Newsletter

Prostate Cancer 101, Inc.

http://prostatecancer101.org

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The Prostate Cancer Information and Support Group of the Mid-Hudson

Prostate Cancer Treatment Study Changing the Way Doctors Practice

Published: April 4, 2013. by University of Texas Health Science Center at San Antonio

A study published today in the New England Journal of Medicine recommends a dramatic shift in the way doctors treat metastatic prostate cancer.

"These results have changed the way I treat patients," said Ian M. Thompson Jr., M.D., director of the Cancer Therapy & Research Center at The University of Texas Health Science Center at San Antonio and senior author on the international study.

Hormone therapy in hormone-sensitive prostate cancer has been shown to help extend the lives of patients, but it causes a range of unpleasant side effects in men like moodiness, hot flashes, bone loss and sexual dysfunction. To give patients relief, doctors have, in some cases, "pulsed" the therapy — giving it to men for a time and then stopping it until the signs of prostate cancer activity reappear, then starting the hormone therapy again until the cancer appears to be under control.

The study shows that the continuous therapy helps men more. Men with less advanced metastatic prostate cancer who received the "pulse" or intermittent hormone therapy died an average of two years sooner than those on continuous therapy. The study results first drew attention when they were announced last summer at the annual meeting of the American Society of Clinical Oncology.

After that, prostate cancer survivor Floyd Balter switched from pulse to continuous therapy.

"Last year Dr. Thompson told me about the study results," said Balter, 78. "I said, 'Let's do it.'"

Surviving 17 years beyond a diagnosis where he'd been given two years to live, Balter said he's determined to watch his grandchildren grow for as long as possible.

"I want to live as long as I can," he said. "I can live with the side effects. They're a pain but I can tolerate them."

In the study results, if men with more extensive disease are included in the group, survival was more modest, extended by an average of 7 months, "which is longer than any other intervention," said Dr. Thompson,

director of the CTRC. Often advances in cancer treatments will only extend life by an average of two or three months, he noted.

"I can now give a patient the option of putting up with some side effects in order to spend several more months or even years with his grandchildren," Dr. Thompson said. "I can tell you they are happy to have that choice."

Also, Dr. Thompson pointed out, because of the increase in PSA testing, most men who are diagnosed with metastatic prostate cancer present with disease that is still minimal.

The study followed 1,535 men with metastatic prostate cancer for a median of almost 10 years. It was led by SWOG, an international network of research institutions.

The significance of the results, adding months if not years to the lives of many men, means every physician with prostate cancer patients should take them into account, Dr. Thompson said.

Source: www.ScienceNewsLine.com

Salesmen in the Surgical Suite
Ann Johansson for The New York Times By RONI CARYN RABIN
Published: March 25, 2013

When Fred E. Taylor arrived at Harrison Medical Center in Silverdale, Wash., for a routine prostatectomy, he expected the best medical care new technology had to offer: robotic surgery, billed as safer, less painful and easier on the body than traditional surgery.

The operation, on Sept. 9, 2008, was supposed to take five hours. But it was marred by a remarkable cascade of complications and dragged on for more than 13 hours, leaving Mr. Taylor, who had been an active 67-year-old retiree, incontinent and with a colostomy bag, and leading to kidney and lung damage, sepsis and a stroke.

Mr. Taylor survived his injuries but died last year. Now, his wife, Josette, is suing Intuitive Surgical Inc., the company that makes the equipment and trained the surgeon to use it. As it turned out, the surgeon, Dr. Scott Bildsten, had never before used the robotic equipment without supervision.

"We are the old school, where you trust the doctor," said Mrs. Taylor, who noted that her husband's life was so limited after the operation that he used to cry about being "trapped in this body."

It is not the first time patients have claimed they were harmed by Intuitive's robotic surgical equipment, called the da Vinci Surgical System. But the Taylor case, set for trial in April, is unusual.

Internal company e-mails, provided to The New York Times by lawyers for the Taylor estate, offer a glimpse into the aggressive tactics used to market high-tech medical devices and raise questions about the quality of training provided to doctors before they use new equipment on patients.

