



# POUGHKEEPSIE MAN TO MAN



*Prostate Cancer Education & Information Support Program since July 1993*

January 8, 2004 Issue 1 (Meetings to date # 141)

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**Our web sites** <http://www.geocities.com/charl2ep/Cancer/> or <http://www.boodrow.com>

Man to Man (M2M) is an educational, not for profit, prostate cancer support program of the American Cancer Society. It is a forum for discussing medical developments & experiences. Protocols discussed at M2M meetings are sometimes based on anecdotal information. It is always advisable to consult a physician before adopting any form of treatment.

## **PROGRAM for Jan 8, 2004**

**Guest Speaker  
Evan R. Goldfischer, M.D.**

### **In This Issue:**

- Program for M2M on January 8, 2004
- Guest Speaker: Dr. Evan Goldfischer
- Newcomers & PCa 101
- New drug for advanced prostate cancer
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- Med Cost Update
- Testosterone Controversy
- Joke Du Jour
- Slide presentation by Dr. Goldfischer

A joint meeting of Man to Man (M2M) and Side by Side (SXS), the prostate cancer (PCa) support and education groups sponsored by the American Cancer Society, was held on January 8, 2004 in the Central Hudson Electric Company Auditorium-6, Rt.9, Poughkeepsie, NY. There were 61 in attendance including 1 new M2M member and 11 SXSs. Four Newbie books were handed out.

**PLEASE NOTE Poughkeepsie M2M has back issues of our newsletters & information on PCa.**

**go to:**

**<http://www.geocities.com/charl2ep/Cancer/>  
or <http://www.boodrow.com>**

Dr. Evan Goldfischer is with Hudson Valley Urology. His topic was "PCaTrials Update." He is a graduate of Cornell Medical Center with an MD in May, 1992. He interned at U. of Chicago Hospitals in Urology, and was Chief Resident in 199. He had a Fellowship at Long Island Jewish Med. Ctr.

Dr. Goldfischer's presentation was upbeat & informative. He was very current in all that he presented. He addressed many of the problems men have following RP or RT such as ED, and the two l's incontinence & impotence.

HVU is also conducting trials for women who are experiencing sexual dysfunction for a wide variety of reasons such as child bearing, change of life or from surgical procedures.

Dr. Goldfischer was good enough to allow us to use his slides for this newsletter which outline most of the clinical trials HVU is conducting. The slides will be found beginning on page 7.

## **A Few Words From our new Medical Advisor, Evan R. Goldfischer, M.D.**

On January 8, 2004, I had the distinguished pleasure of addressing the Poughkeepsie chapter of Man-to-Man for the sixth year in a row. The Poughkeepsie Man-to-Man meetings are always well attended and the group is very enthusiastic. Dennis and Paul offered me the opportunity to be the group's medical advisor. I am honored that you considered me for the post, and I am happy to accept the position. For those of you who could not attend the talk, I have summarized, below, the main topics of the evening.

Hudson Valley Urology has always strived to offer the best in urologic care, and to be the premier group in region. In order to enhance the care we provide to our patients, three years ago we established our own research program. We have three full time providers on our staff, in addition to the five urologists, PA, and nurse practitioner. The members of the research team include, Andres Hidalgo, M.D., Jeannie Hefele, R.N., and Lorraine O'Donnell, M.A. Patients participate in clinical trials for many reasons including the opportunity to advance science, to obtain a treatment for their condition when one is not available or all FDA approved therapies have failed, to receive free care, or to earn a patient stipend. Some of the drugs that are now on the market, that have been available to our patients in clinical trials include Viagra, Levitra, Cialis, Detrol LA, and Cipro XR.

At this time, we are conducting trials in prostate cancer detection, prevention and treatment, erectile dysfunction, overactive bladder, urge incontinence, stress incontinence, and premature ejaculation. This list is constantly changing as some trials fill up and new ones are added. Please feel free to call our office and talk to a research team member if you need more information.

