Newsletter

Prostate Cancer 101, Inc.

http://prostatecancer101.org

November, 2008

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

Come Meet Dr. John Phillips on November 13th, 2008

On **Thursday,** November 13th at 4:30 p.m., PCa 101 is proud to present another in our Distinguished Lecture Series.

Dr. John Phillips of Westchester Medical Center will be speaking about Men's Prostate Health and Treatment Options.

Dr. Phillips is a graduate of Wesleyan University and received his Doctor of Medicine from Yale University School of Medicine, New Haven, CT in 1992. He continued at Yale to complete his internship and residency in Urology. At that point he became a Lieutenant Commander, Commissioned Corps, US Public Health Service and worked at the National Cancer Institute/National Institutes of Health in Bethesda, MD from 1998 to 2003.

In June of 2003 he was appointed the Physician-in-Charge Urologic Oncology at Beth Israel Medical Center, NY.

Since 2007 he has been Section Chief of Uro-Oncology and Robotic Minimally Invasive Urology at Westchester Medical Center. In addition to his clinical diagnostic work he has published many articles related to prostate and other urologic cancers in the Journal of Urology.

Prostate cancer treatment has evolved into a wider range of modalities each year, and while this can enhance one's quality of life by reducing the untoward side effects, it also leads to much apprehension and anxiety over which treatment is **best for me**? Knowing that prostate cancer is not a "one size fits all" diagnosis, any insight into new treatments can only be beneficial in helping determine an individual right course of treatment. Dr. Phillips has clinical expertise in Laparoscopic (Robotic) Radical Prostatectomy, Cryotherapy, and High Intensity Focused Ultrasound (HIFU).

One of our PCa 101 members recently told us that Dr. Phillips was not only an excellent physician, but also an extremely caring and compassionate individual. So bring your spouse and don't forget a friend, write down your questions and join us on the 13th of November at the Hurley Reformed Church and remember it's a **Thursday!**

Dendreon Rises After Prostate Drug Improves Survival

by Catherine Larkin | Bloomberg News | 10.06.2008

Oct. 6 (Bloomberg) -- Dendreon Corp., the company developing a treatment for prostate cancer, rose the most in more than a year in Nasdaq trading after its experimental drug reduced the risk of death 20 percent in an ongoing study.

The Seattle drugmaker gained $1.73, or 33 percent, to $6.93 at 4 p.m. New York time in Nasdaq Stock Market composite trading. It was the biggest percentage jump since March 30, 2007. The treatment, Provenge, would be Dendreon's first product.

Dendreon expects the study in 512 men to meet its goal of improving survival 22 percent when it ends in mid-2009, Chief Executive Officer Mitchell Gold told investors today on a conference call.

The U.S. Food and Drug Administration last year delayed Dendreon's application to sell the treatment and requested more evidence to support the survival claim.

``We maintain our view that any meaningful survival advantage of Provenge treatment would become apparent only upon final analysis," said Joel Sendek, an analyst at Lazard Capital Markets in New York, in a note to clients today. ``We assume a 50-50 likelihood that the trial may demonstrate a survival benefit upon final analysis."

The company received the interim results from the study from an independent monitoring committee. Had the data showed the 22 percent survival benefit, Dendreon would have been able to submit the findings to the FDA, possibly expediting Provenge's approval. The study has shown no safety concerns, the company said.

`Success Probability'

``While we would like to receive a result that would have allowed us to amend" our application, ``the final analysis by design has a higher probability for success," Gold said.

Provenge, if approved, would be the first drug to train the body's immune system to attack cancer cells. Prostate cancer kills 27,000 men a year in the U.S., and some analysts estimate that Provenge sales may reach up to $1 billion a year. Sendek predicts $105 million in global sales in 2011.

Dendreon asked for approval last year after a study of 127 men showed the drug prolonged lives with few side effects, while a second study didn't show a benefit.

The FDA's decision not to approve Provenge in May 2007 sparked protests among advocates for prostate-cancer patients and almost led to a Congressional probe.

To contact the reporter on this story: Catherine Larkin in Washington at clarkin4@bloomberg.net.

