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MORE HARM THAN GOOD? NEW PSA SCREENING GUIDELINES

By Diane Johnson

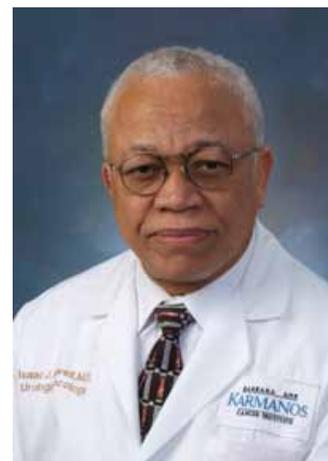
In August of 2008, the U.S. Preventive Services Task Force (USPSTF) issued updated recommendations for prostate cancer screening. (Their statement can be found online at <http://www.ahrq.gov/clinic/uspstf08/prostate/prostaters.htm>.) Citing “convincing evidence” that screening can lead to more biopsies, cancer diagnoses, and, therefore, more potentially harmful treatment, they now recommend “against screening for prostate cancer in men age 75 or older.” Their stated rationale is that “some men... would never have developed symptoms related to cancer during their lifetime,” so treatments create more problems than they cure. Relative to men under the age of 75, they concluded that “current evidence is insufficient to assess the balance of benefits and harms of prostate cancer screening in men younger than age 75 years.”

The Task Force further indicated that these recommendations apply even to men at high risk of developing and/or dying of prostate cancer (older men, African American men, and men with a family history of prostate cancer): “Unfortunately, the previously described gaps in the evidence regarding potential benefits of screening also apply to these men.” The new guidelines are a departure from the recommendations of organizations like the American Cancer Society and the American Urological Association, who advise prostate cancer screening for men over 50, who are expected to live at least 10 more years, and over 40 for men at high risk.

The USPSTF statement goes on to counsel clinicians not to order a PSA test “without first discussing with the patient the potential but uncertain benefits and the known harms of prostate cancer screening and treatment.” They cite a need for studies and randomized controlled trials to “clarify the potential benefits of screening.”

For more insight into this announcement, I spoke with Dr. Isaac Powell, Professor at Wayne State’s Department of Urology and Karmanos Cancer Institute in Detroit, Michigan.

Dr. Isaac Powell



what they say except when they say something that makes the national news.

DJ: The Task Force refers to the harms and risks of screening and treatment. Are these worse in men over 75?

IP: *There is minimal risk in the screening process (blood test and digital rectal exam) for men of any age. As for treatment, men over 75 do worse with surgery, that’s why we don’t usually recommend surgery for them. With radiation, there may be an increased risk, but I haven’t seen any evidence of that. In terms of hormonal therapy, there’s a slight risk, so we now use intermittent therapy rather than continuous. This reduces the risk of side effects like bone fractures. The intermittent therapy seems to be as effective as the continuous. There is a study in progress now to verify that.*

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MORE HARM THAN GOOD?

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DJ: How do you decide which men to screen?

IP: *In prostate cancer screening, a man's general health is more important than his age. A man in his 50's or 60's who is in very poor health—with a cardiac condition or bad lungs-- may not be appropriate to screen. On the other hand, you might have a man who is 78 or 79, whose parents lived to be in their 90's, and is in good health. It might be appropriate to screen him. It should be an individual decision made by the physician and the patient. Many people disagree with the generalization that men over 75 shouldn't be screened.*

DJ: What questions should a man ask his doctor about having a PSA test?

IP: *First, they need to know their risk of getting prostate cancer. If they have a family history of prostate cancer, they may need a PSA test every six months. If they are an African-American man, they have an elevated risk also. I also advise men to look at changes in their PSA over time and ask what degree of change might signify prostate cancer. We find the degree of change from one year to the next is more important than the actual PSA value.*

DJ: If a man's doctor refuses to do a PSA test, should he get a second opinion?

IP: *Yes.*

DJ: What impact might this new recommendation have on men, especially those who are at high risk of developing prostate cancer?

IP: *Our concern is that it might prevent men from getting tested. That damage has already been done. Men come in, quote the published findings, and argue that they don't need a test. Some of them are there only because their wives or significant others have suggested they get the test.*

Many men associate cancer with death and that's an issue they don't want to discuss. They're looking for reasons not to have the test anyway, and this just adds more reasons not to get a PSA.

DJ: Anything else we should know about this issue?

IP: *As I've said, this Task Force has been out of step with the rest of the prostate cancer world from the very beginning. The main issue is the generalization of this recommendation relating to men over 75. Age as a*

single factor and within reason shouldn't be used as the basis to determine whether someone should have a PSA. It should be based on general health status and possible risk factors, more than age.

In addition, their stated rationale that "some men would never have developed symptoms related to cancer during their lifetime" raises two issues:

Men are living longer.

By the time men have symptoms related to prostate cancer, it is too late to cure. There are no specific symptoms for early prostate cancer.

Their second statement that "treatments create more problems than they cure" is not supported by current evidence. For example, it has been reported by the UCLA group that not all men who lose their erectile function are bothered by that loss.

