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PROSTATE CANCER
EDUCATION & SUPPORT

HOTSHEET

October 2008

CELL GENESYS HALTS GVAX TRIAL DUE TO HIGHER DEATHS

Cell Genesys Inc. said it stopped a late-stage trial of its prostate cancer therapy, GVAX, after 20 more deaths were reported in patients on the drug versus those on a dummy treatment, and its shares crashed more than 75 percent to an all-time low. The cause for the "imbalance in deaths" has not yet been identified, the biotechnology company said. An independent committee, which pointed out the death mismatch, reported no new safety issues for the therapy, it added.

"This is obviously a negative event for Cell Genesys and stock will take a big hit. We also believe that Dendreon will be negatively impacted based on how the two stocks have been linked to date," analyst Joe Pantginis from Canaccord Adams said.

Both GVAX and rival Dendreon's Provenge are potential vaccines designed to stimulate the body's immune system to fight an existing cancer. This development could slow the path to regulatory approval for both Provenge and GVAX, Cell Genesys's lead program. "We are right now reviewing this disappointing development with our partner Takeda. We are reviewing

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THE WRONG CALL ON PROSTATE CANCER SCREENING

Numerous media reports followed a federal task force's announcement this month that there is insufficient medical evidence to assess the risks and benefits of prostate cancer screening in men younger than 75 and that doctors should stop testing men over age 75 ["US Panel Questions Prostate Screening; 'Dramatic' Risks for Older Men Cited," front page, Aug. 5].

It's important to note that consideration was not given to the overwhelming body of emerging evidence that screening with PSA tests and digital rectal exams saves lives. Rates of death from prostate cancer and rates of diagnosis at advanced stages have decreased markedly since testing became widespread. As a physician and a researcher specializing in prostate cancer, I worry that this recommendation will result in delays in potentially lifesaving treatment and possibly the unnecessary loss of life.

The US Preventive Services Task Force did not even recommend screening for men at higher risk because of race or family history. The task force reasoned that screening might harm more men than it helps and that in

(Continued on page 2)

BLOOD CALCIUM TIED TO LETHAL PROSTATE CANCER

Test may identify men at risk for deadliest form of disease, study finds

Men with elevated levels of calcium in their blood may have a much higher risk of getting fatal prostate cancer, US researchers said. The findings indicate that a simple blood test may identify men at high risk for the most dangerous prostate tumors, and there already are drugs available that cut calcium levels in the bloodstream, the researchers said.

They tracked 2,814 men in a government health survey in which they gave blood samples that revealed calcium levels. The men in the top third of blood calcium levels had 2.68 times the risk of developing fatal prostate cancer later in life compared to those in the bottom third, the study found.

"If serum calcium really does increase your risk for fatal prostate cancer, that's wonderfully exciting because serum calcium levels can be changed," Gary Schwartz of Wake Forest University School of Medicine, who helped lead the study, said in a telephone interview.

"One way to think of it is to think of the tremendous advances in the control of cardiovascular disease that occur

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THE WRONG CALL ON PROSTATE CANCER SCREENING

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mover 75 there was moderate certainty that the harm outweighs the benefits.

Physicians and patients who are concerned about preventing prostate cancer deaths choose to screen with prostate-specific antigen (PSA) tests because an inconclusive but increasingly compelling body of evidence shows that the screening reduces suffering and death from prostate cancer – the second-leading cause of cancer death among men in the US.

Numerous studies have shown that PSA-based tests, such as those that detect increases in PSA over time and the percentage of PSA floating free in the blood, help to decrease unnecessary biopsies and also identify men with the most aggressive tumors so that they can receive timely treatment.

Eliminating screening also eliminates the possibility for early diagnosis and curative treatment in healthy men.

Until we can prevent prostate cancer or cure patients at advanced stages of the disease, the only practical strategy for reducing death rates is early diagnosis and effective treatment. Because this tumor arises silently and often passes into an incurable stage before symptoms occur, the only way to detect it early is through screening.

