

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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PROSTATE UPDATE

Tip of the Month

How many times have you wound up with a large contusion (black and blue mark) for days after having a blood draw?

To help reduce bruising don't bend your arm. Tight skin punctures are less painful also.

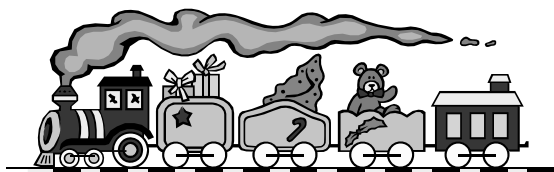
Make a fist while blood is being drawn. It will flow faster and as the tube fills up open your hand.

Put firm pressure on the puncture area before tape is applied and for a short time after and don't bend your arm. Bending forces blood under the skin resulting in larger black and blue mark.

And remember... For fasting blood draws, no food or drink for 12 hours **except for water**. Don't let yourself get dehydrated by avoiding water.

Also, No gum or coffee! Even mouthwash can interfere with glucose levels.

- Al Rosenberg



"There are no hopeless situations; there are only people who have grown hopeless about them." – Clare Boothe Luce

From the Editor

Wow, where did the year go? Time sure flies! The holiday season is in full swing and a new year is arriving. This has to be one of the best times of the year. But then again, as a cancer survivor, every day is one of the best days of the year.

There is a lot of hope and expectation for each New Year. For one, we always look forward to new and better treatments coming out. Personally, I have hopes that this issue

about screening, or testing, or whatever the correct legal term is, will get resolved and clarified. Since many of us men are not attorneys, we find it difficult to understand the difference between screening and the recommendation that men get PSA tested after age 45 and a discussion with their doctor. Sounds like "screening" to me, but I guess not. And that is where the disconnect lies. What's the difference? We need plain language explanations. It is interesting to note that breast cancer is under the same gun as prostate cancer as far as "screening". And the rationale for reducing testing for both has the same dubious basis. But kudos to the women, they did not sit by idly and take it. They made their voice heard. Perhaps there is another message in that for us men. We cannot sit by and let this same issue go unnoticed for PCa. It is curious that in both cases, it seems that a few deaths are acceptable so that others will not be "inconvenienced", or "worried", or unnecessarily treated. The later is the most concerning: that a single point of diagnosis - just knowing that it is present but not knowing the level of aggressiveness - means immediate harsh treatment. That is the unacceptable situation. So, my hope for the New Year is that the medical (and legal) community will come to grips with this for both prostate and breast cancers. Do not throw out the best test we have so far, but find ways to better understand the danger level associated with a patient's cancer, and then decide on treatment options.

You will find in this issue some continuing discussions of this matter, along with some very interesting group reports. The articles again are very informative and in some cases eye-opening. In the nutrition section, I added a short article that gives you some ideas of what to do when overeating (something I think most of us are guilty of doing at this time of year). And then I have to follow it with a cookie recipe. Sorry, I couldn't resist.

I want to take a moment now for some honors and recognition. First I want to present the "Reader of the Year" award to Leo C. Leo not only reads what we put in this newsletter, but he thinks about it and considers what is said. He then took the time to cut out some related articles and actually mailed them to me. You have seen some of the thoughts and ideas

Leo passed to us sprinkled throughout the last few issues. Thanks Leo! (Sorry, nothing comes with the award, just our thanks.)

I also want to honor Jay Lomberk. Jay is the person who wrote the reports for the Red Bank support group. As those who do the reports can attest, it is not an easy job nor is it filled with exceptional accolades. Jay did a superb job on his reports. However, he has moved on, physically (he moved to a new home). Jay will not be able to attend the Red Bank group and thus no reporting on it. We thank Jay for his tireless service to our PCa community and know that he will continue to stay actively involved. Thanks and take care Jay!

Starting next year, we will be doing this newsletter on a bi-monthly basis as a cost saving measure for the American Cancer Society. That means the next issue will be a January plus February issue, mailed out in late February. Another one of my hopes for the New Year is that this change will allow us to be more regular with the publication. If anyone would like to help us with the newsletter or defray the costs of publishing this newsletter, feel free to contact the local Shrewsbury office and make a donation. Sorry, but no matter how much you donate, it will not get better writers! We are all volunteers, so you are stuck with us.

This holiday season means time with family and friends, and maybe even some gifts. I am always thankful for the gift I have received, that is being a cancer survivor for over 11 years now. I cherish every day so much more. For this New Year, I wish you more time to be with those you love, and a greater appreciation and enjoyment of the everyday moments of life. That's the best resolution I could encourage you to adopt.

With the New Year, please continue to give of yourself to help those joining us on this long road to beat cancer. Let your voice be heard on issues affecting us and our cancer. There is nothing like hearing it from someone who's been there. And add support group attendance to your list of resolutions. I wish you all the best for every day of the New Year.

Be well and take care! Enjoy the issue.

- Jeff Ozimek, Editor
anjoz@verizon.net

Long Branch Support Group Meeting

December 3, 2009

By Bob Sherman

The Monmouth Medical Center US,TOO! support group met Thursday December 3, 2009 15 men attended. Our speaker was Melisa L. Donahue, LCSW a certified Sex Therapist, who has a practice in Ridgewood NJ (www.md-counseling.com 201 240-9788). Melisa is also a co- facilitator at a prostate cancer support group at Hackensack Medical Center.

