



# PROSTATE CANCER *HOT SHEET*

**Us Too! INTERNATIONAL**

**OCTOBER 2003**

## **MORTALITY FROM FOUR LEADING CANCERS CONTINUES TO FALL IN US**

Mortality from the four most common cancers in the US — lung, breast, prostate, and colorectal — continued to drop in the late 1990s, according to a report released Tuesday in the *Journal of the National Cancer Institute*.

Mortality for all cancer sites combined started to drop in 1994 and stabilized from 1998 through 2000, indicate the findings from the “Annual Report to the Nation on the Status of Cancer, 1975-2000.” The report is a joint effort of many US health groups including the Centers for Disease Control and Prevention (CDC) and the American Cancer Society.

“This report shows that we have made some progress in reducing the burden of cancer in the US, but much still needs to be done to reach the Healthy People 2010 goals — including wider application of what science has shown to be effective in preventing, screening, and treating cancer,” CDC director Julie Gerberding said in a statement.

Analysis of data from state and metropolitan area cancer registries revealed that incidence rates for all cancer sites increased between 1975 and 1992 and then dropped between 1992 and 1995, lead author Dr. Hannah K. Weir, from the Atlanta-based CDC, and colleagues note. Rates stabilized between 1995 and 2000.

The apparent stability in this most recent period was actually the result of two divergent trends, the researchers note. Although the incidence of lung cancer among men continued to fall, this trend was offset by a rise in new cases of breast and prostate cancer.

Death rates from all cancer sites started  
(continued on page 5)

## **THE OUTDOOR CHANNEL PARTNERS WITH Us Too! TO FIGHT PROSTATE CANCER**

The Outdoor Channel, a subsidiary of Outdoor Channel Holdings, Inc., and *Us Too! INTERNATIONAL* announced today a commitment to join forces in the war against prostate cancer. Executives from both organizations met to lock in the agreement at The National Conference on Prostate Cancer held in September in Burbank, California and release the news on the first day of National Prostate Cancer Awareness Week.

Based in Temecula, CA, The Outdoor Channel is a national cable network



dedicated to providing the best in traditional outdoor programming to America’s sixty million anglers and hunters. The Outdoor Channel is available to nearly sixty million homes in the U.S. through a combination of cable networks and satellite providers. The network recently announced its launch to an international audience, reaching nearly eight million homes in Latin America. For more information, visit The Outdoor Channel’s web site at [www.outdoorchannel.com](http://www.outdoorchannel.com).

The partnership calls on The Outdoor Channel to lend its resources in an  
(continued on page 8)

## **BROTHERS, NOT FATHER, HAVE MORE AFFECT ON PROSTATE CANCER**

Men are more at risk for prostate cancer if their brother — rather than their father — has the disease, according to new research. Researchers say this new finding may suggest that the risk is related to shared environmental factors like diet.

Led by Deborah Watkins Bruner, Ph.D., at Fox Chase Cancer Center in Philadelphia, researchers analyzed 23 published studies. They found an increased risk of prostate cancer for men with a family history, but if the affected family member was a brother, the risk increased nearly threefold. Links between first-degree relatives (father, son or brother) and second-degree relatives (a grandfather or uncle) were examined to see which relationship posed the greatest risk. Researchers found the risk increased 1.8 fold when the affected relative was a second-degree family member and 2.1 fold when the relative with prostate cancer was a father.

Bruner says, “Unlike the maternal-child pattern we see with inherited breast cancers, a brother with prostate cancer was associated with a significantly increased risk of the disease compared to a father or any other relative with the disease.” In addition to the environmental factors, she theorizes the age of onset of the disease may reveal a stronger genetic risk. Although more research is needed, she says a combination of genetic and environmental factors likely contribute to increased risk.

Bruner also says, “We need to assess the risk of disease associated with younger age [less than 65 or 70 years] of onset, dietary habits and lifestyle behaviors that may interact with inherited genes to increase prostate cancer risk.”

Source: *International Journal of Cancer*

## PROSTATE CANCER NEWS YOU CAN USE

Us Too! publishes a FREE e-mail based news service which provides updates on the latest prostate cancer related news. To subscribe or link to the archives simply visit the Us Too! Website: [www.ustoo.org](http://www.ustoo.org)

News items contained in Us Too! publications are obtained from various news sources and edited for inclusion. Where available, a point-of-contact is provided.

All 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 upon any course of action.

## RESEARCHERS ORGANIZE PROSTATE CANCER INTO GENETICALLY DISTINCT CATEGORIES

Daniel J. George, MD  
Veritas Medicine

With over 180,000 new cases of diagnosed each year, there is an enormous number of men with prostate cancer. But is it all the same disease?

The natural history of prostate cancer has taught us that a subset of men - roughly 30,000 each year - will die from this disease, despite our best treatment efforts. Another subset - perhaps as many as 90,000 cases each year - may be incidental and pose minimal risk to the patient. Why then do we classify all these cancers by the same name?

