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Us TOO[®]
PROSTATE CANCER
EDUCATION & SUPPORT

HOTSHEET

February 2009

US TOO NAMES NEW BOARD OFFICERS, MEMBERS FOR 2009

At their December 6, 2008 meeting, the Us TOO International Board of Directors elected the new Chairman of the Board and Executive Committee officers, announced two new members, and bid a fond farewell to our Chairman of the last 4 years.

The new Executive Committee officers

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*Fred Mills, Chairman of the Board
Us TOO International, 2009*

FDA APPROVES FERRING PHARMACEUTICALS' DEGARELIX (GENERIC NAME) FOR TREATING ADVANCED PROSTATE CANCER

New gonadotropin-releasing hormone (GnRH) receptor antagonist demonstrates rapid, long-term suppression of testosterone.

Ferring Pharmaceuticals, USA today received approval from the US FDA for degarelix, a new injectable gonadotropin-releasing hormone (GnRH) receptor antagonist, indicated for patients with advanced prostate cancer. Potential trade names are still under review with the FDA.

Phase III studies showed that degarelix is at least as effective as leuprolide (Lupron Depot[®]), a luteinizing hormone releasing hormone (LHRH) agonist, in sustaining castrate testosterone levels. At Day 3 of treatment, 96% of degarelix patients achieved a castrate testosterone level compared with zero percent receiving leuprolide. By Day 14, 99% of degarelix patients achieved castrate levels of testosterone, compared with 18% receiving leuprolide.

Degarelix is the only GnRH receptor antagonist approved by the FDA for the treatment of hormonally-sensitive advanced prostate cancer. Degarelix

(Continued on page 3)

GEOGRAPHY HAS ROLE IN MEDICARE CANCER COVERAGE

CyberKnife[®] is a new but fast-growing radiation treatment for prostate cancer, spurred by radio and newspaper ads that stress its convenience and results. But geography appears to play a big role in determining which men diagnosed with prostate cancer are eligible for CyberKnife.

As it turns out, Medicare pays for the treatments in 33 states — but not in 17 others. States that do not provide coverage include big ones like California and Texas, but also smaller states like Colorado, Hawaii, Montana, Nevada, New Mexico, Oklahoma, Utah, Oregon, Vermont, Virginia, Washington, South Dakota, Wyoming, and Alaska. Medicare will pay for a man's CyberKnife treatments in New Hampshire, but not across the border in Vermont.

The disparities result from a policy principle as old as Medicare itself, in which officials in Washington leave many reimbursement decisions to the discretion of 15 regional contractors around the country. A dozen of them willingly pay for CyberKnife treatments among other prostate options. But three of the regional contractors have balked at covering CyberKnife, saying there is not enough evidence of

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**LOW-INCOME MEN MORE OFTEN DIAGNOSED WITH
ADVANCED PROSTATE CANCER**

In a study scheduled for publication in the February 2009 issue of *The Journal of Urology*, researchers report that low-income men are more likely to be diagnosed with prostate cancer until it has reached an advanced stage.

The records of 570 men enrolled in the California IMPACT (Improving Access, Counseling and Treatment for Californians with Prostate Cancer) program designed to provide high-quality care for disadvantaged prostate cancer patients, were examined.

Results showed that 19% of these men had metastatic cancer at diagnosis, in contrast to approximately 4% of men from the general population tracked in other studies. Furthermore, the diagnosis rate for low-risk, less advanced cancers in the IMPACT patients did not increase over time, in contrast with a significant rise in these diagnoses in the more affluent population.

The proportion of men in the program presenting with metastatic cancer did not change over time, indicating that low-income men were not receiving prostate cancer screening services that can reduce the diagnosis of late-stage cancers in the general population.

Writing in the article, David C. Miller states, "Our principal findings clarify some of the challenges (and opportunities) faced by public assistance programs designed to reduce cancer related disparities. Without question IMPACT enables eligible men to receive previously unattainable—and high quality—prostate cancer care..."