Source:Bloomberg News

Great quote from Dr. Strum

I would state that this is a critical failing on the part of so-called "modern" day medicine to think that all physicians are created equal--that's just not the case. In fact, all people may be created with some things equal, e.g. the number of chromosomes, two eyes, etc but for the most part we are definitely not created equal in talent, ability, caring, persistence, nurturing, etc. Thus when it comes to something as critical as the pathology of cancer, how can we be so damn naïve to think that one pathologist is as good as the next.

Dr. Strum - 10/8/2008 prostate pointers

Study Reveals Photodynamic Therapy Promising for Recurrent Prostate Cancer

The September issue of BJU (British Journal of Urology) International reports the results of "the largest study to date" of Tookad (padoporfin, WST09), a minimally invasive vascular-targeted photodynamic (VTP) therapy agent. The study suggests that Tookad can help men with recurring cancer of the prostate. Tookad was developed by researchers at the Weizmann Institute of Science (Rehovot, Israel), which has also worked to advance adaptive optics for tissue imaging.

Dr. John Trachtenberg of the Ontario Cancer Institute/Prince Margaret Hospital (Toronto, Ontario, Canada) led a team of Canadian and Israeli investigators in the work to evaluate the photodynamic therapy (PDT) approach. Patients received a fixed photosensitizer dose of 2 mg/kg and patient-specific light doses as determined by computer-aided treatment planning. Up to six cylindrical light-diffusing delivery fibers were placed transperineally in the prostate under ultrasonographic guidance. The treatment response was assessed by measuring serum prostate-specific antigen (PSA) levels, lesion formation (avascular areas of tissue) measured on 7-day gadolinium-enhanced T1-weighted magnetic resonance imaging (MRI) and a 6-month biopsy.

The team reports that treatment of the whole prostate was possible with minimal effects on surrounding organs. An increased light dose improved the tissue response, with MRI-detectable avascular lesions, encompassing up to 80% of the prostate in some patients. A complete response, as determined by the 6-month biopsy, required that patients received light doses of at least 23 J/cm2 in 90% of the prostate volume (D90 > 23 J/cm2). Of the 13 patients who received at least this light dose, eight were biopsy-negative at 6 months. In this group of eight patients, PSA levels decreased and did so to negligible levels for those patients with a baseline PSA level of <5 ng/mL.

Side-effects were modest and self-limited in most patients, the researchers say. The study concluded that Tookad, a novel palladium-bacteriopheophorbide photosensitizer, can produce large avascular regions in the irradiated prostate, and result in a complete negative-biopsy response at high light doses. A response rate of more than half for those patients receiving the highest light doses shows the clinical potential of Tookad to manage recurrence of prostatic carcinoma after external beam radiation therapy (EBRT).

Source:Bio Optics World | 09.16.2008

Thank you for your Contributions

David & Hedwig Lustig
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Rethinking Prostate Cancer in Older Men

Research suggests aggressive treatment is viable, even for patients in their late 70s

by Karen Pallarito | HealthDay News | 10.17.2008

With increasing life expectancies, improved surgical tools, and better information on patient results, many older men diagnosed with early prostate cancer are taking a pass on the traditional advice to hold off on treatment for a period of time.

So-called "watchful waiting" -- or closely monitoring the cancer's progression -- is still a viable option. But many experts now believe that aggressive treatment -- even for older men -- may be the better way to go.

"We're pushing the limits on the upper end," said Dr. Edouard J. Trabulsi, assistant professor in the department of urology at Jefferson Medical College and co-director of the Jefferson Prostate Diagnostic Center in Philadelphia.

A study published recently in the Journal of the American Medical Association helped shake up the conventional wisdom. The study, which involved some 44,000 men, found that the death risk for those who received prostate cancer treatment was nearly one-third lower than for men who received no treatment. And that was true across all age categories, including the oldest men in the study, aged 75 to 80.

"We often think of prostate cancer as an indolent disease, and it is for many men, which is why observation is a very reasonable treatment option for patients with low and intermediate risk disease," said the study's lead author, Dr. Yu-Ning Wong, a medical oncologist at the Fox Chase Cancer Center in Philadelphia.

