Us TOO® PROSTATE CANCER EDUCATION & SUPPORT

HOTSHEET

SEPTEMBER 2012

Celebrating National Prostate Cancer Awareness Month

THE ORIGINAL BLUES BROTHERS BAND TO PERFORM A SPECIAL CONCERT IN CHICAGO TO BENEFIT US TOO INTERNATIONAL

THE STORY:

The history of Chicago Blues Music is a long and storied one. No other city has more significance in the history and unique character of American Blues. It was here, near Joliet, Illinois that the two infamous fictional "blues brothers," Jake and Elwood Blues created the "concept" prototypical blues band. That band morphed into a legendary TV skit, movie/DVD and then live musical phenomenon, now spanning its fourth decade.

Now called THE standard by which all Rhythm & Blues bands are measured, The Original Blues Brothers Band is considered by the public and music industry insider alike as the most recognizable brand name in the hallowed world of the blues. The high energy original 10-piece band, led by guitarist/songwriter and Rock n' Roll Hall of Famer: Steve "The Colonel" Cropper and King Tut Sax player "Blue Lou" Marini…. is returning to Chicago.

THE BIG NIGHT:

On September 22, 2012, for the FIRST time in over 10 years, The Original Blues Brothers Band is returning… to perform in "Sweet Home" Chicago. Us TOO International is pleased and very excited to be producing this long awaited return at a gala benefit concert, at the historic Park West Theater in Lincoln Park, Chicago. The comfortable and well-equipped venue is a well known major, live act destination that has a maximum capacity of 900.

SEPTEMBER EVENTS:

September is National Prostate Cancer Awareness Month. This year, Us TOO International is celebrating Awareness Month with two major events: starting with the SEA Blue Run/Walk in Lincoln Park on Sunday, September 16th, and ending in the First Annual Benefit, "Blue for the Blues" Concert at 8:30 pm on Saturday, September 22nd. Prior to the concert, Us TOO is pleased to be hosting two special VIP receptions: on Friday, September 21st a private cocktail reception at Buddy Guy's Legends Nightclub, then on Saturday, the 22nd, just prior to the show, a cocktail reception, blues memorabilia auction and raffle of the famous "Briefcase Full of

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PIVOT RESULTS: OBSERVATION INSTEAD OF PROSTATECTOMY

Most men with localized prostate cancer, especially those with either low-risk disease or PSA levels lower than 10 ng/mL, should be monitored initially rather than treated with radical prostatectomy (RP), according to the authors of a major randomized trial.

Overall, RP did not significantly reduce either all-cause or prostate-specific cancer mortality when compared with observation (OBS) among men with localized disease, report the investigators from the Prostate Cancer Intervention Versus Observation Trial (PIVOT). These results, from a median follow-up of 10 years, were published in the July 19 issue of the New England Journal of Medicine (Vol. 367, pp. 201-213, 2012).

The absolute differences in the 2 mortality measures between the OBS and RP groups were less than 3 percentage points and were not statistically significant, report lead author Timothy Wilt, MD, MPH, from the Minneapolis Veterans Affairs Health Care System and the University of Minnesota, and colleagues. Specifically, 47.0% of the RP group died from all causes vs 49.9% of the OBS group (hazard ratio [HR], 0.88; 95% confidence interval [CI], 0.71–1.08; P=0.22). In addition, 5.8% of the

(Continued on page 4)

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URINE TMPRSS2:ERG FUSION TRANSCRIPT INTEGRATED WITH PCA3 SCORE, GENOTYPING, AND BIOLOGICAL FEATURES ARE CORRELATED TO THE RESULTS OF PROSTATIC BIOPSIES IN MEN AT RISK OF PROSTATE CANCER

Cornu JN, Cancel-Tassin G, Egrot C, Gaffory C, Haab F, Cussenot O

Prostate 20 July 2012 [Epub]

Background: Detection of fusion gene TMPRSS2:ERG transcripts in urine have been recently described in order to refine urine-based detection of prostate cancer (PCa), but data [about] its clinical impact remain scarce. We aimed at investigating the correlation of TMPRSS2:ERG, prostate cancer antigen 3 (PCA3), prostate specific antigen (PSA) density, genetic variants, and androgenic status with outcome and pathological findings at prostatic biopsy.