"However, from a population perspective the persistent preponderance of metastatic and higher risk localized cancers suggests that more comprehensive strategies are needed to eradicate socioeconomic disparities in prostate cancer specific morbidity and mortality. ..." While much attention now focuses on potential overdiagnosis and overtreatment of men with screen detected prostate cancer, our findings serve as a reminder that for disadvantaged men underdetection and undertreatment of prostate cancer remain significant concerns."

In an accompanying editorial, M. Norman Oliver of the University of Virginia

School of Medicine comments that men from minority groups who live in poverty and are diagnosed with prostate cancer are more likely to die of their disease than those men with a higher socioeconomic status. He writes, "However, we must address more than socioeconomic disparities in prostate cancer care... African-Americans have a disproportionately high rate of poverty with some 25% living below the federal poverty level compared to 8% of the white population in that category."

This racial disparity in combination with the socioeconomic disparity already discussed places African-American men diagnosed with prostate cancer at an even greater risk of presenting with incurable disease."

E! Science News, 16 December 2008

**FDA COMMISSIONER TO
STEP DOWN**

Food and Drug Administration Commissioner Dr. Andrew C. von Eschenbach said that he would resign on Inauguration Day, 20 January 2009, part of a parade of expected departures at the US's crucial public health agencies.

Leaders of these agencies have in the past often straddled administrations, but the Obama administration is expected to make a clean sweep in part because of repeated claims that the Bush administration allowed politics to play an unusually forceful role in science policy. The administration's choices for each slot will signal how it plans to deal with such controversial issues as stem cell policy, the safety of imported drugs and foods, and whether huge investments in bioterrorism prevention will continue.

Dr. Elias A. Zerhouni, the director of the National Institutes of Health, has already left his post. Dr. Julie Gerberding, director of the Centers for Disease Control and Prevention, wrote in a November e-mail that she expects to leave "after the administration changes." And Dr. John E. Niederhuber, director of the National Cancer Institute, is also expected to surrender his leadership job, although he may remain at the institute.

New York Times, 18 December 2008

US TOO PLEASANTON, CALIFORNIA CHAPTER HONORS MEMORY OF BILL STONE

DEGARELIX

(Continued from page 1)

Terry Allen, Chairman of the Us TOO Prostate Support Group in Pleasanton, CA, writes, "Last year, we lost a long-standing member who had battled prostate cancer for many years. Unfortunately, and despite significant interaction with the University of California, San Francisco, the disease process had metastasized in an extremely rapid manner and claimed him, not unlike other men.

"However, in the case of Bill Stone, he was truly "a guy's guy." Here he was fighting the cancer with fierce intensity—yet, he had the desire, wisdom and wit to offer counsel to others—some of whom had failed several forms of therapy. When Bill was informed that his participation in clinical trials failed to arrest the disease-process, he continued to offer his support to the rest of the membership."

"The chapter collected personal checks totaling \$575 "in support of Us TOO efforts" and especially "in memory of Bill Stone." Terry states, "Each one of us is especially beholden to Us TOO. On behalf of our Members, past and current, please accept the enclosures as our way of saying "THANKS!!"

Terry asked us, "My request is simple: Please cite our collective donation in memory of Bill Stone by including it in the monthly *Hot-Sheet*. We "Thank You" in advance; Bill's family would further realize Bill's contributions; and Us TOO would be identifying, posthumously, one of its greatest adherents."

We are honored and happy to recognize the contributions of Bill Stone, Terry Allen and all members of the Pleasanton, California Us TOO Prostate Cancer Support Group – thank you!

CYBERKNIFE (Continued from page 1)

its long-term effectiveness.

At an average Medicare cost of \$29,000, CyberKnife prostate treatment is not cheap. But it can be less expensive than some other radiation methods – which may cost as much as \$50,000 – because fewer treatments are given at heavier doses than conventional systems through the use of highly focused beams of radiation. So, if CyberKnife became the standard treatment for prostate cancer, Medicare might save significant money.