Intuitive, based in Sunnyvale, Calif., declined to comment on the lawsuit but said studies showed that its robotic equipment results in better outcomes than conventional open surgery.
"The most objective and therefore best measure of efficacy for all of those involved in training — from Intuitive Surgical, the hospitals, the proctors and the surgeons themselves — is represented in the comparative clinical outcomes of da Vinci surgery," said Angela Wonson, the company's vice president for communications.

According to Intuitive, 1,371 hospitals in the United States have purchased a da Vinci system, and many have purchased two. Nearly half a million procedures worldwide were performed robotically last year, including prostatectomies and hysterectomies, among other operations.

A surgeon using the da Vinci system sits at a console with a camera that provides a high-definition, three-dimensional image of the surgical site. He or she manipulates miniaturized instruments; computer and robotic technology translates and scales the surgeon's hand movements.

Hospitals are responsible for setting the credentialing standards, or training requirements, for physicians who will use the equipment on patients. But internal company e-mails suggest that Intuitive's sales representatives were intimately involved in the process, presenting themselves as experts and pressing for lower standards in order to ease the training path for busy surgeons, to increase use of the equipment and to drive sales.

In an e-mail dated May 31, 2011, a Western regional sales manager for Intuitive noted that area surgeons had used robotic equipment only five times, although the company's goal was to see 36 robotic operations performed by the end of June. He urged sales staff to persuade surgeons to switch upcoming cases to robotic ones.

"Don't let proctoring or credentialing" — shorthand for supervised surgery and hospital certification — "get in our way," the e-mail said.

In December 2009, a sales representative urged a hospital in Billings, Mont., to ease up on its credentialing requirement, saying in an e-mail that requiring surgeons to do five supervised operations using the robot before going solo was "on the high side" and could have "unintended consequences." Hospital officials replied, saying, "We will review and most likely will decrease the 5 down to 3."

Ms. Wonson, the Intuitive spokeswoman, said the company does not get involved in determining who is qualified to operate its robotic equipment, which is the responsibility of the hospitals. "We do not make recommendations," she said in an e-mail.

Dr. Bildsten was one of six doctors given free training by Intuitive, including one day of hands-on training at the company's facility in California. He also had done two practice runs on the equipment with a more experienced surgeon before operating on Mr. Taylor, he said in a legal deposition. Still, he said, no one warned him that a patient like Mr. Taylor, who weighed nearly 300 pounds, was not a good candidate for robotic surgery.

He did not respond to telephone messages requesting comment. Company e-mails submitted in the Taylor case also suggest that members of the sales staff at Intuitive worked diligently to persuade surgeons to choose the da Vinci procedure for patients even when they were planning to use a different method.

In one e-mail on June 28, 2010, a clinical sales director urged the sales team — whose compensation was linked to filling a quarterly quota of operations — to "scrub" doctors' schedules and get procedures moved up by a few days in order to make the quarterly goal. "Let's bring it home!" she wrote. "Be sure you scrub all schedules, identify cases on Thursday and Friday that can be moved up."

On Aug. 9, 2010, a clinical sales director wrote to his team: "Be proactive in finding cases to convert. Be prepared to challenge each trained surgeon every time you see a lap or open case. Be unsatisfied with the thought of ending a day without a converted case." ("Lap" refers to laparoscopic procedures, an alternate form of minimally invasive surgery.)

The sales representatives were often in the operating rooms, where they offered advice to newly trained surgeons who were having technical difficulties with the robot, according to legal depositions in the Taylor

case. The representatives also appear to have had access to the operating room schedules and were urged to "partner" with surgical teams "to review and select appropriate cases," according to court documents.

On March 3, 2011, a sales representative wrote in an e-mail to his team that he had met with a gynecologic surgeon in Utah who was trained a year earlier but had stopped doing robotic cases. The surgeon subsequently "agreed to convert the next two to da Vinci."