"However, the life expectancy for a 70-year-old man is about 13 years, and patients who are otherwise healthy should recognize that if they live long enough, they may be at risk of developing complications from prostate cancer," she added.

Prostate cancer is the second most common type of cancer in American men, after skin cancer. In 2008, about 186,320 new cases of the disease will be diagnosed, and about 28,660 men will die from it, according to the American Cancer Society.

Because prostate cancer is generally a slow-growing cancer, some men may never need treatment. And for many older men without symptoms, watchful waiting has been recommended, because it was believed they would die from other causes before their cancer advanced.

But as men's life expectancy creeps higher and new robotic techniques improve the precision of surgery, the decision is becoming more complicated.

"Patients should understand the risks and benefits of all their treatment options -- radiation, surgery and observation," Wong noted. "If they choose observation, they should be committed to careful follow-up with their physicians."

Watchful waiting does not mean watching someone die. Many oncologists today prefer the term "active surveillance," Trabulsi said, because it more accurately describes the diligent approach to monitoring these patients, including the use of PSA blood tests, digital rectal exams and biopsies of the prostate to detect changes in the

cancer.

Still, determining the best course of treatment is difficult, because there isn't good data to help guide patients and their families on the effectiveness and harms of treatments for clinically localized prostate cancer, according to a recent literature review prepared for the federal Agency for Healthcare Research and Quality.

But oncologists hope to have better information on the benefits and risks of active surveillance, also known as "expectant management," compared with treatment, by late next year. The National Cancer Institute and the Department of Veterans Affairs are co-sponsoring a study, called the Prostate Cancer Intervention Versus Observation Trial, to compare radical prostatectomy -- which is removal of the gland -- and expectant management on patient survival and overall quality of life.

For now, Wong advises: "They [patients] should place the potential benefit of treatment found in our study in the context of the potential side effects of treating the patient's other medical problems."

Source:HealthDay News 2008

Do You Have BPH?

Approximately 50% of all men experience symptoms of enlarged prostate, BPH, by age 75. If you're one of them, you'll want to take this easy, self-scoring questionnaire to calculate the severity of your symptoms.

The International Prostate Symptom Score questionnaire, also called the American Urological Association Symptom Index, was developed by the American Urological Association to help men evaluate the severity of their symptoms from benign prostatic hyperplasia (BPH) -- enlarged prostate.

This self-administered BPH test can help determine which type of prostate treatment is needed, if any.

However, the BPH questionnaire alone cannot be used for diagnosis for two main reasons. First, other diseases can cause lower urinary tract symptoms similar to those of BPH. Second, as men age, the bladder naturally becomes less efficient at storing urine, and symptoms of urinary frequency and urgency become more common.

Therefore, a careful medical history, physical examination, and laboratory tests are required to exclude conditions such as urethral stricture (narrowing of the urethra) and bladder disease. In fact, some reports indicate that as many as 30% of men who undergo surgery for BPH are found not to have urethral obstruction (meaning their symptoms were caused by something other than BPH).

Prostate Symptoms Questionnaire:

Use this key to answer each question, then tabulate your score to assess your BPH severity: mild BPH (1 to 7), moderate BPH (8 to 19), or severe BPH (20 to 35).

Generally, no treatment is needed if BPH symptoms are mild; moderate BPH symptoms usually call for some form of BPH treatment; and severe symptoms indicate that surgery for BPH is most likely to be effective.

Not at all = 0
Less than 1 time in 5 = 1
Less than half the time = 2
About half the time = 3
More than half the time = 4
Almost always = 5

1. Over the past month, how often

have you had the sensation of not emptying your bladder completely after you finished urinating?

2. Over the past month, how often have you had to urinate again less than two hours after you finished urinating?

3. Over the past month, how often have you found you stopped and started again several times when you urinated?

4. Over the past month, how often have you found it difficult to postpone urination?

5. Over the past month, how often have you had a weak urinary stream?

6. Over the past month, how often have you had to push or strain to begin urination?

7. Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?