But some leading radiation oncologists worry that the cumulative radiation that CyberKnife delivers over a course of treatments — ultimately lower than what patients would receive in standard therapy — is not adequate to treat the disease. "They are basically pushing the envelope," said Dr. W. Robert Lee, a radiation oncologist at Duke University. "If they're right, it's going to be an important advance. If they're wrong, there's a potential for a big downside."

CyberKnife, made by Accuray of Sunnyvale, Calif., was allowed onto the market by the FDA in 1999 as a treatment for brain and spine tumors. Two years later, the FDA authorized it

for use throughout the body.

The board of the American Society for Therapeutic Radiology and Oncology, or ASTRO, has called CyberKnife promising, but raised questions this year about the evidence supporting its use in prostate cancer, saying "there is not sufficient or mature data to demonstrate equivalency to existing standard treatment modalities."

Some critics of ASTRO, though, say the group has its own financial motives in preferring previous forms of external radiation — which, because they involve more trips to the doctor, tend to be more profitable for radiation oncologists.

Dr. Witten, a Long Island physicist, runs the CyberKnife program at Winthrop-University Hospital in Mineola, NY, actively advertises the treatments. He said CyberKnife should be viewed in the context of the way radiation oncology has evolved in the past — with new methods being developed and pushed into service before long-term clinical data is available.

"From what I see with our patients, anecdotally, they are doing wonderfully, Dr. Whitten observed"

New York Times, 17 December 2008

achieves medical castration differently than LHRH agonists, specifically by binding reversibly to GnRH receptors on cells in the pituitary gland, quickly reducing the release of gonadotropins and consequently testosterone.

"Use of a GnRH receptor antagonist is a highly efficient way to stop the production of testosterone," said Neal Shore, MD, FACS, Medical Director for Carolina Urologic Research Center, a clinical trial investigator and advisor to Ferring. "The approval of degarelix offers the medical community an effective alternative in the treatment of hormonally-sensitive prostate cancer. Now prostate cancer can be treated with immediate inhibition of the GnRH receptors, inducing rapid reduction of testosterone to castrate levels, and sustaining those levels over time, which are the goals of systemic therapy. When a patient has disease recurrence, it is always encouraging to clinicians and patients to see PSA levels fall so rapidly."

Overall, the most commonly observed adverse reactions during degarelix therapy included injection site reactions, hot flushes, increased weight, fatigue, and increases in a serum liver enzyme GGT. Specifically relating to the injection site adverse reactions, most were transient, of mild to moderate intensity, occurred primarily with the starting dose and led to few discontinuations (<1%). Grade 3 (severe) injection site reactions occurred in 2% or less of patients receiving degarelix.

Degarelix is contraindicated in patients with known hypersensitivity to degarelix or to any of the product components. Degarelix is not indicated in women or pediatric patients. Long-term androgen deprivation therapy prolongs the QT interval. Physicians should consider whether the benefits of androgen deprivation therapy outweigh the potential risks in patients with conditions or taking medications associated with QT prolongation.

For complete prescribing information, call 1-888-FERRING (1-888-337-7464) or visit <www.FerringUSA.com>.

*Ferring Pharmaceuticals USA
24 December 2008*

NEW US TOO BOARD OFFICERS, MEMBERS FOR 2009 *(Continued from page 1)*

servicing from January through December 2009 are Fred Mills, Chairman; George Ledwith, Vice Chairman; Carl Frankel, Esq., Secretary; Greg Bielawski, Treasurer, David Houchens, PhD, Assistant Treasurer and Jo Ann Hardy, At Large Member. The newly appointed Board members are Rick Lyke and Ridge Taylor, whose 3-year terms begin 1 January 2009.

