Newsletter

Prostate Cancer 101, Inc.

http://prostatecancer101.org

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

A More Accurate Prostate Cancer Grading System

Jonathan I. Epstein, M.D.

Do you want to know what a prostate tissue specimen looks like when I view it under my microscope? Imagine looking at an abstract painting, with its countless shades and variations of color all swirled together on the canvas. Within this mass on my biopsy slide are normal cells and, in some cases, cells that are not normal. By viewing this sample, I am able to determine if cancer is present and, if so, how much.

What I am looking at are specific patterns of the cells from the part of the prostate that produces seminal fluid and the proteins within it. Prostate cancers arise in this part of the gland. When prostate cancer is present, the cellular configurations are altered and can be divided into five recognizable patterns that are added together to form a score.

A look at the Gleason score

Donald F. Gleason, M.D., Ph.D., first described the five patterns in the 1960s, when he served as chief of pathology at the Minneapolis VA Medical Center. He devised a method of ranking them that bears his name: the Gleason score. This prostate cancer grading system is still the most accurate predictor of the cancer's aggressiveness and is used widely to guide cancer management. The higher the Gleason score, the more virulent the prostate tumor tends to be.

There are five Gleason patterns, or grades, from 1 through 5, which describe the extent of gland alteration. Grades 1 through 3 describe glandular patterns that appear more normal and orderly, whereas grades 4 and 5 describe cell patterns that appear chaotic. Glandular patterns of 1, 2, and 3 are associated with a more benign clinical course, while grades 4 and 5 tend to behave aggressively and spread beyond the prostate.

Prostate cancer cells are often made up of an array of grades, some of which appear to be fairly normal and others quite disorderly. Gleason discovered that by adding the two most prevalent grades together to arrive at a score, and tumor aggressiveness could be predicted with a high degree of precision.

For example, if the most prevalent, or primary, glandular grade seen is 3, and the second most prevalent, or secondary, grade is 4, the Gleason score would be 3 + 4 = 7, with 3 the primary and 4 the secondary grade. However, if the most prevalent grade is 4, and the second most prevalent grade is 3, then the Gleason score would also equal 7 (4 + 3), but with 4 the primary grade and 3 the secondary grade. The tumor that is scored 3 + 4 behaves less aggressively than the 4 + 3 tumor because the primary pattern is 3 rather than 4.

To complicate matters further, pathologists have decided to abbreviate the Gleason grading system, and only scores of 3, 4, and 5 are used to describe prostate biopsies for both primary and secondary grades; these are added up to obtain scores from 6 through 10. Gleason score 6 cancers tend to behave less aggressively than Gleason score 7 cancers, which, in turn, behave less aggressively than cancers scored as 8, 9, and 10.

Today, 60 percent to 70 percent of cancers diagnosed on a pros-

tate biopsy are graded as Gleason score 6; about 20 percent to 30 percent are Gleason score 7; and 5 percent to 10 percent are Gleason score 8 and higher. The vast majority of cancers picked up on a prostate biopsy are the least aggressive type. As you might expect, assigning higher grades contributes to the higher rates of prostate cancer treatment.

The new prostate cancer grading system

The Gleason prostate cancer grading system, which has 25 possible scores, has been confusing to many doctors and patients, and this has led to unnecessary treatment of prostate cancer. This is why I, along with other researchers, have created a new five-grade system that is easier to use and understand, but also more accurate than the Gleason system, with only five possible scores. The new prostate cancer scoring system has the potential to substantially reduce overtreatment of low-risk cancer.

The five-grade system is based on an analysis of 2013 data from more than 7,000 prostate cancer patients at The Johns Hopkins Hospital. To verify the accuracy of the new stratification, we also analyzed data obtained from tissues of more than 20,000 men whose prostates had been surgically removed between 2005 and 2014 at Hopkins and four other medical institutions. We also included data from biopsies of more than 5,000 men treated with radiotherapy at two medical centers during the same period.

A better predictor?

The results suggested that the prognostic discrimination for the new grading system was higher than the most commonly used combinations of the Gleason scores. For example, the original Gleason system typically considers Gleason score 7 as requiring radiation therapy. However, the new system broke up Gleason 7 into Grade Group 2 and Grade Group 3, in which 3's prognosis is twice as bad as 2's.

