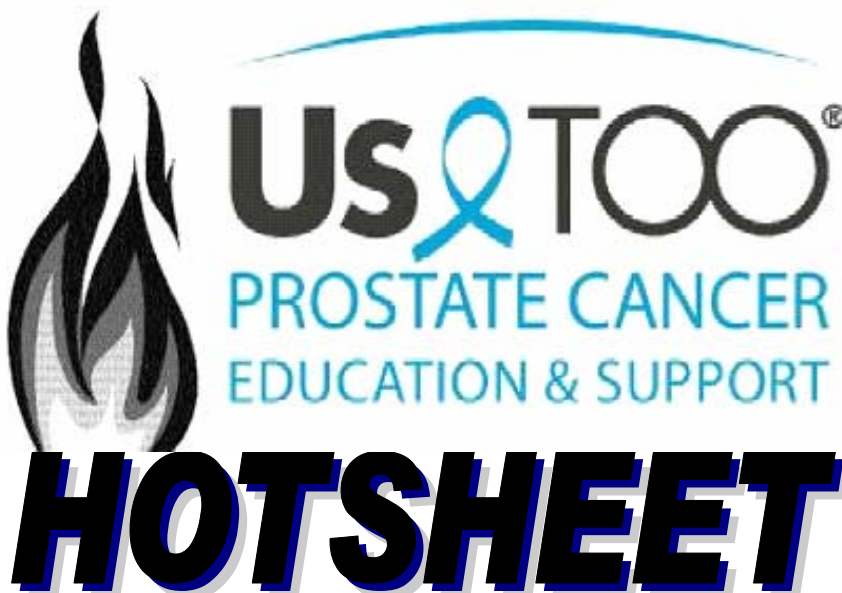


INSIDE THIS ISSUE

- MRI in Managing Prostate Cancer
- FDA Panel Backs New Prostate Vaccine
- Adjuvant ADT Can "Cure" Nonmetastatic Prostate Cancer
- Alendronate Increases BMD in Prostate Cancer Patients Receiving ADT
- Doc Moyad's What Works and What is Worthless Column—Lycopene
- Number of Prostate Biopsies and the Nature of the Cancer Identified
- COX-2 Inhibitor and Green Tea Synergize Against Prostate Cancer
- Soy Shows Paradoxical Results
- Poorer Health Care Ups Black Men's Prostate Cancer Risk
- From the Doctor: Physician Commentary on Selected Articles in This Month's *HotSheet*
- In Memory of Board Member Ron Fabrick



May 2007

WHAT IS THE ROLE OF MAGNETIC RESONANCE IMAGING IN THE CLINICAL MANAGEMENT OF PROSTATE CANCER?

John Kurhanewicz, PhD

Professor of Radiology and
Pharmaceutical Chemistry
Director, UCSF Prostate Cancer
Imaging Program
University of Calif., San Francisco

From the Editor: The Us TOO International Advocacy Committee voted at the June 2006 Board meeting to identify imaging as one of the top priorities, and is working with the AdMeTech Foundation to enhance funding for imaging for prostate cancer patients. This article has been made possible for our readers by an unrestricted charitable grant from MEDRAD.

The American Cancer Society estimates that 218,890 men will be diagnosed with prostate cancer in the United States in 2007, a higher incidence figure than any other cancer in men. Due to increased screening using serum prostate specific antigen (PSA) and extended-template transrectal ultrasound (TRUS) guided biopsies, thousands of patients with prostate cancer are being identified at an earlier and potentially more treatable stage.

(Continued on page 2)

FDA PANEL BACKS NEW PROSTATE VACCINE

A government advisory panel backed a new biotech vaccine for treating advanced prostate cancer March 29th, saying the treatment showed limited evidence of prolonging life in seriously ill patients.

In a 13-4 vote, the Food and Drug Administration advisors backed Dendreon Corp's. claim that Provenge®, its new generation cellular treatment, can extend survival in men who no longer respond to hormone treatment. Several experts said they were uneasy about supporting the treatment because it showed only marginal evidence of benefit. But a majority recommended approval anyway, citing scant options available to advanced prostate cancer patients, many of whom are facing a terminal illness.

"Given the dire landscape of other drugs out there, it should be opened up," said Dr. Steven M. Dubinett, a cancer researcher at UCLA who was a member of the advisory panel.

Dendreon touted the treatment as the first cellular therapy against cancer. To undergo treatment, patients have white blood cells removed and treated with immune agents. The cells are then reintroduced back into the body

(Continued on page 3)

ADJUVANT ANDROGEN DEPRIVATION CAN "CURE" NONMETASTASIZED PROSTATE CANCER

An analysis of 5 prospective randomized trials presented at the European Association of Urology (EAU) 22nd Annual Congress shows that adjuvant androgen deprivation therapy (ADT) with early hormone therapy can provide a normal life expectancy and essentially cure a significant proportion of men with M0 prostate cancer.

Thomas Ebert, MD, PhD, head of the Department of Urology, Euromed-Clinic, Fuerth, Germany, initially indicated during his presentation that based on historical data from before the PSA era, hormone therapy was believed to be a mainly palliative treatment for advanced prostate cancer. "We know now that adjuvant ADT following radiation therapy (RT) in M0 patients prolongs survival compared with RT alone," he added.

However, Dr. Ebert and colleagues asked whether this early hormone therapy can actually normalize the life expectancy of the patient with nonmetastatic prostate cancer, as with the local interventions of radical prostatectomy (RP) and external beam RT (EBRT).

(Continued on page 4)

THIS ISSUE OF THE US TOO PROSTATE CANCER
HOT SHEET IS MADE POSSIBLE BY
CHARITABLE CONTRIBUTIONS FROM



AND PEOPLE LIKE YOU!

ITEMS CONTAINED IN US TOO PUBLICATIONS ARE OBTAINED FROM VARIOUS NEWS SOURCES AND EDITED FOR INCLUSION. WHERE AVAILABLE, A POINT-OF-CONTACT IS PROVIDED.

REFERENCES TO PERSONS, COMPANIES, PRODUCTS OR SERVICES ARE PROVIDED FOR INFORMATION ONLY AND ARE NOT ENDORSEMENTS. READERS SHOULD CONDUCT THEIR OWN RESEARCH INTO ANY PERSON, COMPANY, PRODUCT OR SERVICE, AND CONSULT WITH THEIR LOVED ONES AND PERSONAL PHYSICIAN BEFORE DECIDING ON ANY COURSE OF ACTION.

THE INFORMATION AND OPINIONS EXPRESSED IN THIS PUBLICATION ARE NOT RECOMMENDATIONS FOR ANY MEDICAL TREATMENT, PRODUCT SERVICE OR COURSE OF ACTION BY US TOO INTERNATIONAL, INC., ITS OFFICERS AND DIRECTORS, OR THE EDITORS OF THIS PUBLICATION. FOR MEDICAL, LEGAL OR OTHER ADVICE, PLEASE CONSULT PROFESSIONAL(S) OF YOUR CHOICE.

