

In The

Know

Confronting Prostate Cancer

June 2013



Why You Should Absolutely, Positively See A Medical Oncologist If You Have Just Been Diagnosed With Prostate Cancer!

by William K. Oh, MD

STOP! You have just been diagnosed with prostate cancer. Your main source of information is the urologist (let's call him Dr. P). Your primary care doctor referred you to Dr. P because your PSA was high. During a consultation, Dr. P recommended a prostate needle biopsy which he performed in his office. This showed prostate cancer in 2 of the 12 samples taken.



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Another Fine Mess....

by Virgil Simons

While hardly a laughing matter, the current situation surrounding the “guidelines” for PSA testing remind me of the famous line from the comedians Stan Laurel and Oliver Hardy, “Another Fine Mess You’ve Gotten Us Into!”

The American Urological Association (AUA) recently released the following set of guidelines (Editor’s Note: the full text of the release can be seen at: <https://www.auanet.org/education/guidelines/prostate-cancer-detection.cfm>) relative to the Detection of Prostate Cancer:

- **Guideline Statement 1:** The Panel recommends against PSA screening in men under age 40 years.
- **Guideline Statement 2:** The Panel does not recommend routine screening in men between ages 40 to 54 years at average risk.
- **Guideline Statement 3:** For men ages 55 to 69 years the Panel recognizes that the decision to undergo PSA screening involves weighing the benefits of preventing prostate cancer mortality in 1 man for every 1,000 men screened over a decade against the known potential harms associated with screening and treatment.
- **Guideline Statement 4:** To reduce the harms of screening, a routine screening interval of two years or more may be preferred over annual screening in those men who have participated in shared decision-making and decided on screening.
- **Guideline Statement 5:** The Panel does not recommend routine PSA screening in men over age 70 years or any man with less than a 10 to 15 year life expectancy.

All of this comes in the wake of the recommendation (<http://www.uspreventiveservicestaskforce.org/prostatecancerscreening/prostatefinalrs.htm>) from the United States Preventative Services Task Force (USPSTF) against doing PSA screening. It also is distinct and different from those guidelines supported by the National Comprehensive Cancer Network (NCCN) and a myriad number of others proposed by leading medical centers, state public health agencies, national service organizations, etc. So, we have now as patients, and professionals in many cases, the conundrum of being tested or not, under which guidelines to follow, and with the added onus of determining if we’re in a high-risk category or not, and whether we’re going to live for another 10 to 15 years. A very fine mess! No wonder that many health professionals don’t bring up the subject and many patients question whether there is really a need to do it.

At root is the reality that there have been too many unnecessary biopsies ordered up and too many unnecessary “curative” procedures done on men who did not need to be cured. However, the criticism has been placed on the test rather than on the system that encourages a more aggressive set of procedures in the face of uncertain risk to the patient from the disease. So, we see being promulgated the concept of “informed decision-making”; having the patient make a decision based on communication with his doctor and other credible reference sources. How is that decision going to be truly informed when there is a lack of consensus on what the specific criteria should be! Another fine mess!



So what are we to do as patients to deal with this situation as well as to advise our family, friends, and community as to the choices they need to make? While not cast in stone, here are some recommendations that I’m passing along to those around me:

1. As with his cholesterol level, blood sugar level, blood pressure, body mass index (BMI), and every other clinical measure that can impact on his health, every man **has the right to know their PSA level** as a guide to current, and future, health decisions
2. **The PSA level** is solely an indication of activity connected with the prostate and **NOT a confirmation of prostate cancer**; a “high” level can be a function of an enlarged prostate (that comes with age), an infection, or some other non-cancerous cause
3. Be certain to **discuss your PSA level** in the context of family history of cancer, personal risk factors, velocity of change in PSA level, etc.
4. A diagnosis of cancer can only be confirmed by a **biopsy**; however, this is a procedure that should not be undertaken lightly because it **may result in an unnecessary surgical or radiological treatment**
5. If you do have a biopsy it is critical to **understand the pathological results**, i.e. number of cores in which cancer was found, volume of cancer in each biopsy core, etc.
6. **Not all cancers require invasive treatment** (surgery or radiation); many can be managed as a chronic disease, like diabetes, high blood pressure, etc. with Active Surveillance
7. Before making a final decision, **consult with physicians in different disciplines** (urology, radiology, medical oncology) to get different perspectives on your particular situation and differing recommendations on therapeutic options.

