

March 2004 Newsletter
40 (v. 5, 3)

PCNG

PROSTATE CANCER NETWORKING GROUP

of
Greater Cincinnati

PCNG (www.pcngcincinnati.org) is a chapter of USToo

Founder: Bob Kanter - Conveners Emeriti: Adrian Boie, Lou Stadler - Facilitators: 8/03: Stan Moczydlowski;
9/03: Steven Plymire; 10/03: Tom Young; 11/03: Steve Steiner; 1/04: Jerry Glenn; 2/04: Jack Ramsay
Newsletter (325 copies this issue) editors: Kees DeJong & Fran Stanton

779-0144 Adrian Boie: 1989, PSA 13, GS 9; RP, EBRT, IHT
751-6888 Kees DeJong: 1996, PSA 24, GS 9; IHT, EBRT+Brachy, IHT
253-6768 John Hoffmann: 1997, PSA 5, GS 6; RP, EBRT

TELEPHONE CONTACTS:

528-2769 Gordon Huntley: 1999, PSA 4, GS 9; RP and Orchiectomy
733-5745 Bill Riggs: 1995, PSA 33, GS 6; RP, EBRT, HT

761-9645 Lou Stadler: 1987, PSA NA, GS 7; EBRT, HT
542-4908 Fran Stanton: 1999, PSA 157, GS 8; HT, EBRT+Brachy, HT
984-3343 Tom Young: 2002, PSA 7.8, GS 6; RP

19xx: year of diagnosis - PSA: Prostate Specific Antigen - GS: Gleason Score - RP: Radical Prostatectomy - EBRT: External Beam Radiation Therapy - Brachy: Brachytherapy ('seeds') - HT: Hormonal Therapy - IHT: Intermittent Hormonal Therapy

Next Large Group Meeting Will Be Held On Wednesday, March 31st

at The Wellness Community, 4918 Cooper Road *Women Are Welcome!*
6:30 pm: hospitality and networking - 7:00 pm: new members & sharing; 7:45 pm: additional networking

8:00 pm – – MRI/MSRI: A Non-Invasive Tool for Diagnosing and Evaluating Prostate Cancer

Michael Lamba, PhD

Dr. Lamba is Research Physicist at the Barrett Center, Dept. of Radiation Oncology. This talk, originally planned for our January meeting, had to be canceled because of illness of the speaker.

We are fortunate that we have been able to reschedule Dr. Lamba's presentation for this month.

Next Small Discussion Group Meetings will be held on

Wednesday, April 14th from 7.00-9.00 pm at the Wellness Community

One Discussion Group for men, and a separate discussion group for their spouses, partners, or family members

Robotic Prostatectomy in Cincinnati

March 16, 2004 was a significant day for prostate cancer patients in Cincinnati. That day a 56-year old patient's prostate was removed by Drs. Delworth and Kuhn, using joy sticks to direct four robotic arms inserted in the patient's abdomen.

This was in Good Samaritan Hospital, and the operation is known as a robotic prostatectomy. Good Sam could do as many as 8-10 robotic RPs per month.

The robotic procedure corrects for the natural tremor in the human hand and eliminates the need for a large incision, thus decreasing trauma and shortening recovery time. If the nerves have to be

severed because of cancer, they can be grafted during the operation.

The results appear to be excellent. After treating 100 patients in a similar 'da Vinci' surgical system in Detroit, Dr. Menon et al. wrote (*J Endourol.* Nov. 2003) that none of the patients required blood transfusion. The positive surgical margin rate was 15%. At 1, 3, and 6 months, the continence rates were 37%, 72%, and 92%, respectively, and the potency rates were 11%, 32%, and 59%.

There are two more da Vinci systems in UC's Medical Center, one for research and one for patient care. According to the Cincinnati Enquirer the first robotic RP at UC will be done this month.

Inside: **Provence Vaccine Trial** & **Results of Intensive Screening and Treatment**

PROVENGE

Vaccine Therapy for Prostate Cancer Patients

Prostate cancer does not kill; hormone-refractory prostate cancer does. The PSA can be kept 'undetectable' in almost all patients with hormonal medications (Lupron, Zoladex, Casodex, etc.) for two or more years, but when the PSA increases during hormonal therapy the patient is said to be hormone-refractory. He has AIPC: androgen independent prostate cancer. There will be, most likely, metastases, and a life expectancy measured in one or two years. Standard chemotherapeutic treatments –Taxotere +Emcyt, or Taxotere+calcitriol are among those commonly used– can increase life expectancy with a few months.

A new experimental treatment for terminal prostate patients has shown that the life of some of these patients can be prolonged for several months and without the considerable side effects of chemotherapy. This therapy is not based on the destruction of cancer cells (and many other healthy cells) by chemicals, but on teaching the immune system to recognize and kill prostate cancer cells. This therapy is known as a *vaccine* therapy.

