Us TOO® PROSTATE CANCER EDUCATION & SUPPORT

HOTSHEET

DECEMBER 2012

FINAL RESULTS IN 'DEFINITIVE' PROSTATE CANCER TRIAL

Two treatments are better than 1 for men with locally advanced prostate cancer, according to the final results of a landmark cooperative-group trial. Radiation therapy (RT) plus androgen-deprivation therapy (ADT) improved survival in these men, reported senior investigator Padraig Warde, MBChB, from the Princess Margaret Hospital in Toronto, Ontario, Canada at the American Society for Radiation Oncology (ASTRO) 54th Annual Meeting.

An estimated 15% to 25% of all newly diagnosed prostate cancer is locally advanced, Dr. Warde said. Currently, up to 45% of these cases in the US continue to be treated with ADT alone, he added. This remains the case despite results of randomized controlled trials showing that men with high-risk locally advanced prostate cancer live longer if they receive ADT at the same time as RT. Until now, it has been unclear whether ADT or RT was responsible for the improved survival in these studies. An answer for that question would require a randomized trial.

From 1995 to 2005, men were randomized to lifelong ADT (bilateral orchiectomy or a LHRH-agonist) with or without RT. The standard dosage of RT at the time of the study, i.e., 65 to 69 Gy was given to the prostate, with or with-

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SURGICAL FEATURES KEY TO SURVIVAL IN RADICAL PROSTATECTOMY PATIENTS

The impact of adjuvant radiotherapy (ART) on cancer-specific mortality (CSM) and overall survival (OS) in men who have undergone radical prostatectomy (RP) depends on the cumulative number of certain pathologic features found during RP, researchers say.

Only men with at least 2 of the features are at a significantly higher risk for CSM and are likely to benefit from ART, say Firas Abdollah (Vita-Salute University, Milan, Italy) and colleagues. "Conversely, patients with fewer than two of the risk factors would hardly benefit from ART and may only suffer from its potential adverse effects."

The team evaluated 1,049 men treated with RP and extended lymph node dissection alone, or in combination with ART, and who had at least one of the following pathologic findings: positive surgical margins (PSMs), extracapsular extension (ECE), seminal vesicle invasion (SVI), pathologic tumor (pT) stage 4, and/or lymph node invasion (LNI).

Cox regression analysis revealed that only 3 adverse pathologic features observed during RP were significantly associated with higher rates of CSM. Namely, a Gleason score of at least 8, a pT stage 3 or 4 (categorized by TNM [tumor, nodes, metastasis] classifica-

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PSA SCREENING RATE DROPS AFTER MAJOR TRIAL RESULTS RELEASED

The number of men screened for prostate cancer has sharply declined since the publication of a major trial showing no improvement of mortality rates from screening with the PSA test. Reasons for screening have also shifted, according to research presented at the American Public Health Association (APHA) 140th Annual Meeting.

Researchers evaluated data gathered from participants who received prostate cancer screenings at 41 cancer screening sites across the country as part of Prostate Cancer Awareness Week campaigns in 2008 and 2011. These years were chosen because they represent those before and after the publication of the highly publicized US Prostate, Lung, Colorectal, and Ovarian (PLCO) Cancer Screening Trial, which found no statistically significant effect of PSA-based screening on prostate cancer mortality after 10 years.

For the study, the researchers analyzed data on social and health-related issues obtained in self-reported questionnaires given at the screenings. The findings showed a decline in screenings from just over 8,000 in 2008 to just over 6,000 in 2011, which was a bit of a surprise, said lead author Wendy L. Poage, MHA, of the Prostate Conditions Education Council.

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BMI, BP DO NOT UP PROSTATE CANCER RISK

Results of a large cohort study showed that metabolic factors did not increase the risk of prostate cancer but modestly raised the risk of prostate cancer mortality, an article published online the journal Cancer concluded.

Relatively few studies have examined relationships between specific metabolic factors and prostate cancer, and most investigations have involved small numbers of patients, the authors noted in their introduction. The effect of combined metabolic factors on prostate cancer risk has a mixed history in the literature.