## **The second part of the talk dealt with the three pills currently FDA approved for ED.**

The pills are Viagra, Levitra and Cialis. All three pills work well, but each one has its strengths and weaknesses. For example, Viagra is the most tested of the three, but some patients suffer from blue vision. It should be taken on an empty stomach, and some men do not respond to it. The 50 and 100 mg doses of Viagra should not be taken within four hours after ingesting an alpha blocker. Levitra is completely contraindicated with alpha blocker. It may have less visual side effects, and some patients who have failed Viagra do respond to Levitra and vice versa. Cialis is the newest agent with a 17.5 hr half life and efficacy up to 36 hours. It can be taken with food and with Flomax an alpha blocker but is contraindicated with other alpha-blockers. Please feel free to make an appointment with one of the urologists at Hudson Valley Urology, and ask if a free sample of one of these pills is right for you.

**Evan R. Goldfischer, M.D.,  
Hudson Valley Urology- 845-452-8730**

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### **Newcomers & PCa. 101**

1) He is 52 years old, with a history of PCa in his family. In Sept. 03 his PSA was 4.3; a month later it was 6.0. He underwent a biopsy in Dec. 03. 12 samples were taken half of them were positive for PCa, with a GG= 3+3. CAT & bone scans were negative.

### **Herb Ilker PCa 101 Poughkeepsie M2M**

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#### **Attention: M2M Meeting cancellations**

In the future we will base our decisions whether to cancel a M2M & Side by Side meetings dependent on what the school systems in our area do. When the schools either delay or close the schools in our area, we will probably cancel. Call the local ACS at 845-452-2932, press 3, then 10 to reach the operator or answering machine. Listen to the local radio stations; they will also announce cancellations of M2M meetings. You can also call our own hot line 297-7737 and listen to message.

## **New Drug for Advanced Prostate Cancer Lowers Testosterone in Men With No Other Alternatives**

Nov. 26, 2003 -- The FDA has approved Plenaxis, a drug for advanced prostate cancer for men who have no alternative treatment.

The drug is approved for the treatment of the symptoms of advanced prostate cancer in men who cannot take other hormone therapies and refuse surgical castration. Removal of the testicles is one way of significantly lowering the levels of the male sex hormone testosterone, which can spur the growth of prostate cancer.

Because of an increased risk of serious, and potentially life-threatening, allergic reactions associated with Plenaxis, the drug will be restricted to men with advanced prostate cancer who have no alternative treatment. About 5%-10% of men with prostate cancer have the type of advanced, symptomatic disease that would make them eligible for Plenaxis.

### **Less Testosterone Production**

Plenaxis is a type of medicine that lowers the male hormone testosterone, which is a key factor involved in most prostate cancer growth.

The effectiveness of Plenaxis in lowering testosterone production in men with advanced, symptomatic prostate cancer was demonstrated in a study of 81 men. The study showed that such patients could avoid surgical castration by undergoing at least 12 weeks of treatment. Some of the men also experienced other benefits from the use of this product, including decreased pain and relief from urinary problems. However, three of the 81 men in the clinical trial experienced serious allergic reactions, one of which included loss of consciousness.

### **Severe Side Effects**

Because of the risk of low blood pressure and fainting as part of the allergic reaction to Plenaxis, men who receive the drug are to be monitored for at least 30 minutes after receiving a dose of the drug in their health-care provider's office setting. Moreover, the manufacturer will not be distributing the drug through retail pharmacies; rather, the drug will be distributed directly to physicians and hospital pharmacies enrolled in the Plenaxis risk management program (RMP).

Plenaxis is administered as an injection into the muscles of the buttocks every two weeks for the first month of treatment, followed by once every four weeks thereafter. Because the drug may stop working in certain patients, doctors should perform blood tests about every two months.

The most common side effects seen in the clinical trial were hot flashes, sleep disturbances, pain, including back pain, breast enlargement or pain, and constipation.

The Plenaxis RMP that the drug's manufacturer will be implementing is designed to help ensure that patients and physicians are fully informed of the risks and benefits of Plenaxis before using it. The RMP emphasizes the need for doctors, patients, and hospital pharmacists to work together to maximize the benefit of Plenaxis and minimize the risk.

