Newsletter

Prostate Cancer 101, Inc.

http://prostatecancer101.org

December, 2008

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

It's our Annual Sharing and Caring Gathering Tuesday, December 16 at 4:30 PM

This is the meeting where our members are the stars. It's the opportunity to share your journey, give thanks, and to ask those questions that may be preying on your mind. Another member may just have had the same problem and will share his

experiences with you.

We are keeping our fingers crossed that three fine Kingston doctors

will be able to join us to help answer any specific medical questions you have pertaining to prostate cancer, it's treatment and possible side effects. **Dr. Elizabeth Tapen**, **Dr. Paul Pietrow and Dr. Naeem Rahman** are hoping there will be no emergencies so that they can all be there on the 16th.

And just to sweeten the pot, there will be refreshments along with the sharing. Now, how can you resist? So don't!

Be there, share and don't forget to smile!

Merry Christmas, Happy Chanukah and a Happy, Healthy and Economically stable New Year from your Officers and Board.

Discovery Offers Way of Tracking Cancer in Blood

By using exosomes, doctors might be able to get specific information about a cancer from a simple blood test

By Julie Steenhuysen

Monday, Nov. 17 (Reuters Health) -- Tiny sacs released from tumor cells and circulating in the blood carry genetic information about the tumor, offering a new way to track and treat the cancer, U.S. researchers said on Sunday.

"They contain a little piece of the tumor cell in the blood stream. If you just look at these packets, you basically know what kind of mutations are in the tumor cell," said Xandra Breakefield of Massachusetts General Hospital in Boston, whose study appears in the journal Nature Cell Biology.

These membrane-covered packets, called exosomes, represent a new way of getting information about a cancer, offering a means of choosing the best therapy, seeing how a patient responds to treatment, and possibly offering a way to deliver therapies back to the tumor, Breakefield said.

"It's a whole new concept of cell communication we didn't know tumors used," Breakefield said in a telephone interview.

She said for most forms of cancer, there is no good way to know what genetic mutations are in a tumor, short of taking a sample and doing a biopsy.

Many current blood tests, such as the prostate specific antigen, or PSA, test for prostate cancer, simply check for elevated levels of a specific protein.

By using exosomes, doctors might be able to get specific information about a cancer from a simple blood test.

"It's a blood biomarker," she said.

Johan Skog, who works in Breakefield's lab and led the study, said many types of cells release exosomes as part of normal cell-to-cell communication, and several types of tumors are known to shed exosomes containing proteins that can alter the environment to make it more favorable to tumor growth.

"It's a form of cell communication that normal cells use but tumor cells use with a vengeance," Skog said in a telephone interview.

For the study, the researchers carefully analyzed the contents of the exosomes shed from glioblastoma cells. Glioblastoma is a type of aggressive brain cancer.

Inside, they found fragments of genetic messenger ribonucleic acid, or RNA, including cell messengers related to cell growth, immune response and the construction of new blood vessels.

When they exposed these exosomes to normal cells in the lab, the tumor RNA delivered its genetic message into the cells.

"That is important to know. We didn't realize they had this external means of communicating with their surroundings," Breakefield said.

The team also analyzed blood and tissue samples from 25 brain cancer patients. They were able to find tumor exosomes in both. In two patients, this analysis turned up a specific genetic mutation in the epidermal growth factor receptor, or EGFR, gene that a surgical biopsy had missed.

The first step would be to develop a blood test, but eventually Skog thinks it may be possible to use the exosomes to deliver therapies to the cancer.

Massachusetts General Hospital has licensed the technology to Exosome Diagnostics Inc, where Skog is director of research in addition to his duties at the hospital.

Source: Prostate Cancer Foundation as reported by Reuters

Personality Predicts Prostate Cancer Treatment Decision-Making Difficulty And Satisfaction

by Christopher P. Evans | UroToday.com | 11.03.2008

UroToday.com - In the online edition of *Psycho-Oncology*, a group of American investigators reported on the link between personality and prostate cancer (CaP) decision-making and satisfaction. This intriguing paper evaluated the optimist's ability to engage more fully and effectively in coping with or meeting an important challenge and how optimism may also positively impact CaP decision-making outcomes. The group hypothesized that patients with greater optimism in CaP decision-making would be more satisfied and experience less difficulty with the process and that these effects would be partially mediated by their self-efficacy for making treatment decisions. In the research, they controlled for covariates to include the importance of treatment side effects, demographic characteristics and levels of agreement between preferred and perceived levels of decisional control.