The Gleason score, or grade of prostate cancer, has been the most successful method to date for sub-classifying the disease. The Gleason score, however, is not based upon any molecular or genetic markers in prostate cancer. In this month's issue of the journal Cancer Research, investigators at the Dana-Farber Cancer Institute published an attempt to sub-classify prostate cancers by their genetic makeup. A technique known as single nucleotide polymorphisms, or SNP mapping, allows researchers to create a genetic fingerprint of tumors. Cancers with similar fingerprints are clustered together to create an overall genetic map.

The efforts of the Dana-Farber team represent one of the first to genetically sub-classify prostate cancer, but more work still needs to be done to get a complete picture of the different types of prostate cancer. The SNP mapping technique is likely to improve with greater technological breakthroughs, and the general principle of classifying tumors according to their genetic profile has been validated in other diseases such as lymphoma. Ultimately, a more accurate classification of prostate cancers should lead to treatments customized to certain types of prostate cancer, and perhaps target therapy more effectively.

*Reference:*  
ME Lieberfarb et al. Genome-wide Loss of Heterozygosity Analysis from Laser Capture Microdissected Prostate Cancer Using Single Nucleotide Polymorphic Allele (SNP) Arrays and a Novel Bioinformatics Platform ChipSNP. Cancer Research 63, 4781-4785 (2003).

## TREATMENT OF ORGAN CONFINED PROSTATE CANCER WITH THIRD GENERATION CRYOSURGERY: PRELIMINARY MULTICENTER EXPERIENCE

Han KR, Cohen JK, Miller RJ, Pantuck AJ, Freitas DG, Cuevas CA, Kim HL, Lugg J, Childs SJ, Shuman B, Jayson MA, Shore ND, Moore Y, Zisman A, Lee JY, Ugarte R, Mynderse LA, Wilson TM, Sweat SD, Zincke H, Belldegrun AS.

J Urol. 2003 Oct;170(4):1126-1130

### SUMMARY:


**PURPOSE**  
Cryosurgical ablation of the prostate is 1 approach to the treatment of localized prostate cancer. Third generation cryosurgery uses gas driven probes that allow for a decrease in probe diameter to 17 gauge (1.5 mm). The safety, morbidity and preliminary prostate specific antigen (PSA) results of 122 cases are reported.

**MATERIALS AND METHODS**  
A total of 106 patients have undergone percutaneous cryosurgery using a brachytherapy template with at least 12 months of PSA followup. Immediate and delayed morbidities were evaluated. PSA results at 3 and 12 months were recorded, and failure was defined as the inability to reach a nadir of 0.4 ng/ml or less.

**RESULTS**  
Complications in patients undergoing primary cryosurgery included tissue sloughing (5%), incontinence (pads, 3%), urge incontinence/no pads (5%), transient urinary retention (3.3%) and rectal discomfort (2.6%). There were no cases of fistulas or infections. Postoperative impotence was 87% in previously potent patients. For patients who underwent salvage cryosurgery there were no fistulas reported and 2 (11%) patients required pads after salvage cryosurgery. A total of 96 (81%) patients achieved a PSA nadir of 0.4 ng/ml or less at 3 months of followup,

(continued on page 8)

THE Us Too! PROSTATE CANCER HOT SHEET IS MADE POSSIBLE BY AN UNRESTRICTED EDUCATION GRANT FROM



THE INFORMATION AND OPINIONS EXPRESSED IN THIS PUBLICATION ARE NOT ENDORSEMENTS OR 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.

**Us Too! HEADQUARTERS STAFF**  
JOHN A. PAGE, FHIMSS, PRESIDENT AND CEO  
PAMELA BARRETT, DEVELOPMENT DIRECTOR  
JACQUELINE KONIECZKA, OFFICE ASSISTANT  
CRAIG KUREY, DIRECTOR OF OPERATIONS  
MARY BETH MICCUCCI, CHAPTERS COORDINATOR  
DOROTHY WIENCEK, PATIENT INFORMATION ASSISTANT  
5003 FAIRVIEW AVENUE - DOWNERS GROVE, IL 60515  
PHONE: (630) 795-1002 / FAX: (630) 795-1602  
WEBSITE: WWW.USTOO.ORG  
SUPPORT HOTLINE (OUTSIDE CHICAGO) 1-800-80-US TOO!

**Us Too! BOARD OF DIRECTORS:**  
LEWIS MUSGROVE, CHAIRMAN  
RUSS GOULD, VICE CHAIRMAN  
JOANN HARDY, SECRETARY  
JIM KIEFERT, EDD, TREASURER  
JOHN A. PAGE, FHIMSS, PRESIDENT AND CEO

**DIRECTORS:**  
GREGORY BIELAWSKI  
RONALD W. FABRICK, DDS  
ROBERT HUSTEAD, MD  
DON LYNAM, PHD  
DANNY PARKER, PHD  
HARRY PINCHOT  
JOE PIPER  
JAMAL RASHEED  
CHARLES SELDEN



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.  
COPYRIGHT 2003, Us Too! INTERNATIONAL, INC.