HOT SHEET EDITORIAL TEAM:
JONATHAN MCDERMED, PHARM D
PAMELA BARRETT
THOMAS N. KIRK

US TOO INTERNATIONAL STAFF & CONSULTANTS:
THOMAS N. KIRK, PRESIDENT AND CEO
KAREN BACHER, PROGRAM DIRECTOR
PAMELA BARRETT, DEVELOPMENT DIRECTOR
TERRI GIBBONS, EXECUTIVE ASSISTANT
JAQUELINE KONIECZKA, OFFICE MANAGER
DAN REED, DEVELOPMENT &
MARKETING COORDINATOR
EUGENE WHEELER, UNDERSERVED
PROGRAM DIRECTOR
ELIZABETH CABALKA, PROGRAM CONSULTANT

US TOO BOARD OF DIRECTORS:
EXECUTIVE COMMITTEE/OFFICERS
JIM KIEFERT, EDD, CHAIRMAN
DON LYNAM, PH.D, PE, CHD, VICE-CHAIRMAN
JO ANN HARDY, SECRETARY
GREGORY BIELAWSKI, TREASURER
THOMAS KIRK, PRESIDENT AND CEO

DIRECTORS:
CHRIS BENNETT
ROBERT FIDOTN, PH.D
CARL FRANKEL
TOM HIATT
GEORGE LEDWITH
FRED MILLS
BILL PALOS
HARRY PINCHOT
STUART PORTER
RON WITHERSPOON



US TOO INTERNATIONAL, INC. IS INCORPORATED
IN THE STATE OF ILLINOIS AND RECOGNIZED
AS A 501(C)(3) NOT-FOR-PROFIT
CHARITABLE CORPORATION.

**DONATIONS / GIFTS TO US TOO
ARE TAX DEDUCTIBLE.**

5003 FAIRVIEW AVE. DOWNER'S GROVE, IL 60515
PHONE: (630) 795-1002 / FAX: (630) 795-1602
WEBSITE: WWW.USTOO.ORG

COPYRIGHT 2007, US TOO INTERNATIONAL INC.

MRI IN PROSTATE CANCER

(Continued from page 1)

The decision on how to manage prostate cancer once detected poses a great dilemma for patients and their physicians because prostate cancers demonstrate a tremendous range in biologic diversity and risk and are treated with a broad spectrum of approaches from "active surveillance" to aggressive surgical, radiation-based, and other focal therapies. Such therapies have tradeoffs in that treatment, no matter how well delivered, is frequently associated with changes in health-related quality of life. Moreover, many prostate tumors follow such a slow-moving course that they would never threaten the duration or quality of lives of affected men if left untreated, but the natural history of individual tumors cannot be predicted with great confidence in individual patients using current prognostic markers.

A significant number of men present with clinically advanced prostate cancer, and between 22% and 35% of men treated with what was thought to be definitive radiation or surgery, suffer a post-treatment biochemical recurrence. Such men most often undergo additional treatment and a subset will progress to metastatic disease and cancer-related mortality. Earlier and more accurate identification of such men would allow for better selection of initial treatment, accrual to clinical trials whose goal is to improve outcomes, and earlier selective application of systemic therapy. This a critical questions since there is currently no cure for metastatic prostate cancer, and an estimated 27,050 men will die of the disease in the U.S. in 2007, a figure surpassed only by lung cancer.

Currently, the risk assessment of individual patients primarily relies on a number of clinical parameters including serum PSA, clinical stage (determined by means of digital rectal examination and TRUS), and systematic TRUS-guided biopsy results (number, % positive and grade of malignant biopsies). However, these are often inaccurate or inadequate, particularly when used alone for individual patients. An important advance has been the development of multivariable risk prediction instruments such as the

(Continued on page 7)

**ALENDRONATE INCREASES
BMD IN MEN WITH
PROSTATE CANCER
RECEIVING ANDROGEN
DEPRIVATION THERAPY**

In men with nonmetastatic prostate cancer who received androgen deprivation therapy (ADT), 70 mg of alendronate once weekly prevented bone mass loss, according to the results of a randomized trial in the March 19th issue of the *Annals of Internal Medicine* (Vol. 146, pp. 416-24, 2007).

"ADT in men with prostate cancer is associated with bone loss and fractures," write Susan L. Greenspan, MD, from the University of Pittsburgh (PA), and colleagues. "Because prostate cancer is a common and growing problem and an increasing number of men are receiving ADT, we sought to determine whether once-weekly alendronate would improve bone mass and reduce bone turnover in men with nonmetastatic prostate cancer receiving ADT."

At a university medical center, 112 men with prostate cancer who were receiving ADT were randomized to receive alendronate, 70 mg once weekly, or placebo. All patients also received calcium and vitamin D supplementation. At baseline, 39% of men had osteoporosis, and 52% had low bone mass. Alendronate treatment was associated with increase in bone mineral density (BMD) for more than 1 year by 3.7% at the spine ($P < 0.001$) and 1.6% at the femoral neck ($P = 0.008$).

In the placebo group, men had losses of 1.4% at the spine ($P = 0.045$) and 0.7% at the femoral neck ($P = 0.081$). At 12 months, the difference between groups was 5.1 percentage points at the spine ($P < 0.001$) and 2.3 percentage points at the femoral neck ($P < 0.001$).

Compared to placebo, alendronate demonstrated a statistically significant decrease in bone turnover. Adverse events were similar in both groups. Study limitations were short duration (1 year), small sample size, baseline hip BMD higher in the alendronate group than in the placebo group, and inability to determine whether alendronate reduces fractures.

(Continued on page 4)

FDA PANEL BACKS NEW VACCINE *(continued from page 1)*

with chemical programming that, in theory, allows them to mount an immune response against cancer cells. A pair of studies suggested Provenge may slow by one to two weeks the progression of prostate cancer in men whose cancer no longer responds to treatment with hormones. Men who used the treatment also showed some evidence of living longer than those who took a placebo. In one trial men who got active treatment lived an average of 3.3 months longer. In another, they lived four-and-a-half months longer.

Experts criticized the studies for enrolling only about 100 to 130 patients, a relatively small number that can limit scientists' ability to interpret results. But most said they support Provenge anyway, given the limited choices for men with advanced disease.

"I think that patients and physicians could look at some of this data in labeling and make their own decisions," said Dr. Kurt C. Gunter, medical director of Hospira, Inc., and a member of the panel.

Nearly 30,000 American men died of prostate cancer in 2003, according to the Centers for Disease Control and Prevention. Dendreon estimated 27,000 patients per year could be candidates for Provenge. "If approved,

Provenge could become a breakthrough treatment for patients with advanced prostate cancer who currently have few treatment options," company CEO Michael Gold said.

Federal regulations compel FDA to make a decision on the treatment by May 15. The agency isn't required to follow advisory panels' recommendations, but it usually does.

Despite the vote, several experts said they were unconvinced that Dendreon had established Provenge's effectiveness. Many backed the treatment anyway when FDA officials asked them to vote only on whether evidence was "substantial."

But panelists urged FDA to base its final decision largely on the results of a third study designed to test whether Provenge improves survival in more than 400 patients.

Several patients testified before the committee about the need for more therapies, even ones of questionable benefit. Patients "are pleading for something other than the one drug that's been approved in the last 30 years," said Jim Kiefert, chairman of Us Too, a non-profit group for prostate cancer patients.

United Press International, 29 March 2007

DOC MOYAD'S WHAT WORKS & WHAT IS WORTHLESS COLUMN— ALSO CALLED "NO BOGUS SCIENCE" COLUMN

"You say tomatoe (from the Ex-Vice President Dan Quayle spelling bee) and I say watermelon – lets call the whole thing off or just worthless?!"

