



Newsletter

Prostate Cancer 101, Inc.

<http://prostatecancer101.org>

September, 2006

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

Our September 19 Guest Speaker is Mr. H. Robert (Bob) Carter

Mark your calendars and make a point of being at the Hurley Reformed Church on Tuesday, September 19, at 4:30 PM, to hear a presentation and interactive discussion led by Bob Carter, and bring a friend. With the title of, The Rest of the Story, you can be sure he will have a lot of interesting points to help each of you deal with events that doctors often fail to mention.

Bob is a prostate cancer survivor and has shared his journey with many groups. He will be bringing a variety of printed material and a large display with photos of survivors from other support groups noting their individual stories for you to look at prior-to and after the lecture. There is nothing like finding commonality to make you feel less alone.

Read Bob's biography, which follows, to get a flair for the man whom I found both interesting and humorous in our phone conversation and emails. He is certainly a "keeper."

Diane Sutkowski



Age 74, very happily married for 50 years, with one son, one daughter, and one grandchild.

I was diagnosed with early stage prostate cancer in 1994 at age 62. Most locally invasive treatments at that time were fairly primitive so decided not to do any of them. Instead, for almost 12 years I have done (IHB) **Intermittent Hormonal Blocking** (i.e. Lu-

pron, Casodex & Avodart) plus many supplements and diet changes. I have mostly followed what I call "**Innovative Conventional Therapy**" plus selective Alternatives.

After being OFF of my third IHB cycle for about three years, in April 2005 I restarted an even more aggressive version of IHB therapy under the care of Dr. Charles Myers, which included a few more medications. By September 2006 I felt that the locally invasive technologies had improved enough to produce a good "risk-benefit analysis" and I proceeded to receive radiation therapy at the Dattoli Cancer Center in Sarasota, FL.

(IG-IMRT + Seeds + IG-IMRT see www.dattoli.com). By June 22, 2006 my PSA was 0.003 and my most annoying side effect was a stuffy nose.

Since my diagnosis I have been investigating prostate cancer research starting with books, newsletters, internet, videos, and attending seminars. The first seminar that I attended was a three day International Congress held in Quebec City, Canada in 1995. Others include a few in Michigan, New York, Washington DC, Pennsylvania, and many in New Jersey. In 2001 I attended a full day course in transrectal ultrasound (TRUS) biopsies, which included investigation of Doppler Color Enhancement at Thomas Jefferson University Hospital in Philadelphia.

I have also been active in the following organizations: several NJ Prostate Cancer Support Groups; served on two ACS Planning Task Forces; been an active member of the NJ Prostate Cancer Summit Task Force; been on the Board of Directors of a National Prostate Cancer Organization. I worked as a

consultant on an interactive CD-ROM project for newly diagnosed PCa patients for Schering-Plough; and I receive an average of 20 calls per week from patients from as far away as New Zealand and Hawaii.

As a Prostate Cancer Activist, I encourage and guide all patients to: get an **ACCURATE** diagnosis; investigate all appropriate treatment options; locate the best centers of excellence for each test or therapy; obtain current and long term data on a doctor's rate of cures and side effects, and to take charge of their own illness lest they may just be treated using their particular doctor's specialty.

Formal Education (before my diagnosis) BS in Industrial Arts Education, MA in Administration, and Thirty four credits beyond my MA in courses which led to six separate certifications.

Employment "SHORT VERSION" (before I was diagnosed, and before I "**failed**" retirement)

I taught 10 different Industrial Technology courses in both New Jersey and California High Schools for 28 years, while simultaneously serving as Department Chairman for

23 years. I took an early retirement in 1983 to join a man and his wife who were starting a business making fiber optic connectors and cable assemblies. The company grew to 300 people within 3 years, and was then sold to 3M's Telecommunications Division. I then worked for 3M for another 8 years.

I held a variety of positions along the way including: actually manufacturing product; designing the manufacturing equipment; Quality Control; Plant Manager; Training Manager; Product Manager; and for the final 4 years with 3M, as International Technical Support Manager for all 3M fiber optic products. I retired again in 1993 because I did not have time to go to work, due to having to take care of several relatives in their 90's.