Melisa spoke about sexual activity and the intimacy between partners after treatment for cancer, and addressed the particulars that affect prostate cancer patients. One of Melisa's main points was speaking about erection difficulty and that intercourse is part of love making but does not have to be the main part. If treatment has affected the nerve bundles such that erection is difficult or impossible couples should still have intimacy and that the skin is a major sex organ, in that simple touching and sharing together is important to all humans.

The group shared that our expectations before treatment were not met, that doctors should advise patients to understand the ramifications of surgery or radiation as it applies to the future of their sex lives. One of the important subjects discussed penile rehabilitation as soon as possible after treatment to keep the muscles and erectile tissue in tune, using pumps, masturbation, or other means. Few doctors' deal with the "after treatment" to help with incontinence and sexual function before it's too late. We discussed the possibility that it could take up to 2 years or longer to regain erections.

We also discussed penile length before and after surgery. According to some of our group members they feel that surgery was the cause of losing some length due to the reattachment of the urethra, I brought up my conversation with Dr. John Muhall, MD who is a Urologist and Micro surgeon at the MSK Sidney Kimmel Center in NYC. Dr. Mullhall has a book out "Saving your sex life: A guide for

men with Prostate Cancer". During his lecture at the conference I attended in Los Angeles in September. Dr. Muhall claims The penis is shorter because of dis-use, not from surgery. The answer is that all men contemplating surgery for prostate removal should have counseling on improving pelvic floor muscles and retaining blood flow and muscle tone of the penis before and directly after treatment. There is a clinical trial now in place that is studying the before and after of penis length. So we should come to some kind of objective view in the next few years.

Also discussed was the testing for testosterone level, as well as Vitamin D3, we have discussed this before as well as my theory of high prolactin contributing to low testosterone levels and a possible connection to the cancer itself. And one of our members visited Dr. Meyer the week before and finds that his PSA is moving up, 8 years after surgery.

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 4th 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.

Toms River Support Group

October, 2009

By Al Rosenberg

Our Modern Day

PILGRIM'S PROGRESS!

Bob F. continues his great journey facing obstacles large and small, man-made and cancer-spawned in his quest to be cured of his PCa!

After much investigation, Bob chose to be treated at Fox Chase Cancer center in Philadelphia, which he considered a "Center of Excellence."

In our last issue, we described his procedure, the daVinci robot-assisted laparoscopic prostatectomy.

He also conveyed to us the very uncomfortable problems he was having with painful bladder spasms evidenced by the necessity of his leaving our September meeting in the middle of the session.

But Bobby-ever the battler-has taken what his PCa and treatment has given him in full stride. At his last visit to the Emergency Room, a bladder scan showed that he wasn't retaining a lot of fluid and that maybe his discomfort was due to an infection and inflammation.

So, the doctors prescribed Levaquin, an antibiotic usually effective in urinary tract infections and Flomax. Well, guess what? It worked and Bob showed up looking great announcing, "No more bladder spasms, pads, no incontinence and my incisions are healing just fine."

At five weeks out of surgery, Bob is living proof that doing your homework and choosing the best team available for your circumstances is the only way to go.

MORE SUCCESS AT "THE LIGHTHOUSE"

Anyone who has ever been involved in the great game of baseball knows the old axiom: When a pitcher is throwing a no-hitter, you never mention it while the game is going on.

That tradition is going out the window this month as all our members have "perfect games" going and are feeling relatively well.

Tom is still on *Active Surveillance*, has been for a several years with low PSAs and never any primary treatment. He keeps his numbers low with good diet, supplements and a positive attitude.

Dom had his prostate removed eight years ago and still maintains an undetectable PSA as does Larry, a ten year survivor and our group facilitator.

The ever-irascible Tony is still battling not only his PSAs, but his doctor who wants him to stay on his meds. Naturally, he'll wind up doing what he thinks is best!

And of course, yours truly, who had hormone therapy and seed implants seven

years ago and is now relegated to complaining only about his occasional attacks of gouty arthritis, "in those damn big toes!"

CAN VITAMIN D CURE OR PREVENT PROSTATE CANCER?

In the last several years or so, much has been researched and written about vitamin D and its possible effectiveness against cancer. It seems our USToo **group has been kicking the vitamin D subject around quite a bit lately.**

Here's an excerpt from an article appearing on the www.curetoday.com website, a cancer information source:

"New findings are showing that vitamin D acts as a sentinel to help regulate cell growth and prevent a cell from becoming malignant, says Boston University Medical Center researcher Michael Holick, PhD, M.D. "And that's why we think that you need an adequate vitamin D level throughout your entire life, and that [anytime] you become vitamin D-deficient, you put yourself at increased risk of potentially developing a malignancy later in life, because you've lost the policing ability of vitamin D to help keep cell growth in check."

The prescription? Sensible sun exposure for your skin type, plus vitamin D supplements.

The payback? Greatly reduced risk of colon, breast, prostate, and other cancers, a growing body of research is showing."

