



PROSTATE CANCER HOT SHEET

Us Too! INTERNATIONAL **MARCH / APRIL 2001**

Us Too! PARTICIPANTS CRITICAL TO SUCCESS OF 2000/01 PC-SPES SURVEY

BY PAUL ANDERSON

I want to thank all of you who participated in the *Us Too!* 2000/01 PC-SPES Survey. It involved those of us who have been taking PC-SPES from six months to over four years. We had our highest number of participants in three years.

As you read over the results, should you have questions relating to interpretation, content, or questions relating specifically to your stage of PC, please give me a call at (1-888-784-0399) and we'll be happy to clarify it for you. If you received a survey and **didn't** fill it out and return it to *Us Too!* this year, please endeavor to participate next year. The more people we have reporting, the more meaningful the survey will become, and we will all benefit from it.

RESULTS OF THE *Us Too!* 2000/01 PC-SPES SURVEY

SUMMARY

Surveys received	168
Surveys recorded	137
Surveys not recorded	31
(Incomplete, erratic dosage, etc.)	

- 128 (93%) Positive experience (PSA reduced or stable).
- 9 (7%) Negative experience (PSA reduced and then rose over time).
- 67 (49%) had PSA readings below 2 after taking PC SPES 6 months to 4 years.
- When first diagnosed with prostate cancer before any treatment 52 (43%) had PSA levels below 10.
- 35 (27%) followed watchful waiting (no treatment) before taking PC SPES.
- The two primary side effects when taking PC SPES were gynomastia (tender and enlarged breasts) and reduction in libido.

- Of 168 responses, 11 embolisms occurred (6.5%) over a six-month to four-year period (8 leg surface veins, 1 leg deep vein, 1 foot, 1 lung). 5 were carried over from previous years. 10 of the 11 have resumed taking PC SPES after treatment.
- When rating quality of life (10 best, 1 worst), 71% indicated levels of 7 and higher. 20% recorded levels of 10.
- The age of 78% of respondents was in the 60 to 79 year range.

TABLE 1

PSA AFTER 6 MONTHS TO 4 YEARS		
PSA	RESPONDENTS	% OF TOTAL
Below 1	46	35.0%
Below 2	21	13.5%
Below 3	6	4.0%
3 to 4	15	11.0%
5 to 9	19	13.5%
10 to 20	10	6.0%
21 to 30	0	0.0%
31 to 40	4	3.0%
Over 41	16	13.0%
	137	100.0%
49% below 2		

TABLE 2

PSA at Diagnosis		
PSA	RESPONDENTS	% OF TOTAL
0 to 4	15	13.0%
5 to 9	41	32.0%
10 to 19	25	20.5%
20 to 29	7	6.0%
30 to 49	9	5.0%
50 to 99	9	6.0%
100+	10	7.0%
200+	3	2.5%
300+	2	1.5%
400 to 600	3	2.5%
700 to 1,000	3	2.5%
Over 1,000	2	1.5%
	129	100.0%
43% below 10		

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Us Too! LOSES A FOUNDER

VinceYoung was born in Chicago on August 20, 1916, the fourth of six children of Edwin and Agnes Young. Growing up on Chicago's South Side, he was a graduate of Calumet High School.

A good-natured perfectionist whose family construction company built and rehabbed Chicago Public Schools from the 1930s to the 1960s, and then did the same at the University of Chicago Hospitals died on December 23, 2000. He had suffered a heart attack the week before.



**VINCENT EDWIN YOUNG
1916 - 2000**

He became a skilled carpenter early in his career, joining his father and two of his brothers during the 1930s in Young and Sons Construction Company. In later years he headed the company, retiring in 1996 after almost 60 years. Vince supervised or helped build intricate projects at Chicago Vocational and Dunbar High Schools, doctors' offices and operating rooms at the University of Chicago, and the entranceway to the U. of C.'s Mitchell Hospital during his career. The long hours

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CLINICAL TRIALS

Us Too! has agreements with two of the internet's leading clinical trials databases: VeritasMedicine (www.veritasmedicine.com) and HopeLink (www.hopelink.com). A recent search found the following clinical trials.

To learn more about the trials listed here, including detailed information about the treatment protocol used, and specific contact information for enrollment, simply visit the Us Too! website (www.ustoo.org) and click on the appropriate clinical trials banner.

KEEP THIS LIST AS A REFERENCE.

Updates published in future HotSheets.



- 1) A Pharmacokinetic Study of Genistein, a Tyrosine Kinase Inhibitor
- 2) A Safety and Feasibility Study of Active Immunotherapy in Patients with Metastatic Prostate Carcinoma Using Autologous Dendritic Cells Pulsed with Antigen Encoded in Amplified Autologous Tumor RNA

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- 3) Androgen Suppression Plus Radiation Therapy in Treating Patients With Prostate Cancer
- 4) Arsenic Trioxide in Treating Patients With Stage IV Prostate Cancer That Has Not Responded to Previous Hormone Therapy
- 5) Brachytherapy in Treating Patients With Recurrent Prostate Cancer
- 6) Broxuridine Plus Surgery in Treating Patients With Stage I or Stage II Prostate Cancer
- 7) Calcitriol in Treating Patients With Prostate Cancer
- 8) Capecitabine in Treating Patients With Metastatic Prostate Cancer That Has Not Responded to Hormone Therapy
- 9) Chemotherapy and Hormone Therapy in Treating Patients With Prostate Cancer
- 10) Chemotherapy in Treating Patients With Prostate Cancer
- 11) Chemotherapy Plus Hormone Therapy Versus Androgen Suppression in Treating Patients With Metastatic or Unresectable Prostate Cancer
- 12) Combination Chemotherapy in Treating Pain in Patients With Hormone Refractory Metastatic Prostate Cancer
- 13) Combination Chemotherapy in Treating Patients With Advanced Prostate Cancer
- 14) Combination Chemotherapy in Treating Patients With Prostate Cancer That Has Not Responded to Hormone Therapy
- 15) Combination Chemotherapy Plus Filgrastim in Treating Patients With Stage IV Prostate Cancer That Has Not Responded to Hormone Therapy
- 16) Combination Chemotherapy With Ketoconazole in Treating Patients With Prostate Cancer
- 17) Combination Chemotherapy With or Without Peripheral Stem Cell Transplantation in Treating Patients With Prostate Cancer
- 18) Combination Hormone Therapy Followed by Radiation Therapy in Treating Patients With Prostate Cancer
- 19) Combination Therapy in Treating Patients With Advanced Prostate Cancer That Has Not Responded to Hormone Therapy
- 20) Computer Planned Radiation Therapy in Treating Patients With Stage I or Stage II Prostate Cancer
- 21) Cyproterone Acetate in Treating Hot Flashes Following Surgical or Chemical Castration for Prostate Cancer
- 22) Diet and PSA Levels in Patients With Prostate Cancer
- 23) Docetaxel in Treating Patients With Stage II or Stage III Prostate Cancer
- 24) Doxorubicin Plus Estramustine in Treating Patients With Metastatic Prostate Cancer
- 25) EF5 Prior to Surgery or Biopsy in Patients With Breast, Prostate, or Cervical Cancer or High Grade Soft Tissue Sarcoma
- 26) Effect of Androgen Suppression on Bone Loss in Patients With or Without Bone Metastases Secondary to Prostate Cancer
- 27) Estramustine, Docetaxel, and Carboplatin in Treating Patients With Prostate Cancer That Has Not Responded to Hormone Therapy
- 28) External-Beam Radiation Therapy Plus Implanted Radiation Therapy in Treating Patients With Prostate Cancer
- 29) Gene Therapy in Treating Patients With Cancer
- 30) Genistein in Treating Patients With Stage III or Stage IV Prostate Cancer
- 31) Green Tea Extract in Treating Patients With Metastatic Prostate Cancer That Has Not Responded to Hormone Therapy
- 32) Hormone Therapy and Radiation Therapy in Treating Patients With Prostate Cancer
- 33) Hormone Therapy in Treating Men With Stage IV Prostate Cancer
- 34) Hormone Therapy in Treating Patients Who Have Stage I or Stage II Prostate Cancer
- 35) Hormone Therapy in Treating Patients With Advanced Prostate Cancer
- 36) Hormone Therapy in Treating Patients With Prostate Cancer
- 37) Hormone Therapy in Treating Patients With Rising PSA Levels Following Radiation Therapy for Prostate Cancer
- 38) Hormone Therapy Plus Radiation Therapy in Treating Patients With Prostate Cancer
- 39) Hormone Therapy Plus Radiation Therapy With or Without Combination Chemotherapy in Treating Patients With Prostate Cancer
- 40) Hormone Therapy With or Without Mitoxantrone and Prednisone in Treating Patients Who Have Undergone Radical Prostatectomy for Prostate Cancer
- 41) Hormone Therapy With or Without Surgery or Radiation Therapy in Treating Patients With Prostate Cancer
- 42) Hydrocortisone Plus Aminoglutethimide or Ketoconazole in Treating Patients With Localized Stage IV Prostate Cancer
- 43) Hyperthermia Plus Radiation Therapy in Treating Patients With Nonmetastatic Advanced Prostate Cancer
- 44) Leuvectin Followed By Surgery in Treating Patients With Stage II or Stage

