

# PROSTATE UPDATE

Jersey Shore Region-American Cancer Society:  
Grassroots News and Information"

## ***Latest News on Cancer, Health and Nutrition***

Man to Man is an educational, not-for-profit prostate cancer support program of the *American Cancer Society*. M2M does not dispense medical advice. Protocols discussed at M2M meetings are often based on anecdotal information. Please consult your physician before choosing any form of treatment.

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***"Act as if what you do makes a difference. It does." - William James***

### PROSTATE UPDATE

#### **TIP OF THE MONTH**

**If you are on Medicare:** It is always important to ask any new physician or medical facility if they accept Medicare.

Some hospitals have on their staffs doctors or anesthesiologists who do not accept Medicare. Make sure any hospital registration paper you sign specifies, Medicare only.

Some doctors are currently opting out of Medicare due to lowering reimbursements and lengthening payment times and the situation may worsen with government intervention in our healthcare system.

Whenever you call for an initial appointment with a new doctor, the first thing to ask is if he (or she) takes Medicare.

- Al Rosenberg

#### From the Editor

Autumn has arrived. It signals the end of those warm, sunny days of summer. To some it is the end, but to me it is the start of that next step. I think part of that comes from when I was a kid and starting a new grade in school. Perhaps the rest of that feeling takes root in my cancer experience. I had surgery for my cancer in September, 11 years ago. So that signals the start of my new life as a survivor. I found a new "normal", physically, and a fresh new attitude for the rest of my life. These past several months have seen a bit of controversy in our PCa business – the issue of screening and testing of men. That controversy still continues. It still strikes me as odd that

supposed “experts” still think we are over diagnosing and over treating. I guess some doctors and perhaps patients, not withstanding lawyers, still believe that diagnosis equals mandatory immediate treatment. Just because you know you have cancer, you still have to understand its aggressiveness and spread. Knowing that one piece of information, that it is there, is not sufficient to warrant immediate treatment. It scares me so much that these “experts” just don’t want us to even know if we have it. What we don’t know can kill us! If we wait for symptoms to show, it is probably too late. My dream for this new season beginning is that reason prevails over those “experts” and that better methods to understand the scope and aggressiveness of a man’s prostate cancer are found so we can separate initial detection from immediate treatment.

All of these arguments still explain things in the context of statistics. Statistics are nice, but need to be taken with a grain of salt. Please look at the statistical indications very carefully. For example, watchful waiting seems to be of value in the 10 year survival rates. What is not said is what happens afterward. That lack of analysis is due mostly to the fact that the researchers have not had a long enough time interval of data (survivors) enough to support a conclusion. The PSA test hasn’t been around long enough to assess its really long term impact. In my case, 11 years ago at age 48, I was looking for a much longer term survival than 10 years. So you can’t blindly apply the watchful waiting statistics to say that you will survive for 30 or 40 years, but that does not make their results wrong. There are limits to interpretation of the study results. Similarly, statements of broad sweeping statistical numbers on things like incontinence or recurrence have to be looked at carefully. The results of an individual doctor and the individual patient’s situation may differ dramatically from other doctors and the general statistics.

Having said all that, the results are flowing in that show a healthy lifestyle seems to produce healthy results. Your mom was right – eat your veggies! The Wellness Community had an excellent speaker on nutrition and PCa. In spite of that, I included a recipe for cupcakes! Wow, that takes guts!

Again, we have a slightly longer issue. There are some really good meeting reports plus some excellent technical articles. I hope you find something of interest in this issue and that it is not too long.

Now that the summer activities are winding down, it is a good opportunity to attend and give a little of your time at support groups. Let’s all do our part to help beat this disease!

As always, be sure to take some time to appreciate every day! Be well and take care! Enjoy the issue.

- Jeff Ozimek, Editor  
anjoz@verizon.net

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## Long Branch Support Group Meeting

October 1, 2009

By Bob Sherman

The Monmouth Medical Center US,TOO! support group met on Oct. 1. We had 16 attendees. Our guest speaker was Kathy deRenzy who is a Physical & Lymphedema Therapist.

Within her practice Kathy has treated many women for urinary and fecal incontinence but noticed men were not being treated. Upon the urging of a physician, she initiated a program geared toward men who have had prostate cancer treatment with incontinence issues. Kathy uses biofeedback and other exercises to help strengthen the pelvic floor muscles. One of the members of the group has had 5 sessions with Kathy and has gone from “flowing” to 90% back to normal and spoke very highly of her compassion and professionalism in his treatments. Kathy brought along a biofeedback computer to demonstrate how it works. Although just placed on an arm one could see the lines on the screen change due to muscle contraction and release. She also spoke about the Neotonus Chair, which has pulsing magnetic fields that generate pelvic floor contractions.

We discussed the fact that doctors do not prepare us patients for the possible side effects of prostate cancer treatment. As was discussed at the Prostate conference in Los Angeles, which I attended in September, the

statistics that some of the doctors put out there are flawed. Either they do not know how to measure the data or they don't care enough to follow up with patients after treatment. As we all know from our group discussions many men experience ED or some kind of Incontinence or both. Patients should be coached on penile rehabilitation and proper Kegels BEFORE TREATMENT!

We asked Kathy to come up with a protocol for teaching men to do proper strengthening and Kegel exercises so they can prepare for PCa treatment and perhaps have a better outcome. One of the main questions is how much each individual training a person needs and how long before treatment does treatment have to be started for the most benefit. Kathy can be reached at the Progressions Rehab Center in Neptune 732-776-4558.

We heard from Bob P, a new member who had open surgery this past summer, and his wife. He had a slow rising PSA. When it reached 4.2, a biopsy revealed 8 positive cores with Gleason 7 and 8. Bob's doctor at NYU had him see experts on the usual issues after surgery, including nutrition. Good going Bob's doc! More on Bob and his doc at the next meeting.

We also heard from Tony, a new member and physician who was diagnosed 11 years ago, now seeing a rise in PSA. Tony has done many years of his own research and has been dealing with Dr. Myers for most of that time. Although not a urologist Tony is an expert in his own right and hopefully can help with new men as they come along.

The Monmouth Medical Center PCa Support Group meets the first Thursday of every month at 7 PM until 9 PM in the Goldsmith Wellness Center on the 4<sup>th</sup> floor.

Members of the group who are not signed into the Long Branch Bulletin Board may do so by going to <http://health.groups.yahoo.com/group/LongBranchNJ-UsToo/> and clicking on "Join This Group!" Anyone with questions about signing in should contact Rich G. at [rguilfoy@monmouth.edu](mailto:rguilfoy@monmouth.edu).

## Toms River Support Group

September, 2009

By Al Rosenberg

### ***\*\*I HAD daVINCI ROBOTIC TWO WEEKS AGO AND I FEEL GOOD...But...***

Our newest surgery survivor, Bob F. announced to us that he recently had his cancerous prostate removed at Fox Chase Cancer Center in Philadelphia.

"Unlike the open radical prostatectomy, I didn't have to deposit any blood prior to my surgery because there was very little blood loss," said Bob. He went on to explain, "I had the daVinci robot-assisted laparoscopic method where the surgeon sits at a console some feet away from the operating table."

*>>>[EDITOR'S NOTE: I would like to interrupt this excellent story to clarify a misconception before it spreads too far. Not all open field radical prostatectomy surgeons require you to deposit blood prior to surgery! When I asked my surgeon, before doing my open field surgery 11 years ago, if I should do so, he said there was no need to, since his "patients don't bleed that much". He was correct; no blood was needed. As it turns out, the vast majority of blood loss comes from the neurovascular bundles that service the prostate and other nearby tissue. All methods of surgery to remove the prostate, open field, laparoscopic, and robotic, attack this issue the same way, by clamping off the bundles before removing the prostate. So, some surgeons do not need to replace blood afterward. Perhaps that is a measure of a surgeon's skill. Now, back to the story.... - Jeff ] <<<*

He said that several small incisions were made into which the camera and cutting instruments were placed. "The amazing part of it was I went home after one night in the hospital. My catheter was removed shortly after and they told me to get lots of exercise--mostly walking--and to urinate every two hours."