Changes in Latitudes: As early as the 1940s, scientists noticed that people who lived in northern states—like Vermont, New Hampshire, and Massachusetts—were more likely to die of malignancies other than skin cancer than people who lived in Texas, South Carolina, or Georgia, says Holick. The implication even then, he adds, was that "there is some immunity provided by the sun."

Another "HOT BUTTON" topic We're Discussing Lately

Most of our guys are seeing red when they read that some new studies are aimed at dissuading men from being screened for PCa. This is especially true since most of us were diagnosed and have had treatment for our cancers as a result of early screening.

The following is part of an article appearing in the latest issue of www.zerocancer.org which has a slightly different perspective on this matter than some other organizations...

ZERO –... The PSA test, the most prevalent method to detect prostate cancer, has saved the lives of thousands of men with rapidly growing tumors. Prostate cancer testing, along with advances in treatment, has led to a 34 percent reduction in deaths since 1994.

...“No one disputes the PSA test cannot distinguish slow-growing tumors from rapidly growing ones, yet this failure to denote the pussycats from the tigers is not really the main issue. Until a better diagnostic test is introduced, the PSA test is still the only short-term solution for early diagnosis and prompt treatment.

“Prostate cancer is the second most deadly cancer among men. Ask anyone whose life depended on taking the PSA test. They will say it’s better to be tested than to roam in the dark and hope you won’t get this disease.”...

DaVinci Surgery Less Invasive But INCREASES RISK OF INCONTINENCE!

Our ever-vigilant group facilitator, Larry Puccio, brought to our attention a new news story from the Associated Press datelined Chicago.

The article tells of latest comparative results between daVinci robotic prostate surgery and traditional open prostatectomy. It suggested that the newer robotic-assisted method “*may mean a higher risk for lasting incontinence and impotence*” than the open method.

Laparoscopic, or keyhole surgery, is increasingly chosen by men having their prostates removed. “*DaVinci’s popularity has been rising even though there’s never been a rigorous head-to-head comparison between it and standard surgery.*”

The study appears in the latest JAMA (Journal of American Medical Association) analyzing several thousand patient data from Medicare. At 18 months the keyhole patients

had more incontinence and erectile dysfunction.

“The take-home message for men is they need to dig deeper than simply the message they might be getting from planted stories from device manufacturers or radio ads or billboards.

“To compete for patients more hospitals are buying robotic systems and advertising faster recovery times. More doctors are taking the two-day training to learn daVinci surgical system.

*“But many doctors perform too few robot-assisted surgeries to get good at it. Previous research has shown doctors who perform the most surgeries get the best results.”**

***(It’s important to note here that Bob F. visited our group, asked a lot of questions and did an awful lot investigation on the different procedures and facilities available to remove his cancerous prostate. He finally decided on the top-notch team at Fox-Chase in Philly and he’s glad he did. Way to go, Bob!)**

Toms River US,Too! Prostate Support Group meets every third Thursday at 2PM. Located in Community Hospital’s “Lighthouse” building at Rte 37 & Lakehurst Road.

For more information and directions contact our facilitator “Lucky” Larry Puccio at 732-349-2950 or you can email him at www.lpuccio1@comcast.net.

And don’t forget...

◆NO REGISTRATION!

◆NO DUES!

◆NO DEDUCTIBLES!

◆NO CO-PAYS!

◆NO PRESSURE...EVER!

Walk-ins always welcome!

Neptune Support Group Meeting October 15, 2009

By Donald Blue and Rich Guilfoyle

Rich G. provided opening remarks. There were ten attendees, which included one spouse. Not a bad attendance number considering the weather. Our opening

discussion was on relative benefits of keyhole (laparoscopic and robot assisted) vs. open field procedures for radical prostatectomy prostate cancer surgery. Two members that were present had laparoscopic surgery with good results. The discussion was triggered by an Associated Press article by Carla Johnson that was provided via e-mail to the group by Rich. The article titled: Robotic Surgery May Mean Big Trade-off. A new study suggests less-invasive keyhole surgery for PC may mean a higher risk for lasting incontinence and impotence when compared with traditional surgery. We also discussed generic vs. name brand meds. Wal-Mart, COSCO, Target, etc. offer good prices on various generic meds. Men with PC can save money by checking these and other sources for meds. Dick G. stated his PSA dropped 20% since he's been taking 10,000 IUs of vitamin D3. Dick recommended that men include a 25-hydroxy blood level check as part of their normal blood work. The 25-hydroxy level should be between 50–80 ng/mL, which indicates a sufficient vitamin D3 level. Bill T. provided an update on his status. He's doing OK but didn't have a good response when taking vitamin D3 in the past. Another member stated that D3 and fish oil is a very beneficial combination for men with PC.

A segment from a DVD titled, Guided Meditations by Anne and Dean Ornish, MD was shown. The DVD was bundled with Dr Dean Ornish's book titled *The Spectrum* which deals with Feeling Better, Living Longer, Losing Weight and Gaining Health. In the DVD segment we viewed, Mrs. Anne Ornish provided yoga based techniques for relaxation, boosting energy through proper breathing and stress management. The DVD segment was different from our normal DVD's but it was well received by the attendees.

Don B. distributed copies of the October 2009, UsToo Hot Sheets. He also had September 2009, Hot Sheets for those members that couldn't attend the September meeting.