My life has been a fantastic adventure, beyond anything that I could have imagined or planned. I still do not know what I want to do when I grow up, but I am sure that God will think of something.

FDA Approves Label Change for Flomax Following Report of Cataract Surgery Complications

Study Shows Prostate Drug Causes “Intraocular Floppy Iris Syndrome”: Doctors Must Anticipate Using Alternative Surgical Strategies

SAN FRANCISCO, Monday, November 14, 2005 – Who knew that the most commonly prescribed prostate drug may complicate cataract surgery in male patients? David F. Chang, MD and John R. Campbell, MD suspected this after conducting a recently published study that examined the incidence of Intraoperative Floppy Iris Syndrome (IFIS) in their cataract surgery practices.

“Flomax does not affect vision or eye health,” said Dr. Chang. “But it blocks the dilator muscle in the iris, and during cataract surgery, the pupil needs to be dilated.”

Following the announcement of their findings, ophthalmologists were asked to track the incidence of IFIS in cataract patients on Flomax and other prostate drugs, and send reports on verified cases to the Federal Drug Administration. The FDA responded to the doctors concerns and approved a label change for the drugs that reads “The pa-

tient’s ophthalmologist should be prepared for possible modifications to their surgical technique.” The Academy has notified its members of the FDA label change regarding the Flomax/IFIS link, and recommended that they thoroughly question their male cataract patients about prostate medications prior to surgery. Other prostate drugs in this class include Hytrin, Cardura, and Uroxatral.

In addition to having a pupil that dilates poorly, a patient with IFIS will have an iris that behaves erratically during cataract surgery. It will tend to be floppy and the pupil may suddenly constrict during the middle of surgery. This increases the risk of having surgical complications. .

Dr. Chang and Dr. Campbell suggest that cataract surgeons inquire specifically about prior use of Flomax as IFIS can occur several years after the drug has been discontinued.

“The persistence of IFIS long after the discontinuation of Flomax suggests a semi-permanent loss of iris dilator muscle tone,”

Dr. Chang said in his paper.

Dr. Chang continues to say that it is not necessary to stop the use of Flomax, but patients should inform their ophthalmologist if they are taking the drug, or any type of prostate medication prior to having eye surgery.

“Flomax is an excellent drug for treating the symptoms of an enlarged prostate, and patients taking it should not worry,” concluded Dr. Chang. “However, prior to cataract surgery, they absolutely need to inform their eye surgeon if they are, or have taken prostate drugs.”

“Being forewarned that the patient is taking Flomax allows the eye surgeon to anticipate the need for special measures during surgery,” he added.

Note to editors: For additional information on the intraocular floppy iris syndrome, please visit Dr. Chang’s Web site at www.changcataract.com and go to the link for “articles for physicians.”

Source: American Academy of Ophthalmology

Think left and think right and
think low and think high. Oh,
the thinks you can think up if
only you try!
Theodor Geisel (Dr. Seuss)

Coping with prostate cancer: the partner's point of view

By Marija Papaurelis

Prostate cancer may not kill every man it touches, but it transforms the life of the afflicted man as well as of those who love him. For me, learning to recognize and live with the side effects of my husband's treatment was very difficult. I sometimes felt I was living with a stranger.

Why is this happening?

We knew nothing about prostate cancer when Ludwick got the diagnosis. We sat together in that office, numb and feeling as good as dead already. If only the doctor had said something like "This is going to be one wild ride for both of you," I might have been better prepared for what followed. The problem is that prostate cancer and its treatments are peculiarly selective in how they affect individuals. While our experience didn't follow the typical "treat-it-and-beat-it" routine that many celebrate, we're aware that some others are worse off than ourselves.

Ludwick and I were naively confident about our genetic potential for a long life to-

gether. His parents were already well into their venerable 90s, and my grandmother was 100 when she died. After the death of several friends from other cancers, his parents had assured us there was no cancer in their family history. Ludwick's diagnosis blew our genetic predisposition theory out into space.