**Mark A. Moyad, MD, MPH
University of Michigan Medical Center, Department of Urology**

***E-mail and for more information on general health now at:
<www.drmoayad.com>**

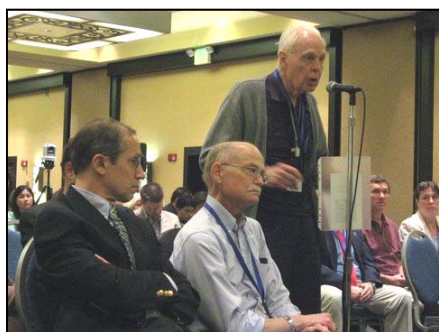
Hey, just a few years ago, lycopene and lycopene supplements were hotter than my bell bottom, powder blue, ruffled feathered tuxedo I wore at the high-school prom as I suffered numerous groin injuries attempting to dance to disco music, and lycopene was even hotter than my tight fitting Calvin Klein jeans I wore on my first date in ninth grade that probably increased my chances of permanent infertility (no wonder she never called me again). Let's face a simple fact, there was tremendous excitement that lycopene would solve prostate problems, but a lot of this initial excitement around the pills, in my opinion, was generated by advertising dollars and greed. In short, lycopene has simply cooled off.

In the past year, two separate wonderful studies have tried to determine the impact of lycopene in patients diagnosed with prostate cancer. The first was by Clark, et al¹, that found that lycopene supplements at even ridiculously high doses had no impact on a rising PSA after conventional localized therapy (surgery, radiation...).

The second and most recent study was by Jatoi, et al², in men with androgen-independent prostate cancer. This was also a fabulous study with 46 patients receiving 30 mg of dietary lycopene daily, but only one patient had a short-term PSA response, which means only 2% of the patients had an impact and this is similar to what would happen by chance using almost nothing.

The ultimate issue or question is that how can these compounds like lyco-

(Continued on page 8)



Richard Gillespie, survivor, President of the Virginia Prostate Cancer Coalition and Chapter Leader of Us TOO's Westminister-Potomac support group in Lake Ridge, VA



Jim Kiefert, Us TOO Chairman (standing behind podium)

Editor's note: Jim Kiefert, Chairman of the Board, Us TOO International, leaders from the Fairfax and Lake Ridge Us TOO support group chapters including Jim Waldenfels, Ed Grove, Alvin Chin and Richard Gillespie, and Jan Manarite from the Raise A Voice Initiative testified at the Cellular, Tissue & Gene Therapies Advisory Committee meeting held on March 29, 2007 in Washington DC, and made comments toward the need for more options for those living with advanced prostate cancer.

The Raise A Voice Initiative is a collaboration of leaders from Us TOO, PCRI, ProstateNET, NASPCC and other interested individuals who want to see earlier access to treatments, and want to raise awareness of the needs of advanced prostate cancer patients.

Photos courtesy of Fred Gersh, Us TOO Regional Director

DOES THE NUMBER OF PROSTATE BIOPSIES PERFORMED AFFECT THE NATURE OF THE CANCER IDENTIFIED?

Background: As methods of prostate cancer detection have improved, it has been increasingly difficult to strike an appropriate balance between early diagnosis and overdetection, leading to overtreatment. Recent evidence has suggested that performing a greater number of prostate biopsies results in the detection of smaller tumors, but limited data are available.

Objective: To determine the impact of an increased number of biopsies on the nature of prostate cancers identified.

Design and Intervention: This was a retrospective analysis of patient data recorded in the Cancer of the Prostate Strategic Urologic Research Endeavour (CaPSURE) database, an observational disease registry of men with biopsy-proven prostate cancer recruited by community-based urology practices across the US. There are no treatment protocols, and participating urologists treat patients according to their usual practice and report clinical data to the database. Additionally, information on health-related quality of life, use of health resources, and demographic parameters is compiled from the results of regular patient questionnaires. Patients are followed until they withdraw from the study or die. Patients included in this analysis were diagnosed with prostate cancer between 1999 and 2002 using ultrasound-guided biopsy with at least six cores removed, and had complete clinical data available at diagnosis. Clinical risk was assessed using the Kattan nomogram and Cancer of the Prostate Risk Assessment scores. The number of biopsies obtained was compared

with patient sociodemographic variables, clinical characteristics, and risk of progression and recurrence (with biochemical recurrence defined as two consecutive PSA levels of ≥ 0.2 ng/ml following radical prostatectomy [RP]).

Outcome Measures: Outcome measures included the associations between the number of prostate biopsies performed and various sociodemographic variables and clinical characteristics, disease-free survival, and biochemical-free survival.

Results: In total, 4,072 men were eligible for inclusion in the analysis. Of these, 30% had 6 biopsies, 47% had 7-11 biopsies, and 24% had >12 biopsies. After controlling for study site and year of diagnosis, a significant correlation was found between the number of biopsies performed and the PSA level at diagnosis ($P = 0.01$), number of comorbidities ($P = 0.02$), and household income ($P = 0.01$). The Pearson correlation coefficient between the number of biopsies and Cancer of the Prostate Risk Assessment score was -0.07 ($P < 0.01$), and 0.02 ($P = 0.27$) for the Kattan nomogram score. Of the 1,548 men who underwent RP, there were no significant associations between biopsy number and actuarial disease-free survival or 3-year biochemical-free survival after a median follow-up of 2.2 years.

Conclusion: The authors conclude that there seems to be no association between prostate cancer risk characteristics and the number of biopsies performed, supporting the continued use of extended biopsy patterns.

Nat Clin Pract Urol, Vol. 4, pp. 132-3, 2007.

ALENDRONATE, BMD AND ADT

(Continued from page 2)

"Bone loss that occurred with ADT was prevented and improved with once-weekly oral alendronate," the authors conclude. "Because most men have low bone mass or osteoporosis, physicians should assess their patients' bone density and provide therapeutic measures as appropriate."

The National Institutes of Health, the National Institute of Diabetes and Digestive and Kidney Diseases, the General Clinical Research Center of the University of Pittsburgh by the National Institutes of Health and the National Center for Research Resources supported this study. Some of the authors have disclosed financial relationships with Merck & Co., Inc, the maker of alendronate.

*Medscape Medical News
March 22, 2007*

ADJUVANT ADT

(Continued from page 1)

This analysis used a Medline search to include all published peer-reviewed prospective randomized trials from the past 10 years of the effects of adjuvant castration therapy after local therapy compared with local therapy alone, with median follow-up of more than 5 years. The overall survival (OS) and progression-free survival (PFS) curves were compared with those of age-, time-, and country-matched men without prostate cancer from the Human Mortality Database.

Five studies satisfied these inclusion criteria. Differences in OS could be calculated for 3 of these studies: the addition of adjuvant ADT to EBRT provided an OS that was not significantly different from the normal life expectancies of 70-year-old Belgium men (EORTC 22863) and 69-year-old Swedish men (Granfors), with many, but not all, 70-year-old US men (RTOG 85-31) showing similar benefit.

Across all 5 studies, the proportion of patients with a normal life expectancy due to adjuvant ADT ranged from more than 17% (after 9 years, RTOG 86-10), to more than 25% (after 12 years, RTOG 85-31), more than 35% (after 8 years, EORTC 22863; after 10 years, ECOG 7887), and more than 45% (after 11 years, Granfors).

In the single study of adjuvant ADT after RP, 66-year-old US males (ECOG 7887) also showed no significant differences in PFS from the equivalent normal population.

Thus, while it is accepted that adjuvant ADT in patients with M0 prostate cancer leads to a survival advantage compared with local treatment alone, Dr Ebert stressed that, "This may lead to a normal life expectancy for most of these patients as compared to standard age- and country-matched men."

Furthermore, a normal life expectancy without tumor progression is seen in a great proportion of these patients, which, Dr. Ebert and colleagues suggest, effectively constitutes a cure for nonmetastasized prostate cancer.

Presented at the EAU 22nd Annual Congress, Abstracts #20 and #21, March 2007.