To expand the investigation of metabolic factors and prostate cancer risk, Christel Häggström, MSc, of Umeå University in Sweden and colleagues analyzed data from the ongoing Metabolic Syndrome and Cancer Project (Me-Can). The Me-Can database comprises 289,866 men from Sweden, Norway, and Austria and contains records of blood pressure, lipids, glucose, height, weight, and other clinical and demographic characteristics. Investigators grouped the men into quintiles on the basis of metabolic parameters and calculated relative risk for individual parameters and a cumulative risk score.

During a mean follow-up of 12 years, 6,673 men developed prostate cancer, and 961 study participants died of prostate cancer. Comparing highest versus lowest quintiles for each metabolic parameter, the investigators found that neither the individual parameters nor the composite risk score predicted an increased risk of prostate cancer. Two risk factors were associated with a lower risk of prostate cancer: fasting glucose (RR 0.82, P=0.03 for trend) and triglycerides (RR 0.88, P=0.001 for trend).

Analysis of associations between risk factors and prostate cancer mortality identified 3 parameters that predicted an increased risk: BMI (RR 1.36, $P = 0.013$ for trend), systolic blood pressure (RR 1.62, $P = 0.001$ for trend), and diastolic blood pressure (RR 1.24, P=0.001 for trend). Also, the adjusted composite score (z score) predicted an increased prostate cancer mortality risk (RR 1.13 for trend).

"The results of the current study add

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Us TOO Needs Your Help

I hope you are enjoying reading this month's ***HotSheet***. This is just one of the many resources provided by Us TOO for those with prostate cancer and their families...resources that are timely, accurate, and written in language that we can all understand. When we come to the end of the year, we have to ask ourselves, "Who's paying for all this?" There are printing costs, plus the costs of the very small staff and dedicated volunteers needed to assemble, print and distribute this information.

Printing is just a small part of Us TOO's overall activity in support of YOU who are dealing with prostate cancer. There is the website, which must be constantly updated to stay current, plus the one-on-one support given to individuals, chapters and support groups.

Where does the money come from? Well, from you, actually, and unfortunately we're barely getting enough to keep going. Now, if everyone reading this issue of the ***HotSheet*** was to contribute just $5, funding pressures would be greatly decreased. Of course, not everyone can afford even $5, but if YOU could afford to send $5, $10, maybe even $20, we would be much stronger financially going into the New Year.

Please consider making such a contribution, now while it's on your mind. A handy form can be found conveniently placed on the back page of this issue. Thank you for your consideration.

Bill Seidel

Us TOO Chapter Leader and Member Us TOO Board of Directors

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

"A daily adult Centrum® Silver®, or children's multivitamin can potentially reduce your risk of cancer, but not cardiovascular disease? Yes, and 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: Wow! Wow spelled backwards! The first major randomized clinical trial of a single daily multivitamin reduced the risk of cancer being diagnosed in men 50+ years old and even in those with a history of cancer, but it had no impact on cardiovascular disease even though it may have reduced the risk of dying from a heart attack (read the column please).[1] Still, this now solidifies after 10 years the Dr. Moyad long standing recommendation to take a single children's multivitamin daily or something close to an older version of Centrum® Silver (if you want to take a multivitamin). However, stay tuned for the final analysis and results of this study, which will report the impact of this multivitamin on eye and mental health, in a near future *HotSheet*!

Some people laugh at me not only because I am funny looking, but because I would tell audiences in my books and at lectures that there is no solid research yet on whether or not men or women should take a daily multivitamin. And, I warned folks that some multivitamins contain too many ingredients and too many pills and was not based on human research. So, I have been saying for years that if you want to take a multivitamin please take what I take which is "a children's multivitamin." Keep in mind that a children's multivitamin today contains basically all the things an adult multivitamin contained 15-20 years ago! Now keep this in mind.

The Physicians' Health Study II was a randomized, double-blind, placebo-controlled trial (Centrum® Silver® multivitamin or placebo) of over 14,500 male physicians initially aged 50 or older (average age of 64 years), which included 1,312 men with a personal history of cancer. The study actually began in 1997. Cut to the chase Moyad….okay quit being so pushy….men taking a multivitamin had a significant 8% reduction in the risk of being diagnosed cancer, which does not seem great, but it is great in my opinion. A closer look at the data showed that men with a history of cancer had a 27% reduction, but men with prostate cancer appeared to get neither benefit nor harm, but I believe the data looks as if they received a small benefit especially if they already had a personal history of cancer!