The difference in Grade Groups is especially critical for selecting a therapy. For example, Grade Group 3 is treated with hormonal therapy in addition to radiation, which carries significant side effects, whereas Grade Group 2 is treated only with radiation. Similarly, the Gleason scores 8 to 10 are typically considered one grade, yet in the new prostate cancer grading system, these grades can be split into Grade Group 4 and Grade Group 5, where, again, Grade 5 is twice as aggressive.

When we looked at our study data, 40 percent of the men in the study fell into either Grade Group 2 or 3 and would be affected by distinguishing between the two, and 10 percent of the men fell into either Grade Group 4 or 5. Therefore, by using the new system, 50 percent of the men in the study would have received a more appropriate treatment than if their doctors had used the most common combinations of the Gleason score.

A major plus of the new grading system is that it will reduce overtreatment of prostate cancer that develops slowly by allowing more rational, less emotional decision-making. Men who are assigned Grade Group 1 will know that their cancer has no metastatic potential. This should also reassure men in this group who choose active surveillance.

The World Health Organization has now recommended that the new prostate cancer grading system be used worldwide. Change doesn't come quickly in the medical world, but I am confident that over time this new grading system will be widely adopted internationally.

Jonathan I. Epstein, M.D., ***is a professor in the departments of pathology, urology, and oncology at Johns Hopkins Medicine and the Reinhard Professor of Urologic Pathology at Johns Hopkins Medical Institutions. He is also director of surgical pathology at Johns Hopkins Hospital.***

Source: https://www.healthafter50.com/prostate/article/a-more-accurate-prostate-cancer-grading-system?utm_source=email&utm_medium=email&utm_content=EPH_160929_001&utm_campaign=EPH&spMailingID=9597478&spUserID=MTQxMTQwMzkzMDU1S0&spJobID=1002299575&spReportId=MTAwMjI5OTU3NQS2

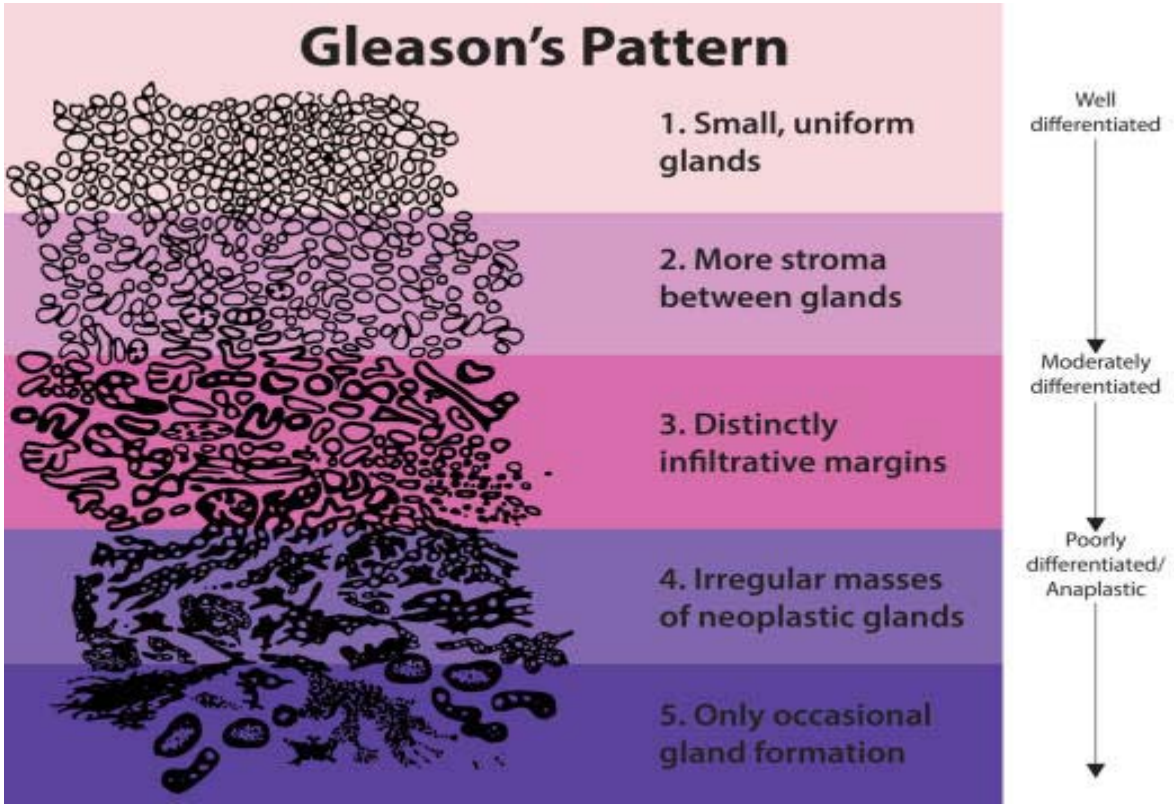
What is a Gleason score?