My mother-in-law had a simple explanation for why her son got prostate cancer. She looked me squarely in the eyes and said "It was your cooking." As both she and her husband lived to see 98 years of age, maybe she knew something we didn't! But at that moment, years before she died, I didn't expect to cry at her funeral. At that moment, I felt that access to a very important support system was slammed shut in my face.

We worried about the significance this cancer had for our children's health. Are sons and daughters more susceptible to cancer? Why did he get it? Could it really have had something to do with how we ate?

Shared decisions

Our goal was simple — get rid of the cancer. We had several weeks to research the various treatment strategies. To learn how to go about fighting this disease, Ludwick disappeared on a solitary sabbatical with his computer.

Those days, nearly all our conversations revolved around prostate cancer, and they weren't always calm. We had always consulted each another about serious decisions. Ludwick shared his thoughts about the different options, but I found it impossible to support any one treatment without getting hung up on its side effects. It seemed to me then that whatever treatment he chose, he had to be the one convinced that it was the right one, because he was the one who would have to live with the consequences. At the time, I had no inkling how those side effects would also affect me!

In school, nuns taught me that true love is noble and self-sacrificing. The nuns shared an exceptional marriage; their spouse loved them infinitely, provided well for them, never generated any laundry or criticized their cooking, and was unlikely to have prostate cancer. I struggled with the reality that when a loved one develops a deadly disease, you effectively give up your own life to help them cope, even when you

would passionately prefer to be doing something else. This is sometimes very hard to do — I'm no nun, and my husband isn't perfect, either. Marriage can be a pretty bewildering place, and going through this together has shown us that compromise and patience are part and parcel of love.

Dealing with depression

Ludwick chose to undergo hormonal therapy as part of his treatment. We'd been warned about possible side effects, but I wasn't prepared for the changes in his personality. This type of treatment, like others, affects everyone differently. Aging itself brings on some unwelcome transformations — that wisdom and medical science can moderate — but my husband's prostate cancer treatment further aggravated these changes.

Ludwick had never before been prone to depression, so I was caught off-guard. My initial reaction when it started was to wonder: "Is he losing it? Is it aging? Burnout? Is this the end of our marriage?" Not knowing what was happening, my imagination soared. No one had warned us that these drugs, designed to weaken and push prostate cancer away, can also threaten to drive the patient and his loved ones apart.

When he stopped the hormone

therapy, the depression stopped, too, and the man I love returned. But this may also result in the cancer coming back. It is a wild ride.

Prostate cancer made us question our old habits, for example our diet. We've eaten more fish since the diagnosis than I had during my entire preceding life. (They say you are what you eat, but I still can't swim!) We discovered food combinations that seemed to help dissipate the depression while he was on the hormone therapy, but this didn't solve all our problems.

To look at Ludwick, you'd never know he was ill — he looks as handsome and sexy as before! It took me a long time to appreciate how insidiously the treatment was affecting him, despite his healthy physical appearance. Before the cancer, I'd try to help when I saw he was distressed, listless, frustrated or just not himself. On occasion, we frankly disagreed and argued. But during the cancer treatment, I found it hard to see past the aggravation and recognize which moods — like the depression — were now out of his control. I read them as normal everyday interactions gone awry. Often, I heeded the urge to run for cover or tune out entirely, and this compounded my husband's misery many times.

Finding support

My Eureka! moment exploded when we went to our first Montreal West Island Prostate Cancer Support Group meeting. It was like visiting old family friends. Members greeted us and welcomed us into comfortable surroundings. When I heard other healthy-looking cancer fighters talk about their difficulties, I began to understand Ludwick and his new problems through a different perspective. Until then, I thought he'd been mostly fishing for excuses to avoid situations and commitments.

Prostate cancer is complicated and Ludwick and I don't always agree on what the war against it is about

Still regular members of the group years later, we've both learned many valuable lessons. While the cancer continues to dominate our household routine, we're surviving and getting better at it every day. We continue to go to meetings to hear interesting guest speakers, get answers to nagging questions and share experiences with other men and women living with this disease.