- III Prostate Cancer
- 45)Leuvectin in Treating Patients With Locally Recurrent Prostate Cancer
- 46)Low, Intermediate, or High Dose Suramin in Treating Patients With Hormone-Refractory Prostate Cancer
- 47)Mitoxantrone and G-CSF in Treating Patients With Metastatic Prostate Cancer
- 48)Mitoxantrone and Prednisone With or Without Leflunomide in Treating Patients With Stage IV Prostate Cancer
- 49)Monoclonal Antibody Therapy in Treating Patients With Kidney or Prostate Cancer
- 50)Monoclonal Antibody Therapy in Treating Patients With Prostate Cancer
- 51)Nitrocaptoprothecin in Treating Patients With Stage IV Prostate Cancer That Has Not Responded to Hormone Therapy
- 52)Paclitaxel and Bryostatins 1 in Treating Patients With Metastatic Prostate Cancer
- 53)Paclitaxel Plus Estramustine in Treating Patients With Metastatic Prostate Cancer
- 54)Pain Control in Patients With Recurrent or Metastatic Breast or Prostate Cancer
- 55)Peripheral Stem Cell Transplantation and White Blood Cell Transfusions in Treating Patients With Refractory Metastatic Solid Tumors
- 56)PET Scan in Treating Patients With Metastatic Prostate Cancer
- 57)Photodynamic Therapy With Lutetium Texaphyrin in Treating Patients With Locally Recurrent Prostate Cancer
- 58)Prostatectomy Compared With Watchful Waiting in Treating Patients With Stage I or Stage II Prostate Cancer
- 59)PSA Vaccine or Nilutamide to Treat Advanced Prostate Cancer
- 60)PSA-Based Vaccine and Radiotherapy to Treat Localized Prostate Cancer
- 61)R115777 in Treating Patients With Progressive, Metastatic Prostate Cancer That Has Not Responded to Hormone Therapy
- 62)Radiation Therapy in Treating Patients With Bone Metastases From Breast or Prostate Cancer
- 63)Radiation Therapy in Treating Patients With Prostate Cancer
- 64)Radiation Therapy in Treating Patients With Stage I, Stage II, or Stage III Prostate Cancer
- 65)Radiation Therapy Plus Amifostine in Treating Patients With Primary Prostate Cancer
- 66)Radiation Therapy With Androgen Suppression in Treating Patients With Prostate Cancer
- 67)Radiation Therapy With or Without Antiandrogen Therapy in Treating Patients With Prostate Cancer
- 68)Radiation Therapy With or Without Bicalutamide in Treating Patients With Stage II, Stage III, or Recurrent Prostate Cancer
- 69)Standard Therapy With or Without Dalteparin in Treating Patients With Advanced Breast, Lung, Colorectal, or Prostate Cancer
- 70)SU5416 Compared to Dexamethasone in Treating Patients With Progressive Prostate Cancer That Has Not Responded to Hormone Therapy
- 71)Surgery in Treating Patients With Prostate Cancer
- 72)Testosterone in Treating Patients With Progressive Prostate Cancer That No Longer Responds to Hormone Therapy
- 73)Thalidomide for the Treatment of Hormone-Dependent Prostate Cancer
- 74)Trastuzumab and Docetaxel in Treating Patients Who Have Metastatic Prostate Cancer That Is Refractory to Hormone Therapy
- 75)Trastuzumab in Treating Patients With Prostate Cancer
- 76)Trastuzumab Plus R115777 in Treating Patients with Advanced or Metastatic Cancer
- 77)Ultrasound in Treating Patients With Recurrent Stage I or Stage II Prostate Cancer
- 78)Vaccine Therapy in Treating Patients With Advanced Prostate Cancer
- 79)Vaccine Therapy in Treating Patients With Metastatic Prostate Cancer
- 80)Vaccine Therapy in Treating Patients With Metastatic Prostate Cancer That Has Not Responded to Hormone Therapy
- 81)Vaccine Therapy Plus QS21 in Treating Patients With Progressive Prostate Cancer
- 82)Vinorelbine Plus Paclitaxel in Treating Patients With Metastatic Prostate Cancer That Is Refractory to Hormone Therapy
- 6. Phase I Randomized Study of Genistein for Prevention of Cancer in Patients With No History of Cancer or With Asymptomatic Early Prostate Cancer or Other Malignancy
- 7. Phase I Randomized Study of Genistein in Patients With Stage III or IV Prostate Cancer
- 8. Phase I Study of 3-Dimensional Conformal Radiotherapy in Patients With Locally Advanced (Stage T2c and T3) Adenocarcinoma of the Prostate
- 9. Phase I Study of Calcitriol in Patients With Prostate Cancer
- 10. Phase I Study of Docetaxel, Estramustine, Mitoxantrone, and Prednisone in Patients with Advanced Prostate Cancer
- 11. Phase I Study of Doxorubicin/ Estramustine in Hormone-Refractory Metastatic Prostate Cancer
- 12. Phase I Study of Estramustine, Docetaxel, and Carboplatin in Patients With Hormone Refractory Prostate Cancer
- 13. Phase I Study of Lycopene for the Chemoprevention of Prostate Cancer
- 14. Phase I Study of Monoclonal Antibody ABX-EGF in Patients With Renal or Prostate Cancer
- 15. Phase I Study of Photodynamic Therapy With Lutetium Texaphyrin in Patients With Locally Recurrent Prostate Adenocarcinoma
- 16. Phase I Study of R115777 and Trastuzumab (Herceptin) in Patients With Advanced or Metastatic Adenocarcinoma
- 17. Phase I Study of Recombinant Human Interleukin-12 in Refractory Advanced Stage Ovarian Cancer and Other Abdominal Carcinomas
- 18. Phase I Study of Recombinant Prostate Specific Membrane Antigen (rPSMA) Pulsed Autologous Dendritic Cells (CaPVax) in Patients With Metastatic Hormone Refractory Prostate Cancer
- 19. Phase I Study of T Cells Activated In Vitro and Modified with Chimeric Anti-CEA Immunoglobulin T Cell Receptors (Ig TCR) and Reinfused in Patients with CEA Expressing Adenocarcinomas
- 20. Phase I Study of Testosterone in Patients With Progressive Androgen Independent Prostate Cancer
- 21. Phase I Study of the Etanidazole Derivative EF5 for the Detection of Hypoxia in Patients With Breast, Prostate, or Cervical Carcinoma or High Grade Soft Tissue Sarcomas
- 22. Phase I Study of Thompson-Friedenreich [TF(c)]-Keyhole Limpet Hemocyanin (KLH) Conjugate Plus Adjuvant QS21 in Patients with Progressive Prostate Cancer
- 23. Phase I/II Dose-Escalation Study of 3-Dimensional Conformal Radiotherapy for Stages I-III Adenocarcinoma of the Prostate



- 1. A 16-Year Randomized Screening Study for Prostate, Lung, Colorectal, and Ovarian Cancer - PLCO Trial
- 2. Genetic Mapping of Interactive Susceptibility Loci in Patients and Siblings with Breast, Colon, Lung, or Prostate Cancer
- 3. Genetic Study of Familial Prostate Cancer
- 4. Identification of Men Under Age 55 w/ a Genetic Predisposition to Prostate Cancer
- 5. NCI HIGH PRIORITY CLINICAL TRIAL — Phase III Randomized Study of Prostatectomy vs Expectant Observation with Palliative Therapy for Stage I/II Prostate Cancer (PIVOT)
- 6. Phase I Randomized Study of Genistein

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PROSTATE CANCER NEWS

News items contained in the *Us Too!* HotSheet are obtained from various news sources and edited for inclusion. Where available, a point-of-contact and phone number/website address is provided.