In depositions, some Intuitive sales representatives defended their involvement, saying that it was important for surgeons to use the robotic system frequently in order to maintain and improve their skills.

The Food and Drug Administration allowed the sale of the da Vinci system in 2000 under a controversial process called "premarket notification," often used to bring medical devices to market without the rigorous trials of safety and efficacy typically required of new drugs. Manufacturers are able to exempt devices from the rigorous trials by claiming they are similar to existing devices already on the market.

When devices are brought to market this way, the F.D.A. "cannot require training programs as a condition of clearance," said Synim Rivers, an agency spokeswoman.

Before allowing this type of market clearance, the agency twice asked Intuitive for more information about how doctors would be trained to use company equipment. Intuitive provided details of a 70-item exam for surgeons and a three-day hands-on training protocol.

By 2002, however, the company had revamped its training program, replacing the 70-item exam with a 10-question online quiz and reducing the time spent in hands-on training at Intuitive's facility to one day.

The largest study to date of robotic hysterectomies has questioned the use of robot-assisted surgery over more conventional forms of minimally invasive surgery. A study published in February in The Journal of the American Medical Association evaluated outcomes in 264,758 women who had laparoscopic or robotically assisted hysterectomy and found no overall difference in complication rates between the two groups.

But the researchers did find that robotically assisted surgery for hysterectomy costs on average about one-third more than laparoscopic surgery.

Last week, Dr. James T. Breeden, the president of the American Congress of Obstetricians and Gynecologists, publicly urged patients "to separate the marketing hype from the reality" when considering a surgical method for hysterectomy. "Just because it's newer and higher technology," he said, "doesn't mean it's better."

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Men with Early Prostate Cancer Should Be Offered Additional Testing to Confirm Severity of Disease
Research from NewYork-Presbyterian/Columbia University Medical Center Improves Decision Making for Patients and Their Doctors

NEW YORK (Mar 19, 2013)

New research from NewYork-Presbyterian Hospital/Columbia University Medical Center suggests that men who are considering their treatment options for low-risk prostate cancer may benefit from additional biopsy testing before making a decision. Based on this research, doctors at the medical center are modifying their practices to more accurately distinguish early and low-risk prostate cancers from more aggressive disease.

"Active surveillance" is an alternative to immediate treatment of prostate cancer that allows men with low-risk tumors to monitor the disease with their physician and proceed with curative treatment at a later time, if ever. This approach delays, and may even prevent entirely, the possible side effects of radical surgery or radiation therapy.

There are two important factors for a successful active surveillance program. First is the accurate identification of men with low-risk prostate cancer. Active surveillance should be offered only to men with cancers that are considered at low risk for spread or growth beyond the prostate. Second, once a patient and his doctor choose active surveillance, the cancer must be carefully monitored to recognize if and when treatment is required. Monitoring includes regular blood tests, prostate exams, and repeat biopsies.

A standard prostate cancer biopsy takes 12 samples, known as cores, from different regions of the prostate. In men who have a persistently elevated risk of prostate cancer but have had a previous negative prostate biopsy, up to 24 cores are commonly taken. However, while 24 cores can offer a more accurate assessment, this approach requires more sedation and may increase the risk of complications.

In a new approach, doctors in the Department of Urology at NewYork-Presbyterian/Columbia University Medical Center are offering a 24-core repeat biopsy to men with low-risk prostate cancer who are being considered for active surveillance. The goal is to more accurately identify men most appropriate for active surveillance before entering them into the active surveillance program.

"In about one-third of men who enter active surveillance, a second biopsy performed one year later shows that they are no longer candidates for active surveillance, as the cancer has become more aggressive or extensive. They are then advised to receive treatment. It has been thought that the disease progresses over the course of the year," says Dr. Sven Wenske, a urologist at NewYork-Presbyterian/Columbia.

New published research suggests that those men who chose active surveillance and subsequently were thought to have "failed," or required treatment, a year later should not have been started on active surveillance in the first place. Researchers now think that their cancer did not progress or become more aggressive over the year, but that the initial biopsy

may have been inadequate. This finding became apparent after two recent studies conducted in the Department of Urology at NewYork-Presbyterian/Columbia University Medical Center.