As many of us who are members in the Prostate Cancer Roundtable have said: “It is unacceptable that the data on the risks and benefits of prostate cancer screening available today is still not good enough to offer sound advice to any individual patient about risk related to the most common form of cancer now identified in American males. Until such definitive evidence is available, we further believe that every man should be encouraged to have a serious discussion with his primary care physician about whether some forms of testing for risk of prostate cancer may be appropriate for him as an individual.”



Drug Sequencing For Advanced Prostate Cancer

By Diane Johnson

Thankfully there are more treatment options than ever for men with advanced prostate cancer. The questions now revolve around which to use and when. Celestia Higano, MD, a prostate cancer expert with the Seattle Cancer Care Alliance and the University of Washington, gave her guidance on this topic in an interview from the American Society of Clinical Oncology's annual conference last year. A summary of her comments follow (full interview can be found at www.patientpower.info).



"Everybody wants to know how we're going to sequence these drugs best over time,"

Dr. Higano said. She went on to share her own perspective:

1. Begin with Provenge, the first vaccine (immunotherapy) approved in 2010 for prostate cancer.

Dr. Higano: "This is a treatment I feel should be given earliest...for men with early castration-resistant prostate cancer."

2. Xtandi [Enzalutamide] could follow next.

Dr. Higano: "...because it does not require the addition of prednisone."

3. Zytiga (abiraterone) and prednisone could follow when Xtandi is no longer effective.

4. When both drugs above stop being effective, chemotherapies could follow.

Of course, each patient and doctor needs to determine which treatments are right for them and when. But, as Dr. Higano summarized, "These new oral drugs [abiraterone and Xtandi] are going to be pushing chemotherapy out further, which I think is great news for patients."

Editor's Note: We asked the same question of two other leading physicians; their comments can be found as noted below:

Dr. Amit Bahl -

http://www.oncologytube.com/index.php?page=videos§ion=view&vid_id=1031634

Dr. Daniel Petrylak -

http://www.oncologytube.com/index.php?page=videos§ion=view&vid_id=1031548

AHRQ Funding Eliminated In House Subcommittee Vote

By Erin McCann,
Contributing Editor, Healthcare Finance News

A House Appropriations subcommittee voted Wednesday to go ahead with a controversial bill that would cut \$1.3 billion from the Department of Health and Human Services (HHS) while also eliminating all funding for the Agency for Healthcare Research and Quality (AHRQ).

Cleared by an eight to six vote, the Labor, Health and Human Services (LHHS) bill would effectively prohibit any federal funding of patient-centered outcomes research, which is conducted by AHRQ. Other provisions of the bill include withdrawing funding from the prevention fund incorporated in the Patient Protection and Affordable Care Act.

Proponents of the drafted bill say the included cuts target unnecessary, ineffective or lower-priority programs.

"This legislation reflects our strong commitment to reduce over-regulation and unnecessary, ineffective spending that feeds the nation's deficits and hampers economic growth," said House Appropriations Chairman Hal Rogers (R-KY) in a Tuesday press release. "A careful look was given to all programs and agencies in the bill, with the budget knife aimed at excess spending and underperforming programs, but also with the goal of making wise investments in programs that help the American people the most," Rogers continued.

Subcommittee Chairman Denny Rehberg (R-MT) told POLITICO the decision to cut AHRQ funding all came down to the budget. "It's not a reflection on anything other than that we're just trying to bring our fiscal house back in order."

Other groups say that the bill may appear penny-wise but would prove to be pound-foolish.

"Terminating the Agency for Healthcare Research and Quality, as House appropriators propose, would badly undermine important research on health care quality, disparities in care and patient safety - research that benefits our nation's most vulnerable people," said Bruce Siegel, MD, chair of AHRQ's National Advisory Council, speaking on behalf of the National Association of Public Hospitals and Health Systems (NAPH), of which he's president and CEO.

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Blueberries And Red Wine – New Therapies For Prostate Cancer?

