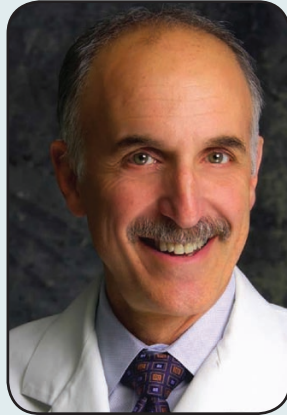




COMMUNITY NEWSLETTER



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Understanding the Basics of Prostate Cancer

by Thomas M. Schroeder, MD & Vincent Ortolano, M.D.

Prostate cancer can be difficult to understand. The media, relatives, friends, and even doctors say a lot of different things about prostate cancer. This makes it difficult for a man with prostate cancer to understand the basic issues and choose an appropriate treatment. Hopefully, this article will help. It will cover the basic statistics of prostate cancer, what the prostate does and where it is, how prostate cancer is diagnosed, how it is ranked or staged, and finally focus on treatment options.

The American Cancer Society estimates that 192,000 men were diagnosed with prostate cancer in the U.S. during 2009. Approximately 27,000 men died of prostate cancer in the U.S. during 2009. This shows two important things. One, a lot of men in the U.S. are diagnosed with prostate

cancer. Two, only about 15% of men diagnosed with prostate cancer, die from prostate cancer. Overall this is pretty good news. If you are diagnosed with prostate cancer, most likely you will not die from prostate cancer. In fact, some men with prostate cancer may not even need treatment. They can simply watch their cancer, and as long as it does not appear to be growing or

spreading, no treatment is necessary. The trick is figuring out who needs treatment and who does not.

The prostate is a gland that sits just beneath the bladder and directly in front of the rectum. The prostate creates and stores the seminal fluid that allows for reproduction. It is sensitive to testosterone and this may cause it to grow over time. This growth can cause irritation or pressure on the base of the bladder and the urethra resulting in urinary symptoms. The condition is known as benign prostatic hyperplasia (BPH) and affects approximately 50% of men by 50 years of age. The symptoms of BPH are very similar to prostate cancer and can also cause elevations in prostate specific antigen (PSA).

Prostate cancer for the last 20-25 years has been diagnosed at an earlier stage than in previous years. This is because of the prostate specific antigen (PSA). PSA is a protein that comes from the prostate and is found in the blood. In most patients with prostate cancer, the amount of PSA in the blood is elevated. This allows us to find men with prostate cancer before they develop symptoms, simply by checking their blood PSA levels and performing a digital rectal exam. Unfortunately, there are other conditions that can cause elevations of PSA. Only about 30% of men with an elevated PSA (≥ 4 ng/mL) will be diagnosed with prostate cancer. Diagnosis is by needle biopsy. Multiple (twelve or more) biopsies are obtained using ultrasound imaging to guide the needles.

Once diagnosed with prostate cancer, a stage or risk is assigned based on a series of clinical factors. Many different staging systems and risk assessments are used to help physicians and patients determine prognosis and treatment. The most commonly used clinical risk assessment is based on three factors: the PSA, the digital rectal exam, and the Gleason score.

Continued on page 2

INSIDE AT A GLANCE



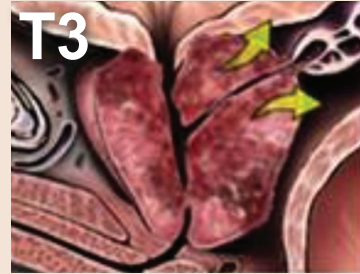

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Understanding the Basics of Prostate Cancer

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The Gleason score is an assessment of the prostate cancer based upon its microscopic appearance. The pathologist assigns a grade of 1-5 to the most common tumor pattern and a grade to the second most common tumor pattern. These grades are added together to give the Gleason score (e.g. 3+4=7). A higher score indicates a worse prognosis.

The digital rectal exam is used to determine the "T" stage or tumor stage. This is an assessment from 1-4. Stage T1 is a cancer that cannot be felt on digital rectal exam, T2 is tumor that can be felt but is confined to the prostate, T3 is tumor that can be felt to extend beyond the prostate, and T4 is a tumor that invades adjacent tissues.