Interestingly, the overall benefit increased with increasing age so that the men 70 years and older had the largest reductions in overall cancer risk (18%-not bad). Additionally, there was a non-significant 12% lower risk of dying from cancer in the multivitamin group that almost became statistically significant. And, what was not well reported in the media was that the men in this study were arguably some of the healthiest men I have ever seen in a clinical study! They were active, great diet, most did not smoke…, which means the next time someone tells me I am incredibly healthy and I do not need a multivitamin I will say "you are wrong based on the largest and best multivitamin study ever done in medical history." Additionally, "experts" said that the multivitamin did NOT impact cardiovascular risk, which was primarily true except there was a significant reduction (almost 40%) in the risk of dying from a heart attack, which was not really discussed, in the men receiving multivitamins!

Finally, if you see the new ads for Centrum Silver published in the past few weeks praising themselves for being in this study (and they should get a lot of credit) there is a small line at the bottom of their ad that states "A prior formulation of Centrum Silver was used in a long-term study evaluating the health benefits for men 50 and older." This means the Centrum Silver used in the study is not the one offered today, which has several more ingredients! The one used in the big study closely matches most children's multivitamin formulas today! So, until the makers of Centrum revive sales of the pill formulation used in the study, you may consider taking a children's multivitamin or something close to the 1990's Centrum silver, although some may argue that you should just stick with the current Centrum Silver!

Wow! For all the "experts" that said the results were not that great, please find me one insurance plan or pill sold in the US that truly costs pennies a day, that has a similar side effect to a placebo and reduces the risk of getting cancer or possibly dying from one! Even if you follow all the current healthy lifestyle advice thrown at the public, I will show you a pill that everyone, including your doctor, would take in a second if these and other results in this study remain positive over the next several months of further analysis! DANG – THIS IS EXCITING STUFF!!!

Reference

1. Sesso HD, Christen WG, Bubes V, et al. JAMA 308:1751-1760, 2012.

US TOO SEEKS BOARD MEMBER APPLICATIONS

Us TOO International, is seeking qualified individuals to serve on its Board of Directors. Members have been diagnosed with prostate cancer, are a member of such a man's family or significant other, or any person involved in or interested in support or treatment of such patients. Other qualifications include familiarity with an Us TOO chapter, ability to think globally, skills or experience deemed beneficial to the work of Us TOO and commitment to Us TOO's purpose and mission. See details at www.ustoo.org/SeekBoardMembers.asp.

Send letters of nomination with a vita or resume to Thomas Kirk, President and CEO, Us TOO International, 5003 Fairview Avenue, Downers Grove, IL 60515 or e-mail tom@ustoo.org.

DRUG AIDS SEXUAL FUNCTION OF PROSTATE CANCER PATIENTS FOLLOWING RT

Sildenafil citrate (Viagra®) improves overall sexual function of prostate cancer patients who received radiation therapy (RT), according to trial results presented by researchers from Memorial Sloan-Kettering Cancer Center at the American Society for Radiation Oncology (ASTRO) annual meeting.

A prospective, randomized, double-blind, placebo-controlled trial was done to determine if daily, adjuvant use of Viagra, would preserve erectile function (EF) in prostate cancer patients. The drug has proved beneficial to men after radical prostatectomy (RP). "We wanted to see if it could help preserve EF after RT as well" explained radiation oncologist Dr. Michael Zelefsky, Vice Chair for Clinical Research in the hospital's Department of Radiation Oncology.

The study included 290 men with clinically localized prostate cancer who were treated with external-beam RT (EBRT) and/or permanent brachytherapy (BT). They were randomly assigned to receive Viagra, 50-mg daily or a placebo. Medication/placebo was initiated 3 days before RT and continued daily for 6 months, after which therapy was discontinued and taken on an as-needed basis.