All references to persons, companies, products or services are provided for information only, and are not endorsements. Readers are encouraged to conduct their own research into any person, company, product or service, and consult with their personal physician before deciding upon any course of action.

NEW VA HOTLINE FOR AGENT ORANGE

Vietnam veterans now have a new national toll-free helpline to answer their questions about Agent Orange exposure, health care and benefits. The new helpline — 800-749-8387 — is part of the continuing efforts of the Department of Veterans Affairs (VA) to reach America's 2.3 million Vietnam veterans. Callers can speak directly to VA representatives Monday through Friday from 8 a.m. to 4 p.m., Central Standard Time, or access a 24-hour automated system. They can leave voice mail messages to have information sent to them or listen to recordings about exposure to Agent Orange, VA benefits, health care and disability compensation. VA now recognizes 10 medical conditions as being associated with Agent Orange. It has been linked to a variety of health problems, ranging from rare conditions and certain birth defects in veterans' offspring to diseases that are somewhat common in middle age, such as prostate cancer and adult-onset diabetes.

MEN DON'T TALK TO THEIR SONS ABOUT CANCER

(2dayuk March 28, 2001)

Men don't talk to their sons or siblings about cancer because they respect the need for "privacy" according to new research. Communication between male family members is "minimal" which is worrying when the cancer has a genetic base. Medical sociologist Clare Moynihan, who carried out the research, said new ways must be found of getting men to share information. She added: "This is of major importance as determining the risk of a man get-

ting a genetic cancer, such as prostate or testicular, relies heavily on families talking to each other." The study found knowledge among men about prostate and testicular cancer, two of the most curable forms of the disease, is negligible.

MEN CANNOT IDENTIFY EARLY WARNING SIGNS OF PROSTATE CANCER

A large number of men cannot identify the possible early warning signs of prostate cancer, according to a new poll. Almost four in 10 could not pinpoint the symptoms of the disease that kills more than 10,000 people each year in the UK. The Mori poll, commissioned by the Prostate Cancer Charity, also found that almost a quarter of men surveyed admitted they did not know what the prostate gland did. More than a fifth incorrectly thought that it helped process urine and a similar number wrongly said it opens and closes the bladder.

TEXAS STUDY TO FOCUS ON PCA

(NY Times Syndicate March 13, 2001)
Researchers here hope to enroll 10,000 men in an important new study that seeks to answer some major lingering questions about prostate cancer, the most common cancer to strike males. The goal of the San Antonio-based study is to improve screening and early detection of prostate cancer, identify new biochemical clues to the disease and answer questions about the link between diet and prostate cancer, according to the researchers involved. "Guys are at risk for this disease; your lifetime risk is about one in six," said Dr. Ian Thompson, professor of surgery at the University of Texas Health Science Center and the lead investigator of the study. "Prostate cancer has no symptoms. And it appears that early detection makes a difference."

VOLUME-WEIGHTED MEAN NUCLEAR VOLUME PREDICTS PSA FAILURE IN ORGAN-CONFINED PROSTATE CANCER

Volume-weighted mean nuclear volume [MNV] is a powerful predictor of PSA failure for patients with clinically organ-confined prostate cancer treated with radical prostatectomy, according to a retrospective prognostic study of 71 patients (median age, 67 years) with T1/T2 disease. The researchers estimated MNV by utilizing biopsy specimens obtained by a stereological method. In addition, MNV was compared with other preoperative clinical variables. For patients with PSA failure, the investigators determined the correlation of

MNV with PSA doubling time (PSA DT). The PSA DT was measured by using PSA values obtained with an ultrasensitive assay. None of the patients received adjuvant endocrine therapy until PSA failure, except one patient who had lymph node metastasis and gross positive surgical margins. . . . "MNV can be a useful new parameter for prediction of tumor biology after radical prostatectomy," the authors concluded. "Further study with a larger patient population is needed to elucidate the role of MNV in predicting the tumor biology of prostate cancer."

ITS YOUR LIFE SO MAKE TIME FOR TESTING

(The Record, Bergen County, NJ March 06, 2001) Ask upper- or middle-class men why they have not been screened for prostate or colorectal cancer, and many will say they are simply too busy. The response is no different for those on the bottom economic rung, said Dr. Naipaul Rambaran, a St. Joseph's Hospital and Medical Center physician who performs about 15 free prostate and colorectal screenings a month for the poor under a state grant. "We even go into homeless shelters," said Rambaran, "and it takes a lot of coaxing to get those men to be screened. They have all they can do just to get through the day, but we still work hard to convince them."

SLIGHTLY ELEVATED PSA POINTS TO YEARLY TESTING

(Fax Watch Inc / www.faxwatch.com)
Men with a slightly elevated PSA levels should undergo a yearly PSA test, according to research published in the Feb. 15 issue of *Cancer*. To determine how often patients should be rescreened for prostate cancer "in view of the need to minimize the cost of testing, and to maximize detection of early stage prostate carcinoma," researchers conducted a 10-year study of 8,595 men. The study participants were aged 50 years or older and had PSA levels of 4.0 ng/ml or less. Tumor marker measurement and/or digital rectal examination (DRE) and/or transrectal ultrasonography screening was performed as a first step. Individuals with abnormal findings underwent a prostate biopsy. Among men whose initial PSA levels were lower than 1.0, 1.0-1.9 and 2.0 to 4.0 ng/mL, cancer was detected in 0.18 percent (8 of 4,526), 1.0 percent (27 of 2,724) and 3.6 percent (49 of 1,345), respectively. Among these men with prostate cancer, 75 percent (six of eight) were detected by initial PSA levels less than 1.0, 56 percent (15 of 27) by lev-

els less than 1.0 to 1.9 and 63 percent (31 of 49) by levels less than 2.0 to 4.0. Prostate cancer detection rates within three years following the initial visit were 0.07 percent, 0.24 percent and 1.2 percent in cases with initial PSA levels lower than 1.0, 1.0 to 1.9 and 2.0 to 4.0 ng/mL, respectively. "It is recommended that DRE and PSA measurements should be performed once every three years in individuals with initial PSA levels of less than 1.0 ng/mL," and ... "PSA screening should be performed once every year for individuals with initial PSA levels of 1.0 to 4.0 ng/mL," the researchers concluded.

RESEARCHERS DEVELOP EARLY CANCER DETECTOR

(United Press Intn'l March 23, 2001)
AMES, Iowa — Researchers are developing a new biosensor that could someday allow doctors to detect early indicators of cancer with a simple, inexpensive urine test. Researchers at the U.S. Department of Energy's Ames Laboratory, have created a biosensor technology that works by mounting antibodies (proteins that fight foreign agents and infection in the body) to a gold chip that is then exposed to a urine sample. Depending on their design, the antibodies bind to disease indicators known as adducts. When scientists then apply a laser to the chip at very low temperatures, the adducts, if present, begin to emit light. "This technology essentially could give us an effective way to perform precancer diagnosis for a range of cancers," said Professor Ryszard Jankowiak, a senior scientist at Ames. "With advances in genetics and our increased knowledge about the origin of disease, we now need to exploit that information to screen for disease indicators," said Marc Porter, a project contributor and chemistry professor at Iowa State. "This is basically a development to achieve that goal." Jankowiak said that while the technology is still far from being commercially available, he is working to design antibodies that detect the beginnings of prostate and breast cancer.