The study cohort included 202 patients recently diagnosed with localized CaP. Of these, 159 (78.71%) returned the survey. Independent variables included optimism (assessed by the Life Orientation Test-Revised), and treatment decision-making self-efficacy (assessed by 3-questions). Dependent variables evaluated decision-making satisfaction (assessed with the Holmes-Rovner Decision Scale) and decision-making difficulty (assessed with 3 items). Covariates included influence of side effects, agreement between preferred and perceived levels of decisional control, and demographic characteristics.

Two sets of predictor variables were related. Optimism varied as a function of education, with more educated patients displaying greater optimism. Self-efficacy and agreement between preferred and perceived levels of decisional control were positively associated. Mean scores for the continuous predictor variables were 2.27 out of 4 for importance of side-effects, 3.71 out of 5 for optimism, and 2.67 out of 3 for decision-making self-efficacy. Difficulty with the decision was reported by 31%, indicating that they either agreed or strongly agreed with the statements about finding the decision process difficult. Hierarchical multiple regression revealed the relative contributions of the predictors to difficulty with decision-making, including the contributions of optimism, and treatment decision-making self-efficacy over and above those predictors of decision-making satisfaction previously reported in the literature. Demographic characteristics and agreement between preferred and perceived levels of decisional control did not contribute to the model. Influence of side effects contributed significantly to the model. Optimism was added to the model and explained an additional 7% of the variability in difficulty, and decision-making self-efficacy accounted for an additional 8% of the variability in decision-making difficulty. Controlling for other variables in the model, a unit increase in self-efficacy was associated with a 0.70-point reduction in difficulty on a scale rang-

ing from 1 to 5. When all the variables were in the equation, influence of side effects, race and education were significant predictors of treatment decision-making difficulty. African-American race was associated with more difficult decision-making.

Addition of treatment decision-making self-efficacy to the model reduced the effect of dispositional optimism on difficulty with decision-making by 32.5%, suggesting that self-efficacy partially mediated the effect of optimism on decision-making difficulty. The authors reported that 34% of patients claimed dissatisfaction with the decision-making process. In hierarchical multiple regression analysis, optimism explained 14%, and decision-making self-efficacy 12% of the variability in satisfaction.

These data suggest that education and modification of self-efficacy may help in the decision-making ability of patients low in optimism, and potentially improve their confidence in their ability to make decisions.

Orom H, Penner LA, West BT,

doi:10.1002/pon.1385

Source: Zero-The Project to End Prostate Cancer

Clinical Trials: At Your Own Risk

ORLANDO, Fla. (Ivanhoe Newswire) -- There are 40,000 clinical trials going on in the United States right now and more than a million people are taking part in them. That's more people than in the state of Alaska. All participants hope for a breakthrough that will save their life and the lives of others, but is the risk worth it? Ivanhoe reports on the good, the bad and the unknown of clinical trials.

The lives of Karen DeGray, Joshua Pelling and Cyndi Williams were all threatened by serious illness.

"I was diagnosed originally with lymphoma and it didn't look very promising," DeGray recalled to Ivanhoe.

"I noticed his heart was racing a little more," Leticia Pelling said of her son Joshua. "He was breathing 100 times per minute."

"Two or three times a week I was having low sugars," Williams described. "They put me on a bunch of IVs. They were giving me all kinds of fluids."

All three individuals were saved by clinical trials.

"I really truly am a miracle," DeGray, who was treated at the University of Miami Sylvester Comprehensive Cancer Center, said.

"He would have died," Leticia recalled. "As far as I know, there really isn't another option."

"I don't take shots anymore and I'm not diabetic," Williams said.

But not all stories have a happy ending.

"Someone who says they have nothing else to lose, that's exactly the populate you have to worry about," Michael A. Grodin, M.D., professor and director of the Law, Medicine, Ethics and Human Rights Program, Boston University, told Ivanhoe.

Less than five percent of people in phase one trials receive any health benefit, but when a University of Chicago study asked patients why they enrolled, 85 percent were hoping to be cured.

"For every 100 drugs that are out there tested, 70 of them don't work," Dr. Grodin said. "Another 10 of them hurt people. Another five of them may be of some benefit, and one of them is better than what already exists."

Federal records show since 1999 at least four people who entered clinical trials in good health died.

"The first and most important thing patients need to be aware of is that clinical trials are not being done for the patient," Dr. Grodin said.