Determining the extent of prostate cancer is important for predicting the course of the disease and in choosing the best treatment. Results from the digital rectal exam (DRE), prostate-specific antigen (PSA) tests, and prostate biopsy, give the urologist a good idea of whether the cancer is confined to the prostate or has spread outside the gland. The pathologist's examination of the biopsy specimen is crucial.

After studying the characteristics of the tumor, the pathologist assigns a Gleason score to the cancer. The Gleason score provides an estimate of how aggressive the cancer is. Depending on the Gleason score and the initial PSA results, the physician may order imaging studies to determine whether the cancer has spread to distant sites.

What is a Gleason score?
The most important factor in predicting the current state of the prostate cancer and the success of any treatment is the Gleason score. This score is based on tumor grade, which is an indication of the tumor's aggressiveness. The tumor grade reflects how far the cancer cells deviate from normal, healthy cells.

Normal prostate epithelial cells form highly organized glands, with well-defined borders. Cancer cells, in contrast, display various degrees of disorganization and distortion.



Cancers whose cells appear closest to normal are considered grade 3 and generally are the least aggressive; those with highly irregular, disorganized features are classified as grade 4 or 5 and generally are the most aggressive.

The Gleason score is derived by determining the two most prevalent organizational patterns in the tumor, assigning each a grade and then adding the two numbers together. For example, if the most common pattern—the primary grade—is 3 and the next most common pattern—the secondary grade—is 4, the Gleason score would be 7 or 3+4. But if the primary grade is 4 and the secondary grade is 3, the Gleason score would be 4+3, and this would be considered to be more aggressive.

In other words, the primary grade carries more weight than the secondary pattern in determining the aggressiveness of the cancer. In some cases the pathologist will report a tertiary pattern that is associated with prognosis but is not a part of the overall score. For example, a pathologist may report that the biopsy shows a Gleason 3+3 (score 6), with a tertiary pattern 4.

Most doctors classify a Gleason score of 6 as a low -grade tumor, a Gleason score of 7 as intermediate, and Gleason scores of 8, 9 and 10 as high grade. Gleason scores of 8 to 10 are associated with the least favorable outlook.

Imaging studies

Some men will need to undergo a bone scan to determine whether their prostate cancer has spread to the bones. The bone scan involves intravenous injection of a radioactive substance that is preferentially taken up by the damaged bone. (Bone can be damaged by cancer as well as by osteoporosis and other bone diseases.) A special scanner is then used to detect the radioactivity. Areas of the body that show increased radioactivity have bone damage, possibly because cancer has spread to the bone.

A bone scan is not typically ordered when PSA levels are less than 10 ng/mL because the likelihood of cancer spread is very low. Men who have a PSA level of 20 ng/mL or higher, a Gleason score of 8 to 10, or disease extensive enough to be felt on both sides of the prostate or beyond the prostate should have a bone scan and a computed tomography (CT) scan of the pelvis.

A ProstaScint scan may be used to look for prostate cancer cells that have spread to the lymph nodes or soft organs. It uses antibodies that attach to a protein called prostate-specific membrane antigen on prostate cancer cells. These antibodies mark cancer cells with a radioactive isotope that is then picked up by a special scanner. This scan is not considered very accurate, but it may be used when PSA levels start to rise again after surgery or radiation therapy.

