Newsletter

Prostate Cancer 101, Inc.

http://prostatecancer101.org

December, 2011

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

PCF Responds to U.S. Preventive Services Task Force Recommendation on PSA Screening

While needing better guidelines, the PSA test still plays an important role in detecting early prostate cancer in informed patients.

LOS ANGELES/October 10, 2011—The mission of the Prostate Cancer Foundation (PCF) is ending suffering and death from prostate cancer through research. PCF received a copy of the U.S. Preventive Services Take Force report late Friday. Today, PCF issued its analysis of the heavily-debated recommendations of the U.S. Preventive Services Task Force regarding PSA screening in healthy men.

The Prostate Cancer Foundation:

Supports continued routine PSA screening of informed patients until new American Urological Association clinical guidelines on PSA screening are issued and disseminated.

Supports a patient's choice to have a PSA test. The decision should be made between a man and his personal physician based on his individual status with respect to age, symptoms, family history or concerns about prostate cancer.

Supports American Cancer Society communications calling for far better processes of informed patient decision-making both prior to, and after, PSA screening in healthy men.

Opposes the elimination of reimbursement for an informed patient requesting screening.

Strongly recommends intensified National Cancer Institute focus and research investment in better early detection tests of lethal prostate cancers. We also recommend new public-private research partnerships drawn from substantially increased and coordinated research investments from the American Cancer Society (ACS) and the American Urologic Association (AUA) partnering with the NCI and PCF. Such public-private partnerships will accelerate the discovery, testing, and validation in U.S. men of new biotechnologies for lethal cancer detection that are superior to PSA screening.

Calls for greater patient participation in clinical studies evaluating new genomics-based prostate cancer detection tests.

Calls for greater eligible patient participation in and physician referral of patients to ongoing new clinical trials evaluating Proactive Surveillance (watchful waiting).

Additional Observations

The USPSTF has heightened awareness with new data of the issue of severe complications

and patient suffering from the over diagnosis and overtreatment of indolent prostate cancers. In addition to the emotional and physical suffering experienced by men and their families, a recent cost-effectiveness analysis of PSA screening estimated that the cost of diagnosis and treatment is over $5,227,306 per patient to prevent one U.S. prostate cancer death.

The USPSTF's position provides a teachable and actionable moment for the medical community to improve targeting of PSA screening in patients, reduce overtesting and improve processes of patient education on the risks of overtreatment from PSA screening.

In the abstract, "task force" recommendations can create patient confusion and may result in unquantifiable numbers of men who will get a delayed diagnosis of a lethal and curable cancer. However, it should be noted that the recommendation clearly states, "…while the USPSTF discourages the use of screening tests for which the benefits do not outweigh the harms in the target population, it recognizes the common use of PSA screening in practice today and understands that some men will continue to request and some physicians will continue to offer screening. An individual man may choose to be screened because he places a higher value on the possibility of benefit, however small, than the known harms that accompany screening and treatment of screen-detected cancer, particularly the harms of over diagnosis and overtreatment. This decision should be an informed decision, preferably made in consultation with a regular care provider. No man should be screened without his understanding and consent; community-based and employer-based screening that does not allow an informed choice should be discontinued."

PCF is encouraged that the AUA has convened a panel of medical experts who work routinely with prostate cancer patients, to improve guidelines for more targeted use of the PSA test as a screening tool.

Moving Past the PSA Debate

The PSA test still has a role to play in early detection and treatment for millions of men. It should be noted that in the pre-PSA era, approximately 80% of patients who were diagnosed with prostate cancer, were already in advanced stages of the disease with metastatic cancer. Today, the number of patients who are diagnosed with metastatic disease at time of initial diagnosis is around 20%. In the past 15 years, the death rate has been reduced from 42,000 annually to 33,000.

The PSA debate can become moot with intensive and accelerated research that delivers a better test. For more than a decade, PCF has been supporting research to find new and better molecular biomarkers for prostate cancer. At PCF's 2011 Scientific Retreat, data on 17 new biotechnologies that complement or have the potential to replace PSA screening was presented. Many of these biotechnologies have the potential to discern between indolent and lethal prostate cancers. Essential will be patient participation in clinical trials to evaluate these new tests. New data on urine and blood tests using genetic biomarkers also offer the promise of eliminating a large number of unneeded biopsies and subsequent unnecessary treatment.