The development of natural product agents with targeted strategies holds promise for enhanced anticancer therapy with reduced drug-associated side effects. Resveratrol, found in red wine, has anticancer activity in various tumor types. A compound in blueberries – pterostilbene – helps keep prostate cancer tumors from growing and spreading, based on research studies performed on mice at the University of Mississippi Medical Center (UMMC).

Dr. Anait Levenson, the lead investigator on these studies, has shown that diet-derived polyphenols are attractive clinical candidates for primary and secondary cancer chemoprevention due to their ability not only to block or inhibit initiation of carcinogenesis, but also to reverse the promotional stages. “It’s too early to say that wholesale quaffing of blueberries could cure prostate cancer, but the findings suggest more research might yield a promising cancer treatment”, said Dr. Levenson, associate professor of pathology and a researcher at the UMMC Cancer Institute.



Of all the compounds, pterostilbene did the best at inhibiting MTA1, a protein associated with prostate cancer aggressiveness. Metastasis-associated protein 1 is a critical oncogenic protein and its overexpression correlates with parameters of aggressive tumors: higher Gleason grade, angiogenesis (the growth of new blood vessels from pre-existing vessels), and poor prognosis. Further data has shown that MTA1 can be considered as a potential prognostic biomarker for aggressive forms of prostate cancer.

These findings substantiate new approaches in Pca management with the inclusion of natural product drugs not only for primary chemoprevention, but also for anticancer and antimetastatic therapy. As a patient, you should look to include physicians experienced in complementary medicine therapies and the use of nutraceutical agents in managing prostate cancer.

The full text of Dr. Levenson’s study can be seen at: <http://www.plosone.org/article/author/info%3Adoi%2F10.1371%2Fjournal.pone.0057542;jsessionid=5D3C98FOCBF6381B5144F76141BC9580>.

Additionally you can view a video of Dr. Levenson speaking on the use of MTA1 in determining the aggressiveness of prostate cancer in African-American men and how the use of it as a biomarker can help stem racial health disparity. The link to her video is:

http://www.oncologytube.com/index.php?page=videos§ion=view&vid_id=1031675

XOFIGO (radium 223) Now FDA Approved For Men With BONE Metastases & Castrate Resistant Prostate Cancer (previously called Alpharadin)

By Jan Manarite, PCRI Senior Educational Facilitator

The FDA has approved another new drug for men with Castrate Resistant Prostate Cancer (CRPC) who have bone metastasis, no known visceral metastases and demonstrate bone pain. As happens so often – medicine is creating new words for things we already have words for...so...XOFIGO was previously called “Alpharadin”. You will see the term Alpharadin dropped from most materials. And most of us know that Castrate Resistant Prostate Cancer has also been called Hormone Refractory Prostate Cancer in the past.

Here are the important Take-Home Messages for our readers:

1 minute Injection – Xofigo is not an IV drip, and not a shot. It is an injectable radiation (see Figure 1) given slowly over about 60 seconds. The best comparison is probably the injection you receive before your Bone Scan – very similar. The suggested schedule is one treatment every 4 weeks, for up to 6 total treatments. (1)

The Doctors – Xofigo will be administered by either Radiation Oncologists, or Nuclear Medicine Physicians. Medical Oncologists may often be the prescribing doctors. Discuss this with your physicians, especially the physician who is most knowledgeable about your bone metastases, pain, and CRPC.

Availability – The timing on availability in your neighborhood may take a while. To be fair, no pharmaceutical company is capable of getting their drug into the hands of the entire public right after FDA approval. There are legal restrictions, training issues, and a simple gearing up process that cannot start until FDA approval is issued. In the interest of getting you accurate information, initial availability may be in only 1 place in each state, and even that may take 1-2 weeks to get fully underway. This means that many people will have to travel. Bayer has stated the following: “For patients who are unable to access needed therapy due to geographic constraints, assistance through travel support programs administered independently by 501(c)3 organizations may be available. These foundations independently set eligibility criteria for their support programs. Manufacturers have made contributions to these foundations in support of their charitable missions of helping patients access needed therapies.”

Visit www.XOFIGO-US.com for current info from Bayer on availability and patient assistance programs. You can also call **1-855-696-3446** (1-855-6 Xofigo), which is up and running.