As part of the program, the sponsor will only be distributing Plenaxis to physicians who attest to certain qualifications and are enrolled in Praecis' Plenaxis PLUS (Plenaxis User Safety) Program. In addition the company is establishing educational programs for physicians, patients, and hospital pharmacists about the risks and benefits of Plenaxis. Patients will be asked to read and sign a patient information leaflet before receiving the drug.

<http://www.fda.gov/bbs/topics/ANSWERS/2003/ANS01268.html>

**About 5-10% of men with prostate cancer have the type of advanced, symptomatic disease that would make them candidates for Plenaxis.**

Medical News Reviewed By Michael Smith, MD  
on Wednesday, November 26, 2003

**Submitted by Danny Jacobs, M2M Florida**

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## **PSYCHOLOGY OF CANCER**

(Part 3 of a series)

Summarizing the previous article, I talked about two opposing schools of thought: one contending that there is no solid evidence to support the relationship of a person's psychological makeup and the onset of cancer, the other predictably saying that there is a direct relationship between the two.

I am a proponent of the second position. Our personal stories, I believe, have a strong bearing on whether or not we get sick. Any psychological picture of cancer can only be a general one as we are dealing with "soft" evidence. Numerous examples from other people and controlled studies do serve as guideposts. Though the broad features are frequently the same, the specifics are different from individual to individual.

Part of our mindset as to our own health is conscious and deliberate. Without being overly obsessive, do we take care of ourselves by eating right, exercising, getting enough sleep, getting our PSA tested, wearing a seat belt, etc.? Each of these are a statement as to how much we value ourselves and how much we care about living. Our conclusions, I believe, are the single most important predictors as to our state of health. The trouble is that most people have unconscious agendas around fulfilling these basics, leaving us often with mixed intentions.

There is more than enough evidence of the major role our unconscious mind plays in our decisions. Freud likened the unconscious to a massive

underwater iceberg with the conscious mind above the water. Many offshoots of unconscious thought are achieved in the body's tissues, without our being aware of it. Take some of the common expressions like "You're breaking my heart. Get off my back. This problem is eating me up alive." Bernie Siegel, M.D. in *Love, Medicine & Miracles* says that our body responds to these mind messages as "live" or "die" reactions. Like the fight-or-flight response, he is convinced that we not only have survival mechanisms but also "die" ones "that actively stop our defenses, slowing the body's function and bringing us toward death when we feel our life is not worth living."

We don't yet understand all the ways in which brain chemicals are related to thought and emotions, but we do know that our state of mind is closely linked to our state of body. We can change our body by the way we feel. Thus, if we feel hopeless we give the body a "die" message. If we successfully confront our negative feelings where the message is changed to "life is tough but worth the effort," then the immune system works in our behalf for life. There is evidence that emotions such as grief, suppression of anger, feelings of failure produce over-secretion of hormones in the bloodstream or directly through the nerves and neurochemicals, which actually suppress the immune system.

I have no illusions that there are those who believe that PCa is an exception to the above. After all, PCa increases rapidly as we grow older so that 80% of men in their 80s have PCa at autopsy. This only demonstrates to me that age is one of the many factors in contracting PCa, as the body and its immunity breaks down. This does not, however, make our psychological mindset any less important.

In the next articles I will discuss stressors, psychological profiles and body targets of cancer.

**Mike Kulla, Ph.D. Clinical Psychologist  
Poughkeepsie Man to Man**

## MED COST UPDATE

It's time again to weigh in on the topic of buying meds from Canada and Europe. The FDA, not content to have jurisdiction over regulation of drugs in the US, is now trying to tell Canada what to do.

FDA commissioner, Mark McLellan, made a trip to Canada last month to persuade officials to lift the prescription drug controls and thereby put an end to cross-border sales. His rationale: the US foots the bill for most of the research to develop popular meds.

A spokesperson for the Canadian International Pharmacy Association put it in perspective. The job of the FDA, he said, is patient safety, not to comment on research costs or profit margins. He added: They (FDA) are heavily influenced by the pharmaceutical industry and I think they are stepping outside their bounds." It seems that the commissioner's suggestions were not exactly treated with open arms.