*Now for the but...* "This morning after urinating, I had a terrible pain in my lower abdomen." Then Bob explained, " I phoned the hospital and they told me it was a bowel spasm and it went away soon after, but I did see some blood for the first time."

Bob looked great and we were glad he came through the procedure well. "Yeah, I'm feeling okay now."

Then another but... Another twenty minutes into our meeting, Bob arose and announced, "I'm sorry I have to leave early, but I think I'm having another of those spasms," and he left us hoping that he would feel better soon.

### **"I HOPE THIS ISN'T A RECURRENCE!"**

We hope so too, Paul S. He was treated with external IMRT five years ago and his subsequent PSAs have always been flat lined around 0.7. "But earlier this year my PSA was 0.47 and last week it came back at 0.99," he said nervously.

We suggested that Paul not worry yet. because Post-radiation PSAs tend to bounce around for up to up to several years. Paul and his urologist will be closely monitoring those PSAs.

### **Tony's Still Fighting... HIS CANCER AND HIS DOCTOR!**

A fourteen year brachytherapy (seed implants) veteran, Tony M. had a recurrence a few years ago. He reminded us, "I never liked those damn hormones and Casodex and Avodart too. All those hot flashes and muscle pains, bouts of depression and my rising blood glucose. I think I'm gonna stop!"

So, although his doctor cajoled and sometimes threatened him, "Don't wait till it gets into your bones," Tony would take them for a while and then stop.

At 88 years-old, we wondered if Tony might be better off just enjoying the rest of his years without "those damn hormones." With his PSA in the low teens, maybe he could watch his doubling times to get a better hold of the aggressiveness. Heck, Tony might not get symptoms until he nears one hundred!

Anyway, Tony's two sons expressed a desire to have him around for awhile and asked him to reconsider taking the three month Lupron again since it did bring his PSA down and put his PCa on hold for the time being.

Tony remarked to us, "Since there are people who seem to want me around a little longer, I'll consider staying with the hormone

blocking and keep looking for ways to overcome those pesky side-effects!"

### **DOES BONE PAIN MEAN MY CANCER HAS SPREAD?**

That was the big question Murray L. had for his doc and so they scheduled a bone scan. After six years of diligently watching his diet on Watchful Waiting, or as he preferred, "Active Surveillance," Murray had been experiencing a series of rising PSAs.

He finally consented to hormone therapy, but lately had been getting some pain in his bones particularly lower back and pelvic area.

When he got the results of the bone scan, he was relieved and not too surprised that the scan was negative for metastatic activity, but showed a widespread arthritic condition to which he remarked, "What else could I expect at 89 years-of-age!"

### **JUST FINISHED 45 EBRT SESSIONS, NOW I WAIT...**

79 year-old Gene S. was diagnosed with PCa in March of this year after a 7.3 PSA and some BPH enlargement. He was put on Casodex and then a three month Lupron depot ostensibly to shrink his gland somewhat before his 45 sessions of EBRT which ended Sept. 1.

Gene claims to have had, "not much in the way of side effects, but the tiredness and fatigue is annoying." Now he's waiting three months for his first post-procedure PSA.

### **Twenty Months of Zoladex= WEIGHT GAIN, HOT FLASHES, MUSCLE SPASMS, INSULIN RESISTANCE , and now, I CAN'T PEE!**

Hank S. has been through the wringer since the VA discovered his PCa with a Gleason score of 9. While he was pleased that the Zoladex seemed to be working, he developed the usual series of complications that go along with hormone ablation.

Hank celebrated our 4th of July holiday in the hospital's Emergency Room after he realized he couldn't urinate...at all! "Maybe I drank to much beer," he quipped. In any case, they inserted a catheter and drained, "About a quart of suds." He is now self-catheterizing, "three times a day, whether I need it or not!"

At sixty four years, Hank has a positive outlook. "In just a few more months I'll hit sixty five and join Medicare. Then I can choose my own doctors. Oh boy!"

### **HOW HORMONE THERAPY WORKS**

At almost every one of our meetings, the subject of hormone therapy--and just how it works--arises. The following is a brief synopsis of how the major players in androgen blockade work.

The greatest source of androgens (testosterone) is the testicles. (LHRH agonists (Lupron, Zoladex, Trelstar etc.) alert the pituitary gland in the brain to signal the testicles to shut down androgen release almost completely.

But another source of androgens, albeit in small amounts, are the adrenal glands. The Lupron type agonists are most effective at "starving out" prostate cancer cells.

Anti-androgen drugs such as Casodex (bicalutamide) and Eulexin (flutamide) block androgens from attaching to receptors on prostate and prostate cancer cells.

Even at testosterone castrate level, LHRH agonists are not 100% effective and will usually "leak" some testosterone. For this reason, Casodex may be used together with Lupron to block the small amount of testosterone getting out from the testicles and adrenals.

The 5-alpha reductase drugs, Proscar and Avodart prevent the conversion of testosterone to DHT (dihydrotestosterone) which is a much more powerful hormone than testosterone. Each can be an added factor in bringing on and/or prolonging remission, especially in those men who have failed on Lupron alone, but this technique is still somewhat controversial.

Medical castration via LHRH agonists like Lupron have significant metabolic and cognitive side effects and the anti-androgens (Casodex, Eulexin) can cause painful breast swelling (gynecomastia). Unlike the previously mentioned agents, Proscar and Avodart have relatively minor side effects.

In hormone blocking therapy, Lupron alone may be used or combined with Casodex and is referred to as CAB2 (Complete Androgen Blockade). Proscar or Avodart may

be added to the mix and thus the therapy will be referred to as CAB3.

The LHRH implants are currently covered by Medicare and generic versions of the others are available.

*\*Beating Prostate Cancer: Hormone Therapy, Myers*

*\*Prostate Cancer Guide for Men, PC Foundation*

*\*Gerald Chodak, MD-Prostate Videos.com*

### **TO SCREEN OR NOT TO SCREEN...**

#### **That is the Question!**

*"Whether 'tis nobler in the mind\** to screen men for prostate cancer, or let them await the possibility of systemic disease and painful bony metastases, has become a pervading conundrum. And the opinions of top "prostate pundits" are as diverse as the forms of this cancer itself.

In its recent publication, *Cancer Facts & Figures 2008*, ACS has this to say: *"The American Cancer Society (ACS) does not support routine testing for prostate cancer at this time."*

That position has been affirmed by ACS's chief medical director who writes, *"Prostate cancer screening has resulted in substantial over diagnosis and in unnecessary treatment."*

On the other hand, the ACS has recently announced that they have teamed up with Meridian Hospitals to offer their Man to Man prostate cancer support groups at Meridian's Ocean Medical Center.

Now, in the latest Meridian quarterly publication the following announcement appears:

#### **Prostate Cancer Screening**

Screenings will be offered to men ages 40 to 75 who are not under the care of a urologist. Screenings are conducted by certified urologists and include a physical exam (DRE) and PSA blood test. **FREE\***.

Talk about ambiguity. And what if you're older than 75? In his July issue of Prostate Forum Dr. Charles Myers has an interesting angle on PSA screening for older men, which we hope the President's new health care study panel doesn't see.

*"If you look at the number of years saved, rescuing the life of an infant can provide an additional 70 years of life. The older you are, the fewer years of life are saved by*

rescuing you. Since prostate cancer happens to men largely after age 50, the number of years saved is small compared to other diseases.

Another way to look at it is to examine productivity lost when someone dies. If you save a life of someone just entering the workforce, you retain a lifetime of productivity...the death of someone who has retired involves no loss in productivity. In fact, you lose the cost of paying for their retirement."<sup>\*</sup>

Another viewpoint on testing was offered by Prostate Cancer Research Institute's director, Mark Scholz, M.D.: "whether or not to do PSA testing is not the issue; the issue is deciding what to do with the information the PSA provides."<sup>\*</sup>

One more point from oncologist, Stephen Strum, M.D.: "I am seeing a lot of young men with a diagnosis of PCa who should have been alerted to the diagnosis years earlier. This would serve to enhance the chance of OCD (organ-confined disease) as well as provide a possibility for altering the milieu factors to allow for an AOS (active objectified surveillance) approach."