DJ: Thank you for your time and perspective, Dr. Powell. I also want to refer our readers to a podcast you recorded for The Prostate Net discussing more specifics about PSA testing [http://theprostatenet.org/DrIsaacPowell_200805.mp3]

Editor's Note: The controversy on the issue of screening and use of the PSA test continues. Most of the U. S. prostate cancer advocates still support the concept. See: A Joint Statement from America's Prostate Cancer Advocacy, Education, and Support Organizations on the PLCO study reported in the New England Journal of Medicine on the efficacy of PSA screening (<http://theprostatenet.org/news.html>)



Virgil's Blog

When The Prostate Net inaugurated the “In The Know Awards” in 2005, we envisioned the fight against health disparities in high-risk, minority and medically underserved communities. However, changes in the spectrum of health care in America have caused us to begin to re-think the impact of disparity on a broader spectrum of our population.

The U.S. spent last year over \$1.6 trillion on healthcare, roughly 15% of our total Gross Domestic Product, yet we have over 47 million Americans without insurance coverage. We spend 40% more per capita than other developed nations, yet we are the only one that doesn't offer a basic health benefits package to its citizens. We spent 1/7 of our nation's productivity and we see corporations reducing retiree health benefits, increasing the active employee's share of health care costs, yet we still are non-competitive in the global marketplace due to the cost of domestic healthcare. Despite the amount being spent on healthcare, the World Health Organization ranks the U.S. at 37th place in health system performance versus France and Italy who ranked #1 and #2 respectively.

Government “protectionism” has given oversight, if not exacerbation, to the demise of jobs and industries through programs such as NAFTA and the elimination of Fair Trade Agreements. We stand at a point wherein our health insurance system creates a level of non-competitiveness in global markets. We stand at a point where specialization in healthcare delivery is causing a decline in primary care physicians when many of the major disease conditions facing our society need to be addressed at a prevention level best served by that primary care doctor. We have a healthcare compensation structure that rewards performance in clinical management of illness versus prevention of disease onset.

The future doesn't hold a great deal of promise either because our “Baby Boom” generation is moving into the age range wherein most critical and chronic diseases are diagnosed. Exacerbating this situation is the fact that we are projecting a continuing shortage of nurses all the while we're moving into the time frame when health care costs are their highest and nurse practitioners could be utilized to provide a degree of primary care and preventive services. The W.H.O. again projects that by 2020 we will still be 10% lower than the global average per 100,000 for health service professionals.

Today we spend more than \$37 Billion annually to provide healthcare to the uninsured through governmental and private indigent care programs - a safety net that is rapidly evaporating with medical establishment guidelines based on pay-for-performance. The reality of life in America is that our healthcare costs will rise as we age; but that fact is further impacted based on the anticipated increase in the number of years we will have to work - by 2014 more than 20% of our labor force will be actively employed past the age of 55.

Since 1944 our Presidents have promised a reform in healthcare, the promise of an unbridled future for our children, the right to adequate medical care and the opportunity to achieve and enjoy good health. The Status Quo is not working for the masses of consumers, nor is it economically sustainable even if it were. It is imperative that multi-tangential approaches be used to change the system to insure equitable access to care and economic stability within our society. It is the best of times and the worst of times; but, for our present and our future, it must become changing times.

Virgil H. Simons
Founder & President
The Prostate Net, Inc.

Men Run to Save Lives

In September 2008, the first ever Man Run was held in Knoxville, Tennessee to raise community awareness of prostate cancer and its devastating effects. The event was a collaboration of many dedicated volunteers working with the University of Tennessee Medical Center's Cancer Institute and generous support from corporate and non-profit partners. Over 200 runners/walkers participated, more than \$13,000 was raised, and over 300 men received free prostate cancer screenings as a result. Even better results are expected from next year's Man Run!





**“Make sure you
assemble the right
pit crew to stay on track!”**

- Kyle Petty, NASCAR champion

A DRIVING PASSION TO SAVE LIVES: A CONVERSATION WITH KYLE PETTY

By Diane Johnson (7/08)

Kyle Petty is proud to carry on his family’s winning legacy as a third generation NASCAR champion. But there is another part of the family’s history he is determined not to carry on: prostate cancer. In 1995, Kyle’s grandfather, the late racing legend Lee Petty, was diagnosed with prostate cancer while he was being treated for another illness. Aware that it can be a hereditary disease, the family’s physician strongly suggested that Lee’s son, Richard, also be tested. So it happened that Kyle’s grandfather and father were both diagnosed with prostate cancer in the same year. Sadly, Lee passed away in 2000 from other medical complications, but Richard’s cancer was caught early and treated successfully with surgery. Today, 13 years later, he remains cancer-free.