In the first study, published in the November 2012 issue of the journal Urology, researchers retrospectively looked at 60 patients from NewYork-Presbyterian Hospital who had been diagnosed with low-grade prostate cancer and were considered candidates for active surveillance. All of the men had had an immediate repeat biopsy within, on average, two months after the initial biopsy with, on average, 17 cores. In about one-third of the men, this immediate repeat biopsy revealed a prostate cancer grade that made them ineligible for active surveillance. The men were then advised not to undergo active surveillance, but to consider one of the treatment options, such as removal of the prostate.

Two factors on the initial biopsy result predicted an upgrading of the cancer on the repeat biopsy: the presence of precursor lesions and grade of the cancer. "Interestingly, the proportion, one-third, of patients who are thought to show progression of their disease upon biopsy after one year of active surveillance is the same as the proportion of men in this study sample who showed features on their immediate rebiopsy upon entering the active surveillance program that no longer made active surveillance a viable option. Our suspicion is that these are the same patients, just identified before initiation of active surveillance and referred to appropriate treatment without delay," says Dr. Mitchell Benson, the George F. Cahill Professor of Urology and chair of the Department of Urology at Columbia University Medical Center.

To effectively identify which men are more likely to fail on active surveillance, doctors should perform an immediate repeat biopsy after the initial diagnosis, taking an increased number of tissue samples, according to Dr. Benson: "The 24-core biopsy offers additional clues to the cancer's aggressiveness and eliminates nearly all of the one-third of men who would have failed active surveillance at the one-year point. This will better reassure patients and may reduce anxiety about cancer progression.

"Effective treatment options are available, but prostate cancer grows slowly and not every patient requires immediate treatment, making active surveillance a valid option for many men. Therapies that may cause significant side effects, such as urinary incontinence or erectile dysfunction, could be delayed or avoided entirely. Though treatment may eventually become necessary, through close monitoring of the cancer, quality of life could be significantly improved and maintained without risking significant progression of the cancer," adds Dr. Benson.

A separate study, published in the December 2012 issue of the Journal of Urology, showed that during active surveillance, repeat biopsies do not need to be performed on the transition zone of the prostate unless the cancer was initially found in that zone.

The majority of cancers originate in the peripheral zone of the prostate and only approximately 10 percent in the transition zone. "This may help reduce the number of biopsies needed to be taken, thereby reducing side effects and complications," says Dr. Wenske.

Prostate cancer is the most commonly diagnosed cancer in American men, affecting one in six men over their lifetime, and the second leading cause of cancer death.

For more information on active surveillance, visit:

http://columbiaurology.org/specialties/cancer/prostate_cancer/active_surveillance.html.

The research was funded by the Doris Duke Clinical Research Fellowship Program at Columbia University Medical Center. Authors of the first study, "Role of Immediate Confirmatory Prostate Biopsy to Ensure Accurate Eligibility for Active Surveillance," are P. Motamedinia, J. RiChard, J. McKiernan, G. DeCastro and M. Benson. Authors of the second study, "Routine Transition Zone Biopsy During Active Surveillance for Prostate Cancer Rarely Provides Unique Evidence of Disease Progression," are J. RiChard, P. Motamedinia, J. McKiernan, G. DeCastro and M. Benson

NewYork-Presbyterian Hospital

NewYork-Presbyterian Hospital, based in New York City, is the nation's largest not-for-profit, non-sectarian hospital, with 2,409 beds. The Hospital has nearly 2 million inpatient and outpatient visits in a year, including 12,797 deliveries and 195,294 visits to its emergency departments. NewYork-Presbyterian's 6,144 affiliated physicians and 19,376 staff provide state-of-the-art inpatient, ambulatory and preventive care in all areas of medicine at five major centers: NewYork-Presbyterian Hospital/Weill Cornell Medical Center, NewYork-Presbyterian Hospital/Columbia University Medical Center, NewYork-Presbyterian/Morgan Stanley Children's Hospital, NewYork-Presbyterian/The Allen Hospital and NewYork-Presbyterian Hospital/Westchester Division. One of the most comprehensive health care institutions in the world, the Hospital is committed to excellence in patient care, research, education and community service. NewYork-Presbyterian is the #1 hospital in the New York metropolitan area and is consistently ranked among the best academic medical institutions in the nation, according to U.S.News & World Report.

