PROSTATE CANCER HOT SHEET

Us Too! INTERNATIONAL NOVEMBER 2003

CENTERS FOR DISEASE CONTROL AND PREVENTION AWARDS *US TOO!* INTERNATIONAL A $1.46 MILLION GRANT

Us Too! International has received notification from the Department of Health and Human Services Centers for Disease Control and Prevention that a grant request had been approved and they will enter into a cooperative agreement beginning on 9/1/2003 and ending 8/30/2008.

This five-year award, in the amount of $292,530 per year, will fund direct patient education services and outreach to prostate cancer patients from target minority and medically underserved populations and will be an integral part of the CDC's National Strategies for Prevention, Early Detection or Survivorship of Cancer in Underserved Populations initiative. This project will be 100% funded by the grant and no other financial support will be utilized to fund this project.

Us Too! has proposed to reduce the higher mortality rates and increase survivability among minorities, culturally diverse, and medically underserved populations by increasing awareness and education of the disease and removing cultural barriers blocking access to timely healthcare services across the spectrum of disease management.

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US TOO! UNVEILS NEW LOGO AND WEB SITE

Us Too! International has adopted a new logo as part of an ongoing program to enhance awareness of Us Too! and the products and services we provide to men, their companions and men at risk. "The new logo is intended to convey a sense of support and unity." said John Page, President and CEO of ***Us Too!***. "The incorporation of an arch and the prostate cancer blue ribbon – in addition to using the tag line 'Prostate Cancer Education and Support' - into the new logo provides an immediate awareness of the ***Us Too!*** mission and identity."

In addition to the logo ***Us Too!*** in September unveiled an updated website which is easier to navigate and find the information for which you are searching. The goal of this first 'facelift' to the website was to simply make the site more user friendly. Over the next few months we'll be incorporating new and expanded content to the site.

If you haven't seen the new website feel free to go surfing today! (See graphic on p7). An updated chapters listing, archives of the Hotsheet, and links to current Prostate Cancer News are all now just one click away!!

Suggestions and comments are always appreciated. Contact Craig Kurey at craig@ustoo.org

US TOO! BOARD OF DIRECTORS RECOGNIZES FOUNDING MEMBERS

At it's Fall meeting the *Us Too!* International Board of Directors were informed that recently deceased *Us Too!* Founder John Moenck left a substantial number of books, papers, video and audio tapes as well as volumes of historical records to *Us Too!*. In recognition of this gift the Board voted to rename the *Us Too!* Resource Center the ***"Us Too! / John Moenck Memorial Prostate Cancer Resource Center***" in recognition of the bequest by Mr. Moenck. The Resource Center is located at *Us Too!* Headquarters and is available daily at no cost for those interested in prostate cancer to conduct personal research into the disease. Resources - such as video tapes - are also made available to Chapter Leaders for use in local chapter meetings. (For more information about the Rescource Center or any Us Too! product or service contact *Us Too!* Headquarters).

In addition, the Board of Directors has voted to recognize *Us Too!* Founder Edward Kaps as a Director Emeritus in consideration of his significant contributions to the prostate cancer community and the organization. Mr. Kaps joins fellow *Us Too!* Founder John De Boer who was voted as a Director Emeritus in 2002. Mr. Kaps said that he was honored to have been recognized and praised the *Us Too!* Leadership for the enormous progress made in continuing to help men with prostate cancer. "I am so proud of my long association with *Us Too!* and will continue to support the organization and its mission to the best of my ability."

PROSTATE CANCER NEWS YOU CAN USE

Us Too! publishes a FREE e-mail based news service which provides updates on the latest prostate cancer related news. To subscribe or link to the archives simply visit the ***Us Too!*** Website: www.ustoo.org

News items contained in ***Us Too!*** publications are obtained from various news sources and edited for inclusion. Where available, a point-of-contact is provided.

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

THE *US TOO!* PROSTATE CANCER HOT SHEET IS MADE POSSIBLE BY AN UNRESTRICTED EDUCATION GRANT FROM

AstraZeneca

MAJOR STUDY INDICATES COMPLEXED PSA TEST MORE ACCURATE THAN TRADITIONAL PSA TEST IN DETECTING PCA

A major study on detecting prostate cancer indicates that measurement of serum concentration of complexed prostate specific antigen (cPSA) is more accurate than the total PSA (tPSA) test currently used by most physicians.[1] The study, published in the November issue of The Journal of Urology, showed that the cPSA test is more predictive of prostate cancer and results in fewer false diagnoses and unnecessary biopsies compared to the traditional tPSA test. (Note: The full article can be accessed via http://www.jurology.com).

