



Newsletter

Prostate Cancer 101, Inc.

<http://prostatecancer101.org>
April, 2008

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

Our Guest Speaker will be Dr. Samson Fine Of Memorial Sloan Kettering On Thursday, April 10th

Here's your chance to talk to a first rate pathologist and get the questions answered about the reports that confuse most of us. So mark your calendar in red and be there on **Thursday**, April 10th at 4:30 PM at the main hall at the Hurley Reformed Church!

Dr. Fine's talk will be: Using Pathology to Diagnose and Treat Prostate Cancer. He will discuss the major elements of prostate needle biopsy and radical prostatectomy reports and how they can be used to plan therapy and predict outcome. He will be happy to answer your questions after his presentation, so write them down and help yourself to better understand your disease and treatment.

Through my correspondence via email with Dr. Fine, I can

tell you he is a good family man who gives his time and talents where he can – he coaches Little League among other things. His answers should be forthright and straightforward to you and he certainly seems to be a person who cares about what he does. A great combination!

Dr. Fine was born and raised in New York City. He did his training at Albert Einstein College of Medicine (AECOM), his pathology residency at Montefiore Medical Center, an affiliate of AECOM, and Urologic Pathology Fellowship at Johns Hopkins Hospital.

He joined the Memorial Sloan-Kettering Cancer Center faculty in July 2005 as a member of the Genitourinary Pathology group.

He is Assistant Attending Pathologist at this esteemed hospital.

In addition to clinical diagnostic work, he actively pursues clinicopathologic and molecular research aimed at providing the most accurate diagnosis and classification of prostate cancer and investigating emerging tumor markers for their biologic and prognostic potential.

This promises to be an interesting and informative lecture, so come and learn more about how to be an informed patient. This time it's on a **THURSDAY**, same time, same place as usual. Hope you'll be there.

Weighing Costs in Choosing Cancer Care

WASHINGTON (AP) -- You've just been diagnosed with cancer, and the doctor is discussing treatment options. Should the cost be a deciding factor? Chemotherapy costs are rising so dramatically that later this year, oncologists will get their first guidelines on how to have a straight talk with patients about the affordability of treatment choices, a topic too often side-stepped.

"These are awkward discussions," says Dr. Allen Lichter of the American Society of Clinical Oncology, which is writing the guidelines. "At least we can bring this out in the open."

It's a particular issue for patients whose cancer can't be cured but who are seeking both the longest possible survival and the best quality of life -- and may be acutely aware that gaining precious months could mean bankrupting their families.

The prices can be staggering. Consider: There are two equally effective options to battle metastatic colon cancer, the kind spreading through the body -- but one costs \$60,000 more than the other, says Dr. Leonard Saltz of Memorial Sloan-Kettering Cancer Center.

What's the difference? The cheaper one, irinotecan, causes hair loss that makes it impossible for people trying to keep a job to hide their cancer treatment, he explains. The pricier oxaliplatin can cause nerve damage in hands and feet that might make it a worse option for, say, a musician or computer worker.

Saltz offers a tougher example: A drug for pancreatic cancer -- an especially deadly cancer with few treatment options -- can cost \$4,000 a month. Yet while Tarceva has offered some people remarkable help, research suggests that extra survival on average is a few weeks.

"Is it a good investment, a high-risk investment, or buying a lottery ticket?" is how Saltz puts these choices.

Drug prices are a growing issue for every disease, especially for people who are uninsured. But cancer sticker shock is hitting hard now, as a list of more advanced biotech drugs have made treatment rounds costing \$100,000, or even more, no longer a rarity. Also, patients are living longer, good news but meaning they need treatment for longer periods. The cost of cancer

care is rising 15 percent a year, Lichter notes.

Make no mistake: Some of these newer drugs have greatly helped some patients -- Gleevec, for example, has revolutionized care for a type of leukemia -- and the prices reflect manufacturers' years of research and development investment.

Also, drug companies do donate a certain amount of medication to prescription-assistance programs that provide them for free to patients who otherwise couldn't pay. Since 2005, nearly 5 million people -- cancer patients and people with other diseases -- have been matched to such programs through the drug industry's "Partnership for Prescription Assistance."

But few patients get a Gleevec-style home run, and there's very little research that directly compares competing treatments to guide cancer patients on which might offer the best shot at survival for the money.