The Hospital has academic affiliations with two of the nation's leading medical colleges: Weill Cornell Medical College and Columbia University College of Physicians and Surgeons.

Columbia University Medical CenterMColumbia University Medical Center provides international leadership in basic, pre-clinical, and clinical research; medical and health sciences education; and patient care. The medical center trains future leaders and includes the dedicated work of many physicians, scientists, public health professionals, dentists, and nurses at the College of Physicians & Surgeons, the Mailman School of Public Health, the College of Dental Medicine, the School of Nursing, the biomedical departments of the Graduate School of Arts and Sciences, and allied research centers and institutions.

Established in 1767, Columbia's College of Physicians & Surgeons was the first institution in the country to grant the MD degree. Among the most selective medical schools in the country, the school is home to the largest medical research enterprise in New York State and one of the largest in the United States. For more information, please visit

www.cumc.columbia.edu.

Third-Generation Device Significantly Improves Capture of Circulating Tumor Cells

Apr. 3, 2013

Apr. 3, 2013 — A new system for isolating rare circulating tumor cells (CTCs) -- living solid tumor cells found at low levels in the bloodstream -- shows significant improvement over previously developed devices and does not require prior identification of tumor-specific target molecules. Developed at the Massachusetts General Hospital (MGH) Center for Engineering in Medicine and the MGH Cancer Center, the device rapidly delivers a population of unlabeled tumor cells that can be analyzed with both standard clinical diagnostic cytopathology and advanced genetic and molecular technology.

The MGH team's report has been published in *Science Translational Medicine*.

"This new technology allows us to follow how cancer cells change through the process of metastasis," says Mehmet Toner, PhD, director of the BioMicroElectroMechanical Systems Resource Center in the MGH Center for Engineering in Medicine, the paper's senior author. "Cancer loses many of its tissue characteristics during metastasis, a process we have not understood well. Now for the first time we have the ability to discover how cancer evolves through analysis of single metastatic cells, which is a big step in the war against cancer."

The new device -- called the CTC-iChip -- is the third microchip-based device for capturing CTCs developed at the MGH Center for Engineering in Medicine. The first two systems relied on prior knowledge of a tumor-specific surface marker in order to sort CTCs from whole blood and required significant adjustment for each different type of cancer. The systems also required four to five hours to process a single blood sample.

The only U.S. Food & Drug Administration-cleared, commercially available device for capturing and enumerating CTCs -- the CELLSEARCH® system developed by Veridex, LLC -- relies on magnetic nanoparticles that bind to the same epithelial protein used in the MGH -developed microchip-based devices and cannot always find CTCs present at very low numbers. In January 2011 the MGH entered into a collaborative agreement with Veridex and its affiliate Janssen Research & Development, LLC, to establish a center of excellence in research on CTC technologies.

Combining elements of both approaches -- magnetic labeling of target cells and microfluidic sorting -- the CTC-iChip works by putting a blood sample through three stages. The first removes from the sample, on the basis of cell size, all blood components except for CTCs and white blood cells. The second step uses a microfluidic process developed at the MGH to align the cells in a single file, allowing for extremely precise and rapid sorting. In the third stage, magnetically labeled target cells -- either CTCs tagged via the epithelial marker or white blood cells tagged on known blood-cell antigens -- are sorted out. Tagging white blood cells instead of CTCs leaves behind a population of unlabeled and unaltered tumor cells and doesn't rely on the presence of the epithelial marker or other known tumor antigens on the cell surface.