Kyle was 35 when his grandfather and father were diagnosed and, of course, it had a profound impact on him. He learned that, because of his family history, he is four times more likely to be diagnosed himself. That would be daunting for some, but Kyle has chosen to confront prostate cancer head-on. “It’s a guy thing,” he said. It blows me away that a guy will buy the most expensive car in the world and put the best fuel in it and treat it like it’s a baby. But when it comes to his body, he totally disregards it.” He acknowledges that some men have a “stigma” about

getting tested and the DRE (digital rectal exam) procedure itself. He’s been getting prostate exams since his late 30’s and has, on occasion, been teased about it at the racetrack. But he doesn’t let that slow him down. “I told them I’d rather go through the exam and find out that I had prostate cancer...know what I’m fighting...rather than have something sneak up on me.” He believes it’s as simple as preventive maintenance for your body. “With race cars, you need preventive maintenance, so you don’t beat yourself. If you get beat on the racetrack by somebody else, that’s okay,” he said. “But if a wheel falls off or an engine breaks...and you could have fixed it, then that’s your fault. It’s the same with your body. Forget the stigma and what other people think. It’s your life.”

Now Kyle Petty is taking his ownership message to the public. He announced in June that he will be driving the STAY ON TRACK for Better Prostate Health program, sponsored by the Prostate Cancer Education Council (PCEC) and sanofi-aventis, a pharmaceutical company. He is urging men to take the Kyle Petty Inspection Pledge to “visit my doctor for an annual prostate cancer screening.” For every pledge received, sanofi-aventis will donate a dollar to the PCEC to be used for prostate cancer education.

(The free companion manual, “Stay on Track for Prostate Health”, contains detailed information about prostate cancer prevention, symptoms, and treatments, and is available on the PCEC website (www.pcaaw.com) or by calling 866.321.3114.)

Another part of the pledge states, “...if diagnosed, [I] will seek to assemble a pit crew of professionals, including a medical oncologist along with a urologist, to evaluate all treatment options.” Kyle relies on his pit crew everyday. “I’m in a business where no one does it alone,” he said. “You want to have the best person in the best place [on your team].” In the case of Team Petty, the best crew chief is Kyle’s mother, Lynda. She asked the doctors the hard questions no one wanted to ask and then educated the rest of the family. She also encouraged Kyle to take care of himself and get checked. He has passed that same advice on to his 26-year-old son.

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Dr. Eric Klein



PETTY (Continued)

Official results of the campaign will be announced during Prostate Cancer Awareness Week (September 14-20, 2008), but Kyle feels the program has already made an impact. "It's amazing how many people come up to me now to talk about their prostate cancer and what's happening with their treatment. It's opened up

a whole different dialogue." But he also knows there is still much work to be done. "I have two friends who have just been diagnosed," he added. "One friend had surgery. [He] is a marathon runner and couldn't wait to run again. Now he's running for prostate cancer awareness."

When I asked him to describe his vision for the Stay on Track program, Kyle said, "It's such a simple process; it just blows me away. In the business I'm in, I have to take a physical every year. I don't see anything wrong with [that]. If people had a physical once a year and understood where their health is, then maybe we wouldn't have some of the health issues that are so catastrophic in this country. I would like to see this one test performed each year as part of your physical, [especially] if you're in a high risk group, like African-American men. Listen to what your doctor says. Just get it on the radar screen."

We live in a time when celebrities add non-profit causes to their portfolios in name only for the sake of publicity and public favor. It's refreshing to talk to a celebrity who knows all too well the pain and devastation of prostate cancer and chooses to use his public forum to try to spare others that pain. Kyle Petty is carrying on the proud Petty family tradition of giving back. As he would say, "Don't beat yourself. Get checked."

ANOTHER LOOK AT FINASTERIDE

By Diane Johnson

It seems the story of finasteride has yet another chapter. Approved in 1992 by the FDA as a treatment for Benign Prostatic Hyperplasia (BPH), finasteride was the basis of the Prostate Cancer Prevention Trial (PCPT). Beginning in 1993, the trial included almost 19,000 men and was designed to see if finasteride was a prostate cancer preventative. When the drug was found to reduce the risk of developing prostate cancer by 25%, the study was stopped almost a year early.

This exciting news was dampened, however, by another finding: the men in the study who developed prostate cancer while taking the drug were more likely to have high-grade cancer. As Gina Kolata said in the New York Times ("New Take on a Prostate Drug, and a New Debate," June 15, 2008), "The concern was that the drug might be preventing cancers that never spread. At the same time, finasteride might actually be causing aggressive cancers that can kill." But some researchers thought that wasn't the whole story, and have spent the last several years digging deeper.

In May of this year, Cancer Prevention Research published three separate analyses of the PCPT data that appear to solve the mystery. I spoke with Dr. Eric Klein, Director of the Center for Urologic Oncology at the Cleveland Clinic, to get the specifics:

DJ: The initial results from the Prostate Cancer Prevention Trial (PCPT) published in 2003 were mixed and rather alarming. What has changed since then?

EK: *There has been a more detailed analysis of the biopsy and radical prostatectomy specimens, as well as some statistical modeling studies, that clearly suggest that prior concerns over whether finasteride causes high-grade cancer are unfounded. The new studies also used a tool derived from the PCPT, known as a Risk Calculator, to estimate the prevalence of cancer in the men who did not undergo biopsy at the end of the trial.*

DJ: The new analyses also found that finasteride was an even better preventive drug than first reported (nearly 30% reduction in the risk of any prostate tumor). Why the difference?

EK: *At the time of the initial report, not all men who completed the trial were included in the analysis. Longer follow-up has expanded the number of men who could be studied.*

DJ: Then, should men take finasteride to prevent getting prostate cancer? If so, which men?

