PROSTATE AWARENESS FOUNDATION

# Prostate Self Help

Volume 7, NO.1 Summer/Fall 2005 | Produced by Prostate Cancer Veterans | A Quarterly Newsletter From PAF

## From the Director's Desk

Here's some great news about prostate cancer: **Deaths rates have dropped 25% over the past ten years.** That's 10,000 fewer men dying from the disease. With that said, we need to do an even better job. 30,000 men will die from prostate cancer this year. That's untenable.

The general consensus is that the keys to reducing the death rate are prevention and early detection. There is a growing body of evidence that indicates that diets high in fat, red meat, dairy products and calcium are precursors to prostate cancer. We need to spread the word and get men to reduce or eliminate these foods. So what are healthy foods we can substitute? Recent studies from Harvard found that a prostate healthy diet includes a regular daily intake of vegetables and whole grains along with lots of cooked tomato products a good source of lycopene. Sound familiar? More and more, we are learning that a prostate friendly diet is similar to eating for cardiovascular health!

Detection is another story. Reliable screening remains elusive. Although PSA testing can be given credit for saving lives, there is a cost! Dr Peter Carroll from UCSF Medical School recently reported that one out of four men was over treated for prostate cancer. Over treatment has its problems which include emotional trauma, high rates of impotence and incontinence. For many men, especially with early stage disease, these consequences are worse than the disease itself which rarely exhibits symptoms!

Dr Carroll suggests that doctors need to move away from a "seek and destroy mentality toward a posture of target and control." Dr Thomas Stamey, from Stanford Medical School, considered the father of PSA testing, now feels that the PSA test is no longer valid for diagnosing prostate cancer.

While we wait for improved diagnostic tools, one thing becomes apparent: one needs to get as many markers as possible. Make sure you ask your doctor for a DRE (digital rectal exam) along with a PSA test. Palpable tumors are more likely to need treatment.

All of the prostate cancer experts seem to agree on the fact that if you are diagnosed with the disease, you should take your time with your treatment path decision. Make sure you do your due diligence and learn more about the different choices and their side effects. When you buy a new car, you do your homework, right? You need to look at your prostate treatment choices the same way.

Wishing you a healthy and happy prostate.
**Ken Malik,** Executive Director

# The Latest on Treatment, Diagnosis, Prevention, and More

*By Jan Zlotnick, R.N., M.Ed., Ed.S*

### Good News on the Treatment Front

The biggest news in treatment comes out of the office of my own oncologist Eric Small, MD. After a disappointing report in January about the efficacy of the vaccine drug Provenge, Dr. Small presented a paper in February that demonstrated the drug produced a three-fold increase in survival after three years for men with androgen-independent prostate cancer (AIPC). There were few side effects from this intravenous therapy. What's even more significant is that the drug's success proves that using a patient's own immune cells can lead to an effective cancer treatment. As a result this approach is likely to receive more funding and interest for prostate cancer (PC), as well as for other diseases. This kind of scientific synergism will almost certainly expedite refinements that lead to still better treatments.

### International Research Developments

And there's more good news from the world of immunological research. A team at the Weizmann Institute in Israel has found a way of getting cancer-fighting cells from both of the main branches of our immune systems into bone tumors. Their work used chemotherapy or radiation to pre-condition bone cells to be more receptive to antibodies and T-cells. They then injected hybrid cancer-fighting cells called T-bodies into mice with PC bone metastases. This resulted in decreased tumor load, a significant drop in PSA, and greater longevity (for mice, at least). What's exciting about this therapy is that it bypasses the body's natural barriers to getting cancer-fighting cells into bone, providing for a multi-pronged attack by the immune system right where the tumors are growing. Since 70% of PC fatalities involve bone metastases, this form of treatment will likely move into clinical trials soon.

Meanwhile, doctors at the University of Bristol in England have found a form of vascular endothelial growth factor (just call it VEGF) that prevents blood vessel formation to metastatic tumors. Other forms of VEGF promote blood vessel formation. Various methods have been tried during the past decade to turn-off or block VEGF in order to starve tumors of their blood supply. Most of those studies have proven to be disappointing. But this novel form of VEGF could potentially be mass produced and subsequently injected into the body to shut down tumor growth.