Both the American Urological Association and the American Cancer Society recommend offering screening beginning at age 50 in men with a life expectancy of 10 years. High-risk men, such as African Americans and those with a strong family history of prostate cancer are urged to consider screening at an earlier age.

The National Comprehensive Cancer Network's guidelines recommend that screening begin at age 40. The guidelines include emerging evidence to help guide physicians and patients in their diagnostic and treatment decisions. These organizations, unlike the US Preventive Services Task Force, have urologists on their panels that see firsthand the ravages of prostate cancer.

Consider that in the US alone, the rate of advanced cancer at the time of diagnosis has fallen 75 percent since the

PSA screening era began, and age-adjusted prostate cancer death rates have declined 35 percent. Statistical studies suggest that 45 to 70 percent of this decrease is due to PSA screening. Evidence from US cancer registries shows less advanced cancer and lower prostate cancer death rates in regions where PSA testing is more prevalent. On a global scale, prostate cancer death rates have decreased in countries where PSA screening and active treatment are typically practiced and have remained stable or increased in countries where screening and active treatment are not practiced.

PSA tests are a powerful marker for the risk of developing prostate cancer and dying from it. Reports of over-diagnosis and over-treatment are exaggerated. More often, prostate cancer is diagnosed too late rather than "too early." If screening detected only harmless cancers, treating them could not produce the striking decline in prostate cancer death rates that has occurred. We should combat the risk of over-diagnosis through continued research for improving the accuracy of screening and high-quality treatment.

This misguided recommendation, and the resulting media coverage, could give reluctant men an excuse to postpone or forgo screening. The consequence might be that many men die of prostate cancer unnecessarily. Men should follow the recommendations of the American Urological Association, the American Cancer Society and the National Comprehensive Cancer Network, all of which recommend screening for early detection and treatment of prostate cancer.

William J. Catalona is medical director of the Clinical Prostate Cancer Program at the Robert H. Lurie Comprehensive Cancer Center at Northwestern University's Feinberg School of Medicine. He receives research support and honorariums for speaking from Beckman Coulter Inc., a manufacturer of PSA tests.

<www.WashingtonPost.com>
26 August 2008

UW RESEARCHERS FIND NEW GENE MARKER FOR PROSTATE CANCER

Prostate cancer affects one of six men as they age, and UW (Univ. of Wisconsin) researchers think they have discovered one reason why. Blame it on a misbehaving gene.

“We’ve found that there’s a gene in the prostate that alters its expression with aging, and that aberrant gene behavior is what promotes the development of cancer,” explained Dr. David Jarrard, the study’s principal author and a professor of urology at the UW Paul P. Carbone Comprehensive Cancer Center in Madison, WI. The findings were published in the Aug. 15th edition of *Cancer Research*.

The diagnosis and treatment of prostate cancer remains riddled with contrary advice and confusion. Just recently, the US Preventive Services Task Force reversed years of advice that early detection is the key to saving lives, and recommended instead that doctors stop screening men 75 and older for prostate cancer, which will kill an estimated 28,600 US men this year.

UW’s latest research offers hope that one day in the not-so-distant future a screening test can be developed to find men at special risk.

“Because this aberrant gene behavior is more common in men who develop prostate cancer, it may be an early marker,” Jarrard explained. If all goes well and additional data from other researchers confirm UW’s findings, he said, in five years it might be possible to determine from a biopsy whether some are susceptible to this particular gene change and prostate cancer.

The advantage of developing a marker for prostate cancer is that those who have it can then fight back. UW researchers have found encouraging evidence that the genetic misbehavior that leads to prostate cancer can be reversed with dietary changes. In a mouse model, researchers have found some very early indications that caloric restriction or staying “very skinny,” might help. There is also evidence that a substance called resveratrol, which is naturally found in red wine and grapes and has been linked

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REGULAR NSAID USE MAY REDUCE PSA LEVELS

Regular use of nonsteroidal anti-inflammatory drugs (NSAIDs) is associated with reduced levels of prostate-specific antigen (PSA), according to a report in the October 15th issue of *Cancer*, issued online September 8th. The drop in PSA levels may suggest that NSAIDs protect against prostate cancer. Alternatively, and of concern, these agents may have no anti-cancer effect but instead reduce PSA levels, possibly masking the presence of cancer.

