

## INSIDE THIS ISSUE

- First Annual Edward C. Kaps Hope Award
- Overall Survival Analysis of SPARC Trial
- Patients Often Get Contraindicated Therapy
- \$1.6M Appropriated to Continue Research
- Us TOO's 2008 Board Members/Officers
- Post-Prostatectomy Incontinence Treatment
- Letter to the Editor
- The Editorial Team's Reply
- Doc Moyad's What Works and What is Worthless Column—Statins
- Screening Tests May Miss Prostate Cancer in Obese Men
- Family Program Helps Prostate Cancer Patients and Spouses Cope
- Index of Articles Appearing in the 2007 Us TOO *HotSheets*



**Us TOO**<sup>®</sup>  
PROSTATE CANCER  
EDUCATION & SUPPORT

# HOTSHEET

January 2008

## US TOO INTERNATIONAL'S FIRST ANNUAL EDWARD C. KAPS HOPE AWARD

Us TOO International is pleased to open nominations for our *First Annual Edward C. Kaps Hope Award*.

Ed Kaps was one of the organizing and founding Board Members and remains Director Emeritus of Us TOO International. Ed traveled extensively throughout the U.S. and internationally establishing the first chapters for Us TOO International. Ed approached the Us TOO Board with the concept of this award and donated the plaque that will be housed in the Us TOO home office.

The Edward C. Kaps Hope Award is given to "An outstanding leader in an Us TOO support group who has shown unselfish, dedicated service to prostate cancer survivors and their families."

### Who can be nominated?

Any Us TOO International support group volunteer can be nominated. Nominees can include, but are not limited to, support group leaders, leaders of your spouses/companions group, special event volunteers, or any other volunteer whose leadership and commitment is vital to the success of your chapter. The size of your support group is not a criteria; the size of the heart of your nominee is!

(Continued on page 3)

## GPC BIOTECH AND PHARMION ANNOUNCE RESULTS OF OVERALL SURVIVAL ANALYSIS FROM THE SATRAPLATIN PIVOTAL PHASE 3 TRIAL

GPC Biotech AG and Pharmion Corporation (NASDAQ: PHRM) have announced top-line overall survival results for the double-blinded, randomized satraplatin Phase 3 registration trial, the SPARC trial (Satraplatin and Prednisone Against Refractory Cancer). The trial evaluated satraplatin plus prednisone versus placebo plus prednisone as a second-line treatment in 950 patients with hormone-refractory prostate cancer (HRPC). The companies reported that the trial did not achieve the endpoint of overall survival ( $p=0.80$ , stratified log rank analysis). The median was 61.3 weeks for the satraplatin arm compared to 61.4 weeks for the control group and the hazard ratio was 0.97 (95% CI: 0.83, 1.13). The companies are currently conducting pre-specified subset analyses.

GPC Biotech is now re-evaluating its development plans for satraplatin, including SPERA, the Satraplatin Expanded Rapid Access protocol in the US.

<<http://www.gpc-biotech.com>>  
30 October 2007

## PROSTATE CANCER PATIENTS OFTEN GET CONTRAINDICATED THERAPY

More than a third of prostate cancer patients have some form of pretreatment condition that contraindicates the therapy chosen by clinicians, investigators here have concluded.

For instance, therapeutic "mismatch" worsened urinary and bowel dysfunction for patients treated with brachytherapy (BT) or external-beam radiation (EBRT), James A. Talcott, MD, of Massachusetts General Hospital and Harvard, and co-authors reported online in *Cancer*, a paper slated for publication in the Jan. 1, 2008 issue.

Also, they found, nerve-sparing radical prostatectomy (RP) did not take pretreatment sexual dysfunction into consideration. "Pretreatment dysfunction does not appear to reliably influence treatment choices, and patients receiving mismatched treatments had worse outcomes," they wrote.

"Further study is needed to determine why mismatched treatments were chosen, including the role of incomplete patient-physician communication of baseline dysfunction, and whether using a validated questionnaire before treatment decision-making would bypass this difficulty," they added.

(Continued on page 2)

THIS ISSUE OF THE US TOO PROSTATE CANCER  
HOT SHEET IS MADE POSSIBLE BY  
CHARITABLE CONTRIBUTIONS FROM



ITEMS CONTAINED IN US TOO PUBLICATIONS ARE OBTAINED FROM VARIOUS NEWS SOURCES AND EDITED FOR INCLUSION. WHERE AVAILABLE, A POINT-OF-CONTACT IS PROVIDED.

REFERENCES TO PERSONS, COMPANIES, PRODUCTS OR SERVICES ARE PROVIDED FOR INFORMATION ONLY AND ARE NOT ENDORSEMENTS. READERS SHOULD CONDUCT THEIR OWN RESEARCH INTO ANY PERSON, COMPANY, PRODUCT OR SERVICE, AND CONSULT WITH THEIR LOVED ONES AND PERSONAL PHYSICIAN BEFORE DECIDING ON ANY COURSE OF ACTION.