Given the enormity of the problem of overdiagnosis and overtreatment, PCF is also supporting a $5 million research project, the National Proactive Surveillance Network, to determine which patients can be maintained on proactive surveillance and which patients need to be recommended for surgery or radiation. Additional clinical trials of proactive surveillance are urgently needed to develop guidelines for men whose cancer is not life-threatening.

Source: PCF Prostate Cancer Foundation

Furor Over New Prostate Test Recommendations

Thursday, October 6, 2011 10:53 PM

Reports that an influential group of advisers plans to recommend against routine screening of prostate cancer has drawn criticism from health groups worried the move will increase cancer deaths in men.

The New York Times on Thursday reported that the U.S. Preventive Services Task Force, the same group that recommended doctors scale back on mammograms for women, is thinking of recommending against use of the prostate-specific antigen or PSA test.

The Times and other news outlets said the task force, an independent panel appointed by the federal government, plans to give a common blood test known as the PSA test a rating of "D," suggesting there is moderate or high certainty that the test has no net benefit or that the harms outweigh the benefits.

Current recommendations say there is insufficient evidence to support the use of the test.

"Today's decision of no confidence on the PSA test by the U.S. government condemns tens of thousands of men to die this year and every year going forward if families are to believe the out-of-date evidence presented by the USPSTF," said Skip Lockwood, chief executive of ZERO, a group devoted to ending prostate cancer.

"A decision on how best to test and treat for prostate cancer must be made between a man and his doctor. This decision is coming from a panel that doesn't even include a urologist or medical oncologist."

Dr. Scott Eggener, an expert in prostate cancer from the University of Chicago, said the new recommendations, if adopted, would discourage men from getting prostate cancer screening.

Eggener said the move "is a classic example of 'throwing the baby out with the bath water.' A more sensible approach is to use all of our currently available tools to intelligently determine which patients are most likely to benefit from screening and treatment."

The prostate-specific antigen or PSA test measures levels of a protein produced by the prostate gland to gauge a man's risk of prostate cancer, but the test has a high rate of false positives.

Many studies have suggested that PSA screening does more harm than good because it can identify slow-growing cancers that may never have posed any health threat.

And once men hear they have a risk of prostate cancer, they often opt for treatment, which can cause impotence and incontinence.

The problem is that there is no accurate way at the moment to tell which tumors are deadly, and which are harmless.

And prostate cancer remains deadly. It is the second leading cause of cancer death in the United States behind lung cancer.

Lockwood said recent studies, including one from Sweden, have suggested the PSA test saves lives.

According to the American Cancer Society, around one man in six will be diagnosed with prostate cancer during his lifetime. More than 2 million men in the United States who have been diagnosed with prostate cancer at some point are alive today.

Dr. Virginia Moyer of Baylor College of Medicine who chairs the task force, told Reuters the task force has an evidence report coming out in the Annals of Internal Medicine on Tuesday.

And she confirmed that an evidence recommendation statement will be released, which is a draft statement that will be posted for a month-long public comment period.

A spokeswoman for the journal did not respond to requests for comment.

Source: Newsmax Health
[newsmax@reply.newsmax.com]

Merry Christmas!
and
Happy New Year!
and
Happy Hanukah

Prostate Cancer: Prediction Tools

Our prostate cancer nomograms are online prediction tools that can be used to decide which treatment approaches will result in the greatest benefit for men at various stages of prostate cancer. Doctors at Memorial Sloan-Kettering have created four nomograms that are customized for men at different stages of prostate cancer treatment:

Pre-Treatment (Diagnosed with Cancer But Not Yet Begun Treatment)
Post-Radical Prostatectomy (Recurrence After Surgery)
Salvage Radiation Therapy (Considering Radiation Therapy After Surgery)
Hormone Refractory (Progression of Metastatic Prostate Cancer That Can No Longer Be Controlled by Hormones Alone)
We have also created additional tools for measuring PSA doubling time and tumor volume.