If the DRE, PSA, and Gleason score suggest that the cancer has spread, CT or magnetic resonance imaging (MRI) may be performed to look for enlarged lymph nodes. The urologist may recommend a laparoscopic biopsy. In this procedure, a surgeon uses a laparoscope (an instrument with a tiny light and camera) to view the lymph nodes near the prostate and take samples to check for cancer.

New approaches for detecting the presence or progression of prostate cancer are being investigated. These include positron emission tomography (PET) and PET/CT. Further development of these imaging procedures may provide more precise ways to diagnose recurrences and locate metastases (cancers that have spread).

After gathering this information, the physician can then describe the clinical stage (or extent) of the cancer. Clinical stage takes into account whether the cancer has spread to the lymph nodes, bones, or other areas. One of two methods is used—the Whitmore-Jewett method or, more commonly, the TNM (tumor, node, metastasis) system.

Risk classification

The National Comprehensive Cancer Network (NCCN), an association of 23 cancer treatment centers, convenes expert panels to make recommendations for diagnosis and treatment of cancers, including prostate cancer. Currently, the NCCN recommends that after a diagnosis of prostate cancer is made, the man should be categorized in one of four categories to help determine optimal management.
The categories are: very low risk, low risk, intermediate risk and high risk. The determination is based on PSA level, prostate size, needle biopsy findings and the stage of cancer.

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Source: https://www.healthafter50.com/cancer/article/what-is-a-gleason-score

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PCa101 Honored by Ulster Co. Legislature

Thanks to the efforts of our own Jack Hayes, Prostate Cancer 101 was honored by the Ulster County Legislature as a Pride of Ulster County at their regular session on Tuesday, September 20. Along with a beautiful, framed award noting PCa 101 as a Pride of Ulster County, a proclamation was given to us declaring September Prostate Cancer Awareness month in Ulster County.

Jack Hayes spoke quite eloquently of the work done by our organization noting our many years in existence and how he had been helped by us more than 10 years ago. He then introduced Diane Sutkowski who paid homage to the founders of our group in 1995, particularly Ron Koster, John Breithaupt and John Decker. Kudos were given to Fred Bell and Gene Groelle for their many years of voluntary and excellent service.

You may still be able to see the livestream by going to the Ulster County Legislature internet site and looking for September 20. The PCa 101 presentation and speeches are about 5 minutes into the session. http://livestream.com/accounts/1512750/events/1824203

Contributions

Our thanks to those who help us continue our reach out

Yavuz Birturk
Edward & Evelyn Hill
Joseph & Florence Hoffman
Walter & Susan Libenson
Donald Murat
Kenneth Newman
Earl Prochaska
Joseph & Helen Sullivan
Edward Surowitz
Edward Weber
The New Paltz Elks

Your Cause – Price Waterhouse

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In Honor of Walt Sutkowski
Thomas Donovan

A special Thanks to our friends
Men2Men

Prostate Cancer 101 is a 501 (c) (3) IRS approved non-profit organization. Your ***tax deductible*** donations should be mailed to:

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Little Growth of Protons for Prostate Cancer
Cost still high, data still limited

by Charles Bankhead *Senior Associate Editor, MedPage Today*

10.02.2016

Action Points

- Note that this study was published as an abstract and presented at a conference. These data and conclusions should be considered to be preliminary until published in a peer-reviewed journal.
- Note that this report from a national proton-therapy trade group suggests use of the technology has seen little growth over the past 3 years.
- Reasons for this may include the lack of a robust evidence base supporting the use of proton therapy in more common cancers.

BOSTON -- Use of proton therapy to treat cancer continued a modest but steady increase, although the biggest driver of the therapy -- prostate cancer -- remained stagnant, according to data from a national trade group.

From 2012 through 2015, the annual photon therapy case volume increased from 5,377 to 7,711 at the centers in operation during that period. Prostate cancer remained the largest single contributing condition to case volume throughout the period. However, any hoped-for increase in volume never materialized.

The total number of prostate cancer patients treated with proton therapy stood at 2,336 in 2012 and remained at 2,311 at the end of 2015, William F. Hartsell, MD, of Northwestern University Medical Center and Radiation Oncology Consultants in Chicago, reported here at the American Society for Radiation Oncology meeting. In between those 2 years, the prostate cancer case volume dipped to 2,094 in 2013 and then rose to 2,355 in 2014, survey data from the National Association for Proton Therapy (NAPT) showed.