THE INFORMATION AND OPINIONS EXPRESSED IN THIS PUBLICATION ARE NOT RECOMMENDATIONS FOR ANY MEDICAL TREATMENT, PRODUCT SERVICE OR COURSE OF ACTION BY US TOO INTERNATIONAL, INC., ITS OFFICERS AND DIRECTORS, OR THE EDITORS OF THIS PUBLICATION. FOR MEDICAL, LEGAL OR OTHER ADVICE, PLEASE CONSULT PROFESSIONAL(S) OF YOUR CHOICE.

HOT SHEET EDITORIAL TEAM:

JONATHAN MCDERMED, PHARM D  
PAMELA BARRETT  
THOMAS N. KIRK  
GEORGE LEDWITH, BOARD REPRESENTATIVE

US TOO INTERNATIONAL STAFF & CONSULTANTS:

THOMAS N. KIRK, PRESIDENT AND CEO  
PAMELA BARRETT, DEVELOPMENT DIRECTOR  
TERRI GIBBONS, EXECUTIVE ASSISTANT  
JAQUELINE KONIECZKA, OFFICE MANAGER  
DAN REED, DEVELOPMENT & MARKETING COORDINATOR  
EUGENE WHEELER, UNDERSERVED PROGRAM DIRECTOR  
ELIZABETH CABALKA, PROGRAM CONSULTANT

US TOO BOARD OF DIRECTORS:

EXECUTIVE COMMITTEE/OFFICERS

JIM KIEFERT, EDD, CHAIRMAN  
JOANN HARDY, VICE-CHAIRMAN  
GEORGE LEDWITH, SECRETARY  
GREGORY BIELAWSKI, TREASURER  
THOMAS N. KIRK, PRESIDENT AND CEO

DIRECTORS:

CHRIS BENNETT  
ROBERT FIDOTIN, PHD  
CARL FRANKEL  
TOM HIATT  
DAVID P. HOUCHEMS, PHD  
KAY LOWMASTER, MSW  
FRED MILLS  
BILL PALOS  
STUART PORTER  
RON WITHERSPOON

US TOO INTERNATIONAL, INC. IS INCORPORATED IN THE STATE OF ILLINOIS AND RECOGNIZED AS A 501(C)(3) NOT-FOR-PROFIT CHARITABLE CORPORATION.

**DONATIONS / GIFTS TO US TOO ARE TAX DEDUCTIBLE.**

5003 FAIRVIEW AVE. DOWNER'S GROVE, IL 60515  
PHONE: (630) 795-1002 / FAX: (630) 795-1602  
WEBSITE: WWW.USTOO.ORG

COPYRIGHT 2008, US TOO INTERNATIONAL, INC.

**CONTRAINDICATED THERAPY** (Continued from page 1)

The three most common treatment modalities for prostate cancer -- EBRT, BT and RP -- have demonstrated similar efficacy in clinical trials but differ with respect to their adverse effects on bowel, urinary, and sexual function, they pointed out. After treatment modality, pre-existing dysfunction is the strongest predictor of quality-of-life outcomes.

To assess the frequency and impact of therapeutic mismatch, the investigators analyzed data from a survey of bowel, urinary, and sexual dysfunction administered to a prospective cohort of patients undergoing treatment for early-stage prostate cancer. The analysis included 438 patients who completed a pretreatment questionnaire and follow-up questionnaires at three, 12, 24, and 36 months. The patients were grouped according to baseline dysfunction:

- Group 1 -- 50 with severe dysfunction in one organ domain
- Group 2 -- 76 with moderate dysfunction in one organ domain
- Group 3 -- 195 with dysfunction in multiple organ domains
- Group 4 -- 74 for whom all treatments were relatively contraindicated

The data showed that 389 (89%) pa-

tients had intermediate or poor function relevant to treatment choices, including 266 patients with urinary obstruction/irritation, 281 with sexual dysfunction, and 215 with bowel dysfunction. More than 70% of the patients had dysfunction involving two or more organ domains.

The investigators found that 34% of patients with severe dysfunction received mismatched treatments. The frequency of mismatch did not increase appreciably with the complexity of dysfunction. Patients with pre-existing urinary or bowel dysfunction had further deterioration in function when treated with mismatched therapy.

"The results provide reason for concern," the authors said. "We expected mismatches to be infrequent, especially when the contraindications are strong and confined to one of several available treatment modalities, but to increase significantly as the clinical scenario became more complex."

A pretreatment questionnaire to elicit information on baseline dysfunction might help improve physician-patient communication and reduce the chance of therapeutic mismatch, they added.

*MedPage Today, 26 November 2007*

**\$1.6M APPROPRIATED TO CONTINUE RESEARCH**

Dear Colleagues,

I am pleased to announce that the U.S. Congress appropriated \$1.6 Million in 2008 to continue a prostate imaging research program led by the AdMeTech Foundation. This is a direct result of our Public Conference on Prostate Imaging in held in Washington DC on September 16-18, 2007 and the combined efforts of our partners in Advocacy, Academia, Industry, Government, Communications and Entertainment.

This funding will make it possible for AdMeTech Foundation to build on its earlier success of stimulating innovative ideas and early stages of high-risk, high-impact projects in prostate imaging, including novel tools for molecular imaging and image-guided treatment, such as prostate-dedicated optics, MRI/MRS, Nuclear Medicine & PET.