"These findings are important because they suggest that use of the cPSA test can decrease the number of unnecessary prostate cancer biopsies particularly if a lower PSA threshold is utilized. This approach will not only save healthcare expenditures but will also spare many men the discomfort and anxiety associated with biopsy procedures," said investigator Richard Babaian, M.D., from MD Anderson Cancer Center. "In view of these findings, physicians and patients should consider using the cPSA test when screening for prostate cancer."

Serum PSA, a protein produced in the prostate, has proven to be an extremely useful marker for early detection of prostate cancer and in monitoring patients for disease progression and the effects of treatment. PSA serum levels of 4.0 ng/ml or less are usually considered normal; higher levels (4 to 10 ng/ml or higher) are often found in men with prostate cancer. However, current PSA testing generates up to 60 percent "false positive" diagnoses because PSA levels can also increase due to enlargement of the prostate, a non-cancerous condition increasingly common as men get older, as well as acute infections of the prostate (prostatitis), prostate surgery and other factors. On the other hand, testing can also generate "false negatives" because a significant number of cases of prostate cancer have been found in men whose PSA was "normal," between 2.5 to 4 ng/ml.[2]

The ability of a test to detect cancer is defined as "sensitivity;" the ability to detect those without cancer is defined as "specificity." Sensitivity can be increased by lowering the tPSA "cutoff" value at which a physician suspects cancer, but doing so will decrease specificity, since it will also increase the number of men suspected of cancer but who don't actually have it. Therefore, much research has focused on ways to improve the accuracy of PSA testing, i.e., to increase both sensitivity and specificity. Some studies have shown that the cPSA test is equivalent to the tPSA test while others have shown it is better than tPSA.[3] Other PSA tests include those that measure free (vs. complexed) PSA and the percentage of tPSA comprised of free PSA and of cPSA.

Study and Findings

In this study, conducted at seven prostate cancer treatment centers, sera was collected from 831 men who were about to undergo initial prostate biopsy. The biopsies showed that 313 (37.5 percent) had prostate cancer.

Knowing which patients actually had prostate cancer, the investigators compared the accuracy of the predictions of the cPSA and tPSA tests. They found that cPSA was significantly more predictive of cancer than tPSA, and provided an improvement in specificity (reduced false positives) compared to tPSA. For example, for men whose tPSA levels were in range of 2 to 4 ng/ml (cPSA range 1.5 to 3.2 ng/ml), using a cutoff of 2.2 ng/ml for cPSA and 2.5 ng/ml for tPSA resulted in both tests correctly identifying cancer 85 percent of the time, which is considered highly sensitive. However, at this 85 percent sensitivity level, the cPSA test correctly identified 35 percent of patients who did not have cancer, compared to 21.2 percent for the tPSA test. Therefore, the cPSA test would have saved significantly more men — 14 percent — who did not have cancer from undergoing an unnecessary biopsy and the inconvenience and anxiety associated with that procedure.

"Urologists are increasingly looking at the lower range of PSA values to maximize the detection of prostate cancer," said Dr. Babaian. "Since this lower range also includes many men without cancer, the enhanced specificity of the cPSA test to detect those who are cancer free and avoid unnecessary biopsies is an important advantage over the standard tPSA test."

The investigators compared the predictive value of the tests in other ranges as well. For the range of 2 to 10 ng/ml tPSA (1.5 to 8.3 ng/ml for cPSA), the cutoffs of 3.37 ng/ml tPSA and 2.87ng/ml cPSA

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KNOWING HOW TO CHOOSE AND WORK WITH DOCTORS

By John Messmer, M.D.
Penn State Milton S. Hershey Medical Center

Many people don't think much about doctors until they need one. Take it from a physician, if you don't have a doctor, a crisis is not the best time to pick one. Although an emergency room or urgent care center may help you with your immediate need, having your own doctor will allow you to manage your health and the health of your family for the long term.

Each fall, employers conduct their annual benefits enrollment. As a participating employee, you may be asked by your health insurance plan to select a primary care physician (PCP). How selective are you?