These nomograms were designed to be used by physicians and by men diagnosed with prostate cancer. If you are a patient, we recommend that you use these tools in consultation with your doctor or healthcare provider. You should speak with your physician before making any treatment decisions.

Pre-Treatment
Our pre-treatment nomogram can be used to predict the probability of cancer remaining progression-free following radical prostatectomy or brachytherapy.

You will need the following information to use the nomogram:

Most recent PSA (prostate-specific antigen) value
Primary and secondary Gleason grade
Doctor's assessment of patient's clinical tumor stage (using the 1992 or 1997 UICC system)
Number of positive cores (samples) found during biopsy
Number of negative cores (samples) found during biopsy
Planned radiation therapy dose if patient has already seen a radiation oncologist
Whether patient has had neoadjuvant hormones
Whether patient has had neoadjuvant radiation
If you are a patient, print the Pre-Treatment Worksheet and bring it with you to your next appointment. The worksheet contains a list of what you need to use this prediction tool.

Post-Radical Prostatectomy
Our post-radical prostatectomy nomogram can be used to predict the probability that a patient's cancer will recur after radical prostatectomy; that is, the probability at two, five, seven, and ten years that the patient's serum PSA level will become detectable and begin to

rise steadily. This prediction tool should only be used for patients when radical prostatectomy has been the sole, primary treatment.

You will need the following information in order to use the nomogram:

Patient's PSA (prostate-specific antigen) value prior to surgery or other treatment
Primary Gleason grade at surgery
Secondary Gleason grade at surgery
Year of prostatectomy
Number of months the patient has been disease-free
Whether surgical margins were positive
Whether cancer was found in the seminal vesicles
Whether cancer was found in the lymph nodes (if any were removed)
Whether there was extracapsular extension
Whether the patient has received neoadjuvant hormones
Whether the patient has had neoadjuvant radiation

Salvage Radiation Therapy

Our salvage radiation therapy nomogram is designed for men who have experienced a recurrence of their prostate cancer after treatment with radical prostatectomy. The tool predicts the probability the recurrence can be successfully treated with salvage radiation therapy (SRT), calculating the probability that the cancer will be controlled and the PSA will be undetectable six years after SRT.

You will need the following information in order to use the nomogram:

Number of months patient was disease-free
Primary Gleason grade at surgery
Secondary Gleason grade at surgery
Pre-radiotherapy PSA
PSA at time of prostatectomy
PSA doubling time
Radiation dose (if applicable)
Whether surgical margins were positive
Whether there was seminal vesicle involvement
Whether there was lymph node involvement
Whether there was extra capsular extension
Whether neoadjuvant hormones were received
Whether the patient had an elevated postradical prostatectomy PSA

If you are a patient, print our Salvage Radiation Therapy Worksheet and bring it with you to your next appointment.

Hormone Refractory

Our hormone refractory nomogram can be used by patients with advanced, metastatic prostate cancer, who have a rising PSA and evidence of progression of their cancer despite maximal treatment with hormone therapy. (Cancer at this stage is also called "hormone refractory.") The nomogram can be used to predict the probability of survival one and two years later based on a man's age, his PSA level, his performance status, and a variety of standard laboratory tests.

If you are considering receiving hormone refractory treatment, you will need to know the following information to complete this nomogram:

Karnofsky Performance Status (KPS)
Hemoglobin (HGB) value
PSA
Lactate dehydrogenase (LDH) value
Alkaline phosphatase (ALK) value
Albumin value

If you are a patient, print the Hormone Refractory Worksheet and bring it with you to your next appointment.

Additional Tools

We have also developed a set of statistical devices for measuring PSA doubling time and tumor volume. These are not required to complete the nomograms above.

PSA Doubling Time

Our PSA doubling time tool can be used to calculate the rate of rise of PSA, expressed as the velocity in nanograms/ml/year, or the PSA doubling time, in months or years. To use this tool, you will need to know the following information:

At least two PSA test results
Date the tests were taken
Prostate Volume

Our prostate volume tool calculates prostate volume, which is used to interpret PSA results. To use this tool, you will need to know the following information:

Prostate length
Width/transverse
Prostate height
Pretreatment PSA

Contact Us
If you have questions or comments, please contact us at publicaffairs@mskcc.org.