“Our biggest finding was the slightly reduced level of PSA among men who were current NSAID users, which was consistent with our hypothesis prior to starting this study,” senior author Dr. Edwin van Wijngaarden told Reuters Health. “A surprise was to find reduced PSA levels among acetaminophen users, although this effect was not statistically significant.”

According to Dr. van Wijngaarden, a researcher with the University of Rochester School of Medicine and Dentistry in New York, the present study is novel in that it looked at the impact of NSAID and acetaminophen use on PSA levels, rather than on clinical outcomes. “Furthermore, our study is the first to look at this relationship in a study population that is representative of US men over the age of 40.”

NSAIDs are used by millions of people
(Continued on page 8)

GVAX DEATHS

(Continued from page 1)

all of our business operations with respect to any commensurate adjustments in the scope of those operations,” the company said on a conference call with analysts.

“We are currently notifying all participating clinical trial sites and regulatory agencies that enrollment of new patients into VITAL-2 has been suspended as has treatment with GVAX immunotherapy for prostate cancer of patients enrolled in the study,” Cell Genesys CEO Stephen Sherwin said in a statement. GVAX was being tested in two late-stage trials, coded VITAL-1 and VITAL-2, of which the second has now been scrapped.

The company said it has requested the independent committee to conduct a “futility analysis” on VITAL-1 and expects results from this in about a month. VITAL-2 enrolled 408 patients and had 114 deaths – 67 were in the treatment arm and 47 in the control arm. GVAX was given along with the cancer drug docetaxel (Taxotere®) in the treatment arm. The control arm received Taxotere with prednisone.

Shares of South San Francisco, California-based Cell Genesys were trading down \$2.04 at 76 cents. They earlier hit a life-low of 69 cents.

Reuters, 27 August 2008



The Renaissance Ladies Golf Association in Manchester, NJ, held their 2nd Annual Cancer Awareness Days over a 3-day period in June. They held a ladies golf event, tennis round-robin, walk-a-thon, golf tournament and a luncheon, and sold bows honoring those who have or had cancer, doubling proceeds raised over their previous year event. They donated \$1,500 to Us TOO! Thanks to all, including RLGAC committee workers (L to R): Marylou Deady, Ellen Patton, Ellen Decker and Joyce Demonte.

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

"I.V. (intravenous) vitamin C by itself given to advanced cancer patients does not seem to help."

Mark A. Moyad, MD, MPH

University of Michigan Medical Center, Department of Urology

**Support Dr. Moyad and his team for the 2008 Greater Chicago Prostate Cancer Run Walk 'n Roll event. Donations will be accepted until Friday, October 31, 2008 at <www.ChicagoProstateWalk.org>

Bottom Line: Vitamin C is one of the safest dietary supplements in the world and may reduce the risk of a cold or lung infection, but when given in mega-doses to advanced cancer patients it does not seem to harm, but it also does not seem to help that much.

In the 1970s, Nobel Prize winner Linus Pauling suggested that mega-doses (10 grams/day) of vitamin C may treat advanced cancer, but this was not substantiated from two clinical trials completed a few years later. However, part of the criticism of these trials was that patients were given oral and not i.v. (intravenous) vitamin C where larger blood levels of vitamin C can be achieved that may be toxic to cancer cells.

So, recently researchers completed a first-ever phase I dose-escalating trial of i.v. vitamin C to determine if it is safe, and if there may be a hint that it can kill cancer cells in humans with advanced forms of certain cancers. This was a safety and tolerability study using groups of patients that were sequentially infused with 0.4, 0.6, 0.9 and 1.5 g vitamin C per kilogram of body weight three times a week over a 90-120 minute period.