In deciding on a doctor, you should consider your needs and preferences —not just pick a name out of a catalog. Your age, gender, marital status, family members and any current medical problems will (should?) influence your decision. Almost everyone should have a primary care physician (PCP) — a medical professional who will be responsible for your health on a continuing basis with emphasis on prevention of future health problems. The PCP, usually a family physician, internist or pediatrician, should also coordinate the care provided by other specialists.

Do you like the idea of the entire family seeing the same doctor? Not everyone does. If you do, consider a family physician. If you prefer a doctor specifically trained in one area, you should choose a pediatrician for your children, an internist for the adults and an obstetrician-gynecologist for women's health care.

Pediatricians provide both preventive care and treatment for children into adolescence. General internists provide care for all adults, usually from about age 18. Family physicians care for people of all ages, including children and older adults. Sounds pretty straightforward, but the differences among these types of physicians are more than the ages of their patients.

Pediatricians spend time training for the more complicated problems of childhood, including hospital care such as intensive care, problems of prematurity, cancers, heart disease and so on. In practice, pediatricians do not commonly do office surgery and many do not provide gynecology treatment. Internists, or doctors of internal medicine, emphasize prevention and treatment of diseases of bodily systems and often focus on hospital treatment. Internists do not manage gynecology or do office surgery, but their training includes both common and unusual medical problems.

Family physicians are trained in the broad range of medicine and learn to care for infants, older children and adults of all ages including office surgery, gynecology and obstetrics and hospital care. Because of the wide scope of family practice, some family physicians focus more closely on certain areas and refer patients for things they do not handle often, such as obstetrics. Similarly, internists and pediatricians may refer people for medical conditions that require a more focused approach to treatment.

Many primary care practices include nurse practitioners (NP) and physicians assistants (PA), often referred to as "mid-level" practitioners. NP's are registered nurses who earn a master's degree by training for two years after college in a specialized field of medical care. They work with a physician in a variety of ways — treating common problems, evaluating chronic health conditions, educating patients, helping with hospital rounds and so on. PA's have a four year college degree and train specifically to work with a physician in the day-to-day management of routine problems, both in and out of the hospital. These practitioners are not substitutes for doctors but are considered "physician extenders" because by working with a physician, they allow physicians to focus on people with complex or time-consuming problems.

Once you have decided what type of doctor you want, you should consider the style of practice you prefer. Recommendations from friends and relatives are often helpful. Of course, you may have to choose from a panel of practitioners that participates with your insurance. However deep the field of choices, it's worth taking the time to do a little research.

Many physicians and group practices have Web sites you can surf for information and most will have a brochure about the practice and with profiles of their physicians. No longer is the typical physician a man; more than a third of primary care physicians under 45 are women and most U.S. physicians are less than 50 years of age. Some older physicians may have a large panel of patients already and may not take new patients because adding new patients means less time available for existing patients. You should always check with the physicians practice before listing a doctor as your PCP.

Physicians, like everyone else, have different personalities. Your health depends as much on your relationship with your doctor as it does on the physician's expertise. You must trust your doctor so it should be someone with whom you can relate.

Once you have decided the type of physician and practice, consider asking to meet with one or two doctors who can accept new patients. Find out the doctor's training and if the doctor is certified in his or her specialty. Certification means the doctor has passed a test of his or her knowledge. Some specialties require recertification regularly to assure that the doctors keep up with advances in medicine. Ask about the doctor's approach to patient care, how information is communicated, whether electronic communication is available, how the practice is covered after hours, whether the doctor can meet the needs you have for yourself and your family. Do you feel comfortable with this person? With the office and office policies? If not, keep looking.

Once you have established yourself in a practice, ask to sign a records release for the old records of your prior physicians so your new doctor will have a complete file on you. See if you are due for any regular check ups, screening exams or immunizations. If you are already on medications, schedule an office visit well before they are due for renewal and bring along all your medications.

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HIGHLIGHTS FROM THE 2003 ASTRO ANNUAL MEETING OCTOBER 19 - 23, 2003

EXTERNAL BEAM RADIATION THERAPY EFFECTIVE IN PROVIDING BONE METASTASES PAIN RELIEF

A single treatment of external beam radiation therapy is very effective in providing relief for painful bone metastases from breast and prostate cancers, according to a new study presented October 20, 2003, at the American Society for Therapeutic Radiology and Oncology's Annual Meeting in Salt Lake City.