Another British study has led to a genetic therapy breakthrough. Scientists at Cancer Research UK have found that blocking a gene called IGF1R can decrease the survival of many kinds of cancer cells. In addition, cancer cells become twice as sensitive to radiation and chemotherapy when IGF1R is blocked. On a similar note, researchers from China and Japan have discovered that genistein, an isoflavone found in soy, enhanced the effects of radiation therapy.

### Conventional Treatment Developments

In the more traditional world of cancer research the combination of docetaxel and thalidomide (yes, that thalidomide!) has been found to be more effective at reducing PSA and prolonging survival in men with AIPC than docetaxel alone. Men in the combined treatment group were over 50% more likely to live at least 18 months. While this regimen has yet to be FDA approved the initial FDA approval summary on another chemotherapy regimen, this one using docetaxel and prednisone, an anti-inflammatory drug, showed a modest survival benefit. And Cetrorelix, a new LHRH analogue (like Lupron and Zoladex), seems to have a cancer-fighting effect beyond the usual chemical castration. A recent article in the British Journal of Cancer indicates this drug keeps tumor cells from breaking-off and causing metastases in other parts of the body.

### Survival, Prevention, & Quality of Life

If you are considering radiation to treat your PC, here is some news you will likely want to consider. A study published in the Journal of Urologic Oncology found that 51% of all patients treated with [continued on page 2]

# Prostate Self Help

published by the
**Prostate Awareness Foundation** (PAF)
2166 Twelth Avenue
San Francisco, CA 94116
415 675-5661
www.prostateawarenessfoundation.org

Managing Editor: Jan Zlotnick, R.N., EdS
Contributing Editor: Robert Gumpertz
Executive Director: Ken Malik




### The Latest on Treatment

[continued from page 1]

primary radiotherapy died from PC. This study followed PC veterans longer than previous studies. The recurrence-free survival rate after 25 years was only 17%.

Alcohol has long been associated with cancer, and an article published in the January issue of the journal Cancer gives the first clue as to the mechanism involved. It turns out that alcohol stimulates the production of a type of VEGF that promotes blood vessel growth (angiogenesis) to tumors. The intensity of this effect appears to be dose-related. The study was done on chick embryos, so don't start preaching total abstinence yet. But none other than Judah Folkman, the father of angiogenesis research, agrees with the logic of the alcohol connection. Since moderate alcohol consumption - one to two drinks per day - can provide cardiovascular benefits, Folkman asks the question, "At what level [of alcohol consumption] would it be counterproductive for people who are at risk for cancer?" Until we know more it's probably a good idea to minimize your drinking and encourage your sons and brothers to do likewise.

The dairy debate continues among greater minds than mine. The Harvard School of Public Health reports that the recommended daily intake level of calcium in the U.S. is inflated (it's far lower in Europe) and that research consistently indicates high dairy consumption does not reduce bone fractures. In addition, consuming a lot of dairy products increases the risk for prostate, breast and colorectal cancer. But Robert Heaney, a Creighton University professor who has studied calcium for 50 years, defends the current U.S. guidelines and claims that the connection between dairy products and prostate cancer is weak. Still, he agrees that calcium can come from other sources than dairy. Indeed, taking a calcium supplement, ideally with vitamin D, avoids the dairy controversy completely, and will likely decrease calories and saturated fat in your diet.

On a related note, researchers at the University of Texas reviewed the records of over 50,000 men with PC to determine the impact of androgen deprivation therapy (ADT) on bones. They found a whopping 50% increase in fractures and osteoporosis in men treated with drugs such as Lupron and Zoladex. There are ways to combat this bone loss, and you should ask your doctor to treat you prophylactically (in advance of any bone loss) if you are on ADT.

The term 'prophylactic' also applies to PC itself. A study presented at a recent meeting of the American Society of Clinical Oncology found that overweight and obese men were far more likely to have advanced cancer at diagnosis than men of healthy weight. Using the Body Mass Index (BMI), the easy-to-find gold standard for weight, this study followed men with PC for 21 years. Those with a BMI of 25-29, the overweight range, were 30% more likely than healthy weight men to have died from PC, while those with a BMI of 30 or greater were twice as likely. PSA scores at diagnosis were irrelevant to the mortality rates. While we can't do anything now to change what we weighed at the time of diagnosis, we can act prophylactically by giving our sons, brothers and friends yet another reason to get and stay slim. We could be helping to save their lives, or at least helping them to live longer.