*Medscape Medical News
26 March 2007*

COX-2 INHIBITOR AND GREEN TEA SYNERGIZE VS. PROSTATE CANCER

A low dose of a cyclooxygenase (COX)-2 inhibitor and green tea synergistically inhibit the growth of human prostate cancer cells in vitro and in a mouse model, according to a report in the March 1st issue of *Clinical Cancer Research* (Vol. 13, pp. 1611-9, 2007).

"Our work suggests that two agents acting through different mechanisms may have better prospects than high doses of a single agent," Dr. Hasan Mukhtar from the University of Wisconsin, told Reuters Health. Dr. Mukhtar and associates investigated the effects of COX-2 inhibitors and green tea extract, alone and in combination, on human prostate cancer cells in vitro and in an athymic nude mouse model.

In vitro treatment of human prostate carcinoma cells with either a COX-2 inhibitor or green tea extract significantly inhibited cell growth, the authors report, but the combination increased cell inhibition 15% to 28% more than additive effects of the two.

The two compounds, alone and in combination, increased levels of proapoptotic Bax, decreased levels of antiapoptotic Bcl-2, and increased activation of caspase-6 and -9, as well as expression of PARP (a marker of cell apoptosis), the results indicate. The combination generally showed synergistic effects on these markers. In the mouse model, similar results were seen, with intraperitoneal celecoxib plus oral green tea extract providing 81% inhibition in tumor growth, compared with 42% with green tea extract alone and 57% with celecoxib alone.

"Although growth inhibition and apoptosis of prostate cancer cells has been shown with (green tea extract) and COX-2 inhibitors," the investigators say, "we here report for the first time a synergism between these agents against prostate cancer cells. The dose of celecoxib we used will translate to 200 mg/day per 70 kg individual."

Before using in humans, we would like to test the efficacy of this combination in a transgenic mouse model of human prostate cancer," Dr. Mukhtar added.

Reuters Health, 14 March 2007

SOY AS PROSTATE CANCER PROTECTION YIELDS PARADOXICAL RESULTS

Diets rich in soy protect against prostate cancer. Then again, they don't.

This paradoxical finding came from a study of 43,509 Japanese men. While some soy isoflavones in the diet decreased the risk of localized prostate cancer, soy-containing miso soup increased the risk of advanced prostate cancer. So reported Norie Kurahashi, MD, of the National Cancer Center of Japan, and colleagues, in the March 2007 issue of *Cancer Epidemiology, Biomarkers & Prevention*.

"The present findings provide no clear understanding of when or how localized cancer will develop to aggressive cancer, and of the related effect of isoflavones," said Dr. Kurahashi. The investigators recommended that Japanese men continue their high consumption of soy from foods, but they discouraged the use of supplements.

The investigators hypothesized that soy in general, and its isoflavones genistein and daidzein in particular, may attenuate but not prevent progression of latent prostate cancer. Soy isoflavones are estrogen mimics and strong antioxidants in vitro, and appear to be protective against cancer in animal models. The Japanese study, the largest of its kind, prospectively evaluated the relationship between soy consumption and prostate cancer in men who were part of an even larger cohort study. The men, ages 45 to 74 years, responded to a validated questionnaire that included 147 foods and beverages, including questions about portion size and frequency of consumption.

The authors focused on the consumption of miso, a soy-based soup, at tofu in various forms, at natto (fermented soybean) and soy milk. They also looked at consumption of the isoflavones, which they estimated based on food composition tables listing isoflavone content of Japanese foods.

The study used as its baseline the five-year follow-up interval from the Japan Public Health Center-Based Prospective Study. Beginning in 1995 and continuing through 2004, there were 307 new cases of prostate cancer: 74 advanced, 220 organ-localized, and 13 of indeterminate stage. The authors found that intake of genistein, daidzein, miso

or soy foods did not have a significant effect on the risk of developing total prostate cancer (localized and advanced) for the entire cohort. But when they broke the data down according to cancer by stage and age they found that men older than 60 in the highest quartile of intake of three of the four items -- genistein, daidzein, and soy foods -- had significantly decreased risk for localized prostate cancer versus those in the lowest quartile.

Of the men older than 60 with localized cancer, genistein was associated with a relative risk for cancer of 0.52 (95% CI, 0.30-0.90, *P* for trend = 0.03) in 25,538 person-years of follow-up. Similarly, highest consumption of daidzein was associated with a relative risk of 0.50 (95% CI, 0.28-0.88, *P* for trend = 0.04) in 25,276 person-years, and soy foods were associated a relative risk of 0.52 (95% CI, 0.29-0.90, *P* for trend = 0.01).

There were no significant differences between the highest and lowest quartiles for any of the four items among men younger than 60, however.

When the investigators looked at advanced cancer among men older than 60 in a multivariate analysis adjusted for energy intake, there was a dose-dependent increase in risk for advanced prostate cancer associated with miso soup. There was a multivariable relative risk for the highest versus lowest quartile of 2.79 (95% CI, 1.19-6.55; *P* for trend = 0.02). Consumption of soy foods or the isoflavones was not associated with advanced prostate cancer in multivariate analysis, however.

"In the present study, we observed a dose-dependent decrease in the risk of localized prostate cancer with isoflavone consumption," the investigators wrote. "Men with the highest intake of isoflavones (as genistein, ≥ 32.8 mg/d) had a decreased risk of prostate cancer compared with those with the lowest intake of isoflavones (as genistein, <13.2 mg/d). To our knowledge, this is the first prospective study to report an inverse association between isoflavone and localized prostate cancer in Japanese, whose intake of soy food is high."

Reasons for their paradoxical findings

(Continued on page 8)

POORER HEALTH CARE UPS BLACK MEN'S PROSTATE CANCER RISK

Black American men are at a higher risk for developing prostate cancer and dying from their illness, because they often lack access to routine health care, a new study suggests.

While black men face a 60+ percent higher risk for prostate cancer than whites, prior efforts to explain that disparity have focused on a mix of genetic predisposition, poor education, and a general distrust of the medical system among the black community.

But the new findings, published in the April 15, 2007 issue of *Cancer*, reveal that black American men are, in fact, well-educated when it comes to prostate cancer risk. Instead, the authors find that, compared with white Americans, black men too often lack health insurance or a regular relationship with a primary care doctor. In those cases, the diagnosis and treatment of prostate trouble falls behind.

“To explain worse outcomes among African-Americans, there's been this idea that ‘these uneducated people don't get it,’” said Dr. James A. Talcott, director of the Center for Outcomes Research at Massachusetts General Hospital Cancer Center and a professor at Harvard Medical School in Boston. “And, if anything, it is the opposite. It isn't about cultural beliefs, and it isn't that they're uneducated or uninformed. It is that many are poor, lack insurance, and have lousy access to health care.”

Overall risk rises with age, with more than 65 percent of all cases occurring among men 65 and older. Black Americans, in particular, are almost 2.5 times more likely to die of the disease than whites.

Talcott teamed up with colleagues at

the University of North Carolina at Chapel Hill School of Medicine to survey 84 black American men and 253 white men from North Carolina, all of who had been diagnosed with localized prostate cancer between 2001 and 2004. Patients were between the ages of 40 and 75. Questions centered on prostate cancer screening history, family history, access to care, general attitudes toward health and health care providers, physician relationships, treatment experience, co-existing disease, and symptoms.

While 55 percent of blacks earned below \$40,000, just 23 percent of the white men fell into that income bracket. Black participants were also more likely to have blue-collar jobs, lower educational backgrounds, co-existing disease, and to be jobless as a result of illness or disability.

At the same time, black men also reported a greater sense of responsibility for their health and were less likely to trust their doctors. Many expressed the suspicion that doctors based their decisions more on the basis of cost than the patient's health.