Use our prostate cancer nomograms.
Source: **http://www.mskcc.org/cancer-care/adult/prostate/prediction-tools**
See pdf at this site

We try to keep our lists and files up to date, but we need your help to do so. If you have had additional treatment for prostate cancer or recurrence, please let us know which doctor you went to for such treatment so we can add that data to our membership list next to your name. If you no longer wish to have your name on the membership list distributed to newly diagnosed men so they can talk to you in person, then let me know that too.
While we are at it, if you have moved or have a new email address, please let me know so that I can keep you informed of important notices, such as flu shots, special programs and the like.
And finally, your donations help us pay for ads in newspapers, copy information for newly diagnosed packets and even print the newsletter, which is not inexpensive to do. So if you can find it in your heart and pocketbook to help, we'd be most grateful. And if you'd like to help in hands on fashion, we'd welcome you with open arms.
Diane Sutkowski
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Bayer Prostate Cancer Drug Cuts Death Risk by 30%, Study Shows

By Simeon Bennett - Sep 23, 2011 6:01 PM ET

An experimental drug developed by Bayer AG (BAYN) and Algeta ASA (ALGETA) prolonged the lives of men with prostate cancer that's spread to their bones, a study found.

A trial of the drug, called Alpharadin, in 922 men was stopped early after an interim analysis showed that patients receiving it on top of standard treatment had a 30 percent lower risk of dying than those receiving just the current therapy, according to data presented today at a cancer conference in Stockholm.

The results suggest Alpharadin may be the first drug to improve survival in men with cancer of the prostate that's spread to the bone, a worsening of the disease that occurs in 90 percent of men with the advanced stage. Bayer plans to apply for regulatory approval in Europe and the U.S. by the middle of next year, said Anna Koch, a spokeswoman for the Leverkusen, Germany- based company.

"This is really practice-changing," Jean-Charles Soria, a professor of medicine at the Institute Gustave Roussy in Paris, said at a briefing with reporters. "Pending approval, it's going to be a major player in prostate cancer."

Alpharadin, also known as radium-223 chloride, may generate peak sales of 640 million euros ($864 million) by 2018, according to Alistair Campbell, an analyst at Berenberg Bank in London. The drug works by emitting small doses of alpha radiation that damage the DNA of cancer cells, killing them, without harming healthy cells.

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Source: Bloomberg
http://www.bloomberg.com/news/2011-09-23/bayer-prostate-cancer-drug-cuts-death-risk-by-30-study-shows.html

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Nobel Prize for medicine goes to immune system pioneers

By Laura Shin | October 3, 2011, 5:48 AM PDT

Three scientists whose work on the immune system has paved the way for new approaches to disease treatment and prevention won the Nobel Prize for Medicine in Stockholm, Sweden, on Monday.

The three scientists were American Bruce Beutler and French scientist Jules Hoffmann, who jointly shared half the 10 million-kronor ($1.5 million) award, and Canadian-born Ralph Steinman, the recipient of the other half.

The Nobel committee said in a written statement that they have "revolutionized our understanding of the immune system by discovering key principles for its activation."

Dr. Steinman died Friday, but the Nobel committee was not aware of his death until after announcing the winners on Monday. While Nobels are not, as a rule, awarded posthumously, the committee decided, by mid-afternoon Eastern time, to stick with its decision because they did not hear about his death until after its announcement.

Understanding the First Two Stages of Immunity
Dr. Beutler and Dr. Hoffman discovered, in 1996, protein receptors in fruit flies and mice that recognize bacteria microorganisms and activate the first stage in the immune response, which is called innate immunity.

Since their discovery, more than a dozen such protein receptors have been found in the human body.

Dr. Steinman discovered, in 1973, dendritic cells, which help decide whether to kick in the second stage of the immune response, called adaptive immunity.

The dendritic cells activate T-cells, which are central to this stage, in which antibodies and killer cells fight and clear infections from the body. They also retain the memory of the infection, helping the body rally defenses next time it experiences a similar attack.

Dr. Steinman, who died of pancreatic cancer Friday at the age of 68, designed his own dendritic cell-based immunotherapy, which he used to extend his life.

Potential Applications
"Their work has opened up new avenues for the development of prevention and therapy against infections, cancer and inflammatory disease," the Nobel committee said of the three scientists.