The average duration of treatment was 10 weeks. Median age was 61 years and 24 patients with advanced tumors that had originated from various localized sites (breast, head and neck, liver, lung, lymphoma, ovarian, pancreatic prostate, renal, sarcoma...) were included. No patient had an objective treatment response and all patients eventually had their cancer progress or advance further.

There was a suggestion of a potential quality of life benefit for patients that completed this study. I.V. vitamin C given in large doses appeared to be

safe and free of toxic effects, but provided no treatment impact by itself. Perhaps in combination with conventional therapies, and used earlier in the course of the disease there may be a better chance of a treatment response.

These same researchers have decided to start a new study of using conventional chemotherapy in combination with I.V. vitamin C to see if they get a better result. Stay tuned (sorry, no jokes in this column because this topic was way too serious to throw in a joke, but I do want to say that "Michigan Football rules, and we will upset Ohio State this year")!

Reference: Ann Oncol, released early on-line, 2008

Moyad seeks support for Us TOO

"If there's ever a reason to call Us TOO or get involved or start your own support group, it's not only that are they great for the patients themselves, but ultimately they push advocacy and they help push funding. They help us get the tools we need to push this disease more in the forefront to get those dollars to make those changes," says Mark Moyad MD.

"Look what's happened in breast cancer. Breast cancer support groups have pushed Washington DC to get the kind of funding they do. Look what's happened in HIV and AIDS. If we start seeing that, with the help of groups like Us TOO, I think in the next few years you're going to see dramatic increases in funding. That's what I want to see."

Make a donation in honor of Dr. Moyad by contributing to his team at the Greater Chicago Prostate Cancer Run Walk 'n Roll event. Go to <www.ChicagoProstateWalk.org>, and look for his team name - "Dr. Moyad and the Upset Stomachs." Thank you!

**SHORT-TERM MORTALITY
INCREASED AFTER
PROSTATE BIOPSY**

A small but significant increase in mortality is seen within 120 days of transrectal ultrasound guided (TRUS) prostate biopsy, according to a report in the August 1st issue of the International Journal of Cancer (Vol. 123, pp. 647-52, 2008). The authors caution, however, that further studies are needed to verify this association and to uncover the mechanisms involved.

The results stem from a population-based study of 22,175 patients who underwent prostate biopsy from 1989 to 2000. A control group included 1,778 similar men who did not undergo biopsy. Half in the patient group were used to generate a predictive model for 120-day mortality and half were used to validate the predictors.

Overall, 120-mortality in the biopsy group was higher than in the control group: 1.3% vs. 0.3% (p < 0.001), Dr. Pierre I. Karakiewicz, from the University of Montreal, and colleagues report. Age, comorbidities, and number of biopsy procedures also affected mortality. Men younger than 61 years had a mortality rate of 0.2%, compared with 2.5% for men over 75 years. Without comorbid disease, mortality was 0.7% versus 2.2% with multiple comorbidities. First-ever biopsy had a mortality rate of 1.4%, while subsequent biopsies were associated with a rate of 0.8% or less.

A model incorporating all of the identified risk factors was 79% accurate in predicting mortality within 120 days of prostate biopsy, the report shows.

The findings suggest that the indications for prostate biopsy may need to be reconsidered, the researchers comment. In particular, careful prescreening of older and less healthy men is warranted to determine if the benefits of biopsy outweigh the risks, they note. Research has already shown that these men gain the smallest benefit from diagnosis of early prostate cancer.

Reuters Health, 2 September 2008

PSA SCREENING IN YOUNGER BLACK MEN REMAINS SUBOPTIMAL

Blacks have begun to be screened for prostate cancer at higher rates at age 40, but too many are still going unchecked, investigators here have concluded. Although most recommendations are for PSA to begin in the general population at age 50, some groups recommend that for high-risk patients such as African Americans, annual testing should begin a decade earlier.