This randomized prospective phase III study of palliative external beam radiotherapy was conducted for patients with breast or prostate cancer and painful bone metastases. More than 160 hospitals and universities in the United States and Canada participated in the study. Eligible patients, 897 of the 949 enrolled, had moderate to severe pain, radiographic evidence of bone metastases at a painful site, a life expectancy of more than 3 months, no prior surgery or palliative external beam radiation therapy to that site and no change in systemic therapy for 30 days. The group was evenly divided between women with breast cancer and men with prostate cancer and patient pre-treatment characteristics were equally balanced between the two treatment arms.

"This is good news for patients with pain from cancer. Radiation therapy was effective in significantly reducing pain in two-thirds of these patients. Treatment with a single larger dose was just as effective as the longer treatment course of 10 treatments in 2 weeks. There were very few side effects from the treatments as well." said William F. Hartsell, M.D., a radiation oncologist at Advocate Lutheran General Hospital in Park Ridge, Ill., and lead author in the study. "We also found that 33 percent of the patients no longer needed narcotic medications."

SOURCE: ASTRO abstract entitled "*Phase III Randomized Trial of 8 Gy in 1 Fraction vs. 30 Gy in 10 Fractions for Palliation of Painful Bone Metastases*," by William F. Hartsell, M.D., et al

ADVANTAGES TO A COMPRESSED RADIATION SCHEDULE FOR PROSTATE CANCER PATIENTS

There are many advantages to a compressed or hypofractionated prostate radiotherapy, setting the stage for further studies, according to a study presented on October 20, 2003, at the American Society for Therapeutic Radiology and Oncology's Annual Meeting in Salt Lake City.

The optimal radiation dose-fractionation schedule for localized prostate cancer is unclear. The purpose of this study was to determine if a shorter 4-week radiation schedule was as effective as a longer 6.5-week schedule.

Patients with T1 and T2 prostate cancers were randomized to 66 Gy in 33 fractions over 6.5 weeks or 52.5 Gy in 20 fractions over 4 weeks. The choice of the dose for the short arm (hypofractionated) was based on the available literature and the experience at two of the participating institutions. The primary outcome was the cluster defined by biochemical failure, clinical local failure, distant failure, hormonal intervention prostate cancer death. The treatment arms were compared in a time-to-event analysis. Secondary outcomes included presence of tumor on prostate biopsy at 2 years, survival and toxicity. The trial was a joint project of the Ontario Clinical Oncology Group and the National Cancer Institute of Canada Clinical Trials Group.

Between 1994 and 1998, 936 patients were randomized at 16 Canadian centers, 470 to the long arm and 466 to the short arm. The median follow-up was 59 months. At baseline, the treatment groups were well balanced with regard to stage, Gleason score and pre-treatment PSA level. To September 2002, there have been 460 failures: 216 in the long arm and 244 in the short arm. At 2 years, 73 percent of patients had a planned post-radiotherapy biopsy. In the long arm, 53.2 percent of the patients who underwent biopsy were positive while in the short arm, 50.7 percent were positive. The overall survival at five years was 85.7 percent and 88.3 percent in the long and short arms respectively.

"This is the first reported randomized study evaluating the use of hypofractionated radiotherapy in the management of localized prostate cancer," said Himu Lukka, lead author of the study. The PSA failure rate is 7 percent higher in the shorter arm and statistically investigators cannot exclude the possibility that the short arm is inferior to the long arm. "Although the acute toxicity was higher in the short arm, it is reassuring that the late toxicity was comparable between the two treatment arms. This trial provides useful clinical data to design future studies to help the choice of appropriate hypofractionated dose and fractionation using dose escalation protocols in the settings of conformal and IMRT radiotherapy techniques."

SOURCE: ASTRO abstract entitled "*A Randomized Trial Comparing Two Fractionation Schedules for Patients with Localized Prostate Cancer*" by Himu Lukka, M.D., et al

VIAGRA EFFECTIVE OVER LONG TERM FOR PCa PATIENTS RECEIVING RADIATION THERAPY

Viagra effectively treats erectile dysfunction for years after prostate cancer patients receive radiation therapy, according to the first study to look at the effectiveness of the medication in a large number of patients over an extended time period. Four years after undergoing 3-dimensional conformal radiotherapy (3D-CRT) and brachytherapy for prostate cancer, the medication successfully treated ED in seventy-five percent of patients. The new study was presented at the American Society for Therapeutic Radiology and Oncology's Annual Meeting.