I want to express my gratitude to our champions: Congressmen Michael Capuano, Elijah Cummings, and Ed Towns, and Senators John Kerry, Barbara Mikulski, and Ben Cardin. Senator Kerry and Congressman Cummings are also sponsors of the PRIME Act (Prostate Research, Imaging, and Men's Education Act), which calls for federal investment of \$650 million over 5 years for research and education. The PRIME Act is currently gathering momentum in the U.S. Congress, and the number of co-sponsors has grown to 6 members of U.S. Senate and 20 members of the U.S. House of Representatives.

Thank you for your partnership that makes all of this possible.

With gratitude,

Faina Shtern, MD, President and CEO, The AdMeTech Foundation

## US TOO INTERNATIONAL'S FIRST EDWARD C. KAPS HOPE AWARD *(Continued from page 1)*



*Ed Kaps, Director Emeritus and one of the Founders of Us TOO International*

### How to make a nomination:

Please send a letter of nomination, 500 words or less, indicating why your nominee should be considered for the Edward C. Kaps Hope Award.

You will want to indicate the positive impact that this person has had on the life of your chapter, and how men and their families have benefited from their committed service. Also, please list the location and name of the Chapter that this individual represents.

### Who may make a nomination?

Members of any chapter of Us TOO International are eligible to submit a nomination. The awardee of the Edward C. Kaps Hope Award will receive:

- Us TOO International Logo Watch
- Honorary Plaque
- Shopping spree in the Us TOO In-

ternational Store, where resource and education materials can be selected to share with men and their families. (Value up to \$100.00)

- Name engraved on our Hope Award plaque in the Us TOO home office
- Special recognition in an upcoming edition of our *HotSheet*.

Please submit an application online at <www.ustoo.org> or send your letter of nomination to the Us TOO office in care of Terri Gibbons, Program Manager, or e-mail it to her at <terri@ustoo.org>. Letters of nomination must be received no later than January 31, 2008 and will be reviewed by the Us TOO Awards Committee.

We look forward to sharing the stories of the Edward C. Kaps Hope Award nominees in upcoming publications of Us TOO International.

## US TOO NAMES NEW BOARD MEMBERS, OFFICERS FOR 2008

At their December 8, 2007 meeting, the Us TOO Board of Directors announced the new Executive Committee officers, appointed two new members to their ranks, and bid a fond farewell to two outgoing Board members.

New Executive Committee officers serving from January through December 2008 are: Jim Kiefert – Chair (reappointed from 2007), Jo Ann Hardy – Vice Chair (new appointment), Greg Bielawski – Treasurer (reappointed from 2007), and George Ledwith – Secretary (new appointment).

The newly appointed Board members are Kay Lowmaster, MSW and David

P. Houchens, PhD, whose 3-year terms begin January 1, 2008.

Kay is Chapter Leader of the Us TOO Hillman Cancer Center Chapter, and Regional Director for Ohio, Pennsylvania and West Virginia. She is a licensed clinical social worker, and is the Community Outreach Program Coordinator at the University of Pittsburgh Medical Center in Pittsburgh, PA.

David has a PhD in microbiology and immunology from George Washington University, and is a senior scientist/administrator with extensive experience in pharmaceutical research and development with industry, university medical centers, contract laboratories

and government funding agencies. He currently serves as a Program Manager at the Battelle Memorial Institute in Columbus, OH.

The two outgoing Board members are Donald R. Lynam, PhD and Harry Pinchot. Both Don and Harry served on the Board from January 2002, and are both prostate cancer survivors.

Don served on the Executive Committee as Vice Chair, and made a significant impact on Us TOO's visibility and influence as head of the Legislative Advocacy Committee. He participated as a consumer reviewer in the U.S. Department of Defense Prostate Cancer Research Program. He holds advanced degrees in Civil Engineering and Environmental Health, and recently moved back to Lexington, KY after retiring in March 2004 from Ethyl Corporation as a corporate vice-president. Don intends to become an active chapter leader in Lexington and stay active with Us TOO.

Board Chairman, Jim Kiefert, states "Don has been a dedicated board member who fulfilled his responsibilities as a board member in a very professional manner. Don is a gentleman who is soft spoken, but shows his passion for helping others deal with pros-

*(Continued on page 5)*



*Don Lynam, retiring Vice Chair, is presented with an Us TOO watch by Jim Kiefert, Chair (far left), Tom Kirk, President & CEO, and Jo Ann Hardy, incoming Vice Chair. Harry Pinchot (not pictured) will also receive an Us TOO watch in appreciation of his years of service on the Us TOO Board of Directors.*

## POST RADICAL PROSTATECTOMY TREATMENT OF INCONTINENCE

By Earl A. Surwit, MD, Director, Southern Arizona Urogynecology Center

Urinary incontinence after radical prostatectomy is not uncommon. This can have a significant impact on quality of life. Factors that have been associated with an increased risk for post-prostatectomy incontinence include: older age, advanced stage, and the presence of anastomotic stricture.

While most patients experience transient incontinence after catheter removal, many studies report an achievement of urinary continence in the majority of patients that can take up to 2 years although in the majority of patients this appears to occur within the first 6 months. The most common injury leading to incontinence is that of intrinsic sphincter deficiency (ISD), which presents as insensible incontinence or constant dripping.