Rick Lyke is a Senior Partner, Public Relations and Public Affairs with Eric Mower and Associates in Charlotte, NC, a marketing communications firm with seven offices along the east coast. Lyke is also a drinks journalist whose work appears in many brewing magazines including *All About Beer* and *DRAFT Magazine*.

Last year, a colleague with prostate cancer urged Rick to get a blood test, which revealed that the 47-year-old had the disease. After successful surgery in April 2008, he initiated a pro-bono initiative with Us TOO International to create the successful *Pints for Prostates* awareness campaign using the universal language of beer to reach men with a critical health message. So far the campaign has reached about 25 million people with information about PSA testing and prostate health.



Rick Lyke, New Director

Mr. Lyke is accredited in Public Relations (APR) with the Public Relations Society of America, and has a BA from SI Newhouse School of Public Communications, Syracuse University in New York. He and his wife, Sandy, have two daughters.

Ridge Taylor is the California / Nevada Sales Manager and Engineered Wood Products Group Manager at a commodity lumber trading business located in Portland, OR. He began his career 28 years ago at Shelter Products Inc., over half of which has been spent in management. Diagnosed at age 50 with prostate cancer, he underwent RLRP in January, 2007. Taylor is currently active in the OHSU



Ridge Taylor, New Director

Prostate Cancer Support Group, has been instrumental in the development of a separate OHSU Prostate Cancer Advocacy Group, and serves on the Pacific Northwest Prostate Cancer SPORE in Seattle, WA. He has been blissfully married to wife Lisa for 19 years. His daughter attends the University of Oregon.

Continuing their service on the Us

TOO International Board of Directors are: Bob Fidoten, PhD, Pittsburgh, PA; Jo Ann Hardy, Detroit, MI; Tom Hiatt, Esq., Hilton, NY; Kay Lowmaster, MSW, LCSW, Pittsburgh, PA; Bill Palos, Coal Valley, IL; Stu Porter, Boston, MA; Ron Witherspoon, Shelby Township, MI, and Tom Kirk, President & CEO, Us TOO International, Downers Grove, IL.

In other Board business, Directors Fred Mills, Bill Palos and Ron Witherspoon were each re-nominated to serve 3-year terms. David Houchens, PhD, was named Assistant Treasurer, and two members completed their terms of service, including immediate past Chairman Jim Kiefert, EdD, and Chris Bennett. The Board also honored Kiefert with distinction of being named Director Emeritus, joining Us TOO founders John De Boer and Ed Kaps.

Jo Ann Hardy, Vice-Chair of the Board, recognized outgoing Chair Jim Kiefert for his service at a dinner function, and presented him with a world clock that reads, "Presented to Jim Kiefert, Warrior, with heartfelt appreciation for your leadership, commitment and passion. December 2008."

"It has been indeed a pleasure for me to work with Jim as colleague and friend during our time together on the Board of Us TOO International," said Hardy. "Jim's vision, hard work and dedication have been such an important catalyst and integral part of Us TOO's transformation into the leading organization providing prostate cancer support and education to men and their families." Hardy continued, "He is a compassionate warrior, facing his own prostate cancer journey with the same toolbox that he equips others with: dignity, tenacity, spiritual awareness and acceptance, a relentless drive for education, self advocacy and efficacy and love, lots and lots of love! I am delighted that he will continue his work with Us TOO in his role as director emeritus."

The Board dinner also featured a presentation by Dr. Gerald Chodak, and included special corporate guests Chris Lockett from Dendreon Corporation, Christine Wiedmayer from Abbott

NEW US TOO BOARD OFFICERS, MEMBERS FOR 2009 *(Continued from page 4)*

Laboratories, Susan Small from GTx, and Ray Tantillo and Greg Coloian from American Medical Systems.