Meanwhile the pharmaceutical companies are out there lobbying against allowing consumers to get their meds from Canada and Europe. Many Americans can no longer afford to bear the artificially inflated costs levied in the US which it has been said is bankrupting our healthcare system.

The FDA and the drug companies promote the idea that somehow the other countries' drugs are unsafe. Many argue that this is a ruse to maintain a stronghold to force Americans to pay incidentally the highest prices in the world for prescription drugs. If we were allowed free market forces to compete for business, prescription drugs prices would take a nosedive, thereby mitigating the need for tax dollars to be taken from consumers to pay for prescriptions.

The industry's biggest rationale for maintaining their price structure is to support research, but the fact is that most of the R & D is aimed at developing competitive drugs that are often no

better than existing counterpart meds, enabling the drug companies to reap huge profits without providing medical breakthroughs. A study done last year found that only 15% of drugs approved by the FDA between 1989 and 2000 offered significant clinical advantage to their users.

For information relating to the prescription drug cost crisis you can log on to the web site-

[www.stopfda.org](http://www.stopfda.org)

**Mike Kulla, Poughkeepsie Man to Man**

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## TESTOSTERONE CONTROVERSY

**(first in a series of two articles)**

After a 13 month course of hormone deprivation therapy my testosterone level shot up to 1165. The standard normal range for men 50 and over -- that includes me -- is 212 to 775. My oncologist wanted to immediately resume hormone treatments even though my PSA was at a nice 2.3 level. I decided to get a second opinion, consulting with Dr. Stephen Strum, an international authority on PCa. He was moved more to have me resume treatments based on my slightly elevated PSA, not on my elevated testosterone level. I'm glad to say I took a little from each doctor and did not resume treatments. Over two years later my PSA remains in the same general range.

**What is testosterone?** It is one of the masculinizing hormones and is responsible for many of the male features including libido, sexual drive, muscularity, lower voice and male hair patterns.

The sacred assumption is that testosterone contributes to PCa and BPH (benign prostate hypertrophy). Some doctors refer to testosterone as the "fertilizer for prostate cancer growth." A few medical researchers, however, have questioned this hallowed hypothesis. Some background as to why is in order.

We have known for over 50 years that PCa is dependent on age. Eighty percent of men in their 80s have PCa at autopsy, while PCa is a rarity in men in their 20s. You can chart the dramatic incidence of PCa as men's' ages rise.

Not everyone knows that testosterone decreases as we age. But the incidence of PCa increases as testosterone levels decrease! Surely, this does not fit the mold.

### **Why does PCa occur so frequently in aging men? According to John Lee, MD:**

1). Progesterone levels, vital to good health, falls. Further, Progesterone is a potent inhibitor of an enzyme that converts testosterone to DHT. It does so far more effectively than Proscar and Saw Palmetto, two of the more standard agents.

2).DHT is more stimulating to prostate cell growth than is testosterone. As I said before, testosterone and progesterone levels are on the wane. Due to progesterone's decline more testosterone is converted into the bad DHT. Testosterone is a direct antagonist of estradiol, and DHT is not. Research has shown that estradiol turns on cancer while progesterone turns on anticancer activity.

3). Bottom line: estradiol's effect increases. Lee concludes that "perhaps estradiol (along with DHT) is the culprit in prostate growth and the cause of prostate cancer." Breast cancer abates when women are on progesterone therapy.

PCa growth is not due to a linear progression of cancer cells multiplying from one rogue cell to another; it is due to an underlying metabolic imbalance, according to Lee. "The underlying metabolic imbalance in all hormone dependent cancers is estrogen dominance." There are three major estrogens, estradiol being one of them. If you prevent estrogen dominance you prevent the cancer, he says.

Peter Eckhart, MD, says that testosterone given to test mammals after PCa cells have been transplanted in them will slow tumor growth and

kill cancer cells. He believes it's time for a new hypothesis.

**This article will be continued  
in the next newsletter.**

**Michael Kulla, Poughkeepsie Man to Man**

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#### **Joke Du Jour**

#### **THE FROG**

What with Dr. Evan Goldfischer talking to our January meeting about Viagra and its look-alikes, I thought a good anecdote would be in order. Are there other alternatives to the "lift" we seek in Viagra?