"Other studies have reported on the initial effectiveness of Viagra for prostate cancer patients receiving radiation therapy, but there was scant information on the continued use and effectiveness of the medication for longer periods of time," said senior author Michael J. Zelefsky, M.D., Chief of Brachytherapy at New York's Memorial Sloan-Kettering Cancer Center.

From 1998 to 2002, the trial followed 363 prostate cancer patients at Memorial Sloan-Kettering Cancer Center who received 3D-CRT and brachytherapy. The patients had normal erectile function before therapy, and all experienced some degree of ED after treatment.

Among patients who reported success with the drug after the initial trial, 96 percent continued to use and find the medication effective. Higher external beam radiation doses were associated with decreased efficacy of Viagra.

"The good news for men facing therapy for prostate cancer is that Viagra does not seem to lose its effectiveness over time," Dr. Zelefsky concluded. "As more younger patients opt for non-surgical approaches, ED is obviously an important issue."

SOURCE: ASTRO abstract entitled "*Prognostic Factors for Maintained Efficacy of Sildenafil Citrate in the Management of Erectile Dysfunction*" by Michael Zelefsky, M.D., et al

TALKING WITH YOUR HEALTH CARE PROVIDER ABOUT CLINICAL TRIALS

William Rodriguez, M.D.
Chief Medical Director, Veritas Medicine
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As a patient, one of the unusual aspects of enrolling in a clinical trial is that the discussion tends to involve people not typically part of your health care decision-making. Research physicians, study nurses, coordinators, trial recruiters, even relative strangers asking questions by telephone patients may come in contact with all these clinical trials personnel at one time or another in the enrollment process.

Moreover, patients may feel, rightly or wrongly, that their personal physicians are not involved in the decision-making process. Rather than setting up a situation where participation in a clinical trial becomes separate from their regular health care, patients considering clinical trial enrollment should also consider how they can integrate clinical trial participation into their routine health care. Several simple steps can make this easier.

Identify your health care provider.
This may sound odd, but in fact many patients, especially those with a disease or condition requiring specialist care, are unable to establish who their primary provider is. Is it their primary care physician, their rheumatologist who sees them monthly, or the nurse practitioner they speak with by phone twice weekly? In this setting, enrolling in a clinical trial may seem like adding another layer of doctors, phone numbers, confusion, and paperwork. Identifying a single person as your primary provider can simplify the medical maze. Ideally, this person will be the health provider you trust most to speak openly and frankly about your condition, and about the risks and benefits of a clinical trial.

Discuss clinical trials and experimental therapies as part of a normal office visit.
Patients often hear about a clinical trial for a new treatment through an advertisement, a magazine article, or on the internet. Doctors often learn of new treatments from clinical research organizations, medical journals, or their colleagues. And yet, patients and doctors rarely discuss what they have learned between clinic appointments during an office visit. Patients may be reluctant to bring up a drug they may not even know how to pronounce correctly. Doctors may assume that patents wouldn't be interested in a clinical trial, or may not know enough about a new therapy to be comfortable discussing it. Both may be misinformed. However, the best place for both patient and physician to understand whether a clinical trial is appropriate for a patient is during routine office care. If visits with your doctor are rushed, set up a separate appointment, or even a phone appointment, specifically to discuss clinical trials.

Discuss experimental treatments before they become necessary.
For some patients, enrollment in a clinical trial can seem like their last hope. For others, they may represent a much better option than their current therapy, easier to take or with fewer side effects. Waiting until the last minute, as with most medical care, is never a good idea. Both you and your doctor may be reluctant perhaps unconsciously to review in detail the potential risks of an experimental treatment when other treatments have not worked. You may misunderstand the potential benefits if your condition has progressed significantly. Most importantly, since many treatments, new and old, are most beneficial early in the course of a disease, it is important not to wait too long before changing therapies. Discussing the timing of clinical trial enrollment, and setting some triggers (such as a change in test results, or increasing limitations on activity) months early may offer the best chance that a new therapy obtained through a clinical trial will work.

Don't expect your primary health provider to have all the answers.
Medical research is moving so quickly these days that even with medical journals and conferences, many physicians even specialists cannot keep up with the latest news on an experimental drug that is just

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PRESIDENT BUSH SIGNS DEPARTMENT OF DEFENSE APPROPRIATION FOR 2004 WITH CONTINUED FUNDING OF PROSTATE CANCER RESEARCH

On October 1, 2003, President Bush signed the Department of Defense Appropriation for fiscal year 2004 (FY04) funding for the Congressionally Directed Medical Research Programs of the United States Army Medical Research and Materiel Command was initiated.