Prize committee member Hans-Gustav Ljunggren told The Associated Press that drug companies are using these discoveries to develop better vaccines, some of which (such as for hepatitis) are now in large clinical trials.

Eventually, their discoveries could also be used to improve prevention methods and treatments for diseases such as cancer, rheumatoid arthritis, type 1 diabetes, multiple sclerosis, and chronic inflammatory diseases.

Dr. Beutler is a professor of genetics and immunology at The Scripps Research Institute in La Jolla, California. Dr. Hoffmann headed a research laboratory in Strasbourg, France, from 1974 to 2009 and served as president of the French National Academy of Sciences from 2007 to 2008.

Dr. Steinman headed the Center for Immunology and Immune Diseases at Rockefeller University in New York.

This is the first in a weeklong string of Nobel Prize announcements by Stockholm's Karolinska institute that will recognize achievements in physics, chemistry, literature, peace and economics.

via: Associated Press, BBC, CNN, Rockefeller University

Post updated at 3:23pm EDT with information on Dr. Steinman's death and the Nobel committee's decision to bestow the award on him though Nobel prize rules normally prohibit posthumous awards.

Source: smartplanet sponsor IBM

MDV3100

With PCF support through every step of development, this new drug will soon make its way to castrate-resistant patients in record time.

Fast on the heels of five new prostate cancer drugs approved for patients with advanced disease in the past 18 months, a promising new drug, MDV3100 (Medivation and Astellas), should soon be approved by the FDA for patients who have failed hormone therapy and chemotherapy with docetaxel. The companies at the close of last week announced that, based on positive trial data, the Phase 3 AFFIRM Trial of MDV3100 will be stopped early and the drug will be offered to men in the placebo arm of the study.

The development of MDV3100 began with a PCF Board of Directors meeting at UCLA where the world's top cancer scientists in leukemia were invited to apply for funding and work on prostate cancer. What then ensued was a competitive CaPCure (PCF) research award to Owen Witte, MD, Michael Jung, PhD, and Charles Sawyers, MD in 2002. The drug has a novel mechanism of action, inhibiting androgen receptor (AR) at three distinct points in the signaling pathway. In the study, MDV3100 increased median survival by 4.8 months, providing a 37% reduction in the risk of death compared to placebo. Some patients have very durable remissions well beyond the average and some do not respond so the median survival is a statistical description for the FDA and clinical researchers.

This is the second time the trial of a prostate cancer drug was stopped and the drug offered to patients in the placebo arm. The first such incidence was with abiratrone (Zytiga) which was approved earlier this year.

"The clinical advancement of MDV3100 is one of the most important events in the history of prostate cancer research and PCF," says Howard Soule, chief scientist for PCF. "For men whose disease has progressed since receiving hormone and chemo therapies, MDV 3100 should provide a new treatment option to extend survival."
MDV3100 directly blocks the activity of the androgen receptor, the engine of prostate cancer progression. Abiraterone affects prostate cancer progression by shutting off the supply of fuel,

testosterone. Having both drugs available to patients will represent an important advance in patient treatment. Both drugs are being evaluated in Phase 3 trials in CRPC chemo naïve patients. Results are not yet available but the trend will be to use both medications earlier in the natural history of the disease. Both drugs are also being tested in the pre-surgical setting (funded by PCF Challenge Awards) with curative intent for primary high risk prostate cancer.

Many additional clinical trials are needed to determine the optimal sequence or combination of abiraterone and MDV3100 and to determine if combinations of MDV3100 with other experimental targeted therapies are synergistic.

Headed To Patients in Record Time

Equally impressive as the trials data for MDV3100 is the research and development period that has been a comparatively short nine years. PCF's total investment of $14.75 million in MDV3100, supported by the PCF's investment in the Prostate Cancer Clinical Trials Consortium, accelerated the drug's progression. Medivation plans to meet with the U.S. Food and Drug Administration in early 2012 to discuss when they might seek approval for MDV3100.

Source: Prostate Cancer Foundation

Lipitor Price Plunges as Generics Hit Market

Lipitor is so valuable that Pfizer is practically paying people to keep taking its blockbuster cholesterol medicine after generic competition hits the U.S. market this week.