Chris Lockett of Dendreon announced the funding of a new Us TOO University scholarship, and presented outgoing Chair Jim Kiefert with a plaque that reads: "In honor of the visionary and compassionate leadership as Chairman of the Board, Us TOO International has proudly established the Dr. James Kiefert Scholarship to help emerging chapters attend Us TOO University to enhance their educational and support initiatives for prostate cancer patients." Chapter leaders will be able to apply for funds to reimburse their travel and transport expenses to the next Us TOO University Chapter Leader Training Workshop.

"Jim has been a great ambassador for Us TOO and the entire Prostate Cancer community as a whole," Lockett stated. "During his tenure he has elevated the stature and visibility of Us TOO as the preeminent Prostate Cancer patient organization in the world, all on limited resources."

Lockett continued, "In Jim's honor, Dendreon is establishing an Us TOO University scholarship fund to help those Us TOO Chapters in need of assistance attend the Us TOO University education programs. The scholarship criteria and awards will be at the sole discretion of Us TOO leadership. Dendreon is proud of its association with Us TOO over the years and we believe supporting patient education programs is the best way to celebrate Jim Kiefert's service."

Elected by the Board to serve as Chairman for 2009, Fred Mills is a prostate cancer survivor, and has more than 30-years experience as a health care executive and consultant, with expertise in the area of medical staff and board relations.

He is President of Praxis Medical Management in San Antonio, TX, is Board Certified in Healthcare Management and a Fellow in the American College of Healthcare Executives, and currently serves on the board of several healthcare related organizations. Fred has been married for 46 years to

wife Sylvia, and has 3 grown sons and 8 grandchildren.

Mills states, "I am proud to be chosen as the new chairman of Us TOO and look forward to the New Year to continue our support and educational activities for prostate cancer patients,

survivors and their families. Jim Kiefert has done an outstanding job over the past 7 years serving the organization and we will miss his leadership. His shoes will be hard to fill and we will continue to look to him as we enter this very exciting and challenging year."



2009 Us TOO Board members (top, L to R): Carl Frankel, Kay Lowmaster, Greg Bielawski, David Houchens, George Ledwith, Tom Hiatt, (bottom, L to R): Jim Kiefert, Bill Palos, Fred Mills. Not pictured: Bob Fidoten, Jo Ann Hardy, Rick Lyke, Stu Porter, Ridge Taylor, Ron Witherspoon, Tom Kirk.



Jo Ann Hardy, Vice-Chair, presents retiring Chairman, Jim Kiefert, with a world clock in honor of his 7 years of service on the Us TOO Board of Directors, first as Treasurer, then ending with 4 years as Chair.



Chris Lockett of Dendreon presents Director Emeritus Jim Kiefert with a plaque announcing the Dr. James Kiefert Us TOO University Scholarship.

THE DOCTORS NOTE

Dr. Gerald Chodak

An exciting new drug has recently been approved for the treatment of men with advanced prostate cancer. The drug, called degarelix, was able to achieve a much more rapid decline in testosterone than the GnRH agonists currently on the market. By three days after initiating treatment, a high percentage had already reached castrate levels. The reason this drug is important is that the other drugs available that are approved to lower testosterone all cause a rise in testosterone during the first two weeks of the first injection. Consequently, some men can get a flare response such as increased bone pain if they have bone metastases or urinary difficulties. Although several drugs can be used to block this flare, patients now have another alternative that avoids the flare altogether.

And yet, a number of questions now arise. First, since so many men get castration therapy and are not at risk for a flare, does it matter if they avoid a short term rise in their testosterone? Second, will men have a longer survival if they avoid the flare? Third, will survival be increased when degarelix is combined with an anti-androgen? And lastly, if men are going to go on intermittent hormone therapy, will they be better off by avoiding mini-flares each time the drug is restarted? Hopefully these answers will be forthcoming.