"Despite the publicity that is given to proton therapy about prostate cancer, and despite the fact that there are double the number of proton centers from the time of the 2012 survey to the time of the 2015 survey, the number of prostate cancer patients treated is basically the same," said Hartsell. "That actually means that the number of prostate cancer patients treated per center is going down."

The lack of change in proton-treated prostate cancers mean that prostate cancer's representation in the total case volume decreased from 43% in 2012 to less than 30% in 2015, Hartsell added.

Small Piece of Pie

To some extent, the lack of growth in prostate cancer cases treated at proton centers mirrored the ongoing state of proton therapy in general. Case volume has failed to keep up with capacity, as the number of proton centers has increased despite modest growth in the total number of patients treated. According to ASTRO, two-thirds of the 1.5 million newly diagnosed cancers each year are treated with radiation therapy at some point. Three types of cancer -- lung, breast, and prostate -- account for a majority of all newly diagnosed cancers, and radiation therapy plays a prominent role in all three diseases.

Since 2008, the number of cancers treated with proton therapy has more than doubled from 3,172 to 7,731. However, the 2015 total represented less than 1% of all cancers treated with radiation therapy. The 2016 NAPT data have yet to become available, but Hartsell estimated the total case volume would approach 9,000.

After prostate cancer the malignancies most commonly treated with protons were pediatric solid tumors (1,090 cases) and central nervous system tumors (1,014), both of which had steady growth during 2012 to 2015. Those two tumor groups have some of the most robust supporting evidence and literature for proton therapy, Hartsell noted.

The volume of head and neck cancers had one of the largest proportional increases. The total volume of head and neck cancers treated at proton centers increased from 316 in 2012 to 576 in 2014 and then had a large jump to 808 in 2015.

Other cancers with good supporting evidence for proton therapy exhibited little or no growth, possibly because of their uncommonness. The number of intraocular melanomas treated at proton centers declined from 250 in 2012 to 176 in 2015. The total volume of base of skull and axial skeleton tumors increased from 179 to 270 in 2014 but then declined to 232 in 2015.

The case volume for major drivers of cancer epidemiology exhibited little growth. The number of lung cancers treated with protons increased from 437 in 2012 to 596 2015, but rose by only one case from 2014 to 2015. The number of breast cancers treated with protons increased from 93 to 425. The number of proton-treated gastrointestinal cancers increased from 170 to 480, but slowed from 2014 (427) to 2015.

Hartsell prefaced his report from the NAPT with a borrowed and paraphrased observation that noted philosopher Homer Simpson once applied to beer: "Protons are the cause of and solution to all of radiation oncology's problems."

Suggestions for Growth

When the presentation ended, members of the audience were quick to the microphones to continue the discussion. Joel Greenberger, MD, of the University of Pittsburgh, probably reflected the thoughts and questions of many in the room.

"Right now, protons are more expensive, but we're at sort of a watershed. If we're going to get more data, we need to have more proton machines in more places and have them less expensive to buy and to run. What are we going to have to do to make that happen?" asked Greenberger, who acknowledged, "We don't have protons in Pittsburgh and I wish we did."

Hartsell said the proton industry is taking steps to make proton therapy less expensive, noting a trend toward centers with a single treatment room or vault instead of several. However, he conceded that the upfront cost will remain high.

Borrowing and paraphrasing again, Hartsell said, "If you want to make a small fortune in protons, you start out with a large fortune to buy a proton center. This is not something where you are going to make a lot of money. The [profit] margins are very narrow."

Craig Stevens, MD, PhD, of William Beaumont Hospital in Royal Oak, Mich., was shocked to learn that the building that houses the proton equipment accounts for a third of the cost and that annual maintenance costs can run as high as 10% of the equipment's cost. He characterized both costs as "staggering," compared with other forms of radiation therapy.

"Those costs have to come down, and I think that's how you're going to save money in the future," said Stevens.

On the technology/safety side, the pencil-beam scanning permitted by proton therapy leads to "much, much better dose distribution -- at least on paper," which could be a boon to specific types of cancers, such as head and neck cancer. "It is to IMRT (intensity-modulated radiation therapy) what IMRT was to 3D conformal. It gives a staggering amount of normal-tissue protection," Stevens added.