Overall, about 20% of all men ages 40 to 49 had had PSA evaluations within the previous year, according to data from a national surveillance program, and black men in that age group were more than twice as likely to have been screened as men in the general population. Yet that translated into just a third of those who could have been screened, Judd Moul, MD, of Duke, and colleagues reported online in the journal *Cancer* (Vol. 113: DOI: 10.1002/cncr.23667).

The American Cancer Society, Us TOO and the American Urological Association recommend annual PSA screening for prostate cancer in men ages 50 and older. All groups recommend a start of screening at age 40 for higher risk patients, including African-Americans. The US Preventive Health Service Task Force says there is not enough evidence of benefit, compared with risk, to recommend screening.

The study reviewed data from the 2002 CDC-sponsored Behavioral Risk Factor Surveillance System. After excluding men younger than 40 and those with a history of prostate cancer, the investigators analyzed data on 58,511 men ages 40 and older. The survey included five questions related to prostate cancer

diagnosis, two of which involved PSA screening. Overall, 22.5% of the men ages 40 to 49 said they had PSA testing within the past year, compared with 53.7% of men ages 50 and older. The authors found that 36.7% of the younger men had at least one PSA test in their medical history.

Analysis by race/ethnic group showed that 33.6% of younger African-American men had been screened in the previous year, and 50.1% had a PSA at some point in their lives. That was statistically higher than the 21.5% of white men who had been screened in the past year and 36% who had ever had a PSA test (P <0.001).

The authors acknowledged several limitations of the study: reliance on self-reporting, inability to determine whether PSA tests were performed for reasons other than cancer diagnosis, absence of information about family history, and no data on screening in men younger than 40.

In an accompanying editorial, urologist Robert Nadler, MD, of Northwestern University in Chicago, said the Duke study adds to existing evidence that "serial PSAs starting at age 40 years will allow practicing clinicians to determine which patients are at higher risk for developing prostate cancer and, specifically, allow clinicians to calculate and follow the PSA velocity initially at a time when BPH is less prevalent and PSA is more predictive of cancer. This, in turn, should allow for early detection in young men, who should benefit the most."

MedPage Today, 11 August 2008

BRACHYTHERAPY MAY REDUCE TREATMENT FAILURE IN OBESE PROSTATE CANCER PATIENTS

Brachytherapy for prostate cancer appears to overcome the adverse effects of obesity that lead to high PSA failure rates with surgery and external beam radiation, investigators here have concluded. In fact, PSA failure after brachytherapy had an inverse relationship with body mass index, Jason A. Efstathiou, MD, PhD, of Massachusetts General Hospital, and colleagues, reported in the August issue of the *International Journal of Radiation Oncology, Biology, and Physics* (Vol. 71, pp.1302-8, 2008).

PSA failure occurred in more than 30% of patients with a BMI 25, double the rate among patients with a BMI >30. "The possibility that brachytherapy is a preferred treatment strategy for obese patients warrants further study," the authors concluded.

Greater BMI has been associated with an increased risk of PSA failure after radical prostatectomy and radiation therapy. Little is known, however, about PSA failure after brachytherapy, the authors said. The issue warrants investigation because of the increasing use of brachytherapy, they continued. From 1994 to 1999, the number of prostate cancer patients treated with the technique increased 12-fold.

To examine the influence of obesity on PSA failure after brachytherapy, the investigators retrospectively analyzed medical records for 374 patients who had brachytherapy for nonmetastatic T1c-T2c prostate cancer. In 13% of cases, patients received supplemental

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Arizona Update

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PROSTATECTOMY IMPROVES OUTCOME OF SOME MEN WITH PROSTATE CANCER OVER WATCHFUL WAITING

Men with early prostate cancer who undergo radical prostatectomy have a lower rate of death due to prostate cancer than men who are followed without treatment, known as watchful waiting, according to a randomized controlled trial published on-line in the *Journal of the National Cancer Institute*.