Methods: Between 2007 and 2011, 291 patients at risk of PCa because of PSA > 3.0 ng/ml (55%) or candidate to active surveillance protocol justifying restaging biopsy management (45%) were recruited. TMPRSS2:ERG was detected by urine assay (Progensa™). PCA3-score, PSA level, bioavailable testosterone level, prostate volume, rs1447295 and rs6983267 genotypes were prospectively assessed. Univariate and multivariate analysis by logistic regression model (logit) were conducted to study the correlation of TMPRSS2:ERG status, PCA3, and PSA density (PSAD) with biopsy results, and Gleason score.

Results: Of 291 patients, 173 had PCa and 118 had negative biopsy. PCA3 score, PSA density and TMPRSS2:ERG-score were correlated with presence of PCa (P <0.0001, P=0.046, and P <0.0001, respectively). This correlation remained strong on multivariable analysis model (area under curve 0.743). PCA3 score and PSAD were significantly associated with presence of Grade 4 through multivariable analysis. PCA3 score was also correlated to the percentage of positive cores at biopsy (P=0.008).

Conclusions: Integration of levels TMPRSS2:ERG transcripts in urine, with PCA3-score, androgenic status, genetic status and traditional clinical variables could significantly increase detection of high risk localized PCa.

PREVENTION OF GYNECOMASTIA AND BREAST PAIN CAUSED BY ADT IN PROSTATE CANCER: TAMOXIFEN OR RADIOTHERAPY?

Viani GA, Bernardes da Silva LG, et al

Int J Radiat Oncol Biol Phys 83:e519-24, 2012

Purpose: To determine, in a meta-analysis, whether gynecomastia and breast pain rates in men with prostate cancer treated with androgen deprivation therapy (ADT) are reduced if treated with prophylactic radiotherapy (RT) or tamoxifen (TMX).

Methods and Materials: The MEDLINE, EMBASE, CANCERLIT, and Cochrane Library databases, as well as proceedings of annual meetings, were systematically searched to identify randomized, controlled studies comparing RT or TMX with observation (OBS) for men with prostate cancer using ADT.

Results: Six RCTs (three RT trials and three TMX trials, N=777 patients total) were identified that met the study criteria. Pooled results from these RCTs comparing RT vs. OBS showed a significant reduction in the incidence of gynecomastia and breast pain rates in patients treated with RT (odds ratio [OR] = 0.21, 95% confidence interval [CI] = 0.12-0.37, P <0.0001, and OR=0.34, 95% CI 0.20-0.57, P <0.0001, respectively). Use of RT resulted in an absolute risk reduction (ARR) of 29.4% and 19.9%, with a number needed to treat (NNT) of 3.4 and 5 to avoid one case of gynecomastia and breast pain, respectively. Pooled results from trials comparing TMX vs. observation showed a statistical benefit for breast pain and gynecomastia in favor of TMX arms (OR=0.04, 95% CI 0.02-0.08, p <0.0001 and OR=0.07, 95% CI 0.0-0.14, P <0.00001). TMX resulted in an ARR = 64.1% and 47.6%, with an NNT of 1.56 and 2.1 to avoid one case of gynecomastia and breast pain, respectively. Considering adverse effects, TMX had 6 times more adverse effects than RT.

Conclusions: TMX and RT prevented gynecomastia and breast pain in prostate cancer patients receiving ADT. Although TMX was two times more effective in preventing gynecomastia, RT should represent an effective and safe treatment option, to take into account mainly in patients with cardiovascular risk factors or thrombotic diathesis.

TEN-YEAR COST OF ACTIVE SURVEILLANCE AKIN TO RADICAL PROSTATECTOMY

The cost of providing active surveillance (AS) for 10 years to a man with prostate cancer is about the same as the cost of initially performing surgery. Researchers estimated that 10 years of AS costs $28,784 vs. a cost of $31,612 for an initial radical prostatectomy (RP) and the related 10 years of office follow-up in an economic analysis published in the July 15 issue of *Cancer*.

However, some other treatments for prostate cancer are much more expensive than these options. The most expensive include initial image-guided radiation therapy (RT) with short-term ADT, ($61,131 cost at 10 years) and long-term ADT ($84,055 cost at 10 years).

