response to stress. Why is that important? We want our immune system to be in excellent condition to fight off all manner of illness, including prostate cancer. Depression and hostility can trigger an inflammatory response leading to greater risk of heart disease and other medical conditions susceptible to an inflammatory response. And I haven't even mentioned the effects of your depression on others. For example, emotional eruptions are likely to negatively affect the ones we love.

The fact is that as we age, we are more prone to depression. It's been said tongue-in-cheek that the biggest depressor is retirement! Why? Perhaps it's the recognition of unmet expectations, the loss of mobility and other physical limitations, and loss of dear friends, or a combination of like factors. Frankly, this topic often goes unaddressed by many medical providers. Patients seeking understanding and help with anxiety, low energy, and other depression-related malaise are likely to be disappointed. The response may be, "Well, after all, you **ARE** 70 years old!" But we know that untreated depression makes concurrent medical problems worse.

WOMEN ARE FROM VENUS, MEN ARE FROM MARS, RIGHT?

I am not making this up! We know from studies that women perceive and report more health problems than men. Men, on the other hand, are less likely to report

symptoms lest they see themselves as vulnerable. One study showed that men with prostate cancer try to avoid disclosure of their disease for as long as possible. Women rely on family members and friends for support, while men tend to underestimate their psychosocial needs; to do otherwise would be "unmasculine." Overall, men prefer active problem-solving, while women prefer social support and emotionally-focused ways to deal with stressful situations. Thus, women share emotions, and men share information. Who is to say that either approach is superior?

So, are you still "sucking it up" these days? If so, you may be affecting your wives or partners in ways you never realized. Data shows that it may induce symptoms of depression and anxiety, increased sleep disturbance, and increased feelings of helplessness in them. As I noted above, talking and emotion-focused problem solving help women to cope. If you are not having full and open discussion of your prostate cancer, for instance, then you may be contributing to increased levels of distress in your wives or partners.

SUMMARY

Talking is important, very important. Talking is a way of sharing and connecting for the women who love you. Talking helps you to bring order to sudden disorder, such as getting a diagnosis of prostate cancer, for example, by promoting adjustment. Talking helps to process unexpected and overwhelming life events. Talking is a form of self-care and helps to facilitate approach-oriented strategies such as planning. Talking is a form of connection and relating to and with others, and it reduces feelings of loneliness and isolation. No doubt about it, social support increases the healing process. We know that; there are no two ways about it. The flip side is that chronic marital discord will slow the healing process. Finally, studies show that talking is linked with reduced pain levels throughout treatment.

Have I convinced you that talking is good? Try it, you'll like it!

The WRAMC Prostate Cancer Support Group's newsletter is posted on the web site of WRAMC's Center for Prostate Disease Research. You can access the current issue and back issues by going to www.cpdr.org/patient/ustoo/newsletter.html.

♦ OUR MEETING SCHEDULE ♦

The WRAMC Prostate Cancer Support Group meets 28 times a year. There are four quarterly evening meetings held on the first Wednesday of February, May, August, and November at 7:00 pm in Joel Auditorium in the main hospital building. They feature a guest speaker. The speaker and topic of these meetings are announced in our newsletter.

We also meet twice on the second Wednesday of every month. These meetings are informal discussion groups. The daytime session is from 1:30 - 3:00 pm; the evening session is from 6:30 - 8:00 pm. Both sessions meet in the conference room of the Center for Prostate Disease Research (Ward 56).

You need not have a military affiliation to participate in our meetings. All are welcome.

♦ WRAMC US TOO COUNSELORS ♦ (As of October 31, 2009)

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

SURGERY			
Tom Assenmacher	Kinsvale, VA	(804) 472-3853	
Jack Beaver	Falls Church, VA	(703) 533-0274	
Gil Cohen	Baltimore, MD	(410) 367-9141	
Richard Dorwaldt	San Antonio, TX	(210) 310-3250	(Robotic Surgery)
Michael Gelb	Hyattsville, MD	(240) 475-2825	(Robotic Surgery)
Robert Gerard	Carlisle, PA	(717) 243-3331	
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	
Sergio Nino	Dale City, VA	(703) 590-7452	
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	
PROSTATE CANCER AND SEXUAL FUNCTION			
James Padgett	Silver Spring, MD	(301) 622-0869	
RADIATION			
John Barnes	Springfield, VA	(703) 354-0134	(Intensity-Modulated Radiation Therapy)
Leroy Beimel	Glen Burnie, MD	(410) 761-4476	(External Beam Radiation)
Ron Gabriel	Bethesda, MD	(301) 654-7155	(Brachytherapy)
Harvey Kramer	Silver Spring, MD	(301) 585-8080	(Brachytherapy)
Bill Melton	Rockville, MD	(301) 460-4677	(External Beam Radiation)
Joseph Rosenberg	Kensington, MD	(301) 495-9821	(Brachytherapy)
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			
Ray Walsh	Annandale, VA	(703) 425-1474	
HORMONAL			
"Mac" Showers	Arlington, VA	(703) 524-4857	
WATCHFUL WAITING			
Tom Baxter	Haymarket, VA	(703) 753-8583	
CLINICAL TRIALS			
Philip Brach	Washington, DC	(202) 966-8924	
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 ♦

WEDNESDAY, NOVEMBER 4, 2009
7 PM

JOEL AUDITORIUM (SECOND FLOOR)
MAIN HOSPITAL BUILDING, WRAMC

♦ SPEAKER ♦

DR. MYRON MURDOCK

Medical Director, Vibrance Associates

Urologic Surgeon, Educator, Author, Clinical Trial Expert. Special Interests are Male Sexual Health, Urinary Incontinence, and Erectile Dysfunction

♦ TOPIC ♦

“Prostate Cancer, Male Sexual Health, and Incontinence”