A continuing search

We use simple strategies to

cope with this disease, one step at a time. Many little adjustments are ingrained in our lifestyle, for example:

Whenever possible, we avoid setting deadlines because we've discovered that the present becomes more significant when we're not busy planning future schedules.

For entertainment, we choose comedies and silliness over serious drama, because a good laugh is so invigorating.

Ludwick's cancer was discovered before it had a chance to spread to his bones and he's now in his sixth year of miracle drugs. Prostate cancer is complicated and Ludwick and I don't always agree on what the war against it is about. I sometimes wish we could simply put it out of our minds and get on with living. But he continues to search for the nugget of information that will further improve his chances for victory. One thing is certain: as long as this cancer persists, we'll keep on learning to live through it together.

Source: psa rising

Don't worry about avoiding temptation... as you grow older, it will avoid you.

Winston Churchill

My wife has a slight impediment in her speech. Every now and then she stops to breathe.

Jimmy Durante

Provenge prostate cancer vaccine linked to longer survival for asymptomatic hormone refractory stage

Median survival for patients with advanced hormone refractory prostate cancer was 25.9 months for men treated with 3 infusions of Provenge vaccine versus 21.4 months for placebo. Median time to disease progression (11.7 weeks compared to 10.0 weeks for placebo) gave no statistically significant advantage. But overall survival benefit of 4.5 months is the longest ever reported from a Phase 3 study in advanced prostate cancer. This study suggests that Provenge may provide a survival advantage to asymptomatic HRPC patients.

June 28, 2006 - A University of California, San Francisco study has found that men with advanced, often untreatable prostate cancer who received a therapeutic cancer vaccine went on to survive longer than those receiving a placebo.

Study findings showed the vaccine group lived up to an average of four-and-a-half months longer and had a greater than three-fold increase in survival at 36 months when compared to patients in the placebo group.

The study is reported in the July 1, 2006 issue of the Journal of Clinical Oncology [abstract]. The double-blind, placebo-controlled phase III clinical trial was conducted to test the efficacy of the vaccine, called Provenge (sipuleucel-T), in delaying disease progression and prolonging survival in patients with asymptomatic metastatic hormone refractory prostate cancer (HRPC).

Study results showed that the vaccine was well-tolerated by participants. The most common reported side effects such as fever and chills were typically mild.

Led by Eric J. Small, MD, UCSF professor of medicine and urology, the study was conducted in collaboration with 19 institutions in the United States and funded by the Dendreon Corporation, a biotechnology company that developed the vaccine.

"This trial is an important milestone in the development of new treatments for prostate cancer patients," said Small. "The potential survival benefit that was observed may offer important benefits to patients

and would represent the first time that immunotherapy has provided a survival advantage in prostate cancer."

Provenge is an investigational immunotherapy vaccine designed to stimulate T-cell immunity to prostatic acid phosphatase, an antigen found in about 95 percent of prostate cancers but not in non-prostate tissue.

A total of 127 patients with asymptomatic metastatic HRPC received three transfusions of Provenge or placebo every two weeks. Of this group, 115 patients had progressive disease at the time of data analysis and all patients were followed for survival for 36 months.

Asymptomatic metastatic hormone refractory prostate cancer (HRPC) is a relatively advanced stage of the disease. HRPC develops if androgen deprivation treatments fail following either late diagnosis or failure of timely primary treatments (surgery, brachytherapy or external beam radiation). Treatment options are limited for patients at this stage of the disease except for chemotherapy.

The study showed that the median overall survival was 25.9 months for Provenge-treated patients and 21.4 months for placebo-treated patients. After three years, survival was 34 per-

cent for those treated with the vaccine compared to 11 percent for those taking the placebo.

The clinical trial did not meet its primary endpoint of demonstrating a statistically significant difference in progression of the disease from diagnosis, according to Small.