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PROGRESS AGAINST CANCER: 100 YEARS OF STRIVING

By Diane Johnson

The American Association for Cancer Research meets once a year to present papers, compare notes, and share all they've learned in the previous year. It sounds like any other annual meeting, except that this organization has been on the front lines of cancer research for 100 years. The AACR has about 26,000 members working in more than 70 countries, all with a singular goal of eliminating the pain and suffering of cancer. The need for a cure becomes more urgent with each passing year. In comments to Scientist—Survivor Program members, Dr. Anna Barker, Deputy Director of NCI's Strategic Scientific Initiatives, outlined the scope of the problem and the critical need for solutions. Dr. Barker said the number of new cancers will increase as much as 30% to 50% as the baby boomers age. Global cancer mortality, about 560,000 this year, could increase to as many as 10 million in the year 2020. In 2007, more than 12 million survivors were living in the U.S. Even that good news presents a whole new set of issues and challenges relating to survivorship: long-term side effects of primary cancer treatments, secondary cancers, impact on reproductive health, etc.

In recognition of the explosion of new information technology and the complexity of cancer, this year's meeting focused on "forging partnerships to accelerate progress against cancer." Dr. Barker described it as needing "a network of networks"—scientists reaching across disciplines to find their commonalities. Dr. John Niederhuber, Director of the National

Cancer Institute, said, "We must look at new ways to innovate and collaborate." He believes technology is the link and, in his list of NCI goals, described the need to "ensure access to the latest science for all people."

Here are a few highlights from the hundreds of papers and studies presented at the meeting (abstracts and references can be found at www.aacr.org, 2008 Annual Meeting):

Putting metastases to sleep:

"The vast majority of cancer morbidity and mortality are associated with the development of metastases, but only 1% of grant money goes to researching the metastatic process," said Danny Welch, PhD, University of Alabama at Birmingham. He and his team are researching a novel approach to controlling metastases. They have identified a hormone (KISS1) that acts as a met suppressor. KISS1 intercepts malignant cells that have migrated to a secondary site, keeps them from establishing there, and maintains them in a permanent dormant state. "If any part of the metastatic process is blocked, the mets can't continue," Dr. Welch stated. "If disseminated cells could be maintained in a permanently dormant state, cancer then becomes a controllable disease..."

Gene methylation as cancer marker:

The process of methylation (methyl group chemicals attach to genes) shuts off gene expression in normal cells causing abnormal cell growth and increased mutations. Saraswati Sukumar, PhD, Johns Hopkins School of Medicine, says that methylated cells can be

used as a biomarker for cancer. Even if post-surgical tests seem clear of cancer, for example, DNA tests determining methylation patterns and levels may be an indicator of a recurring malignancy

Health disparities from a different angle:

Personal lifestyle and behavior has a direct impact on disease development. In a symposium titled, "Health Disparities from a Biopsychosocial Approach" Beverly Lyn-Cook of the FDA presented findings that diet, environment, occupational exposures and smoking could lead to abnormal methylation levels (see above). She suggested a move toward "personalized nutrition"—tailoring dietary recommendations depending on each person's genetic make-up. Paige McDonald of the National Cancer Institute presented another example of biobehavioral influences on the development of cancer: people who are socially isolated and/or depressed experience chronic stress. This stress activates the autonomic nervous system that releases chemicals affecting cell growth and processes." "Stress affects every single cell in the body, so why would cancer cells be exempt?" she added. Research into health disparities has moved beyond the study of genetic differences.

Focus on the tumor microenvironment:

Tumors do not develop in a vacuum. Malignant cells do not a cancer make. All of the elements in its environment affect if, how, and how fast it will grow. Research continues to expand into all aspects of tumor biology.

EK: *It's an individual decision for each patient. It seems to me the broad answer is yes, because I believe that the benefits of taking finasteride (reduced risk of prostate cancer and symptoms and surgery related to non-cancerous prostate enlargement; improved diagnostic accuracy of PSA while on finasteride) far exceed the downsides. Furthermore, the study showed that the risk of prostate cancer was reduced equally among all groups of men, even those with no special risk factors.*

DJ: Are there any side effects or long-term health risks?

EK: *The main concern was related to the adverse effects of finasteride on sexual function, but a parallel study published in the Journal of the National Cancer Institute showed minimal effects with long-term use.*

DJ: What questions should a man ask his doctor to decide if he should be taking finasteride?

EK: *In men without cancer, finasteride causes an average reduction in PSA of 50% by 6 months. So he should ask, "What's my PSA?" before starting finasteride, and continue to be followed with PSA's and DRE's (digital rectal exam) on a regular basis while taking it.*

DJ: Thank you, Dr. Klein, for making a complex and critical issue easier to understand.

Some would find a conference that deals with nothing but cancer a depressing experience. The papers and presentations talk about innovations that are a long way from being available to the public who so desperately needs it. But the very fact that so many people from all walks of life and all corners of the world have dedicated their lives to finding answers for all of us is a moving and inspiring experience. Some of the science still seems more like science fiction. Consider: Cells can now be manipulated at the nano level. Sub-cellular imaging will follow anti-cancer drugs and determine if they hit their precise target in real time. Personalized medicine is right on the horizon. Diseases will be diagnosed before symptoms even appear. Every day brings us closer to seeing cancer as another chronic disease—somewhat mysterious, but controllable.