<sup>\*</sup>Cancer Facts & Figures, ACS 2008

<sup>\*</sup>Prostate Forum, Vol. 11, Number 3

<sup>\*</sup>Journal National Cancer Institute, Aug.31, 2009

<sup>\*</sup>Meridian Healthways, Autumn, 2009

### **WHAT MY OWN UROLOGIST HAS TO SAY ABOUT PCa SCREENING!**

And finally, an observation from my own urologist; whom I recently visited. Dr. L. who has 30 years experience in the field originally treated and has been following up my own PCa case for eight years, "Before we had PSA, I saw many men who came to me with serious urinary symptoms, pain, even broken bones and spinal compressions and many of them died of prostate cancer. Since we've been using PSA screening, I haven't had one man die directly related to prostate cancer."

So, be ready to "suffer the slings and arrows, and take arms against"<sup>\*</sup> those who would deprive our fellow men the opportunity of early prostate screening which may--in the long run--prolong their lives.

<sup>\*</sup>Hamlet, William Shakespeare, Act III, Sc I

**Toms River UsTOO® prostate support group** meets every third Thursday at 2 PM. We're located in Community Hospital's "Lighthouse" building at Rte 37 & Lakehurst Rd.

For more information and directions phone facilitator Larry Puccio at 732-349-2950 or you may contact him by email at [www.lpuccio1@comcast.net](mailto:www.lpuccio1@comcast.net). Walk-ins are always welcome!

**You can't afford to miss it!**

And don't forget...

◆**NO REGISTRATION!**

◆**NO DUES!**

◆**NO DEDUCTIBLES!**

◆**NO CO-PAYS!**

◆**NO PRESSURE...EVER!**

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## **Red Bank Support Group Meeting**

**August 13, 2009**

By Jay Lomberk

The meeting, chaired by Joan Toole, had a turnout of eight men and one spouse. One man, Bob, was a newcomer this month and recently had a radical prostatectomy. Most of the meeting was devoted to general discussion.

We started the meeting by reviewing the case of our new member. This gentleman, who is only 57, had a radical done in June of this year after a diagnosis of PSA 5.3, 8 of 12 cores positive and Gleason scores of 6's and 7's. Because his PSA had risen quickly and he had significant tumor involvement, his doctors recommended a radical prostatectomy as soon as possible. Although he was operated on in June, he has not yet seen his operating room or pathology reports, so the group recommended that he get both of those reports. He is still experiencing perineal pain and some incontinence. Bob also mentioned a very helpful program he is participating in for incontinence called "Progressions" run by Jersey Shore Medical Center.

There were several members attending this month who also had surgery for their PCa and they were able to provide some good information and answer questions for Bob and

his wife. Two members who also had radical prostatectomies, Dick and Walt, have both had PCa recurrence since being operated on a number of years ago. Walt experienced a recurrence only one year after surgery and has gone on intermittent hormone blocking with good results. Dick also had a recurrence after his RP and is now doing a vitamin and supplement program recommended during his recent visit with Dr. Myers in Virginia. Dick has already seen a PSA drop after being on a program of 10,000 units of vitamin D3 per day. Another group member, Tom, who had robotic surgery 4 years ago, commented on his experiences and that he is now doing well with no recurrence. There was also some discussion as to the overall success/failure rates of RP and that the failure rates can be anywhere from 20 to 30 percent.

>>>[EDITOR'S NOTE: *This statistic, like most in this business, is highly dependent upon the specific patient's case and the doctor's skill. It may not be very representative of a person's prognosis. Each individual should discuss this possibility with his doctor before entering into any treatment. It is also important to discuss this matter after surgery with the doctor who treated you. At that time the doctor will have a comprehensive pathology report, which will provide him with a sound basis to determine the likelihood of the patient experiencing recurrence.* - Jeff ] <<< We also discussed what options are available if PCa returns in a patient who has had surgery. The more common treatments include salvage radiation and hormone blocking.

The group continued discussing the importance of vitamin D3 in fighting PCa. It was stressed that everyone should be tested for D3 levels (test is called "25 hydroxy vitamin D3") and then, if needed, begin doctor-recommended daily doses to get the levels to the desired range, preferably between 50 and 80 ng/ml.

Another regular member, Jack, who has not yet been diagnosed but who has been monitoring his PSA for a number of years, made his latest trip to Dr. Lee for another Color Doppler ultrasound. Again, nothing was found on the Color Doppler so no biopsy was taken. Jack has been to Dr. Lee in the past due to rising PSA (now in the 7-8 range) but nothing

has shown up on the Color Doppler scan so Dr. Lee has yet to see the need for a biopsy. Jack's PSA has fluctuated wildly for a number of years with no real explanation but he wisely continues to monitor it and see Dr. Lee periodically.

Thanks again to Bill "The Candy Man" for his contributions.

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## **Red Bank Support Group Meeting September 10, 2009**

By Jay Lomberk

The meeting, chaired by Joan Toole, had a turnout of seven men and one spouse. Most of the meeting was devoted to general discussion.

Unfortunately, several members at this month's meeting have recently been experiencing rising PSA following treatment so we devoted a good part of the meeting to discussing their cases and possible options. All had been treated a number of years ago (approximately 10 years or more). Art, who had been treated with intermittent hormone blocking for nearly 14 years is now back on hormone blocking and also considering radiation due to high PSA levels. Another man who had RP ten years ago has seen a rise from 0.1 to 0.3 in the last 2 years. He is also considering additional tests and exploring possible treatment options should that become necessary. Since this man is planning to be in Florida for the winter, it was suggested that he visit Dattoli Cancer Center in Sarasota. Dattoli is well known for his success with salvage radiation for men with PCa recurrence following surgery.

One of the men with rising PSA is also facing urinary issues as a result of surgery and has been investigating getting some form of treatment such as a bladder sling. The group discussed various options and how they work. This man also has obtained a DVD on the procedure, which he will bring in for the next meeting.

I reported having just seen a news article regarding a lawsuit filed which claims fraud in the study results for the new EPCA-2 prostate cancer test. This test has been under

development for a number of years by Dr. Robert Getzenberg, a researcher at the University of Pittsburgh and Johns Hopkins. The EPCA-2 blood test has been touted as being the next generation of diagnostics in prostate cancer screening. The article reports that the company funding the research, Onconome, Inc., is suing University of Pittsburgh and Dr. Getzenberg on the grounds that the study reports and success figures were falsified. The article can be found at the following link:

<http://www.psa-rising.com/blog/2009/09/onconome-sues-for-fraud-in-epca-2-prostate-test-case/>.

Bob discussed his experiences with using the "CELLECT" supplement program ([www.cellect.org](http://www.cellect.org)). He hasn't had sufficient time in the program to evaluate its effects yet although he reported that his vitamin D3 level had dropped somewhat after changing from his previous supplement program. We discussed the importance of vitamin D3 in fighting PCa. It was stressed that everyone should be tested for D3 levels (test is called "25 hydroxy vitamin D3") and then, if needed, begin doctor-recommended daily doses to get the levels in range, preferably between 50 and 80 ng/ml. Bob also mentioned that there could be some significant variations in the D3 tests from one lab to another. He mentioned that Quest labs have had problems with their vitamin D3 testing. Others such as LabCorp were fine.

Of course, no group meeting these days is ever complete without discussing that dreaded subject, "Health Care" or "Obama-Care" or whatever you want to call it. Much concern was expressed over what will happen with health care reform, especially as it applies to Medicare. Bob reported that Medicare reimbursement at Dattoli Cancer Center in Florida has already been reduced by 20% this year with another significant reduction expected for next year. And health care reform hasn't even kicked-in yet! Since many patients who go to Dattoli and other prostate cancer treatment centers are older men who rely on Medicare for their treatment, the effect on these centers could be devastating. This certainly doesn't sound like progress since things seem to be going in the wrong direction, at least for prostate cancer patients.