The new system was able to process blood samples at the extremely rapid rate of 10 mil-

lion cells per second, handling a tube of blood in less than an hour. Both the mode of sorting out tagged CTCs, called tumor-antigen-dependent, and the technique that depletes white blood cells, called tumor-antigen-independent, recovered more than 80 percent of tumor cells from different types of cancer that had been added to blood samples. Comparison of the antigen-dependent-mode CTC-iChip with existing commercial technology for processing blood samples from patients with prostate, breast, pancreatic, colorectal and lung cancer showed the CTC-iChip to be more sensitive at detecting low levels of CTCs.

In the antigen-independent mode, the CTC-iChip successfully identified CTCs from several types of cancers that had lost or never had the epithelial marker, including triple-negative breast cancer and melanoma. CTCs isolated through this mode were put through standard cytopathological analysis, which revealed structural similarities to the original tumor, and detailed molecular genotyping of CTCs from a single patient found significant differences in gene expression patterns among individual CTCs.

"We're only beginning to identify potential applications of the ability to analyze how tumors mutate as they spread, but this should help improve our understanding of the fundamental genetic principles of metastasis," says Toner, the Benedict Professor of Surgery at Harvard Medical School (HMS). "We hope to develop this technology to the point where it could be used for early diagnosis, which is the 'Holy Grail' that all of us working on CTC technology have been striving for."

Ravi Kapur, PhD, of the Center for Engineering in Medicine, leader of the innovation team within the MGH Circulating Tumor Cell Center, says, "The CTC-iChip provides a first-in-class device for high-efficiency, high-speed tumor cell sorting from a clinically relevant blood volume. The chip is designed for mass manufacturing, and simple automation for clinical translation." The team is working with collaborators at Veridex and Janssen to refine the system for commercial development.

Study co-author Daniel Haber, MD, PhD, director of the MGH Cancer Center and Isselbacher/Schwartz Professor of Oncology at HMS, adds, "The study of cancer metastasis has been limited by the inability to quickly and reliably isolate tumor cells in transit in the blood. This new approach is likely to be a game changer in the field."

Source:www.ScienceDaily.com

Mediterranean diet aims to keep heart healthy

Frank Lee, St. Cloud Times, Minn. Knight Ridder/Tribune Business News

March 24--WAITE PARK -- A taste of the Mediterranean may just reduce one's chances of having a heart attack or stroke, according to health experts.

A recent analysis of more than 1.5 million healthy adults who were on the Mediterranean diet had a reduced incidence of cancer and cancer mortality, and a reduced incidence of Parkinson's and Alzheimer's diseases, according to the Mayo Clinic.

"The basics of it are really great ... focusing on not necessarily just reducing one thing or another -- for example, just low fat or low protein or low carb," said Dr. Julie Anderson, a family physician at St. Cloud Medical Group. "It's more about making wise and healthy choices."

The heart-healthy eating plan combines elements of Mediterranean-style cooking of countries bordering the Mediterranean Sea. The Mediterranean diet traditionally includes fruits, vegetables, pasta and rice.

"It's more of an olive oil-based diet rather than just the trans fats that we tend to see, and it's all about healthy, natural foods rather than pre-prepared foods, and emphasizing vegetables and fruits rather than red meat and whole grains instead of

processed grains," Anderson said.

Cafe Renaissance in Waite Park offers pan-Mediterranean cuisine from the south of Italy, France, Greece, Spain, Turkey, Morocco, and the Eastern and Middle Eastern Mediterranean and has done so for years.

"The Mediterranean diet is extremely healthy -- being lower in processed foods and animal fats -- and is often based on local produce, wheat products, such as bread, pastry and pasta, fresh fruit and vegetables, fish and olive oil," said Jim Rakhshani, general manager of Cafe Renaissance.

Rakhshani said business is up at the Waite Park restaurant since the Mediterranean diet made headlines recently based on its health benefits.

"It's the Mediterranean lifestyle choice that those people who live in the Mediterranean choose to live by, partly because they haven't been influenced by Western pressures and partly because they can't get access to the prepared foods that America has," Anderson said.