"As long as a therapy provides a benefit, it will tend to be offered to patients. Whether

it's a small benefit or a moderate benefit, it may be offered with the same level of enthusiasm," says Dr. Neal J. Meropol of Philadelphia's Fox Chase Cancer Center, who is leading the panel writing ASCO's new guideline on how to weigh treatment costs.

The idea: treat cost essentially as another side effect to weigh in choosing a therapy. Meropol has watched patients do those calculations on their own, like the colon cancer patient who asked to switch from oral chemo to cheaper but more laborious intravenous chemo, or the woman who refused a pricey anti-nausea drug that would make her chemo more bearable.

Even if doctors want to discuss cost, they may not know it -- it's not included in treatment standards. At a meeting of the standard-setting National Comprehensive Care Network earlier this month, Sloan-Kettering's Saltz and other doctors urged adding chemo prices to those treatment guidelines.

"If there's a need to spend it, let's talk about it. If we can do it just as well less expensively, I think doctors should know that and be able to make a decision," Saltz says.

Even the well-insured are feeling the bite as patients are having to shoulder a higher portion of the

bill.

When Medicare began its Part D prescription coverage, retiree Helen Geiger of Whiting, N.J., paid for a premium plan and put it to good use when she was diagnosed with multiple myeloma, a blood cancer. She said the plan listed the cost of her dose of Thalomid at \$5,500 a month but her copay was \$60 a month.

In renewing the prescription plan last year, the 71-year-old Geiger didn't notice that Thalomid coverage had been changed. It now was classified a specialty drug, costing a \$1,051 monthly copay that she couldn't afford. She went several months without the anti-cancer pills, as her doctors at Philadelphia's Fox Chase Cancer Center and her family appealed to the insurer and then scoured charities in hopes of finding her free or cheaper drug.

"You don't need this kind of stress when you're sick," says Geiger, who finally stumbled onto a prescription assistance program that provided her free medicine.

Source: The Associated Press

Thank you all for your Contributions

- Sanford & Nancy Bernstein
Frederick & Gertrude Coons
K. M. Gellhaus
Eugene & Athena Groelle
John J. Hayes
Joseph & Florence Hoffman
Marilyn Koster
Donald & Janet Lattof
Douglas & Nancy McBride
John Nadalin
Bill & Arlene Ryan
Daniel & Margaret Sickles
Louis & Mary Smith
Joe & Sandra Steinman
Don & Joan VanLoan
Edward Weber

In Loving Memory
of Ron Koster
Ward Miller

Prostate Cancer 101 is a 501 (c) (3) IRS approved non-profit organization. Your tax deductible donations should be mailed to:
Prostate Cancer 101
c/o Diane Sutkowski,
Treasurer
8 Alcazar Avenue
Kingston NY 12401-4302

Clinical Depression Rare Following Prostate Cancer Diagnosis

When a man is diagnosed with prostate cancer, the typical reaction is shock and distress. Surprisingly, however, most men do not experience actual clinical depression following diagnosis. In fact, according to a study of nearly 1,000 men conducted by Michael A. Diefenbach, PhD, a psychologist on the staff of the Deane Center, only 10 percent of study subjects experienced what could be called a “pervasive level of distress,” which is different than depression.

The classic symptoms of depression are described as a persistent feeling of sadness and helplessness; a loss of interest in previously enjoyable activities; appetite and/or weight changes; fatigue and a disruption in sleep patterns; an inability to concentrate; and physical discomforts, such as aches and pains, headaches, and stomach upsets.

“To measure distress, we use an ‘Impact of Events Scale,’ which was originally developed to assess Post Traumatic Stress Disorder.” Dr. Diefenbach explains. “Traumatic events, which certainly would include a diagnosis of prostate cancer, usually result in intrusive thoughts that replay the experience in your mind over and over again, even while dreaming. Avoidance is the intense cognitive process the mind

uses to try to keep these thoughts at bay. Although 90 percent of our study subjects displayed average to moderate levels of intrusive thoughts and avoidance behavior, this is not related to clinical depression.”

But Dr. Diefenbach is also quick to add, “By no means does this imply that the emotional impact of a diagnosis of prostate cancer is not significant. One of the primary reasons we developed PIES, The Prostate Interactive Education System, and offer the program to our newly diagnosed patients is to educate them about the various treatment options and openly discuss side effects, as well as to assess their emotional state and provide support.”