Our next meeting is scheduled for November 18, 2009 at the Midtown Community Elementary School. Dane S. Mihlon, Certified Senior Advisor (CSA) will be the guest speaker. Dane's topic will cover the latest

information on Medicare Supplements, Medicaid and various types of health insurance(s). This will be the third time Dane has spoken to our group. His return appearance is welcomed. Hopefully, Dane will provide some insights on the on-going health care debates in Washington.

The remainder of the meeting was used for general discussions including plans for our Christmas Party in December.

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

Neptune Support Group Meeting November 19, 2009

By Donald Blue and Rich Guilfoyle

Marc G. provided opening remarks. There were twenty-three attendees who included three wives, one first time attendee (Chuck R.) and seven folks associated with The Prostate Cancer Coalition of New Jersey (PCCNJ), 2010 Stand by Your Man Calendar. The meeting was divided into two parts:

Part 1 provided an opportunity for the calendar group to give an overview on the calendar. About three years ago, twelve ladies volunteered to pose for photos that appear in the 2010 edition of the calendar. Everyone, including Gabe Rosko, head of PCCNJ who attended our meeting, worked very hard to make the calendar a complete success. The five models (wives of PC survivors) that attended our meeting were: Shelia; Ms April, Naomi; Ms June, Nancy; Ms July, Donna; Ms September and Marion; Ms December. They have sold thousands of calendars across the country. Representatives of the group have appeared on several TV programs; The Today Show, LX New York, Cablevision Local News Channel 12, etc. Several newspaper articles including a front page write-up in the Star Ledger have been written about the calendar. They are hoping to appear on the Opra show sometime in the future. Calendars can be ordered on-line from www.pcc-nj.org or by calling the PCCNJ hotline at 1-877-877-1262. Calendars are \$20.00 each. Several calendars were sold during our meeting.

Part 2 dealt with Medicare/Medicaid issues. Our guest speaker was Dane Mihlon, Certified Senior Advisor (CSA). This makes the third time Dane has spoken to our group. His talk centered on a handout he provided titled: Part D Standard Benefit 2006-2010. He reminded attendees to pay attention to the Medicare Open Enrollment period 18 Nov to 31 Dec 2009. Any changes planned must be selected/implemented by enrollees by the end of the period. See www.medicare.gov for more detailed information on health care plans that are available in New Jersey during the Open Enrollment session. Dane told the group about the negative impacts when several large companies for example, GM canceled their respective employee health care plans.

Dane answered many questions from attendees including several wives. Numerous questions concerned the "donut hole" issues that affect several members. Dane stated that he feels Medicare/Medicaid are the best, government sponsored health care programs in the world. That statement was well received by attendees. His feelings about the pending health care program are mixed. Finally, Dane invited anyone that have questions about his presentation may contact him at (732) 741-5211, (732) 915-4371 Cell or via the internet at www.medsupamerica.com As usual, Dane did an outstanding job and he will be invited back to speak to us next year.

The remainder of the meeting was spent greeting the first time attendee; Chuck R. Rich G. invited Chuck to attend our meeting. He told the group he recently selected radiation as his treatment option. We didn't have a lot of time to discuss treatment options. So we invited Chuck to attend a meeting in the near future. Don gave Chuck a copy of the new, UsToo, Hope-Recovery-Support document that offers insights to help men live life restored after prostate surgery. Chuck said he would attend a meeting in the near future. Finally, we discussed our planned Christmas Party scheduled for 17 Dec 2009. Members planning to attend were asked to pay \$5.00 per guest to help cover the cost of the goodies. They were also asked to consider participating in a fun gift swap. It was suggested gifts should not cost more than \$5.00. Don will send a Yahoo Group Bulletin Board e-mail to members with details

of the party. Our next meeting (Christmas Party) is scheduled for December 17, 2009 at the Midtown Community Elementary School. It will be the only time during the year Prostate Cancer issues will not be addressed.

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

Freehold Support Group Meeting October 26, 2009

By Chris Papa

One of our regular members requested we show a DVD he had purchased from "Dr. Bob" Liebowitz, which mentioned among lots of other verbiage in this 2 hour marathon, the use of high dose testosterone in men with advanced prostate cancer. I prescreened the entire presentation, a labor of love, and decided to show most of the first half, which dealt with his triple therapy approach to advanced cancer, the portion dealing with the testosterone and the final short discussion period.

There were 13 regular members, with six spouses and two new men, one with a spouse, in attendance. All were subjected to what was essentially an "infomercial". Unfortunately, the new couple decided to walk out half way through the presentation. There was much self promotion to be suffered with "Dr. Bob" telling us over and over that he had been trained at Harvard, there was much colleague bashing (very unethical), and more than a taste of "It's me and the patient against the rest of the medical profession". "Dr. Bob" showed many slides of other physicians' data when he wished to, but only presented an endless review of anecdotal case reports. When asked during the discussion period about his data, he did not answer but turned to an assistant in the audience who shouted that they had a 95% success rate, whatever that means. The worse canard uttered was that the medical profession seeks to gain knowledge with clinical studies which are at the detriment of the patient and that "cancer studies are always done with a placebo group". This is patently false, but the gentleman who provided the DVD was ready to buy this premise,

despite the fact that he had been in a clinical study recently. Even when he admitted that his therapy had to be halted from all the side effects of the chemotherapeutic agents he was receiving, he still insisted that he had been a “placebo” subject. Go figure! “Dr. Bob” may help some of his patients but his merchandising is tough to take.

