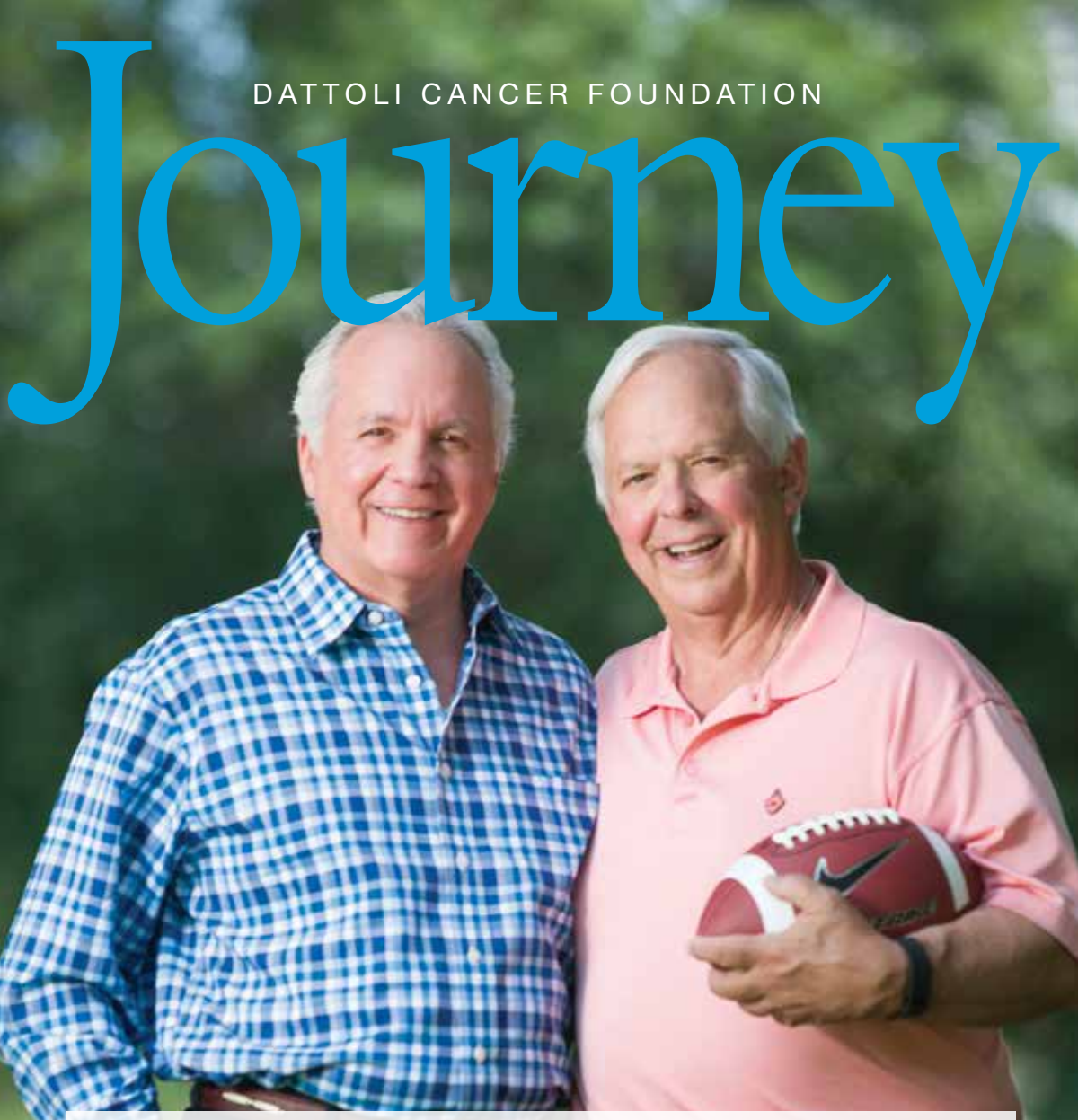
DATTOLI CANCER FOUNDATION

Journey



SPRING 2015

DATTOLI
CANCER FOUNDATION

ALEX STAFFORD

A decade and more of progress.

FROM THE EDITOR

I recently came across an article entitled Prostate Cancer: 10 Years of Progress.* Skimming through it, I realized rather surprisingly that I had been right in there for the entire 10 years. In fact, I've been working alongside Dr. Dattoli and Dr. Sorace for 15 years. Time flies – and it has been an amazing journey.

The article looks back to the first Genito-urinary Cancers Symposium, convened in 2005, and highlights major improvements through the past decade from the standpoint of medical oncology, radiation oncology, surgery and screening.

According to the author, perhaps the greatest gain has come in the development of chemical agents to treat or slow the progress of advanced prostate cancers. We have only to look at the list of new drugs in the formulary: docetaxel, sipuleucel-T (Provenge®), cabazitaxel (Jevtana®), abiraterone acetate (Zytiga®), enzalutamide (Xtandi®), radium RA 223 dichloride (Xofigo®), zoledronic acid (Zometa®), and denosumab (Xgeva®). One medical oncologist says, "We have an embarrassment of riches" to offer our patients. (I just want to know: Who comes up with the crazy names for these drugs?)