Posted in Enlarged Prostate on October 14, 2008

Source: Johns Hopkins Health Alert

NSAIDs May Lower Prostate Cancer Markers

Study Shows Ibuprofen and Other NSAIDs Reduce PSA Levels

By Salynn Boyles
WebMD Health News
Reviewed by Louise Chang, MD

Sept. 8, 2008 -- Regular use of aspirin, ibuprofen, and other anti-inflammatory pain relievers appears to lower blood levels of the prostate cancer biomarker prostate-specific antigen (PSA).

In a newly reported study, men who used nonsteroidal anti-inflammatory drugs (NSAIDs) almost every day had average PSA levels that were lower than men who didn't use the pain relievers.

The study is among the first to link NSAID use to lower PSA levels, but the clinical significance of the findings is not clear, researchers say.

The findings may mean that regular NSAID use helps protect against prostate cancer. Or NSAIDs may offer no protection at all, and may simply reduce the sensitivity of PSA as a screening tool for prostate cancer.

"All we can say from this study is that taking these medications regularly resulted in lower PSA values," urologist and study researcher Eric A. Singer, MD, of the University of Rochester Medical Center tells WebMD.

NSAIDS, PSA, and Prostate Cancer

Chronic inflammation is increasingly suspected of playing a role in several cancers, including those of the colon, bladder, and stomach.

There is also some evidence that inflammation plays a role in prostate cancer and that regular NSAID use may help protect against the cancer. But these studies are not conclusive, study co-author Edwin van Wijngaarden, PhD, tells WebMD.

"Several studies have reported a small benefit for NSAID use on prostate cancer, but there is very little information on its impact on PSA, which is the main screening tool for prostate cancer," he says.

In an effort to better understand the impact of NSAID use on PSA levels, the researchers analyzed data collected by the CDC in 2001 and 2002 as part of a nationwide health and nutrition survey. Information about dosage and reason for taking NSAIDs or acetaminophen were not available for analysis.

PSA levels and information on NSAID and acetaminophen use were available for 1,319 men included in the analysis. All the men were 40 or older, but most (72%) were not yet 60.

Men who reported using NSAIDs nearly every day had PSA levels that were about 10% lower than men who reported no current NSAID use.

The study is published in the Oct. 15 issue of the journal Cancer.

Study 'Raises Many Questions'
More study is needed to confirm the findings and to determine if regular NSAID use really does lower prostate cancer risk, the researchers conclude.

"This study raises many questions, but it is far too early to recommend aspirin, ibuprofen, or other NSAIDs to lower prostate cancer risk," says Singer.
Len Lichtenfeld, MD, who is deputy chief medical officer for the American Cancer Society, agrees.

"NSAIDs are powerful drugs, so we would never recommend them unless the benefits clearly outweighed the risks," he tells WebMD.
Most of the men in the study were younger than 60, and most prostate cancers occur in older men.

"This is an intriguing study, but the association clearly needs to be looked at in larger populations of men and in older populations," Lichtenfeld says.

SOURCES:
Singer, E.A. Cancer, Oct. 15, 2008; vol. 113: online edition.
Eric van Wijngaarden, PhD, department of community and preventive medicine, University of Rochester Medical Center, N.Y.
Eric A. Singer, MD, department of urology, University of Rochester Medical Center, N.Y.
Len Lichtenfeld, MD, chief deputy medical officer, American Cancer Society.

The Wrong Call on Prostate Cancer Screening

By William J. Catalona

Numerous media reports followed a federal task force's announcement this month that there is insufficient medical evidence to assess the risks and benefits of prostate cancer screening in men younger than 75 and that doctors should stop testing men over age 75 [" U.S. Panel Questions Prostate Screening; 'Dramatic' Risks for Older Men Cited," front page, Aug. 5].

It's important to note that consideration was not given to the overwhelming body of emerging evidence that screening with PSA tests and digital rectal exams saves lives. Rates of death from prostate cancer and rates of diagnosis at advanced stages have decreased markedly since testing became widespread.

As a physician and a researcher specializing in prostate cancer, I worry that this recommendation will result in delays in potentially lifesaving treatment and possibly the unnecessary loss of life.

The U.S. Preventive Services Task Force did not even recommend screening for men at higher risk because of race or family history. The task force reasoned that screening might harm more men than it helps and that in men over 75 there was moderate certainty that the harm outweighs the benefits.