The one new man who remained had recently been diagnosed with a 5.7 PSA and a Gleason 3+3 limited to one of the twelve cores taken. He had had several other twelve-core biopsies, all were negative in the recent year. He was, as usual, quite upset and confused. He is 74 years old and the urologist told him that he wasn't a candidate for surgery, but should seek radiotherapy. He was presented with the option of brachytherapy or HDR. He asked for assistance, and almost everyone in the room had plenty to offer. By the time he left, he had calmed down, pledged to become an active learner, get an expert second opinion on the pathology slides of the positive biopsy and come to our November meeting with the results.

cancer. The panel weighed the potential benefits and harms of PSA testing in this population and concluded that the screening was more likely to have a negative impact on these men than a positive one.

The rationale: Prostate cancer is a slow-growing malignancy that may take 10 or more years to produce significant symptoms. Many elderly men will die of another condition before their prostate cancer becomes life threatening. Thus, an abnormal PSA test would lead to the pain and discomfort of a prostate biopsy and unnecessary worry if no cancer is found. If cancer is found and treated, the man will have to contend with side effects, such as sexual dysfunction and incontinence.

Other medical organizations recommend annual screening for men at average risk for prostate cancer beginning at age 50, but they do not address when screening is no longer necessary. And still others recommend screening for all men with a life expectancy of at least 10 years.

Bottom line advice: If you are age 75 or older, discuss the risks and benefits of PSA testing with your doctor. If you get tested and are diagnosed with a low-grade cancer, keep in mind that active surveillance is an option that allows you to be closely monitored but treated only if your disease progresses.

Posted in Prostate Disorders on October 15, 2009

News and Good Stuff:

Here is a straightforward explanation about one of the “screening” issues. I like their bottom line - getting a diagnosis does not need to equate to immediate traumatic treatment.

- Jeff

Johns Hopkins Health Alert

How Old Is Too Old For an Annual PSA Test?

If you are an elderly man, you may wonder if you should continue to have an annual PSA test to screen for prostate cancer. Here are the latest guidelines.

The U. S. Preventive Services Task Force recently recommended that doctors not screen men age 75 and older for prostate

I think this deserves circulation. It's from Canada and the authors would limit the use of MRI because of costs. If I have prostate cancer, I certainly would want to know its extent before judgments are made regarding choice of therapy. The MRI works. Maybe if it were done prior to even allowing needle biopsies, i.e., there must be a visible tumor before the urologists start peppering the prostate with biopsy needles, we might even save money, to say nothing of unnecessary patient discomfort, pain and risk of side effects. What we need is more and cheaper MRIs.

- Chris

Hidden Prostate Cancers May Be Detectable by MRI

Nick Mulcahy

October 16, 2009 — Clinicians should consider magnetic resonance imaging (MRI) for men who have elevated prostate-specific antigen (PSA) levels or some other "worrisome" prostate cancer variable, but who also have repeated negative biopsies.

This advice comes from the authors of a small Canadian study of patients with anteriorly predominant prostate tumors, which was published online October 8 in the *British Journal of Urology International*.

"We are not advocating the use of MRI in all cases, because this would be costly and a waste of resources," write the authors, led by Nathan Lawrentschuk, MD, Urologic Oncology Fellow at Princess Margaret Hospital Cancer Program, University Health Network in Toronto, Ontario.

However, when repeated biopsy sampling in a worrisome patient does not reveal a tumor, MRI is appropriate because tumors located on the top of the prostate could evade traditional diagnostic procedures, including ultrasound-guided needle biopsy, the investigators say.

"These men benefit from MRI, which guides the biopsy procedure with a high degree of accuracy," said Dr. Lawrentschuk in a press statement, referring to men with anterior tumors.

In retrospect, I can see these men had anterior prostate tumors.

"Looking back over my career, I can recollect many men with a high PSA and a small prostate volume and repeat negative biopsies. In retrospect, I can see these men had anterior prostate tumors," principal investigator and coauthor Neil Fleshner, MD told *Medscape Oncology*. Dr. Fleshner is head of the Division of Urology at Princess Margaret Hospital and professor of surgery at the University of Toronto.

The investigators specified that MRI should be reserved for men who have had either repeated negative anterior and transition zone biopsies or who have low-volume prostate cancer accompanied by some worrisome feature.

"Thus, men with a PSA level of more than 10 ng/mL and a velocity of more than 2 ng/mL per year, as well as small-volume higher Gleason grade disease" are those requiring closer attention, the authors write.

Dr. Fleshner said that it was not known what percentage of men with these characteristics will have anterior prostate tumors. "That's the Holy Grail," he said. However, an estimated 30% to 40% of prostate cancers originate anteriorly, he added.

New Syndrome is Proposed: PEATS

The new study consisted of 31 patients with anteriorly predominant prostate tumors (tumors with >70% anterior to the urethra) on MRI. The group was culled from a larger prostate MRI database of 821 patients at the hospital.

MRI was usually undertaken because of the presenting PSA level or PSA velocity, the authors write.