In the past there has been little treatment for ISD except for waiting for it to resolve which it does in many patients. An artificial sphincter is rarely an acceptable alternative for these patients. The second most common injury is to the bladder base which leads to urge incontinence. This has been treated in the past with behavioral modification and/or pelvic floor muscle training (PFMT) with some success.

Similarly, the third injury which is the least common is to the pudendal nerve leading to stress urinary incontinence which is also amenable to PFMT, as well as biofeedback which has taught these patients how to do their pelvic floor muscle exercises leading to shortening of the time to continence.

Electrical stimulation, which is part of our protocol, has not been previously used. Electrical stimulation at 100 Hz will strengthen the pelvic floor and give the patient excellent feedback as to how to do the pelvic floor exercises. The mechanism of action of stimulating the pudendal nerve at 100 Hz is direct contraction of the muscle and neuromodulation through the sacral complex of nerves leading to contraction of the muscles again. Electrical stimulation at 10 Hz will quiet the detrusor muscle and helps lead to successful treatment of the urge incontinence. The mechanism of action of electrical stimulation at 10 Hz is to neuromodulate the hypogastric plexus, thereby calming the bladder down through the muscarinic

cholinergic pathway.

In these postoperative incontinent patients we decided to optimize the pelvic floor rehabilitation, formerly called pelvic floor therapy and/or behavioral modification, by utilizing the pelvic floor muscle training (PFMT) with biofeedback and with electrical stimulation as noted above.

We have added a unique new therapy, percutaneous tibial neural stimulation (PTNS; Urgent PC®, Uroplasty, Inc.), to the pelvic floor rehabilitation. This has produced incredibly synergistic results for women, who we see in large numbers. We have a 93% cure rate in 256 women with urge incontinence, a 91% cure rate in 212 women with stress incontinence and a 91% cure rate in 56 women with insensible incontinence.

When we began to see men, after radical prostatectomy, we had to be able to treat the ISD as it was the most common postoperative urinary incontinence. Fortunately, PTNS goes to Onuf's nucleus which is in the lower lumbar spine (sacral implantation does not do this) and this leads to further suppression of the parasympathetic system through the parasympathetic nucleus. More importantly, however, it leads to the secretion of serotonin and norepinephrine which strengthens the urethra and this is how we have been able to cure the patients with ISD.

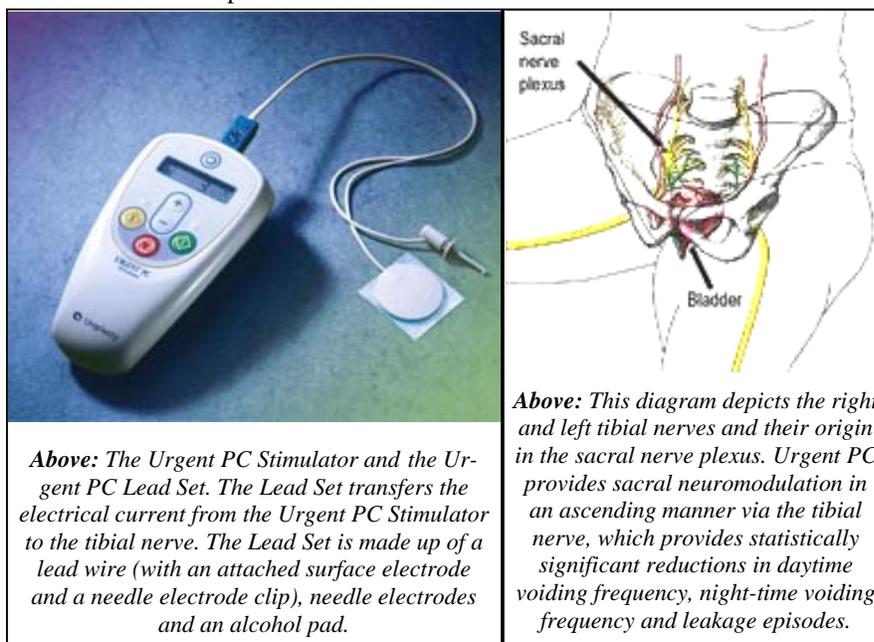
We utilized a rectal probe to treat the

whole pelvis at 100 Hz x 4 in all of these men, as there is clear documentation that a stronger pelvic floor will lead to shortening of incontinence. In patients with urge incontinence, we use a rectal probe with four to six treatments at 10 Hz electrical stimulation, which calms down the cholinergic muscarinic system. The PTNS follows the pelvic floor rehabilitation at the same clinic visit.

We have treated 28 men with postoperative radical prostatectomy incontinence. Sixteen had ISD. Twelve were cured of the ISD, two were not cured and two had a greater than 50% improvement. Among these 28 men, there were 12 who additionally had urge incontinence and all of these were cured. There were four men with stress incontinence and they all were cured as well. These results are very consistent with the results we've achieved in women.

Presently there are only six other centers in America doing both of these treatments. However, we are working hard to spread this technology across the country and certainly, patients such as you that demand such therapy would be a great asset to the progress in getting this combination neuromodulation into other cities around the US.