Physicians and patients who are concerned about preventing prostate cancer deaths choose to screen with prostate-specific antigen (PSA) tests because an inconclusive but increasingly compelling body of evidence shows that the screening reduces suffering and death from prostate cancer -- the second-leading cause of cancer death among men in the United States.
Numerous studies have shown that PSA-based tests, such as those that detect increases in PSA over time and the percentage of PSA floating free in the blood, help to decrease unnecessary biopsies and also identify men with the most aggressive tumors so that they can receive timely treatment.

Eliminating screening also eliminates the possibility for early diagnosis and curative treatment in healthy men. Until we can prevent prostate cancer or cure patients at advanced stages of the disease, the only practical strategy for reducing death rates is early diagnosis and effective treatment. Because this tumor arises silently and often passes into an incurable stage before symptoms occur, the only way to detect it early is through screening.

Both the American Urological Association and the American Cancer Society recommend offering screen-

ing beginning at age 50 in men with a life expectancy of 10 years. High-risk men, such as African Americans and those with a strong family history of prostate cancer, are urged to consider screening at an earlier age. The National Comprehensive Cancer Network's guidelines recommend that screening begin at age 40. These guidelines include emerging evidence to help guide physicians and patients in their diagnostic and treatment decisions. These organizations, unlike the U.S. Preventive Services Task Force, have urologists on their panels who see firsthand the ravages of prostate cancer.

Consider that in the United States alone, the rate of advanced cancer at the time of diagnosis has fallen 75 percent since the PSA screening era began, and age-adjusted prostate cancer death rates have declined 35 percent. Statistical studies suggest that 45 to 70 percent of this decrease is due to PSA screening.

Evidence from U.S. cancer registries shows less advanced cancer and lower prostate cancer death rates in regions where PSA testing is more prevalent.

On a global scale, prostate cancer death rates have decreased in countries where PSA screening and active treatment are typically practiced and have remained stable or increased in countries where screening and active treatment are not practiced.

PSA tests are a powerful marker for the risk of developing prostate cancer and dying from it. Reports of over-diagnosis and over-treatment are exaggerated. More often, prostate cancer is diagnosed too late rather than "too early."

If screening detected only harmless cancers, treating them could not produce the striking decline in prostate cancer death rates that has occurred. We should combat the risk of over-diagnosis through continued research for improving the accuracy of screening and high-quality treatment.

This misguided recommendation, and the resulting media coverage, could give reluctant men an excuse to postpone or forgo screening. The consequence might be that many men die of prostate cancer unnecessarily. Men should follow the recommendations of the American Urological Association, the American Cancer Society and the National Comprehensive Cancer Network, all of which recommend screening for early detection and treatment of prostate cancer.

William J. Catalona is medical director of the Clinical Prostate Cancer Program at the Robert H. Lurie Comprehensive Cancer Center at Northwestern University's Feinberg School of Medicine. He receives research support and honorariums for speaking from Beckman Coulter Inc., a manufacturer of PSA tests.

Source: washingtonpost.com

The Healthy Living Partnership Cancer Testing Assistance

The Ulster County Healthy Living Partnership is a program available through the American Cancer Society. It is funded through the New York State Department of Health and Centers for Disease Control. The Partnership offers free breast, cervical and colorectal cancer screenings to the uninsured and underinsured (high deductible screenings not covered by insurance). Eligibility is determined by age.

The Partnership covers follow-up appointments **up to diagnosis**. If a cancer diagnosis is made through the Healthy Living Partnership hospitals, doctors, imaging centers, then the patient is eligible to apply for their special Medicaid (at over twice the income eligibility) to cover treatment. Uninsured/Underinsured men diagnosed with **Prostate Cancer** who have decided on treatment and have touched base with a Partnership provider may also apply for this Medicaid.

Supportive case management services are also offered.