An older man is walking down the street. "Can you help me?" a voice says, but there is no one in sight. Walking a little further he hears again "Can you help me?" But no one is in sight. Finally, he looks down on the pavement and he sees a huge frog who again asks for help.

A little embarrassed to be talking to a frog the man asks "Did you speak to me?" "Yes" says the frog. "I'm under a curse. If you would kiss me I'd be free of the curse and I'd turn into a beautiful woman who would care for you, warm your bed and make you happy."

The man stands there for a moment, picks up the frog and puts him in his pocket. After a while the frog says "You forgot to kiss me." The man replies. "You know at my age it might be more interesting to have a good talking frog."

**The story helps us see in a humorous way our predicament.**

**Mike Kulla, Poughkeepsie Man to Man**

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### **PESTICIDES: ANOTHER STRONG LINK TO PROSTATE CANCER?**

Prostate Cancer took nearly 31,000 lives in 2001 (1) and remains second only to lung cancer as the leading killer of men (4). The latest research has attributed inheritance as the major factor in prostate cancer (3), a close second being environmental risks. But Belgian researchers have found another strong cause for the environmental impact on prostate cancer, namely in the form of pesticide exposure.

In a study released in the medical journal Occupational and Environmental Medicine (2), researchers analyzed twenty-two epidemiological studies published in the Occupational and Environmental Medicine journal between 1995 and 2001. Results showed men exposed to pesticides on the job stood a 13-percent increased risk of getting prostate cancer, with men working as pesticide sprayers appearing to be at higher

risk than farmers or those in other occupations involving the use of pesticides.

Despite this finding, the researchers caution against over-interpretation of the findings, noting most of the 22 studies did not take other factors, including race and genetics, in account. Nevertheless, the researchers believe the findings send up a "red flag" concerning pesticide use and prostate cancer, noting their results would again stress the necessity to limit the occupational exposure to pesticides as well as other chemicals.

**References:**

- 1). Van Maele-Fabry G. Occupation related pesticide exposure and cancer of the prostate: a meta-analysis. Occupational and Environmental Medicine 2003; 60(9): 634-42.
- 2). Center For Disease Control and Prevention's 2001 Vital Statistics Report, Volume 51 Number 5, released March 14, 2003.
- 3). Nelson WG. Mechanisms of Disease: Prostate Cancer. The New England Journal of Medicine 2003; 349: 366-381
- 4). Diagnosis and Treatment of Prostate Cancer. American Family Physician 1998; 57(7): 1531-1540

Submitted by Greg Arnold, October 29, 2003, Abstracted from "Study Links Pesticides, Prostate Cancer" in Ivanhoe.com newsletter, August 25, 2003

**Danny Jacobs M2M Florida**

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**TO ALL RECIPIENTS OF OUR NEWSLETTER.**

If you are experiencing any problems with receiving the newsletter, possibly your name, address or zip code are wrong. If you are receiving duplicate or triplicate issues or if you know of any other members who are experiencing mailing problems, contact Peter & Teresa Hardin, phone: 845-897-9667, e-mail: <hardin.pt@verizon.net>, or regular ground mail: Peter Hardin, 12 Penn Street, Fishkill, NY 12524

Power Point Presentation  
**“Clinical Trials Update”**  
**Evan R. Goldfischer, M.D.**  
**Hudson Valley Urology**

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**Clinical Research**

- Study medications already on the market**
- Study new medications**
- IRB approval for all trials**
- FDA approval for all trials**

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**Example of New Indication**

- Viagra – agent for primary pulmonary hypertension**
- Viagra – onset of action as early as 14 minutes**
- Viagra – postoperative daily dosing after RRP improves return of normal spontaneous erections**

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**Why Participate**

- Seek treatment for which there are no approved therapies**
- Seek better alternatives to current therapies**

- Advance medical science
- Close supervision and free medical care
- Free drugs and patient stipends.