This past decade has seen a "technology explosion in Radiotherapy," to which we can certainly attest. The result has been significant improvement in dose escalation while reducing toxicity. Randomized trials have shown that dose escalation has led to improved 10-year prostate cancer specific survival in high-risk patients. Our own look-back studies have led the way. We published our 16-year freedom from biochemical progression survival rates for intermediate- and high-risk patients in 2010, setting a very high bar for all other centers.

Regarding surgery, this article cited a shift away from surgical treatment for localized, low-risk disease and more toward "expectant management," but still saw prostatectomies being recommended for high-risk disease. (Quite the opposite of our thinking at Dattoli Cancer Center – high-risk disease is seldom resolved by surgery alone.) Androgen deprivation therapy is being seen as much more successful when planned adjuvantly, rather than waiting until it becomes a salvage therapy.

The take-away statement from this article was that in the past 10 years, advanced imaging techniques have improved staging, treatment planning and monitoring – and multimodality therapy is proving to be useful for the management of high-risk, locally advanced and metastatic disease. Amazingly, there was no mention of USPIO (Ultra-small Super Paramagnetic Iron Oxide), which we think is one of the greatest advancements of this decade.

Virginia 'Ginya' Carnahan, APR, CPRC

*Prostate Cancer: 10 Years of Progress, Charles Bankhead – MedPage Today

Journey
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Journey is published by the Dattoli Cancer Foundation. Established in 2000, The Dattoli Cancer Foundation increases awareness about the importance of PSA screening; offers current, accurate information about leading-edge treatment; and fosters research leading to improved treatment options for prostate cancer.

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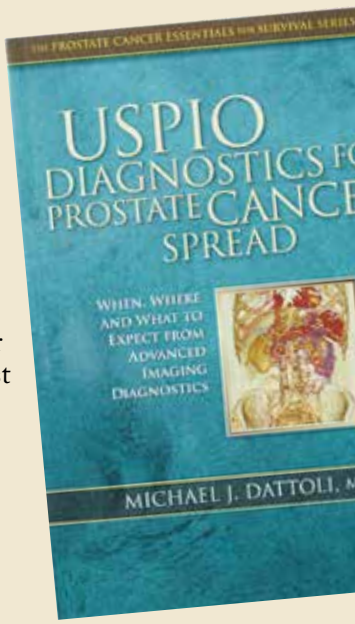
USPIO Booklet Available



The Dattoli Cancer Foundation's newest booklet in the "Prostate Cancer Essentials for Survival Series" is hot off the press and on our bookshelves.

USPIO Diagnostics for Prostate Cancer Spread is a 70-page booklet addressing this latest technology (USPIO: Ultra-small Super Paramagnetic Iron Oxide) for the management of lymph node positive prostate cancer. We have published a couple of articles about this very exciting new procedure in past issues of Journey. Now we have the whole subject covered in this booklet.

The subtitle says it all: "When, where and what to expect from advanced diagnostics." This booklet is good for any man who has been treated – by any method – for prostate cancer. It will alert you to the earliest evidence that your cancer may have spread, and it shares the good news of the potential to "control" the spread of metastatic disease to the lymph nodes.

If you would like a copy, all you have to do is contact us and we'll send a complimentary copy out to you lickety-split. If you belong to a support group, let us know and we'll provide a copy for the group's library as well. Call us at 941.365.5599.

Prostate Cancer ↔ Bladder Cancer: Is there a Connection?

MESSAGE FROM MICHAEL DATTOLI, MD

Occasionally we hear from a patient who, after prostate cancer treatment at Dattoli Cancer Center, has developed bladder cancer. A second primary cancer diagnosis is certainly not welcome, but it is not rare either.

Bladder cancer is the fourth most common internal malignancy in American men, and according to which list you consult, also one of the 10 most deadly. (Prostate cancer is #1 in occurrence, but falls behind lung, colon, breast and pancreatic cancer in mortality.) Bladder cancer is three times more prevalent in men than it is in women. Surprisingly, while prostate cancer is twice as prevalent in African Americans, bladder cancer is thought to be only half as common in African Americans.

Bladder and prostate cancers, along with kidney and testes cancers, are considered in the grouping called "genitourinary cancers." All four organs have similar cells and environment, so it is understandable to occasionally find multiple primary cancers in this part of the body. (A "primary" cancer is a distinct cancer on its own and not a metastasis of another cancer.) That is, if a patient develops a kidney cancer, he is more likely to develop a bladder, prostate or testicular cancer.

Statistics published in the *International Journal of Oncology, Biology and Physics* in 2003 suggest that approximately 1 in 50 men (2 percent) who have been found to have either prostate or bladder cancer will eventually be found to have both. This data is over a decade old, however, so it may not be entirely accurate.

An even earlier study, published in the *Journal of Urology* in 1997, that took its data from the cancer registry at one medical institution, found that "of 100 patients with a diagnosis of bladder cancer, 25 (25 percent) also had prostate cancer." On the other hand, "25 (3.8 percent) of 651 men with prostate cancer also had bladder cancer."