			
<p>T1 Clinically inapparent; tumor not palpable or visible by imaging</p> <p>T1a Incidental finding during transurethral resection of prostate; <5% of tissue resected</p> <p>T1b Incidental finding during transurethral resection of prostate; >5% of tissue resected</p> <p>T1c Tumor identified by needle biopsy (e.g. because of elevated PSA)</p>	<p>T2 Tumor confined within prostate (palpable or visible on TRUS)</p> <p>T2a Involves half of a lobe or less</p> <p>T2b Involves more than half of a lobe one lobe but not both lobes</p> <p>T2c Tumor involve both lobes</p>	<p>T3 Tumor extends through prostatic capsule, bladder neck or seminal capsule</p> <p>T3a Unilateral extracapsular extension</p> <p>T3b Tumor invades seminal vesicle(s)</p>	<p>T4 The tumor has spread or attached to tissues next to the prostate (other than the seminal vesicles).</p> <p>T4a the tumor has spread to the neck of the bladder, the external sphincter (muscles that help control urination), or the rectum.</p> <p>T4b The tumor has spread to the floor and/or the wall of the pelvis.</p>

The digital rectal exam, Gleason score, and PSA are used to determine three basic risk categories for localized prostate cancer:

Low Risk: T1-T2a, Gleason Score ≤ 6, PSA ≤ 10.

Intermediate Risk: T2b-T2c, Gleason Score 7, or PSA 10-20.

High Risk: T3 or higher, Gleason Score 8-10, or PSA > 20.

Many intermediate and all high risk patients will need further testing to make sure that the prostate cancer has not spread to other parts of the body. These tests include, but may not be limited to, a CT scan, bone scan, or an MRI.

Treatment recommendations are based on the risk category. Patients with low or intermediate risk prostate cancer can be treated with surgery, radiation therapy, or

can have no treatment and be closely watched. Patients with intermediate risk prostate cancer can also be treated with surgery, radiation therapy, or can have no treatment. However, hormonal therapy may be used in addition to radiation therapy. High risk patients can be treated with surgery, but due to the high risk of cancer extending beyond the prostate, they may require radiation therapy after surgery. As a result, most high risk patients receive radiation therapy with hormonal therapy. Chemotherapy is being tested in patients with high risk prostate cancer, but is not yet standard of care.

Radical Prostatectomy

Although first done about 100 years ago, radical prostatectomy gained popularity as a treatment in 1982 when Walsh described his "anatomic" version. Over the past few

decades further variations have emerged. Prior to 1982, side effects were often debilitating. Walsh helped identify the neurovascular bundle and as a result the risk of impotence and incontinence decreased dramatically. Today 60-80% of patients who have good sexual performance prior to surgery should anticipate return of function. Incontinence rates now vary from 1-10%. Patients should expect their hospitalization to last 24 hours. The use of catheter drainage is now limited to one week. There are currently three versions being performed, Walsh's retropubic approach, laparoscopic prostatectomy and robotic assisted prostatectomy. Each attempts to remove the prostate, seminal vesicles and sometimes pelvic lymph nodes. Patients should discuss with their surgeon which approach would be best for them.

Understanding the Basics of Prostate Cancer

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Radiation

Radiation therapy can be administered in two different ways: with external beams directed at the prostate or by placing radioactive sources within the prostate. The external beam radiation usually takes place over 8 to 10 weeks with the patient receiving 36-45 daily treatments, Monday through Friday. Some recent studies have looked at shortening the number of treatments, and this may become a more standard practice in the future. Radiation can also be administered using brachytherapy, which is the process of using radioactive sources placed within the prostate. This can be done in a single surgical procedure with the radioactive sources permanently placed within the prostate, or be done in a short series of treatments using small catheters placed within the prostate.

External beam radiation is traditionally administered with x-rays. Typically the x-rays are directed at the prostate from multiple angles with the shape of the beam changing during the treatment. The changing shape of the beam is optimized to the patient's anatomy using a CT scan or an MRI and sophisticated computers. This process is called IMRT (intensity modulated radiation therapy), and most

radiation centers in the United States use this more advanced technique.

External beam radiation can also be administered with particle therapy. In the United States, this is done with a beam of protons directed at the prostate. There is a theoretical benefit to proton therapy that may allow it to spare adjacent tissues from receiving radiation to a greater degree than x-rays. Whether this has any effect on reducing side effects has not yet been proven.

The most common technique of brachytherapy in the United States is permanent seed implantation. This process deposits numerous (30-100) radioactive seeds into the prostate using ultrasound guidance. The seeds permanently reside within the prostate slowly releasing their radioactivity. It requires a single outpatient surgical procedure, and recovery is typically short.