AS could provide "considerable cost savings," compared with initial treatments, conclude the researchers, led by Kirk Keegan, MD, from the Department of Urologic Surgery at Vanderbilt University in Nashville, TN. Dr. Keegan and colleagues project $1.9 billion in cost savings at 5 years if just half of 1 year's new prostate cancer cases underwent AS. This estimation assumes that 30% of the cohort would switch to active treatment within that time period.

The economic analysis addresses 2 very different and powerful concerns. On the one hand, it provides a provocative blueprint for cost savings for an expensive healthcare item in the US. On the other hand, it provides some financial incentive for urologists who perform RP to mix up their case management.

Recently, a group of prominent urologists suggested that the poor uptake of AS among clinicians is partly financial. "AS is labor intensive and reimbursed relatively poorly," stated Peter Carroll, MD, from the University of California, San Francisco.

However, Dr. Keegan and colleagues suggest that, over the long run, reimbursement becomes more rewarding with AS for urologists. The same is not true for medical oncologists who dispense long-term ADT or for radiation oncologists who perform image-guided RT.

The current AS protocol at the University of California, Davis was the basis of the cost estimates and consists of an initial office consultation, 2 prostate biopsies (diagnostic and a 3-month confirmatory), pathology costs, professional and technical fees, PSA measurements and office visits every 3 months for 2 years and every 6 months thereafter. As noted above, repeat prostate biopsy was performed after the second year of follow-up and every other year thereafter.

For the economic analysis, the researchers assumed that 7.0% of the 120,000 men on AS will receive treatment (years 1 to 5), and 4.5% will do so later on (years 6 to 10). In total, 30% and 45% will exit by years 5 and 10, respectively – in keeping with clinical studies.

In the analysis, the men exiting AS chose different treatment for localized prostate cancer, including RP (40%), image-guided RT with or without ADT (25 and 10%, respectively), brachytherapy (15%), and ADT monotherapy (10%). Importantly, the economic analysis excluded costs associated with management of treatment-related complications, which would have made AS even more attractive, the authors suggest.

Individual Costs for AS

Procedure	$US Cost
Prostate biopsy	1,102
Pathology costs	660
Professional/technical fees	635
Office consultation	428
Office visit	118
PSA measurement	52
Reimbursement for biopsy	433

Limitations in this analysis include AS cost projections based on prostate biopsies every other year after year 2. In some institutions, biopsies are taken annually. "A yearly biopsy regimen results in significantly elevated healthcare costs," they acknowledge. Adding the costs of treating the higher number of complications associated with radical therapy over AS would likely only serve to widen the costs savings of an AS paradigm," they write.

Medscape Medical News, 24 July 2012

GO FROM PASSION TO ACTION IN SEPTEMBER

There are many activities being planned during Prostate Cancer Awareness Month! The following lists a few of the exciting things worth mentioning for those of you that want to join in and be active. Please support and join us!

- September 7-9, in Los Angeles: The 2012 Prostate Cancer Conference. Go to www.prostate-cancer.org. Us TOO and other support group leaders will be conducting groups on-site.
- September 8, in Chicago: The 3rd Annual Prostate Cancer Symposium.. Go to www.theprostatenet.org/Symposium.html.
- September 8, at Moraine View State Park in Bloomington: SEA Blue Central IL Walk in Memory of Bill Tucker.
- September 11-13, in Washington, DC: The 2012 Summit to End Prostate Cancer. The Summit will feature a "Pints for Prostates" event on the evening of the 12th.
- September 16 in Chicago: The 8th Annual SEA Blue Prostate Cancer Run & Walk benefitting Us TOO and Chicago-land's Wellness Place and its Prostate Cancer Program led by Russ Gould. Go to www.ustoo.org.
- September 19, online event: A new webinar on Clinical Trials featuring Dr. Tomasz Beer from Oregon Health & Science University is planned and is as a collaborative project of OncoGenex Technologies, Us TOO and Zero. Check Us TOO International's website for more information.
- September 22, at the Park West in Chicago: Us TOO will feature the Original Blues Brothers Band in a special prostate cancer benefit concert. More information is available at the Us TOO website. This will be a major fun-filled event to raise awareness of prostate cancer to new levels in Chicago-land.

THE BLUES BROTHERS BAND

(Continued from page 1)

Blues" will take place during a low key, "down home" barbeque dinner.