With respect to prostate cancer screening, blacks were less likely to have regular check-ups, digital rectal exams, or PSA tests. They specifically noted that black men were more than twice as likely to have to request a PSA test (as opposed to being offered one) than whites.

“So, we have to improve access and trust in the health care system by making sure that these men can build relationships with doctors and access medical care when they need it. That's the answer,” Talcott said.

HealthDay News, 12 March 2007

FROM THE DOCTOR: PHYSICIAN COMMENTARY ON SELECTED ARTICLES IN THIS MONTH'S *HOTSHEET*

By Gerald W. Chodak, MD

This month's *HotSheet* is loaded with new and interesting information starting with the approval of the first vaccine for advanced disease. An FDA panel concluded that although the overall improvement in survival was small, limited options warranted its approval. Interestingly, the survival improvement was similar to that of the chemotherapy agent Taxotere®. A larger, ongoing study should provide more information.

Another VERY important article summarizes the use of adjuvant hormone therapy in non-metastatic disease. A large review of well-conducted randomized trials found a number of clinical situations where using hormone therapy in addition to radiation improved survival. What is most disturbing, however, is that in the United States far too many clinicians do not offer these treatments or follow the regimen found to be effective. The only solution is for patients to learn about these treatments and make sure to ask their physician about them.

Several articles again address the role of supplements in prostate cancer. These include green tea with a cox-2 inhibitor, soy and lycopene. Without beating a dead horse, the recurring problem of needing randomized trials is again brought to light. Dr. Moyad reviews the lycopene story and found that despite its ability to work on cells in a lab, its benefit for patients with prostate cancer remains lacking.

Soy, known to also contain chemicals effective in the lab, had a mixed finding in a Japanese study, but its design prevents any valid conclusions about what to do about soy consumption.

Lastly, the green tea combination is yet another example of our ability to treat cells growing in dishes. Paraphrasing a recent comment from the NIH, ‘the last 30 years in cancer research has largely been our ability to cure cancer in mice rather than in humans.’ We are a long way off from knowing if green tea is useful, how much is needed or when it must be consumed.

(Continued on page 7)

“Living Well with Prostate Cancer”

Us TOO University Patient Education Symposium

Hyatt Regency Austin on Townlake
Friday, May 11, 2007, 4:30 pm - 10:00 pm

Sessions include: Dr. Randy Fagin on DaVinci Robotic Surgery Techniques, Intimacy and Prostate Cancer: Finding Solutions, Incontinence Solutions, New Treatment Options: Advances in Research.

- \$5.00 per person pre-registered, \$10.00 per person day of event, (\$15.00 per couple day of event). Open to the public.
- Pre-Register online at <www.ustoo.org/university>



**IN MEMORY OF PAST
BOARD MEMBER
RON FABRICK**



Us TOO International Director Emeritus Ronald W. Fabrick, DDS, 67, of Mt. Prospect, IL, passed away on March 20, 2007. He served on Us TOO's Board of Directors from 1994 to 2003, reaching Emeritus status in 2004.

Ron was a periodontist, and served as President and Program Chairman of a number of professional dentistry organizations. He was made Honorary Member of the American Dental Society of Europe. The father of three boys and two girls, Ron said in his Us TOO Board member application, "I have had my share of dance recitals, Boy Scouts, and Y-Guides." Ron served on the Barrington High School Parent Faculty Committee, Quarterback Club and Little League. Us TOO Founder and Director Emeritus John DeBoer said of the news, "I have many fond memories with Ron."

Jim Kiefert, Us TOO Board Chairman, served with Ron during his tenure on the Board, and said, "Ron was a warrior who shared his knowledge and caring with those battling prostate cancer like he was. His passion for Us TOO International's mission and vision was always apparent at board meetings and at chapter meetings. While on the Board, Ron kept reminding us that we are 'all about chapters' and asked what we did for our chapters lately. His zest for life will be missed. He made a great contribution to Us TOO."

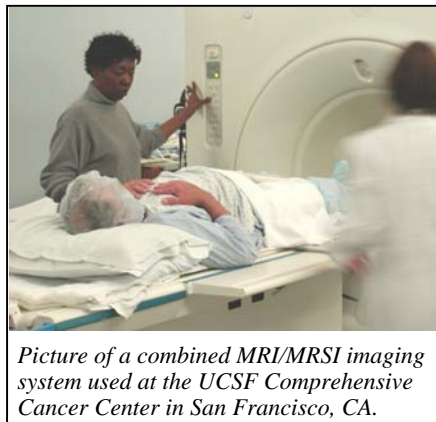
Again from his Us TOO Board application, Ron stated, "Us TOO certainly has been a vital part in my battle with my disease. I feel the support and advice I received were most valuable and, that this activity must be continued. I would like to contribute. We need to supply members with as much

(Continued on page 8)

**MRI IN THE CLINICAL MANAGEMENT OF
PROSTATE CANCER** *(continued from page 2)*

Partin tables and Kattan nomogram, which combine clinical stage, serum PSA levels, and grade of biopsies results to predict the pathologic stage of the cancer and likelihood of recurrence, respectively. Despite improvements in clinical risk stratification, the risk of either under-staging or under-grading remains a significant problem.

With early detection, there also has been increased interest in focal therapies like brachytherapy, radiation therapy, high intensity focused ultrasound or HIFU and focal cryosurgery—targeting a dominant prostate tumor rather than the whole gland. Such a targeted approach potentially could reduce treatment related morbidity and allow patients to maintain their quality of life to a better degree. Although prostate cancer is frequently a multifocal disease (cancer present in more than one location in the gland), there is increasing evidence that with the use of early detection efforts, more unifocal cancers are being detected.



Picture of a combined MRI/MRSI imaging system used at the UCSF Comprehensive Cancer Center in San Francisco, CA.

In a recent study from UCSF, 27% of men undergoing radical prostatectomy were found to have unifocal disease (cancer in one location of the gland only). However, any focal therapy requires an improved knowledge of the location and spatial extent of the disease within the gland. Detection and staging of prostate cancer in a clinical setting still largely depend on tests such as PSA, digital rectal examination, TRUS, computed tomography (CT), and skeletal scintigraphy, all of which lack the capability of precisely resolving disease within the gland or detecting metastases in lymph nodes and distant sites non-invasively. Pros-

tate cancer management requires accurate imaging information for therapeutic selection, guidance of local therapies, following patients on active surveillance and monitoring treatment response in individual patients and very importantly for clinical trials of emerging therapies.

The use of a combination of **Magnetic Resonance Imaging (MRI)** and **Magnetic Resonance Spectroscopic Imaging (MRSI)** represents an exciting new approach that can potentially improve prostate cancer management. MR anatomic images, especially high resolution images obtained with an endo-rectal coil and a surface coil, provide an excellent depiction of prostate anatomy, differentiating regions of benign tissue from regions with prostate cancer. The addition of metabolic information provided by MRSI has complemented the morphologic information provided by high-resolution MRI, and has significantly improved the detection and characterization of prostate cancer. A combined MRI/MRSI exam can be performed in less than one hour using standard clinical procedures. Published studies have also shown that the accuracy of detecting and characterizing prostate cancer can be improved by performing MRI/MRSI at higher strength magnets and through the addition of other functional MR techniques. Since these molecular imaging techniques are globally available to clinicians, it is timely to review what is already known about the utility of them and how they can improve detection and characterization of prostate cancer in the future. This will be accomplished in a series of articles that will appear in upcoming Us TOO publications.