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Why You Should Absolutely, Positively See A Medical Oncologist ...

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What do you do now?

1. Agree with the recommendation to remove the cancer immediately and schedule the operation with Dr. P for next week
2. Call your friend, Joey, who had radiation 12 years ago and was very happy with his doctor at the time
3. Go online and read as much as possible about prostate cancer and make a choice based on your research
4. Start a regimen of alternative therapies since all prostate cancers are basically harmless and can be modified by diet
5. Get a second opinion from an experienced medical oncologist who is an expert in prostate cancer

Of course, it's no surprise I would recommend choice 5, right? As a medical oncologist who has been studying and treating prostate cancer for the past 18 years, I have a bias. In fact, every doctor has a bias—we would not be human unless we had a point of view and acted on it every day. That means a surgeon who operates every day has to believe that his procedures are helping his patients. Otherwise, how could he justify what he does? Same goes for a radiation oncologist. The problem is: when there is more than one choice, the doctor's bias will steer you to what he believes in. For instance, if you could have surgery or radiation, he might lean towards surgery since that is what he does—he's comfortable with it, and understands the pros and cons. The more important question though is: is it the right treatment for you?

As I said, I am biased, but not towards surgery or radiation in particular. I am also not biased towards chemotherapy for localized prostate cancer, which is what I do in my regular practice taking care of advanced prostate cancer. I do discuss active surveillance (sometimes called watchful waiting), but again, have no particular inclination to recommend or not recommend it. To the extent that a medical oncologist is biased, I would say we are generally more aggressive towards some treatment, since we know what happens when treatment fails. Avoiding suffering and death from cancer is something that I focus on every day. But the bottom line is that each man has to make a choice—one choice only—for how to treat or not treat his cancer initially. That is a very hard choice and it is a key focus of my clinical practice.

Start at the beginning

Prostate cancer is a very complex disease. We hear mixed messages all the time about it: it's deadly, but it's slow growing. We over treat it, and yet it's still the second leading cause of cancer death in men. It affects only old men, yet half those diagnosed are in their 50s and 60s. So what's the story? Well...it's ALL of these. This is part of the problem. We talk about prostate cancer like it's a single disease, but in fact, it is a multitude of diseases. They all start in the prostate but they behave very differently from each other.

So for the man with a new diagnosis of prostate cancer, I would recommend: **START AT THE BEGINNING!** What does this mean? During a new consult, I basically get all of the information that I need to understand the status of the cancer. I take nothing for granted and get all of the original information to piece the story together. This includes the following:

1. Every PSA test ever done
2. The original biopsy slides—not just the reading from the outside hospital but the glass slides (more on this later)
3. All imaging tests on CD—again the original images, in addition to the reports
4. Doctor's notes at the time of diagnosis
5. Information about all prostate cancer tests and, if applicable, treatments, including dates, doses, complications
6. Medical history information, including medications

We put all of this information into a summary form (which we call a PSR or 'patient summary report') which I use during the first and subsequent visits. The reason all of this information is requested is that this raw material is used to piece together the "story" around the prostate cancer. It sometimes seems redundant that my office asks for this, but the story is just not complete until all the information is gathered.

Why re-reading the pathology slides is so critical

Study after study has shown that the single most important piece of information in a diagnosis of prostate cancer is the Gleason score. The score (ranging from 1 which is not so bad looking to 5 which is very aggressive) is determined by the pathologist after he or she reads the biopsy samples that were removed from the prostate by the urologist. Two scores are given and added together based on the most common and second most common patterns seen on the slides. So a typical score would be Gleason 3+4 = 7, which means there is more pattern 3 and some 4 on the same slide. Gleason 3+3 = 6 means that all of the cancer on the slide was pattern 3.

It all sounds very objective, but in fact, the Gleason score is completely dependent on the skills of the pathologist. In other words, a good pathologist will "get it right" while a less experienced one may misread the slides and assign the wrong score. This matters, because so much of the prognosis AND treatment depends on the Gleason score. For instance, a Gleason 6 cancer may be offered the option of radiation or seeds alone while a Gleason 7 cancer may need hormone therapy added to radiation. There are serious consequences to not having the right information. I often tell my patients that the second opinion review of the slides is probably more important than any other part of the visit.