More than half of the group (17/31) had a mean of 2 previous negative biopsies and a median PSA level of 12 ng/mL before undergoing the MRI. The rest of the group (14/31) was on active surveillance for low-volume prostate cancer and had a median PSA level of 10 ng/mL before undergoing MRI.

MRI had a positive predictive value for anterior tumors of 87% (27/31). This is 1 of 2 "major findings of the study," say the authors.

"MRI can help direct biopsies to the anterior prostate with a high degree of accuracy," they summarize.

The second major finding is that patients with anterior predominant prostate tumors "appear to have more aggressive tumors than expected."

After reviewing their 31 patients and the literature, the investigators proposed that a subset of patients with anterior prostate tumors fits the description of a syndrome, which they call "prostate evasive anterior tumor syndrome," or PEATS. The hallmark of PEATS is that the tumors are not only evasive but aggressive.

"All clinicians have experienced the scenario of patients with multiple negative sets of biopsies and then seemingly high-volume, high-grade disease diagnosed at some point in the near future," the authors write.

"In addition, a subset of men on active surveillance can have fairly rapid progression despite seemingly low-risk features. We believe that a proportion of men in these clinical scenarios have PEATS," they continue. Evidence of aggressive tumors was found among the 31 patients in the study, 13 of whom went on to have a radical prostatectomy and a very high rate of positive surgical margins (54%), note the authors. Positive surgical margins are an indicator of aggressive biology, and the institutional rate at Prince Margaret Hospital is only 26%.

Not all anterior tumors are aggressive, and therefore not all qualify as PEATS, the author concede. However, clinicians are advised to suspect PEATS when a patient has some worrisome prostate cancer variables, such as escalating PSA and a negative biopsy. PEATS might also be present in men with low-volume disease on active surveillance, they said.

Knowing about PEATS may also be important for men already on active surveillance.

"Knowing about PEATS may also be important for men already on active surveillance — patients with slow-growing prostate cancer who are being regularly monitored through PSA testing and biopsy. Every man does not need an MRI, but knowing about PEATS will help us identify those who do," said Dr. Fleshner.

More study is needed to better delineate the prevalence of PEATS and to provide information on how to better detect it, the investigators conclude.

The researchers have disclosed no relevant financial relationships.

BJU Int. Published online October 8, 2009. [Abstract](#)

This is an interesting study, not so much in the conclusions it reaches, but actually in how few men died of PCa. (Out of 10,000 in the study for over 13 years.)

- Chris

Maybe the sample of men was young or unusually lucky. But still note the fundamental

answer of the study – screening helps reduce mortality!

- Jeff

Cancer. 2009 Oct 7.

Risk of dying from prostate cancer in men randomized to screening: differences between attendees and nonattendees.

Bergdahl AG, Aus G, Lilja H, Hugosson J.

Department of Urology, Sahlgrenska University Hospital, Goteborg, Sweden.

BACKGROUND:: Although the true benefits and disadvantages of prostate cancer screening are still not known, the analysis of fatal cases is important for increasing knowledge of the effects of prostate cancer screening on mortality. Who dies from prostate cancer despite participation in a population-based prostate-specific antigen (PSA) screening program?

METHODS:: From the Goteborg branch of the European Randomized study of Screening for Prostate Cancer, 10,000 men randomly assigned to active PSA-screening every second year formed the basis of the present study. Prostate cancer mortality was attributed to whether the men were attendees in the screening program (attending at least once) or nonattendees.

RESULTS: Thirty-nine men died from prostate cancer during the first 13 years. Both overall (34% vs 13 %; $P < .0001$) and cancer-specific mortality (0.8% vs 0.3 %; $P < .005$) were found to be significantly higher among nonattendees compared with attendees. Furthermore, the majority of deaths (12 of 18) among screening attendees were in men diagnosed at first screening (prevalent cases). Only 6 deaths (including 3 interval cases) were noted among men complying with the biennial screening program.

CONCLUSIONS: Nonattendees in prostate cancer screening constitute a high-risk group for both death from prostate cancer and death from other causes comparable to that described in other cancer screening programs. *Cancer* 2009. (c) 2009 American Cancer Society.

This should help with monitoring patients and, perhaps having more men opting for active surveillance.

- Chris

J Urol. 2009 Nov 12.

Can Prostate Specific Antigen Velocity Thresholds Decrease Insignificant Prostate Cancer Detection?

Loeb S, Roehl KA, Helfand BT, Kan D, Catalona WJ.

Department of Urology, The Johns Hopkins School of Medicine, Baltimore, Maryland.

PURPOSE: A controversy of current prostate specific antigen based prostate cancer screening is the over detection of potentially insignificant prostate cancer. Because PSA kinetics were previously linked to prostate cancer specific mortality, we determined whether prostate specific antigen velocity is associated with clinically significant prostate cancer.

MATERIALS AND METHODS: A total of 1,073 men underwent radical prostatectomy from 1992 to 2008 with data available on prostate specific antigen velocity and tumor volume. Insignificant cancer was defined by the Ohori criteria as organ confined, tumor volume 0.5 cc or less and no primary or secondary Gleason pattern 4 or 5. We calculated the proportion of men with pathologically insignificant prostate cancer stratified by prostate specific antigen velocity.