Dr. Diefenbach points out, “The main reason most men tend not to experience depressive symptoms after a diagnosis of prostate cancer today is that they are being diagnosed at an early stage via PSA testing, when the cancer is still localized. The news concerning outcome is usually very encouraging. We’ve also found that there is no difference between the emotional reactions to different forms of treatment. However, we do know that the more a man learns about the various treatment options, the

less he will experience regret about the choice he ultimately makes.”

Interestingly, men with prostate cancer report fewer depressive symptoms than women with breast cancer, according to a study that appeared recently in Oncology Nursing Forum. This may be explained, according to Dr. Diefenbach, by the fact that the average man diagnosed with prostate cancer is in his early 60s or older, while the average woman diagnosed with breast cancer is in her 40s or 50s and is at a different state of life relative to family obligations. However, the study did note that the relatively small body of research addressing depression in men with prostate cancer is inadequate to estimate overall prevalence.

“If you’ve been diagnosed with prostate cancer and are experiencing symptoms of depression or emotional distress, we encourage you to get help,” Dr. Diefenbach concludes. “Too often, men try to deny their emotions and suffer in silence.” According to the National Institute of Mental Health, “Treatment for depression helps people manage both diseases (cancer and depression), thus enhancing survival and quality of life.”

Study Details Effects of Prostate Cancer

The following strategies for dealing with depression and emotional distress associated with a diagnosis of prostate cancer may be helpful:

Tell your doctor how you're feeling emotionally, as well as physically. He may suggest taking an antidepressant medication for symptom relief.

Knowledge is power. Get all the facts about various treatment options and discuss the pros and cons of each with your doctor.

Join a support group for men diagnosed with prostate cancer.

Maintain relationships with family and friends. It is important to stay involved to avoid feeling isolated from daily life.

Gentle exercise can work wonders. Go for walks, ride a bicycle, enjoy fresh air and sunlight.

Think positive! The vast majority of men diagnosed with prostate cancer today have early stage, localized disease and treatment is curative. Even men with metastatic disease are living significantly longer, thanks to advances in hormone therapy and chemotherapy.

Source: Deane Center Quarterly

ATLANTA (AP) -- One of the first large quality-of-life studies on today's prostate cancer treatments suggests that for some men, it's a matter of picking your poison and facing potential sexual, urinary or other problems.

Of the choices studied -- surgery, standard radiation, hormone therapy or radioactive seeds -- the seeds seemed to carry a lower risk of several of these side effects.

Hormone therapy -- when combined with radiation -- had a big effect on men's vitality and sexuality. The radioactive pellets sometimes led to sexual problems too, but more often involved discomfort in urinating.

The research, published in Thursday's *New England Journal of Medicine*, doesn't address the cure rates of different treatments. Moreover, not every treatment is an option for every man. For example, radioactive pellets are generally used only in men with early-stage cancer that is slow-growing.

Nor does the study speak to decisions about whether to treat at all a slow-growing form of cancer that can take 10 or 20 years to become life-threatening.

An 80-year-old man may choose to avoid all treatment and the assorted complications. But for a man of, say, 50, the study provides some insight into the side effects of different options, said Dr. William Oh, a Harvard University prostate cancer specialist.

"We've just never had the data that put patients side-by-side like this before," said Oh, who was not involved in the study.

The researchers surveyed about 1,200 patients, as well as 625 wives, who were enrolled at nine U.S. hospitals from March 2003 to March 2006. Telephone surveys were done before treatment began and at two, six, 12 and 24 months afterward.

Nearly 300 of the men in the study underwent brachytherapy, which involved the implant of radioactive pellets (often called "seeds") in the prostate to kill cancer cells.

About 300 got more conventional radiation treatments beamed at a tumor. And nearly 600 had their prostate tumors surgically removed, with most of them undergoing nerve-sparing procedures intended to minimize the operation's effect on sexual performance.

About 90 got hormone therapy in addition to conventional radiation, and some got it in addition to brachytherapy. Hormone therapy, which suppresses testosterone production, is used to enhance radiation treatment and improve survival.

Although life-threatening side effects were rare, men in all the groups experienced, to varying degrees, problems with urinating, achieving erections and moving their bowels.

No procedure was clearly best or worst across the board.

The wives of about 13 percent of men who had brachytherapy said they were distressed by problems with their partner's erections one year after treatment. The spouses of about 22 percent of the men in the traditional radiation group and 44 percent in the surgery group reported the same concern.