"We found that the time to disease progression for sipuleucel-T was 11.7 weeks compared to 10.0 weeks for placebo," he said. "This shows the difficulties in using the worsening of the disease as an intermediate marker for overall survival of patients treated with immunotherapy," he said. "The study however, suggests that sipuleucel-T may provide a survival advantage to asymptomatic HRPC patients."

Many of the phase I and II clinical trials of the vaccine were also undertaken at UCSF and led by Small. He first presented results from the phase III trial at the 2005 meeting of the American Society of Clinical Oncology.

Dendreon Corporation, based in Seattle, Washington, hopes to market the Provenge product commercially in the coming year. Co-authors of the study are Paul F. Schellhammer, Eastern Virginia Medical School, Norfolk, VA; Celestia S. Higano, University of Washington; Charles H. Redfern, Sharp Healthcare, San Diego;

John J. Nemunaitis, Mary Crowley Medical Research Center, Dallas; and Frank H. Valone, Suleman S. Verjee, Lori A. Jones and Robert M. Hershberg, Dendreon Corporation. UCSF is a leading university that consistently defines health care worldwide by conducting advanced biomedical research, educating graduate students in the life sciences, and providing complex patient care.

Prostate cancer is the most common non-skin cancer in the U.S. with more than 200,000 new cases each year. It is the third leading cause of cancer deaths in men after lung and colorectal cancer.

Study abstract:

Journal of Clinical Oncology , Vol 24, No 19 (July 1), 2006: pp. 3089-3094

Placebo-Controlled Phase III Trial of Immunologic Therapy with Sipuleucel-T (APC8015) in Patients with Metastatic, Asymptomatic Hormone Refractory Prostate Cancer

Eric J. Small , Paul F. Schellhammer , Celestia S. Higano , Charles H. Redfern , John J. Nemunaitis , Frank H. Valone , Suleman S. Verjee , Lori A. Jones , Robert M. Hershberg

From the University of California San Francisco, San Francisco; Sharp Healthcare, San Diego, CA; Eastern Virginia Medical School, Norfolk, VA;

University of Washington; Dendreon Corporation, Seattle, WA; and the Mary Crowley Medical Research Center, Dallas, TX

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PURPOSE: Sipuleucel-T (APC8015) is an investigational immunotherapy product designed to stimulate T-cell immunity against prostatic acid phosphatase. A phase III study was undertaken to evaluate the safety and efficacy of sipuleucel-T in a placebo-controlled study.

PATIENTS AND METHODS: A total of 127 patients with asymptomatic metastatic hormone refractory prostate cancer (HRPC) were randomly assigned in a 2:1 ratio to receive three infusions of sipuleucel-T (n = 82) or placebo (n = 45) every 2 weeks. On disease progression, placebo patients could receive APC8015F, a product made with frozen leukapheresis cells.

RESULTS: Of the 127 patients, 115 patients had progressive disease at the time of data analysis, and all patients were followed for survival for 36 months. The median for time to disease progression (TTP) for sipuleucel-T was 11.7 weeks compared with 10.0 weeks for placebo (P = .052, log-rank;

hazard ratio [HR], 1.45; 95%CI, 0.99 to 2.11). Median survival was 25.9 months for sipuleucel-T and 21.4 months for placebo (P = .01, log-rank; HR, 1.70; 95%CI, 1.13 to 2.56). Treatment remained a strong independent predictor of overall survival after adjusting for prognostic factors using a Cox multivariable regression model (P = .002, Wald test; HR, 2.12; 95%CI, 1.31 to 3.44). The median ratio of T-cell stimulation at 8 weeks to pretreatment was eight-fold higher in sipuleucel-T-treated patients (16.9 v 1.99; P < .001). Sipuleucel-T therapy was well tolerated.

CONCLUSION: While the improvement in the primary end point TTP did not achieve statistical significance, this study suggests that sipuleucel-T may provide a survival advantage to asymptomatic HRPC patients. Supportive studies are underway.

Supported by the Dendreon Corporation. Authors' disclosures of potential conflicts of interest and author contributions are decalred in the article.