### Diagnostics: What Now, Dr. Stamey?

The big news on the diagnostic front is Dr. Thomas Stamey's much-publicized dismissal of PSA testing as a tool for diagnosing PC. Stamey, a Stanford M.D., is considered the father of the PSA test, so his opinion carries a lot of weight. Dr. Stamey addressed PAF at its monthly meeting earlier this year. (See the recap of this lecture in this issues Conventional Side). If you need some expert advice about this controversy before our next newsletter, check-out the January 2005 issue of the UC Berkeley Wellness Letter.

Spread the word!

*Jan Zlotnick teaches nursing and Men's Health Issues at City College of San Francisco.*

# ALTERNATIVE SIDE

## Treating Early Stage Prostate Cancer

*By Ken Malik*

I was diagnosed with early stage prostate cancer ten years ago and have been successfully managing it with what I call "Aggressive Watchful Waiting." I'm always interested in clinical information on this subject and have some new information to share with you.

But first, let's look at what the experts feel constitutes early stage prostate cancer and who are good candidates for watchful waiting:

1. no Gleason 4 or 5 cancer at biopsy
2. PSA under 10
3. not palpable on DRE
4. Age: the older the man, the less likely his cancer will endanger his life
5. Low PSA doubling time
6. Minimal family history of cancer
7. Minimal number of positive core samples from biopsy
8. Low tumor volume
9. High "Free PSA"

### Conflicting Clinical Studies

Recently there have been two contradictory clinical studies that caught my attention. Both focused on long term survival rates (15 years +) for men who have chosen not to undergo conventional treatment. The first, from the University of Connecticut indicated that there was not much difference in mortality rates between men doing watchful waiting and those undergoing conventional treatment. The second study from Sweden painted a grim picture. This study found that the death rate after 15 years for men in watchful waiting was three times that of men who had had a conventional treatment! So what do we believe? I have been feeling for some time that if you wait long enough or dig deep enough you will always find contradictory clinical information!

### Defining Watchful Waiting

Whatever the reality, there are men all over the country with early stage prostate cancer that appear to be doing well using various watchful waiting protocols. Personally, I have always had a problem with the term watchful waiting as it sounds like one is doing nothing but waiting for the axe to fall! I coined the term "Aggressive Watchful Waiting" because I take a strong proactive approach to healing, and I'm certainly not sitting on my hands waiting for something to happen.

### Chronic Disease Management (CDM)

Ronald Wheeler, MD from Sarasota, Florida and a PAF medical advisor, has a term for this strategy that I like, "Chronic Disease Man-

agement." Dr Wheeler questions the need to "cure" early stage pc, as opposed to managing the disease and keeping it at bay.

I like to compare CDM strategy to diabetes management. If you're diagnosed with diabetes, odds are your doctor will not suggest removal of your pancreas as a treatment path! Diabetics learn to maintain and live with their affliction using diet, exercise and medication while closely monitoring their disease. Why not look at early stage prostate cancer in the same way.

Dr Wheeler reports encouraging results using the Chronic Disease Management (CDM) protocol in his practice. The protocol includes the use of his prostate formula Peenuts and a Mediterranean diet. Twenty of his patients were followed for as long as five years. Ninety percent (90%) reported an average drop in PSA of 48%. (If you would like to read more about this pilot study: visit our website at www.prostateawarenessfoundation.org )

### A Word of Caution

If you embark on a watchful waiting protocol make sure you have the guidance of a qualified health professional. Also, continue to be vigilant and track your progress. Use as many markers as possible including PSA, Free PSA, PAP and DRE. This will help you determine if your protocol is effectively working and that you're not getting yourself in trouble.