Incontinence was most common in the surgery group, with about 15 percent reporting the problem a year or two after treatment. For both standard radiation and brachytherapy, the figures were around 6 to 10 percent.

But when other urinary problems were counted, too - including pain and increased frequency - the brachytherapy group looked worse. About 18 percent of men who underwent

brachytherapy said they had moderate or worse distress from urinary problems one year after treatment, compared with 11 percent of those who had traditional radiation and 7 percent of those who underwent surgery.

Among the most common problems in the brachytherapy group were a burning sensation or other pain, weak urinary stream and a sense of not being able to empty the bladder.

Bowel problems, such as rectal pain and frequency of having to go to the bathroom, were similar in the brachytherapy and radiation groups at one year, and lower in the surgery group.

Men who had radiation reported the least energy and most depression a year after treatment.

The researchers also found that men who had hormone treatments in addition to traditional radiation had worse recovery of sexual function.

Researchers said the study was not designed to provide a head-to-head comparison between treatments, because not each treatment group was the same.

Younger men, white men and college graduates tended to choose surgery more often. Black men tended to favor traditional radiation. Men with the earliest-stage tumors tended to

go for radioactive seeds.

Each man must make his own decision, based on his condition and concerns. But as he weighs particular treatments, this study can give a helpful look at the experiences of men who chose the same option, said study co-author Dr. John Wei, a University of Michigan urologist.

Men should use the study to spark conversations with their physicians about the side effects of different treatments, said Dr. Otis Brawley, national chief medical officer of the American Cancer Society.

Among the men who say they made the right treatment choice is S. Jordan Perlman of Cleveland.

Perlman, 82, for years ran a women's clothing store in Cleveland. He was diagnosed in 1998 with early-stage prostate cancer and chose radioactive seeds, partly out of concern about the impact of surgery on sexual function. He had discomfort sitting down after the seeds were implanted, and a little trouble with incontinence initially.

But those problems quickly ended, and he said he has remained vigorous and continues to take daily power walks.

"I was very lucky," he said.

Source: The Associated Press

Lifestyle therapy for prostate cancer: Does it work?

Prostate cancer is the most common internal malignancy in American men; it's second only to lung cancer among the leading causes of male cancer deaths. That makes it an urgent problem, and it is finally getting the scientific respect it deserves. Still, despite thorough investigations that have yielded major advances, many aspects of the disease remain unknown.

One area of uncertainty is the cause of prostate cancer. Genetics certainly play an important role, but heredity cannot explain most cases. Lifestyle factors have also been implicated; the leading candidate is diet. A high consumption of saturated fat from animal sources is linked to an increased risk of prostate cancer, while whole grains, tomatoes, some vegetables, fish, and soy appear protective. Although the data are less complete, red wine may be protective, while a very high consumption of calcium may be harmful. Some studies also implicate *alpha-linolenic acid*, the omega-3 fat in flaxseeds and canola oil, as a risk factor. Other lifestyle elements that have been linked to the disease include obesity, lack of exercise, and heavy smoking and drinking.

Another area of uncertainty is the best treatment. At one extreme, the evidence favors surgery for men with moderate- to high-grade tumors, especially if

they are younger than 65 and are otherwise healthy. At the other extreme, men with low-grade tumors might be best served by watchful waiting, particularly if they are older than 75 or have illnesses that limit their life expectancy to 10 years or fewer. But many men with early, localized prostate cancer fall between these extremes, and doctors don't know which of them would be best served by active surveillance (deferred treatment with close observation), surgery, radiation, androgen deprivation, or a combination of therapies.

Faced with these uncertainties, it is not surprising that up to 73% of men with prostate cancer take nonprescription supplements, and smaller numbers use diet, exercise, or both in the hope of improving their outcome. Most of these men also receive conventional therapy, but a few depend on lifestyle alone.

The appeal of lifestyle therapy is obvious — but does it work? Experts don't know, though a study raises hope that it may have a beneficial impact.

Designing a trial

Scientists from five American research centers joined forces to study lifestyle therapy for prostate cancer. The trial, conducted in San Francisco, was headed by Dr. Dean Ornish, a nutrition expert, and Dr. Peter Carroll, a noted urologist.