Vitamins are back in the news. Yet another large prospective randomized study was reported looking at the ability of Vitamin E or Vitamin C to prevent prostate cancer. Similar to the recently reported Vitamin E/selenium trial, neither of these vitamins was able to lower the incidence of prostate cancer. Some vitamin proponents suggest that the wrong Vitamin E may have been used and that is why the study failed. Others suggest that the follow-up was just too short. Regardless, these findings are important as yet another example of the need to do proper studies to demonstrate if any supplements have clear cancer benefits rather than rely on anecdotal reports or epidemiological studies.

Another controversy – CyberKnife® radiotherapy is a fast growing alterna-

tive to conventional photon radiation, being promoted without studies demonstrating how the two compare. The *HotSheet* article addresses the concern about inconsistent policies by Medicare payees around the country with some approving it and others not.

The real question is how much data are needed before a new therapy is adopted. Although there are theoretical reasons why it may be good, it may also not be good enough. Why should the government pay for these treatments until the data are forthcoming? This applies not only to CyberKnife but also to proton beam, HIFU, and even cryosurgery where 10 year survival data are lacking. This is now becoming a political and economic debate rather than a scientific one. Patients will argue that they have right to a new therapy when it becomes available. And yet, that may be a very difficult policy to follow in a social environment where 40 million Americans do not have health care and every one of these additional treatments challenge our economy. But why should a new treatment be covered if there is no evidence it delivers better results or is safer for patients?

Do you have prostate cancer or not? That is the subject of another report in this *HotSheet* in which men with an elevated PSA and a negative biopsy underwent ‘saturation’ biopsies with 40 specimens taken per patient. The study found nearly 40% had cancer and the authors suggest that this may be the best approach to determine if cancer is present.

This finding is likely to further stir the debate about over-detection of prostate cancer. Autopsy studies show that by age 50 at least 30% have microscopic cancer which increases to over 50% by age 80. The vast majority of these are not dangerous and do not need treatment. So, should we try to find every last man with some cancer cells? Will this be helpful or not? Does every man needing a prostate biopsy really need a saturation technique? And why only 40 needles, why not 50 or even 60 so every last case can be diagnosed? This article is likely to fuel this debate even further, with no answers on the horizon.

VITAMIN C OR E DO NOT REDUCE THE RISK OF PROSTATE CANCER OR OTHER CANCERS

In a major cancer prevention study, long-term supplementation with vitamin E or C did not reduce the risk of prostate or other cancers for nearly 15,000 male physicians researchers reported online in the *Journal of the American Association (JAMA)*.

In some observational studies, intake or blood levels of vitamins E and C have been associated with reduced risk of certain cancers. “A number of trials have addressed the potential role of vitamins in the prevention of cancer; however, the results from these trials have not been consistent” the authors write. Despite uncertainty about the long-term health effects or benefits, more than half of US adults take vitamin supplements, and vitamins E and C are among the most popular.

J. Michael Gaziano, MD, MPH, of Brigham and Women’s Hospital and VA Boston Healthcare System, Boston, MA and colleagues conducted the Physicians’ Health Study II, a randomized, placebo-controlled trial to examine the effects of vitamin E and vitamin C on prostate cancer and total cancer. Participants were randomized to receive individual supplements of 400 IU of vitamin E every other day and 500 mg of vitamin C daily.

During an average follow-up of 8.0 years, there were 1,943 confirmed total cancer cases and 1,008 prostate cancer cases. Compared with placebo, vitamin E had no effect on the incidence of prostate cancer or total cancer. The researchers also found no significant effect of vitamin C on total cancer or prostate cancer.

Neither vitamin E nor vitamin C had a significant effect on site-specific cancers, including colorectal, lung, bladder and pancreatic cancers. Stratification by various cancer risk factors demonstrated no significant effects of vitamin E on prostate cancer risk or either vitamin on total cancer risk.

“These data provide no support for the use of these supplements in the prevention of cancer in middle-aged and older men,” the authors conclude.