STUDY OF MASS SCREENING INDICATES NEED FOR REPEATED TESTING

(NewsRx.com March 09, 2001)

Prostate carcinoma screening is recommended every three years in men age 50 years or older with initial prostate-specific antigen (PSA) levels of <1.0 ng/mL and annually for individuals with initial PSA levels of 1.0-4.0 ng/mL, according to a study published in the February 15, 2001, issue of Cancer. The prostate carcinoma

detection rate increases steadily during the 10 years after the initial screening with little fluctuation, especially in individuals with initial PSA levels between 2.0-4.0 ng/mL. Researchers believe this group of patients has the highest risk of developing prostate carcinoma in the future. When PSA levels are measured during mass screenings for prostate carcinoma, approximately 85%-90% of the participants have PSA levels of <4.0 ng/mL. Information regarding the likelihood of the future development of prostate carcinoma and the appropriate follow-up methods that should be applied to such a large percentage of people is critical to early detection and successful treatment. Three prior studies have reported longitudinal changes in serum PSA levels in men with initial PSA levels <4.0 ng/mL. However, the follow-up periods for all three studies were relatively short. In addition, the appropriate method of follow-up among patients who were not diagnosed with prostate carcinoma during their first visit was not established.

CANCER COUNSELING SERVICES UNDERUSED DESPITE DOCUMENTED BENEFITS

(AScribe Newswire March 08, 2001) Very few cancer patients take advantage of available counseling services, despite a large body of evidence showing such interventions can improve their treatment outcome. "Given the quality and quantity of cancer support services nationwide, and the positive outcomes of participation shown in the research literature, a high priority should be placed on identifying ways to increase patient use of existing services," say the study's co-authors Elizabeth G. Eakin, Ph.D., and Lisa A. Strycker, M.A., of the Oregon Research Institute. They found that although 68 percent of breast, colon and prostate cancer patients reported being aware of their HMO's Cancer Counseling Center, only 8 percent used the center. Ninety percent of prostate cancer patients also were aware of a HMO prostate support group, but only 5 percent made use of these services. . . . The main reasons patients gave for forgoing support services were they already had adequate support (32 percent), followed by not knowing the support services existed (25 percent) and not receiving a recommendation from their physician (13 percent).

FOREWARNED, FOREARMED: THE FACTS ABOUT CANCER SCREENING

(The Record, NJ - March 07, 2001)
When Dr. Dimitris Zouzas examines his patients, he always asks them to remove

their shoes and socks a request that many consider unusual for a dermatologist. "Many tell me it's not necessary, but I tell them to do it anyway because a melanoma can grow anywhere," said Zouzas, referring to the most deadly skin cancer. "The places that people overlook the most are the scalp, the feet, and the toes." For physicians such as Zouzas, who practices in Wayne, periodic cancer screenings are a medical imperative that must be done correctly every time. The risks, as publicized by anti-cancer organizations, are simply too great. . . . A leading reason patients often cite for failing to get screened is that "their doctors didn't tell them to get tested," said Barbara Rimer, director of cancer control and population sciences at the National Cancer Institute. Just ask Ernest Carson, 60, a retired Defense Department analyst who lives in the District of Columbia. Two years ago, after Carson received a clean bill of health from his annual physical, he saw a notice on television for free prostate cancer screening at Georgetown University's Lombardi Cancer Center.

BIOMERICA TO INTRODUCE A 10-MINUTE DISPOSABLE PSA TEST IN JAPAN

(PR Newswire March 12, 2001) NEWPORT BEACH, CA. — Biomerica, Inc. today announced that the Japanese Ministry of Health has approved for distribution and marketing EZ-PSA(TM), the Company's simple and accurate 10-minute disposable screening test designed to detect Prostate Specific Antigen (PSA), an early warning indicator of prostate cancer. The approval follows extensive clinical trials conducted on the product in Japan. The studies were conducted in collaboration with the Departments of Urology at Dokkyo University School of Medicine and Tokyo University, Dai Memorial Hospital, and the Company's marketing partner. The EZ-PSA product is a simple ten-minute disposable test which doctors can use while the patient is in the office. EZ-PSA utilizes an advanced technology that makes it as simple to use as a home pregnancy test. The one-step test requires only a drop of whole blood from a finger prick. The blood is applied to the test device which will indicate within 10 minutes whether the patient's level of PSA is elevated. The key to the treatment of PCa is to detect elevated levels of PSA early, when cure rates are significantly higher.

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**SURVIVOR
PROFILE:**

Jay Keleske

by Bill Eickelberg

Us Too! Regional Director, Wisconsin; and co-facilitator Southeastern Wisconsin Regional Cancer Center, Racine, WI.

Occasionally we find a prostate cancer patient that becomes more than just a support group member. Someone who just seems to get the itch to do more than attend meetings. Such a person is Jay Keleske.

I remember Jay in a Cancer support group 7 years ago, having been through his first round of treatment with a radical prostatectomy, then radiation. Lo and behold open heart surgery was then his challenge. Having been a very successful insurance salesman, Jay headed for help with his feelings. I remember him feeling very depressed but he beat it by continuing to come to support groups.

Jay's other life came to be at the VA hospital when his prostate cancer started to metastasize. As he was being seen as a patient, he started asking questions about how he could learn more. And overnight a new *Us Too!* unit started. He was very instrumental in providing those veterans with prostate information.

He also had further prostate cancer complications, and started a group at MCW Medical College of Wisconsin.

Here is a man that started off very depressed, and came to a prostate cancer support group for help. After attending this group, he discovered a better way to deal with his disease. A prostate cancer group was starting, and a more open, friendly, humorous climate discovered.

Having had open heart surgery and other medical challenges, Jay continued to fight. After all of his prostate cancer treatment, radical prostatectomy, radiation, his cancer was discovered again. By this time he had become affiliated with the Zablocki Veterans Hospital, in Milwaukee, and found that the therapy was helping very much. True to his salesman form, he started talking about a support group. Overnight 2 groups were formed at the hospital, one to take care of the Wednesday clinic patients, and one

to take care of the Thursday people.

More and more programs were brought in. Jay's cancer was getting better or at least kept at bay anyway. After spending three years there, his PSA started to rise to 1300, a very distressing sign. He was deemed a candidate for 3 clinical trials, along with concurrent radiation of the tumor on the spine. Here is a man who, while he was getting treatment, was also providing such a valuable service for his fellow patients. He wasn't even aware of all of the good that he was doing.

It is extremely helpful to have this kind of success when we are going through the patient process, because we do not see the outcome until the treatment is finished. We do however see some patients that have been successful with their treatment, and that gives a lot of encouragement to keep going.



Jay Keleske

I mean not to single out any one person in the group, and hurt the feelings of the other members with this acknowledgement of Jay. Certainly, each one does his/her part for prostate cancer, but I do want to make the point that someday some of us will be faced with the challenge of Prostate Cancer recurrence. For those in our group we observe many younger men that have been fortunate and not have had the cancer spread. We too, have people who are no longer with us, because their cancer cut short their lives.

Some perspective is necessary in reading this article. I too, am faced with a rising PSA, and when I started going to *Us Too!* meetings in Chicago, Joe Palmari used to ask why I was there when most of these people were substantially older than I was. (I was 50 when I had my surgery

and radiation). Age was unimportant. We shared a common bond - fighting prostate cancer!

Seven years later some of our members have rising PSA's, and must make some advanced treatment decisions. These are very difficult, especially those of us who are dating and are with partners that enjoy intimate moments. Many of the advanced treatments will substantially reduce their libido - but are necessary for life!

In conclusion, I would like to commend all prostate cancer patients in support groups, for by being there, ready to help the newly diagnosed patients with some ideas to make better informed treatment decisions. I also know that I receive strength when I work personally with men who have recently been diagnosed, and it gives me some hope for the future.

Such is the case with Jay Keleske, being the salesman that he is, and a man who has chosen his priorities in life. He said to me once, "Don't bother me during fishing season, for I will be gone the entire summer enjoying that important part of my life." The other times we can expect Jay to be talking up *Us Too!* to his doctors. He is now in his second clinical trial in cooperation with the Medical College of Wisconsin and the VA Hospital in Milwaukee. Through that contact and with his burning desire to promote help in the prostate cancer community, he has responded to MCW's interest in establishing another chapter.

Perhaps Jay's place here is to be successful in promoting help for cancer patients, and serve as an advocate and example for all of us to promote *Us Too!*'s support group movement. But he is also a friend to many.

Congratulations Jay! We all thank you for your example on fighting to keep up the support group activity growing.

Jay's last PSA was 1300. We wish him continued success, luck and prayers in his treatment. We know he WON'T give up.