Trials happen in phases. Phase one uses a small group of perhaps 20 people. Researchers evaluate safety, dosage and side effects.
"One potential side effect is death," Kevin Weinfurt, Ph.D., an associate professor in the department of psychiatry at Duke Clinical Research Institute in Durham, N.C., told Ivanhoe.

Phase two involves about 80 people. The goal is to determine effectiveness and measure side effects. Phase three involves a thousand or more people for longer periods of time. Phase four trials are post-marketing studies confirming risks and benefits.
"The researcher is there to gain generalized knowledge," Dr. Grodin said. "They're not there to benefit you."
We asked doctors what are the critical questions people need to ask before joining a clinical trial.

"They need to know why they are being approached, what the goals are, what the purpose is of the research, and then what the risks, the benefits and the alternatives are," Dr. Grodin explained.
"How is participating in this study different than if you were providing regular care?" Dr. Weinfurt said.
One of the most important questions to ask: will there be a placebo group? If that's the case, that means no one in the trial will know if they're getting the real drug or a fake.
"It's just going to be a coin toss, and so you want to be very careful about that when there is a placebo group involved," Dr. Weinfurt explained
On average, 20 drugs make it from the clinical trial to the pharmacy each year. That's not a lot of new drugs, but they can pack a powerful impact for people they save.
"I'm just happy to be alive," DeGray said.

For each life saved, there are thousands more waiting and wondering if medicine will make it in time for them.
You can find the most comprehensive lists of ongoing clinical trials on the web at http://www.centerwatch.com http://www.clinicaltrials.gov.

If this story or any other Ivanhoe story has impacted your life or prompted you or someone you know to seek or change treatments, please let us know by contacting Lindsay Braun at lbraun@ivanhoe.com.

FOR MORE INFORMATION, PLEASE CONTACT:

http://www.centerwatch.com
ClinicalTrials.gov, U.S. Na-

http://www.clinicaltrials.gov
University of Miami Sylvester Comprehensive Cancer Center
http://www.sylvester.org/

Thank you all for your Contributions

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PSA Doubling Time and Time to Biochemical Failure may Predict Prostate Cancer-specific Mortality

HemOnco Today | 11.05.2008
Time to biochemical failure and PSA doubling time may be useful surrogate markers for prostate cancer-specific mortality among patients who fail curative treatment.

Researchers from the School of Medicine and Public Health in Newcastle, Australia and the Wellington Cancer Centre in New Zealand conducted a surrogacy study to determine the efficacy of time to biochemical failure and PSA doubling time as surrogate markers using data from the Trans-Tasman Radiation Oncology Group 96.01 trial.

The trial included 802 men with locally advanced prostate cancer. From 1996 to 2000, participants were randomly assigned to prostate irradiation or to three or six months of maximum short-term androgen deprivation therapy before and during radiation, according to the researchers.

Compared with radiation alone, short-term androgen deprivation for six months decreased prostate cancer-specific mortality (HR=0.56; P=.01); however, deprivation for three months did not (HR=0.95; P=.79).

PSA doubling time successfully predicted the time from randomization to death from prostate cancer and satisfied four Prentice criteria at cut points of <12 months and <15 months. Proportion of treatment effect ratios was between 0.36 and 0.56.

However, time to biochemical failure was superior at predicting the trial finding and satisfying Prentice criteria at cut points <1.5 years, <2 years and <2.5 years. The proportion of treatment effect ratios was between 0.45 and 0.64.

According to the researchers, PSA doubling time and time to biochemical failure may have the potential to reduce follow-up in clinical trials. by Stacey L. Adams

Lancet Oncol. 2008;9:1058-1068.

Source:HemOnco Today 2008

Prostate Cancer and Masculinity

BY CHARLES (CHUCK) MAACK – Prostate Cancer Advocate

In opening: The capability to have an erection does not define what constitutes the title "Man."

I've become exasperated reading of men claiming they are less a man because they are unable to get an erection or have lost libido/potency. "I'm less a man," "I'm a eunuch," "I'm a girly-man."

Where in God's name have such ridiculous thoughts come from? This, in my mind, is the perfect example of some men's brains being enclosed within their penis rather than in their head.

I can agree that loss of capability for erection plus loss of libido are blows that strike at key capabilities associated with being a male.

But I am absolutely no less a man than I was through all the decades of my life before discovery of the prostate cancer made it necessary for me to take medical treatments that resulted in my loss of li-

bido/potency/erection.