# CONVENTIONAL SIDE

## The PSA Era Is Over!

*By Ken Malik*

### The Controversy

Thomas Stamey, MD from the Stanford University Medical School, Department of Urology dropped a bombshell on his peers recently with a clinical study in the Journal of Urology titled "The Prostate Specific Antigen Era In The United States Is Over For Prostate Cancer: What Happened In The Last 20 Years?" (This paper is available at www.prostateawarenessfoundation.org). The new research is significant because Dr Stamey has long been considered the father of PSA testing for the diagnosis of prostate cancer. His work in the 1980's was instrumental in making the PSA test universally accepted by doctors all over the United States. Dr Stamey's latest clinical research is now challenging pc specialists to re-evaluate their position and take a stand on this issue. But like all stories, there's more here than meets the eye. Dr Stamey, a member of the PAF medical advisory board, recently lectured to PAF. Here is a review and clarification of his latest study.

### What Is He Really Saying and Not Saying!

After closely reviewing the available data from 1983 to 2003, Dr Stamey now feels that using PSA as a tool to diagnosis initial prostate cancer is no longer valid. He points out that PSA is still an excellent marker for determining if one has BPH. It also has merit for tracking disease progression after diagnosis (PSA doubling time) and to determine if an intervention has been a success or failure.

Other important points that Dr Stamey made in his lecture to PAF in April were:

- Prostate cancer is an age related disease. The older you are the more likely you are to have it!

  8% of men from 20-29 years of age
  31% of men from 30-39 years of age
  37% of men from 40-49 years of age
  44% of men from 50-59 years of age
  65% of men from 60-69 years of age
  83% of men from 70-79 years of age
- We should biopsy by age not because of high PSA
- Most of the PSA between 2 and 10 is BPH derived
- 20 years ago the average PSA at diagnosis was 25, today it is 8. We are over diagnosing and over-treating.
- Less and less of the prostate cancer diagnosed today is palpable from a DRE exam.
- 20 years ago 10% of pc was un-palpable, today that figure is 83%. Doctors may be relying too heavily on PSA and not performing a DRE. Make your doctor do a DRE at least once per year.
- Find out where your cancer is located. This is critical! Transitional zone cancers are far less malignant and likely to kill you than peripheral zone cancers. Ask your doctor exactly where your cancer is before deciding on a treatment path.
- We desperately need to find a better marker for diagnosing prostate cancer.
- The higher the Gleason score the higher the rate of failure after intervention
- Why are we finding so much prostate cancer upon biopsy? Because it's age related.
- The weight of your prostate is directly related to your level of PSA. PSA is proportional to prostate size and associated with BPH.

### The Good News

Prostate cancer is not a death sentence. In the vast majority of cases, you are not going to die from prostate cancer. With a death rate for men over 65 years at 226 per 100,000 our odds of survival are excellent. Men are not dying from Gleason grade cancers of 1, 2 or 3 but from the 4 & 5 grade Gleason scores. Make sure you know what your Gleason is before deciding on a treatment path.

### What's a Man to Do?

Dr Stamey says that there will be no solution to the prostate cancer problem until we have a marker that is not just positive for detecting cancer but how much of it you have! He states that in most cases "getting a PSA test is the first step toward an unmitigated disaster." He suggests that doctors should review with their patients the risks and side effects of treatment along with the benefits before the PSA test is administered.

### Words of Wisdom!

Peter Scardino, MD, the Chief of Urology at New York's Sloan Kettering Cancer Center noted recently that "although PSA testing has become popular, it has not proven to be a reliable marker. In one way the test is too sensitive – detecting small, slow growing tumors that may not ever require treatment." He recommends regular screening using both PSA and DRE to detect almost all cancers that are curable. We at PAF agree with this recommendation and feel that " the only thing to fear is fear itself." It's more critical than ever that men get educated about prostate health issues so they can make intelligent decisions.

*You can get a video tape of Dr Stamey's recent lecture to PAF by sending $20 to PAF to cover the cost of the tape and mailing.*