**SHOW YOUR
SUPPORT!**



PCa Awareness stamps are available on-line (Item #448240) at: <http://shop.usps.com>

AACR ANNUAL MEETING NEWS

Many developments in prostate cancer research were presented at the 92nd Annual meeting of the American Association for Cancer Research (AACR) in New Orleans, March 24-28.

1. MGI PHARMA PRESENTS FURTHER DATA ON IROFULVEN'S ANTI-TUMOR ACTIVITY — MGI PHARMA, INC. presented preclinical data which serves as the basis for MGI's plans to expand the clinical development of irofulven in a variety of cancers. In one presentation, complete regressions of hormone-refractory human DU-145 prostate tumors growing in nude mice were reported when irofulven was used in combination with Taxotere(R) (docetaxel). Complete regressions were observed in 17 of 20 animals administered the drugs in combination, whereas Taxotere alone produced no complete regressions and a submaximal dose of irofulven produced complete regressions in two of 10 animals. MGI now plans to initiate a Phase 1 clinical trial to evaluate this promising drug combination in cancer patients. Another investigation reported on the activity of irofulven in combination with other anti-cancer agents in human tumor cell lines and drug-resistant human tumor xenografts. Irofulven combined with taxanes, topoisomerase I inhibitors, mitomycin C, thiotepa, or carboplatin exhibited statistically significant synergistic (or greater than additive) anti-tumor effects. Such activity suggests a basis for possible new clinical investigations. MGI PHARMA's Medical Communications Help Line at 1-800-562-5580 / www.mgipharma.com

2. STUDIES SHOW SUPERGEN'S RUBITECAN HAS ANTI-TUMOR ACTIVITY AGAINST MELANOMA, PROSTATE AND LUNG CANCER. -- SuperGen Inc. announced that its novel drug compound, rubitecan — which is now in the final stages of Phase III clinical testing as an oral therapy against pancreatic cancer — showed anti-tumor activity against melanoma, prostate cancer and lung cancer, in three separate studies. Data from three studies were presented. The first study, under lead investigator Dr. Devasis Chatterjee of Brown University, Providence, R.I., concluded that raf kinase inhibitory protein (RKIP), when added to 9-NC (rubitecan), plays an integral function “in the sensitization of 9-NC responsive

3. CaP CURE-FUNDED STUDY SHOWS THAT LOW CONCENTRATIONS OF HALOFUGINONE 'INHIBIT HUMAN PROSTATE CANCER GROWTH', SUGGESTING 'IT MAY BECOME A SUCCESSFUL AND EFFECTIVE ANTI-CANCER THERAPY' - (PR Newswire March 28, 2001) NEWTON, Mass. — Collgard Biopharmaceuticals Ltd., a privately held company, announced today that low doses of its proprietary lead compound, Halofuginone, caused a four- to five-fold decrease in human tumor weight and volume in SCID mice when administered orally (in the diet) and via injection. The study was made possible, in part, by an award from CaP CURE. “Halofuginone is an extremely potent anti-cancer agent, which works by a novel Panstasis(TM) mechanism of action,” said Mark Pines, Ph.D., Volcani Institute, Rehovot, Israel, the lead investigator and founding scientist of Collgard Biopharmaceuticals. “In this study, we have demonstrated that Halofuginone, given in low concentrations, blocked the synthesis of collagen type I, resulting in the reduction of blood vessel formation to the prostate cancer tumors. These results suggest that Halofuginone may become a successful and effective anti-cancer therapy,” added Dr. Pines, who collaborated with Zelig Eshhar, Ph.D., Weizmann Institute of Science, Rehovot, Israel. This work consequently garnered Dr. Pines and his collaborators a second CaP CURE award. Collgard Biopharmaceuticals Ltd. / www.collgard.com

and resistant prostate cancer cells to apoptosis induction (cell death).” The second study, under lead investigator Dr. Howard Sands of Morrisville, N.C.-based Piedmont Research Center, showed that a proprietary intravenous formulation of 9-NC (rubitecan) had “outstanding antitumor activity against human melanoma xenografts in nude mice. Furthermore, we now are investigating whether the I.V. activity of 9-NC extends to other human tumor xenografts, and how its spectrum of activity compares to that of oral prep.” / 800-353-1075/ www.supergen.com

4. FLAVONOID COMPOUND COULD PREVENT PROSTATE CANCER (Health Media Ltd March 27, 2001 - <http://www.health-news.co.uk>) The research, carried out by scientists at the Mayo Clinic, Minnesota, was presented. Although quercetin has been studied for the past 30 years, and has been proven safe for the treatment of conditions such as gout

and asthma, this is the first time that it has been associated with an effect on prostate cancer. The flavonoid compound, which is found in red wine, tea, green vegetables and citrus fruit, has been shown to inhibit androgen receptors in types of prostate cancer that respond to the hormone. Such an effect could slow or even stop growth of the tumour, says the lead author of the study, Dr Nianzeng Xing. The researchers believe that non-hormonal treatments for prostate cancer could become increasingly important in the future as, despite surgical or radiation therapy to suppress androgens, recurrence is still likely in most men, possibly due to mutations in the androgen receptor.

5. BOOSTING BELIEF THAT FOODS FIGHT CANCER (HealthScout March 27, 2001 - www.HealthScout.com) What you eat just might ward off cancer. Several food ingredients and synthetic vitamins may prevent cell changes associated with a variety of tumors, report a series of new studies which were presented. So far, the evidence indicates that people who eat plenty of fruits and vegetables and only small amounts of animal fat seem to have a lower risk of certain cancers, such as colon, breast and prostate. Formal studies have been mixed on how much difference a meal plan makes. However, the latest findings offer yet more evidence that certain nutrients have anti-cancer properties.

6. LUMICYTE ESCALATES ITS PURSUIT OF EARLY CANCER DETECTION; NEW ALLIANCE DEDICATED TO IMPROVE THE LIVES OF MILLIONS (PR Newswire March 27, 2001) FREMONT, Calif. — LumiCyte, Inc. (Fremont, CA) announced that it is amplifying its efforts to enable the early diagnosis of cancer based on the success of its early investigations. “We are pleased to see so many presentations (14) at the AACR meeting this year involving the application of SELDI biochip technology to the discovery of new protein biomarkers for cancer,” said T. William Hutchens, inventor of the SELDI technology and CEO of LumiCyte. “However,” continued Hutchens, “a much more significant effort is needed to help this important pursuit, and now is the time.” The genomics revolution has resulted in considerable effort to identify genes involved in the predisposition of certain individuals to various cancers. While this work shows great promise, there is an urgent need for routine access to reliable information that signals the actual onset of cancer. To address this need, LumiCyte has developed powerful new

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(AACR News - Continued from Page 7)

protein BioChip products to help map and identify even trace quantities of serum proteins that are altered in association with the early development of cancer. LumiCyte has designed its BioChips to be used beyond the laboratory(TM) where immediate clinical utility can be realized. / www.lumicyte.com

7. NEW CLINICAL DATA CONFIRM ENDOSTATIN'S PHARMACOLOGICAL PROFILE IN CANCER PATIENTS AND EXTEND PRECLINICAL RESULTS PRECLINICAL DATA DEMONSTRATES ENDOSTATIN INTERACTS SYNERGISTICALLY WITH A CURRENT LEADING CHEMOTHERAPY DRUG AND MAY EXERT ITS ANTIANGIOGENIC EFFECTS

EntreMed, Inc. released favorable data from one clinical and two preclinical studies on recombinant human Endostatin, one of its three lead product candidates. This latest round of data comes from three separate studies, which collectively provide important insights into the behavior of the endogenous angiogenesis inhibitor which, in clinical studies reported last fall, was very well tolerated and demonstrated signs of clinical benefit and biological impact on tumor blood supply. "We are pleased with the Endostatin data presented at this conference. The three posters presented today contain data that have potential clinical impact. Through our internal research efforts we continue to build a broader understanding of how Endostatin behaves in the human body. The latest data bolster Endostatin's potential as a therapeutic candidate for a wide variety of cancer patients," said Dr. Edward Gubish, EntreMed's Executive Vice President of Research and Development. A Phase I clinical study at University of Wisconsin Comprehensive Cancer Center, Madison, WI, demonstrated that the pharmacokinetics of Endostatin administered with a daily i.v. are linear and very consistent at all doses. In addition, as the Endostatin circulates through the bloodstream, it undergoes limited degradation. The poster is entitled, "A Phase I and Pharmacokinetic Study of Recombinant Human Endostatin." ABSTRACT INCLUDED: Prostate Specific Antigen, an Anti-Angiogenic Protein Induces Apoptosis in Endothelial Cells / www.entremed.com