President Bush signed the FY04 Defense Appropriations Act into law (Public Law 108-87) and thereby appropriated the funds to continue the Prostate Cancer Research Program $85 million.

Many Us Too! members have worked very hard to encourage the funding of these programs. You can easily learn of the CDMRP / DoD PCRP research highlights and new developments on their website http://cdmrp.army.mil.

"The early signing of the appropriations act, and process improvements made, mean that the CDMRP will be able to post Program Announcements describing the funding opportunities and proposal submission process several months earlier for many programs." said Gail Whitehead, Public Affairs Coordinator for the DoD, USAMRMC, Congressionally Directed Medical Research Programs "The DoD Prostate Cancer Research Program hopes to move up their Program Announcement from February to November. By getting funds to researchers faster, our mission of improved diagnosis, treatment, and cure for prostate cancer will be accomplished sooner."

Since its inception in 1997 the PCRP has funded nearly $300 million in funding for Prostate Cancer Research (second only to Breast Cancer funding which from its inception in 1992 has funded more than $1.1 billion).

Research Program	FY	Appropriation	Proposals Received	Proposals Funded	Amount for Research
Breast Cancer	92–01	$1,223.8 M	16,517	3,217	$1,043.3 M
Defense Women's Health	95	$40.0 M	559	69	$32.8 M
Osteoporosis	95	$5.0 M	105	5	$3.7 M
Neurofibromatosis	96–01	$69.3 M	223	85	$58.7 M
Prostate Cancer	***97–01***	***$310.0 M***	***2,733***	***651***	***$263.0 M***
Ovarian Cancer	97–01	$51.5 M	374	45	$43.4 M
Peer-Reviewed Medical Research	99–01	$94.5 M	436	67	$70.7 M
DOD/VA	99–01	$6.8 M	88	9	$6.0 M
Institutionally Based Programs	95–01	$85.8 M	N/A	32	$76.1 M
TOTALS >>>		**$1,886.7 M**	**21,035**	**4,180**	**$1,597.7 M**

NEWS YOU CAN USE: cPSA

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provided 85 percent sensitivity, but the cPSA test correctly identified 35 percent of patients who did not have cancer, compared to 29 percent with the tPSA test — saving unnecessary biopsies in six percent more of the men without cancer, also statistically significant.

STUDY REVEALS IMPORTANCE OF TESTING PSA LEVEL DURING FIRST MONTHS AFTER RADIOTHERAPY

The success or failure of radiation therapy for prostate cancer may be predicted as early as three months after completion of therapy, rather than waiting one to two years as conventional wisdom indicates, a new study from The University of Texas Health Science Center at San Antonio (UTHSC) suggests.