Dendritic cells (immune system cells able to identify harmful cells in the body) are taken from the subject's own blood, sensitized in the laboratory to recognize prostate cancer cells, and put back into the body to alert T-cells (the immune system's "attacker cells) to attack and kill the cancer cells. This is an approach fundamentally different from chemotherapy, and the excitement is because, in the very first phase III trial, the results are as good as or even better than had been obtained after decades of chemotherapeutic trials.

The results of the first phase III trial were presented last year during the Annual Meeting of ASCO (American Society of Clinical Oncology), abstract No. 1534 by Dr. Small and 7 others: 127 patients with asymptomatic metastatic hormone refractory prostate cancer were randomized in a 2:1 ratio to receive vaccine treatment (Provenge) or a placebo (n = 45) six times (3 times in two weeks). The placebo patients also had their dendritic cells removed, but they were put back into the body unaltered.

The results were quite encouraging, in particular for patients who had a Gleason Score of 7 or less at diagnosis. Side effects included flu-like symptoms for a few days following infusion.

According to the American Cancer Society 230,110 men will be diagnosed with prostate cancer in 2004; if caught early and removed, commonly with

surgery or radiation, the cancer is highly curable. But 29,500 will die, and for those patients Provenge could be used, if the treatment wins approval from the Food and Drug Administration. The results of the first phase III trial will have to be confirmed in an additional phase III trial with 275 patients before Provenge shows enough evidence to win approval from the FDA. That process is expected to take two more years – even with Provenge having a 'fast-track' status!

The 275 patient phase III trial accepts patients in Cincinnati. Dr. Bruce Bracken (call Alison Kastl 513-584-0436 for more information) is the Principal Investigator in Cincinnati. It is a double-blind trial: neither doctor nor patient knows who gets the treated dendritic cells and who gets the untreated cells.

If a patient decides to participate, is eligible, and fulfills all qualifications, he will be randomly assigned to receive either active Provenge or placebo. There are two chances in three that a patient will receive Provenge. At the end of the trial, men who received placebo will have the opportunity to be treated with Provenge.

According to the official web site at clinicaltrials.gov two eligibility factors are that one must be 18 years or older, and a male. But although we are all eligible, not all of us will qualify. The patient must have ALL of the following: A) "Histologically documented adenocarcinoma of the prostate" In lay terms: a biopsy for diagnosis is necessary; B) "Cancer that has progressed while on adequate hormone therapy. This state of the disease is androgen independent prostate cancer (AIPC)"; C) "Cancer that has spread outside the prostate (metastatic) to lymph nodes or bone"; D) "Gleason Score of 7 or lower" and E) "No current cancer-related pain". Please note that there are additional eligibility criteria. The study center will determine if you meet all of the criteria.

An essential aspect of this (or any other clinical trial) is *informed consent*. Hours will be spent reviewing with patients the potential risks and benefits involved in any trial. The consent process is comprehensive and must be approved by research advisory boards and patient review boards. Only after patients have a clear and comprehensive understanding of the program, alternative treatment options and standard medical care are they permitted to participate in the program.

More Intensive Screening & Treatment Did Not Lead to Lower Prostate Cancer Specific Mortality

“Natural experiment examining impact of aggressive screening and treatment on prostate cancer mortality in two fixed cohorts from Seattle area and Connecticut”

full text & figures in BMJ 2002;325:740 (5 October) <http://bmj.bmjournals.com/cgi/content/full/325/7367/740>

Grace Lu-Yao, director, Peter C Albertsen, professor of surgery, Janet L Stanford, member and head, Program in Prostate Cancer Research, Therese A Stukel, professor of biostatistics, Elizabeth S Walker-Corkery, research coordinator, Michael J Barry, associate professor of medicine, Harvard Medical School.

Objective: To determine whether the more intensive screening and treatment for prostate cancer in the Seattle-Puget Sound area in 1987-90 led to lower mortality from prostate cancer than in Connecticut.

Design: Natural experiment comparing two fixed cohorts from 1987 to 1997.

Setting: Seattle-Puget Sound and Connecticut surveillance, epidemiology, and end results areas.

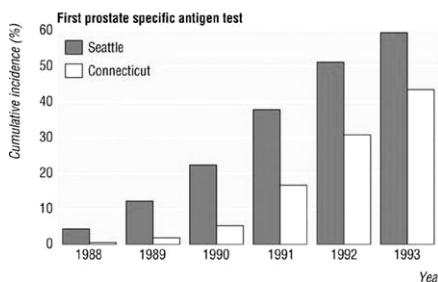
Participants: Population based cohorts of male Medicare beneficiaries aged 65-79 drawn from the Seattle (n=94 900) and Connecticut (n=120 621) areas.

Main outcome measures: Rates of screening for prostate cancer, treatment with radical prostatectomy and external beam radiotherapy, and prostate cancer specific mortality.