The concert and these two private VIP events join together Us TOO and The Original Blues Brothers Band for the first time. It is hoped this team-up will be the first in a serious of collaborative efforts by these two fine organizations for future events. Us TOO and The Original Blues Brothers Band bring together on September 22nd the amazing history and staying power of American Rhythm & Blues music… in the effort to help fund public awareness for the issues surrounding prostate cancer. We hope you and your associates will be with us.

OUR MISSION:

Us TOO International has a 20-year history educating the world about prostate cancer, providing men and their loved ones support, education and prostate health awareness… all cost free.

EVENT DETAILS:

Please contact: John M. Lupton, at Us TOO for further details to reserve your table at the VIP Events. Visit Us TOO's website dedicated to the September Events: www.ustoo.org/blueforthebluesto purchase general admission tickets, and obtain more information about the concert and VIP Events. Also visit the main Us TOO website www.ustoo.org for information about Us TOO's important programs and affiliations.

We look forward to YOU being a part of this exciting celebration of brotherhood in Chicago.

John M. Lupton
Director of Marketing & Development
Us TOO International

johnl@ustoo.org
Telephone 630.795.1002
Mobile 203.346.4882

Want to learn more about local prostate cancer support group activities? Read the

CHAPTER NEWS!

at www.ustoo.org!

PIVOT TRIAL RESULTS *(Continued from page 1)*

RP group died from prostate cancer or treatment vs 8.4% of the OBS group (HR, 0.63; 95% CI, 0.36–1.09; P=0.09).

Notably, a PIVOT subset analysis also indicated that RP provided no mortality benefit at all in men with early-stage (localized) disease that was low risk. Instead, OBS appeared superior in low-risk men; it was associated with a non-significant reduction in both mortality measures. Subset analyses also indicated that RP did not provide a significant mortality (all-cause and disease-specific) benefit for men with PSA levels lower than 10 ng/mL.

However, the authority of these findings is undermined by the fact that the PIVOT study was insufficiently powered, suggest editorialists Ian Thompson, MD, from the University of Texas Health Science Center in San Antonio, and Catherine Tangen, DPH, from the Fred Hutchison Cancer Research Center in Seattle, WA. The original design called for 2000 men randomized to OBS or RP, but due to low accrual the trial only enrolled and randomized 731 men.

"The study was thus underpowered to detect this relatively large clinical effect," the editorialists write, referring to the stated goal of detecting a 25% relative reduction in all-cause mortality, the primary endpoint. Despite this objection, Drs. Thompson and Tangen agree with the PIVOT investigators: Men with low-risk, localized disease should be monitored first, not treated.

OBS is a "wise, healthy choice for the large majority of men diagnosed with prostate cancer in the US," said Dr. Wilt, explaining that the harms related to treatment can be avoided, and that in PIVOT, the risk for death from prostate cancer in the OBS group was "low."

"Our study showed that men with early-stage prostate cancer treated with OBS had similar length of life and deaths from prostate cancer," Dr. Wilt stated. "Physicians can now confidently recommend OBS as the preferred treatment approach for most of their patients diagnosed with [early] prostate cancer."

RP was associated with reduced all-cause mortality among men with a PSA higher than 10 ng/mL (P=0.04 for interaction), and "possibly" among those with intermediate-risk or high-risk tumors (P=0.07 for interaction), they report. The editorialists were encouraged that, despite the trial's limitations, there was a trend toward reduced mortality among men with high-risk cancers.

The ultimate challenge moving forward in the management of prostate cancer is in accurately differentiating risk so that treatment can focus on men with "lethal cancer," say the editorialists. "Future clinical trials must focus on "cancers that matter," they added.

Medscape Medical News, 19 July 2012

MORE MEN WITH PROSTATE CANCER MANAGED BY A 'TEAM' WAIT ON TREATMENT

Men with low-risk prostate cancer are more likely to opt for active surveillance (AS) when they receive care from a multidisciplinary team, results of a new study shows. Researchers say that may be because these teams can provide the most balanced view of the risks and benefits of different options.

Recent studies have suggested that for men who have low-risk cancers, AS may be just as effective as primary surgery or radiotherapy (RT) [see Reuters Health story of July 18, 2012.] Patients on AS often avoid the side effects, such as incontinence and impotence, as well as the costs of unnecessary treatment.