All forms of radiation have similar side effects. During the period of receiving the radiation, the radiation causes inflammation and irritation of the prostate and adjacent tissues (bladder & rectum). This can cause urinary and rectal symptoms. Urinary symptoms include: increased frequency of urination, urgency, burning with urination,

a decreased urinary stream, and having to urinate at night (nocturia). Rectal symptoms include: diarrhea, gas, urgency, frequency, and pain or burning with bowel movements. For the majority of men, the radiation side effects are mild or absent. Radiation can also cause fatigue that can range from unnoticeable to moderate (requiring an afternoon nap). In most cases, these side effects wear off within a few weeks of completing the radiation.

One to two years following radiation, late side effects can emerge. These are a result of microscopic scar tissue that forms within the irradiated tissues. This scar tissue can reduce blood flow to the area and interfere with the function of the tissues radiated. With prostate radiation, this can cause an ulcer to form within the rectum or bladder. If an ulcer is present, blood will appear in the urine or in the stool. This occurs in less than 5% of patients receiving radiation.

With modern radiation techniques, more radiation dose can be administered to the prostate. Studies suggest that the more radiation administered, the less likely the prostate cancer will return. Unfortunately, the more radiation administered the more likely late side effects will occur. As a result, it is important to talk to your doctor about the dose of radiation.

Through the New Mexico Cancer Care Alliance multiple prostate cancer studies are available. These are important studies to help discover improvements in the care of prostate cancer patients.

Here is a list of upcoming or currently available prostate studies:

ADJUVANT PROSTATE

RTOG 0232: A Phase III Study Comparing Combined External Beam Radiation and Transperineal Interstitial Permanent Brachytherapy with Brachytherapy Alone for Selected Patients with Intermediate Risk Prostatic Carcinoma

ADVANCED PROSTATE

CALGB 90202: A Randomized Double-blind, Placebo-controlled Phase III Study of Early Versus Standard Zoledronic Acid to Prevent Skeletal Related Events in Men with Prostate Cancer Metastatic to Bone

RTOG 0815: A Phase III Prospective Randomized Trial of Dose-Escalated Radiotherapy with or without Short-Term Androgen Deprivation Therapy for Patients with Intermediate-Risk Prostate Cancer

RTOG 0534: A Phase III Trial of Short Term Androgen Deprivation with Pelvic Lymph Node or Prostate Bed Only Radiotherapy (SPPORT) in Prostate Cancer Patients with a Rising PSA After Radical Prostatectomy

NEOADJUVANT PROSTATE

CALGB 90203: A Randomized Phase III Study of Neo-Adjuvant Docetaxel and

Androgen Deprivation Prior to Radical Prostatectomy versus Immediate Radical Prostatectomy in Patients with High-Risk, Clinically Localized Prostate Cancer

VA 553: Chemotherapy After Prostatectomy (CAP) For High Risk Prostate Carcinoma: A Phase III Randomized Study

INST 0808: A Phase III Biomarker Study of Neoadjuvant Vitamin E in Patients with Locally Treatable Prostate Cancer Prior to Prostatectomy or Brachytherapy



“Our journey is a step upward each day.”

When I was asked to do this article I was thrilled because of the opportunity for my wife and me to be heard about our own experience with this devious foe. We have been monitoring my PSA counts since 1998 (as I had been struggling since the mid to late 90s with the common prostate urinary problems that so many men face). Though my PSA “numbers” may be a little off, the overall journey is descriptive of what we have gone through.

The first PSA test (in 1998) was elevated but not of great concern to my primary care physician, as a swollen prostate (which I had) can cause those conditions. It doubled in 2000 to around 2.0. It doubled again in 2004 to around 4.0 and I believe it was about then my physician suggested I have a biopsy (the standard digital rectal exams had been given during these prior times with no indication of growths or tumors). The biopsy came back negative

Our Journey with Prostate Cancer

by: **Steve Brannan, Prostate cancer survivor and warrior**

(much to our relief) and it was “put off” to “normal” male problems of a swollen prostate.

When it doubled again in 2006 to about 9.0, my physician stated, “You’ve got prostate cancer.” This was because data shows that a PSA greater than 10.0 is highly suspicious for cancer. Once again the results came back negative, to which I replied, “That means I’m cancer free.” His reply was rather devastating. “A biopsy is like fishing with a net in the sea. There is only a 70% chance the first go around of finding anything, the second go around those chances increase to 90% and the third go around to 99%.” (Actually, I believe these words were spoken between my first and second biopsy because I recall asking the technician to “skip the second trolling and jump to the third!” On that second biopsy a total of 20 plugs were taken!)