ScienceDaily, 16 December 2008

CHEMOTHERAPY DOES NOT DELAY APPEARANCE OF CASTRATE-RESISTANT PROSTATE CANCER

In men receiving androgen ablation for advanced prostate cancer, the emergence of castrate-resistant disease is not delayed by three cycles of systemic chemotherapy, according to a report in the *Journal of Clinical Oncology* published ahead of print on November 24, 2008.

“Do not assume that Taxotere or any other chemotherapy works in androgen dependent disease,” Dr. Randall E. Millikan advised in comments to *Reuters Health*.

Dr. Millikan from the University of Texas M. D. Anderson Cancer Center, Houston, and colleagues conducted a phase 3 trial in patients with previously untreated metastatic prostate cancer to test the hypothesis that three 8-week cycles of ketoconazole and doxorubicin alternating with vinblastine and estramustine, given in addition to standard androgen deprivation, would delay the appearance of castrate-resistant disease.

Overall, median time to castrate-resistant progression did not differ significantly between the androgen ablation arm (24 months) and the chemohormonal therapy arm (35 months), the researchers report.

Median overall survival was similar for patients in the control arm (5.4 years) and in the chemotherapy arm (6.1 years), the report indicates.

Just over half the patients exposed to chemotherapy had at least one grade 3 adverse event (most of them attributed to treatment), compared with only 9% of the patients in the androgen-ablation control group (with most events considered unrelated to treatment).

“For the present,” the authors conclude, “it is remarkable that more than half a century after its introduction, androgen suppression remains the preferred front-line approach to the treatment of metastatic prostate cancer, and that so far, there is no cytotoxic regimen with clinically relevant activity against hormone-sensitive prostate cancer.”

Reuters Health, 12 December 2008

PROSTATE CANCER DISCOVERED IN 40% OF MEN TESTING NEGATIVE FOR THE DISEASE

Forty percent of men with prostate cancer may not even know they have it, according to a new research study by the Prostate Cancer Foundation of Chicago. The study revealed the standard office biopsy procedure often isn't enough to properly detect prostate cancer. This new research will be published in an upcoming issue of *Urology*, a national medical journal.

Researchers used an advanced biopsy technique called stereotactic transperineal prostate biopsy (STPB). This was performed on patients with persistent elevated prostate specific antigen (PSA) levels who previously had at least one negative office biopsy. All patients had received transrectal prostate biopsies (TRPB), administered by a urologist.

Between April 2004 and January 2008, 747 patients with high PSA levels were studied. All patients had been tested using TRPB at least once and all results had been negative. All patients received the STPB. Biopsy results identified the presence of cancer in 291 (39%) of the patients.

“Men who have negative transrectal biopsies and continue to have elevated PSA levels should consider STPB because 40% will harbor malignancy,” says Michelle Braccioforte, director of research and education for the Prostate Cancer Foundation of Chicago. “Our level of confidence is greatly enhanced with regards to the presence or absence of cancer, and more specifically, the exact location of the cancer within the prostate.”

STPB is performed by taking a median of 40 samples of the prostate through the perineum while the patient is under general anesthesia. Performed as an outpatient procedure, it allows more comprehensive sampling, compared to the transrectal method, which takes fewer samples through the rectum. In addition, by taking more samples during STPB, the exact location of the cancer can be pinpointed.

<EmaxHealth.com>, 16 December 2008

SEEKING NEW MEMBERS FOR THE CIRCLES OF LOVE COMPANIONS & FAMILIES ADVISORY PANEL The Unseen Patient

Prostate cancer is a disease of the patient, the partner or spouse, and the family. While the patient experiences cancer in their body, those closest to the patient have an experience of prostate cancer that is very real. Us TOO's companion and family advisory panel continues to uphold this belief and actively seek opportunities to acknowledge, empower and support companions, partners, spouses and family members of men with prostate cancer.