Why Many Latinas Don't Participate in Clinical Trials

By Venus Ginés

1957

In the tenements of Spanish Harlem, a 28-year-old Puerto Rican single mom feels pressured into making an important decision: either undergo La Operación, a surgery which was supposed to keep her from unplanned pregnancies, or risk losing her Welfare benefits. Rosa was alone in this country, with limited reading and marketable skills and only an 8th grade education. She was raising a little girl with no child support from her ex-husband. She had no choice but to accept her doctor's recommendation. He said it was just the tying of the tubes, which to her meant that if and when she remarried, she would simply go back and untie them and have more children. Rosa died at 56 having failed to detect her liver disease in time. Resentful over being duped by her doctor 28 years earlier, Rosa made sure that her daughter learned to never trust doctors in this country.

1992

Although my day job as a flight attendant for TWA brought in the paycheck, it was my community work

as a paralegal that fulfilled my passion for social justice. So in 1992, after being accepted at UNC Law School, I applied for an "early out" program being offered by TWA. I was finally going to become the civil rights attorney. That dream would soon be threatened by a set of shocking circumstances.

While at 35,000 ft., on a routine flight to Los Angeles, I suffered a slip and fall that required immediate attention at the local ER. As the doctor proceeded to ask some general questions, he asked if I ever had a mammogram; I said no. He explained that at 41, I should have had a baseline test. I asked why and he went on to say that mammograms can detect breast cancer in its early stages. My initial response was "but I'm Latina, we Latinas get cervical cancer; breast cancer is a White Woman's disease." The fact that I only saw white women on TV discussing breast cancer led me to believe that this type of cancer would not strike us Latinas. I felt a bit uncomfortable with all this talk about cancer; however, I reluctantly accepted the doctor's offer to have a clinical breast exam. I was utterly shocked when he

found a suspicious lump on my left breast. In that instant, I asked him if my constant fatigue could be the signal that I was dying of cancer. The doctor ordered additional blood work and gave me a referral for a mammogram. As I walked out of the room, I remembered my mother Rosa's warnings not to trust doctors and quickly discarded the prescription.

A week later, while packing for my move to North Carolina, I received a call from the doctor that the blood work he ordered came back positive for LUPUS and insisted that I get a mammogram as soon as possible. So after a mammogram and subsequent ultrasound; I learned that a biopsy was necessary. The bad news came in a phone call the day before my Orientation at the law school. The nurse's words will be forever deep-rooted in memory, "Venus, I wish I could say it was benign" - I dropped the phone. My life was over! As a single mom, I now had to prepare a will and figure out who would take care of my young son upon my death. For many years as an activist for human rights, I feared nothing in my fight for social

injustice but now this disease proved to be a battle with an unidentified enemy. That night, I overheard my little boy's prayer "Please God, don't take my Mommy away cause she is all I got in the whole world-I will give up all my toys if you let her stay with me" and the fear I heard in his voice gave me the power to fight breast cancer then and there.

I began researching this disease to see if other Latinas had breast cancer and found very little statistics. So when I presented the doctor with my 20 questions, his abrupt comment left me cold, "I don't have the time for all your questions, but my nurse will provide you with the latest New England Journal of Medicine article on breast cancer." I sat in my car and cried. I could not even get past the first paragraph of this complicated literature. I felt isolated and more confused about this disease, yet determined to continue my search for answers.

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this vulnerable population into hiding and increase their anxiety, fear, distrust and worst yet, their risk to late-stage, undetected cancers.

In attempting to introduce the value of clinical research trials to Latinos, we must understand their history, their non-traditional healing methods, the natural support system of the family, as well as the disproportionate burdens of this disease. In order to recruit Latinos into clinical trials, it is vital that educational material be ethnically-specific, such as a “user-friendly” fotonovelas (picture books), depicting the value of the study and the important contribution they would make if they chose to participate. Furthermore, the messenger should be bilingual and bicultural in an effort to answer any questions completely and accurately. Training more Latinas as Promotoras and Patient Navigators (health educators/advocates) in clinical settings will reduce the fear and distrust that exists within this at-risk population. Employing culturally competent personnel, as well as certified medically interpreters at every medical facility and cancer center is critical in the recruiting and retaining of underrepresented populations. Fostering a sense of teamwork by inviting participant feedback, engaging them in decision making, and reporting the results of the clinical research findings will create the best envoys among at-risk communities. Moreover, creating a “safe” environment conducive to learning and early detection screening, such as my Dia de la Mujer Latina health fiesta project will eliminate many of the system and cultural barriers to access of preventive care programs and a better understanding about the importance of clinical research trials to finding a cure.

Why Many Latinas Don't Participate
(Continued...)