So. Arizona Urogynecology Center  
6296 E. Grant Road, Suite 130  
Tucson, AZ 85712  
Phone: (520) 795-9300



## LETTER TO THE EDITOR

I am a radiation oncologist at the University of Massachusetts Medical Center, and my practice consists almost entirely of men with prostate cancer. I'm a frequent presenter at the Central MA Us TOO chapter, and receive (and read) the *HotSheet*. I'm writing because I believe that an article in the November 2007 issue was taken out of context, and thus is misleading, and deserves clarification.

The ancient wisdom, "a little knowledge is a dangerous thing", certainly applies to medicine. That's what came to my mind when I read the article, "Simple nomogram predicts life expectancy for prostate cancer" in the November issue of the *HotSheet*. Every bit of information in the article was correct, but it was what was left out that makes the difference...

The article cites the work of Dr. Pierre Karakiewicz in Montreal. Based upon thousands of men treated in Quebec, Dr. Karakiewicz and his colleagues devised a nomogram (a mathematical tool) to predict survival in men with prostate cancer, treated with either surgery (RP) or radiotherapy (RT). As related in the *HotSheet*, the 10-year survival after RP was 81.1%, but was only 30.4% after RT. This suggests that surgery is a more effective treatment for prostate cancer.

It seems that way, unless you actually read Dr. Karakiewicz's article (in the *Journal of Clinical Oncology*, August 20, 2007). His study was not about survival from prostate cancer; rather it was about survival from other causes, after successful treatment of prostate cancer. He demonstrated that, after successful treatment, men who had undergone RP lived, on the average, more than a decade longer than men treated with RT. Why should that be? The article explains that men receiving RT were, on the average, more than 6 years older and had more medical problems. Consequently, they were half as likely to survive 10 years after successful treatment.

This should come as no surprise to members of Us TOO, who know that surgery is considered more risky than RT for older patients (or those with medical problems), and is generally reserved for younger, healthier patients. We would expect younger, healthier

*(Continued on page 6)*

## DOC MOYAD'S WHAT WORKS & WHAT IS WORTHLESS COLUMN ALSO KNOWN AS "NO BOGUS SCIENCE" COLUMN

**"Did you hear the joke about the guy taking the cheap statin drug for heart health that also found out that drug reduced his/her risk of stroke, certain cancers, improved eye health, erectile function, prostate cancer prognosis and now may increase his vitamin D levels. Well, this is actually no joke!"**

Mark A. Moyad, MD, MPH

University of Michigan Medical Center, Department of Urology

*\*Email and to sign up for more information on general health now!*

*Go to the journal at <www.seminarsprevaltmed.com>*

### **Bottom Line: Statins (cholesterol-lowering drugs) may actually increase vitamin D levels, how about that for a 7 for 1 effect!**

Increases in vitamin D levels, apart from summer sun exposure, is a challenge so researchers are looking at various other methods to assist in increasing these blood levels. Lets face it, fortification of dairy products with vitamin D sucks (sorry mom, I meant stinks)! We need better ways to increase the vitamin D blood levels of men, women and children (sounds like I am running for President)!

This clinical study used atorvastatin (Lipitor®) and included 83 individuals (31 women and 52 men) with heart disease compared to a control group of 73 hypertensive subjects not taking statins.<sup>1</sup> Patients were evaluated for 12 months. The average age of the participants was 62 years of age. The statin drug increased vitamin D levels significantly (p=0.003) from an average of 41 nmol/L to 47 nmol/L. Regardless, the majority of these patients still were deficient in vitamin D according to their blood levels despite the increases with the statin drug, so keep that in mind. In addition, levels of total cholesterol (182 to 161 mg/dL), LDL cholesterol (114 to 90 mg/dL) and triglyc-

erides (152 to 117 mg/dL) were significantly reduced, and HDL (39 to 49 mg/dL) significantly (p=0.001) increased on the statin medication. Low doses (10 to 20 mg) as well as higher doses of the statin drug were utilized to achieve appropriate cholesterol numbers for each patient. The control group had no increase in vitamin D.

Let me see if I get this straight! Three of the six statin drugs are now generic so they are getting cheaper in price every day! Statins reduce the risk of cardiovascular disease, and they seem to reduce the risk of dying young from all causes. In addition, there is now increasing evidence that they may improve bone health, brain health, eye health, kidney health, and may reduce the risk of dying from prostate cancer.

Oops, I will and should apologize if it does not do all these amazing things in the future except reduces your risk of dying young from the number 1 killer of men and women in the US (cardiovascular disease)?! So, remind me again why we are not putting every man impacted by prostate cancer on a statin drug?! Oops, that's right, I forgot, because then that would make sense!!

1. Perez-Castrillon JL, Vega G, Abad L, et al. *Am J Cardiol* 99:903-5, 2007.

## BOARD MEMBERS, OFFICERS FOR 2008 *(Continued from page 2)*

tate cancer. He could always be depended upon to gently carry his load and help lead others."

"I'll miss Don a great deal as he's been around since I met him as part of the search committee back in 2004," says Tom Kirk, President & CEO. "He is a kind, gentle and strong leader who was a pleasure to work with."