Men in both groups were asked to complete the International Index of Erectile Function (IIEF) and International Prostate Symptom Score (IPSS) questionnaires before therapy and at 6, 12, and 24 months after RT.

Results from 144 evaluable patients, indicated that those in the Viagra group experienced improved overall sexual function compared to the placebo group at all time points. Patient characteristics including age, brachytherapy use, androgen-deprivation therapy, and baseline IIEF scores were similar among both treatment groups.

"The most significant improvements were seen at six and 12 months following treatment, with a slight dip at the 24-month mark," said Zelefsky. "This suggests that future clinical trials need to be conducted to demonstrate if a longer treatment can further improve patient outcomes."

Aunt Minnie.com, 6 November 2012

PSA SCREENING RATE DROPS *(Continued from page 1)*

"Our findings did indicate a reduction in participation in screening, which we expected," she said. "However, we were surprised by the magnitude of this, as it is a 25% reduction in participation between 2008 and 2011 in this longitudinal study group." Poage added,

"We didn't find any real difference in terms of who participated in 2008 and 2011 based on age, so it was pretty consistent between the 2 years," which she said is good. "We would like to see an increase in the number of 41- to 55-year-olds receiving screening," she added.

Data also showed some interesting shifts in the reasons men received screenings. In 2008, for instance, 7.8% of respondents said they received the screening because they believed they were at high risk, compared with just 3.2% in 2011. "There was a significant drop in those participating just because they were generally health conscious, and a very significant drop of almost 20% for men just visiting for their concerns for prostate cancer," Poage said. "But the only good statistic that we were a little excited to see was family history. That rate doubled, which means men understand that there are significant risk factors across racial barriers for prostate cancer."

The impact from the recent recommendations against screening is evidenced in the decline seen in the Prostate Cancer Awareness Week data, and will likely be seen for years to come, however, Poage said. "We know already from the last 6 months since the most recent (USPSTF) guideline change that there has been a decrease in referrals for prostate cancer from primary care physicians," she said. we certainly have a lot of work to do," she concluded.

2012 APHA Meeting, abstract 267022.
Medscape Medical News, 1 November 2012

DEFINITIVE' PROSTATE CANCER TRIAL *(Continued from page 1)*

out RT to seminal vesicles. If needed, 45 Gy was delivered to the pelvic nodes. All men had T3/T4 prostate cancer or T2 disease with a PSA above 40 ng/mL, or T2 disease with a PSA above 20 ng/mL and a Gleason score of 8 or higher.

RT+ADT significantly improved overall survival by 30% (hazard ratio [HR], 0.70; 95% confidence interval [CI], 0.57 to 0.85; $P = 0.0003$) and significantly improved disease-specific survival by 54% (HR, 0.46, 95% CI, 0.34 to 0.61; $P < 0.0001$), compared with ADT alone. Of the 603 men randomized to the combination, 205 have died, 65 due to disease or treatment. Of the 602 men randomized to ADT alone, 260 have died, 134 due to disease and/or treatment. Median follow-up was 8.0 years.

Late treatment toxicity with the combination increased marginally, Dr. Warde reported. For late gastrointestinal toxicity (above grade 2 proctitis), RT+ADT had a small detrimental effect, compared with ADT alone (1.0% vs 0.3%).

"This is the definitive trial in patients who are suitable for radical treatment, referring to men with locally advanced disease who are in good health and have a life expectancy of 5 to 10 years stated Dr. Ward. For older men and those with major comorbidities such as cardiovascular disease, RT should be avoided, he said. He hopes that the results will be "practice-changing" by shifting away from treatment of locally advanced disease with ADT alone.

An estimated 15% to 25% of all newly diagnosed prostate cancer is locally advanced and is therefore high risk, Dr. Warde said. He hopes the message reaches urologists because they are the primary prescribers of ADT alone for this stage of disease. One reason may be it is easy to prescribe, said Jeff Michalski, MD, from the Siteman Cancer Center and Washington University School of Medicine, who was not involved with the study. "With ADT, there's an initial favorable response, but there is also an inevitable progression and decline in quality of life," he said.