For further information call:
845 339-7896, Ext. 12
Carol Martineau-Lopez, Program Director, Ext. 29
Bonnie Benjamin, Outreach Coordinator & Case Manager, Ext. 20
Deborah Fury, Data Management & Screening Intake Coordinator, Ext. 12

Two new sites for Pro-Act, phase 2 Provenge clinical trial

Two new sites for **ProAct,** phase 2 Provenge clinical trial for:

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Sites:
1. Indianapolis
Indiana University
Contact: **Rhoda Loman (317) 274-1791; rloman@iupui.edu**

2. NY City
Mount Sinai
Contact: **Cynthia Knauer (212 241-8122**

Understanding Your Pathology Report

Pathologists are the unseen and unsung heroes in cancer diagnosis and treatment. Their reports set the entire process in motion, determining in large part the treatment decisions that follow.

The pathologist is a medical doctor who has at least four years of residency training beyond the four years of medical school. The pathologist studies the slivers of prostate tissue (cores) removed during your prostate biopsy. The doctor who performed the prostate biopsy will have indicated the sites in the prostate gland from which each core was removed.

The pathologist examines the tissue samples under a microscope and records a description of each, along with the area of the prostate where it was obtained. The descriptions indicate whether the sample contains prostate tissue that is normal (benign), atypical/ suspicious, or cancer (malignant).

Additional descriptions may be included. For example, a description of a benign sample may indicate "benign prostatic tissue with mild chronic inflammation" or "high-grade prostatic intraepithelial neoplasia" (PIN). Benign tissue with chronic inflammation may be a sign of prostatitis.

The pathologist may find high-grade PIN in one or more cores. Although PIN is not prostate cancer, it is thought to be precancerous and could suggest that the biopsy may have missed an area of cancer. The current recommendation for men who have PIN in a prostate biopsy sample is careful monitoring with prostate specific antigen (PSA) testing and digital rectal examination, but they have no need for an immediate repeat biopsy.

The atypical/suspicious description is definitely a red flag. This means the pathologist could not conclusively identify the cellular patterns in the tissue and, therefore, could not rule out the presence of prostate cancer. In these instances, the biopsy slides are often sent to an outside pathologist with expertise in prostate cancer.

This is especially true if your prostate biopsy was performed in a small community hospital. In smaller hospitals, a general pathologist may examine tissue from a relatively small number

of prostate biopsies each year. As with the surgeon who performs the radical prostatectomy, experience also counts when it comes to the pathologist who interprets the biopsy findings. If the atypical/suspicious finding is confirmed, then a repeat prostate biopsy should be performed, because in about 50% of cases cancer is found on the repeat biopsy.

Ideally, the slides should be sent to a major referral center with pathologists who specialize in analyzing prostate tissue. The Urologic Pathology Laboratory at Johns Hopkins gives second opinions on thousands of prostate biopsy samples each year. About a third of the original diagnoses turn out to be wrong.

When you speak with your doctor about your prostate biopsy results, be certain to ask whether there is any uncertainty about them. If the answer is yes, you can and absolutely should request that the slides be sent to a referral lab for expert review.

If one or more core samples contain malignant tissue, the pathology report will provide additional information about the prostate cancer's aggressiveness. The least aggressive cancer cells retain a structure similar to that of normal cells and are described as well-differentiated and low grade. Moderately differentiated (intermediate-grade) cancers are disorganized and have lost many of their distinguishing features, but they retain some semblance of normal cell structure. Poorly differentiated (high-grade) cancers are distorted and bear little resemblance to normal cells.

The pathologist will assign a Gleason score to the prostate cancer by looking for specific cellular patterns in the tumor tissue.

The Gleason system is based on five patterns or grades that are represented by the numbers 1 through 5. The patterns range from the most well-differentiated and normal-looking cells (Gleason pattern 1) to the most abnormal looking cells (Gleason pattern 5). The pathologist determines a man's Gleason score by adding the Gleason grade of the most prominent pattern within the tumor (primary pattern) to the grade of the next most prominent pattern (secondary pattern). For example, if the primary pattern area is a Gleason grade 3 and the second most prominent is a Gleason grade 4, the Gleason score is 7 (3+4=7).

In Prostate Cancer, Pick a Number, Any Number

By BURT SOLOMON
Published: August 25, 2008

My internist warned me that nobody understands enough about prostate cancer to make easy decisions about how to treat it, but he didn't prepare me for the barrage of numbers that kept pretending that all is known.