Harry Pinchot is extremely well known within the prostate cancer community through his tireless work to

help eradicate the disease. Harry is the senior member of the Prostate Cancer Research Institute (PCRI) and many other prostate cancer organizations. Harry has also been involved with Us TOO as a Regional Director and chapter leader.

"Harry is one of the most knowledgeable people I know regarding prostate cancer. He has kept abreast of the latest clinical trials as well as clinical

*(Continued on page 6)*

## SCREENING TESTS MAY MISS PROSTATE CANCER IN OBESE PATIENTS

Higher blood volumes probably cause lower concentrations of prostate-specific antigen, or PSA, in obese prostate cancer patients, reports a study today, leading the authors to speculate that screening with PSA tests might miss some cancers in obese men.

Most U.S. prostate cancers are diagnosed by a biopsy prompted by a high PSA, the researchers write in *The Journal of the American Medical Association*. "The ability to accurately detect prostate cancer can be compromised by any factor that decreases PSA concentrations," they write.

The study of more than 13,000 men who had undergone prostate cancer surgery found that patients with a body mass index (BMI) of 35 or greater had PSA concentrations that were 11% to 21% lower than normal-weight patients. A 5-foot-8 man who weighs 230 pounds has a BMI of 35, which is considered moderately obese. A BMI of less than 25 is considered normal.

Obese prostate cancer patients have a higher risk of dying than normal-weight patients, says senior author Stephen Freedland, assistant professor of urology and pathology at Duke University. One reason could be that screening is missing some early cancers.

Although the link between obesity and lower PSA concentrations remains unproven in men who have not been diagnosed with prostate cancer, Freedland says, he has begun to use a 20% lower PSA cutoff when screening men whose BMI is 35 or higher. So instead of 4, he's using 3.2 or 3.3.

Freedland's study "just drives one more nail in the coffin of the concept that one size fits all for PSA," says Bruce Roth, a professor of medicine and urology at the Vanderbilt-Ingram Cancer Center in Nashville. Still, Roth says, it's too soon to start using a lower PSA cutoff to screen obese men. "It's hard to say what you should do in a screening population based on data only in diagnosed patients. If an obese man has no symptoms and a normal-sized prostate, lowering the PSA threshold for performing a biopsy "is stretching it a little bit."

*USA Today, 23 November 2007*

## FAMILY PROGRAM HELPS PROSTATE CANCER PATIENTS AND SPOUSES COPE

A family intervention program aimed at prostate cancer patients and their spouses was shown to help the couples better manage the effects of the illness and maintain their quality of life, according to a study published online November 12<sup>th</sup> in the journal *Cancer*.

The study involved 235 couples who were randomized to standard care or standard care plus a family-based intervention called the FOCUS Program. The supportive-education program consists of three 90-minute home visits by nurses and two 30-minute telephone sessions spaced 2 weeks apart and delivered between the baseline assessment and 4 months.

The five core areas in the acronym FOCUS included:

- Family involvement;
- Optimistic attitude;
- Coping;
- Uncertainty reduction, and
- Symptom management.

At 4-month follow-up, intervention patients reported less uncertainty and better communication with spouses than control patients, noted researchers led by Dr. Laurel Northouse of the University of Michigan School of Nursing. Intervention spouses reported "higher quality of life, more self-efficacy, better communication, and less negative appraisal of caregiving, uncertainty, hopelessness, and symptom distress at 4 months compared with controls, and some effects were sustained to 8 months and 12 months."

Although patients benefited from the intervention, "the effects were far greater for their spouses," the researchers noted. "At a minimum, the findings suggest that spouses of men with prostate cancer need to be included in programs of care. Too often, they are viewed as outside observers or only as providers of care. Instead, clinicians need to recognize that spouses are affected by the cancer and to treat them as co-recipients of care."

*NCI Cancer Bulletin, 20 November 2007*

## LETTER TO THE EDITOR

*(Continued from page 5)*

patients to live longer. But why would Dr. Karakiewicz and his colleagues undertake this study? Was it to provide a tool to predict non-prostate cancer prognosis for men being considered for "watchful waiting?" A man unlikely to live more than 10 years (due to age or a serious medical condition) may be better advised to avoid treatment for a low-grade prostate cancer.

To sum up, Dr. Karakiewicz and his colleagues performed a thoughtful study that should be of interest to members of Us TOO. The *HotSheet* reported the study accurately... but incompletely. And what was omitted could lead to misinterpretation of the study's findings.

*Jesse Aronowitz, MD*

## EDITORIAL TEAM'S REPLY

We appreciate Dr. Aronowitz's Letter to the Editor clarifying the information in the news release "Simple Nomogram Predicts Life Expectancy for Prostate Cancer" appearing in the November 2007 *HotSheet*. Us TOO welcomes your feedback and we love to hear from you.

*(Continued on page 8)*

## 2008 BOARD MEMBERS

*(Continued from page 5)*

information from researchers collecting data on what works at the individual level. Harry is always on the cutting edge of "what works." Harry provided leadership at the local, regional, and national levels. He knows the leading prostate cancer researchers on a first name basis because he was so knowledgeable and has passion for helping others. Harry really cares!!!"