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Medicare Prescription Drug Appeals & Grievances

We have seen many new drugs be approved for the treatment of advanced stage prostate cancer, but in many cases the patient may not be able to obtain the medication prescribed by your healthcare provider. For example, your health plan might not consider the drug because it is not on the drug list (formulary), or your plan will only cover it with a higher cost sharing, or you are unable to meet certain requirements for coverage.

In these situations, you and your healthcare provider have the right to ask the health plan to explain its decision and to consider making the drug available to you as an **exception** to its policies.

Effective January 1, 2012, Section 3012 of the Affordable Care Act requires that providers of Medicare Advantage drug plans or Part D Medicare drug plans use a **standardized appeals process** for beneficiaries who cannot receive a particular prescription drug.

Information about the **exceptions process** is available from each health plan and may be found in your benefits manual, at the plan's website, or by calling the customer service number usually found on the back of your prescription drug card.

If your exception request is denied, you have the **right to appeal** the decision. Information about the appeals process will usually be in your denial letter, or on the plan's website, or through its customer service department.

Specific information on the process can be seen at:

https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/index.html?redirect=/MedPrescriptDrugApplGriev/14_PlanNoticesAndDocuments.asp

or contact the Medicare Service center at: 1.800.633.4277.



“Extra Help” from Medicare

Certain low-income Medicare beneficiaries can receive financial assistance in the form of a Low-Income Subsidy (LIS), oftentimes referred to as “extra help” to supplement the premium and cost-sharing (including deductibles, prescription drugs, and gap coverage) associated with the Medicare Part D benefit.

Those who are eligible may:

- receive assistance in paying monthly premiums
- have a reduced or no deductible
- have reduced or no prescription co-insurance and co-payments
- have no gap in coverage

To be eligible for this program, you must meet all 3 requirements listed below:

- Be enrolled in a Medicare Part A and/or Part B plan
- Be enrolled in a private Part D plan
- Meet the income and resource requirements outlined in the program

There are two basic types of applicability for this program; those that are **“deemed eligible”** and are automatically qualified to participate in the program, and those who must apply to be **“determined eligible”** for benefits.

For more information on the LIS program:

The publication **“Medicare and You 2012”** provides helpful information regarding Part D “extra help.” To receive this publication:

- Call 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048) or
- Visit <http://www.medicare.gov>

To obtain an application for “extra help” and instructions:

- Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778)
- Visit <http://www.socialsecurity.gov/prescriptionhelp>

To find out more about Medicaid in any state, visit:

<http://www.cms.gov/medicaid/consumer.asp> for a list of state-specific toll-free numbers.



Notes From the European Association of Urology Congress

March 15 - 19, 2013 – Milan, Italy

This event continues to be a major focal point for global research presentations and evolution in the practice of all urological diseases and conditions. The abstracts are available online via:

<http://www.eaumilan2013.org/scientific-programme/abstracts/>

Some key presentations noted:

Lars Homberg – Pca Risk Factors

- Age/place of birth
- Lifestyle
- BMI – late weight gain
- IGF1
- Tobacco use – possible inherited Susceptibility
- Chronic Inflammation
- Inherited susceptibility – 30 to 40% of risk
 - 40 different alleles identified thus far w/ thousands of combos

• Bleak prospects for Pca Prevention

Hans Lilja – Kallikrein markers

- PSA at age 60 is an excellent predictor of death
- Most men with an elevated PSA do have Pca
- **Kallikrein markers can be used to reduce surgeries of non-lethal cancers**

H. Rittenhouse – Urinary PCA3

Prostate cancer is a spectrum of disease > summary of several cancers

- Progenza PCA3 assay (Gen-Probe) in combo with PSA and TMPRSS2-ERG>
 - Can reduce biopsies and over-diagnosis
 - Beckman-Coulter test PHI=PSA/fPSA/proPSA2)
- **Can the clinical information available be used in a practical way**
- **The best factor to insure survival is not to be diagnosed at all**

New clinical tests – PCA3, TMPRSS-ERG2 – can aid in personalizing diagnosis and treatment, but at higher costs. Cost of medical care will increase going forward based on costs of drugs, imaging, genetic and other diagnostic tests.