The breast surgeon was pressuring me to have a double mastectomy but the rheumatologist treating the LUPUS was concerned about my weak immune system. I did not know who to trust. A friend of mine called to say that a breast cancer guru, Dr. Susan Love, was on TV discussing a variety of options, so I called to get a second opinion. Initially I was told that she was not seeing any new patients but that changed when I explained that as a single mom with both breast cancer and LUPUS, I was desperate for answers and hope. Fortunately, I had a lumpectomy and Dr. Love encouraged me to enroll in the Tamoxifen Study. After being on the clinical trial for 6 months, I was getting restless with the tedious paperwork, costly time off from work and negative side effects. I decided to quit. No one even noticed that I left.

This early experience with the health system transformed me into a passionate advocate for patient rights, especially as it related to Latinas and breast cancer. During the course of my therapy; I developed a fotonovela with an accompanying video (Una Nueva Esperanza (A New Hope)) on breast cancer in Latinas for the American Cancer Society. The project was a huge success and I was able to present it at the 1995 Intercultural Cancer Council's Biennial Symposium. It was there that I discovered the wide range of innovative projects and

cancer therapies from all across the USA. I also learned about the unequal burden of cancer and how it unfairly burdened other communities of color. I pleaded for more consistent data, linguistically-proficient cancer education, as well as more accurate research on Latinas and cancer. The ICC Symposium re-charged my spirit and I decided to focus my graduate work on the system and cultural barriers to cancer rate among Latinas. By 1997, I founded Dia de fa Mujer Latina, a culturally-specific health fiesta project specifically for Latinas to celebrate their culture and their health.

Breast cancer is known as an “epidemic” among our communities of color. However, to determine the gravity of this appalling disease on the rapidly growing Latino population, it is essential to obtain data by way of outreach, education and early detection screening. Yet, gathering information can be challenging because of the fear and distrust that exists with this vulnerable community, Furthermore, there are major gaps in the collection of data as well as how it is analyze. For example, Georgia has seen a remarkable increase in the Latino population base, yet their

data still reflects Black, White and Other. Latinos represent it mix of racial and ethnic lines from 22 different countries of origin. This specific population-at-risk has unique demographic characteristics and degrees of acculturation in addition to differences in history and cultural background. For this reason, it is essential to understand the difference between the two terms of “Hispanic” and a “Latino” when developing outreach programs in each particular community. With no data, there's no funding for research or preventive programs, which results in more late-stage cancers discovered.

Aside from the common factors that might impede Latinas from obtaining access to screening, such as education, finances, and language, there are negative issues that rarely surface in investigative cancer studies. We must take into account how the system and the culture affect the health care priorities of these at risk communities. Today, many Latinas are fearful of accessing medical services or participating in community outreach programs because of the anti-immigrant sentiment, The current fallout of the immigration reform will further drive

“Historically the voices of women, especially woman of color, have been silenced. As we begin to uncover our past, the oppression we experienced is being detailed, however embarrassing it may be. To continue the silence would be a detrimental step backwards. The more we learn about our *historia*, the better we can serve our *gente*.”



GOLF BUDDIES BECOME PROSTATE CANCER WARRIORS

By Diane Johnson

One day in 2004, a group of friends known as The Central Ohio Hackers were sharing some guy-talk after a “rough day of golf”. “We decided we wanted to do something positive for the community,” said Michael Hughes, one of the six friends. As they talked, they realized they had all “experienced the trauma of prostate cancer through a loved one or friend.” On the 19th hole that day, the Hackers changed focus and became the Central Ohio Men Against Prostate Cancer (COMAPC) [www.comapc.org].

Since they were building their group from the ground up, they did their homework first. “Both my father and grandfather had prostate cancer, so I was familiar with the disease,” said Michael. During his research he found Us TOO, an international grassroots prostate cancer education and support organization [www.ustoo.com]. “They were actively recruiting African-American leaders,” he said, so COMAPC soon became an Us TOO chapter. He also heard a radio ad about the Diversity Enhancement Program at The Ohio State University’s James Cancer Hospital [www.jamesline.com]. After he contacted Jaci Holland, the program’s director, another productive partnership was born. “Jaci and Chastity Cooper have played a huge part in our education, organization, and development,” Michael said. Next they built a board of medical and healthcare professionals, friends, advocates, and an often overlooked constituency, prostate cancer survivors. “I thought it was very important to include those who are currently dealing with prostate cancer on a regular basis,” Michael added. But they didn’t stop there. In recognition that there is strength in numbers, they have developed and nurtured other partners dedicated to the same fight, such as the American Cancer Society and the National African-American Prostate Cancer Association.

But they haven’t forgotten about golf. This year COMAPC will hold their 4th annual “Par for Life” Golf Tournament at the Scioto Reserve Golf and Athletic Club in Powell, Ohio. The tournaments raise funds to support their mission to “reduce the high mortality rate from prostate cancer among minorities, culturally diverse and medically underserved populations” through education, outreach and support. “This year’s tournament was the most successful yet,” Michael said. “We will be able to increase those activities and provide increased funding for screenings.”