"For most older men who have low-risk disease, the treatment is not going to change the outcome that we all think about, which is living the rest of their life without being harmed by prostate cancer," said Dr. H. Ballentine Carter, a urologist from Johns Hopkins Medicine in Baltimore, who wasn't involved in the new research.

Of the estimated 240,000 US men diagnosed with prostate cancer in 2012, more than half will have low-risk cancers. Still, more than 90% of men with prostate cancer opt for treatment, researchers noted in the new study, published in the *Journal of Clinical Oncology*.

Dr. Laurence Klotz, head of urology at the Sunnybrook Research Institute in Toronto, told Reuters Health that up to half of all newly-diagnosed prostate cancer patients are candidates for AS. Dr. Klotz, who didn't work on the study, said multidisciplinary teams "tend to enhance the degree to which a balanced view is presented to the patient."

In contrast, urologists seeing a patient alone may recommend the procedure they know best – radical prostatectomy (RP) – whereas radiologists might push for RT, researchers said.

For the new study, Dr. Jason Efstathiou from Massachusetts General Hospital and his colleagues analyzed treatment choices made by 701 men with low-risk prostate cancer seen at hospitals in Bos-

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ASK DOCTOR SNUFFY MYERS

Editors' note: Us TOO has invited certain physicians and others to provide information and commentary for the *HotSheet* to enrich its content to empower the reader. This column contains the opinions and thoughts of its author and is not necessarily those of Us TOO International.

Three months shy of my 57th birthday I was diagnosed with prostate cancer. My PSA rose to 6.24 ng/mL in April 2012 and I was referred to a local urologist. My DRE was negative and I underwent a 12-core prostate biopsy in May. The pathology report showed 2 positive cores – a Gleason 3+3=6 involving ~7% of the left lateral apical core and a Gleason 4+4=8 involving ~7% of the left lateral "mid" core. Three other cores from the left side showed HGPIN or ASAP, and all 6 cores from the right side showed chronic inflammation and/or "basal cell hyperplasia."

I had my biopsy slides sent to Bostwick Laboratories for a second opinion. Gleason scores of the 2 positive cores were confirmed each with 5% tumor involvement. However, Bostwick identified cancer in 6 other cores – 2 more on the left side and 4 on the right side, all with ≤5% tumor involvement. One core was Gleason 4+3=7, 2 were 3+4=7 and 3 were 3+3=6. According to Memorial Sloan Kettering Cancer Center's Pre-Treatment Nomogram, my chances of having organ-confined disease, extracapsular extension, seminal vesicle invasion and lymph node involvement at radical prostatectomy (RP) are 49, 20, 4 and 2.1%, respectively. My estimated likelihood of developing biochemical recurrence at 5 and 10 years post-RP is 21 and 30%, respectively.

My PSA is less than 10 ng/mL yet 8 out of 12 biopsy cores are positive for prostate cancer. My tumor involvement is ≤5% in all of my cores suggesting that I have an insignificant volume of cancer, yet one of my cores shows Gleason 4+4=8 disease. My PAP is 3.0 ng/mL (normal up to 3.5 ng/mL). In light of the recently published results of the PIVOT trial, do you believe that I am a suitable candidate for active surveillance (AS)?

AS is best done with a small Gleason 3+3=6. Even Gleason 6, if multifocal like this, would make AS risky. The presence of Gleason 8 effectively means that AS is a very high- risk option for you. Additionally, you have a Gleason 4+3=7, which would be expected to behave badly over time. Then there are two Gleason 3+4=7. This points to a very active process creating cancers and it is only a matter of time before you develop an invasive cancer. The tip off for you should be you only have a 49% chance of organ-confined disease.

You are still a candidate for RP, but I have some concerns there. A PAP above 2.5 comes with an increased risk of recurrence and this factor is not incorporated into the Memorial Sloan-Kettering nomogram. In fact, I think the nomogram dramatically underestimates your risk of lymph node recurrence sometime during the first 6 years. Certainly if you did have a PSA recurrence, you should use one of the advanced imaging techniques such as the Feraheme MRI or carbon-11 acetate or choline PET/CT.

While controversial, I think your best bet would be radiation therapy to the prostate gland and iliac/obturator nodes.

US TOO WANTS TO ANSWER YOUR QUESTIONS!