8. IMMUNOMEDICS SCIENTISTS INVENT IMPROVED METHOD OF LABELING ANTIBODIES WITH RADIODIODINE FOR CANCER

THERAPY — Immunomedics, Inc. reported an advance made by the Company's scientists in the attachment of iodine-131 (I-131), a potent therapeutic isotope, to antibodies. By using a new peptide-based linking method, degradation of I-131 from the antibody after it is bound to tumor is reduced. This has been one of the major limitations of using I-131-labeled antibodies for cancer therapy. Dr. Gary Griffiths, Executive Director of Chemistry at Immunomedics, explained "these new linkers showed significantly enhanced retention and improved targeting of the I-131-labeled antibody in a human lung cancer growing in mice. This was especially impressive with the use of an internalizing antibody that targets lung, breast, ovarian, and prostate cancers, which we plan to take into clinical trials," he added. "Up to now, most therapeutic antibodies using I-131 have required individualized patient dosing, because the isotope is detached quickly and distributes differently among patients," Dr. Griffiths said. "By improving retention in the tumor, we are hopeful that we have developed a more potent yet safer cancer therapeutic product, although considerably more animal and clinical experimentation is needed before it becomes a viable alternative to our current investigational products," he remarked. / www.Immunomedics.com

9. NEW DATA ON PANZEM DEMONSTRATES ACTIVITY AGAINST A WIDE VARIETY OF CANCERS

EntreMed, Inc. released data from a preclinical study of Panzem (2-Methoxyestradiol), indicating that in addition to significantly reducing the size of primary tumors, Panzem very effectively inhibited the spread of metastatic disease in mice. "Panzem demonstrated dose-dependent antiangiogenic and antitumoral effects, inhibiting the growth of tumor cells and their blood cells. This is significant in that the effects translate across a broad range of tumor types and include both primary and metastatic tumor models," said Dr. Edward Gubish, EntreMed's Executive Vice President of Research and Development. The poster, "2-Methoxyestradiol: An Orally Active Agent in a Broad Range of Primary and Metastatic Tumor Models," is one of five abstracts presented at AACR that have clinical implications for EntreMed's leading drug candidates. / www.entremed.com

10. DISCOVERY OF CANCER CELL STRUCTURE OFFERS NEW TARGETS FOR TREATMENT

-- Scientists have figured out the precise three-dimen-

sional structure of a spot where cancer cells receive growth instructions, a discovery that may speed the development of exquisitely precise new treatments. One of the forces that makes cancer grow rampantly is a substance called insulin-like growth factor, or IGF. Without this hormone, many cancers will shut down and die. Researchers have long understood the importance of IGF but so far have been unable to exploit this knowledge to make new cancer drugs. The obvious strategy is to block the spot that lets IGF get into cells. However, this structure, called a receptor, is extremely similar to another one that serves as the entry point for insulin. / www.amgen.com

11. PROGENICS, CYTOGEN DEVELOP PROSTATE TREATMENT

Progenics Pharmaceuticals, Inc. and Cytogen Corporation have formed a joint venture to develop a treatment for prostate cancer using newly-created human monoclonal antibodies. Both the joint venture — PSMA Development Company LLC — and the successful creation of the human antibodies were announced. The two companies will use Xenomouse(TM) technology from Abgenix Inc. to create the antibodies. The antibodies target prostate-specific membrane antigen (PSMA), a chemical marker abundantly produced by prostate cancer cells. The Progenics-Cytogen joint venture plans to develop three approaches to the use of human monoclonal antibodies: by themselves; beefed up with anti-cancer toxins; or radio-labeled. Directed to the target tumor, the antibodies would sweep out to selectively target PSMA-expressing cancer cells. Compared to surgery or radiation/chemotherapy treatment, a monoclonal treatment is expected to be much less invasive and have comparatively minimal side effects. / www.progenics.com

ABOUT AACR: The American Association for Cancer Research is a scientific society of over 15,000 laboratory and clinical cancer researchers, was founded in 1907 to facilitate communication and dissemination of knowledge among scientists and others dedicated to the cancer problem; to foster research in cancer and related biomedical sciences; to encourage presentation and discussion of new and important observations in the field; to foster public education, science education, and training; and to advance the understanding of cancer etiology, prevention, diagnosis, and treatment throughout the world. For more information visit www.aacr.org

(PC SPES - continued from P.1)

TABLE 3

DOSAGE PER DAY

Pills per Day	Respondents
1 Pill	1
2 Pills	11
3 Pills	20
4 Pills	17
5 Pills	7
6 Pills	42
7 Pills	6
8 Pills	1
9 Pills	21
10 Pills	1
12 Pills	7

134 Reporting

TABLE 4

SIDE EFFECTS

(Some respondents reported 2 or more)

Tender Breasts	Most
Leg Cramps	31
Diarrhea	3
Low Libido	Most
Nausea	3
Lost Appetite	2
Fatigue	3
No Side Effects	23

137 Reporting

TABLE 5

EMBOLISMS (BLOOD CLOTS)

Location	Respondents
Leg	9 (8 surface veins - 1 deep vein)
Foot	1
Lung	1 (clot in one lung)

Of 11 embolisms, (6.5%) 5 were carried over from previous years.

There are no known fatalities when taking PC SPES

10 of the 11 are continuing to take PC SPES after treatment

TABLE 6

SEX DRIVE

(SCORING: 10 BEST, 1 WORST)

Rating	Respondents	% of Total
1	88	65.0%
2	23	17.0%
3	10	7.0%
4	4	3.0%
5	6	5.0%
6	2	1.5%
7	2	1.5%
8	1	1.0%

136 Reporting 100.0%
10 taking Viagra

TABLE 7

AGE OF RESPONDENTS

Age	Respondents	% of Total
40-49	1	1%
50-59	17	11%
60-69	48	34%
70-79	59	44%
80-89	13	10%

137 Reporting 100%

TABLE 8

QUALITY OF LIFE (SCORING: 10 BEST, 1 WORST)

Level	Respondents	% of Total
10	24	19%
9	19	15%
8	33	26%
7	13	10%
6	9	7%
5	24	19%
4	1	1%
3	2	2%
2	1	1%
1	0	0%

126 Reporting 100%

71% are 7 and higher - feeling well

TABLE 9

TREATMENTS BEFORE PC-SPES

Treatments	Respondents
W.W.	35
RP	19 (2 negative)
RT	14 (1 negative)
CHT	22 (1 negative)
Orch	4
Brachy	3
RT-CHT-Chemo	1
RT-CHT	6 (1 negative)
RT-Cryo-Brachy	1
RT-CHT-Cryo	1
RT-Chemo	1 (1 negative)
RT-Brachy	1 (1 negative)
RP-RT	6
RP-CHT	2
RP-RT-CHT	2
Orch-CHT	3
Orch-RT-CHT	1
Orch-Brachy	1
Orch-RT	2
CHT-Chemo	3

129 Reporting

Legend

WW – Watchful Waiting
 RP – Radical Prostatectomy
 RT – Radiation Therapy
 CHT – Combined Hormone Therapy
 Orch – Orchiectomy (castration)
 Brachy - Brachytherapy (seeds)
 Cryo – Cryosurgery (freeze)
 Chemo – Chemotherapy
 Negative – PSA reduced then rose over time

REMEMBER: This information is provided for information only. *Us Too!* does not endorse any treatment or distributor. For more information about PC-SPES and/or alternate distributors for this product contact:

Botanic Lab (1-800-242-5555)
 www.Botaniclab.com

or an alternate PC SPES website such as: www.pc-spes.com

ALWAYS CONSULT WITH YOUR PERSONAL PHYSICIAN BEFORE TAKING ANY MEDICATIONS AND/OR DIETARY SUPPLEMENTS.