Many men define what makes a man in terms of strength and power. I am a former martial arts competitor and Sensei/instructor Black Belt in Kodokan Judo. I still know as much about self defense (and offense) as I did prior to the onset of my cancer. Despite my loss of libido/potency/erection capability, in strength and power I am still just as much a man.

The true stature of a man is measured by his accomplishments, his attention to family, and his concern for others. Fulfillment of the duties of husband and father is part of the male role. Loss of libido or erection capability does not circumvent that role nor make the person in that role any less a man.

As for concern for others, I've chosen to research and study prostate cancer and its treatment in order to help other men and their caregivers wade their way through the complexities of our insidious men's disease. I've done so to ease the burden of anxiety that so often accompanies diagnosis. Loss of the capability for erection and loss of libido/potency has had absolutely no effect in my ability in this regard.

I don't waste my life lamenting over losses that followed, unavoidably, on my fight to stay alive. I do not accept that my acceptance of medical necessity makes me any less a man.

The foregoing remarks are intended to help men recognize that despite losses of capability because of medical necessity, they are no less a man.

This does not mean I would want anyone to quit the good fight. As long as there is the possibility of return of libido and/or erectile function, men should strive for that opportunity.

But if and when circumstances dictate that restoration of the libido and erections is unlikely, quit agonizing. Accept and move on. One is no less the man than he ever was; medically restricted, yes, less a man, no.

As in opening, so in closing: The capability to have an erection does not define what constitutes the title "Man."

My opinion

Chuck, a member of U.S. NAVAL CRYPTOLOGIC VETERANS ASSOCIATION, is Treasurer of Wichita, Kansas Chapter Us TOO Intl., Inc.

Source: psa-rising.com

10 Lessons of Prostate Cancer

By Dana Jennings

Every week, New York Times editor Dana Jennings shares his experiences coping with prostate cancer.

By Dana Jennings

Dana Jennings. (Lonnie Schlein/The New York Times)

Prostate cancer is a dark waltz, not the raging battle of popular imagination. From that first elevated PSA blood test, to the biopsy, to treatment, to those evil twins of impotence and incontinence and beyond, I'm still learning some very complicated steps more than seven months after my diagnosis.

Cancer is a hard teacher. No matter how much you glean from the Web, how many fellow travelers you talk to, how many questions you ask nurses and doctors, there are some lessons — physical, practical, emotional — that can only be learned firsthand.

I confess that I feel utterly vulnerable. But, as the poet Theodore Roethke wrote, "Those who are willing to be vulnerable move among the mysteries." So, as I continue to move among these mysteries, here are 10 nuggets of prostate cancer wisdom that I had to learn for myself.

1) **Cancer takes you home.** The hardest thing I've had to do since my diagnosis — and that includes having my radical open prostatectomy — was tell my parents that I had prostate cancer. My folks are working-class country people. They're both 68, and they were 17 when I was born in 1957 — eight days after they got married. The three of us, literally, grew up together, and I've always been their little hyper-verbal mystery. They never quite understood why I needed to get the hell out of Kingston, N.H. And when I called them last April to say that I had cancer — maybe, after all these years, confirming their worst fears about life in and around New York City — I could barely speak for my fierce tears. Tears more for them, I know, than for me.

2) **Doctors forget to share the gory details.** After my prostate was removed, my testicles swelled to the size of shot-puts — bright, red shot-puts — and stayed that way for days. Nobody told me to expect this condition, and only ice brought relief. (Conversely, now that I'm undergoing hormonal therapy, my testicles are shrinking.)

3) **Insurance can cause more stress than cancer.** The goal of your insurer — no matter how singular or complex your case is — is to try to turn you into a statistical cliché, a cipher, in the face of your very human flesh-and-blood disease. In the months after my diagnosis, as my wife and I struggled to find the right pair of highly-skilled hands to perform my potentially difficult surgery, wrestling with my insurer caused me more grief, stress and depression than my cancer did. In our modern health-care-industrial-complex — and I'm talking about the bureaucrats who try to herd you into the cheapest cattle car available, not the nurses and doctors who are on the front lines — the emphasis is neither on health nor care, but on the bottom line. It's our job, as patients, to resist with all our strength.

Prostate Cancer Journal

One Man's Story

Dana Jennings blogs about his experience with prostate cancer.

- Real Men Get Prostate Cancer
- The Good Cancer?
-
-

4) **Humor is all around you.** On Halloween morning my wife and I were driving to the Cancer Institute of New Jersey in New Brunswick for my treatment. Just a quarter-mile from the institute we were stuck in traffic behind a truck … a casket truck: "Batesville Casket Company," it read, "A Hillenbrand industry, helping families honor the lives of those they love." All I could do was laugh harder than I had in days. (On a different drive down, the Beatles' "Do You Want to

Know a Secret" came on the radio, and I dissolved into tears. I still don't understand why.)