RESULTS: Preoperative prostate specific antigen velocity greater than 0.4 ng/ml per year was significantly associated with high grade disease ($p = 0.008$), positive surgical margins ($p = 0.003$) and seminal vesicle invasion ($p = 0.007$) at radical prostatectomy. Median tumor volume was also significantly higher in men with preoperative prostate specific antigen velocity greater than 0.4 ng/ml per year (3.1 vs 2.4 cc, $p = 0.0001$). Overall 69 men (6%) met the Ohori criteria for insignificant cancer. Patients with preoperative prostate specific antigen velocity greater than 0.4 ng/ml per year were 50% less likely to have insignificant disease (10% vs 5%, $p = 0.003$).

CONCLUSIONS: A prostate specific antigen velocity threshold of 0.4 ng/ml per year was associated with the likelihood of insignificant prostate cancer. This suggests that prostate specific antigen velocity may be a useful adjunct in prostate cancer screening to increase specificity for identifying patients with clinically significant disease.

One might have expected the radiation to do better than cryotherapy, but what is unsettling about this study is the degree of failure with both therapies. One problem is that the abstract doesn't tell you much about the makeup of the groups, only that they are "newly diagnosed".

- Chris

Cancer. 2009 Nov 24.

A randomized trial of external beam radiotherapy versus cryoablation in patients with localized prostate cancer.

Donnelly BJ, Saliken JC, Brasher PM, Ernst SD, Rewcastle JC, Lau H, Robinson J, Trpkov K.

Department of Surgery, Tom Baker Cancer Center, Calgary, Alberta, Canada.

BACKGROUND: Localized prostate cancer can be treated several different ways, but head-to-head comparisons of treatments are infrequent. The authors of this report conducted a randomized, unblinded, noninferiority trial to compare cryoablation with external beam radiotherapy in these patients.

METHODS: From December 1997 through February 2003, 244 men with newly diagnosed localized prostate cancer were assigned randomly to receive either cryoablation or radiotherapy (122 men in each arm). All received neoadjuvant antiandrogen therapy. The primary endpoint was disease progression at 36 months based on a trifecta definition: 1) radiologic evidence of metastatic disease, or 2) initiation of further antineoplastic therapy, or 3) biochemical failure. Two definitions of biochemical failure were used: 1) 2 consecutive rises in prostate-specific antigen (PSA) with a final value >1.0 ng/mL, and 2) a rise above PSA nadir + 2 ng/mL. Secondary

endpoints included overall survival, disease-specific survival, and prostate biopsy at 36 months.

RESULTS: The median follow-up was 100 months. Disease progression at 36 months was observed in 23.9% (PSA nadir + 2 ng/mL, 17.1%) of men in the cryoablation arm and in 23.7% (PSA nadir + 2 ng/mL, 13.2%) of men in the radiotherapy arm. No difference in overall or disease-specific survival were observed. At 36 months, more patients in the radiotherapy arm had a cancer-positive biopsy (28.9%) compared with patients in the cryoablation arm (7.7%).

CONCLUSIONS: The observed difference in disease progression at 36 months was small, 0.2%; however, because of the wide confidence interval, from -10.8% to 11.2%, it was not possible to rule out inferiority (defined a priori as a 10% difference). With longer term follow-up, the trend favors cryoablation. Significantly fewer positive biopsies were documented after cryoablation than after radiotherapy. Cancer 2010. (c) 2009 American Cancer Society.

This is curious, we don't often think of surgery for high risk patient treatment. Looks like something to consider.

- Jeff

Urology. 2009 Nov 19.

What Are the Outcomes of Radical Prostatectomy for High-risk Prostate Cancer?

Loeb S, Schaeffer EM, Trock BJ, Epstein JI, Humphreys EB, Walsh PC.

Department of Urology, Johns Hopkins Medical Institutions, Baltimore, Maryland, USA.

OBJECTIVES: To examine the long-term survival following radical prostatectomy in the population with high-risk prostate cancer. Despite considerable stage migration associated with widespread prostate-specific antigen screening, as many as one-third of incident prostate cancers have high-risk features. These patients are often treated with combined radiation and androgen deprivation therapy, and less is known about the long-term

survival in this population after radical prostatectomy (RP).

METHODS: Between 1992 and 2008, 175 men underwent RP by a single surgeon with D'Amico high-risk prostate cancer (clinical stage \geq T2c, biopsy Gleason score 8-10, or prostate-specific antigen >20 ng/mL). In this population, we examined the rates and predictors of biochemical progression, metastatic disease, and cancer-specific mortality.

RESULTS: Among 175 high-risk patients, 63 (36%) had organ-confined disease in the RP specimen. At 10 years, biochemical recurrence-free survival was 68%, metastasis-free survival was 84%, and prostate cancer-specific survival was 92%. The 10-year rate of freedom from any hormonal therapy was 71%. Of the high-risk criteria, a biopsy Gleason score of 8-10 (vs \leq 7) was the strongest independent predictor of biochemical recurrence, metastases, and prostate cancer death.

CONCLUSIONS: National data suggest that RP may be underutilized for the management of high-risk clinically localized prostate cancer. Our data suggest that surgical treatment can result in long-term progression-free survival in a subset of carefully selected high-risk men. Further prospective studies are warranted to directly compare the outcomes of RP vs combined radiation and hormonal therapy in high-risk patients.