Bill raised a great question of "how does prostate cancer actually kill?". The general consensus was that prostate cancer kills when it escapes the prostate gland and metastasizes in areas such as bone or lungs. As most of us know, prostate cancer confined entirely in the prostate gland is virtually harmless. The trouble starts when it escapes and travels to other parts of the body. So the moral of this story is "get it early and do it right".

Thanks again to Bill "The Candy Man" for his contributions. The next meeting is scheduled for Thursday, October 8th, 3:00 PM, at Riverview Medical Center, Red Bank.

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## Neptune Support Group Meeting August 20, 2009

By Donald Blue and Rich Guilfoyle

Marc G. provided opening remarks. A total of 10 individuals including 2 wives attended the meeting. Marc G. made some remarks about the benefits of taking Vitamin D3. Dick G. told the group that he is taking part in Dr. Myer's Vitamin D3 study. Dick is currently taking 10,000 IUs of Vitamin D3 daily. He takes 5,000 IUs after breakfast and 5,000 IUs after dinner. Alcohol should be used sparingly and calcium levels in the body must be monitored when Vitamin D3 is taken at elevated levels. Dick said he hasn't noticed any bad side effects and his PSA level has gone down since he's been involved in Dr. Myer's study.

Marc's wife, Naomi reported that a group she belongs to is currently working on a new "Stand by Your Man, 12 Women in Support of a Cure for Prostate Cancer" calendar for 2010. Their 2009 calendar was very successful with 1500 calendars sold at \$18.00 per unit. The funds are being used by the sponsor, the Prostate Cancer Coalition of New Jersey (PCCNJ) to support programs benefiting men with PC. Naomi and Marc requested support for the new, 2010 Stand by Your Man calendar.

A DVD was shown titled, State-of-the-Art Treatments for Early Stage and Relapsed Prostate Cancer from the Prostate Cancer Research Institute's Prostate Cancer

Conference held 6-7 September 2008. The DVD segment shown was chaired by Dr. Stephen Strum. His topic was Suppressing Relapsed Disease. The segment contained a lot of good information that generated lively comments and discussion from the attendees. The same DVD will be available for continued viewing at our September meeting.

Don B. announced the Neptune PC Support Group's Application to the Neptune Board of Education (BOE) for continued use of the Midtown Community Elementary School for our meetings for the upcoming school year was approved. This was an important development because if the Application was not approved, the group would meet in one of Jersey Shore University Medical Center's community meeting rooms. The hospital setup would have worked but the location is not as convenient as the Midtown Community School plus it does not have the school's hi-tech A/V capabilities. Don B. will send a thank you note to the Jersey Shore POC, Shirley T. who obtained an OK for our group to meet in the hospital in case our Application to the Neptune BOE was not approved.

August UsToo International Hot Sheets were not available in time for the meeting. Beginning in September, Hot Sheets will be mailed to Don B. for distribution at future meetings.

The remainder of the meeting was used for general discussions.

Marc Gordon, Rich Guilfoyle, Don Blue and Jim Allen.

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## **Neptune Support Group Meeting September 17, 2009**

By Donald Blue and Rich Guilfoyle

Marc G. provided opening remarks. He gave an update on Frank R., one of the founders of the Neptune PC Support Group. Frank has had some health issues recently but his current condition is stable. Frank is very knowledgeable on all topics dealing with PC. He was very helpful to members of our group. He helped Don when he joined the group back in 2003. Frank has relocated from Pennsylvania to Florida. We wish Frank and

his family well. Eleven individuals including 2 wives attended the meeting. Marc G. made some remarks about the benefits of taking Vitamin D3. He said he would bring data on Vitamin D3 to our next meeting. Dick G. gave a follow-up his participation in Dr. Myer's Vitamin D3 study. Dick said he hasn't noticed any side affects and his PSA level has gone down since he's been involved in Dr. Myer's study. James H. also expressed satisfaction with Vitamin D3.

Marc's wife, Naomi gave an update on the 2010 edition of the Prostate Cancer Coalition of New Jersey (PCCNJ) Stand By Your Man Calendar. She had a 2010 calendar for members to review. Several members expressed an interest in purchasing calendars from Naomi. The price is \$20.00 each. The funds from sales will be used to support programs benefiting men with PC. Naomi and Marc requested continued support for the new, PCCNJ 2010 calendar.

A DVD was shown titled, State-of-the-Art Treatments for Early Stage and Relapsed Prostate Cancer from the Prostate Cancer Research Institute's Prostate Cancer Conference held 6-7 September 2008. The DVD segment shown was chaired by Dr. Verne Varona. His topic was, "A Diet for Stopping Cancer Growth". The segment contained a lot of good information concerning the effects of diet on PC. The benefits of a whole food diet vs. a diet based mainly on food products were thoroughly covered. He recommended that sugar, alcohol and "nightshade" vegetables be reduced or avoided in order to lessen the chance for inflammation. Nightshade vegetables include white potatoes, tomatoes, eggplants and paprika. Note: tomatoes have a proven record of being a healthy food so the negative nightshade issue is questionable. Some foods that are anti-inflammatory include; fish, fruits, whole grains, green tea, almonds and walnuts. Although the information on tomatoes is counter to previously stated benefits, the DVD segment was very informative.

The meeting was the first one held in the Midtown Community Elementary School (MCES) under the Neptune Board of Education's agreement for our group to meet in the school from September 2009 to August 2010. Everything went OK except there was a

minor disconnect due to a scheduled Parent Teacher meeting/open house. The meeting caused parking to be very tight. We also had to use Don's DVD player to view the Us,Too! DVD. Don reported that our Jersey Shore Medical Center POC, Shirley T. is no longer employed at Jersey Shore. She has a similar but better position in one of the major hospitals in NYC. She said she would provide a Jersey Shore POC if we need any assistance from the hospital in the future. September 2009 Us, Too! International Hot Sheets were distributed during the meeting. Henceforth, Us, Too! Hot Sheets will be mailed to Don for distribution at future meetings.

The remainder of the meeting was used for general discussions. Our next meeting is scheduled for 7:00PM, October 22 at the Midtown Community Elementary School.

Marc Gordon, Rich Guilfoyle, Don Blue and Jim Allen.

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## **Freehold Support Group Meeting July 25, 2009**

By Harvey Yesowitz

Our July meeting was attended by 16 men and women. We viewed a DVD presentation by Dr. Mark Scholz, on the topic of "Suppressing Relapsed PC Without Blocking Testosterone" presented at the 2008 Prostate Cancer Conference sponsored by PCRI. Dr. Scholz discussed various medical approaches, including several new treatments still in trial or awaiting FDA approval. He emphasized that using multiple interventions simultaneously would likely effect a better result.

In the category of non-prescription drugs are several supplements or foods that can be added by each of us today. First is Pomegranate Juice, which has shown great promise in slowing the progress of PC. While the juice itself is high in sugar there are supplements that can be equally effective. Modified Citrus Pectin (MCP), made from the peels of oranges has shown the ability to increase PSA doubling time in several small studies. There are larger trials currently

underway that will clarify the usefulness of this supplement.

Leukine, which must be injected daily, supports the immune system in its battle against PC. It is more often used to stimulate a quicker recovery after chemotherapy but has been found to also slow the progress of PC when utilized during off periods from Hormone therapy.

A medication called CTLA4, still in trials, is believed to have a beneficial effect on metastases. Low dose Cytoxan has been shown to kill the harmful Regulatory T Cells with minimal side effects.

Celebrex, Thalidomide, and Avastin are administered for rising PSA numbers in relapse situations, and to extend "holiday" periods (off months from hormone therapy). They function by blocking VEGF.

VVAX, currently in trials, is comprised of two genetically modified prostate cancer cell lines and is a potential vaccine against prostate cancer.

Provenge, another drug that has shown some success against Prostate cancer, is still awaiting approval from the FDA. Protest groups have been complaining, even picketing, over the slow progress of the approval mechanisms. Provenge + Avastin is believed to be effective, against bone metastases in particular.