Currently, 24 proton centers are in operation, and another 10 are expected to open within the next year and a half, which will expand access to proton therapy, Hartsell said in response to another question. Additionally, randomized trials involving proton therapy for specific types of cancer have begun, which will help build the evidence base.

Hartsell disclosed relationships with Cadence Health, Radiology Oncology Consultants, National Association for Proton Therapy, Proton Collaborative Group, Illinois Cyberknife, and Elk Grove Radiosurgery

Reviewed by F. Perry Wilson, MD, MSCE Assistant Professor, Section of Nephrology, Yale School of Medicine and Dorothy Caputo, MA, BSN, RN, Nurse Planner

This activity is part of our Clinical Context curriculum in Prostate Cancer

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American Society for Radiation Oncology

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Source: http://www.medpagetoday.com/clinical-context/ProstateCancer/60561?xid=nl_mpt_DHE_2016-10-03&eun=g957619d0r&pos=0

IMRT-treated Prostate Cancer Patients Don't Have Increased Risk of Secondary Disease, Study Reveals

by Kara Elam

Prostate cancer patients treated with intensity-modulated radiation therapy (IMRT) do not have an increased risk of secondary cancers such as leukemia or myelodysplasia, compared to the standard 3D conformal radiotherapy.

The study, "Second Primary Cancers After Intensity-Modulated vs 3-Dimensional Conformal Radiation Therapy for Prostate Cancer," was published in the online version of *JAMA Oncology*.

IMRT is used often in clinical practice for the treatment of prostate cancer and has been shown to reduce radiation exposure to the healthy tissue, allowing focused radiation dose escalation to the specific tumor site. Although questions have been raised over whether this exposure could increase a patient's risk of developing secondary cancers due to increased radiation exposure to the bone marrow, no concrete observational studies have been conducted to validate this hypothesis.

Amy Berrington de González, DPhil, senior investigator of the National Cancer Institute's Radiation Epidemiology Branch, was the lead author of this study. González's research focuses on quantifying potential cancer risks from therapeutic radiology to provide information for public health and clinical purposes.

González and her colleagues compared the health risks associated with IMRT compared to 3D-CRT in terms of the patient's risk of developing secondary cancers after treatment of their primary prostate tumor. This was an important clinical question because, according to the authors, the radiation dosing for the treatment of prostate cancer is of "particular concern given the potentially higher bone marrow dose."

Using SEER (Surveillance, Epidemiology, and End Results) Medicare data, the research team analyzed secondary cancer rates in 39,028 men with nonmetastatic prostate cancer treated with intensity-modulated versus 3D-conformal radiotherapy.
The findings showed that:

- 2,901 men developed second cancers; 1,691 were treated using IMRT, and 1,210 were treated using 3D-CRT

- There was no difference in the risk of leukemia or myelodysplasia after IMRT compared to 3D-CRT

Risks of colon cancer and rectal cancer were significantly lower after IMRT

When discussing the findings, González and her team found that "IMRT was not associated with an early elevated risk of leukemia or myelodysplasia. There was some preliminary evidence of reduced risks of colon and rectal cancers compared with 3D-CRT, which is potentially consistent with lower radiation doses from IMRT to these organs."
The authors also point out that further confirmatory as well as follow-up studies to monitor the potential impact of IMRT on secondary cancer risks are needed.

Source: https://prostatecancernewstoday.com/2016/08/01/imrt-treatment-prostate-cancer-doesnt-increase-risk-secondary-cancers/?utm_source=Prostate+Cancer&utm_campaign=96aed27842-RSS_MONDAY_EMAIL_CAMPAIGN&utm_medium=email&utm_term=0_a6d9c27ca8-96aed27842-71812337

Finding Out About Prostate Cancer Clinical Trials

by Ana de Barros, PhD

The research community is working to discover and test new prostate cancer therapies that promise to improve patient outcomes and potentially lead to a cure. Yet many people are unaware that clinical trials are currently enrolling prostate cancer patients to assess such experimental therapies. Information about these clinical trials and how to participate in them is available by visiting this website.