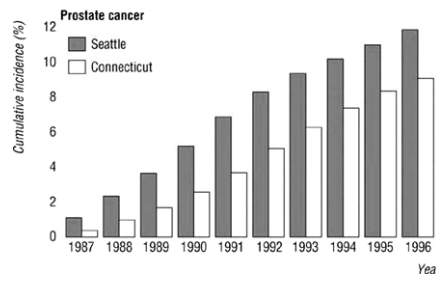
Results: The prostate specific antigen testing rate in Seattle was 5.39 (95% confidence interval 4.76 to 6.11) times that of Connecticut, and the prostate biopsy rate was 2.20 (1.81 to 2.68) times that of Connecticut during 1987-90. The 10 year cumulative incidences of radical prostatectomy and external beam radiotherapy up to 1996 were 2.7% and 3.9% for Seattle cohort members compared with 0.5% and 3.1% for Connecticut cohort members. The adjusted rate ratio of prostate cancer mortality up to 1997 was 1.03 (0.95 to 1.11) in Seattle compared with Connecticut.

Conclusion: More intensive screening for prostate cancer and treatment with radical prostatectomy and external beam radiotherapy among Medicare beneficiaries in the Seattle area than in the Connecticut area was not associated with lower prostate cancer specific mortality over 11 years of follow up.

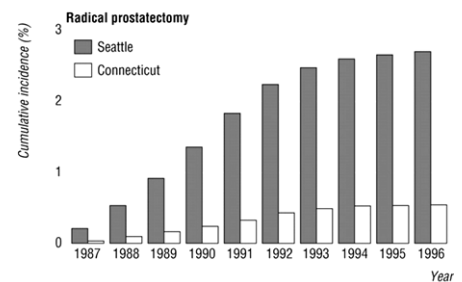
- Prostate cancer screening and treatment were much more intensive among men in the Seattle-Puget Sound area than in Connecticut early in the "prostate specific antigen era"
- Over 11 years of follow up, no difference in prostate cancer mortality was seen in the two cohorts
- The lack of association between more intensive screening and treatment and lower prostate cancer mortality suggests that trials should continue in order to settle this question.



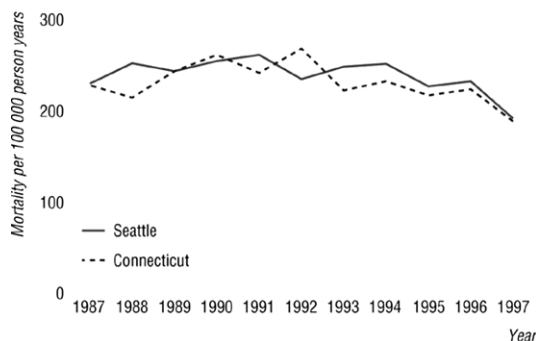
Cumulative First PSA Test



Cumulative Prostate Cancer Incidence



Cumulative Radical Prostatectomy



“Given the greater intensity of screening, diagnosis, and treatment documented among cohort members in the Seattle-Puget Sound area than in Connecticut, we would have expected to see lower prostate cancer mortality in the Seattle region over time. However, we found no significant difference in prostate cancer mortality over 11 years of follow up. ... The results of this study therefore do not support the hypothesis that the intensity of screening and treatment with surgery or radiation was related to the reduction in prostate cancer mortality seen in the two regions.”

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PROSTATE CANCER NETWORKING GROUP
OF GREATER CINCINNATI

c/o The Wellness Community
4918 Cooper Road
Blue Ash, OH 45242

ADDRESS SERVICE REQUESTED



speaker:

MRI & MRSI

features:

- **Provenge**
- **Intensive Screening/Treatment did not lead to Lower Prostate Cancer Mortality**

In every struggle the only ones who can truly grasp your fear, your pain, your grief, your stamina that may sometimes fail are those who share the battlefield with you.

It is no different when the enemy is prostate cancer, and the fight is for your integrity as a man as well as your life.

www.phoenix5.org

visit our web site

www.pcngcincinnati.org

you'll find links to information sites
from patients, the government and
various other organizations, and there are also
links to mailing lists, books,
print magazines and web magazines

According to the Am. Cancer Society - www.cancer.org - 230,110 new cases of prostate cancer will occur in the USA in 2004 (8,620 in Ohio); 29,500 men will die (1,290 in Ohio); 1 man in 6 will get prostate cancer during his lifetime, but only 1 man in 32 will die of this disease. ----- 2,410 clinical trials on cancer are listed at www.clinicaltrials.gov, with 169 trials on prostate cancer of which 19 trials are in Cincinnati, one described in this issue of our Newsletter. ----- 44,561 citations (of which 32,508 are abstracts) on prostate cancer can be found at www.ncbi.nlm.nih.gov - PubMed (3/23/2004).