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## Hudson Valley Urology Research Department

- Evan R. Goldfischer, M.D.  
-Principal Investigator
- Andreas Hidalgo, M.D.  
- Coordinator
- Jeannie Hefele, R.N.  
- Coordinator
- Lorraine O'Donnell, M.S.  
- Coordinator

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## Areas of Research

- Prostate disorders – Prostate  
-Cancer, BPH
- Kidney Stones

- Infections/Prostatitis
- Incontinence
- Erectile Dysfunction/Rapid ejaculation
- Female Sexual Dysfunction
- Urologic Oncology

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## Former HVU Investigational Drugs

- Viagra
- Levitra
- Cialis
- Cipro XR
- Detrol LA

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## Prostate Cancer Prevention

- GlaxoSmithKline  
Patients with elevated PSA/  
negative biopsy - only one  
biopsy- performed within the  
last 6 months
- Drug: Avodart  
Randomized double-blind  
placebo controlled

## Prostate Cancer Treatment

- Drug: 3 month Leuprolide
  - Have not received GnRH agonist for one year after length of injection
  - Needs 6 months therapy
  - Not on Avodart, Proscar, DES, chemotherapy
  - All patients receive drug!
- 

## Prostate Cancer Treatment

- Drug: Degarelix monthly GnRH antagonist
  - Off hormonal therapy for at least 6 months
  - PSA > 2
  - All patients receive drug!
- 

## Prostate Cancer Treatment

- Drug: Zometa
- IV infused bisphosphonate
- Prevention of osteoporosis in patients with prostate cancer

on androgen deprivation who began within the past 12 months

- No history of treatment for osteoporosis DES or PC=SPES
- 

## Rapid Ejaculation

- Drug: Dapoxetine
  - Oral SSRI
  - Randomized double-blind placebo controlled
  - Must have a steady partner
- 

## Erectile Dysfunction

- Drug: Viagra
- Oral PDE-5 inhibitor
- Male with ED, steady partner
- Randomized double-blind, placebo controlled
- Viagra naïve patients
- Measure female satisfaction

## Erectile Dysfunction

- Drug: To be named PDE 5 inhibitor
- Oral agent
- Randomized, double-blind placebo controlled
- Radical prostatectomy/radiation excluded
- ED for at least 6 months

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## Overactive Bladder

- Drug: Fesoterodine
- Oral agent for OAB
- Randomized, double-blind placebo controlled
- 8 micturitions/24 hrs
- Radiation therapy patients can be included

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## Overactive Bladder

- Drug: Oxybutynin
- Randomized, double-blind placebo controlled
- Low dose taken on demand
- Women with at least 10 voids/day

## Stress Incontinence

- Drug: Duloxetine
- Randomized, double-blind placebo controlled
- Cough, sneeze = leak urine
- No hormonal treatment or radiation for CAP.

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**Volunteer drivers** are always needed by the American Cancer Society to transport patients for treatment. This is a good cause. As little as an hour a week will make a huge difference in someone's life. Contact Byllye (BILLY) at our local ACS office at 452-2932 press #3 and then #10 mention M2M. Side by Sider's are welcome to volunteer.

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### *Meetings and speakers for 2004*

Feb---5 Dr. Robert Sullivan, Marist College "Further Discussions of PSA testing and (Video) Dr. David Bostwick "PCa Pathology" from Burbank PCRI Conf.  
March---Video from Burbank "The History and Future of PCa." Dr. Donald Coffey, Johns Hopkins Hosp.  
April---1 Meeting to be held at Vassar Bros Hospital Pizza and tour of Dyson Center.  
May---6 Fred Pescatore, MD., M.P.H., Active Hexose Correlated Compound (AHCC) adjunct therapy cancer, hepatitis & immune enhancer.  
June---3 (TBA)  
July---8 (TBA)  
August--5 (TBA)  
September--- 2 (TBA)  
October----7 (TBA)  
Nov,---4 (TBA)  
Dec---2 (TBA)

### **Attention:**

**We always meet the first THURSDAY OF THE MONTH UNLESS OTHERWISE SPECIFIED**

Next meeting Thurs, Feb. 5, 2004 at 6pm held at Central Hudson Auditorium Rt 9 in Poughkeepsie--SXS Joins us For information Call 452-2932 ask for Byllye (BILLY)