The first challenge was to identify patients who were medically and

ethically appropriate for the study. Only men who had already decided against active conventional therapy were eligible. All the men had newly diagnosed low-grade to moderate-grade prostate cancers (*Gleason score*, less than 7) that were localized to the gland (*stage T1 or T2*). All the men had elevated blood PSA levels of 4 to 10 nanograms per milliliter (ng/ml); none had already made major lifestyle changes, and none was abusing alcohol, tobacco, or drugs. After giving informed consent, 93 men enrolled in the trial; 44 were randomly assigned to the lifestyle therapy group, 49 to the untreated control group. At the start of the trial, the two groups were similar in age, weight, marital status, cholesterol levels, testosterone levels, PSA levels, and in Gleason scores (which predict the likely aggressiveness of prostate cancer cells).

The next challenge was to design a program that was intensive but sustainable. It included four elements:

- **Diet.** Based on Dr. Ornish's ultra-low-fat vegan diet that is sometimes used for heart disease, the regimen provided less than 10% of calories from fat and contained only trace amounts of cholesterol. The menu consisted mainly of fruits, vegetables, whole grain products, legumes, and soy products.
- **Supplements.** Each man took 58 grams of powdered

soy protein, 3 grams of fish oil, 400 IU of vitamin E, 2 grams of vitamin C, and 200 micrograms of selenium every day.

- **Exercise.** The men walked for 30 minutes at a moderate pace six days a week.

- **Stress reduction.** The men performed yoga-based stretching, breathing, meditation, and relaxation exercises for a total of an hour a day.

The third challenge was to measure the effect of the program. Two techniques were used. The main standard was the blood PSA level. The second was the effect of each man's blood serum on the growth of *LNCaP cells*, a standard line of human prostate cancer cells grown in tissue culture.

Results

The trial lasted one year. Three members of the lifestyle treatment group dropped out because the program was too arduous, but none left because they required conventional therapy. Six members of the control group required conventional therapy during the year because of the progression of their disease, indicated by rising PSA levels (4 patients) or MRI images that showed tumor enlargement (2 patients).

Initially, the treatment and control groups had identical PSA levels, which averaged 6.3 ng/ml. At the end of the year, a small but significant difference was evident. The average PSA in the intensive lifestyle group fell to 6 ng/ml whereas the average PSA in the untreated men rose to 6.7 ng/ml. And tests of how the men's blood affected the growth of prostate cancer

cells showed similar changes. Blood samples from the lifestyle treatment group inhibited prostate cancer cell growth by 70%, while samples from the control group inhibited growth by only 9%.

Limitations

The intensive lifestyle study did not answer the \$64,000 question: Can this program improve a man's outlook? Since all the men had early-stage, less aggressive tumors, the cancers would be unlikely to grow fast enough to demonstrate clinical differences in just a year. The scientists are continuing to track the men to see if other differences in symptoms or survival emerge over time. After just a year, though, the trends in PSA levels and cancer cell growth inhibition raise hope that lifestyle treatment may prove helpful. The fact that six of the untreated men, but none of the men who underwent lifestyle changes, required conventional treatment within the first year is another hint that intensive lifestyle treatment may be clinically beneficial.

If this treatment does help, what elements made the difference? Since all the treated men engaged in an intensive program of diet, supplements, exercise, and stress reduction, it is not possible to say how much each part contributed or if milder interventions would have also worked. It's an important question. The intensive program might prove too difficult for many patients. True, only three men quit the

lifestyle regimen, but the trial provided regular counseling by nurses and nutritionists to promote compliance.

Finally, if lifestyle therapy does prove clinically useful, doctors will want to know how it works. The San Francisco study does not explain the mechanism of action. Since testosterone levels did not change, hormones are unlikely to have played a role. Lifestyle therapy did produce an average weight loss of 10 pounds; since obesity is a prostate cancer risk factor, weight loss could play some role. Cholesterol levels also declined in this group, but there is no known link between cholesterol and prostate cancer.

Other investigations

Although the intensive lifestyle trial was careful and scientifically rigorous, it is only one study. But other investigations, though smaller and shorter, tend to support the possibility that lifestyle changes may slow the growth of prostate cancer cells. Here are some examples.

- A four-month 2001 study of 10 men with recurrent prostate cancer reported that a low-fat, plant-based diet combined with stress reduction appeared to slow the rise in PSA levels.
- A 2001 study of 13 overweight men reported that an 11-day regimen of a low-fat, high-fiber diet plus exercise improved the ability of

blood samples to inhibit the growth of LNCaP prostate cancer cells.