It is difficult to quantify the success of any advocacy group. But one man out of the many they have reached and counseled tells the story. Michael told about a man who was diagnosed, but had made no treatment decision because he was confused about his options. “Most of what he heard was about the side effects: incontinence and impotence. His doctor had recommended surgery,” said Michael. “But he wasn’t going to have any treatment at all, because he didn’t want to be a burden on his mate, and might not have the ability to have sex ever again.” Michael met with them, answered questions, discussed options, and encouraged them to meet with their doctor to discuss their concerns. After that meeting, he decided to have the surgery. He even invited Michael to observe! The surgery was successful and there are no long-term side effects.

And so the golf buddies who dreamed of doing more for their community became advocates in the battle against prostate cancer. These days they are making a life and death difference --one guy at a time.





Prostate Cancer Clinical Trials Offered by the Southwest Oncology Group

The Southwest Oncology Group is one of the largest clinical trial cooperative groups in the United States. Funded by research grants from the National Cancer Institute, the Group conducts clinical trials to prevent and treat cancer, and to improve the quality of life for cancer survivors. Approximately 120 clinical trials are underway at any given time in breast, gastrointestinal, genitourinary, gynecologic, and lung cancers, as well as melanoma, myeloma, leukemia and lymphoma. The Group's network consists of more than 5,000 physician-researchers at nearly 550 institutions including 18 of the National Cancer Institute's 61 designated cancer centers.

The Genitourinary Committee of the Southwest Oncology Group is a strong, multi-disciplinary committee that has made significant contributions to clinical research. The committee is focused on improving survival and the quality of life of patients with genitourinary cancers while investigating novel biologically based therapies.

The following clinical trials are currently being offered by the Southwest Oncology Group for prostate cancer patients. If you are interested in participating in a clinical trial, contact your doctor for a referral or check the Southwest Oncology Group website, <http://swog.org>, for a list of participating institutions. Final eligibility for a clinical trial is determined by the health professionals conducting the trial.

Advanced Prostate Cancer: S0421 – “Phase III Study of Docetaxel and Atrasentan versus Docetaxel and Placebo for Patients with Advanced Hormone Refractory Prostate Cancer”

Prostate cancer spreads to bone. Docetaxel + prednisone have been shown to prolong life. Atrasentan target the bone and may interfere with the growth of prostate cancer cells in the bone and limits their damaging effect. So the combination is intended to stop the growth of tumor cells, either by killing the cells or by stopping them from dividing by different methods. Giving more than one drug (combination chemotherapy) may kill more tumor cells. It is not yet known whether docetaxel, prednisone, and atrasentan are more effective than docetaxel and prednisone in treating prostate cancer. This randomized phase III trial is studying docetaxel, prednisone, and atrasentan to see how well they work compared to docetaxel and prednisone in treating patients with stage IV prostate cancer and bone metastases that did not respond to previous hormone therapy.

Eligibility criteria include:

- at least 18 years old
- no brain metastases
- no ascites
- no more than one previous biological therapy regimen
- at least 4 weeks since biological therapy, flutamide, or ketoconazole
- at least 6 weeks since bicalutamide or nilutamide
- at least 6 months since amiodarone
- at least 3 weeks since radiation therapy or surgery
- no previous strontium

Patients will be randomly assigned to one of two treatment groups. Patients in group one will receive a 1-hour infusion of docetaxel in week 1. They will also receive prednisone by mouth and atrasentan by mouth once a day for 3 weeks. Treatment may repeat every 3 weeks for up to 12 courses. Some patients may then receive atrasentan alone by mouth once a day for as long as benefit is shown. Patients in group two will receive a 1-hour infusion of docetaxel in week 1. They will also

receive prednisone by mouth and placebo by mouth once a day for 3 weeks. Treatment may repeat every 3 weeks for up to 12 courses. Some patients may then receive a placebo alone by mouth once a day for as long as benefit is shown. Quality of life will be assessed periodically. After finishing treatment, patients will be evaluated every 3 months for 1 year and every 6 months for up to 3 years from study entry.

CTSU/C90202 – “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”

Zoledronate may prevent or decrease bone-related events (such as pain or fractures) caused by bone metastases and androgen deprivation therapy. It is not yet known whether treatment with zoledronate is effective in preventing bone-related events in patients who have prostate cancer and bone metastases. This randomized phase III trial is studying how well zoledronate works in preventing bone-related events in patients who are receiving androgen deprivation therapy for prostate cancer and bone metastases.

Eligibility criteria include:

- at least 18 years old
- more than 1 year since hormone therapy that lasted no more than 6 months
- no more than 3 months since starting current androgen deprivation therapy
- at least 4 weeks since radiation therapy
- no previous bisphosphonates (such as zoledronate)

Patients will be randomly assigned to one of two groups. They will receive an infusion of either zoledronate or a placebo every 4 weeks for as long as benefit is shown. All patients will continue to receive their current regimen of androgen deprivation therapy. They will also receive calcium and vitamin D by mouth once a day. Patients who have disease progression will receive an infusion of zoledronate every 3 weeks for as long as benefit is shown. Patients will be evaluated periodically for approximately 10 years after starting study treatment.