Post USPSTF recommendation on PSA > 50% decline in prostatectomies, increase in Active Surveillance

Lycopenes (tomatoes, strawberries, watermelon) protect DNA from oxidation into cancer mutations. No clinical evidence of anti-Pca effect, but can decrease PSA levels

Some documented benefit of aspirin on Pca survival; but macular degeneration is associated with long-term aspirin usage

In the next issue...

One of my colleagues on the Department of Defense Prostate Cancer Research Program, Dr. Robert Gillies, recently published an extremely important paper relative to the management of advanced stage prostate cancer, *"Evolutionary dynamics of carcinogenesis and why targeted therapy does not work."*

The full text of Dr. Gillies study can be seen at:

[http://neurosurgery.med.wayne.edu/pdf/evolution of cancer review.pdf](http://neurosurgery.med.wayne.edu/pdf/evolution%20of%20cancer%20review.pdf)

In short what he is saying is that "malignant cancers are dynamically evolving clades (familial groups) of cells living in distinct microhabitats that almost certainly ensure the emergence of therapy-resistant populations. Cytotoxic cancer therapies also impose intense evolutionary selection pressures on the surviving cells and thus increase the evolutionary rate."

This concept was simplified for me by Dr. Frank Rauscher at the AACR Annual Meeting when he gave the analogy that cancer cells will take residence in the primary tumor site, but they send their relatives out into the blood stream to seek out potentially "new neighborhoods" to live in, to find a house and decorate it, and make it hospitable for whenever the cancer cells decide to move.



Dr. Robert Gillies



Dr. Frank Rauscher

This brought to mind conversations at ASCO-GU with Dr. Ken Pienta who observed that many of his patients, recently treated with androgen receptor targeting drug agents, were presenting with secondary neuroendocrine cancers, which he believes are related to the treatments themselves. A video with Dr. Pienta's comments on the subject can be seen at:



Dr. Ken Pienta

http://www.oncologytube.com/index.php?page=videos§ion=view&video_id=1031557



Dr. Cory Abate-Shen

Dr. Cory Abate-Shen further postulated that it is possible that these neuroendocrine tumors are the really lethal forms of the disease resistant to other targeted therapies. A video of Dr. Shen speaking on this subject can be viewed at:

http://www.oncologytube.com/index.php?page=videos§ion=view&video_id=1031677



Dr. Donald Coffey

Additionally, we will look at the new diagnostic and prognostic biomarkers and genetic tests coming on the scene and try to assess their viability for patients in the detection and management of prostate cancer. Some commentary of the subject is provided by Dr. Donald Coffey at:

http://www.oncologytube.com/index.php?page=videos§ion=view&video_id=1031678

XOFIGO

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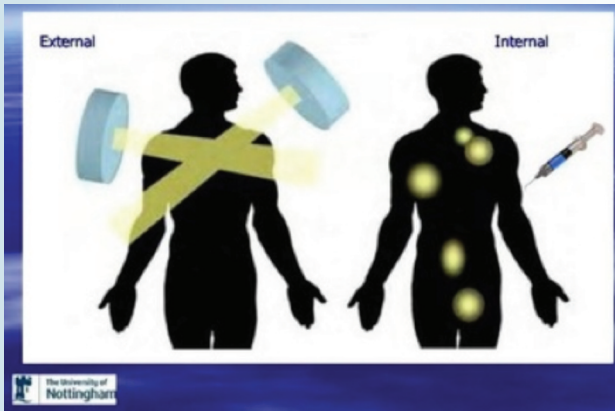


Figure 1.

Other treatments during Xofigo – It is important to state that all men in the phase 3 trial for XOFIGO (radium 223 dichloride) were also on another type of CRPC treatment. This phase 3 trial, called ALSYMPCA, had men on “Best Standard of Care” (BSoC) in addition to radium 223. This was several years ago – before FDA approval of PROVENGE, Zytiga, or Xtandi.