The results of this study are "exciting," but they might "underestimate" the effect of combination therapy, said Dr. Warde. Radiation oncologists now use 76 to 80 Gy to the prostate, Dr. Warde pointed out. "We now have the technology to do better," he added.

Presented at the ASTRO 54th Annual Meeting, Abstract 8, 28 October 2012

Medscape Medical News, 31 October 2012

DEFINITIVE TRIAL OF ADT+RT

(Continued from page 1)

tion), and a positive lymph node count of 1 or more significantly increased the risk for CSM, at hazard ratios 5.4, 2.2, and 2.6, respectively. The total number of factors shared by each man was used to construct a novel risk score and CSM-free survival curves were then analyzed after stratification according to the score.

Men who were treated with and without ART had 10-year CSM-free rates of 79.9% vs. 69.6% when they had a risk score of 2 or more (more than two of the predictors) while the rates were 97.6% vs. 96.6% when the risk score was less than 2. Similarly, 10-year OS in men treated with vs. without ART was 75.6% vs. 62.7% for men with a risk score of at least 2, while it was 95% vs. 88.5% for men with a risk score of less than 2.

"From a clinical perspective, the classification of patients according to our novel risk score might be considered easier and more practical, especially when a physician has to decide on the need for ART after RP," suggests the team.

MedwireNews, 5 November 2012

METABOLIC FACTORS

(Continued from page 2)

further evidence to support the hypothesis that high levels of metabolic factors, separately or combined, are not related to the development of prostate cancer but are related to an increased risk of disease progression, but with no evidence of synergy between the metabolic factors," wrote Häggström. He added that this data should encourage efforts to control these factors to decrease risks of cardiovascular disease, diabetes and perhaps prostate cancer death.

"The question now becomes 'why' "said Stephen Freedland, MD, of Duke University, who was not involved in the study. "Both elevated glucose and triglycerides are common among men with diabetes, which is an end state of insulin resistance wherein the pancreas can no longer keep up and starts to fail." He argues that low insulin is protective for prostate cancer death, which would directly support prior work by others suggesting this mechanism.

MedPage Today, 22 October 2012

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.

I was diagnosed with prostate cancer April 2005 and had robotic surgery in September 2005. At the time my PSA was 4.0, Gleason score 3+2=5, and stage T1. I see my urologist every 6 months since surgery and my PSA has been 0.0. Since my surgery I do have little leakage when straining and ED. My problem is that my libido is very low. Prior to surgery I did not have this problem.

My average testosterone level after surgery (7 samples) is 348 ng/dL with a low of 193 and a high of 474. I don't know what it was prior to surgery. I did see an endocrinologist. He told me my symptoms were compatible with hypogonadism. Additional lab results from my visit with him are in the table below.

Considering all of this, would it be advisable to raise my testosterone level by injection? Hopefully this would increase my libido and energy. I would have 3 monthly injections and then be monitored by my urologist.

Your opinion on this issue is appreciated.

Laboratory test	Test result	Normal results
Testosterone, free & weakly bound	42.3 ng/dL	40.0–250.0 ng/dL
Testosterone, % free & weakly bound	15.8%	9.0–46.0%
Luteinizing hormone (LH)	8.6 mIU/mL	1.5–9.3 mIU/mL
Follicle-stimulating hormone (FSH)	17.7 mIU/mL	1.4–18.1 mIU/mL
Sex-hormone binding globulin (SHBG)	28 nmol/L	13–71 nmol/mL

First, let me say I am sorry you were needlessly subjected to a radical prostatectomy. Your case looks to be a classic example of overdiagnosis and overtreatment. The PIVOT trial shows that there is no survival benefit out to 12 years in cases like yours. Unfortunately, sexual function is very rarely the same after surgery. Simply the loss of an ejaculate alters the quality of the sexual experience.

You do not suffer from hypogonadism. Your total testosterone is at the low end of normal, but the free and weakly bound levels are well within the normal range. As a result, it is very unlikely that testosterone replacement would help.

In addition to damage that often occurs to the nerves that cause erections, surgery can have a psychological impact by causing men to doubt their performance. The combination of somewhat diminished erections, loss of the ejaculate and a doubt about performance can combine to cause loss of sex drive. In some men, drugs for ED can also restore confidence and get you back in the groove. We like to use Levitra® or Cialis® as a daily 2.5 or 5 mg dose or Cialis 3 times a week to get men restarted.