For example, residents of Greece eat very little red meat and average nine servings a day of antioxidant-rich fruits and vegetables, according to the Mayo Clinic.

"They don't run to McDonald's or Burger King because they don't have access to those things," Anderson said. "They grow their foods locally and process them themselves, typically, or raise them in their backyard, so it's just a different way of living."

The Mediterranean diet typically includes a moderate amount of wine; alcohol has been associated with a reduced risk of heart disease in some research studies.

"Red and white wine is the basis of almost all of our dishes," Rakhshani said of Cafe Renaissance, which is locally owned and operated.

The Mediterranean diet discourages saturated fats and hydrogenated oils, which contribute to heart disease, and features olive oil as the primary source of fat.

"It's just simple, whole foods that have not been prepared for you. It's basic fruits and vegetables. It's olive oil instead of heavy fats and butter, and then low red meat and eating a lot of fish and chicken, which is available at any grocery store," Anderson said.

Key components of the diet

The Mediterranean diet emphasizes:

-- Getting plenty of exercise

-- Eating primarily plant-based foods, such as fruits and vegetables, whole grains, legumes and nuts

-- Replacing butter with healthy fats such as olive oil and canola oil

-- Using herbs and spices instead of salt to flavor foods

-- Limiting red meat to no more than a few times a month

-- Eating fish and poultry at least twice a week

-- Drinking red wine in moderation (optional)

Source: Mayo Clinic

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Androgen Deprivation Therapy Increases Risk for Gallbladder Disease

March 08, 2013

Because male hormones, or androgens such as testosterone, fuel prostate cancer growth androgen deprivation therapy (ADT) is a mainstay in the treatment for certain forms of prostate cancer and has been proven to improve survival times. However, few therapeutics lack side effects and ADT is no different. Wiping out male hormones form a man's body can cause troubling metabolic fallout, such weight gain, obesity, elevated blood fats and resistance to insulin in the body. These adverse side effects of ADT can also lead to an increase risk of gallbladder dysfunction in men.

To further study this risk of developing gallbladder dysfunctions, also known as biliary disease, researchers from Boston (Massachusetts General Hospital, Harvard Medical School, and Brigham and Women's Hospital) led by PCF Young Investigator Dr. Philip Saylor investigated the link between ADT and the rate of biliary disease in men with prostate cancer. Using the massive Medicare database of Surveillance, Epidemiology and End Results (SEER), Saylor and colleagues examined medical records of almost 200,000 men diagnosed with prostate cancer from 1992 to 2007. The researchers determined that men who were treated with a common form of ADT known as gonadotropin-releasing hormone (GnRH) had a significantly increased risk of biliary disease compared to men who did not receive GnRH—15.7cases per 1,000 men vs. 13.4 cases. Saylor and colleagues also found that the risk of biliary disease increased in men on ADT for longer durations.

The authors write that cholecystectomy, removal of the gallbladder, is the most common elective abdominal surgery in the U.S. In their study, 7 percent of men in the study underwent that or other procedures to treat biliary disease. The study suggests that men undergoing ADT discuss the risk for and symptoms of gallbladder dysfunction with their physicians. The authors write that their findings give further credence to the importance of optimizing the medical management in terms of metabolic syndrome of men receiving ADT. And that, of course, means a high emphasis on maintaining healthy lifestyles for men who need to undergo ADT.

And interestingly, a Canadian study presented at this year's Genitourinary Cancers Symposium in Florida, found that survival outcomes in men with high-risk prostate cancer who were treated with radiation therapy followed by either 36 months of androgen deprivation therapy (ADT) or 18 months of ADT found no significant difference in overall survival. The randomized study had two arms; one with 310 men who received radiotherapy and 36 weeks of ADT and another with 320 men who received radiotherapy and 18 months of ADT.

This study was restricted to a particular cohort of men, as defined above. But for that particular group of patients, the Canadian researchers concluded that long-term ADT can safely be reduced from 36 to 18 months in this cohort of men without compromising overall survival rates.

Source: www.pcf.org

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