Some of the BSoC drugs included in the ALSYMPCA trial were:

- Nizoral (ketoconazole)
- Nilandron (nilutamide)
- Androcur (cyproterone acetate)

The important point here is that Xofigo was not studied as a “primary” treatment for CRPC. Instead, it was used as a “supplemental” treatment along with another CRPC therapy. It needs to be understood in this context.

Also – men who were on bisphosphonates, such as Zometa, continued on the bisphosphonate. About ½ of the men had previous Taxotere.

Cancer Response - Cancer response to radium 223 dichloride was shown in 2 areas – (1) improvement in bone pain (2) survival benefit.

Side Effects – The most common side effects were low lymphocytes (32% more than placebo), low white blood cells (28% more than placebo) and low platelets (12% more than placebo). Overall, side effects were minimal and treatable.

(1) FDA. Full Prescribing Information for Xofigo.

For more information on the Prostate Cancer Research Institute, go to: www.PCRI.org or call 310.743.2116

AHRQ Funding Eliminated In House Subcommittee Vote

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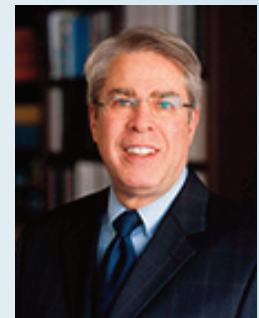
“AHRQ’s budget is a rounding error in the federal budget,” Siegel continued.

One of the most invaluable of AHRQ’s initiatives, according to Siegel, is Project RED (Re-Engineered Hospital Discharge), a randomized control trial developed at Boston Medical Center that re-engineered workflows and reduced preventable patient readmissions. “Hospital readmissions are a big issue for all American healthcare,” said Siegel. “Project RED could save American taxpayers billions of dollars in years. That’s the kind of work AHRQ does, and that’s the kind of work we need today.”

One of 12 agencies within HHS, AHRQ was founded in 1989. Originally created as the Agency for Health Care Policy and Research, it was renamed AHRQ in 1999. The agency funds and conducts research related to patient safety, health information technology, the effectiveness of specific medical treatments, prevention and care management and healthcare value.

Source URL: <http://www.healthcarefinancenews.com/news/ahrq-funding-eliminated-house-subcommittee-vote>

Editor’s Note: Research funding for prostate cancer doesn’t have just a patient benefit, but a spectrum of support for the community at large. View a video with Dr. Howard Soule of the Prostate Cancer Foundation on the subject at:



Dr. Howard Soule

<http://www.youtube.com/watch?v=VOKAIL-EIXk>



Call us: 1.888.477.6763, or email us at: support@prostatenet.org
 Mailing address:
 P. O. Box 10188-#77550
 Newark, NJ 07101-3188
 Fax: 1.270.294.1565
www.prostatenet.org



In Amenable Mortality—Deaths Avoidable Through Health Care—

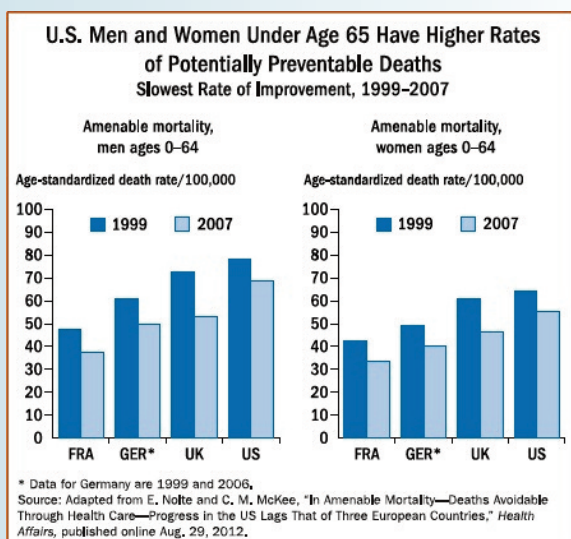
Progress in the US Lags That of Three European Countries

By Deborah Lorber for The Commonwealth Fund

Despite spending twice as much as the average Western European country for its health care, the United States lags on a number of health system performance indicators, including amenable mortality—that is, deaths that could have been avoided with timely and effective health care.