About Provenge
Provenge is designed to stimulate a patient's immune system against prostate cancer. It is developed through Dendreon's proprietary Antigen Delivery Cassette™ technology, which utilizes a recombinant form of an antigen found in 95 percent

of prostate cancers, prostatic acid phosphatase (PAP).

About Provenge Trials

A Phase 3 clinical trial of Provenge (Trial P-11), is also underway to evaluate the safety and potential effectiveness of Provenge in treating men with early stage, androgen dependent prostate cancer. Men whose prostate cancer is responsive to hormone treatment are considered androgen dependent. In addition, Dendreon supplies the National Cancer Institute with Provenge for use in a Phase 2 clinical trial (Trial P-16), testing Provenge together with Genentech, Inc.'s Bevacizumab (Avastin) to treat patients with androgen dependent prostate cancer.

for updates see

http://www.dendreon.com/dndn/provenge_trials

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Source: psa rising

A New Wonder Drug? Just Wait

By E.J. Mundell
HealthDay Reporter

prompting them to try out a new "wonder drug" before all the information is in.

SUNDAY, Aug. 20 (HealthDay News) -- In the 1990s, millions of older women struggling with menopausal symptoms and worried about their bone health turned to hormone replacement therapy (HRT) after trials suggested it might help with both.

About the same time, a new generation of prescription analgesics called cox-2 inhibitors racked up sales in the billions, after trials showed they safely eased pain.

By 2005, the early promise of both of these blockbuster treatments was in tatters.

Evidence emerged that HRT boosted women's risk for cancer and stroke, and long-term use of cox-2s was found to raise cardiovascular dangers.

Based on these later findings, women largely abandoned long-term use of HRT, and the U.S. Food and Drug Administration pulled all but one of the cox-2s, Celebrex, from drugstore shelves.

Consumers have also had to put up with scientific flip-flops on everything from the value of vitamin E and dietary fiber, to the safety of aluminum cookware. So, it's no wonder many now feel mistrustful and con-

fused when it comes to medical research.

A lot of that mistrust is justified, experts say.

"There's a lot of hyping of [study] results -- some of it comes from industry, where they often present results using relative terms, magnifying the benefit and minimizing the harm," said Dr. Lisa Schwartz, co-director of the VA Outcomes Group and an associate professor of medicine at Dartmouth Medical School. "So, there are all these other interests that are promoting drugs to be portrayed in a very favorable light."

One big problem: Many highly hyped trial results are presented at medical meetings. In that setting, researchers often offer up incomplete, "interim" data sets. Findings presented at meetings are also spared the scrutiny of peer review -- a prerequisite to publication in medical journals.

Nevertheless, eager researchers and an enthusiastic media can quickly get doctors and patients excited over results presented at meetings --

In fact, a recent study in the Journal of the National Cancer Institute found that use of the breast cancer drug Taxol soared five-fold after interim data on its efficacy was presented at a 1998 meeting.

Luckily for patients, Taxol lived up to its early promise in fighting tough-to-treat tumors. But that's not always the case, experts say.

"Our message is for the physicians in the community to be aware of the potential risks of adopting therapies too early," said the author of the JNCI study, Dr. Sharon Giordano, a professor of medicine in the department of breast medical oncology at the University of Texas M.D. Anderson Cancer Center, in Houston.

Another expert agreed.

"I don't think there's anything unique to any of these clinical trials -- clinical trials in general suffer from people not doing them appropriately and the pressure to cut corners," said Adil Shamoo, a professor of bioethics at the University of Maryland, Baltimore, and editor-in-chief of the journal *Accountability in Research*.

He said regulation isn't the only answer to this problem.

"We could regulate everybody to

death, and society would stand still -- there'd be no progress," Shamoo said. "We obviously don't want to stop research, of course. But society has to find that fine balance -- how much should we regulate in order to reduce, to a reasonable level, these aberrations?"

Shamoo stressed that clinical trials -- which usually include study populations of only a few thousand -- will never be able to capture all the risks that can pop up when millions of people take a marketed drug.