## WHAT EVERY DOCTOR WHO TREATS MALE PATIENTS SHOULD KNOW

*Stephen B. Strum, MD*

Prostate cancer diagnosis clinical practice guidelines:

Every man should have an annual PSA and DRE starting at forty years of age. Men at risk due to family history of prostate cancer (brothers, fathers, uncles), men with family history of breast cancer (mothers, sisters, aunts) and black men should begin annual screening at age 35.

A PSA of 2.0 and over at any age should be investigated to rule out prostate cancer (PC).

A first step in investigation of PSA's elevated at 2.0 and above should be a free PSA percentage test.

- A free PSA percentage of over 25% is associated with a low risk of prostate cancer.
- A free PSA percentage of under 15% is associated with a higher risk of prostate cancer.
- A benign cause of an elevated PSA and a correspondingly low free PSA percentage would be prostatitis. Four to six weeks of Cipro or similar antibiotic should be prescribed prior to recommending a biopsy if prostatitis symptoms are noted or if expressed prostatic secretions (EPS) are consistent with prostatitis.
- BPH (benign prostate hyperplasia) does not cause a low free PSA percentage. It may cause an elevated PSA, however. So in the case of an elevated PSA but a high free PSA percentage, an estimate of gland volume by DRE or a transrectal ultrasound of the prostate may reveal findings consistent with a diagnosis of BPH.

Blood sampling for PSA determinations, done at least three months apart, and by the same

laboratory using the same testing procedure, are necessary to establish PSA velocity (PSAV) and PSA doubling time (PSADT).

- A PSAV that exceeds 0.75 ng/ml/yr is associated with a higher probability of PC.
- A PSADT of less than 12 years is associated with a higher probability of PC.

PSA's that bounce up and down are more indicative of benign processes than malignant processes.

PSA's that show a persistent rise over time, particularly three consecutive rises, three months apart are suspicious for prostate cancer regardless of the level of the PSA.

Gland volume in cubic centimeters (cc) multiplied by 0.066 yields the amount of PSA produced by a normal, non-malignant gland. Any amount of PSA in excess of this should be considered to be produced by a malignant process until proven otherwise.

### Pussycats vs. tigers:

Pussycats in general, have low PSA values (under 10) and long doubling times, as well as low PSA velocities. If a biopsy is done on a patient with a PSA that is under 10, the Gleason score often turns out to be (3,3). Depending on the calculated tumor volume, T-stage and other factors, many of these patients may be candidates for objectified observation as well as for any of the currently FDA approved local therapies. Patients who choose to monitor their disease status rather than seek immediate local treatment need to be vigilant and need to be aware that if disease progression is evident, they may need to consider a form of local treatment before the window of opportunity for successful local treatment slams shut.

Tigers in general, have high PSA's (over 10) OR very low PSA's associated with very aggressive, high Gleason score cancers. These are very dangerous because they often escape investigation for long periods of time since the PSA's appear to be in the so-called normal range. Investigating all PSA's 2.0

and over will help to catch these prostate cancers while they are still organ-confined and treatable with local therapies. The probability of spotting these low PSA/high Gleason score cancers is enhanced if patients and doctors monitor PSA levels over time to note any persistent increases even if the PSA is very low. High Gleason score cancers often have reverted to such a primitive state that they no longer secrete PSA into the blood. Therefore, in cases such as this, the normal guidelines for PSA velocity and doubling time may not be applicable.

### SELECTED RESOURCES FOR PHYSICIANS AND PATIENTS:

#### On the Web:

The Prostate Cancer Research Institute (PCRI) web site at [www.pcri.org](http://www.pcri.org). This site has a wealth of information including the Prostate Cancer Address Book listing expert prostate cancer physicians, software tools, and articles and the newsletter INSIGHTS.

The Phoenix5 web site at [www.phoenix5.org](http://www.phoenix5.org) This is a vast resource for the prostate cancer student, with information on nearly every aspect of the disease as well as an excellent glossary, many first person stories and the prostate cancer journal of the webmaster who died of prostate cancer in June, 2003.

*Us Too! INTERNATIONAL* – Prostate Cancer Education and Support website at [www.ustoo.org](http://www.ustoo.org) The world's largest independent, charitable network of education and support groups for men with prostate cancer and their families.

#### In print:

*"A Primer on Prostate Cancer, The Empowered Patient's Guide"* by Stephen B. Strum, MD and Donna Pogliano, copyright 2002. Available through *Us Too!* for \$20 (plus \$5 s&h) through the *Us Too!* website or by calling (317) 558-4858 and at web booksellers and fine bookstores everywhere. Everything you ever wanted to know about prostate cancer.

## AFRAID I HAVE BAD NEWS... TWELVE STEPS TO HANDLE A DISTURBING DIAGNOSIS

By Elizabeth Austin

*AARP Magazine - May-June 2003*

It's the bombshell everyone dreads. The doctor calls and asks you to visit so you can discuss your test results. Your biopsy has come back positive. Or your EKG is abnormal. Or your blood test revealed something questionable. Without warning and without preparation, you're suddenly battling a serious health problem.