Key findings of the study:

- Between 1999 and 2007, rates of potentially preventable deaths among men under age 75 fell by 18.5 percent in the U.S. During the same time period, the rate declined by 37 percent in the U.K., by 28 percent in France, and by 24 percent in Germany (2006).
- For women, the rates fell by 17.5 percent in the U.S., 32 percent in the U.K., and 23 percent in both France and Germany.
- In 2007, amenable mortality was highest in the U.S., with rates almost twice those seen in France, which had the lowest level of the four countries studied.
- The pace of improvement was slower in the U.S. than in the other countries for the two age groups examined—individuals under age 65 and those ages 65 to 74. However, the lag was most pronounced among American men and women younger than 65. These individuals are more likely to be uninsured than are Medicare-eligible Americans age 65 and older. They are also more likely to be uninsured than their European counterparts, who have access to universal coverage.



"There is no reason," the authors concluded, "why all Americans cannot benefit equally from living in a country with the most expensive health care system in the world."

Why You Should Absolutely, Positively See A Medical Oncologist . . .

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So what can a medical oncologist really tell you that an urologist or radiation oncologist cannot?

In theory, nothing! In fact, an expert medical oncologist may give you all the same factual information. It is in their interpretation of your situation that you will find them to be the most useful. Treatment recommendations tend to follow the specialty of the recommender. So not surprisingly, urologists (who are trained as surgeons) tend to push surgery and radiation oncologists tend to lean towards radiation, whether as seeds or external beam. A medical oncologist may recommend surgery or radiation or active surveillance. Clearly, no one type of doctor has a monopoly on great ideas or the best recommendation, but it is useful to have a "navigator" for you on your journey to find the best treatment for you.

It's also important to remember that it can't just be any oncologist. Prostate cancer if fact has traditionally represented only a small percentage of most general oncologist's practices. Mostly, they treat lung, colon, breast and other major cancers. While prostate cancer is very common, for many years, medical oncologists often did not see prostate cancer patients until very late in the disease course—usually metastatic castration-resistant prostate cancer. It is still pretty rare for a typical medical oncologist to see newly diagnosed localized prostate cancer patients.

So the key is to see a specialized GU oncologist, usually someone whose practice is exclusively or primarily prostate cancer patients.

What should you expect by the end of the visit?

You should know your cancer:

- How aggressive is it?
- Would more scans or tests help to stage the cancer?
- What are your treatment options, including no treatment at all?
- Who are the best practitioners should you choose therapy?
- What should you expect in the long run in terms of side effects and cancer outcomes?

Of course, no one can predict the future, so this information is based on the best information available at the time. The pathology review is critical. The assessment of all of the available information, including PSA trends, physical examination, imaging tests, all roll together to make the visit with a medical oncologist a launching point for the next step: taking control of your prostate cancer. With your navigator at your side.

A video of Dr. Oh discussing the benefits of a medical oncology consultation can be viewed at http://www.oncologytube.com/index.php?page=video§ion=view&vid_id=1031962

Dr. Oh holds the Ezra Greenspan, MD Chair in Clinical Cancer Therapeutics in the Icahn School of Medicine. Appointments to see Dr. Oh or one of his colleagues can be made by calling 212-241-6756.



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Prostate Cancer Online Support Group

**Monday June 3, 2013 –
Friday, September 13, 2013**

CancerCare is offering a free, 15-week online support group for men diagnosed with prostate cancer. This group provides a safe, confidential space where men can discuss the unique challenges of living with prostate cancer while giving and receiving support, information and guidance.

MODERATOR

Bill Goeren, LCSW
Director of Clinical Services at CancerCare

TO JOIN THIS SUPPORT GROUP, PLEASE VISIT
www.cancercares.org/support_groups/107 to complete our online registration process.

Internet access is required.

Funded by a grant from



((CADRE))

Emulating the success of the National Breast Cancer Coalition's "Project LEAD[®]", **The Cadre Project** will train participants in the acquisition and utilization of the knowledge and skills necessary to make them professional and credible representatives of the prostate cancer patient community fully able to work with scientists, private industry, government agencies and healthcare professionals to make substantive change relative to the negative impact of prostate cancer in their communities.

**Launching June 25, 2013 –
New York University Kimmel Center**



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