5) **Not all blood techs are created equal.** Some glide that needle into your vein as if they're figure-skating on your arm. Others jab and stab as if they got their only training from watching the "Saw" movies. (By the way, only blood is "blood red.")

6) **Nurses know what you need.** I groaned in absolute gratitude in the recovery room at the post-op ice chips the nurses spooned into my swollen, anesthesia-parched mouth.

7) **Cancer can be a punch line.** I learned pretty quickly, with my wife and sons, that the phrase, "I've got cancer," wasn't a bad punch line — as in: "You take out the dog. I've got cancer" or "You answer the phone. I've got cancer" or "I 'call' the TV to watch 'Monday Night Football.' I've got cancer." They'd all roll their eyes, laugh … then go do what I asked.

8) **Home remedies are essential to cancer recovery.** There is no better post-op therapy on a sweltering July day than a cold glass of lemonade, a transcendent oldie on the CD player — say, "Doggin' Around" by Jackie Wilson — a stack of comic books at hand ("The Incredible Hulk," "The Mighty Thor") and the grace of a funny and compassionate visitor.

9) **Don't sneeze after surgery.** My first post-op sneeze felt as if some beyond-feral wolverine had burrowed its way into my gut, possibly seeking a second prostate that the docs had somehow overlooked.

10) **You can find hope in strange places.** A few times a day, after my operation, I'd run my fingers up and down the 25 metal staples that the surgeon had used to close me up — the skin around them red-purple, proud, tender and feeling as if it belonged to someone else. Sometimes, in fingering those staples, I felt that they were the only things in this world, in their plain and utilitarian way, that were possibly holding me together.

Source:nytimes.com Health section

Minority Patients Prefer Empowering Cancer Messages

Harping on negative consequences of a lack of cancer screening among minorities can actually make African-Americans less likely to go for screening, according to behavioral science research published in Cancer Epidemiology, Biomarkers & Prevention, a journal of the American Association for Cancer Research.

"We have typically assumed that one of the best ways to motivate individuals is to point out disparities in health, but we may be having negative unintended consequences," said Robert Nicholson, Ph.D., an assistant professor in the Department of Neurology and Psychiatry at the St. Louis University School of Public Health. "Instead of motivating people who would be less likely to get these services in the first place, we may be driving them away."

Historically, minority communities have been deprived of a fair share of benefits from cut-

ting-edge medical efforts. Sensitive to this history, cancer advocacy groups have tried to reach out to minority communities to raise levels of access to known prevention and treatment strategies. But no one knew whether the message was getting across in an effective way.

Nicholson and colleagues conducted a double-blind, randomized trial among 300 African-American adults. The adults were asked to read one of four articles about colon cancer and then answer questions about their likelihood of getting screened.

The first article emphasized that colon cancer was an important problem for African-Americans.
The second emphasized that outcomes for blacks with colon cancer were worse than for whites.
A third approached said that although outcomes for African-Americans were improving the improvement was less than seen among whites.
Finally, a fourth article discussed how outcomes for blacks with colon cancer were improving over time.
If African-Americans read the article that said outcomes for blacks were improving over time, they were more likely to have a positive emotional response than if they read any of the other three articles. The article most likely to cause a negative response was the one that simply stated the problem.

Those who read the article about African-Americans making progress in outcomes for colon cancer were far more likely to want to be screened than those who read any of the other three articles.

The mean age of the participants was 54.4 years, 76 percent were women and 89 percent had completed high school. Comprehension analysis found that all participants understood what they had read.

Nicholson said his team did not ask questions about motivation, but he believes that a general mistrust of the medical community may be playing a role. If information reinforces that mistrust, then African-Americans are less likely to be screened.

"We believe that a positive message would go a long way toward overcoming mistrust," Nicholson said. "We need the right kind of message for the right kind of person, and not to assume that what we have always done is working."

Source: psa-rising.com

Studies Make Case for Finasteride to Prevent Prostate Cancer

Adapted from the NCI Cancer Bulletin, vol. 5/no. 11, May 27, 2008 (see the current issue).

The initial results from the largest completed prostate cancer prevention trial appear to have underestimated the benefits and overestimated the potential risks of finasteride, according to three new analyses of data from the trial.