What happens next? That depends partly on your individual situation. A cancer scare will bring one set of challenges and choices, and a life-threatening heart ailment will bring others. But experts say there are basic steps that all patients should take, no matter what illness they're facing. This 12-step plan will help you get the best possible care—and the greatest chance for a quick, successful recovery.

1. Start building your team. Don't try to get through this battle alone. Ask at least one trusted person to be your full-time advocate who can accompany you to doctor appointments, says Joni Rodgers, author of *Bald in the Land of Big Hair*, a memoir of her battle with lymphatic cancer. "You need someone who is objective and isn't going to hear just what they want to hear," she explains.

"Your best choice is someone who is not excitable or confrontational and who is good at taking notes," adds Marsha Hurst, Ph.D., director of the health advocacy program at Sarah Lawrence College in Bronxville, New York. If your sister gets hysterical, or your husband's ears hear only good news, ask a friend to step in.

You'll also need to designate an information manager, someone to return the 20 daily phone calls you'll soon be getting from concerned friends and relatives—or those half-forgotten acquaintances who want to hear all the gory details. Don't be timid about ducking out of distressing conversations. A good escape speech: "Although it means so much to me that you're interested, I'm not always able to talk about this. But I'll promise to keep you updated." Then give the friend's number to your information manager.

Call in outstanding favors when asking people to help; if you fed someone's goldfish for a week in 1982, that counts. "The definite skill that every survivor cultivates is the ability to assemble a team they can rely on," says Rodgers.

2. Don't let a gung-ho doctor rush you. Sometimes speed saves lives. When Rodgers was diagnosed with advanced cancer, her life depended on getting immediate treatment (starting the next day). "I had to depend on doctors to make a good decision in that moment," she explains. But whenever possible, take a few days, or even a couple of weeks, to ponder all your options—including the ones your physician may not know about. This is especially hard after you get hit with a diagnosis, and you're anxious. "I felt like I had a roach on me—get it off, get it off!" admits Rodgers. But jumping in to treatment too quickly—and without taking all of the steps outlined in this article—can lead to regret.

3. Take a hard look at your primary care doctor. If you've got a rare disease, the internist you've seen for years may be intrigued—but he's probably not the best physician to monitor your treatment. Make sure your doctor is up to speed on your particular condition. You can get the lowdown on him by calling your state board of medicine and checking his history and training at [www.healthgrades.com](http://www.healthgrades.com). Also, directly ask your doctor if he feels qualified to treat you, and if he regularly performs the surgical procedure you may need done. If he's not the expert you need, he should be happy to refer you to a specialist who's better able to handle your case, says Richard A. Wherry, M.D., a family physician in Dahlonoga, Georgia. "I never worry about losing control, because that's not what this is about." If he can't admit his limitations, consider changing doctors—if your insurance plan is flexible enough to allow this on short notice.

4. Invest 40 bucks in a microcassette tape recorder. This will allow you to record your talks with your doctor. "You can listen to it when you're not so upset and also let your family or other doctors listen to it," says journalist Curtis Pesmen, who wrote about his battle with colon cancer in *Esquire*. (Having a verbatim record can also help bring another doctor up to speed when you're looking for a second opinion.) Also, buy a heavy-duty, hard-to-lose notebook, and hand it over to your advocate during appointments. Don't even think about trying to write while

you're listening to a doctor talk about your life. "It's like trying to take notes while you're being attacked by a dog," Rodgers says.

5. Tap two brains. Don't hesitate to get a second opinion—and don't feel uneasy about telling your doctor you want one. "When one of my patients gets a second opinion, only two things can happen, and they're both good," says Wherry, who is also on the Board of Directors of the American Academy of Family Physicians. "Either I'm right, or the other doctor finds something I didn't diagnose and the patient comes out ahead." Let statistics encourage you: In about one in five cases, the second opinion yields a different diagnosis, says Charles Inlander, president of the People's Medical Society, a consumer health advocacy group in Allentown, Pennsylvania. And even if the second doctor agrees with the diagnosis, she may have different ideas for the best treatment.

A political tip: Don't ask for a second opinion from another physician in your own doctor's practice; they're not likely to contradict each other. A doctor who works with a different hospital, preferably outside your insurance network, is usually the most unbiased choice. (Many insurance plans will pay part of the cost of consulting a specialist outside your network.)

When you're investigating treatment options with each doctor, make sure you're getting the whole story. "Ask 'What is the most aggressive treatment, what's more conservative, and what are the points in between?'" Inlander advises. Then ask the specialist what he or she thinks is the smartest strategy and why. Follow up by asking whether your insurance company covers the other options. If it doesn't, ask why.

You're likely to wind up with some conflicting opinions, which isn't necessarily bad. Tell your primary doctor the options you're considering and ask for help in determining the risks and benefits of each. "I try to take it from the patient's perspective and ask, 'If you had a preference and the outcomes were similar, what would you like to do?'" says Wherry. "Ultimately, you're the one who has to make this decision."