- A 2003 study of 34 healthy men reported that blood samples from men who exercised regularly and from men who followed a low-fat, high-fiber diet slowed the growth of LNCaP prostate cancer cells, but blood from sedentary men following typical American diets did not. Further experiments suggested that diet and exercise may exert their effect in a similar way, by reducing levels of *insulin-like growth factor-1* (IGF-1).

- A 2003 study of 12 men who exercised regularly and 10 sedentary men found that blood from the exercisers had lower levels of IGF-1 and was better able to reduce the growth of LNCaP prostate cancer cells. Additional experiments suggested that exercise may act in part by increasing a protein called *p53*, which protects cells from the effects of damaged DNA.

- A 2004 Harvard study of 675 men with treated prostate cancer linked a high consumption of fish with a reduced risk of recurrent or progressive cancer.

- A 2005 study of 49 men with rising PSAs after surgery or radiation treatment suggested that soy-based dietary supplements might slow the rise in PSA levels.

- A 2006 study of 46 men who had rising PSAs after surgery or radiation treatment for early prostate cancer reported that

pomegranate juice slowed the rise in PSA levels.

- A 2006 Harvard study of 1,202 men with localized prostate cancer suggested that the consumption of fish and tomato sauce may offer some protection against disease progression.

- A 2006 study of 14 men with recurrent prostate cancer suggested that a plant-based diet and stress reduction might slow the rise in PSA levels.

-

About supplements

Supplements have obvious appeal. Remember, though, that they are not subject to FDA oversight, and there is no assurance that they contain what they claim or that they are pure, safe, and effective. Supplements can have side effects, and they can interact with conventional medication. If supplements appeal to you, be sure to discuss them with your doctor; never use them as a substitute for good medical care. Some supplements are best avoided. Although the helpful ingredient in tomatoes appears to be lycopene, an antioxidant in the carotene family, a 2006 study of 36 patients with recurrent prostate cancer found no benefit from lycopene supplements. And since antioxidants appear to blunt the effect of radiotherapy (and possibly chemotherapy), men should avoid them during these treatments.

Perspective

A large body of evidence suggests that lifestyle factors have a powerful influence on

a man's risk of prostate cancer. The intensive lifestyle study is a provocative addition to the small body of evidence that raises hope that these changes may improve the outlook of men who already have the disease.

Much more research is needed before lifestyle therapy can be recommended clinically. And even if these changes prove beneficial, they will add to but not replace conventional treatment.

Men with prostate cancer may choose not to wait until science catches up with their disease. Since regular exercise, stress reduction, and a low-fat, high-fiber, plant-based diet are good for general health, they will make a reasonable addition to any prostate cancer program. The same is true for vitamin D. Since supplements of fish oil and low-dose aspirin are proving useful for cardiovascular health, they are also reasonable — and even if soy, vitamin E, and selenium have less benefit for general health, they may still have a rational appeal for men with prostate cancer.

Lifestyle therapy or conventional treatment? For prostate cancer, as for so many areas of health, it's not a question of "either/or" but an answer of "both."

*Source: Harvard Mens Health Watch
Volume 11 – Number 12 – July 2007*

Racial Disparities Persist in U.S. Cancer Treatment

By Will Dunham | Reuters | 01.07.2008

U.S. blacks continue to get inferior cancer treatment compared to whites, researchers said on Monday in a study showing that disparities first documented in the early 1990s persist despite efforts to erase them.

The researchers assessed the type of treatment given to more than 143,000 Americans over age 65 for lung, breast, colon, rectal and prostate cancer from 1992 to 2002 under the Medicare government health insurance program.

Black patients were consistently less likely than whites to receive the recommended types of treatment, the study found, and the problem was just as bad in 2002 as in 1992.

The findings were published in the journal *Cancer*, published by the American Cancer Society.

"What we found was that the racial disparities did not change during that 10-year time interval," Dr. Cary Gross of the Yale University School of Medicine in New Haven, Connecticut, who led the study, said in a tele-

phone interview.

Despite the publication of studies in the early 1990s documenting the disparities and despite steps taken by some doctors and hospitals to understand and address the problem, the study found little in the way of progress.

The reasons for racial disparities in cancer care and many other areas of health care in the United States remain a contentious issue that touches on the question of whether outright racism exists in the U.S. medical system.

"This sort of thing has been a problem in the United States for a long, long time," Dr. Otis Brawley, chief medical officer of the American Cancer Society, said in a telephone interview.