On the other hand, he said, better trial oversight -- including random, independent "data audits" to keep researchers on the straight-and-narrow -- might not hurt.

Improved training of researchers would also help, said Shamoo, who teaches one of the few U.S. medical school courses devoted to the safety and ethics of clinical trials.

"There's currently no training and education for researchers [in medical schools], believe it or not," he noted. "I'd advocate that all researchers and graduate students undergo a minimum of 30 hours of training in research."

In the meantime, he said, the average consumer needs to listen to the latest report of a

"major new treatment advance" with a healthy dose of skepticism.

"For me, unless I have no other choice, I'll never take a drug that has only one clinical trial behind it," Shamoo said. "I'll wait until two or three are done and show similar effects."

He pointed out that his own doctor prescribed him cox-2 pain relievers years ago to help ease exercise-related discomfort.

"I filled the prescription, just in case I got desperate, but I never used them," he said. "Why? Because I read the package insert, which told me how few clinical trials there were on the drug. So, when I needed pain relief, I took two or three ibuprofen, instead."

More information

For more on clinical trials, visit the U.S. National Institutes of Health.

Sourec: HealthDay

I had a rose named after me and I was very flattered. But I was not pleased to read the description in the catalog: "No good in a bed, but fine against a wall."
Eleanor Roosevelt

By all means, marry. If you get a good wife, you'll become happy; if you get a bad one, you'll become a philosopher. -
Socrates

We could certainly slow the aging process down if it had to work its way through Congress.
Will Rogers

Risky Legacy: African DNA linked to prostate cancer

Ben Harder

The high rate of prostate cancer among African American men may result in large part from a newly identified stretch of DNA passed down from their African ancestors.

A black man's odds of developing prostate cancer by age 55 are more than twice those of a white man. The racial discrepancy is less pronounced when the disease appears later. Researchers have suspected for years that genetic factors account for part of the racial difference in risk.

Most African Americans have both African and European forebears, so their chromosomes are mosaics of genes from the two continents. Previously identified genetic markers indicate that in U.S. blacks, an average of about 80 percent of the DNA is African in origin.

Geneticists have long hypothesized that they could identify disease-causing chunks of DNA by sifting through the genomes of ethnically mixed populations and noting where people with a disease tend to have genes from the same ancestral source, says David Reich of Harvard Medical School in Boston. Recent technical advances have made this ap-

proach feasible.

Reich and his colleagues analyzed the genomes of nearly 1,600 African Americans who had developed prostate cancer. In those men, a portion of chromosome 8 containing nine known genes was more frequently of African origin than were other portions of the DNA.

When the team tested nearly 900 cancer-free African American men, African ancestry of DNA turned up no more frequently in the implicated portion of chromosome 8 than elsewhere in their genomes.

Those findings suggest that having African rather than European DNA at the chromosome-8 location places a man at high risk of prostate cancer, the researchers report in an upcoming Proceedings of the National Academy of Sciences.

The team found the most dramatic link between men's developing cancer at a young age and having the African chunk of DNA. "The risk factor we've identified is clearly more important for younger men than for older men," Reich says.

That finding is the study's most important new observation, says geneticist B. Jill Williams of Louisiana State University Health Sciences Center in Shreveport.

Its other findings merely confirm data reported in the June

Nature Genetics, contends Kári Stefánsson of deCODE Genetics in Reykjavik, Iceland. In that study, he and his colleagues linked an elevated risk of prostate cancer to a gene variant in the chromosome-8 segment examined by Reich's team. That variant is carried by nearly one-third of African Americans but appears at lower frequencies in Europeans and white Americans, Stefánsson says.

However, the variant identified by Stefánsson's group explains only a fraction of the newly reported association between prostate cancer and African ancestry in the critical stretch of chromosome 8. "There must be important and unidentified risk factors for prostate cancer in this section of genetic material," Reich concludes.

"It's also possible and, I think, more likely that there are other variants of the same gene," counters Stefánsson.

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