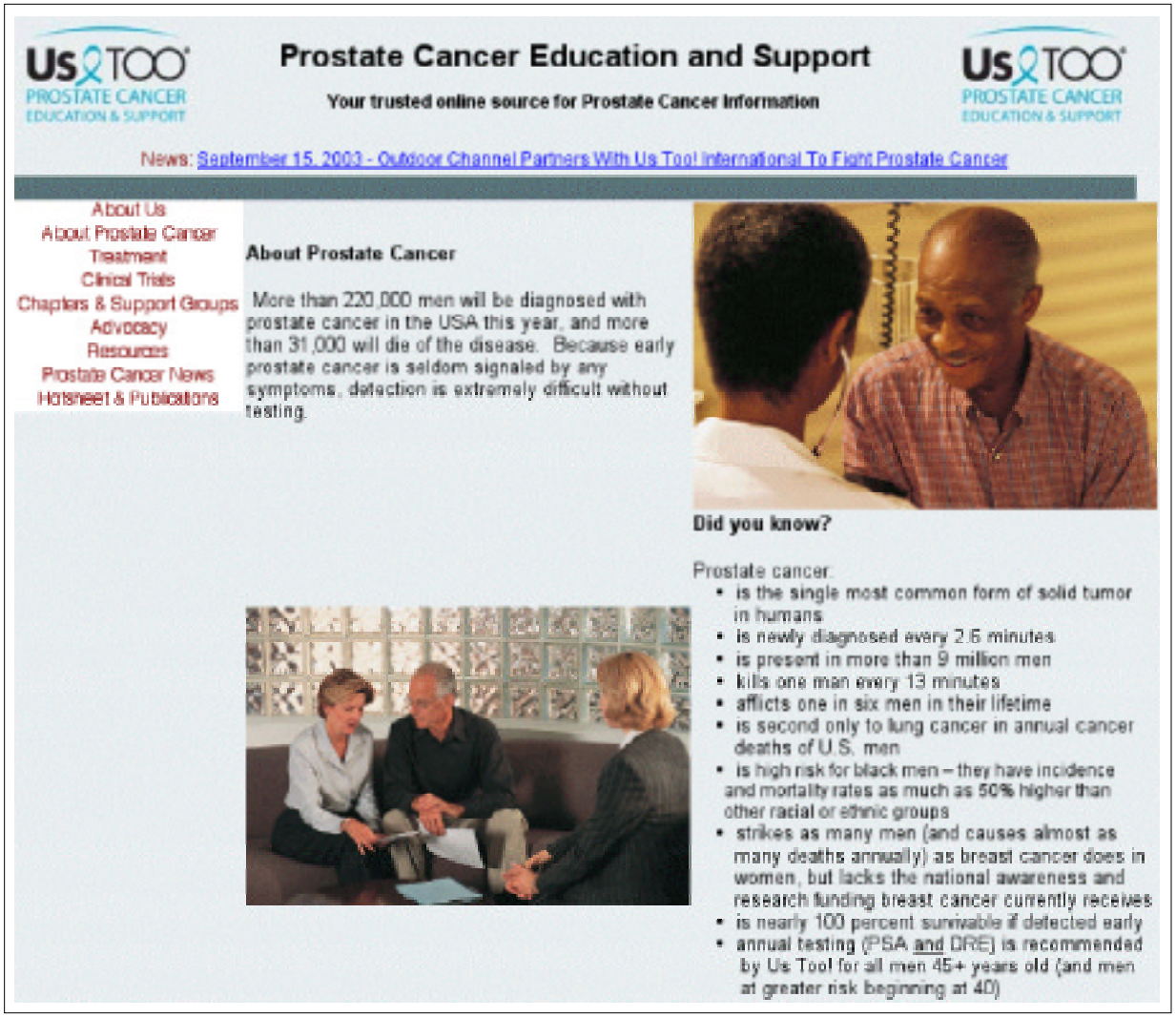
The research also found that men whose blood PSA values stayed above important threshold levels three months after radiotherapy were 30 percent more likely to suffer a recurrence of cancer than men whose PSA values sank lower. The authors studied the prognostic value of early PSA changes in order to establish a model for analyzing improvements in radiation therapy, including intensity-modulated radiation therapy, a rapidly developing technique that pinpoints tiny radiation beams to destroy tumors but spare surrounding healthy tissues.

"Patients generally have their PSA tested soon after therapy, but unless there is a dramatic increase, many physicians wait a year or two and analyze the trend before interpreting the information. My colleagues and I disagree with that approach," said Sean X. Cavanaugh, M.D., lead author of the study and fourth-year resident in the UTHSC department of radiation oncology. "We found that PSA levels at three or six months after radiotherapy were significantly prognostic for long-term outcome. Analysis of early PSA response enables us to accurately identify those patients who have an 80 percent or better chance of being cured of prostate cancer. Once confirmed by follow-up studies, this method may help us to identify men who will most benefit from the addition of hormone therapy, which has some serious side effects and should not be started in all men."

Dr. Cavanaugh and his co-authors studied blood samples of 855 men treated at the Cleveland Clinic with external beam radiotherapy. They compared the early PSA response to the clinical outcome of the patients. The average patient in the study was followed for more than six years. None of the men underwent hormone therapy, which may lower PSA levels. The study also did not examine men whose cancers had spread outside the prostate and who have a much worse prognosis for survival.

Many physicians focus on the time it takes PSA to stabilize or reach a minimum after radiotherapy (known as PSA nadir). A lack of PSA increase during the first few years is associated with a more favorable outcome. Dr. Cavanaugh advocates evaluating every patient at three months after radiotherapy. "At the three-month mark in this study, we established that if a patient's PSA level was lower than 3.0 ng/ml (nanograms per milliliter), his chance of long-term, relapse-free survival was 87.8 percent, compared to the patients whose levels were above 3.0 at three months and who had only a 57.2 percent chance of relapse-free survival."