Dr. Myers would love to provide direct answers to questions posed by Us TOO members. Instead of printing questions answered in the *Prostate Forum*, we'd rather provide readers who subscribe to both publications with fresh content. Questions about imaging, active surveillance, and biochemical relapse would be particularly appreciated right now.

If you have questions, please send them to Jackie@ustoo.org or call the Helpline at 800-808-7866.

ONCOGENEX ANNOUNCES INITIATION OF THE PHASE 3 "AFFINITY" TRIAL FOR PATIENTS WITH ADVANCED PROSTATE CANCER – A PHASE 3 TRIAL EVALUATING THE POTENTIAL CLINICAL BENEFIT OF CUSTIRSEN IN COMBINATION WITH SECOND-LINE CHEMOTHERAPY, JEVTANA® (CABAZITAXEL), IN PATIENTS WITH CASTRATE-RESISTANT PROSTATE CANCER (CRPC)

OncoGenex Pharmaceuticals, Inc. announced today that it has initiated patient enrollment in its second Phase 3 clinical trial evaluating custirsen in patients with advanced prostate cancer. The AFFINITY trial will evaluate if custirsen when combined with second-line chemotherapy has the potential to improve survival outcomes for prostate cancer patients compared to second-line chemotherapy alone.

This Phase 3 trial is an international, randomized, open-label study that will enroll approximately 630 men with CRPC who received first-line docetaxel chemotherapy and have disease progression. Patients will be randomized to receive custirsen, cabazitaxel and prednisone or cabazitaxel and prednisone alone. The primary endpoint of the study is overall survival. Additional analyses will evaluate disease progression parameters and quality of life.

Custirsen has received Fast Track designation from the US Food and Drug Administration (FDA) for treatment of patients with CRPC receiving first-line docetaxel chemotherapy. The Phase 3 SYNERGY study, evaluating a survival benefit in the first-line CRPC setting, continues to accrue patients and is expected to complete enrollment later this year. Additionally, OncoGenex recently announced that a Phase 3 study in patients with non-small cell lung cancer will begin in the second half of this year.

For more information on The AFFINITY Trial, please visit www.prostatecancerstudy.com or http://clinicaltrials.gov/ct2/show/NCT01578655.

www.newswire.ca, 7 August 2012

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

"Vitamin D supplements in large dosages may increase testosterone levels? Maybe"

Mark A. Moyad, MD, MPH
University of Michigan Medical Center, Department of Urology

Editors' note: Us TOO has invited certain physicians and others to provide information and commentary for the *HotSheet* to enrich its content to empower the reader. This column contains the opinions and thoughts of its author and is not necessarily those of Us TOO International.

Bottom Line: Several new studies are suggesting that vitamin D supplements in large dosages may either be increasing testosterone levels or are associated with some other kind of change that makes it seem as if they are increasing testosterone blood levels (regardless-you should be made aware of this).

The Olympics are over and that is sad because everyday I watched the events like Usain Bolt in the 100 and 200 meter track and field events I got a quick mini-midlife crisis and decided to go for a quick sprint outside or on the treadmill! Watching the Olympics makes me want to exercise more and eat less and grow bigger muscles. And, perhaps I can grow bigger muscles by using testosterone or taking higher doses of vitamin D supplements (wow-another brilliant segue)! I have written for years about the problem with doing anything in excess including taking large amounts of prescription pills or dietary supplements. Everything comes with a catch! I have told readers for years that one way to naturally increase your vitamin D blood levels is to lose weight or eat more fish for example. And, I have warned that taking too many vitamin D supplements might come with a catch! Well, I did not want to believe this research, but there is enough preliminary evidence right now to suggest that taking larger doses of vitamin D MIGHT (no one is sure) increase a man's testosterone level! In 2011, researchers reported the results of a small clinical trial of 50 men that took over 3000 IU of vitamin D daily compared to placebo for 1 year.[1] What they appeared to find was that this dosage significantly increased blood levels of testosterone (from an average of 308 to 386 ng/dL) as their vitamin D blood levels increased by 21 ng/mL! Several other recent laboratory and human studies have suggested that this may not be a crazy finding! In fact, a recent Harvard study suggested that this can occur up to a point and then vitamin D might no longer impact testosterone.[2] How can this be possible? The vitamin D receptor and enzymes that impact vitamin D metabolism are found in the male reproductive tract including Leydig cells which are the testosterone producing cells found in the male testes. Look, being physically active, losing weight, eating better…can all naturally increase your vitamin D and testosterone levels a little bit, but researchers took into account these factors. So, no one knows yet if vitamin D really increases testosterone levels or men that have an increase in testosterone also get an increase in vitamin D or possibly both? In the meantime, you should be aware of this controversy and it is probably another reason you want to be careful, especially if you have had prostate cancer and you are not looking for an increase in testosterone, to only get enough vitamin D that can keep your bones healthy and not mega-dose. This is why I never wanted to push dosages more than 1000 IU per day until someone can show me that more is better.