Finding a clinical trial and successfully enrolling in one can be a time-consuming process. But for patients with prostate cancer, participating in a trial is often worthwhile, giving them access to therapies not currently available on the market while helping the research community to advance its understanding of the disease and how best to treat it.

Where to Find Out About Trials

With the rise of the Internet and next-generation information platforms that directly reach out to patient populations, it is becoming increasingly easy for patients with prostate cancer and other diseases to research, inquire into, and potentially enroll in clinical trials. Companies, universities, and research institutions developing treatments often have contact information available on their websites that interested participants can use to be included in a trial. Often, medical centers conducting the trials and serving as investigational sites for experimental therapies also have information available online on trials that are currently enrolling.

Trials conducted both in the United States and abroad are registered with **Clinicaltrials.gov** — a U.S. government-run web resource that provides up-to-date information about the specifications and progress of clinical trials, as well as where therapies in trials are being tested and contact information. Clinicaltrials.gov is designed to serve both patients and the research community, with the information available in this platform updated by trial sponsors, and up-to-date about whether a trial is still enrolling or not.

Clinicaltrials.gov is not the only government-run resource for clinical trial information. The National Institutes of Health maintains two websites that help patients find clinical trials, one being a search engine for NIH-funded clinical research studies and the other called Research Match. Similar to Clinicaltrials.gov, these sites cater to researchers as well as patients, so not all information given in these clinical trial listings is pertinent to patients.

Websites and resources managed by foundations and advocacy groups are more geared toward patients. The Prostate Cancer Foundation (PCF) offers updates on the latest prostate cancer clinical trials, as well as promising experimental therapies currently in the R&D pipeline.

CenterWatch is another site that helps connect people with clinical trials.

Talk to Your Physician

In addition, your physician may have information about clinical trials, particularly if you are being treated at a major medical center or a university hospital. In fact, you may want to access the center's or university's website to see what kind of research might be going on there. For example, the University of Chicago, University of Texas, Stanford University, Cedars-Sinai and Memorial Sloan Kettering Cancer Center all support a wide range on clinical trials for numerous diseases. Many of the major research centers will have information on their websites, so feel free to search for this information at a cancer center closest to your home. You may also decide to travel to a trial site.

Your doctor has access to your medical history and specific information about your diagno-

Prostate Cancer Clinical Trial: What to Expect

By Sonya Collins

A clinical trial could mean a big change in the type of care you're getting now. You may get a cutting-edge treatment that few people have had before.

Before you join, learn about how it works and what it will be like for you.

What Is a Clinical Trial?

It's a study that gives researchers a chance to show that a treatment works and is safe. The FDA won't approve a new drug, procedure, or medical device until it's gone through a clinical trial.

Sometimes clinical trials test drugs and procedures that are already approved by the FDA for other conditions. Researchers want to see if they might work for prostate cancer, too.

Trials also check to see if there's a benefit to taking two treatments together that are usually done alone.

How Does It Work?

There are several types of clinical trials.

There can be trials where patients get the typical medication used to treat cancer and a placebo or the experimental drug. In others, patients get the typical medication used to treat cancer or the experimental drug. There are also trials where patients can get a placebo or the experimental therapy.

Randomized trials. As the name suggests, you're assigned at random to an "experimental" or a "control" group.

If you're in the experimental group, you'll get your regular care and the treatment that the researchers are testing. If you're assigned to the control group, you'll get your regular care and a "placebo," which is sometimes also called a "dummy pill." It doesn't have any ingredients that can treat the disease. Researchers want to see how well the experimental treatment works when compared to the placebo.

Cross-over studies. In these, researchers start out by giving regular care and the experimental treatment to one group while people in the other group get their regular care and a placebo. Then the groups switch. Everyone eventually gets the experimental treatment.

sis, and as such is the best person to ask about participating in a prostate cancer clinical trial. People with prostate cancer may ask their treating physician about the possibility of enrolling in a clinical trial, and specifically about a trial tailored to their stage of the disease and other characteristics of their diagnosis. Specific biomarkers may also determine who should participate in a particular trial. Your doctor may have more ideas about this.