The benefit from the surgery, with respect to prostate cancer death rates, remained constant beyond 10 years, but the overall death rates in the two groups were not statistically different. The applicability of the results to the current generation of prostate cancer patients is unclear, however, because few of the cancers treated in the trial were discovered by PSA (prostate-specific antigen) screening, a practice that is now widespread.

The Scandinavian Prostate Cancer Group launched the current trial in 1989 to examine the impact of radical prostatectomy on cancer-specific mortality relative to watchful waiting. In 2005, with a median follow-up 8.2 years, the researchers reported that men in the prostatectomy arm had lower rates of disease-specific mortality than those in the watchful waiting arm.

The investigators were interested to know if the prostate cancer mortality difference would continue to increase with longer follow-up. Thus far, this is the only completed randomized trial comparing the two treatment options. Lars Holmberg, MD, of the Kings College Medical School in London and colleagues from Finland and Sweden continued to follow the men for an additional three years.

With a median follow-up of 10.8 years, the cumulative incidence rate for prostate cancer death was 13.5 percent in the surgery arm and 19.5 percent in the watchful waiting arm, for an absolute reduction of 6 percent. The benefit, in terms of absolute risk reduction, did not increase after the first 10 years following treatment. For those patients followed at least 12 years, 12.5 percent of the men in the surgery group died due to prostate cancer compared with 17.9 percent of

the men in the watchful waiting group, for an absolute reduction of 5.4 percent. Overall mortality at 12 years, however, was not statistically significantly different in the two arms at 32.7 percent and 38.5 percent, respectively.

“Contrary to our predictions based on shorter follow-up, the absolute difference in cumulative incidence of distant metastasis and prostate cancer death did not further increase after 7 years of follow-up,” the authors write.

The authors note that it is not clear whether their data are applicable to men whose cancer is detected in the era of PSA screening because most of the men in their trial had palpable tumors at diagnosis.

“In settings with a large proportion of PSA-detected tumors, the relative reduction in risk of death following radical prostatectomy might be somewhat larger or similar to that in our study, but the absolute reduction would be smaller,” they write.

In an accompanying editorial, Timothy Wilt, MD, of the Minneapolis VA Center for Chronic Disease Outcomes Research also raises that issue but concludes that the results are applicable to a subset of current prostate cancer patients.

“These results demonstrate that among men younger than 65 years whose prostate cancer is detected by methods other than PSA testing (e.g., due to a digital rectal examination to evaluate urinary or other symptoms), cure with radical prostatectomy is possible, may be necessary, and should generally be recommended,” he writes.

He notes that the current trial is only the first in a series that are evaluating treatments for men with localized prostate cancer, and that at least one included patients whose tumors were discovered through PSA testing.

These trials and trials testing options between these two extremes will be important in guiding prostate cancer care in the future.

ScienceDaily, 13 August 2008

BRACHYTHERAPY

(Continued from page 5)

external-beam radiation therapy, and 35% received androgen deprivation therapy in addition to brachytherapy. Height and weight data were available for 353 (94%) of the patients. Median age was 66, median baseline PSA was 5.7 ng/mL, and median BMI was 27.1. PSA failure was defined as PSA nadir level plus 2 ng/mL.

The analysis revealed 76 PSA recurrences during a median follow-up of six years. The six-year failure rate by baseline BMI was:

- 30.2% for a BMI 25
- 19.5% for a BMI of 25 to 30
- 14.4% for a BMI ≥ 30 (P=0.19 for trend)

The results remained unchanged in analyses that considered BMI as a continuous variable, that used different definitions of PSA failure, and that excluded patients who had supplemental external beam radiation or androgen deprivation therapy. In a multivariate analysis, only baseline PSA value predicted the time to PSA failure (P=0.0006).

The authors offered several potential explanations for BMI's apparent lack of influence on PSA failure after brachytherapy:

- Brachytherapy is reserved for low-risk patients who already have a reduced risk of PSA failure.
- Obesity tends to reduce testosterone values and increase estradiol levels, which may lead to underdetection of biochemical failure.
- The definition of biochemical failure remains controversial.