If there's major disagreement, seek a tiebreaker. Some health insurance companies will pay for a third specialist, Inlander says.

6. Make hurried doctors listen. You'll likely encounter several doctors of different skills and temperaments during this journey. Remember that some of the best physicians are the worst communicators; prescription pads never talk back. To make her doctor listen, Rodgers practiced this line: "I need to say something, and if you promise to listen without interrupting, I promise to speak for 90 seconds or less." It's a surefire way to get silence. It sounds far more reasonable than "just two minutes"—which doctors hear as patient-speak for "a half-hour or so." And, if you're well-prepared, 90 seconds is enough time to say everything you need to say (the "Gettysburg Address" took scarcely longer than that).

7. Get educated, not distraught. Finding health news and research about your condition on the Internet can be helpful, but it can also be a source of misinformation and needless worry. To ensure you're getting reliable information, stick with websites backed by known organizations. A prominent one is MedlinePlus ([medlineplus.gov](http://medlineplus.gov)), a site jointly provided by the U.S. National Library of Medicine and the National Institutes of Health. Also, the site at [healthfinder.gov](http://healthfinder.gov) has links to more than 1,800 health-related organizations.

Offline, some hospitals and university medical centers offer well-stocked medical libraries, with librarians and research assistants to help patients wade through them. For example, the Stanford University Medical Center's Health Library offers free research help to anyone seeking information on an illness or treatment. "We walk through every patient's case individually and provide scientifically based medical information to help them make informed decisions about their health care," says the director of special patient services, Barbara Ralston. To reach the library, call 800-295-5177 or visit [healthlibrary.stanford.edu](http://healthlibrary.stanford.edu).

Don't hand your doctor a thick sheaf of medical journal articles and expect him or her to read them on the spot. Instead, Inlander suggests, use your research to create a list of half a dozen "talking points," and offer your doctor copies of your research.

8. Choose your hospital wisely. The closest hospital may be convenient, but it's probably a poor choice unless its staff has a great deal of experience in treating patients in your situation. You can get a

quick read on this by checking [www.healthgrades.com](http://www.healthgrades.com), and by calling the hospital and asking the medical director how often its doctors treat your condition. If you find that the closest qualified hospital is 500 miles away, ask your doctor if he can consult with the specialists there.

9. After checking in, shake some hands. "When you get into your hospital room, the first thing you should do is call and ask the hospital's patient representative to come up so you can introduce yourself," Inlander says. "If you encounter problems, that person is responsible for making it right." (Ask for the patient representative's number when you check in, or ask a nurse.) Your friendliness will pay off if you have a problem; the advocate knows how to intervene if the night staff keeps waking you up to take your sleeping pill, for instance.

10. Chat up the nurses. It could yield more than extra pillows. "They have terrific insider information," says Dr. Hurst. Not only can they make your stay more comfortable, they can give you important treatment advice, too. You may need to listen for code words; a nurse could lose her job for telling you she wouldn't let your surgeon cut her hair. But if you hear a hint that she thinks you'd be better off with another doctor, take it seriously.

11. Stay sane. The emotional stress of battling a serious illness can take a large toll on your mental health—and the stability of your relationships. Joining a support group and venting to others who have been in your shoes can help; just make sure they're an optimistic bunch. "You can learn from other people who have gone through this situation," says Inlander, "but avoid groups that don't give you positive vibes."

12. Be blissfully self-indulgent. When you're recuperating, forget about being the "perfect patient"—cheerful, brave, and attuned to everyone else's needs. Take all the slack that friends and family readily give you during this furlough, and don't feel guilty. Karma will come around. "The good news, if you can call it that, is that everything you go through will help you be part of someone else's support system six months or a year from now," says Pesmen, who—knock on wood—has been cancer-free for two years. "It's a small bonus at the end of a long, hard ride."

*Elizabeth Austin is an award-winning health writer in Chicago.*

## CANCER MORTALITY CONTINUES TO FALL

(continued from page 1)

to decline in 1994, the investigators state. Although men continued to experience a slight fall in death rates throughout the 1990s, women's rates essentially stabilized between 1998 and 2000.

Mortality due to lung cancer continues to drop among black and white men, while the rate of increase in death rates has slowed among women, the findings indicate. Death rates for cancer of the breast, prostate, and colon all continue to fall.

In a related editorial, Dr. M. J. Quinn, from the National Cancer Intelligence Centre in London, comments that "a principal strength of the report is that it provides a wealth of information on the cancer trends in terms of both incidence and mortality."

"The establishment in the US of state cancer registries, in addition to the high quality Surveillance, Epidemiology, and End Result (SEER) registries, is a major step forward in cancer control," Dr. Quinn adds.

## EARLY DETECTION REDUCES PROSTATE CANCER DEATHS

New research shows earlier detection and wide use of hormone treatment have driven down prostate cancer's death rates.

A British researcher said death rates dropped by one-third in North America and by 20 percent in Europe since 1990 among men aged 65 to 74.

Previous studies have demonstrated hormone treatment delays the progression of prostate cancer and makes patients feel better. The new study offers evidence that the approach can save lives.