Benefits of Participation

Participating in a clinical trial has many benefits, including access to potentially novel treatments that can provide better outcomes. Some patients often worry that they will not receive treatment if they participate in a trial. However, for cancer trials, even the comparison treatment needs to be effective. Sometimes the experimental treatment is also later made available to people placed in the comparison arm. Be sure to discuss the details of any trial that you are considering participating in with your physician and with the study organizers. Also keep in mind that participation is ultimately up to the volunteer, who can decide to be in a trial but can also drop out at any time for any reason.

Source: https://prostatecancernewstoday.com/2016/05/16/finding-out-about-prostate-cancer-clinical-trials/?utm_source=Prostate+Cancer&utm_campaign=5319a62283-RSS_MONDAY_EMAIL_CAMPAIGN&utm_medium=email&utm_term=0_a6d9c27ca8-5319a62283-71812337

Double-blinded studies. If you're in one of these kinds of trials, you'll get assigned to either an experimental group or a control group. But while the trial is going on, neither you nor the doctor will know which group is getting the experimental treatment and which is getting the placebo.

Your Care During a Clinical Trial

Doctors check the health of people in clinical trials closely, because they want to see how the treatment is working.
"Whether we are using a new drug or an established drug in a different clinical stage, we want to make sure that we aren't missing any important signals, good or bad," says Dana Rathkopf, MD, who runs prostate cancer clinical trials at Memorial Sloan Kettering Cancer Center.
This means you'll get a lot of attention and care. But it could mean many trips to the research center.
"For a new drug not used in many people ... the visits can range from daily to weekly to monthly," Rathkopf says. "For more-established drugs, when we already have a greater sense of safety, the visits may be spread out less frequently."
If your doctor isn't running the study, you may be able to continue to get your regular treatment from him. A lot depends on how the study is designed. If you continue to see doctors outside the study, research doctors will coordinate care with them.
"We work closely with their local physicians when patients want us to, and when they request that we manage more of their care in one site to save them multiple trips to multiple doctors, we do that, as well," Rathkopf says.

The Cost of a Clinical Trial

Usually the sponsors of a trial pay for the experimental drugs and everything that's related to it, such as tests and lab work. The bills for your regular treatment are sent to your insurance company.
Insurance companies can't drop you for enrolling in an approved study.

Your Safety During a Clinical Trial

Before researchers begin a clinical trial, a board reviews the plans to make sure they are safe. Before you join, a member of the research team will go over these points with you:

- What the experimental treatment is
- Known and possible risks
- Whether you might be getting a placebo
- Any treatments you might consider instead of experimental treatment
- Everything you need to do during the study, such as take medications, get tests and procedures, and see doctors

Any money you'll have to pay
You get the chance to ask all your questions before you agree to take part.

How Do I Find a Prostate Cancer Clinical Trial?

Your doctor may suggest a specific clinical trial to you as one of your treatment options. If not, ask if he knows about one that would be right for you. He may also help you search for one.
Check these groups to find out about where to join a trial:

- National Cancer Institute
- The U.S. National Institutes of Health
- World Health Organization
- Prostate Cancer Clinical Trials Consortium

Online clinical trial listing services, such as eCancerTrials, CenterWatch, and ClinicalTrialsSearch
The National Cancer Institute offers an online checklist of the information you need to search for a trial. Your doctor can help you fill it out. Once you find a trial that looks right for you, you or your doctor can contact the research team so you can apply.
WebMD Feature
Reviewed by Gerald Chodak, MD on June 09, 2016

Source: http://www.webmd.com/prostate-cancer/decision-point-clinical-trials-16/what-to-expect?ecd=wnl_can_083016&ctr=wnl-can-083016_nsl-ld-stry_1&mb=IHb0bPtGTXzn%2fZ72N%2fgTKuBPk9ElyaPiRLJhlZSwcrw%3d

Prostate Cancer 101, Inc.
8 Alcazar Avenue
Kingston, NY 12401-4302

1st Tuesday

SEMINAR For Newly Diagnosed

3rd TBA

Distinguished Lecturer Series

4:30 p.m. monthly

Hurley Reformed Church Hall, Hurley, NY

Notice to Members

If you have moved, have a new email or phone or no longer wish to receive the newsletter, please let us know.

It's up to you to keep us informed so we can keep you informed.

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If you need or want to help:

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First Tuesday of every month

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