ABOUT: Paul Anderson

Paul is a prostate cancer survivor since 1986. At that time Dr. Patrick Walsh at Johns Hopkins removed his prostate and all was well for 9-1/2 years. Surprisingly, my PSA started to rise, slowly at first and then faster. Then a miracle happened. Hank Porterfield, Us Too! Chairman learned about PC SPES and initiated a study group of 12 prostate cancer survivors, of which Paul was one. Taking various numbers of pills, 10 out of 12 had dramatically positive results. Three to four years later, all 10 survivors have PSA readings at very low levels - 9 are below 1.0. Paul's PSA remains undetectable.

For over three years, Paul has given PC SPES presentations to prostate cancer survivor groups on a volunteer basis. In the fall of 1999, Botaniclab executives thought it was a good idea for him to become a distributor of PC SPES and some of their other herbal supplements. Paul graciously provides counseling, one on one, to those interested in PC-SPES. You can reach him at 1.888.784.0399.

**QUARTERLY JOURNAL
REVIEW - Q1 2001**

The following prostate cancer related articles have appeared in well-known scientific journals. Abstracts only have been posted at the US TOO! website (www.ustoo.org). US TOO! cannot provide copies of the complete article.

TO OBTAIN A COPY OF THE ARTICLE: take the citation to your local public or hospital library. The librarian can assist you in obtaining a copy of the article from their collection or from interlibrary loan.

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**VINCE YOUNG
(continued from Page 1)**

Mr. Young put in during that time apparently set the pace for him throughout his life, said Mr. Young's son, James. Mr. Young retired in 1995, handing the business over to son, Richard, who died two months ago.

"No matter what it was, he was able to complete a project. It was very high quality," said Ron O'Drobinak, project manager at the U. of C. Hospitals, who added "Mr. Young definitely had his heart and soul into it."

Mr. Young paid extraordinary attention to details while on job sites, and expected the same drive from employees. Along the way, his work in specialized construction became much sought after by Institutions and culminated in his relationship with U. of C. Hospitals.

Off the job Vince was a man who enjoyed light moments. He was also as outgoing as a showman, an amateur pianist almost as widely known for his ability to tickle the ivories as for his proficiency in erecting buildings. His lifelong interest in music led him to play the piano for many social and church groups.

For years he played the piano at weekly Kiwanis club meetings and, at the Mitchell Hospital at the University of Chicago, where, after finishing the grand marble entrance and lobby in the mid-1980's, he donated a piano, and then came to the lobby every Tuesday until 1996 to play it for an hour for the enjoyment of patients, and staff.

Vince was a prostate cancer survivor and a founding member and member of the Board of Directors of *Us Too!* International.

Always generous, Vince was a member of the Hyde Park, IL Kiwanis chapter, served as president of the South Side Swedish Club in 1957, was a trustee of the Cancer Foundation at the University of Chicago, a board member of the Covenant Benevolence Community's Bjorklund House, an enabling residence for disabled adults, and was recently named an honorary vice president of the Indiana Society of Chicago.



**VINCE YOUNG
tickles the ivories for an
appreciative audience**

Throughout his life he was active in church, both at Trinity Covenant Church in Oak Lawn, IL and in Bethany Beach, Michigan.

The son of Swedish Immigrants, he grew up in the South Shore neighborhood and was a 1934 graduate of Calumet High School, where he met Leona Jane Birney; she became his sweetheart and they were married in 1938.

In addition to his wife and son James, Mr. Young is survived by two daughters, Patricia Johnson and Barbara Styles; another son, Eric; four grandchildren; and five great-grandchildren. His son Richard preceded Vince in death October 11, 2000.

He will continue to be remembered by family and friends as truly being - **Young at Heart.**

(CLINICAL TRIALS - Continued from Page 3)

24. Phase I/II Study of Active Immunotherapy With Prostate Specific Antigen RNA Pulsed Autologous Dendritic Cells in Patients With Metastatic Prostate Cancer
25. Phase I/II Study of Estramustine, Vinorelbine, and Paclitaxel in Patients with Advanced Cancers or Metastatic PCa
26. Phase I/II Study of Interstitial Colloidal Phosphorus P32 and Macroaggregated Albumin in Patients With Locally Recurrent Prostate Cancer That Has Failed Conventional Therapy
27. Phase I/II Study of Leuvectin in Patients With Locally Recurrent Organ Confined Prostate Cancer Following Radiotherapy
28. Phase I/II Study of Mitoxantrone with Filgrastim (G-CSF) Support in Patients with Metastatic, Hormone Refractory Prostate Cancer
29. Phase I/II Study of Weekly Intravenous Estramustine in Combination With Paclitaxel & Carboplatin in Patients With Advanced Prostate Cancer
30. Phase II Neoadjuvant Randomized Study of Short and Protracted Hormonal Therapy Prior to Radiotherapy In Patients with Stage I-IV Localized Prostate Cancer
31. Phase II Pilot Study of Neoadjuvant Docetaxel in Patients With High Risk Stage II or III Prostate Cancer
32. Phase II Randomized Study of Docetaxel and Estramustine Versus Busulfan and Thiotepa With Autologous Peripheral Blood Stem Cell Transplantation in Patients With Hormone Refractory Metastatic Prostate Cancer
33. Phase II Randomized Study of Docetaxel With or Without Thalidomide in Patients With Androgen Independent Metastatic Prostate Cancer
34. Phase II Randomized Study of High Dose Ketoconazole With or Without Alendronate Sodium in Patients with Androgen Independent Metastatic Adenocarcinoma of the Prostate
35. Phase II Randomized Study of Mitoxantrone, Estramustine, and Vinorelbine Versus Isotretinoin, Interferon alfa, & Paclitaxel in Patients w/ Metastatic Hormone Refractory Prostate Cancer
36. Phase II Randomized Study of Paclitaxel, Etoposide, and Estramustine Versus Ketoconazole, Doxorubicin, Vinblastine, and Estramustine in Patients With Androgen Independent Prostate Cancer
37. Phase II Randomized Study of Radiotherapy With or Without Vaccine Containing Recombinant Vaccinia Prostate Specific Antigen (PSA) and rV-B7.1 Plus Recombinant Fowlpox PSA Vaccine in Patients With Localized Prostate Cancer
38. Phase II Randomized Study of Recombinant Fowlpox Prostate Specific Antigen (PSA) Vaccine and Recombinant Vaccinia PSA Vaccine in Patients With Advanced Adenocarcinoma of the Prostate
39. Phase II Randomized Study of SU5416 Versus Dexamethasone in Patients With Hormone Refractory Prostate Cancer
40. Phase II Randomized Study of Vaccine Containing Recombinant Vaccinia Prostate Specific Antigen (PSA) Admixed With rV-B7.1 Plus Recombinant Fowlpox PSA Vaccine, Sargramostim (GM-CSF), and Interleukin-2 Versus Nilutamide Alone in Patients With Hormone Refractory Prostate Cancer
41. Phase II Study Doxorubicin and Cyclophosphamide With Sequential Docetaxel in Patients With Chemotherapy Naive Hormone Refractory Adenocarcinoma of the Prostate
42. Phase II Study of Amifostine Plus Fractionated Radiotherapy for Primary Prostate Adenocarcinoma
43. Phase II Study of Androgen Deprivation Followed by Three Dimensional Conformal External Beam Radiotherapy and Continued Androgen Deprivation in Patients w/ Adenocarcinoma of the Prostate
44. Phase II Study of Antineoplaston A10 and AS2-1 Capsules for Stage III or IV Adenocarcinoma of the Prostate
45. Phase II Study of Antineoplastons A10 and AS2-1 Capsules with Total Androgen Blockade in Patients with Stage III or IV Adenocarcinoma of the Prostate
46. Phase II Study of Antineoplastons A10 and AS2-1 in Patients with Metastatic, Hormone Refractory Adenocarcinoma of the Prostate
47. Phase II Study of Antineoplastons A10 and AS2-1 in Patients with Refractory Stage IV Adenocarcinoma of the Prostate
48. Phase II Study of Arsenic Trioxide in Patients With Advanced Hormone Refractory Prostate Cancer
49. Phase II Study of Broxuridine in Patients w/ Stage I or II Prostate Cancer
50. Phase II Study of Capecitabine in Patients With Metastatic Hormone Refractory Prostate Cancer
51. Phase II Study of Docetaxel Plus Estramustine in Combination With Androgen Deprivation Therapy in Patients With PSA Elevation Following Radiotherapy or Radical Prostatectomy for Early Prostate Cancer
52. Phase II Study of DX-8951f in Patients w/ Hormone Refractory Prostate Cancer
53. Phase II Study of Endorectal MRI for Prediction of Biochemical Control of Prostate Cancer Following Radiotherapy with Androgen Suppression
54. Phase II Study of Estramustine, Docetaxel, and Carboplatin With Filgrastim (G-CSF) Support in Patients With Hormone Refractory Prostate Cancer
55. Phase II Study of Flutamide and Finasteride in Patients with Elevated Serum PSA After Radiation Therapy or Radical Prostatectomy for Adenocarcinoma of the Prostate
56. Phase II Study of Green Tea Extract in Patients With Androgen Independent Metastatic Prostate Cancer
57. Phase II Study of Hyperthermia and Radiotherapy for Locally Advanced Adenocarcinoma of the Prostate
58. Phase II Study of Mitoxantrone in Combination With Vinorelbine as First Line Therapy in Patients With Metastatic Hormone Refractory Adenocarcinoma of the Prostate
59. Phase II Study of Neoadjuvant Leuvectin Followed by Retropubic Prostatectomy in Patients With Stage II or III Prostate Cancer
60. Phase II Study of Nitrocaptopotecin in Patients With Stage IV, Hormone Refractory Prostate Cancer
61. Phase II Study of Nonmyeloblastic Allogeneic Peripheral Blood Stem Cell and Donor Lymphocyte Infusions in Patients with Refractory Metastatic Solid Tumors
62. Phase II Study of Paclitaxel & Bryostatins I in Patients w/ Hormone Refractory Metastatic Adenocarcinoma of the Prostate
63. Phase II Study of Paclitaxel Plus Estramustine in Patients with Metastatic Hormone Refractory Prostate Cancer
64. Phase II Study of R115777 in Patients With Progressive, Metastatic, Hormone Refractory Prostate Cancer
65. Phase II Study of the Role of Salvage Prostatectomy after Radiation Failure in Patients With Prostate Carcinoma
66. Phase II Study of Three-Dimensional Conformal Radiotherapy (3D-CRT) in Patients with Stage I or II Adenocarcinoma of the Prostate
67. Phase II Study of Trastuzumab (Herceptin) and Docetaxel in Patients With Hormone Refractory, Metastatic Prostate Cancer
68. Phase II Study of Trastuzumab (Herceptin) in Patients w/ Progressive Androgen Dependent and Independent Prostate Cancer
69. Phase II Study of Vinorelbine with Paclitaxel in Patients with Metastatic Hormone-Refractory Prostate Cancer
70. Phase II/III Diagnostic Study of C11-Methionine and 2-F18-Fluoro-2-deoxy-D-Glucose (FDG) Positron Emission Tomography (PET) Imaging in Patients With Progressive Prostate Cancer
71. Phase II/III Randomized Study of Leflunomide (SU101) With Mitoxantrone and Prednisone Versus Mitoxantrone and Prednisone Alone in Patients With Hormone Refractory Prostate Cancer
72. Phase IIB Randomized Chemoprevention Study of Eflornithine (DFMO) in Men at High Genetic Risk For Prostate Cancer