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.

News From the Wellness Community:

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.

Nutrition:

Since it is the holiday season, with the required dose of overeating, I am including an article I found from Eating Well. It has some good tips for helping with all that excess food we will consume.

And, you know me, I can't resist a good cookie recipe. For my taste, I would not include the coconut. And that might even make it a bit healthier. Enjoy the bounty of the holiday season!

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 or call toll-free 1-800-337-0402.

-Jeff

3 Antidotes to Overeating

By Amy Paturel, May/June 2008

These 3 foods will help fix the damage of a rich meal.

We're all guilty of overindulging sometimes—an extra helping of potatoes here, a wedge of key lime pie there. But loading up on calories forces your body into overdrive as it tries to deconstruct the damage. "Just metabolizing food—especially fatty and carbohydrate-rich fare—causes the body to produce free radicals, which attack cells and can promote the development of chronic conditions including heart disease, diabetes and cancer," says Ronald L. Prior, Ph.D., research chemist and nutritionist with the USDA at Arkansas Children's Nutrition Center. The more you consume, the more free radicals you produce. In fact, that's one theory why caloric restriction—a practice of cutting calories by 25 to 30 percent—may protect against some disease. But recent research suggests that there are two ways to reduce free radicals: eating fewer calories and consuming more nutrient-rich fare, such as the following. (We suggest you do both.)

1. Drink Wine. Antioxidants in red wine, called polyphenols, may reduce the negative impact of high-fat foods, according to a study published in the Journal of the Federation of American Societies for Experimental Biology in January. In the study, people who ate a turkey cutlet cooked with wine had 75 percent lower levels of malondialdehyde (MDA)—a by-product of fat digestion linked with heart disease—than those who had the cutlet without wine. Other research shows that a compound called resveratrol in red wine mimics the effects of caloric restriction and improves health in mice.

Cook with red wine or enjoy a glass with dinner. (But remember, moderation is key!)

2. Drizzle Vinegar. Having a tablespoon of vinegar with your meal, perhaps drizzled on your salad, may temper the spike in blood sugar (a.k.a. glucose) that occurs after eating a big, carbohydrate-rich meal. This sugar surge is a problem particularly for people with diabetes, who can't clear glucose effectively; over time, excess glucose in the blood damages tissues. (For the rest of us, a steep rise in glucose triggers an equally rapid drop—which stokes appetite.) But in a 2005 study published in the Journal of the American Dietetic Association, consuming about 1 tablespoon of apple cider vinegar along with a bagel and fruit juice slashed the postmeal rise in glucose in half. It also resulted in subjects eating 200 to 275 fewer calories through the day. "The acid in vinegar may inhibit the digestion of the starch, so the starch is rendered into something like fiber, which can't be digested well," says Carol Johnston, Ph.D., R.D., professor and chair of the department of nutrition at Arizona State University. Drizzle a tablespoon of vinegar on your salad.

3. Eat Fruit. If you've indulged in a decadent meal, consider fruit for dessert. In the Journal of the American College of Nutrition last April, Prior and his colleagues showed that eating antioxidant-rich fruits—including berries, grapes, kiwi and cherries—helps minimize the free-radical damage that occurs after a meal. Eating caloric meals, without antioxidant-rich foods like fruits and vegetables, can have harmful effects over time, says Prior. Finish your meal with a generous portion of fruit.

Chocolate-Cherry Chews

Full of bright cherry flavor, these chewy chocolate cookies will disappear in no time!

3 dozen cookies

Active Time: 30 minutes

Total Time: 1 hour

Ingredients:

1 cup dried cherries, chopped

1/4 cup cranberry juice

3/4 cup unsweetened cocoa powder, preferably Dutch-process

1/2 cup nonfat sweetened condensed milk

1/2 cup cherry or apple butter

1 tablespoon vanilla extract

2 cups sweetened flaked coconut, divided

Preparation

1. Preheat oven to 350°F. Coat 2 baking sheets with cooking spray.

2. Combine cherries and cranberry juice in a small saucepan. Bring to a simmer over low heat and cook, stirring frequently, until all the juice has been absorbed, about 2 minutes. Set aside to cool.

3. Combine cocoa, condensed milk, cherry (or apple) butter and vanilla in a mixing bowl. Beat with an electric mixer until smooth and blended. Add the plumped cherries and 1 2/3 cups of the coconut; stir just until combined.

4. Using 2 small spoons, form and drop 1-inch mounds onto the prepared baking sheet. Sprinkle the remaining coconut over the cookies. Bake until the cookies are no longer sticky and the coconut has begun to brown, 8 to 10 minutes. (Do not overbake; the cookies firm up slightly as they cool.) Transfer to a wire rack to cool completely.

Nutrition:

Per cookie: 59 calories; 3 g fat (1 g sat, 0 g mono); 1 mg cholesterol; 11 g carbohydrates; 1 g protein; 1 g fiber; 17 mg sodium; 61 mg potassium. 1/2 Carbohydrate Serving.



CONTACT INFORMATION:

Dr. Lee's location: 1202 Walton Boulevard
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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

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
Facilitators: Jack Stauffer, (732) 536-9728, email: lhpjrs@optonline.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)
3rd 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
2nd 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
3rd 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