In March of 2008 I followed the advice of my physicians and had a transurethral resection of the prostate (TURP) the famous “roto-rooter” job. I enjoyed, after the period of incontinence, the pleasure of “normal” urination. So imagine my trepidation a year later at my “release” follow up when my PSA had jumped to almost 20.0! This time the biopsy came back positive much to our devastation. After a PET scan my physician, who assured me he wasn’t God, said that with all the best technology available he was reasonably sure that my best option was radical prostatectomy since the cancer was contained.

The surgery took place October 5th, 2009. Once again, to our devastation, the bad news was that they had to take both nerve bundles. As if this were not enough the surgeons took the surrounding lymph nodes along with the seminal vesicles and, while cancer was not found in the lymph nodes (great news!) it was found in the seminal vesicles!

After my surgery, my physician offered me a new clinical trial that compares standard of care treatment (standard treatment for prostate cancer) and chemotherapy. I was randomized (selected by chance) to the standard treatment which is surveillance or “watchful waiting.” Although I was disappointed that I did not receive the chemotherapy, I know that I am still contributing to prostate cancer research. Future generations will know if adding chemotherapy after a prostatectomy will improve survival. I am still on this study and see my physician every 3 months. The study requires that I have a PSA with a physical exam and that I complete a questionnaire at each visit.

I have improved immensely in the incontinence department with the help of Kegel exercises. We have only made a few strides in the ED department, although those of us with hearing aids, prosthetics, or false teeth will attest, “nothing is as good as what the good Lord endowed us with!” Our hopes are that, almost miraculously, I will have nerve bundles regenerate and we will be able to enjoy our conjugal pleasures with a natural erection.

We have read intensively books like *“Give Yourself a Second Opinion: Guide to Surviving Prostate Cancer”* by Dr. Patrick Walsh and *“Saving Your Sex Life”* by Dr. John P. Mulhall. The Prostate Cancer website and other support group websites like www.ustoo.com all recognize (even as the name of this website indicates) that cancer affects not just the man who has it, but also his family and loved ones.

Our journey is a step upward each day. There are many good resources and we would encourage YOU to seek them out too! We hope and plan, as we travel further into this journey, to start up a self-help group which we choose to call COPE (Couples of PSA Elevation) i.e. *“Couples of PSA elevation cope with hope.”*

Disclaimer:

The opinions contained in this article belong solely to the author. NMCCA is not responsible for the content and the opinions expressed in this article.

5TH ANNUAL HERO Recognition Breakfast

MARCH 11, 2010

HERO is an acronym for "Helping to Enhance Research in Oncology" (SM), and NMCCA believes any person who participates in a cancer clinical trial shows courage by volunteering for a new experimental treatment that may offer hope and possibly a cure to future generations. These people are our HEROs.

Each year New Mexico Cancer Care Alliance honors these HEROs by hosting a breakfast and speaker for patients that have participated on a cancer clinical trial. The 2010 HERO Recognition Breakfast was held at the Albuquerque Marriott Pyramids North. The keynote speaker was humorist and songwriter, Eric Gnezda. Eric entertained and inspired the audience with his music, humor and above all, his faith in his fellow human beings. NMCCA recognized and thanked the cancer patients and their families for participating on a clinical trial. The breakfast also provided an opportunity to raise awareness of the importance of clinical trials to cancer research and advancing treatments; and the important role the human subjects play.

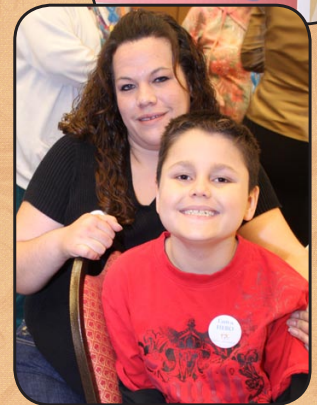


NMCCA also recognized Senator Cynthia Nava and Representative Mimi Stewart for their support during the 2010 Legislative Session. Senator Nava and Representative Stewart sponsored legislation

that requires the convening of a statewide work group to investigate how to expand access to cancer clinical trials to all parts of New Mexico.

New Mexico Cancer Care Alliance would like to thank our sponsors for their support of the 2010 HERO Recognition Breakfast.