Prostate cancer is most often driven by the male sex hormone testosterone. Therapy blunts the ability of the hormone to stimulate cancer cells.

The findings were presented September 22 at a European conference on cancer.

## Make YOUR Best Treatment Choice for Early Prostate Cancer

*Rachel Snyder - CancerSource*

"In the late 80s, we found it was men with prostate cancer who wanted the least involvement in making their treatment decision—" says Lesley Degner, RN, PhD, "how things have changed!"

Today most men newly diagnosed with early stage (localized) prostate cancer—cancer that has not spread outside of the prostate gland—will not be content with saying, "Yes doctor, whatever you think is best." The number of treatment choices has gone up, and the side effects can change a man's life. This will cause many men to get more involved and to seek more information in order to make the "best choice," as described by Donna Berry, RN, AOCN, PhD.

In interviews with CancerSource, Degner and Berry provided treatment decision-making advice for men with early stage prostate cancer. They each have more than 25 years of experience studying decision-making and the human response to cancer, and new research recently published.<sup>1,2</sup> Read what they have to say for help in making the best treatment choice for you.

### *The Diagnosis*

If a man has some of the symptoms of prostate cancer, a doctor or nurse will first ask questions about these symptoms. A physical exam and other tests will be done. If any of these test results suggest that cancer may be present, the doctor will order a biopsy of the prostate. A biopsy is the only sure way of knowing whether a problem is because of cancer.

It takes about a week for the biopsy results to come back. "Physicians have their own preferences and styles," says Berry. "Men should ask their physician before the biopsy how they will hear about the results, for example, 'Will you call me or will you let me know at my next appointment?'"

Men should start learning about

treatment options soon after their diagnosis. Many men find themselves shocked, "I have cancer?!" This can make it hard to take in all of the information. Many people feel like they need to make a treatment decision quickly so the cancer doesn't spread. "Men shouldn't feel rushed to make a treatment decision even if they or their family are feeling anxious about it," says Degner. "A lot of people, when they're diagnosed with cancer, think it's growing like a mushroom. While there are some tumors that are extremely aggressive and very rapidly growing, the majority of prostate cancer tumors have been there for a long time, it was just that they were undetectable."

If you can tolerate waiting and the doctor says it is ok (the tumor is not growing fast), try to slow the treatment decision-making pace down. "Think very carefully about what you're doing and look at all of the options," says Degner.

"With prostate cancer it's never a bad idea to get a second opinion, it's a good idea!" says Berry. "The treatments for prostate cancer are very diverse, so many men feel comfortable when they talk to different specialist." A man should consider a second opinion as soon as they hear the biopsy results.

### *Your Treatment Information and Discussion*

Before hearing about the different treatment options, the man should tell the doctor about himself. "What happens too often is we load the person up with information and we don't listen," says Berry. "The conversation should focus on what the doctor needs to know about the man so decisions can be framed around who the man is and how the treatment fits into his life."

Both Degner's and Berry's new studies showed how personalizing the treatment discussion and information could help a man with his decision. Degner's study<sup>1</sup> looked at 74 couples in which a partner was newly diagnosed with early stage prostate cancer. In counseling sessions, these men and their partners talked about what was most important to them at the time of diagnosis. For example, for some men sexuality after treatment was the most

important to them. So, these men were given information about treatment based on how it would affect their sexuality. After receiving individualized information, four months after diagnosis most men reported that they took on a more active role in making the decision and their partners took on less of a role than they thought they would, and everyone involved had lower levels of stress.

Berry's study<sup>2</sup> looked at 44 men who were within 6 months of a diagnosis of early stage (localized) prostate cancer. The study was to see how men came to "making the best choice" for treatment. The researchers concluded that men make "the best choice for me" based on the medical information they received from all sources (the first doctor, second opinions, Internet, friends, etc.), plus personal factors (their job, past experiences with cancer, etc.). "The health care team has to customize the education they give men based on who they are and what they do," says Berry, "it's not enough to just provide medical information."

You may have to start the conversation about yourself, don't depend on your doctor to do so. "At a minimum men should be talking about what they do for a living, for recreation, who they know that's had cancer and what are the stories they've heard about men with prostate cancer or other people who have had cancer," says Berry. "Men can make a decision based on misinformation if they haven't talked to their doctor about what they've heard and what their priorities are."

Berry recommends that you lead your doctor towards this discussion by saying, "Well, before I hear about the treatment options and outcomes, I would like to tell you more about myself because it has a lot to do with my decision." For example, "I have a job where I walk a lot in my work. It's really important that you know that I can't get to a bathroom on the job, and I can't afford to take too much time off after surgery." Knowing this information, when the doctor talks about incontinence (unable to control urine) he can personalize the information. Rather than saying, "Your chances of incontinence are 15 percent," he can say, "Your chances of incontinence are 15 percent, and if you had surgery you may have to be

prepared to take six months off of work to resolve this side effect.”