The use of zoledronic acid (Zometa) is beneficial in treating patients with bone metastases. It should be noted however, that a severe side effect known as necrosis of the jaw has been associated with use of this drug. In my own case I have my teeth cleaned 4 times/year in order to minimize the need for dental procedures that might result in the problems associated with Zometa.

One of our newer members brought his pathology report, which the group discussed, in detail. As always the members discussed their current status and shared their experiences.

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## **Freehold Support Group Meeting August 24, 2009**

By Chris Papa

Despite the lack of mailed meeting notification, eight men and two of their spouses turned up. They were rewarded by viewing the Charles "Snuffy" Myers, M.D., DVD presentation of "Treating Oligo-metastases". This signifies cancer, which has limited spread beyond the prostate and appears to offer the opportunity to halt its progression to more lethal disease.

Understanding why has led to the new concept that the target cells involved in development of life threatening disease are not the cells which secrete PSA and have androgen receptors, to which most attention has been hitherto paid, but rather the small population of prostate stem cells and their daughter tumor progenitor cells, which have completely different characteristics.

In most men who develop metastases the process is slow and gradual, not explosive, mainly because the stem cells only represent less than one-tenth percent of the tumor population. For men who have fewer than five metastatic lesions, usually bone or lymph gland, which are growing slowly, as measured by PSA doubling time (under 6 months), the chances of long-term survival are very good with available drugs, which seem to affect the stem cells and the tumor progenitor cells. There are problems with determining the extent of metastatic disease, since the usual bone scans only detect late stage lesions. Newer techniques using either a sodium fluoride PET scan or MRI have improved the detection of early lesions. Lymph node detection is an even larger problem and at present the best technique (Combidex) is only available in a single site in the Netherlands.

The presentation stimulated a great deal of spirited discussion by the assembled survivors and their spouses. It was a rather free flowing cornucopia of personal ideas, questions and advice, which was still progressing well beyond the time limit of the meeting. The latest member of the group, now attending his third session, is slowly learning and making progress toward coming to a better understanding of his particular situation, which is complicated by other serious medical problems. He has at least requested expert second opinion of his initial biopsy pathology report (3+3 Gleason) and was encouraged to

also get some imaging assessment. Our member who is regularly followed by MRI and PET scan at the Memorial Sloan Kettering facility in Basking Ridge volunteered to provide him with the information about who to contact.

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## **Freehold Support Group Meeting September 28, 2009**

By Chris Papa

Despite the fact that September 28 was the evening of a Jewish High Holiday, Yom Kippur, and local thunderstorms were a discouraging atmospheric feature, twelve men, three spouses and two guests were in attendance.

The DVD presentation from the 2008 Prostate Cancer Conference featured Dr. Richard Lam discussing "Chemotherapy Combinations". He explained the conditions of Standard Usage of such drugs for high grade malignancies and metastases and hormone refractory prostate cancer. Taxotere had been the first agent approved for prostate cancer, which was able to demonstrate prolonged survival, increased quality of life and pain relief for patients. Its side effects are primarily in the blood, reducing the red blood cells (anemia) and white blood cells (neutropenia), which can be corrected with appropriate therapy. Other significant side effects are on the GI tract, hair loss, tear duct stenosis, peripheral neuritis and fingernail changes. To improve its effectiveness, other agents, which have different properties, have been added to the taxotere. Thalidomide and Avastin, both anti-angiogenesis agents, have been used, either separately or in combination, since they work through very different pathways. Xeloda and Custersen also are current agents used in combinations, all of which seem to improve the outcomes, but introduce additional unique side effects of their own. The addition of vaccine therapy, such as the Dendreon or GVAX is also currently being studied.

Aside from "Standard Usage", "Other Settings" where chemotherapy is indicated includes high risk localized disease and high risk relapse disease. Protocols, which appear promising in these settings, include the use of

preoperative or pre-radiation chemotherapy, as well as the use of such agents prior to or concomitant with hormone therapy.

The evening's guests were from the American Cancer Society. Leonard Thomas, our liaison person, introduced Peter Mangola, R.N., a volunteer with many years experience as an oncology nurse, who will be assisting with support activities.

A new gentleman was diagnosed with high grade cancer (Gleason 8) three years ago at age 51 and had undergone a radical prostatectomy, only to have a recurrence, which was then treated with external beam radiation. The latter therapy has left him with radiation proctitis. He discussed the impotence, which followed prostatectomy and how various oral and injected medications have provided a degree of relief. He borrowed our group's recently acquired text on the subject, still in search of better results. He also benefited from the experiences related by some of our regular members who were, or are still, battling their own proctitis difficulties.

Our other "almost new" member, back for his third visit, is gradually learning more about how his low grade disease might be handled, particularly in light of some rather severe co-existing medical conditions. He had finally obtained an expert pathology second opinion on his biopsies, which confirmed that he had a 3+3 Gleason score with rather limited disease. He was again encouraged to now obtain some imaging of his prostate to augment this vital information and allow him to better make a decision regarding treatment for his individual needs.

Today the diagnosis of prostate cancer typically begins with an abnormal prostate-specific antigen (PSA) test or perhaps a worrisome finding on a digital rectal exam (DRE). But because an elevated PSA level can be caused by benign prostatic hyperplasia (BPH), prostatitis, as well as prostate cancer, there is a need for a more specific screening test. Now a report in the journal *Cancer Research* (Volume 68, page 646) suggests that a urine-based prostate cancer test may be the answer.

An experimental prostate cancer screening test that is performed on a urine sample may be more reliable than the traditional PSA test. In a recent study, researchers evaluated a group of biomarkers found in urine for their ability to detect prostate cancer. (A biomarker is a substance found in the blood or other body fluids or tissues that can be used to detect or monitor a disease or to determine the effects of treatment.)

The researchers examined seven biomarkers in urine samples from men scheduled for a prostate biopsy or radical prostatectomy. Then they correlated the results of the procedures with the presence of the various biomarkers.

Used together, four of the substances -- GOLPH2, SPINK1, PCA3, and TMPRSS2:ERG -- identified which men had cancer. The group of four biomarkers outperformed PSA testing in its ability to specifically identify prostate cancer.

The main problem with PSA testing is that an elevated PSA level may also be caused by benign prostatic hyperplasia or prostatitis. This lack of specificity in PSA testing often leads to unnecessary biopsies. Although early findings are promising, more research is needed to improve the performance of urine tests for prostate cancer. For now, doctors will continue to rely on the current PSA test.

Posted in Prostate Disorders on September 24, 2009

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## News and Good Stuff:

*Here is a very intriguing article. There may be hope for a way to better understand the presence and, maybe someday, aggressiveness of PCa. We can only hope!*  
- Jeff

### Johns Hopkins Health Alert Urine-Based Prostate Cancer Screening Test Looks Promising

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*Here is an article that Chris led me to. It shows some very promising information about the old "watchful waiting" approach. This*

*supports something we have been discussing a lot lately. It is not the initial early diagnosis of PCa that is the problem; it is not knowing the aggressiveness and current status of a patient's cancer that is the problem. WW may be a way to understand that better. It is certainly something that needs to be discussed with one's medical team. Keep in mind that this study relates to 10 year survival. What happens after that is not discussed here. Personally when I was diagnosed 11 years ago at age 48, I was hoping for a lot longer term survival than 10 years*

*-Jeff*

## **Outcomes With "Watchful Waiting" in Prostate Cancer in US Now So Good, Active Treatment May Not Be Better**

From Medscape Medical News

By Zosia Chustecka

September 16, 2009 — Outcomes have greatly improved in recent years for men diagnosed with localized prostate cancer who opt for "watchful waiting" or "active surveillance," and are now so good that this option of conservative management should be considered as a reasonable alternative to immediate treatment.

This is the conclusion from the largest study to be conducted in the United States since the advent of prostate-specific antigen (PSA) screening. The results appear in the September 16 issue of the *Journal of the American Medical Association*.

The study followed 14,516 men diagnosed between 1992 and 2002 for a median of 8.3 years. The results show a 10-year overall survival of 94%.