FROM THE DOCTOR

(Continued from page 6)

Prostate biopsies also are revisited asking whether increasing the number of biopsies is identifying more non-life threatening cancers. Unfortunately, the study design is so flawed that no useful information can be gleaned from this article. The fact remains that more non-life threatening cancers are being identified each year and how to address this problem has not yet been resolved.

PARADOXICAL FINDINGS

(Continued from page 5)

of the effects of soy consumption by disease stage are unclear, but could be related to errors in food measurement, the small sample size of men with advanced prostate cancer (74 out of 307 total cases in a cohort of 43,509 men), or to a differential effect of related to the loss of estrogen receptors in advanced tumors, the authors suggested.

Study limitations include an inability to differentiate total prostate cancer cases from those detected by screening (biasing the sample toward health-conscious men eating more soy), the small number of advanced cancers and possible misclassification of soy and isoflavone exposures from changes in dietary consumption over time.

MedPage Today, 16 March 2007

DOC MOYAD'S WHAT WORKS & WHAT IS WORTHLESS

COLUMN—LYCOPENE *(continued from page 3)*

pene help men with more advanced disease? I think this is asking too much at this stage of the disease for this and for most nutritional products. Perhaps, tons of lycopene early in the disease may help, but this is speculative and it does have side effects.

Lycopene interest remains big for prevention or for men with localized disease. However, this will not stop the hype train because the claims made about the pill have been silly. The USDA has determined that watermelon has as much lycopene as a tomato and most of the positive studies of lycopene have centered on just consuming more fruits and vegetables.

The bottom line is that lycopene has hit

a bump in the road and unless something spectacular happens soon it may just be time to put these pills in the exact same place you just had to put that 10-week-old Chinese takeout that you left in the refrigerator that stunk up the whole kitchen but you didn't realize it until now and your spouse made you feel guilty about it even though it wasn't your fault.

(Sorry Honey, but I really thought I was going to eat it while watching the Super Bowl—please don't make me sleep in the garage again with our scary-looking dog).

References:

1. Clark P, et al: Urology 67: 1257-61, 2006.
2. Jatoi A, et al: Urology 69: 289-94, 2007.

RON FABRICK MEMORIAL *(Continued from page 7)*

varied information on which to make their treatment decisions as possible. Even more important is the support we give the newly diagnosed patient. It greatly benefits them and is an important part of our own continued therapy."

In lieu of flowers, etc., Ron's children, Kenton, Laurine and Kurt Fabrick and Lana Mercer, are establishing an everlasting named memorial to Ronald W. Fabrick, DDS through contributions to endow an activity at Us TOO International. Details about the memorial activity, once finalized, will be announced in an upcoming *HotSheet*. Meanwhile, contributions can be sent to: In Memory of Ronald W. Fabrick, DDS, Us TOO International, Inc., 5003 Fairview Avenue, Downers Grove, IL, 60515-5286. You may also make a credit card donation by calling (800) 808-7866, or by making an online memorial or tribute donation at the Us TOO website Store at: <<http://www.ustoo.org/Shopping/Main.aspx>>

**US TOO INTERNATIONAL:
OUR MISSION**

Communicate timely, personalized and reliable information enabling informed choices regarding detection and treatment of prostate cancer.



US TOO INTERNATIONAL

has received Charity Navigator's highest rating for the second year in a row for sound fiscal management. Less than one quarter of the charities in the US receive this exceptional rating.

US TOO INTERNATIONAL Tax Deductible Donation

Name: _____ Company: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: () _____ Fax: () _____ e-mail: _____

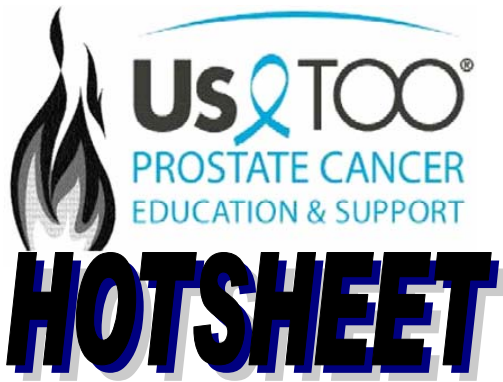
Please accept my enclosed tax-deductible donation to Us TOO a not-for-profit 501(c)(3) organization.

Amount: ___ \$25 ___ \$50 ___ \$75 ___ \$100 Other: \$ _____ Check # _____

VISA/MasterCard # _____ Expiration Date: ____ / ____

Signature _____

Us TOO INTERNATIONAL, Inc., 5003 Fairview Ave., Downers Grove, IL 60515



SPECIAL BURNING ISSUES SUPPLEMENT MAY 2007

Copyright 2007, Us TOO International www.ustoo.org 1-800-808-7866

THIS SUPPLEMENT TO THE *US TOO PROSTATE CANCER HOT SHEET*
WAS MADE POSSIBLE BY A CHARITABLE CONTRIBUTION FROM

AMS
Solutions for Life®

PROSTATE CANCER AND INCONTINENCE: COPING STRATEGIES AND TREATMENT OPTIONS

FROM THE DOCTOR: PHYSICIAN COMMENTARY ON SELECTED ARTICLES IN THIS SUPPLEMENT

By Gerald W. Chodak, MD

This special supplement on incontinence contains some commentary and advice about managing what may be the most devastating consequence of prostate cancer therapy, the impact on urinary control. Importantly, the incidence of this complication has gradually declined, but remains dependent on a patient's age and the experience of the surgeon.

Patients choosing their doctor should never be afraid to ask: "How many have you done in the last 3 years, how many in my age group have any incontinence and how did you assess this information" because not enough doctors actually score their results.

These articles stress the need to recognize that full recovery could take up to two years. As indicated in these articles, there are many options available to help men cope with their problem so that the impact on day to day life is minimized as much as possible. Men should seek out all the resources available to them.

Attend the Incontinence Solutions presentation at:
"Living Well with Prostate Cancer"
Us TOO University Patient Education Symposium, Fri, May 11, 2007, Hyatt Regency Austin on Townlake, Austin, TX. Register online at www.ustoo.org/university

LIFE AFTER PROSTATE TREATMENT: FOCUS ON INCONTINENCE

Jeffrey Albaugh, MS, APRN,
CUCNS

The most common side effects after prostate treatment are sexual and urinary dysfunction. Although you may initially experience these problems, they may be resolved over time with treatment. It is important to be proactive about these problems to have the best chance of recovering potency and continence. This article is meant as a quick overview of the types of incontinence that may occur after prostatectomy and some of the treatment options available.

A recent study showed that as many as 84-87% of men were continent after either radical prostatectomy or laparoscopic prostatectomy, but it can take as long as two years for patients to regain continence.^{1,2} It takes time and consistent pelvic floor exercises to regain continence after surgery, and even then a small percentage of men will not regain continence. If you have had surgery to remove your prostate, you know that when the catheter comes out the leakage can begin.

Although this leakage does resolve over the next year for many men, it does not always. After prostate surgery, part of the mechanisms that maintain the urine in the bladder have been removed and the remaining pelvic floor muscles must work harder to maintain the urine in the bladder with activity, coughing, sneezing, and

(Continued on page 2)

AFTER THE SURGERY: CONQUERING INCONTINENCE

By Maiya Willits

The truth is, you can survive prostate cancer and still feel like you've lost part of your life. To those suffering from urinary incontinence, it can feel like you're missing out on the best that life has to offer. In order to remove the cancer, parts or all of the tissues that help control urine flow may need to be removed. The rate of incontinence after radical prostatectomy surgery ranges from 3% to 60%^{1,2} influenced by factors such as age, general health and the amount of prostate and surrounding tissue removed during surgery.