"I think individual racism likely accounts for a small amount of it, but not a large amount. What I would refer to as institutional or societal ra-

cism accounts for a much larger component of it," Brawley added, referring to enduring educational and socioeconomic inequities faced by U.S. blacks.

SOCIETAL INEQUITIES

The disparities were widest in lung, colon and rectal cancer in the study period of 1992 to 2002.

Among patients with early-stage lung cancer, blacks were 19 percent less likely than whites to get surgical removal of the tumor. Blacks with rectal cancer were 27 percent less likely to get additional chemotherapy to get rid of any remaining cancer cells after surgical removal of a tumor. And blacks with colon cancer were 24 percent less likely to get such chemotherapy.

Among breast cancer patients who had a lumpectomy, black women were 7 percent less likely than whites to get radiation therapy. And black men diagnosed with prostate cancer were 11 percent less likely to

get surgical or radiation treatment.

"It documents the inequities in our society more so than documenting racism among individual providers," Gross said.

Gross cited other possible factors, including blacks having less access to quality care due to socioeconomic and other reasons, some blacks being more likely to have other chronic medical conditions like diabetes that could complicate cancer therapy, and blacks perhaps being less trusting of the medical establishment.

Gross said the study did not look at whether there have been improvements since 2002, noting that some initiatives have been put in place since then that might help close the gap.

Copyright 2008 Reuters

Source: National Prostate Cancer Coalition

Bugs provoke the immune system into fighting cancer

From New Scientist Print Edition

DISEASE-causing bugs could play a valuable role in the treatment of cancer. Deliberately infecting people with the bacteria that cause listeriosis could increase their ability to destroy tumours. The goal is to kick-start the body's immune system by "provoking" it with the bacteria, which are modified to trigger an attack on the cancer.

US vaccine company Advaxis chose *Listeria monocytogenes* because of its ability to stow away in immune cells called antigen-presenting cells (APCs). These cells prime the rest of the immune system to attack a given strain of microbe, say, by showing fragments of antigen from that microbe to the appropriate cells.

Advaxis modified the bacterium so it was no longer harmful, and so that once inside the APC it would secrete fragments of HPV-E7, a molecule found on the surface of cervical cancer cells. By presenting HPV-E7 to other immune cells, the APCs would then prime them to attack the cancer.

In a preliminary trial on 13 women with advanced cervical cancer, four of those injected with the bacteria responded. One is tumour-free more than two years after the treatment, and tumours in the other three shrank by 20 per cent. Seven of the women have died from the cancer. Advaxis hopes to begin a trial on 180 patients with less advanced cervical cancer.

John Stanford of University College London, whose team has had recent success treating cancer patients with dead *Mycobacterium vaccae*, says that Advaxis may need to give booster doses to sustain the therapeutic effect.

Cancer - Learn more about one of the world's biggest killers in our comprehensive special report.

Source: From issue 2649 of New Scientist magazine, 29 March 2008, page 17

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

1st

Tuesday

3rd

Tuesday

4:30 p.m. monthly

**SEMINAR
For
Newly Diagnosed**

**Distinguished
Lecturer
Series**

Hurley Reformed Church Hall, Hurley, NY

**Poughkeepsie Man to Man
Group
Our brothers in support and
education**

Meetings are held the First Thursday of the month at the Central Hudson Auditorium on South Road in Poughkeepsie, starting at 6:30 PM. The April 3 meeting will be at held at the Manor at Woodside, just west of the intersection of Route 9 and Academy Street due to a scheduling conflict. The speaker at the April meeting will be Abraham Mittleman, PhD, MD, a medical oncologist. One on one help is available after the meeting
Contact – Paul Totta 845 297-7992 or Jim Kiseda 223-5007

**If you need or want to
help:**

**PCa 101 Seminar
First Tuesday of every
month**

Fred Bell 845 338-1161
Fwbelljr1@aol.com

Gene Groelle 845 338-1805
Gro226@aol.com

**Website & Newsletters
<http://prostatecancer101.org>**

Walt Sutkowski 331-7241
wsutkowski@hvc.rr.com

**Greeters/Church Hall
Setup**

Bob Miggins 382-1305
GD7M37@verizon.net

Ralph Calcavecchio 331-2369

2008 Programs
Arlene Ryan 338-9229
Aryan@hvc.rr.com

Diane Sutkowski 331-7241
dsutkowski@hvc.rr.com

Membership, etc.
Diane Sutkowski 331-7241
dsutkowski@hvc.rr.com