The dopamine D2 agonist, cabergoline, can also increase sex drive by activating the brain circuits involved. We typically use 0.5 mg 2 or 3 times a week. Much higher doses of cabergoline were once used to treat Parkinson's disease and at those doses actually triggered hypersexuality. One nice randomized controlled trial compared Viagra® alone with Viagra and cabergoline and found cabergoline had a significant impact. Two drugs related to cabergoline, Mirapex® and Requip® also appear to increase sex drive even to the point of causing hypersexuality if the dose is high enough.

You should also check if a drug you are on might be having a negative impact. The antidepressants Prozac®, Zoloft®, Celexa® and Lexapro® all lessen sex drive. The antihistaminic agent, Benadryl® found in many over the counter sleep aids can also lessen sex drive.

RECTAL CLEANSING BEFORE BIOPSY MAY NOT REDUCE INFECTIONS

"Infectious complications after prostate biopsy are a highly relevant clinical issue and we need to find ways to reduce the risk," Dr. Peter C. Black from University of British Columbia in Vancouver, Canada told Reuters Health. "A lot of urologists are changing the antibiotics that they give and are undertaking measures that appear to make sense clinically, but we should base these decisions on clinical trials as best we can, and so we need to continue to do these types of trials."

In this case, Dr. Black and colleagues investigated whether Betadine® (povidone-iodine) cleansing of the anterior rectum prior to transrectal ultrasound guided prostate biopsy would decrease the rate of infectious complications. The randomized trial, reported online 3 October 2012 in *The Journal of Urology*, included 865 men (421 in the treatment group, 444 in the control group).

There were only 11 infectious complications (2.6%) in the treatment group and 20 (4.5%) in the control group, for a relative risk reduction of 42% (p=0.15).

"The trial was negative, so we cannot say with any conviction that povidone-iodine works as we administered it," Dr. Black said. "However, I do believe that we would have had a good chance to demonstrate a statistically significant difference between the groups if we had a larger study. We saw approximately half the number of events that we expected, so our study ended up being under-powered."

Nearly half the men (48%) with infectious complications (including eight of the 11 with sepsis) had ciprofloxacin-resistant gram-negative bacteria in the rectal culture, compared with only 19.5% of the total study population.

It is common to give an antibiotic to a patient with an elevated PSA level to see if it will go down, Dr. Black said. "We know that this does not affect the subsequent risk of being diagnosed with prostate cancer," he added. "This practice will, however, increase the risk of infectious complications after biopsy and should be avoided. If a patient has been on a fluoroquinolone within 3 months, it may be best to delay the biopsy if it does not appear to be clinically urgent."

Researchers say only minimal adverse reactions to povidone-iodine, occurred with 4 patients reporting anal itching.

"It is so easy to perform the cleansing - and so well tolerated by the patients - that it is tempting to adopt it as a routine practice, but we have not done this," Dr. Black concluded. "We are currently in the process of drawing up new recommendations for Vancouver General Hospital for all patients undergoing biopsy."

Reuters Health, 9 October 2012

SELECTED NCI CLINICAL TRIALS FOR CRPC

- A Phase I Study of Cabozantinib (XL184) Plus Docetaxel and Prednisone in Metastatic Castrate Resistant Prostate Cancer
- A Phase II Study of AMG 386 and Abiraterone in Metastatic Castration Resistant Prostate Cancer
- A Phase I/II Study of TRC105 in Metastatic Castrate Resistant Prostate Cancer
- A Randomized, Double-Blind, Phase III Efficacy Trial of PROSTVAC-V/F Plus or Minus GM-CSF in Men With Asymptomatic or Minimally Symptomatic Metastatic, Castrate-Resistant Prostate Cancer
- A Randomized Phase II Trial Combining Vaccine Therapy With PROSTVAC/TRICOM and Flutamide vs. Flutamide Alone in Men With Androgen Insensitive, Non-Metastatic (D0.5) Prostate Cancer
- NaF PET/CT Repeatability, Responsiveness, and Response Assessment in Patients with Metastatic Castrate-Resistant Prostate Cancer to Bone Treated With Either Docetaxel-Based Chemotherapy or Androgen Receptor (AR)-Directed Therapies