### *The Choices*

“Since there is no one best treatment for localized prostate cancer, most men are given the choice in treatment,” says Berry, “the doctor and the man must work together to decide.” Here is basic treatment information and questions that will help you successfully work with your health care team.

Common treatment options for early stage (localized) prostate cancer:

- **Surgery (called prostatectomy).** Surgical removal of the prostate and any remaining tumor.
- **Radiation Therapy.** X-rays used to kill cancer cells. External beam radiation is given outside of the body. Brachtherapy is done inside the body by placing radiation seeds into the prostate.
- **Watchful Waiting.** Monitoring or checking cancer that is growing slowly and will not do any harm for a long time, if ever.
- **Hormonal Therapy.** Lowers or blocks the male hormone, testosterone, to slow the growth of prostate cancer. This can be done by removal of the testicles, by giving an injection, or taking a pill.
- **Cryosurgery.** Kills cancer cells by freezing the prostate gland.

Most men are given the major treatment options of surgery and radiation, and they are usually told about watchful waiting. Whether the other options, such as cryosurgery or hormonal therapy, are discussed depends on the doctor. “It’s hard to imagine that someone who has spent 10 to 20 years learning to do surgery would say that surgery is not a good option,” says Berry. It is good to talk to doctors from various specialties and try to gather more information.

“In our research we have found that thousands and thousands of men, even if they’re not able to say it, want to know their chances of a cure and how far the disease has spread,” says Degner. “Write down your top questions before your discussion, and don’t leave without having them answered. If you can’t say them, give the doctor the piece of paper.”

Men should ask about the doctor’s record. For example, how much experience does the doctor have doing the treatment? Do they perform two or 100 a year? This will be a bigger issue in a small town or more rural setting. Men should also hear what the doctor’s outcomes are. For example, what percent of the men cannot control their urine after the surgery and what percent are able to be totally dry. “Physicians will often quote the literature,” says Berry, “but you don’t want a quotation of an unknown expert, you want to base your decision on the record of the physician whose office you’re sitting in.”

Men should ask about the treatment scheduling. How often do they have treatment, how much time does it take, how much follow-up will it require? They should ask who will work with them on making the treatment decision and after it is made. “These questions are important just so the man knows what the routine is going to be,” says Berry. “It’s not just the short term stuff that you have to think about,” says Degner, “make sure you also ask about the long term side effects.” For example, with prostate cancer, the most common are erectile dysfunction (cannot get a penile erection) and urinary incontinence.

“Often times you’re just focused on getting through the treatment, which is important,” says Degner. “But, most people go on and survive their cancer and live to die of something else. You don’t want to be living with the serious side effects of your cancer treatment for the rest of your life. But if you have to, it would be nice to know about it before you’re treated, so you can at least make the choice.”

### *References*

1. Davison BJ, Goldenberg SL, Gleave ME, Degner LF. Provision of Individualized Information to Men and Their Partners to Facilitate Treatment Decision-Making in Prostate Cancer. *Oncology Nursing Forum*, 2003 JanFeb;30(1):10714.
2. Berry DL, Ellis WJ, Woods NF, Schwien C, Mullen KH, Yang C. (2003). Treatment Decision Making by Men with Localized Prostate Cancer: The Influence of Personal Factors. *Urologic Oncology*, 2003, MarApr;21(2):93100.

## **Questions to ask about prostate cancer treatments**

### **If you are having treatment**

- What are my treatment choices?
- What are the expected benefits of each kind of treatment?
- What are the risks of each treatment?
- What are the side effects of each treatment?
- Are there new treatments or clinical trials that I should consider?
- What are my chances of being cured?
- How will we know if this is working?
- How will each treatment affect my daily life?
- What are the chances of the tumor coming back again?

### **Surgery**

#### **If considering surgery**

- What kinds of surgery can I consider? Which operation do you recommend for me?
- Will I need radiation after surgery?
- How will I feel after surgery?
- Where will the scars be? What will they look like?
- Will I have to do special exercises after surgery?
- When can I get back to my normal activities?

### **Radiotherapy**

#### **If you are having radiotherapy**

- What is the goal of this treatment?
- How will the radiation be given?
- How many treatments will I get? Over what period of time?
- When will the treatment begin? When will it end?
- How will I feel during radiation therapy?
- What can I do to take care of myself during therapy?

### **Hormonal Therapy**

#### **If you are having hormonal therapy**

- Why do I need this treatment?
- What drugs will I be taking? How often? For how long? What will they do?
- What can I do about side effects?
- If I need hormonal treatment, which would be better for me, drugs or an operation?
- How long will I be on this

## DOES SELENIUM REDUCE THE RISK OF DEVELOPING PROSTATE CANCER?

By Kathleen A. Wildasin

Results of a recent experimental study offer new insights into how dietary supplementation with a trace mineral might reduce the risk of prostate cancer.

David J. Waters, DVM, PhD, Director of the Gerald P. Murphy Cancer Foundation and Professor of Comparative Oncology at Purdue University, is leading a research team in the investigation of how selenium, a nutrient essential to the functioning of several metabolically important enzymes, inhibits the development of prostate cancer.