While men often experience incontinence immediately following surgery, the leakage usually stops within weeks or a few months. When incontinence persists beyond a few months, you should consult your doctor. The good news is that there are more treatment solutions today than ever before.

Absorbent Products

Absorbent pads, diapers and garments can help individuals to deal with bladder control problems. However, absorbent products should not be employed for long-term bladder control unless a physician has evaluated the patient's incontinence. In particular, early reliance on absorbent pads may be a stumbling block for bladder control. The wearer may develop a sense of security and acceptance of the condition, which could lessen the desire to seek adequate diagnosis and treatment.

(Continued on page 3)

LIFE AFTER PROSTATE TREATMENT: FOCUS ON INCONTINENCE

(continued from page 1)

laughing. You also may have a more urgent need to urinate and not be able to get to the bathroom before leakage occurs. If you had radiation therapy, you also may have problems with incontinence related to urinary urgency.

Urinary incontinence is any unintentional loss of urine. Urinary incontinence can be divided into several different categories. There are three main categories for urinary incontinence after prostate cancer treatment. Each type has its own cause and approach to treatment. It is important to remember that urinary incontinence can be a mixture of more than one type of incontinence as well.

Stress urinary incontinence involves unintentional leakage of urine with coughing, laughing, sneezing, lifting, or activity. This type of incontinence is the most common type in men after prostatectomy because they have lost part of the mechanisms that maintain urine in the bladder. The holding mechanisms are sometimes unable to keep the urine in the bladder when the patient is active.

Urge incontinence is an unintentional leak of urine when you have a strong urge to urinate. It is characterized by a sudden, uncontrolled need to urinate and may be triggered by changing positions, running water or the anticipation of getting closer to the toilet. This can occur after prostate treatment with either radiation or prostatectomy.

Overflow incontinence occurs when the bladder fills to capacity and never empties completely. After the bladder has filled to capacity it can overflow causing urinary leakage. This can happen as a result of scar tissue obstructing the outlet of the bladder where the prostate was previously located. The most common types of incontinence in men after prostate cancer treatment are *stress incontinence* and *urge incontinence*. Some men also complain of leakage of urine during sexual relations or with orgasm after prostatectomy. This problem along with erectile dysfunction can greatly impair a couple's ability for intimacy. If you have urinary incontinence or sexual dysfunction, you should talk to your

healthcare provider or see a specialist and develop a treatment plan after a careful history and physical exam.

Most men regain continence and there are a variety of treatment options available to men with incontinence after prostate treatment. Before you even start your treatment for prostate cancer, whether surgery or radiation, you should learn how to do pelvic floor exercises correctly. These exercises can be helpful in treating both urge and stress incontinence if they are not too severe. Learning to do the pelvic floor exercises correctly is essential and may require you to see a specialist nurse or physical therapist who can teach you to do the exercises appropriately and consistently.

The key to appropriate pelvic floor exercises is to isolate the pelvic floor muscles from all other groups of muscles, particularly the abdominal muscles, the thigh muscles and the muscles of the buttocks. There are different muscle fibers within the pelvic floor and there are various exercises that work the different muscle fibers. The exercises are most helpful if you learn to do them correctly with the help of a nurse or physical therapist who specializes in teaching these exercises and if you do the exercises progressively and consistently.

The Agency for Health Care Policy and Research Guideline, "Urinary Incontinence in Adults: Acute and Chronic Management" recommends that the first treatment option for incontinence should be the least invasive options of bladder re-training, timed voiding, and pelvic floor exercises.³ These exercises can be taught to you by a healthcare professional. If you have urge incontinence, there are anticholinergic medications that may help control the urge to urinate in the right group of patients. There are currently no FDA approved medications for treating stress urinary incontinence, although duloxetine is a new drug being investigated for treatment of stress urinary incontinence and has shown some promise in preliminary research.⁴

Surgical interventions for incontinence have been done for many years and

today there are a number of good options including various sling procedures and artificial sphincters to control stress urinary incontinence. The good news is, although urinary problems and erectile dysfunction are the most common side effects from prostate cancer treatment, both problems are very treatable problems and can often be treated successfully. To give yourself the very best chance of successfully becoming continent and potent is essential to talk to your healthcare professional about any problems and find the appropriate treatment options for you.

Jeffrey Albaugh is an Advanced Practice Urology Clinical Nurse Specialist at Northwestern Memorial Wellness Institute where he runs a nurse led sexual health program. He also runs the Us TOO prostate cancer support and information group on the 2nd Thursday of every month at Northwestern Memorial Hospital. He can be reached at (312) 926-4032 or <jaalbaugh@nmh.org>

References

1. Jacobsen NE, Moore K, Estey E, Voaklander D. (2007) *J Urol* 177(2): 615-9.
2. Sacco E, Prayer-Galetti T, Pinto F, Fracalanza S, Betto G, Pagano F, Artibani W. (2006). *Br J Urol Int* 97(6): 1234-41.
3. Clinical Practice Guideline Number 2 (Update). Rockville, MD: Agency for Health Care Policy and Research, US Dept of Health and Human Services; 1996. AHCPR Publication No. 96-0682.
4. Schlenker B, Gratzke C, Reich O, et al. (2006) *Eur Urol* 49(6), 958-60.

Resources

These organizations have resources for treating urinary incontinence:

Society of Urologic Nurses and Associates (SUNA)

Patient Fact Sheets on Incontinence and Overactive Bladder
SUNA National Office
East Holly Avenue, Box 56
Pitman, NJ 08071-0056
(856) 256-2335
<www.suna.org>

National Association for Continence
PO Box 1019

(Continued on page 4)

COPING WITH THE FEELINGS SURROUNDING INCONTINENCE

**By Cheryle B. Gartley
President & Founder**

Simon Foundation for Continence

It is rumoured that men do not enjoy delving into emotions, nor do they appreciate surprises or feeling out of control -all things people with incontinence experience. Coping with a misbehaving bladder means experiencing a wide range of emotions; chief among them is a fear of being wet in public. Feelings caused by incontinence such as embarrassment and the desire to seek isolation lead to changes in self-confidence. Although uncomfortable, focusing on feelings about incontinence may help you prepare for your reactions to a misbehaving bladder.

Toilet training is important in American culture. Everyone has heard someone say "good boy" or "bad girl" depending on the success the child is having learning bladder control. Given society's fixation on this little muscle, is it any wonder that incontinence is an emotional issue?

Often individuals do not recognize the impact of incontinence until they realize the activities they have discontinued (golfing, attending sporting events, or even playing poker) due to the fear of not having immediate access to a bathroom. Anger, depression, and frustration are all common responses to incontinence. Interestingly, research shows that the amount of leakage experienced is not related to the emotional distress a person feels.

No one will claim that a misbehaving bladder is not embarrassing; but there are many occasions for embarrassment in life (spilling coffee, whiffing a golf ball, tripping over microphone cords) - most people cope and move on. Coping is something we don't notice unless a problem continues. Much can be done about incontinence, but still millions will not be completely cured; thus learning good coping skills can avoid incontinence taking up unnecessary emotional energy. It is helpful to think in terms of both coping with the dread of what might happen, and cop-

(Continued on page 4)

CONQUERING INCONTINENCE

(Continued from page 1)

Internal Collection Devices

An internal collection device, such as a catheter (a hollow plastic tube), may be recommended for certain individuals to ensure that the bladder is emptied on a regular schedule and does not overflow. Intermittent catheterization (the periodic insertion of a catheter into the urethra and into the bladder) is performed at regular intervals each day.