# *We Need Your Help*

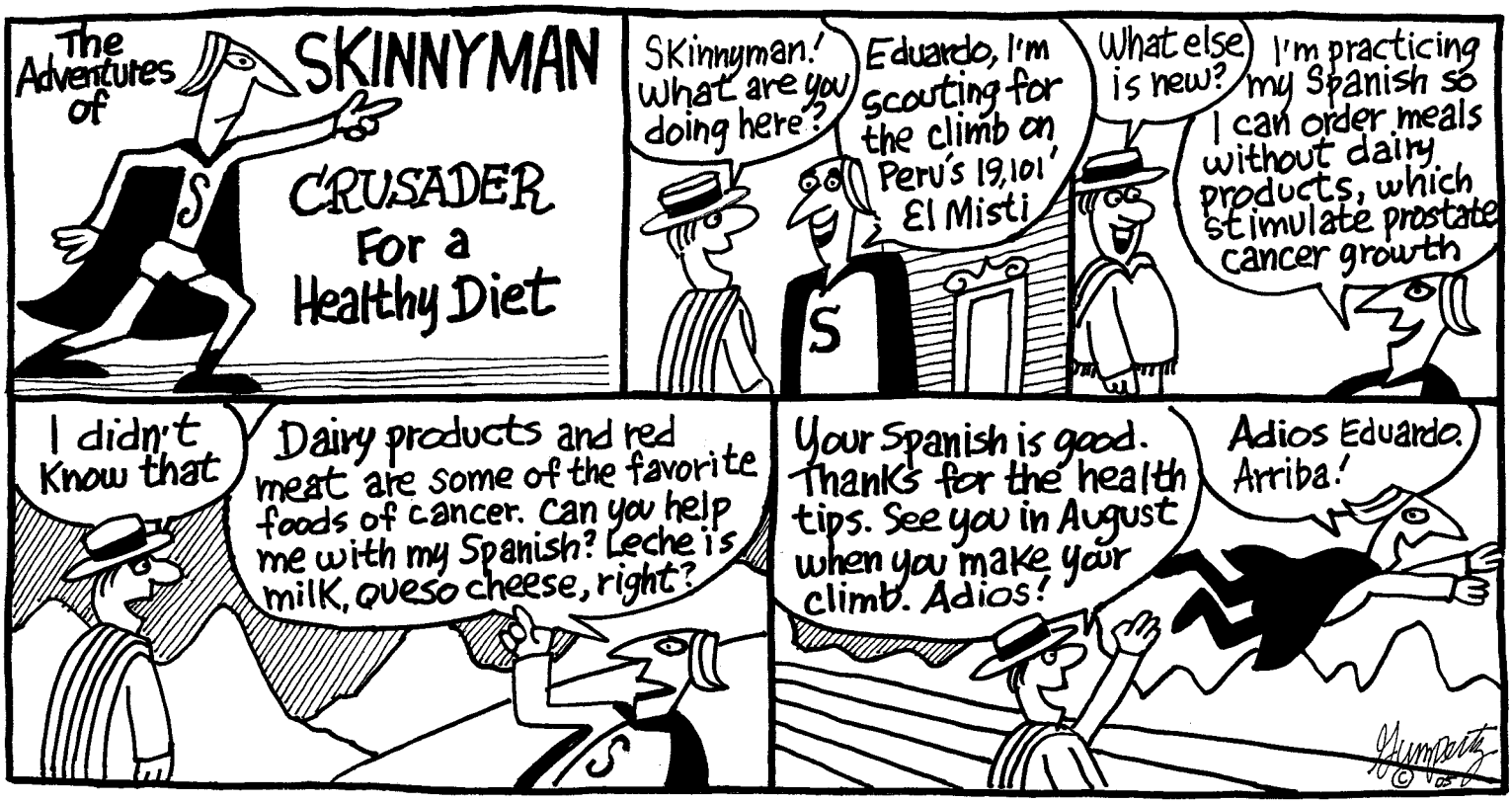
This newsletter is free! It reaches men and their families all over the country with patient driven, honest and understandable information about prostate health issues. PAF is a 501(c)(3) not for profit educational service that served over 6,000 men and their families last year. PAF is not supported by government grants or major corporate funding. We are able to sustain and expand our services because of generous tax deductible contributions from people like you.

For us to continue our work we need your support.

Please help us by supporting the ten climbers that will be attempting to reach the summit of 19,101' El Misti this August on behalf of PAF.

Enclosed is information about this year's Cancer Climb For Prostate Awareness.

***Thank you for your generosity***




*Robert Gumpertz*


**Prostate Self Help**
PROSTATE AWARENESS FOUNDATION
2166 Twelth Avenue
San Francisco, CA 94116


CANCER CLIMB

FOR PROSTATE AWARENESS

19,101' EL MISTI – PERU

August 3 – 20, 2005