"Using elderly beagles to mimic 65-year-old men, we evaluated the effect of selenium on prostate cells in an appropriate context ... *in vivo* in an aging prostate gland," Waters said.

Although most information on the mechanisms of anticancer agents has been gleaned from studies using animal tumor models, studying prostate cancer in the laboratory has been hampered by the fact that only one non-human species, the dog, develops this cancer spontaneously and with appreciable frequency.

The research of Waters and colleagues complements the Selenium and Vitamin E Cancer Prevention Trial (SELECT), a study initiated in 2001 by the National Cancer Institute to evaluate whether selenium and/or vitamin E decreases the incidence of human prostate cancer. The largest prostate cancer prevention study ever undertaken, SELECT will evaluate more than 32,000 men during a 12-year period. The Gerald P. Murphy Cancer Foundation, a not-for-profit cancer research organization in West Lafayette, IN and Seattle, WA, is one of more than 400 sites in North America enrolling men into the SELECT Trial.

"In this study supported by the Department of Defense Prostate Cancer Research Program, we found that 7 months of daily oral supplementation, using the same form and dose of selenium currently being used in SELECT, significantly reduced the accumulation of DNA damage within prostate cells," Waters said.

In the February 5, 2003 issue of the *Journal of the National Cancer Institute*, the group also reported that daily selenium

supplementation was accompanied by a two-fold increase in prostate cell apoptosis. Apoptosis, an orderly process of cell death, can remove damaged cells from the prostate, which may lower the risk of cancer.

"Although several previous studies have shown that selenium can induce apoptosis in the cell culture laboratory, our results represent the most convincing evidence to date that DNA damage and apoptosis are selenium-responsive events within the prostate," Waters said.

Does this study provide evidence that selenium supplementation can be used to effectively treat prostate cancer?

"In our experiments, we studied the effects of selenium on the aging prostate gland prior to the development of prostate cancer," Waters said. "One should always use caution before concluding that an intervention that is beneficial in a prevention setting will also be beneficial for treatment."

Several scientists, including Waters, are actively investigating the effect of selenium on cancer cells in the laboratory. "There is still a lot about selenium's effect on the prostate that remains unknown to us," Waters conceded.

The long-term research goal of Dr. Waters' comparative oncology team is to accelerate the development and application of effective cancer prevention and treatment strategies that will benefit both people and pet animals who are at high risk of developing cancer.

For more information regarding this article, contact Kathleen Wildasin at [kwildasin@insightbb.com](mailto:kwildasin@insightbb.com)

For more information regarding research on selenium and prostate cancer, visit the Murphy Foundation website ([www.gpmcf.org](http://www.gpmcf.org)), under the section "About Selenium."

### SOURCES:

- (1) Personal communication (telephone, e-mail) with Dr. David Waters (May 2003).
- (2) Waters DJ, Shen S, Cooley DM, et al. Effects of Dietary Selenium Supplementation on DNA Damage and Apoptosis in Canine Prostate. *J Natl Cancer Inst* 2003;95(3):237-241.
- (3) Jennifer Warner, Selenium May Fight Prostate Damage. *WebMD Medical News*, February 2003.
- (4) Jodi Knapik, Aultman Hospital Enrolling Men in Prostate Cancer Prevention Trial. *Aultman News Press Release*, accessed May 7, 2003.

## Us Too! AND OUTDOOR CHANNEL PARTNERSHIP

(continued from page 1)

effort to promote awareness, education, prevention and treatment of the disease that will be newly diagnosed in more than 220,000 men in the USA this year. To this end, the International cable network will draw upon its reach to more than 60 million homes in the United States and Latin America.

"Every sixteen minutes someone dies of prostate cancer in this country alone," said John Page, President and CEO of *Us Too! INTERNATIONAL*. "This simply does not have to be. There are more effective treatment options today than ever before, and death from Prostate Cancer can be practically 100% avoidable if men simply take responsibility for their health and get tested annually to detect the disease early."

"Our viewers are mostly male, and men of an age ideal for early awareness and education of prostate cancer prevention," said Amy Hendrickson, Senior Vice President of Affiliate Sales and Marketing for The Outdoor Channel. "We believe this is one of the most effective and meaningful ways we can fulfill our responsibility to help better the community that we serve."

## POSITIVE MULTICENTER CRYO RESULTS

(continued from page 2)

while 79 of 106 (75%) remained free from biochemical recurrence at 12 months. A total of 42 (78%) low risk patients (Gleason score 7 or less and PSA 10 or less) remained with a PSA of 0.4 ng/ml or less at 12 months of followup, compared to 37 (71%) high risk patients. All patients were discharged within 24 hours.

### CONCLUSIONS

After a followup of 1 year 3rd generation cryosurgery appears to be well tolerated and minimally invasive. The use of ultrathin needles through a brachytherapy template allows for a simple percutaneous procedure and a relatively short learning curve. A prospective multicenter trial is ongoing to determine the long-term efficacy of this technique.