These results bolster the case for finasteride as a preventive agent against prostate cancer, say the studies' leaders.

Results from two of the analyses were presented on May 18, 2008, at the American Urology Association annual meeting in Orlando, Fla., and all three appeared online the same day in the journal Cancer Prevention Research.

Initial results from that trial, the nearly 19,000-participant Prostate Cancer Prevention Trial (PCPT), were published in 2003 and showed that men who took 5 mg of finasteride daily for seven years had a 25 percent reduced risk of developing prostate cancer compared with men taking a placebo.

However, finasteride treatment was also associated with a small but statistically significant increased risk for developing high-grade prostate cancers, those with Gleason scores of 7 to 10. And because the preventive benefit was the result of a reduction of

non-high grade cancers, those with a Gleason score of 6 or less, some prostate cancer researchers argued that finasteride only prevents indolent cancers that would never require treatment, explains Dr. Ian Thompson, chair of the Department of Urology at the University of Texas Health Science Center at San Antonio and a senior author on two of the new analyses.

Neither conclusion, he says, now appears to be accurate.

"We've now shown that the cancers prevented by finasteride are often clinically significant, the same kind of cancers that lead to surgery," Dr. Thompson says. "In addition, we showed a 28 percent reduction of high-grade cancer with finasteride."

In a related editorial in Cancer Prevention Research, Drs. Christopher Logothetis and Paul Schellhammer, from University of Texas M.D. Anderson Cancer Center and Eastern Virginia Medical School, respectively, lauded the analyses, arguing that the results demonstrate that "the promise of prostate cancer prevention is a reality."

Two of the analyses were conducted independently, using 500 prostatectomy samples from the more than 2,000 patients diagnosed with cancer in the PCPT, to estimate the "true rate" of high-grade disease in the two study arms (finasteride and placebo). The analyses, one led by Dr. Mary Redman from Fred Hutchinson Cancer Research Center and the other by the National Cancer Institute's (NCI) Dr. Paul Pinsky, used statistical modeling to extrapolate the Gleason scores at prostatectomy to the larger study population. Prostatectomy is the gold-standard for determining Gleason scores. Both analyses adjusted for the fact that, as recent studies have shown, finasteride increases the sensitivity of both prostate-specific antigen (PSA) testing and needle biopsy for detecting high-grade cancer.

No overall increase in high-grade disease associated with finasteride was found by either analysis, Dr. Thompson stresses. Instead, they found that finasteride had a modest protective effect, driven by the reduction in tumors scored as Gleason 7. Because of the limited number of cancers scored as Gleason 8 to 10, says Dr. Howard Parnes from NCI's Division of Cancer Prevention, it's not possible to draw firm conclusions about finasteride's affect on such tumors.

The third analysis, conducted by Dr. Scott Lucia from the University of Colorado Denver and colleagues, addressed whether finasteride prevents "clinically significant" prostate cancer by examining the extent of cancer present in the PCPT biopsy specimens of Gleason score 6 cancers - again, the cancers that finasteride was shown to inhibit in the PCPT. They assessed biopsy samples according to two different sets of criteria that can be used to guide treatment decisions. Sixty percent of tumors given a Gleason score of 6 or less were clinically significant by these criteria.

More than 90 percent of men whose prostate biopsies have Gleason scores of 6 opt to receive immediate treatment, explains Dr. Parnes, a co-author on two of the analyses. So, regardless of whether they would be considered clinically significant by these biopsy criteria, he says, "We shouldn't overlook the importance of preventing the so-called 'clinically insignificant' tumors."

Finasteride is not yet approved by the Food and Drug Administration (FDA) for prostate cancer prevention, Dr. Parnes cautions. "However, men committed to regular screening and those with benign prostatic hyperplasia (BPH) may want to discuss this option with their physicians," he adds. Finasteride is FDA-approved for treating BPH symptoms and, at a lower dose, for reducing hair loss.

FDA approval aside, there are other factors holding finasteride back, says Dr. Brantley Thrasher, chair of Urology at the University of Kansas Medical Center.

Urologists have become "acclimated" to the idea that finasteride increases the risk of high-grade disease, he says. And it's more than that. "Nobody has worked out which patients we should be recommending finasteride to," Dr. Thrasher adds. "I think it will be an uphill battle to get wider adoption."

The AUA and American Society of Clinical Oncology are in the process of developing guidance on finasteride use for prostate cancer prevention, Dr. Parnes says.

Source: NCI (National Cancer Institute)

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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