For details about these trials and to obtain additional information, please go to the NCI Clinical Trials Website: http://bethesdatrials.cancer.gov/prostate/index.aspx

AETNA EXPANDS COVERAGE OF DENDREON'S PROVENGE

In October, Aetna Inc. said it will pay for a greater number of men to receive sipuleucel-T (Provenge®), the prostate cancer drug made by Dendreon Corporation in Seattle, WA.

Aetna will now provide coverage for men with metastatic prostate cancer that has spread to the lungs or the brain and failed to respond to hormone therapy. Previously, patients whose cancer spread to the brain or lungs were not covered. Patients whose disease has spread to the liver still are not covered.

Provenge, the first personalized, therapeutic vaccine to reach the market, has taken off to a disappointing start amid confusion among physicians over reimbursement. It costs roughly $93,000 per treatment. In 2011, it generated just $213.5 million, roughly half of what the company had originally projected.

Provenge was approved in the US in April 2010 based upon the results of clinical trial showing that the drug extended median survival by 4.1 months, to 25.8 months from 21.7 months.

Reuters, 9 October 2012

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

Editor: www.prostatevideos.com

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a1p1c1 The RT community deserves credit for continuing to conduct randomized studies to answer questions about optimal therapy. Ward and co-workers reported the results comparing ADT alone to ADT + RT. Previous studies showed that a castrate testosterone level improved RT results but it could not tell us if the RT was really necessary. Now that question has been put to rest because men treated with the combination had better survival compared to men treated with ADT alone; so it is the combination that really is best. This means that all men with high-risk disease should be counseled about getting the two treatments rather than just one.

The Bottom Line: Men with high-risk prostate cancer have better survival if they receive ADT + RT rather than either treatment alone.

a2p1c2 One of the more controversial management questions is whether men should receive immediate RT after radical prostatectomy (RP) if their pathology is unfavorable. An earlier randomized study found that there was a small but statistically significant increase in survival when immediate RT was compared to no RT. However, updated results from another randomized study were recently reported by Bolla and co-workers. Results showed that immediate RT was beneficial by delaying disease progression, but it did not reduce the chance of metastatic spread, nor did it improve survival. Plus, men getting immediate RT had a 10% higher risk of side effects. The study by Abdollah, et al examined specific post-RP pathologic risk factors to identify the best candidates for immediate RT. If these results are confirmed, immediate RT would only be given to men most likely to benefit from it while RT could be deferred for men that have fewer risk factors present. These results are also important regarding men considering surgery. Should they have an RP followed by RT or chose treatment with ADT + RT? Only a randomized study can answer that question. If these 2 options were found to provide equivalent results, ADT + XRT could be a good option and lead to fewer RP-related complications.

There are 2 important messages here. First, it means that delaying RT is not unreasonable. Yes, getting it right away delays the need for other treatment later but many will wonder why they should do it if it doesn't help them live longer or prevent metastases. A second and VERY important point relates to RT in general. Many studies have reported PSA response rates using newer RT modalities such as Proton beam, stereotactic RT and IMRT + seeds, but did not reported survival results. We are left to assume that if PSA control is good, so will the survival results be. This study is yet another example of why PSA is NOT a valid way to assess the long-term impact of RT; PSA control might appear good yet it does not necessarily translate into a survival benefit. Therefore, men should use caution when considering newer RT treatments until survival results are available. Valid conclusions regarding the effectiveness of these newer therapies cannot be made until survival results become available.