"This has never been seen before," lead author Grace Lu-Yao MPH, PhD, from the Cancer Institute of New Jersey in New Brunswick, told *Medscape Oncology*.

The researchers suggest that now that the survival rate with conservative management is so high, there may be little room for improvement from active treatment.

"This is an important paper," said Timothy J. Wilt, MD, MPH, professor of medicine and core investigator at the Minneapolis VA Center for Chronic Disease

Outcomes Research and the University of Minnesota School of Medicine, who was approached by *Medscape Oncology* for comment.

This study "reinforces accumulating evidence that the vast majority of men with prostate cancer detected by PSA testing have a very good prognosis and are unlikely to die of their cancer or suffer serious medical consequences from disease spread at 10 or more years, even if not treated with surgery, radiation, or hormone therapy," he said.

"This study also supports the view that many men are detected and treated who are unlikely to benefit, and thus may undergo harms that exceed benefits," he added.

## **Survival Rates Better Than Any Seen Before**

Dr. Lu-Yao and colleagues report a 10-year survival of 94%. Studies conducted in the pre-PSA testing era have shown 10-year survival rates of around 77% to 85%, she said in an interview, so these latest data suggest that there has been a reduction in mortality of around 60% to 70%.

The latest results are better than the 90% survival rate in a similar population of men treated with radical prostatectomy in the widely cited Scandinavian study (*N Engl J Med*. 2005;352:1977-1984), she noted. That study found a better survival after prostatectomy than watchful waiting, but it was conducted in a setting in which there is little PSA testing. Now that survival with conservative management is so high, it may be difficult — in the post-PSA era — to show an absolute benefit from surgery such as was seen in the Scandinavian study, the researchers write.

Survival rates have improved because PSA testing detects prostate cancer at a much earlier stage, Dr. Lu-Yao explained, but there have also been changes in the way that prostate cancer is classified, and this reclassification has also contributed. "Survival is getting better all the time," Dr. Lu-Yao said in an interview, adding that "doctors should share these new data with their patients."

"Ultimately, the decision of what to do lies with the patient," she acknowledged, but she added that "patients often overestimate the potential benefit from treatment and they

believe that surgery or radiation can save their life." They also often underestimate the potential risk for harm that can result from these treatments.

This has made it difficult to enroll patients into clinical trials in which patients are randomized to either active treatment or watchful waiting, she added. "Patients usually already have a strong opinion about wanting treatment," she said, adding that it can be difficult to explain to a patient just diagnosed with cancer that what appears to be "doing nothing" might actually be a good option.

These latest data "add weight" to this side of the equation, she explained. They show patients that if they do not opt for immediate treatment, their chance of dying from prostate cancer over the next 10 years is only 6%.

"Considering the favorable 10-year outcomes following conservative management, men with a life expectancy of less than 10 years may wish to consider an active-surveillance or watchful-waiting protocol as an alternative to immediate attempted curative therapy," the researchers conclude.

### **Difficult Now to Show Benefit From Active Treatment**

Dr. Wilt agreed with the researchers that now that survival rates with conservative management have been shown to be 94% at 10 years, it might be difficult to show any improvement from active treatment in the post-PSA era.

"Early intervention with surgery, radiation, or androgen-suppression therapy (hormones) might not have a large absolute impact on disease-specific survival," he said

This issue is being addressed in ongoing randomized clinical trials — PIVOT in the United States and PROTECT in the United Kingdom. These trials are evaluating overall and disease-specific survival and quality of life after early treatment and after conservative management in men with localized prostate cancer primarily detected with PSA testing, Dr. Wilt explained. The results should be available within the next few years.

In the meantime, however, the data from Dr. Lu-Yao's group and others "strongly suggest that many men with PSA-detected prostate cancer may be treated unnecessarily

with early interventions and face the risk of adverse effects, such as erectile, bowel, and urinary dysfunction, that can result in early and long-term negative impact on quality of life," he noted.

"It is very likely that men diagnosed currently and treated conservatively will have even better 10-year results," Dr. Wilt said, because PSA is now more widespread and picks up even smaller cancers. PSA testing (like all screening tests) is more likely to detect slower-growing tumors, and these screened cancers have a better long-term natural history than cancers detected in the absence of screening, even if no treatment is provided.

The men in this latest study were diagnosed between 1992 and 2002, which is considered to be "early-mid PSA era," he said, when PSA testing was just becoming widespread.

"PSA testing has now been widespread for many years. The threshold for calling a test abnormal and obtaining biopsy is currently at lower levels than previously. Many men now have had multiple PSA tests and even multiple biopsies prior to their cancer being detected. Additionally, the percent of men with cancer detected by PSA testing (rather than felt on a digital rectal exam) today is much higher (80%+), and the PSA levels in men detected today are likely much lower and the size of tumors smaller than those reported by Lu-Yao," he explained.

*The study was supported by grants from the US Army Medical Research Acquisition Activity, the Department of Defense, the Ohl Foundation, and the National Cancer Institute. Dr. Lu-Yao reports having received clinical research funding from the Ohl Foundation, the New Jersey Commission on Cancer Research, and the Agency for Healthcare Research and Quality, and is employed by HealthStat. Details of the financial relationships of her coauthors are listed in the paper.*

JAMA. 2009;302:1202-1209.

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*Here is another article that Chris led me to. It brings up an unpleasant effect of one of the weapons in the war on PCa. Please discuss this with your physicians before getting*

over concerned. I have also removed some pieces of the article in the interest of conserving space.

-Jeff

From Medscape Medical News

## **Hormone Therapy May Increase Risk for Death in Men With Prostate Cancer and Heart Disease**

By Nick Mulcahy

August 26, 2009 — In localized or locally advanced prostate cancer, the use of neoadjuvant hormone therapy was associated with a nearly 2-fold risk for death in men who also had a history of coronary artery disease.

This finding comes from a retrospective study of 5077 men who were treated with brachytherapy for their cancer, 30% of whom received neoadjuvant hormone therapy for a median treatment duration of 4 months.

The hormone therapy consisted of both a luteinizing hormone-releasing hormone agonist (leuprolide or goserelin) and a nonsteroidal antiandrogen (bicalutamide or flutamide).

On the bright side of the data, there was no increase in all-cause mortality among men treated with hormone therapy who had either no cardiovascular comorbidity or a single coronary artery disease risk factor, such as diabetes mellitus, hypercholesterolemia, or hypertension. Smoking and a family history of heart disease were not evaluated as risk factors.

The study was published in the August 26 issue of the *Journal of the American Medical Association*.

In an interview with *Medscape Oncology*, the study's lead author stressed that only 5% of the men in the study — a "small subgroup" — had coronary artery disease (congestive heart failure or past heart attack).

"Our results suggest that for these men, either hormonal therapy not be used in the treatment of their prostate cancer or their underlying heart disease be addressed by a primary-care physician and/or a cardiologist before they are considered for hormonal therapy," said Akash Nanda, MD, PhD, from Brigham and Women's Hospital and the Dana-

Farber Cancer Institute in Boston, Massachusetts.

Dr. Nanda acknowledged that it is not known if treatment for heart disease would improve outcome. "The study does not address whether or not treatment for coronary artery disease potentially changes the risk for these patients," he said. Dr. Nanda and his coauthors concluded that "this study should heighten awareness about the potential for harm with neoadjuvant hormone therapy in select men."

### **Study Details**

Several clinical trials have shown that adding hormonal therapy to radiation therapy in the treatment of aggressive prostate cancer leads to an increase in survival, observed Dr. Nanda. However, a recent analysis (*JAMA*. 2008;299:289-295) indicated that "this may not be the case for men with coexisting illnesses," according to Dr. Nanda. The purpose of the new study was to identify comorbidities that might affect survival.

To that end, the investigators looked at 5077 men with clinical stage T1 to T3 N0 M0 prostate cancer treated between 1997 and 2006 at the Chicago Prostate Cancer Center, a community practice in Westmont, Illinois. Men were referred to this center on the basis of their interest in or candidacy for brachytherapy. Among the men, 2653 (52.3%) had no history of a cardiovascular comorbidity, 2168 (42.7%) had a coronary artery disease risk factor, and 256 (5%) had coronary artery disease. The median age of the men was 69.5 years, and 555 (10.9%) had received supplemental external-beam radiation. Most of the men in the study (70%) did not receive neoadjuvant hormone therapy and served as comparators for the men who did.