The researchers did note several limitations of the study, including the retrospective design, which is subject to selection biases. They also noted that they lacked complete information about patients' lifestyle and comorbidities, which may have mediated the effect of obesity. Nor did they have postimplantation dosimetric data for a number of patients.

Finally, they acknowledged, “Some types of indolent PSA failure may be an inaccurate surrogate end point for cancer-specific mortality.”

MedPage Today, 21 August 2008

CALCIUM AND LETHAL PROSTATE CANCER *(Continued from page 1)*

from understanding that things like serum cholesterol predict heart attack,” Schwartz added. Doctors have struggled to find ways to predict if a man who gets prostate cancer will have a tumor that poses little danger, as is often the case, or one that is a killer.

Blood calcium was not very predictive of whether a man would get nonlethal prostate cancer, but was highly predictive of whether a man would get a fatal case, the researchers wrote in the September 2008 issue of the American Association for Cancer Research’s journal *Cancer Epidemiology, Biomarkers & Prevention* (Vol. 17, pp. 2302-5, 2008). The blood samples on average were given a decade before the cancer appeared, they said.

Schwartz said it is unclear whether it is the actual calcium or blood levels of parathyroid hormone, which is supposed to keep calcium levels at normal levels in the bloodstream that is raising the risk. Either way, he said there

are drugs that can lower them, including Fontus Pharmaceuticals’ Rocaltrol® (calcitriol); Genzyme Corp’s Hectorol® (doxercalciferol); Abbott Laboratories’ Zemplar® (paricalcitol); and Amgen’s Sensipar® (cinacalcet).

People treated for high blood calcium usually have chronic kidney disease, which is associated with low vitamin D levels. Low vitamin D levels elevate parathyroid hormone levels, Schwartz said. Halcyon Skinner of the University of Wisconsin, who also worked on the study, said there is little relationship between calcium in the diet and blood calcium levels, so these men would not benefit from eating less foods that are rich in calcium.

Previous research had suggested a role for calcium in prostate cancer. In laboratory studies, parathyroid hormone and calcium promote the growth of prostate cancer cells.

Reuters, 3 September 2008

ESTROGEN PATCH SHOWS PROMISE FOR PROSTATE CANCER

A patch that delivers estrogen through the skin may prove useful in treating advanced cases of prostate cancer, preliminary research suggests. In a study of 13 prostate cancer patients who were given the Fem7 estrogen patch, UK researchers found that the therapy substantially lowered the men’s testosterone levels.

Because testosterone helps fuel the growth and spread of prostate tumors, men with more-advanced prostate cancer commonly receive drugs called LHRH analogues that block the body’s production of the hormone. However, these drugs can also have side effects, including osteoporosis and heart problems.

Estrogen patches have the potential to lower testosterone levels with a lesser risk of such side effects, according to the researchers on the new study, led by Dr. Ruth E. Langley of Imperial College London.

These early results, Langley noted, at least confirm that estrogen patches lower patients’ testosterone to the desirable “castrate” levels. “Therefore

these patches show promise as a potential therapy for men with prostate cancer,” Langley told Reuters Health.

The findings, published in the August 2008 issue of the journal *BJU International*, are based on 13 men who are part of a larger trial designed to compare estrogen patches with LHRH therapy in treating prostate cancer.

The researchers followed the effects of the Fem7 patch on the men’s testosterone levels over 12 weeks. The question of whether the patch should hold a place in the prostate cancer treatment arsenal requires further study, according to Langley.

“Transdermal estrogen therapy,” the researcher said, “is a novel and potentially cost-effective approach to androgen (testosterone) deprivation therapy. Large long-term studies are required to assess its effect on prostate cancer and side effect profile compared to LHRH therapy.”