- Genentech
- Celgene
- The Cancer Center at Presbyterian
- Central New Mexico Affiliate of Susan G. Komen for the Cure
- Memorial Medical Center, Las Cruces
- Southwest Gynecologic Oncology Associates
- University of New Mexico Cancer Center
- Hematology Oncology Associates
- Lovelace Women's Hospital
- New Mexico Specialty Care, LLC
- Radiation Oncology Associates, P.A.
- United Blood Services



NMCCA would like to thank **Presbyterian Healthcare Foundation** and **Wells Fargo** for their overall support of our HERO education programs.

New Mexico Cancer Care Alliance Welcomes New Participants

The New Mexico Cancer Care Alliance, Board of Directors voted to approve William Adler, M.D from the Memorial Medical Center, Las Cruces, Esme Finlay, M.D. from New Mexico Veterans Administration Medical Center, Ashwani Rajput, M.D from the University of New Mexico Cancer Center and Shelly Stepenaskie, M.D. from

Pathology Associates of Albuquerque, P.A. as participants.

Additionally, Ovarian Cancer Together, was approved as an Affiliate Participant. Affiliate Participants are groups involved with cancer treatment, research, support and education. Affiliates work with NMCCA's physician participants to increase

knowledge of the role research may play in cancer treatments.

NMCCA looks forward to working with these new participants and affiliate and to the expertise that they bring to the organization.

For more information visit www.ovariancancertogether.org

Governor Bill Richardson declared March 2010 as "Cancer Clinical Trial Awareness Month."

During this month NMCCA provided the community with information about cancer clinical trials. Less than 5% of adult cancer patients participate on clinical trials nationally so it is important for the public to know and understand the importance of the cancer research that is done through clinical trials. NMCCA will continue throughout the year to heighten the awareness of cancer clinical trials.



2010 Walk for Your Man

1st Annual 5k Prostate Cancer Awareness Walk

An event for the entire family

Women also suffer the effects of prostate cancer



Prostate Cancer Support Association of New Mexico

Saturday, June 12, 2010

Balloon Fiesta Park

5000 Balloon Fiesta Parkway

Time - 7AM-12PM

Official Start Time - 8AM

Distance - 5k (3miles)

Cost - \$25 per person

\$45 per family

\$20 per person for

a team of 2 or more

Sign up at www.active.com or www.pcsanm.org

Call 505-254-7784 for more information

With generous support from KOAT-TV 7, Legacy Church, REI, TLC Plumbing, Southwest Airlines, SED Laboratories, and Waste Management Corp.

Paddle for the Cure Returns!

The Boning and DeFillippo families raised over \$1,600 last year for cancer research in New Mexico because they have several family members fighting cancer. Once again they will be challenging themselves physically by paddling over seven miles across Elephant Butte Lake.

The 2nd Paddle for the Cure event will take place on July 10, 2010 on Elephant Butte Lake. The Boning and DeFillippo families would like to challenge anyone interested in helping raise money for cancer research to join them on Elephant Butte Lake!

For more information please call Cassie Boning at 505-410-1197.



NMCCA Advances Cancer Research



New Mexico Cancer Care Alliance was the idea of a few highly respected, dedicated physicians in Albuquerque. These physicians realized that many local cancer patients left the state to receive the newest treatments that were available only through cancer research studies. These physicians were able to convince the leaders of their health care systems that by the hospitals and physicians working together all New Mexicans would have access to new, experimental research treatments without the expense of leaving the state.

In February 2002, NMCCA became a reality to assist in the complex processes required for physicians to participate in clinical trials. NMCCA has grown in the past 8 years and has accomplished many tasks since we first reported our progress in December 2003.

In 2003, we had hired two staff members and opened our offices, began to schedule meetings of the Medical Scientific Review Committee, and enrolled 43 patients on our trials. Today, NMCCA has 9 staff, moved into our new offices and from 2002 to December 2009 have enrolled 1348 patients on our cancer clinical trials.

NMCCA expanded beyond Albuquerque with participants in Santa Fe and Las Cruces, with Affiliate Participants in Albuquerque, Santa Fe and Los Alamos. NMCCA is a growing network of 120 physicians who work in private practice and in the major healthcare institutions in Central, Northern, and Southern New Mexico. We work together to find the most efficient and effective ways to bring the most promising cancer treatments available through clinical trials to New Mexicans.