Tom Kirk says: "Harry has a unique contribution, despite his advanced disease and personal fight, he inspires others to search for important new breakthroughs in the battle against prostate cancer. Harry has been essential in our successful partnerships with PCRI and Raise a Voice, and at important conferences."

Thank you, Don and Harry, for your time and efforts, and for all you have done – and continue to do – to touch so many lives!

**INDEX OF ARTICLES APPEARING IN THE 2007 *HOT SHEETS***

Title of article	Month	Title of article	Month
A Review of the 2007 Prostate Cancer Symposium	June	Lycopene Doesn't Prevent Prostate Cancer	July
ADT Can "Cure" Nonmetastasized Cancer	May	Medicare Part D and Erectile Dysfunction	March
ADT May Increase Risk of Death from Heart Disease	April supp.	Middleton NY Chapter Honors Rohit Patel, MD	December
After the Surgery: Conquering Incontinence	May supp.	Minority and Underserved Awareness Program	January
Alendronate Increases BMD During ADT	May	MRI in Managing Prostate Cancer	May
Alternative Therapies	August	Natural Treatment May Slow A Rising PSA	March
Androgen Receptor Predicts Cancer Aggressiveness	April supp.	New Agent Synergistic with Chemotherapy	June
Antifungal Drug Stops Blood Vessel Growth	June	New AUA Prostate Cancer Guidelines	July
Antisoma Drug Effective in Advanced Cancers	April supp.	New Combined Federal Campaign Code for Us TOO	September
Biopsy Site Affects Prostate Cancer Detection	December	New Combined Federal Campaign Code for Us TOO	August
Black Men Do Not Have More Aggressive Cancers	November	New Data for PROSTASCINT® in Prostate Cancer	April supp.
Botox for Treating Prostate Problems	September	New Data from ASCO on SPARC Trial	August
BRCA2 Mutation Linked to Aggressive Cancers	August	New Free Kits for Newly-Diagnosed Men	December
Broccoli Prevents Aggressive Prostate Cancer	October	New Genetic Risk Markers for Prostate Cancer	December
Calcitriol with Docetaxel Boosts Survival	April	New changes with Erythropoiesis Stimulating Agents	December
Cell Genesis Reports Phase II Results with GVAX	June	New Members for Us TOO Board of Directors	March
Chapter Honors Fallen Leader	March	New Procedure Minimizes Post-RP Incontinence	August
Charity Navigator Gives Us TOO 4-Star Rating	November	New Product for Chemotherapy, Dialysis Patients	April
Chemohormonal Therapy before RP is Feasible	November	New Tests of Dendreon's Prostate Cancer Drug	January
Chemohormonal Therapy Feasible for Relapse	February	No Micronutrient Benefits for Prostate Cancer	November
CMS Eliminate Medicare Clinical Trials Coverage	October	Nomogram Can Predict Life Expectancy	November
Companies, Chapters Signing Up for	January	October 30 <sup>th</sup> Intimacy Teleconference a Success	December
Conference Call: Intimacy & Prostate Cancer	February	Patient Story: Living Life Dry	May supp.
Consider Source of Cancer Recommendations	July	PCA-3 Urine Test Approved in the EU	January
Coping with the Feelings Surrounding Incontinence	May supp.	PET/CT Assesses Bone Metastases	August
Copper Drug Promising in Fighting Cancer	June	Phase II Trial of Patupilone (EP0906) for HRPC	January
Court Sees No Right to Unapproved Drugs	September	Poorer Health Care Ups Black Men's Cancer Risk	May
COX-2 Inhibitor and Green Tea are Synergistic	May	Possible New Cancer Treatment?	June
CyberKnife® as an Option for Prostate Cancer	December	Predicting Efficacy of Post-RP Radiation	December
Cytogen Launches PSMA Antibody Trial	April	New Data for PROSTASCINT® in Prostate Cancer	April supp.
Dendreon Completes PROVENGE Enrollment	December	President's Message: "Taking Action in 2007"	January
Dendreon Sued after Provenge's Ok Put Off	July	President's Message: "What Is Awareness?"	February
Detecting Cancer at Earliest, Curable Stage	June	Primary Therapy for Intermediate Risk Prostate Cancer	July
EPCA-2: A New Blood Test for Prostate Cancer?	June	Propecia Hinders Prostate Cancer Screening	October
Estrogen Therapy: DES (Diethylstilbestrol)	April	Proscar® Boosts Detection of High-Grade Cancers	November
External RT & Seed Implants for High-Risk Cancer	October	PROSTASCINT® In NCCN® Clinical Practice Guidelines	February
External RT, Seed Implants or RP for Early Cancers	April supp.	Prostate Biopsies and the Nature of Cancers Identified	May
FDA Panel Backs New Prostate Vaccine	May	Prostate Cancer Legislation and September Conferences	September
FDA Requests More Data on Satraplatin	September	Prostate Cancer Prediction Not Skewed by Finasteride	September
FDA Requirements for PROVENGE® Licensure	July	Prostate Px® Test Results Published	October
FDA Sued Over PROVENGE® Delay	September	PROVENGE® Granted FDA Priority Review	March
First Biomarker that Predicts Cancer Outcome	October	PSA Bounce after RT Does Not Predict Clinical Failure	January
First National PCa Workplace Awareness Program	September	PSA Primer	April
Frequent Testing Doesn't Reduce Aggressive Tumors	October	PSA Screening Does Not Increase Stress	November
Friday the 13 <sup>th</sup> Lucky for Prostate Pointers	September	QOL in Survivors Varies with Initial Treatment Type	February
Gleason Score and Prostate Cancer Prognosis	November	<sup>223</sup> Radium in Hormone-Refractory Cancer	July
GPC Biotech Provides Satraplatin for Free	April	Reaching Out to Federal Employees and Military	November
Hormone Inhibitor for Hard-to-Treat Cancers	September	Red Wine Ingredient Prevents Prostate Cancer	October
Hundreds Dial in to Conference Call	April	Satraplatin as 2 <sup>nd</sup> -Line Therapy in Advanced Cancers	April supp.
Impact of Fat, Meat on Prostate Cancer Risk	November	Sneakers@ Work Day, Great Fun, Great Success	August
Importance of Survivorship Care Plan	August	Sneakers@Work Day	January
In Memory of Board Member Ron Fabrick	May	Soy Shows Paradoxical Results	May
Index to 2006 HotSheet Articles	January	Special Thanks to Joe Piper	February
Intermittent ADT as Effective as Continuous ADT	July	Special Thanks to Russ Gould	March
Invite to Participate in February Conference Call	January	Statins Fail to Cut Androgens Fueling Prostate Cancer	October
June 4 <sup>th</sup> Prostate Cancer Rally in Washington, DC	July	Statins May Protect Against Prostate Cancer	July
Leading by Example	March	Stress Management before Prostatectomy	October
Life after Prostate Treatment: Focus on Incontinence	May supp.		