External Devices

External collection devices, such as external catheters, are urine storage products that may be useful for short-term incontinence treatment in men. They are attached to the shaft of the penis by adhesive, latex or foam strap devices, and a tube to a urine-collecting bag connects them.

For men, external occluding (closing) devices can be used to block the flow of urine by squeezing the urethra shut or plugging the urethra. Mechanical devices include penile clamps (e.g., the Cunningham clamp) and compression rings. The penile clamp is a V-shaped casing with a foam cushion that fits over and under the penis. When closed, the penile clamp should stop the flow of urine without causing discomfort. Compression devices are adjustable rings that surround the penis and, when inflated with air, pinch off the urine flow. Improper use of penile clamps and compression rings can result in penile and urethral erosion, penile edema (swelling), pain and obstruction.

Surgical Options

Surgical procedures are available to treat male urinary stress incontinence. Some of these include:

- Injections of bulk-producing agents, such as collagen, into the urinary sphincter.
- Implanting a "male sling," a device designed to support the muscles around the urethra. There are two male sling systems used for this type of procedure, the InVance® sling and the new AdVance™ sling, both from American Medical Systems (AMS) of Minnetonka, MN.

(Continued on page 4)

PATIENT STORY: LIVING LIFE DRY

By Maiya Willits

Suspected Agent Orange exposure during his service in Vietnam left Barrett Brashers with a variety of neuromuscular health problems. He didn't know that a routine shoulder operation to repair his rotator cuff in 1997 would end up saving his life.

"When the nurse tried to put a Foley catheter in, he immediately sensed that I had a prostate problem," said Barrett, of Virginia Beach, VA. Further testing with a urologist revealed advanced stage prostate cancer. Surgery was his only option at that point, and Barrett quickly underwent the procedure.

Unfortunately the cancer wasn't encapsulated; the surgeon performed a radical prostatectomy with bilateral lymphadenectomy and hoped for the best. That turned out to be better than expected: He's been cancer-free for nine years, and for that the 63-year old retired technology executive is resoundingly grateful.

"But the incontinence never went away," said Barrett. "All this time I was going through five to eight pads a day. If I fell asleep in a chair, I'd soak the chair. Sometimes at night I'd soak through everything - my nighttime pad, the bedclothes, everything."

He heard about a seminar addressing incontinence and his wife, a practicing nurse, convinced him to attend. "I wasn't too excited about some of the surgical options I heard about - the artificial urinary sphincter just didn't seem like it was for me. But I read about this new male sling procedure, and made an appointment to talk about it."

Dr. Kurt McCammon of Devine-Tidewater Urology of Virginia felt that Barrett was an ideal candidate for the new AdVance™ male sling procedure, in which a small sling made of synthetic mesh is placed inside the body to support the urethra, restoring normal bladder control.

"I'd had enough," said Barrett. "I was getting rashes from the pads. I couldn't walk my dog. I was getting fat from all the things I was missing out on because of my incontinence. So I said let's do it." Dr. McCammon per-

(Continued on page 4)

LIVING LIFE DRY

(Continued from page 3)

formed the surgery on January 15, 2007. "And I've been dry ever since."

Having undergone various medical procedures over the years, this one didn't seem too bad to Barrett. "I didn't need any painkillers afterwards. I had a little soreness in the groin, but no pain – and no leaking." The male sling is considered a minimally-invasive solution, often performed as an outpatient procedure, and most men are continent right away after the procedure.

The procedure was developed by two urologists from Innsbruck, Austria, Drs. Christian Gozzi and Peter Rehder. According to them, the procedure "represents a paradigm shift in the treatment of male incontinence, giving physicians the opportunity to provide real incontinence solutions to even more prostate cancer survivors."

Two large studies are underway to evaluate long-term efficacy of the procedure, and the preliminary experiences of the centers are promising. In an April 2007 supplement to Urology Times, Dr. Rehder says "We often do not realize how much patients suffer because of incontinence. Many patients are also still traumatized after having had major cancer surgery. Knowing that there is help available for treating urinary incontinence that is not a major operative procedure, most of these men welcome this help and are extraordinarily happy with the quick and so far seemingly lasting success of this procedure."

Barrett Brashers counts himself one of the lucky ones. He's back to walking his dog, shopping with his wife, and beginning to think about getting back to his six-day-a-week gym routine. "I feel great. I'm getting back into shape. I'm not messing around with the pads anymore. I feel like it's improved my life by 50 percent."

CONQUERING INCONTINENCE

(Continued from page 3)

These are highly effective, minimally invasive procedures to correct mild to moderate stress urinary incontinence in men.

- Implanting an artificial urinary sphincter, which mimics the func-

INCONTINENCE COPING

(Continued from page 3)

ing with an actual loss of control.

Strategies for change include refuting irrational ideas and learning assertiveness training. Everyone engages in self-talk, your internal thought language. However, irrational or untrue self-talk leads to anxiety. You can improve how you converse with yourself; for instance try saying I will experience inconvenience and annoyance (not anxiety, depression, or anger) - also learn to be assertive about legitimate rights. You have the right to: put yourself first at times; change your mind; ask for help; not justify yourself; and not respond to questions. You also might want to remind yourself how much that you dread in life never happens!

Realistically, it is not, but when your incontinence may be exposed in public for many people. Plan for this by re-evaluating the term "accident" which is defined as "an unforeseen or unplanned event," because for most people being wet in public is not an unforeseen event. We need to remove "accident" from our vocabulary and incorporate "be prepared" instead.

There is no one correct way to be prepared; however, you might consider: knowing bathroom locations; carrying extra clothing; planning what you'll say to yourself to avoid negative self-talk; and finding an effective collection device or absorbent product designed for the male anatomy.

Remember, interpretations of a situation and self-evaluation are what create emotions... so the bottom line is that when you plan for your emotional reaction, you really are still always in control.

tion of a normal, healthy urinary sphincter. Currently, AMS offers the only artificial urinary sphincter available, and it is widely considered to be the gold-standard solution for moderate to severe stress urinary incontinence following prostate surgery.

Talk to your doctor about which solution may be right for you. The key thing to remember is that nearly every case of incontinence is treatable today

FOCUS ON INCONTINENCE

(Continued from page 2)

Charleston, SC 29402-1019
(800) BLADDER [(800) 252-3337]
<www.nafc.org>

The Simon Foundation for Continence
Box 835-F, Wilmette IL 60091
(800) 23SIMON [(800) 234-4666]
<www.simonfoundation.org>

Products

Editor's Note: This listing is only a sampling of the companies that provide bladder control products or services. Us TOO International does not endorse any products, and provides this listing to simplify patient information gathering.

AlphaDry—condom catheters
<www.alphadry.com>
877-235-9379

American Medical Systems—surgical slings and sphincters
<www.malecontinence.com>
800-529-5744

Better Pant—urology leg bag holder undergarments
<www.betterpant.com>
310-457-8350

Coloplast (formerly produced by Mentor Corp) - urinary catheters
<www.urology.coloplast.com>
800-533-0464

ElderStore—online store, access to many different manufacturers of bladder control products, including Freedom Starter Kit for Male Incontinence
<www.elderstore.com>
888-833-8875

GT Urological—compression pouches
<www.gturological.com>
877-488-4379

Serenity – pads and pants
<www.serenity.com>
877-822-0904

– there are solutions that can help improve your quality of life dramatically.

References:

1. Litwin MS, Hays RD, Fink A, Ganz PA, Leake B, Leach GE, Brook RH. Quality-of-life outcomes in men treated for localized prostate cancer. JAMA 1995; 273(2):129-35.
2. Herr HW. Quality of life of incontinent men after radical prostatectomy. J Urol 1994; 151(3):652-4.