The P.S.A. result was just the beginning. I was grateful, of course, for a simple blood test as an early warning. When mine registered 4.6, crossing the threshold of evil at 4, my internist suggested that I see a urologist, largely because my father's nonfatal prostate cancer increased my risk by 30 percent. (Later I learned that my neighbor's prostate had turned cancerous when his P.S.A., a measure of prostate-specific antigen, doubled from 1 to 2.)

A follow-up test at the internist's, measuring the proportion of antigens clinging to a protein, prophesied a 17 percent chance that I had cancer.

"That sounds high," I said.

"I thought it sounded low," my internist replied. It wasn't his prostate.

After I saw the urologist, the biopsy showed that I was right.

"It's positive," the urologist told me over the phone, with a forced bonhomie. When it comes to cancer, "positive" means negative — bad news. I'd entered a looking-glass world; everything was the opposite of what it seemed.

Yet the unceasing flow of numbers kept promising precision. These were numbers, for God's sake. Of the 12 snippets of my prostate sampled in the biopsy, only 2 pieces showed any cancer, and then just a dusting, of 10 to 12 percent. And the cancer was judged to be only moderately aggressive, a 3 on a scale of 5. I was counseled to pooh-pooh the higher-than-desirable Gleason score of 6, derived by adding the aggressiveness in every spot of cancer, because there was so little cancer in each.

Eager to be convinced, I took heart. My wife accuses me — accurately — of being a glass-half-empty guy, but the flow of happy numbers (plus perhaps a touch of maturity at last, at age 58) left me uncustomarily serene.

I was only dimly aware of the evidence that most prostate cancers never become dangerous, even if left alone. But because nobody can tell which ones will and which ones won't, the information was useless to me.

I quickly decided to have surgery to remove the prostate, but I had to choose between the two types. I cared most about my plumbing returning to normal. But this was when the numbers really began to confuse things.

One option was to go to Johns Hopkins in Baltimore, my hometown, where the older-style, slash-and-scoop surgery was devised. But the doctors there, my urologist said, cherry-picked their patients — no fatties need apply — to minimize the complications in getting the plumbing up and running again.

The other choice, called robotics, was newer and cooler. The surgeon sits at a console across the operating room and essentially plays a three-dimensional video game inside the patient, controlling two thin robotic arms slipped through inch-long incisions. The computer's 15x magnification improves the subtlety of movement, and the less invasive surgery means faster recovery.

But the procedure has statistical distortions of its own. Some robotics surgeons have been known to exaggerate the speed of recovery by removing the catheter too early.

So both sides were skewing the numbers to market themselves.

A college classmate, a physician with a low opinion of his profession, advised me to forget the numbers, to visit both surgeons, look them in the eye and decide which one I liked.

Huh? Why should I care? I wasn't drinking a beer with the guy. Partly, my friend said, a likable surgeon would respond if something went wrong; an arrogant one might not admit a mistake. And partly, well, my friend really couldn't articulate it, but he felt certain.

"Likable" and "surgeon" don't ordinarily cohabit a sentence, but when my wife and I met with the robotics surgeon, we loved him. Patient, personable and the furthest thing from arrogant, he told us how his technique had improved from his first 200 operations to his second 200. (I was No. 431.) Only twice, he said, in Nos. 4 and 17, had the robotics failed and he had proceeded to the more intrusive surgery. His percentage of complications, he added, was as low as at Hopkins. I canceled my appointment in Baltimore.

The surgery wasn't bad at all, and my recovery was startlingly swift. Eight days afterward, I returned to have the catheter removed — none too early — and to learn if the cancer had spread. When I asked the surgeon if the pathology report was "positive" — meaning good news — he winced.

The news was good: The cancer had not spread beyond the prostate. But 35 percent of my prostate had turned out to be cancerous, considerably more than a dusting. I had dodged a bullet; the numbers had lied again.

Burt Solomon is a contributing editor to National Journal.

Source: New York Times

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3rd Tuesday

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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.

Contact – Paul Totta 845 297-7992 or Jim Kiseda 223-5007

If you need or want to help:

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