Neoadjuvant hormone therapy use was not significantly associated with an increased risk for all-cause mortality in men with no comorbidity ... or a single coronary artery disease risk factor ... after median follow-ups of 5.0 and 4.4 years, respectively.

However, for men with coronary artery disease, the therapy was significantly associated with an increased risk for all-cause mortality (26.3% vs 11.2%; adjusted HR, 1.96;

95% CI, 1.04 - 3.71;  $P = .04$ ). These men had a median follow-up of 5.1 years.

In arriving at these findings, the investigators adjusted for age, treatment year, supplemental external-beam radiation therapy, treatment propensity score, and known prostate cancer prognostic factors (such as Gleason score). The authors also noted that, in other research in different settings, hormone therapy has been associated with a variety of adverse effects, including increased risk for cardiovascular death.

### **More on Clinical Significance**

Dr. Nanda and his colleagues recommend that, in men with favorable-risk prostate cancer and a history of coronary artery disease, alternative strategies to brachytherapy and hormone therapy be considered. These include active surveillance, treatment with external-beam radiation alone, and prostatectomy. In such men, hormone therapy is not really needed to "maximize outcome" anyway, explained Dr. Nanda. Instead, hormone therapy is used to reduce the size of the gland, ensuring that brachytherapy is not obstructed by the arch of the pubic bone.

However, in men with unfavorable-risk prostate cancer, hormone therapy offers a survival benefit. "This is a tougher decision because hormone therapy is needed to maximize outcome," said Dr. Nanda. The risks and benefits of hormone therapy must be balanced; as noted above, appropriate medical evaluation or treatment is needed before hormone therapy is used in this setting, Dr. Nanda said.

Dr. Nanda also pointed out that the findings were limited to brachytherapy and, as a result, not necessarily generalizable to men with prostate cancer who are treated with external-beam radiation. "Other investigators will want to validate these findings in other settings," he said.

The authors also note that the duration and extent of hormone therapy are variables in need of study. "Men with locally advanced prostate cancer are frequently treated with 2 to 3 years of hormone therapy in combination with external-beam radiation therapy," they write.

*JAMA*. 2009;302:866-873.

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## **News From the American Cancer Society:**

Just a reminder that we also maintain an email list to distribute this newsletter. So, if you wish to receive this newsletter via email rather than as a paper copy, please let us know.

For good information, and the complete story about prostate cancer testing and treatment, go to the ACS website [www.cancer.org](http://www.cancer.org).

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## **News From the Wellness Community:**

On Monday, Sept. 21 at 6:30pm, our regular PCa support group hosted a special presentation on "Evidence-based nutritional strategies associated with reduced cancer risk" by Dr. Adria Rothfeld-Magenheim. There were about 15 men and 6 women in attendance. Dr. Rothfeld-Magenheim talked to us about a realm of prostate cancer prevention and treatment that is largely ignored but strongly supported by scientific documentation. A sense of frustration spurred her to search for prostate health promoting approaches to correct or blunt the effects relating to increased risk factors.

She started by discussing the new urinalysis test for PCa. It appears to have a better chance of determining that the PSA level is a result of cancer versus BPH or other reasons.

Dr. Rothfeld-Magenheim then discussed the roles of race and family history (genetics) and how to improve our chances against our genes using Nutrigenomics (the field of study of how different foods interact with specific genes to modify our risk of diseases including cancer). Her discussion explained the body's reaction to hormones, toxins, and stresses on our genes. She stated that the Journal of the National Cancer Institute recently presented a study and conclusion that a diet high in refined carbohydrates is associated with increased

tumor growth and with activation of signaling pathways distal to the insulin receptor in a model of prostate cancer. Dr. Rothfeld-Magenheim followed that line of reasoning and discussed insulin and insulin resistance. Her suggestions are to:

- Consume lower glycemic carbs such as whole grains and veggies (other than starches like corn, potatoes, beets, cooked carrots).

- Completely avoid refined flours and sugars as well as sodas and fruit juices.

- Limit caffeine.

- Use healthy Omega 3 oils to enable cells to better recognize insulin.

- Include a protein source at all meals.

- Do not go longer than 4 hours without a healthy snack.

- Have a good breakfast within an hour of awakening that includes protein.

- Include biotin, chromium (not picolinate), gymnema, cinnamon, and glutamine to help sensitize blood sugars and diminish cravings.

- Consume 25-35 grams fiber each day.

Dr. Rothfeld-Magenheim then proceeded to discuss body weight, the effects of inflammation, and free radicals. She sees that Americans now consume far too much omega 6 oils and far too little of the better omega 3's. Increasing the consumption of omega 3 fats while reducing omega 6 promotes an anti-inflammatory, anti cancer state in the body. This has been supported by the National Cancer Institute.

She also addressed the Vitamin D situation. Dr. Rothfeld-Magenheim cited several studies and reports that indicate blood levels of "25 OH Vitamin D" above 55 help prevent or reduce cancer.

She continued on to discuss the benefits of green tea, lycopene, cucumin, isoflavines, Vitamin E, zinc, antioxidants, and probiotics.

Dr. Rothfeld-Magenheim's excellent presentation was thorough and well supported by studies. Judging by the many questions and vibrant discussion, our audience was very involved. Hopefully we all learned something and will strive to do a better job fueling our bodies in the fight against cancer.

The Wellness Community facility is located in the Victoria Commons shopping area on Hope Road in Eatontown, NJ. It is

located less than a mile from the Garden State Parkway Exit 105 and RT. 18. Easy, plentiful parking is free. The location is close to the Monmouth Mall with some very good restaurants nearby. The group meets in a comfortable, home style, living room like atmosphere. The Wellness Community is not associated with any particular hospital and is exclusively focused on cancer survivors.

The Wellness Community Prostate Cancer Support Group meets the 3rd Monday of the month from 6:30-8:00pm. Come join us for a special, informative, and "supportive" session in very comfortable surroundings, and feel free to bring along your personal support team of family or friends, all are welcome. Call the Wellness Community for details!

The Wellness Community offers various educational, mind/body/spirit programs. Please call 732-578-9200 to receive the program calendar and to obtain further information. The Wellness Community offers various educational, mind/body/spirit programs. Please call 732-578-9200 to receive the program calendar and to obtain further information.

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## Nutrition:

*Well, after all the talk above about the benefits of good nutrition, I had to balance that with a cupcake recipe. At least it has healthy apples in it and cinnamon to help digest the sugars. After all, it is the apple season. Ya gotta appreciate life a little. Enjoy!*

*This comes from the folks at Eating Well magazine. Remember, this is © 2009 Eating Well Inc. Reprinted by permission from EatingWell, Where Good Food Meets Good Health. EatingWell delivers delicious, healthful recipes, cooking how-to and nutrition news for readers who are passionate about great-tasting food and lifelong healthy eating. For a sample issue of EatingWell magazine, visit [www.eatingwell.com](http://www.eatingwell.com) or call toll-free 1-800-337-0402.*

*-Jeff*

## Apple Cupcakes with Cinnamon-Marshmallow Frosting

From EatingWell: [September/October 2009](#)

Shredded apple replaces some of the oil and keeps the cake moist in these cinnamon-spiked cupcakes. There is a generous amount of fluffy marshmallow frosting to mound or pipe on top for a festive look. Be sure to frost them right after you make the frosting—it stiffens as it stands and becomes more difficult to spread.