Pfizer has devised discounts and incentives for patients, insurers, and companies that process prescriptions that will, at least for the next six months, make the brand-name drug about as cheap as or cheaper than the generics. Pfizer also has spent tens of millions of dollars this year on marketing to keep patients on Lipitor, which loses patent protection Wednesday.

Normally when a drug's patent ends, generic rivals grab nearly all its market share in a year or less, and the original maker quietly shifts focus to its newer products.

Pfizer Inc., the world's biggest drugmaker, is not giving up that easily on the best-selling drug in history. Lipitor had peak sales of about $13 billion and still brings in nearly $11 billion a year, about a sixth of Pfizer's revenue. With no new blockbusters to fill that hole, the company is making an unprecedented push to hang onto Lipitor revenue as long as possible.

Patients seem to buy into the logic.

"If I can get the name brand at the same price or for pennies more than the generic, I have no motivation to switch," said Richard Shiekman, 59, who has been taking Lipitor for six years and credits the drug with sharply cutting his bad cholesterol. Shiekman, a wine and spirits importer from Redding, Conn., got a $4 copay card two weeks ago after his pharmacy sent an offer guaranteeing that price through December 2012.

Pfizer's strategy is cunning and could become the new norm, as most other drugmakers also face generic competition to top-selling medicines and haven't been coming up with replacements.

"People getting a month of life-saving medicine for the price of a cup of Starbucks is ... pretty impressive," said Michael Kleinrock, a research director at data firm IMS Health.

Pfizer's effort includes:

• Offering insured patients a discount card to get Lipitor for $4 a month, far below the $25 average copayment for a preferred brand-name drug and below the $10 average copay for a generic drug. Pfizer is promoting this heavily through ads, information distributed at doctors' offices, and its website. Pfizer, based in New York, said Tuesday that sign-

ups have exceeded its goals.

• Paying pharmacies to mail Lipitor patients offers for the $4 copay card and to counsel patients that Lipitor lowers bad cholesterol more than rival drugs and helps prevent heart attacks and strokes.

• Keeping U.S. marketing spending nearly level until the last minute, versus the typical two-thirds drop in a drug's final year under patent. From July through September, Pfizer spent almost $90 million on doctor sales calls and free samples, about the same as a year earlier, according to Cegedim Strategic Data. Ads targeting patients fell about 60 percent to $19 million. All that will soon taper off.

• Negotiating unusual deals with some insurance plans and prescription benefit managers, the companies that process prescription claims for insurers or employers, to block pharmacists from dispensing generic Lipitor. Pfizer is giving them rebates that bring their cost for Lipitor down to the price of a generic or slightly less — if they agree to dispense only Lipitor for the six months before additional generic competition slashes prices. The move has generated some controversy and means many of the 3 million Americans taking Lipitor won't be able switch to the generic.

Under those contracts, patients will pay either their plan's standard generic copayment or just $4 — the lowest copayment pharmacies at supermarkets and discounters such as Wal-Mart offer for the most widely used generic drugs.

While generic medicines work the same as brand drugs for nearly everyone, some patients prefer the brand.

"We want to make sure that patients who are currently taking Lipitor and want to continue ... have the opportunity to do so," said David Simmons, who heads Pfizer's Established Products business. He said research shows more than a third of patients want to stay on Lipitor.

Pfizer also is continuing assistance programs that subsidize uninsured patients wanting Lipitor, which costs about $115 to $160 a month, depending on dosage. Generic Lipitor, called atorvastatin, should cost 30 percent to 50 percent less.

People without insurance also can order the generic, with a prescription, through websites such as HealthWarehouse.

Patients could save even more by taking other generic drugs in the same class that have been on sale for several years: pravastatin (Pravachol) and simvastatin (Zocor). But they're not as potent as Lipitor, the key reason its sales have held up.

Typically, brand-name drugs get one or two generic competitors initially, priced about 25 percent lower. Six months later, other generic companies are allowed to jump in and the price drops up to 80 percent.

About 90 percent of the branded drug's sales ultimately vanish, as insured patients seeking a lower copayment switch over and most pharmacies automatically substitute a generic for a brand name.