(CLINICAL TRIALS - Continued from Page 15)

- 73. Phase III Randomized Adjuvant Study of Hormonal Therapy in Surgically Treated PCa Patients at High Risk of Recurrence
- 74. Phase III Randomized Comparison Study of Conformal Standard Radiotherapy Versus Conformal High Dose Radiotherapy in Addition to Neoadjuvant Androgen Deprivation in Patients w/ Localized PCa
- 75. Phase III Randomized Study Comparing Intermittent Versus Continuous Androgen Suppression for Patients with Prostate Specific Antigen Progression in the Clinical Absence of Distant Metastases Following Radiotherapy for Prostate Cancer
- 76. Phase III Randomized Study of Androgen Suppression and Radiotherapy With or Without Subsequent Paclitaxel, Estramustine, and Etoposide in Patients w/ Localized, High Risk Prostate Cancer
- 77. Phase III Randomized Study of APC8015 in Patients With Asymptomatic Metastatic Hormone Refractory Adenocarcinoma of the Prostate
- 78. Phase III Randomized Study of Cyproterone Acetate in Patients with Hot Flashes Following Surgical or Chemical Castration for Prostate Cancer.
- 79. Phase III Randomized Study of Intermittent Versus Constant Combined Androgen Deprivation (Bicalutamide and Goserelin) in Patients With Stage IV Prostate Cancer Responsive to Such Therapy
- 80. Phase III Randomized Study of Low Molecular Weight Heparin (Dalteparin) Plus Standard Therapy Versus Standard Therapy Alone in Patients with Advanced Cancer
- 81. Phase III Randomized Study of Low- vs Intermediate- vs High-Dose Suramin for Advanced Hormone-Refractory PCa

- 82. Phase III Randomized Study of Mitoxantrone and Prednisone With or Without Clodronate in Patients with Hormone Refractory Metastatic PCa and Pain
- 83. Phase III Randomized Study of Neoadjuvant Total Androgen Suppression and Radiotherapy in Patients w/ Intermediate Risk Adenocarcinoma of the Prostate
- 84. Phase III Randomized Study of Oral Thalidomide Versus Placebo in Patients With Androgen Dependent Stage IV Nonmetastatic Prostate Cancer Following Limited Hormonal Ablation
- 85. Phase III Randomized Study of Palliative Radiation Therapy for Bone Metastases From Breast or Prostate Cancer
- 86. Phase III Randomized Study of Postoperative External Radiotherapy vs No Immediate Further Treatment in Patients with pT3 pN0 Prostatic Adenocarcinoma
- 87. Phase III Randomized Study of Radiotherapy to the Prostate With or Without Radiotherapy to the Pelvis in Patients With Stage I, II, or III Adenocarcinoma of the Prostate
- 88. Phase III Randomized Study of Radiotherapy With vs Without Neoadjuvant Flutamide Plus Goserelin or Leuprolide in Patients With Good Prognosis, Locally Confined Adenocarcinoma of the Prostate
- 89. Phase III Randomized Study of the Effect of a Diet Low in Fat and High in Soy, Fruits, Vegetables, Green Tea, Vitamin E, & Fiber on PSA Levels in Pts With PCa
- 90. Phase III Randomized Study of Total Androgen Blockade With or Without Pelvic Irradiation in Patients w/ Stage T3-4, N0, M0 Adenocarcinoma of the Prostate
- 91. Phase III Randomized Study of Weekly Doxorubicin in Patients with Metastatic, Hormone-Refractory Prostate Cancer
- 92. Phase III Randomized Trial of Strontium-

- 89 vs Palliative Local Radiotherapy in Patients with Hormone-Refractory Prostate Cancer w/ Painful Osseous Metastases
- 93. Phase III Randomized, Double-Blind Study of Radiotherapy With Versus Without Bicalutamide in Patients With PSA Elevation Following Radical Prostatectomy for pT3 N0 Carcinoma of the Prostate
- 94. Phase III Study of Chemo/Hormonal Therapy vs Androgen Ablation Alone as Initial Therapy in Patients With Unresectable/Metastatic Adenocarcinoma of the Prostate
- 95. Phase III Study of Long Term Adjuvant Hormonal Treatment with LHRH Analogue (Triptorelin) versus No Further Treatment in Patients With Locally Advanced Prostatic Carcinoma Treated by External Irradiation and a Six Month Combined Androgen Blockage
- 96. Phase III Study of the Ablatherm High Intensity Focused Ultrasound Device in Patients With Stage I or II Prostate Cancer Following External Beam Radiotherapy
- 97. Randomized Pilot Study to Evaluate Educational Intervention and Behavioral Skills Training for Pain Control in Patients with Recurrent or Metastatic Breast or PCa
- 98. Randomized Study to Evaluate the Efficacy of Brief Physician-Initiated Quit-Smoking Strategies for Clinical Oncology Settings
- 99. Study of Androgen Ablation and Bone Resorption in Patients With or Without Bone Metastases Secondary to PCa
- 100. Study of Androgen Receptor Mutations in Hormone Refractory Prostate Cancer
- 101. Supportive-Expressive Group Therapy for Men with Stage I/II Prostate Cancer

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