References

1. Pilz S, Frisch S, Koertke H, et al: Effect of vitamin D supplementation on testosterone levels in men. Horm Metab Res 43: 223-225, 2011.

2. Nimptsch K, Platz EA, Willett WC, Giovannucci E: Association between plasma 25-OH vitamin D and testosterone levels in men. Clin Endocrinol (Oxf) 77: 106-112, 2012.

DOCTOR CHODAK'S BOTTOM LINE *(Ref Key: article #, page #, column #)*

Editor: www.prostatevideos.com

Editors' note: Us TOO has invited certain physicians and others to provide information and commentary for the *HotSheet* to enrich its content to empower the reader. This column contains the opinions and thoughts of its author and is not necessarily those of Us TOO International.

a2p1c3 The article by Wilt may be one of the most important studies done in prostate cancer because it addressed a question that had NEVER been answered; how many men are truly helped by undergoing radical prostatectomy? Sadly, this study found that the percentage benefitting is very low at least at 12 years, possibly only a few percent. Yes, the study did not enroll as many men as intended and it is not a perfect study, BUT the fact remains that the suspected large benefit many doctors have believed existed, is incorrect. In particular, those with low risk cancer, which makes up about 70% of all new cases, showed no improvement. It is possible that at 15 or even 20 years, these results may change, but until that time the fact remains that there is no proof that radical prostatectomy or any other therapy helps large numbers of men. This has many important implications. First, it is critical that every patient be informed about these results. I fear that far too many men will not be told about this study and so they should be prepared to ask questions during their consultation. Second, the results have implications for active surveillance. Based on this study, it would seem that too many men are coming off AS and the reasons for stopping AS are too aggressive. Perhaps this study will encourage a change in the reasons for stopping conservative therapy.

THE BOTTOM LINE: ALL men diagnosed with prostate cancer need to be told about the results of this study before deciding about undergoing any treatment for their disease.

a3p2c3 Some men on hormone therapy develop bothersome breast pain or breast enlargement. This occurs in the majority of men receiving an antiandrogen like bicalutamide (Casodex®), flutamide (Eulexin®) or nilutamide (Nilandron®) although it is much less common for men receiving an LHRH agonist like triptorelin (Trelstar®), leuprolide (Lupron®) or goserelin (Zoladex®). The article by Viani and co-workers reviews the literature for studies using either radiation or tamoxifen to prevent the breast problems and it is clear that both treatments are effective with a high percentage of men benefitting. It is unclear from the report, however, how many men were being treated with antiandrogens vs. LHRH agonists. Radiation appears safer although slightly less effective. Although many radiotherapists recommend several radiation sessions, studies have shown that only one dose is necessary. Consequently, men advised to have more than one session should question their doctor about showing them studies proving that more than one is needed. Another important point is that the treatments are most effective if they are given before breast enlargement occurs.

THE BOTTOM LINE: For men advised to take an antiandrogen, they should discuss having 1 or 2 radiation treatments to their breast before starting therapy. Benefit is less clear for men who will be treated with an LHRH agonist.

a5p3c1 The article by Keegan on the cost of active surveillance raises some interesting points and questions. First, as the authors acknowledge, they omitted computing the cost of treating side effects, which are far more common than people have been told. That alone makes the cost of all other therapies even more expensive. In addition, active surveillance is going through growing pains as researchers try to determine the best way to follow men. One thing clear so far is that many men abandon this approach not because their cancer is getting worse but rather because they or their family cannot cope with the anxiety. This obviously drives up the cost and results in many men getting unnecessary therapy. Another point is the optimal frequency of performing biopsies remains unclear, but probably they are being done too often, which is both dangerous and costly. The danger is that an increasing number of men are developing difficult to treat infections, which is also adding to the cost.