*Continued on page 8*

**INDEX OF ARTICLES APPEARING IN THE 2007 *HOT SHEETS*** (Continued from page 7)

Title of article	Month	Title of article	Month
Stress May Make Cancer Cells Resistant	December	Us TOO U in Austin, Texas – "A Marvelous Evening"	August
Survival Analysis from the SPARC Trial	December	Us TOO U: "Living Well with Prostate Cancer"	April
Survivor Rate Highest with RP for Localized Cancers	March	Us TOO University Chicago Program a Success	December
The Year in Prostate Cancer: Part I	February	Us TOO's 2006 Annual Report Now Available	December
The Year in Prostate Cancer, Part II	March	Survivor Rate Highest with RP for Localized Cancers	March
The Year in Prostate Cancer: Part III	April	Three Years of Adjuvant ADT Should be Standard	October
Three Years of Adjuvant ADT Should be Standard	October	Toremifene May Ease ADT Complications	April supp.
Toremifene May Ease ADT Complications	April supp.	Us TOO's Top 4-Star Charity Rating	January
Us TOO Greenville SC Chapter Honors Art Stamler, MD	August	Using PSA Doubling Time for Stratifying Post-RP Risk	June
Us TOO SEA Blue Campaign	November	Viagra's New Frontier: Treating Post-RP Impotence	September
Us TOO Seeks Board Member Applications	July		

Doc Moyad's "No Bogus Science"	Month	From the Doctor
Vitamin D—Part II	January	January
Vitamin D—Part III	February	February
Vitamin D—Part IV	March	March
Zinc supplements	April	April
Lycopene	May	May
PROVENGE®	June	June
Multiple Vitamins	September	September
Weight Loss Pills	October	October
Ginseng	November	November
Influenza Vaccine	December	

**EDITORIAL TEAM'S REPLY**

(Continued from page 6)

The *HotSheet* Editorial Team agrees with Dr. Aronowitz's criticisms.

We would like to remind our readers that articles printed in the *HotSheet* are obtained from various news sources and edited for inclusion. When results from medical studies are reported, we always provide the name of the journal, the issue and page numbers and its publication or release date. Information and opinions expressed in these articles are not recommendations for any medical treatment. Readers are urged to conduct their own research into any person, company, product or service, and to consult with their loved ones and physicians before deciding on any course of action.

**US TOO INTERNATIONAL:  
OUR MISSION**

Communicate timely, personalized and reliable information enabling informed choices regarding detection and treatment of prostate cancer.



**US TOO INTERNATIONAL**

has received Charity Navigator's highest rating for the third year in a row for sound fiscal management. Less than 9% of the charities in the US receive this exceptional rating.

**US TOO INTERNATIONAL Tax Deductible Donation**

Name: \_\_\_\_\_ Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ e-mail: \_\_\_\_\_

Please accept my enclosed tax-deductible donation to Us TOO a not-for-profit 501(c)(3) organization.

Amount: \_\_\_ \$25 \_\_\_ \$50 \_\_\_ \$75 \_\_\_ \$100 Other: \$ \_\_\_\_\_ Check # \_\_\_\_\_

VISA/MasterCard # \_\_\_\_\_ Expiration Date: \_\_\_\_ / \_\_\_\_

Signature \_\_\_\_\_

**US TOO INTERNATIONAL, Inc., 5003 Fairview Ave., Downers Grove, IL 60515**