The Bottom Line: Although post-RP RT for high-risk men may delay a rise in PSA, it does not improve survival or prevent metastatic disease from developing compared to giving RT after a rise in PSA is confirmed.

a3p1c3 The article on declining PSA screening rates by Poage and co-workers adds support to other data showing that attitudes toward getting tested have changed. All of the publicity about the USPSTF's report that claims a lack of major benefits from screening seems to have led men and their doctors to consciously decide whether or not screening should be done. This study suggests that more high-risk men are getting tested while fewer men in all age groups are getting tested and less often. One clear change is that doctors are becoming increasingly aware that too many men are being diagnosed and then treated for prostate cancers that are not a threat to life. Some argue that it is better that men be diagnosed and then carefully decide if treatment is needed, while others say that many men find active surveillance too difficult to accept and therefore why investigate and make a diagnosis. Other data from a study at VA hospitals found that a large number of older men with a short life-expectancy were getting screened but that may also be changing.

The Bottom Line: The best advice for healthy, asymptomatic men is to make an informed decision about undergoing screening rather than assume screening will definitely be beneficial.

a4p2c2 A growing body of evidence is showing that death due to prostate cancer is related with abnormal metabolic factors. Now another study in Scandinavian men adds additional support to this concern. Obesity, diabetes and high blood pressure appear to increase a man's risk of death. Although this study is not randomized or prospective, it does provide information that is consistent with other studies. The results are also in keeping with the observation that low testosterone levels induced by androgen deprivation therapy (ADT) can cause weight gain and increase the risk of developing diabetes. The take home message from this is that more needs to be done to raise awareness of these problems. Men with prostate cancer should be just as concerned about maintaining their metabolic health as they are about their PSA or the latest new therapy and work on improving their diet, avoiding excessive weight gain and controlling their blood pressure. This requires regular exercise and weight training along with modifying their diet. Otherwise, these men may be reducing their risk of dying from prostate cancer while increasing their risk of dying from something else.

The Bottom Line: Men with prostate cancer who want to maximize their survival should evaluate all aspects of their health that can be modified. That means weight loss and exercise should be part

(Continued on page 8)

DOCTOR CHODAK'S BOTTOM LINE *(Continued from page 7)*

of the overall treatment plan.

a8p4c1 One of the concerns about treating men with prostate cancer is the risk of developing reduced erections. Good studies show that sexual rehabilitation can help men either preserve or regain their ability to have erections after local therapy. Now another well-done study by Zelefsky and co-workers provides additional support for using a phosphodiesterase type 5 (PDE5) inhibitor before and after external beam radiation treatment (EBRT) or radioactive seed implantation. This randomized study tested the effects of sildenafil (Viagra®) for 6 months and found a significant improvement in erectile function. It was not a home run, meaning that there is still much room for improvement. Also, until the paper is published, much of the important information needed to fully evaluate this study is missing. But for now, the results of the study support the use of other PDE5 inhibitors in men undergoing RT.

The Bottom Line: Men who are scheduled to receive either EBRT or seeds should have a discussion with their physician about using one of the available PDE5 inhibitors for 6 months to increase their chances of regaining sexual function after RT is completed.

a10p6c1 One of the arguments against routine prostate cancer screening is the risk of serious infections from a prostate biopsy. More strains of bacteria are becoming resistant to commonly used antibiotics, such as ciprofloxacin. A randomized study by Black and co-workers studied the benefit of cleansing the rectum with povidone-iodine prior to the biopsy to reduce infections; however the study's results were negative. Although the authors believe this treatment would have had positive results if more patients were included, the fact is that the results are negative. One issue that is frequently overlooked is the fact that the antibiotic must be taken at least 30 minutes before the biopsy begins to attain adequate blood levels of the drug. More often than not, the antibiotic is given less than 30 minutes before the procedure. Nevertheless, infectious complications after prostate biopsy remain a serious problem and need to be evaluated further.

The Bottom Line: The risk of infections after a prostate biopsy is a growing problem and more studies are needed to find ways to lower this risk.

a12P6C3 Provenge treatment has generated so much controversy since its approval in 2010. Although it does improve survival, the cost is high and it does not reduce PSA or bone metastases so many doctors have been reluctant to use it. Insurance companies have also held back but it now appears that Aetna is expanding its coverage. Although the median improvement in survival is 4.1 months, it appears that men with a lower PSA at the time the treatment is started have more than a 13-month improvement in survival.

The Bottom Line: Men with metastatic disease and no or limited symptoms who have disease progression on medical or surgical castration should at least consider Provenge as part of their treatment.

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