Research is a complex process, and working together collaboratively adds an additional layer of complexity. The NMCCA is successful due to the efforts and dedication of many individuals and groups. The NMCCA Board of Directors, provides the vision and strategy for our success. The physicians and their research staff who participate in clinical trials, are quality minded and tend to spend more time with patients to explain the trial and closely monitor the results. These physicians and staff, by their involvement in research, are up to date on the latest treatments in their specialties, as they are involved in the clinical trials. The NMCCA staff is dedicated to our mission of making clinical trials available to cancer patients in New Mexico. I am fortunate to work with such outstanding groups of individuals.

It is through the continued hard work and dedication of everyone involved in the New Mexico Cancer Care Alliance, that we will continue to advance the global knowledge of cancer research through local participation in cancer clinical trials.

Yes!

I am pleased to contribute to the New Mexico Cancer Care Alliance

TWO WAYS TO GIVE:

1. Give Online: www.nmcca.org
2. Cut out form and mail check to:
P.O. Box 4428
Albuquerque, NM 87196
(Make checks payable to New Mexico Cancer Care Alliance)

Name: _____

Phone: _____

Address: _____

City: _____

State: _____ Zip: _____

Email address: _____

My gift is for:

\$10 \$15 \$25 \$50 \$100 \$ _____

United Way Donor Option Plan

During your company's United Way campaign drive, you can specify your donation be given to New Mexico Cancer Care Alliance. For questions, call United Way at 505-247-3671.

Correction: 2009 Fall Issue page 4

Referring to the article written by Mary Gutierrez, there is a sentence that currently reads "Specifically, I learned that a negative test results meant that the women in my family had the same risk of getting cancer as the general population." should read "Specifically, I learned that a negative test results meant that the women in my family may still be at higher risk of getting cancer compared to the general population."

This means that women in Mary's family need to seek primary prevention at an earlier age than the general population guidelines (see <http://www.cancer.org> for information on breast cancer prevention).

Sharing Your Thoughts

*Have you participated in a clinical trial?
 Would you like to share a few words about your experience?*

If so, we'd love to include your thoughts in our newsletters. Contact Debbie Putt at dputt@nmcca.org Or write to: NMCCA, P.O. Box 4428, Albuquerque, NM 87196



Don't Miss Out!

Sign up to Receive the **NMCCA Community Newsletter Today!**

email Debbie Putt at dputt@nmcca.org or register on-line at www.nmcca.org

Electronic versions of NMCCA newsletters available at www.nmcca.org/whatsnew/newsletters.htm

NMCCA Community Newsletter is a publication of the New Mexico Cancer Care Alliance.

Any submissions can be sent to Debbie Putt, Communications and Outreach Manager dputt@nmcca.org • Phone 505 925-0365 • Fax 505 272-7799

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Cancer Awareness Calendar 2010

January

National Cervical Cancer Screening Month

March

National Colorectal Cancer Awareness Month

New Mexico Clinical Trials Awareness Month

April

National Cancer Control Month

May

Melanoma and Skin Cancer Detection and Prevention Month

Cancer Research Month

June

National Cancer Survivors Day

July

Sarcoma Awareness Month

September

National Ovarian Cancer Month

Childhood Cancer Month

Gynecologic Cancer Awareness Month

National Prostate Cancer Awareness Month

Leukemia and Lymphoma Awareness Month

October

National Breast Cancer Awareness Month

November

Lung Cancer Awareness Month

Pancreatic Cancer Awareness Month

Ribbon Colors and their Meaning


 Pink... Breast Cancer	 Black... Melanoma	 Gold... Childhood Cancers
 Teal... Ovarian Cancer	 Dark Blue... Colon Cancer	 Burgundy/Ivory... Head & Neck Cancer
 Clear... Lung Cancer	 Burgundy... Multiple Myeloma	 Lime... Lymphoma
 Purple... Pancreatic & Leiomyosarcoma	 Grey... Brain Cancer	 Peach... Uterine Cancer
 Orange... Leukemia	 Blue... Prostate Cancer	 Kelly Green... Kidney Cancer
 Emerald Green... Liver Cancer	 Teal/White... Cervical Cancer	 Teal/Pink/Blue... Thyroid Cancer
 Periwinkle Blue... Esophageal & Stomach Cancer	 Yellow... Sarcoma/Bone/Bladder Cancer	 Lavender... All Cancers

New Mexico Cancer Care Alliance has Moved!

NMCCA is now located in the beautiful University of New Mexico Cancer Center Administration Building, second floor.

Phone Number: 505-272-7813

Mailing Address: P.O. Box 4428 Albuquerque, NM 87196



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