Reuters Health, 8 August 2008

PSA SCREENING MAY BE BIASED AGAINST OBESE MEN, LEADING TO MORE AGGRESSIVE CANCERS

Testing men for elevated PSA levels in the blood – the gold standard screening test for prostate cancer – may be biased against obese men, whose PSA levels tend to be deceptively low. And this bias may be creating more aggressive cancers in this population by delaying diagnosis, according to a new study led by investigators in the Duke Prostate Center and the Durham VA Medical Center.

“We know that obese men tend to have lower PSA values than their normal-weight counterparts, possibly caused by larger blood volumes which dilute the readings,” said Stephen Freedland, MD, a urologist at Duke and the Durham VA, and lead investigator on this study. “Now we know some of the real implications of this – that these men are at a disadvantage in terms of prognosis compared to normal-weight men.” The researchers published their findings online in the journal *BJU International*.

“We used patient data to examine the association between body mass index, or BMI – a measure of obesity – and the amount of disease discovered after surgery to remove the prostate,” Freedland said. “We compared men who had their cancers detected by PSA screening to those who had an abnormal digital rectal exam, which may not confer the same bias against obese men.”

The researchers looked at a total of nearly 3,400 men in the years since 2000, when PSA screening became the gold standard test for prostate cancer. Obese patients whose cancer was diagnosed by PSA testing had more than twice the risk of cancer recurrence after surgery than their normal-weight counterparts, Freedland said. “In contrast, obese men with abnormal digital rectal exams had similar outcomes as normal-weight men,” Freedland said.

Another Duke study published in the same issue of the journal provides further substantiation of the concern that obese men have poorer prognoses than normal-weight men. This study showed that obese men have a higher

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NSAIDS AND PSA LEVELS

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ple for headaches, minor pain, arthritis, lowering fever and reducing swelling. Among them are aspirin, ibuprofen (e.g., Advil, Motrin) and naproxen (e.g., Aleve and other brands).

The study involved 1319 men who participated in the 2001-2002 National Health and Nutrition Examination Survey (NHANES). Regular use of NSAIDs or acetaminophen was defined as current use, nearly every day. The investigators found that 19.8% of subjects were regular users of NSAIDs and 1.3% were regular acetaminophen users. Regular NSAID users had PSA levels that were 90% of nonusers (p = 0.038), while regular acetaminophen users had levels that were 0.76 that of nonusers (p = 0.14). Less than 1% of subjects used both NSAIDs and acetaminophen on a regular basis, but there was a suggestion that this combination actually increased PSA levels.

In light of these findings, the researchers call for "large epidemiologic studies with a prospective design" to better understand how NSAIDs affect prostate cancer development and diagnosis.

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SCREENING OBESE MEN

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rate of positive surgical margins after surgery to remove the prostate, meaning that there was a higher chance cancer was left behind. This suggests that prostate cancer surgery is technically more challenging in obese men, making complete tumor removal harder, according to Jayachandran Jayachandran, M.D., a urological oncology fellow at Duke and lead investigator on the second study.

"The aggressiveness of obese men's tumors, coupled with the fact that they may be more difficult to remove, is like a double whammy for being obese," Jayachandran said. "The least we can do is find a way to level the playing field when it comes to diagnostic tools," Freedland said.

PSA screening is the most common tool used to detect prostate cancer over the past ten years; men are less commonly diagnosed based on digital rectal exam alone. Researchers are hopeful that this data, coupled with earlier data on which it builds, may be a catalyst to encourage alternative screening methods for obese men, or a lower PSA threshold for concern in obese men.

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NEW GENE MARKER

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to the slowing of aging and the prevention of other cancers, might also help undo aberrant genetic behavior.

So does Jarrard ply his patients with kegs of red wine? The researcher laughed and said that he only suggests that his prostate cancer patients receive nutritional counseling.

As for how his research has affected his own personal habits, Jarrard said, "I'm much more concerned about what I eat. As far as drinking a lot of wine, I do drink, but in moderation."

<www.Madison.com>, 15 August 2008

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