Sanford Bernstein analyst Dr. Tim Anderson estimates that for a 90-day supply of Lipitor, even after paying rebates to insurers and patients, Pfizer can make a profit of roughly $100, compared with about $225 before generic competition. That's partly because administrative and advertising costs will decline, and it barely costs a dime to make a pill.

Anderson expects Pfizer's strategy to boost its earnings per share about 2 percent next year.

Meanwhile, Watson Pharmaceuticals Inc. looks to be the biggest loser in this. It has a deal to distribute an "authorized generic" version manufactured by Pfizer but sold under Watson's brand, with Pfizer keeping an estimated 70 percent of the price.

Watson CEO Paul Bisaro said he had thought Pfizer would retain about 25 percent of Lipitor users for the next six months, but now "it looks like it will be 40 to 45 percent."

Bisaro said that could reduce his company's anticipated profit next year.

"This is sort of the new generation of brand protection," he added.

India's Ranbaxy Laboratories is

the only company besides Watson with the right to sell generic Lipitor in the United States for the next six months. But Ranbaxy has had repeated manufacturing quality problems, and it's unclear whether it will have the Food and Drug Administration's approval to ship its version Wednesday.

Ranbaxy said it would not reveal what will happen until then. The FDA, as is its custom, declined to comment. But Pfizer executives say they expect Ranbaxy to have a generic on the market.

An independent pharmacists group called Pharmacists United for Truth and Transparency has raised alarms that the rebate deals will stick plan sponsors — employers, unions, and taxpayers — with higher costs than for generics.

But spokespeople for a few prescription benefit managers that have received Pfizer's offer say it would cost insurance plans and patients the same as, or slightly less than, for generic Lipitor.

"Next year we're going to save clients and members over $1 billion just on this drug," said Tim Wentworth, head of employer and key client accounts for Medco Health Solutions Inc., one of the biggest pharmacy benefits managers.

Source: www.newsmaxhealth.com/health/

Proposed Legislation Would Fund Prostate Cancer Research

On Thursday, November 17, 2011 Congressman Peter King (R-NY) proposed the Taxpayers' Cancer Research Funding Act of 2011. This bipartisan legislation is budget neutral and provides American taxpayers an opportunity to contribute five dollars to the Breast and Prostate Cancer Research fund when filing their taxes. The donations will be utilized to create the Breast and Prostate Cancer Research Fund. The funds will be made available through the National Cancer Institute for peer-reviewed breast and prostate cancer research.

"H.R. 3466 would empower taxpayers to contribute to life saving cancer research initiatives and is a crucial step towards finding a cure, "said King. "This legislation is particularly important in this fiscal environment which has so many programs, including cancer research, in jeopardy. I am grateful to Project Zero for their efforts and advocacy in moving this legislation forward."

Our politicians continue struggle with the tough decisions accompanied by America's fiscal situation but the commitment to eradicating cancer must continue. With the help of taxpayers and the legislative ingenuity promoted by Congressman Peter King, medical research and innovation can proceed despite anticipated cuts from the Super Committee for the coming fiscal year.

Cancer research has been a bipartisan issue since the creation of the National Cancer Institute in 1937. President Richard Nixon's 1971 State of the Union address and the National Cancer Act of 1971 enriched the purview of NCI. President Nixon demanded "an intensive campaign to find a cure for cancer, and I will ask later for whatever additional funds can be effectively be used". Nixon encouraged the American people and politicians to harness the same energy that has been used repeatedly throughout our rich history to win the "war on cancer."

Over the last 40 years the bipartisan commitment to eliminating cancers of all kinds has led to advances in diagnostics, treatments and an increased survival rate. The progress our scientific community has made deserves the attention and allegiance of American taxpayers.

Contact your Representative today and ASK THEM TO CO-SPONSOR H.R. 3466 - The Taxpayers' Cancer Research Funding Act of 2011.

Source: ZERO – The Project to End Prostate Cancer

Prostate Cancer 101, Inc.
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Meetings are held the First Thursday of the month at the Central Hudson Auditorium on South Road in Poughkeepsie, starting at 6:30 p.m. Various doctors and speakers are on the agenda and one on one help is available after the meeting.

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