CTSU/MDA-3410 – “A Prospective Randomized Phase III Trial Comparing Consolidation Therapy with or without Strontium-89 Following Induction Chemotherapy in Androgen-Independent Prostate Cancer”

Drugs used in chemotherapy use different ways to stop tumor cells from dividing so they stop growing or die. Radioactive substances such as strontium-89 may relieve bone pain associated with prostate cancer. It is not yet known whether chemotherapy is more effective with or without strontium-89 in treating bone metastases. This randomized phase III trial is studying giving chemotherapy together with strontium-89 to see how well it works compared to chemotherapy alone in treating patients with prostate cancer that has spread to the bone.

- Eligibility criteria include:
- at least 4 weeks since biological therapy, chemotherapy, or radiation therapy
 - no previous strontium-89 or samarium 153
 - no previous vagotomy
 - no more than one previous cytotoxic regimen

Patients will receive one of two chemotherapy regimens for 12-15 weeks. Some patients will then be randomly assigned to one of two groups. Patients in group one will receive a 24-hour continuous infusion of doxorubicin once a week for 6 weeks plus an infusion of strontium-89 at the beginning of chemotherapy. Patients in group two will receive doxorubicin as in group one.

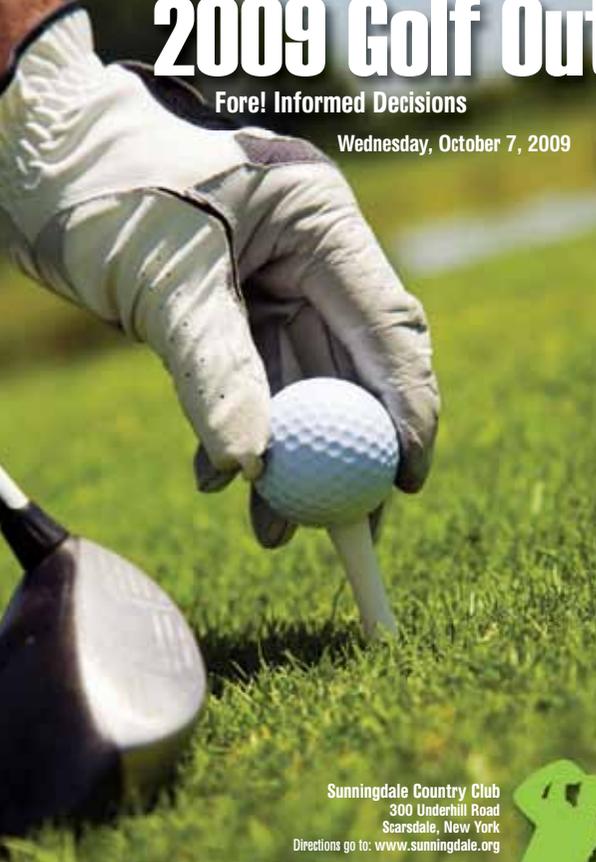
Patients will be evaluated every 1-3 months.

The Prostate Net Presents:

2009 Golf Outing

Fore! Informed Decisions

Wednesday, October 7, 2009





Please join us for this worthwhile event benefiting Prostate Cancer education and intervention programs provided by: The Prostate Net

ALL LEVEL OF PLAYERS, WOMEN & MEN, WELCOME.

Spend a day of fun with patients, family members, physicians, healthcare professionals, community organizations and others supporting The Prostate Net.

REGISTRATION FEE: \$ 325 PER PLAYER*

On-site Registration: \$375
* Registration after September 30, 2009: \$375 per player

**ON-SITE SIGN IN: 8:00-9:00 AM
9:00 AM PRE-ROUND INSTRUCTIONAL CLINIC**

Conducted by:
Michael Breed Host: Golf Channel's Golf Fix
A Top 50 Teaching Professional
Head Professional, Sunningdale Country Club

REGISTRATION INCLUDES:

- Green Fees/Cart/Shot-gun start
- Participation in Pre-Round Clinic
- Continental Breakfast
- Hole-In-One Contest (Win a car!)
- Post-Round Reception
- Golfer Amenities
- Golf Prizes

IN ADDITION:

\$10 Putting Contest
\$10 Mulligans (maximum 2 per person)

SPONSORSHIP OPPORTUNITIES:

Please call The Prostate Net at 201-342-3202

CORPORATE SUPPORTER FOURSOME LEVELS:

Additional Support Opportunities can be found by going to
<http://theprostatenet.org/SymposiumGolf.html>

Click Here to Register

Sunningdale Country Club
300 Underhill Road
Scarsdale, New York
Directions go to: www.sunningdale.org

Honorary Chair: Daniel P. Petrylak, MD
New York Presbyterian Medical Center

10:00 am Shot-Gun Start

- Hole-In-One Contest
- Pre-Round Clinic with Michael Breed, Golf Channel Host; The Golf Fix
- Closest To The Pin
- Longest Drive

- Putting Contest
- Continental Breakfast
- Post Round Reception
- Much more

To Ensure Your Spot, Please Register Early!!

(No refunds after September 30, 2009)
Registration Fee after September 30, 2009: \$375 per player

TO REGISTER:

1. On-line—go to <http://theprostatenet.org/SymposiumGolf.html>
2. By phone: 1.888.477.6763

(Note: \$325 per player)

All proceeds benefit **The Prostate Net**