Are you interested in participating in this vibrant dialog and community? If so, the Us TOO companion and family advisory panel would like to hear from you. We meet for 45-60 minutes via conference call on a quarterly basis, or as needs arise. Please contact Elizabeth at elizabeth@ustoo.org for additional information.

DOCTOR DONALD GLEASON PASSES AWAY AT 88

Dr. Donald Gleason, of Edina, MN, a retired professor of the University of Minnesota School of Medicine, led research at the VA Medical Center in Minneapolis and devised the grading system that doctors around the world use today to determine the proper treatment of prostate cancer.

Gleason, whose system and research underpins continuous research into prostate cancer, died of natural causes 28 December 2008 in Edina. The longtime Richfield resident was 88.

“Worldwide, his system is used annually at least 1 million times – that's the number of people diagnosed with this cancer. In the US alone, about 230,000 are diagnosed with prostate cancer annually,” said Akhouri Sinha, a research scientist who worked with Gleason for 40 years.

Gleason “boiled down the complexities of prostate cancer” to devise his grading system, Sinha said. “His work was comprehensive, yet simple so that the grading system can be used by

(Continued on page 8)

**FREE PSA PREDICTS PROSTATE CANCER WHEN SERUM
PSA 2.5 NG/ML OR LOWER**

Among men with a serum PSA level of 2.5 ng/mL or lower, the percent free PSA is an accurate predictor of prostate cancer at prostate biopsy, according to findings published in the November 15th issue of the journal *Cancer* (Vol. 113, pp. 2695-2703, 2008).

“Recently, urological and oncological associations lowered the recommended total serum PSA (tPSA) cutoff for prostate biopsy from 4 to 2.5 ng/mL,” Dr. Jochen Walz, of Institut Paoli-Calmettes, Marseille, France, and colleagues write. “Up to 17% of men with a PSA level below the accepted prostate biopsy cutoff of 2.5 ng/mL may have prostate cancer.”

The researchers examined the ability of percent free PSA to identify men at an increased risk of prostate cancer, despite tPSA levels no higher than 2.5 ng/mL. They also assessed the pathological characteristics of the cancers detected in this population.

A total of 543 men with a PSA of 2.5 ng/mL or less were referred for initial prostate biopsy between 1999 and 2006. Overall, 125 (23.0%) men in the

entire group and 77 (19.3%) of those with unremarkable digital rectal examination findings had prostate cancer on biopsy.

Seventy-nine of the patients with prostate cancer at biopsy underwent radical prostatectomy. Of these 79 patients, 13 (16.5%) had pathological stage pT3 and 24 (35.6%) had Gleason score of 3 + 4 or higher.

Among patients with percent free PSA below 14%, 59% of the overall group and 49% of those with unremarkable digital rectal examination had prostate cancer. Results of multivariate analysis showed that percent free PSA ($p < 0.001$) and digital rectal examination findings ($p = 0.001$) were the only independent predictors of prostate cancer.

“The routine use of percent free PSA should be strongly recommended in prostate cancer screening or early detection efforts to better risk stratify the probability of prostate cancer at biopsy,” Dr. Walz and colleagues conclude.

Reuters Health, 12 December 2008

DOCTOR GLEASON

(Continued from page 7)

pathologists, clinicians and scientists throughout the world,” said Sinha, a medical school professor who works at the VA Medical Center.

“His achievement remains unparalleled thus far,” Sinha said.

Gleason grew up in Litchfield, MN, and completed his undergraduate work at the University of Minnesota, where he earned his medical degree in 1944 and later earned a PhD in physiology. In the mid-1940s, he served as an Army doctor, and in the 1950s, he became chief of pathology at the VA Medical Center, where he worked until his retirement in 1986.

Among honors he received were the American Urological Association’s Presidential Citation Award and an Outstanding Achievement Award from the University of Minnesota, both in 2001.

He is survived by his wife of 62 years, Nancy, three daughters, and nine grandchildren.

<StarrTribute.com>, Minneapolis-St. Paul, 1 January 2009

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