The wide variation in cost without ANY evidence that one option is more effective than another raises a curious question for people that pay for prostate cancer treatment. Would it be reasonable for payers to limit reimbursement to the amount for the least costly therapy? Anyone wanting a more expensive therapy would have to pay the additional amount. After all, why should they pay over $100,000 for Proton therapy when brachytherapy has no different results, may actually be safer, and costs about 85% less?

THE BOTTOM LINE: The management of localized prostate cancer needs some serious modification otherwise the bank will go broke and too many men will end up with a reduced quality of life without living longer.

MULTIDISCIPLINARY APPROACH

(Continued from page 5)

ton. About a third of them worked with multidisciplinary teams of doctors, and 43% of those patients ended up opting for AS over immediate surgery or RT. That was true for 22% of the men who saw individual practitioners.

On multivariate logistic regression, older age (odds ratio, 1.09; p<0.001), unmarried status (OR, 1.66; p=0.04), increased Charlson comorbidity index (OR, 1.37; p=0.02), fewer positive cores (OR, 0.92; p<0.001), and consultation at a multidisciplinary clinic (OR, 2.15; p=0.02) were significantly associated with pursuit of AS, the authors reported.

"There is no doubt that different environments could sway men toward different management decisions," Dr. Efstathiou told Reuters Health. "A multidisciplinary clinic visit allows the patient to hear multiple views regarding their disease and what could be appropriate management choices. We believe that it allows for greater informed decision-making," he said.

Reuters Health, 30 July 2012

THAILAND MILITARY BASES AND AGENT ORANGE EXPOSURE

Vietnam-era Veterans whose service involved duty on or near the perimeters of military bases in Thailand anytime between February 28, 1961 and May 7, 1975 may have been exposed to herbicides and may qualify for VA benefits.

The following Veterans may have been exposed to herbicides:

- US Air Force Veterans who served on Royal Thai Air Force (RTAF) bases at U-Tapao, Ubon, Nakhon Phanom, Udorn, Takhli, Korat, and Don Muang, near the air base perimeter anytime between February 28, 1961 and May 7, 1975.
- US Army Veterans who provided perimeter security on RTAF bases in Thailand anytime between February 28, 1961 and May 7, 1975.
- US Army Veterans who were stationed on some small Army installations in Thailand anytime between February 28, 1961 and May 7, 1975. However, the Army Veteran must have been a member of a military police (MP) unit or was assigned an MP military occupational specialty whose duty placed him/her at or near the base perimeter.

To receive benefits for diseases associated with herbicide exposure, these Veterans must show on a factual basis that they were exposed to herbicides during their service as shown by evidence of daily work duties, performance evaluation reports, or other credible evidence.

Report on defense tactics in Thailand

A recently declassified Department of Defense (DoD) Report written in 1973, "Project CHECO Southeast Asia Report: Base Defense in Thailand 1968-1972," (8.3 MB, PDF) contains evidence that there was a significant use of herbicides on the fenced-in perimeters of military bases in Thailand to remove foliage that provided cover for enemy forces. To download the report in PDF format, go to: www.afhra.af.mil/shared/media/document/AFD-080819-065.pdf. VA determined that herbicides used on the Thailand base perimeters may have been tactical and procured from Vietnam, or a strong, commercial type resembling tactical herbicides.

VA benefits

Veterans who were exposed to Agent Orange or other herbicides during military service may be eligible for a variety of VA benefits, including an Agent Orange Registry health exam, health care, and disability compensation for diseases associated with exposure. Their dependents and survivors also may be eligible for benefits.

Learn more about benefits related to Agent Orange exposure go to: www.publichealth.va.gov/exposures/agentorange/benefits.asp.

Need help determining exposure?

VA will help determine exposure to Agent Orange or other herbicides during military service when you file a claim for disability compensation or survivors' benefits.

Veterans may be eligible for an Agent Orange Registry health exam. You don't have to file a disability compensation claim to receive the exam. To contact your local VA Environmental Health Coordinator about getting an Agent Orange Registry health exam, go to: www.publichealth.va.gov/exposures/coordinators.asp.

US Department of Veteran Affairs
News release 25 July 2012

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