### 12 cupcakes

**Active Time:** 1 hour, **Total Time:** 2 1/2 hours

### Ingredients:

Cupcakes:

- 1 1/2 cups shredded peeled apples
- 1/2 cup diced dried apples
- 3 tablespoons packed light brown sugar, plus 3/4 cup, divided
- 1 teaspoon ground cinnamon, divided
- 1/3 cup canola oil
- 2 large eggs
- 1 teaspoon vanilla extract
- 3/4 cup whole-wheat pastry flour
- 3/4 cup cake flour
- 3/4 teaspoon baking soda
- 1/4 teaspoon salt
- 1/2 cup nonfat buttermilk

Frosting:

- 1 cup light brown sugar
- 1/4 cup water
- 4 teaspoons dried egg whites (see Note), reconstituted according to package directions (equivalent to 2 egg whites)
- 1/4 teaspoon cream of tartar
- Pinch of salt
- 1 teaspoon vanilla extract
- 1/2 teaspoon ground cinnamon, plus more for garnish

### Preparation:

To prepare cupcakes:

1. Preheat oven to 350°F. Line 12 (1/2-cup) muffin cups with cupcake liners or coat with cooking spray.
2. Combine shredded and dried apples in a bowl with 3 tablespoons brown sugar and 1/4 teaspoon cinnamon. Set aside. Beat oil and the remaining 3/4 cup brown sugar in a large mixing bowl with an electric mixer on medium

speed until well combined. Beat in eggs one at a time until combined. Add vanilla, increase speed to high and beat for 1 minute.

3. Whisk whole-wheat flour, cake flour, baking soda, salt and the remaining 3/4 teaspoon cinnamon in a medium bowl.

4. With the mixer on low speed, alternately add the dry ingredients and buttermilk to the batter, starting and ending with dry ingredients and scraping the sides of the bowl as needed, until just combined. Stir in the reserved apple mixture until just combined. Divide the batter among the prepared muffin cups. (The cups will be full.)

5. Bake the cupcakes until a toothpick inserted into the center of a cake comes out clean, 20 to 22 minutes. Let cool on a wire rack for at least 1 hour before frosting.

6. To prepare frosting: Bring 2 inches of water to a simmer in the bottom of a double boiler (see Tip). Combine 1 cup brown sugar and 1/4 cup water in the top of the double boiler. Heat over the simmering water, stirring, until the sugar has dissolved, 2 to 3 minutes. Add reconstituted egg whites, cream of tartar and pinch of salt. Beat with an electric mixer on high speed until the mixture is glossy and thick, 5 to 7 minutes. Remove the top pan from the heat and continue beating for 1 minute more to cool. Add vanilla and 1/2 teaspoon cinnamon and beat on low just to combine. Spread or pipe the frosting onto the cooled cupcakes and sprinkle cinnamon on top, if desired.

**Make Ahead Tip:** Store unfrosted cupcakes airtight at room temperature for up to 1 day. Equipment: 12 (1/2-cup) muffin cups

**Ingredient Note:** Dried egg whites are pasteurized so this product is a wise choice in dishes that call for an uncooked meringue. Look for brands like Just Whites in the baking or natural-foods section of most supermarkets or online at [bakerscatalogue.com](http://bakerscatalogue.com).

### Nutrition:

**Per cupcake:** 267 calories; 7 g fat (1 g sat, 4 g mono); 35 mg cholesterol; 48 g carbohydrates; 4 g protein; 2 g fiber; 188 mg sodium; 73 mg potassium.

3 Carbohydrate Serving

**Exchanges:** 1 starch, 2 other carbohydrates, 1 fat

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## CONTACT INFORMATION:

**Dr. Lee's location:** 1202 Walton Boulevard  
Suite 211 Rochester Hills, MI 48307  
Phone: 248-650-4699 Fax: 248-650-4696  
The location is on the North side of Walton, opposite Chrittenton Hospital, in a mall-like complex.

**Corporate Angel:** toll free line is 866-328-1313. Website: <http://www.corpangelnetwork.org/>

**National Cancer Institute's Atlantic Region Cancer Information Service:**  
Phone: 215-728-3110, Fax: 215-379-1369, Website: <http://www.cancer.gov>

**American Cancer Society:** Phone: 1-800-ACS-2345, Website: <http://www.cancer.org>

This newsletter is a compendium of prostate, health and nutrition news collected by a team of prostate cancer survivors. None of the editors or anyone associated with this newsletter receives any compensation in regard to this newsletter. It is truly a labor of volunteers.

The goal of this newsletter is to provide a "grass-roots" view to help educate and support prostate cancer patients and loved ones. We do not endorse a specific type of treatment or medication nor recommend a particular product to anyone; a person's physician should do this. We try to be as accurate as possible, and apologize if we misinterpret a speaker's statement, or make some other oversight. Unless noted elsewhere within this newsletter, you have our permission to copy and pass on this newsletter for that purpose. If you reproduce only a portion of the newsletter please be sure to credit its source. You may not charge a fee or sell copies of this newsletter.

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Anyone wishing to help support this newsletter should make a donation to Man to Man, at the American Cancer Society, 801 Broad Street, Shrewsbury, NJ 07702. The ACS provides funding for, reproduces, and mails the newsletter.

The American Cancer Society is the nationwide community-based voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer through research education, advocacy, and service.

**The American Cancer Society**  
**Hope, Progress, Answers**  
**1 (800) ACS- 2345**  
**[www.cancer.org](http://www.cancer.org)**

**Benediction: I place my hands in yours and together we can do what I cannot do alone.**

## LOCAL PROSTATE CANCER SUPPORT GROUPS

### Monmouth County

**Freehold** CentraState Medical Center  
Health Awareness Center, 65 Gibson Place, Freehold, NJ 07728  
4th Monday 7:00 - 8:30 PM  
Contact: Stewart Snyder, (732) 308-0570, email:  
Facilitators: Chris Papa, (732) 946-2694, email: doxite@verizon.net  
Harvey Yesowitz, email: yesowitz@comcast.net

**Long Branch** The Cancer Center at Monmouth Medical Center  
300 Second Ave., Long Branch, NJ 07740  
Goldsmith Wellness Center, (4th Floor)  
1st Thursday 7:00 - 9:00 PM  
Contact: Barbara Sierocki (Contact Trudy Merer, (732) 923-6575, TMerer@sbhcs.com)  
Facilitators: Jeff Ozimek, email: anjoz@verizon.net  
Bob Sherman, email: bobsherm@aol.com  
To register call (732) 923-6575

**Neptune** Neptune Prostate Cancer Support Group  
Meeting location: Midtown Community Elementary School, Neptune, NJ  
(Corner of Rt 33 and Atkins Ave)  
3<sup>rd</sup> Thursday 7:00 - 9:00 PM  
Contact: Rich Guilfoyle (732) 493-3913, email: rguilfoy@monmouth.edu  
Facilitator: Marc Gordon (732) 774-3683

**Red Bank** Riverview Medical Center  
1 Riverview Plaza, Red Bank, NJ 07701  
Meeting location-Booker Health Center, 1st Floor, Cancer Center Conference Room  
2<sup>nd</sup> Thursday 3:00 - 4:30 PM  
Contact: Joan Toole, (732) 530-2468, FAX: (732) 345-2010, email: jtoole@meridian.com

**Eatontown** The Wellness Community "Just Between Men"  
Meeting Location: 613 Hope Road, Eatontown, NJ 07724  
3<sup>rd</sup> Monday 6:30 – 8:00 PM  
Contact: The Wellness Community 732-578-9200, email: jan@twcjerseyshore.com  
Website: www.thewellnesscommunity.org/jerseyshore

### Ocean County

**Brick** Ocean Medical Center  
425 Jack Martin Blvd , Main Conference Room, Brick, NJ 08723  
1st Thursday 7:00-9:00 PM  
Contact: For more information, please call: 1-800-ACS-2345  
Facilitators: Rod Garman, Brenda Dubuss at OMC.  
Dick Muller, (732) 240-5717, email: ram645@comcast.net

**Toms River** Community Medical Center-The Lighthouse Network  
591 Lakehurst Road, Toms River, NJ 08755  
3rd Thursday 2:00 - 3:30 PM  
Contact: Andrea Brandsness, (732) 557-3212, FAX: (732) 557-3218, email:  
abrandsness@sbhcs.com  
Facilitator: Larry Puccio, (732) 349-2950, email: lpuccio1@comcast.net