Dr. Cavanaugh is completing a residency in radiation oncology and a Ph.D. in human imaging in the UTHSC Graduate School of Biomedical Sciences. "This seminal work of Dr. Cavanaugh will alter the way that PSA is used as a prognostic factor after radiation therapy," said Charles R. Thomas Jr., associate professor and vice chairman of the UTHSC department of radiation oncology.



An Updated *Us Too!* Home Page (www.ustoo.org) Makes Navigating The Site Easier and Finding The Information You Need About Prostate Cancer Faster To Locate

TALKING ABOUT CLINICAL TRIALS

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being tested. Patients may hear of a promising new drug or a trial through internet chat rooms, newsletters, or patient advocacy groups, before their physician does. When you discuss a new drug with your doctor, do not be surprised if he or she knows little about it. This does not mean that your doctor cannot be an integral part of helping you decide whether a trial is right for you. In fact, a frank discussion about a new drug may encourage your doctor to explore new treatments, and find out more about a trial that might be right for you. Often, your doctor can obtain more detailed information that can help you understand more about an experimental therapy, and whether it is right for you.

Keep your health care provider involved before and during your clinical trial participation.

Again, this may sound obvious, but be sure to discuss your participation in a trial with your physician. Some patients, especially those who do not have a strong relationship with a single provider, may choose to enroll on their own. It is usually better to discuss enrollment with your provider, as your doctor may have strong feelings in favor or against your participation based on his or her knowledge of your medical history. More importantly, don't lose contact with your doctor after your enroll. Some trials may last a year or more, and require several visits with the research physician. Don't assume that these can substitute for your regular care. Ask the clinical study coordinator to send a copy of the medical note for each clinical trial visit to your doctor. Ask whether you can alternate visits for blood tests between the clinical trial and your regular doctor, rather than visiting the study clinic every time. Discuss your progress, side effects and improvement with both your doctor and the study personnel. In the end, an alliance between you, your provider, and the clinical study team offers you the best chance of success

CDC AWARDS GRANT TO *US TOO!*

(continued from page 1)

Goals of the program include:

- COMMUNITY EDUCATION AND PUBLICATIONS: Provide patients, their families and others interested or involved in prostate cancer with valuable, meaningful, and diverse learning opportunities and materials that are culturally sensitive to the underserved population.
- ADVOCACY: Provide highly valued advocacy and support resources while exceeding the service expectations of men living with prostate cancer and men at risk (and their families), clinicians, and other individuals, organizations and agencies involved / interested in prostate cancer. This proposed program will focus on engaging new patient advocates, as well a using existing patient advocates, to target specific populations and disseminate specific information intended to reach men who are most in need of honest answers and easily understood messages.
- OUTREACH & SUPPORT: Train facilitators from the underserved / minority populations and conduct meetings in the local community to extend the reach of existing prostate cancer awareness programs. The intent is to train community outreach personnel to talk with men (and their companions / families) about prostate cancer awareness and direct them to free early detection testing opportunities.
- AWARENESS: Focus public awareness on the danger and threat of prostate cancer, the importance of greater support for basic and applied research into the disease and the need for men to seek more effective early detection testing opportunities in the minority and underserved community to assure early detection, appropriate diagnosis and effective treatment.

HOW TO CHOOSE AND WORK WITH DOCTORS

(continued from page 1)

Prior to the visit, write down any questions you want to discuss when you get there. If you have many questions or more than a couple things to discuss with the doctor, tell the person scheduling you that you need a longer appointment. Many doctors can arrange to book your appointment for a longer time if you need the doctor to thoroughly evaluate your concerns.

Your health is your responsibility, not just your doctor's, so you should know the details of your health problems, the names and doses of all your medications and why they are prescribed. That "little red pill for my heart" could be almost anything. With so many medications and possible adverse interactions among them, you and your doctor must discuss medications by the exact name and strength.

In order to get the best results from your care, you must understand and agree with the recommended course. Before you leave the office, be certain you understand what you were told. If you disagree, tell your doctor. If you do, you may be able to get more information or perhaps a second opinion.

Your doctor has the expertise but it's your body and well-being. Together, you and your doctor are a team with a common goal — your good health.

For links to Penn State Hershey Medical Center's Primary Care Physicians, visit http://www.hmc.psu.edu/upg/index.htm

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