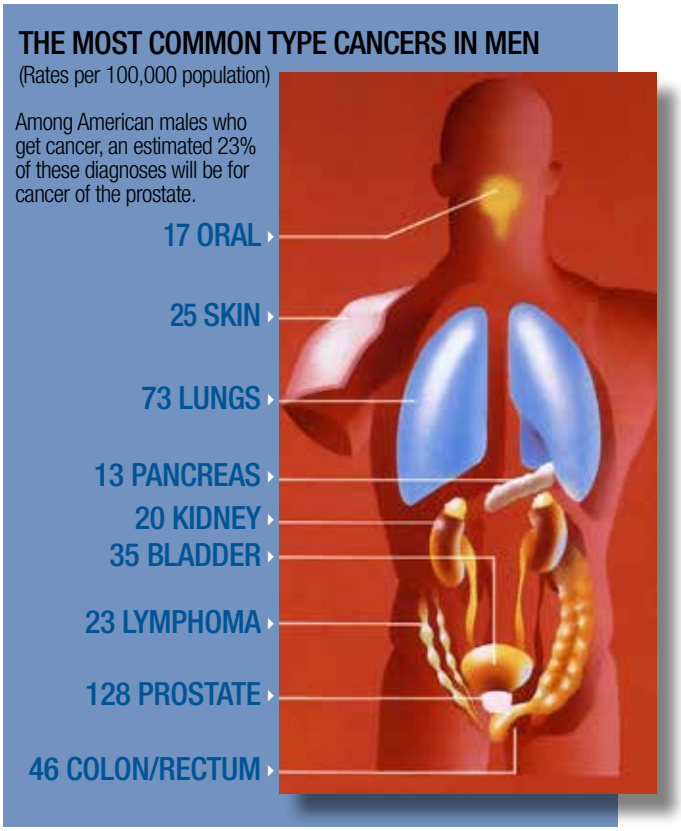
So this seems to mean that if you had bladder cancer, you run a greater chance of later developing prostate cancer, and the same for the other way around (developing bladder cancer after prostate cancer). Don't be alarmed, as the incidence of this happening is only slightly higher than in the general population at risk.

It also means that men in either category should be aware of this possibility of developing another primary genitourinary malignancy and be proactive in screening.

Regarding bladder cancer – the most common symptom is visible blood in the urine (although this can be a symptom of other issues, such as kidney stones, urinary infections, etc.). Early stage bladder cancer is usually painless but could contribute to urinary burning, increased urgency and frequency. Widespread disease, however, can cause pain in the belly, back or bones. Unexplained weight loss might also signal advanced bladder cancer.

After ruling out the common causes for blood in the urine, bladder cancer is diagnosed through a cystoscopy. This office procedure involves inserting a thin, flexible fiber-optic tube through the urethra into the bladder. The cystoscope allows the physician to visualize, photograph and also take biopsy samples from areas within the bladder. Samples are evaluated under a microscope by a pathologist.

Bladder cancer is staged according to location, much the same as prostate cancer



Source: *An Inside Look at Prostate Cancer,* Schering Corporation. Updated data from United States Cancer Statistics, Centers for Disease Control and Prevention.

is. The lesions confined to the epithelium are called Ta; those extending just beneath the epithelial layer are called T1; those infiltrating the superficial muscles are T2a, etc. Also, like prostate cancer, aggressive bladder cancer can escape and invade adjacent tissues and organs, and can even travel to distant lymph nodes and organs.

All cancers are caused by varying combinations of genetic and environmental factors. It is believed that in almost half of all bladder cancer deaths in men, cigarette smoking was the most important cause of the disease. The carcinogens inhaled through smoking are absorbed in the bloodstream, filtered by the kidneys and passed into the urine. Because the urine dwells in the bladder for hours before being expelled, the bladder lining is subject to prolonged contact with those carcinogens.

Treatment for bladder cancer depends on the stage of the disease and whether the tumor cells appear to be low-grade or high-grade (potentially aggressive). For most early stages, the general treatment is surgical removal of all visible tumors through a cystoscope (called a transurethral resection of the bladder tumor – or TURBT). In some cases, this will be followed by a procedure that involves instilling a chemotherapy liquid into the bladder immediately after the TURBT.

If a superficial (Ta or T1) bladder cancer has characteristics that suggest it has a high likelihood of recurring, additional treatment will be needed. The next step is usually an immunotherapy approach called BCG. This is the introduction into the bladder of a bacteria (Bacillus Calmette-Guerin) which has historically been shown to enhance the body's own tumor-fighting immune cells. This is delivered once a week for 6 weeks.

There are a number of other standard treatments for more advanced bladder cancers, up to and including complete surgical removal of the bladder. As with prostate cancer, we have recommended "bladder sparing" approaches at the Dattoli Cancer Center.

Finally, I must address the undercurrent of suspicion that radiation treatment for prostate cancer could cause bladder cancer. You may hear this from someone, maybe even a misinformed urologist or oncologist. That is an outdated way of thinking, although it continues to be perpetuated by many urologists and oncologists. We do not deny that you can find data in the

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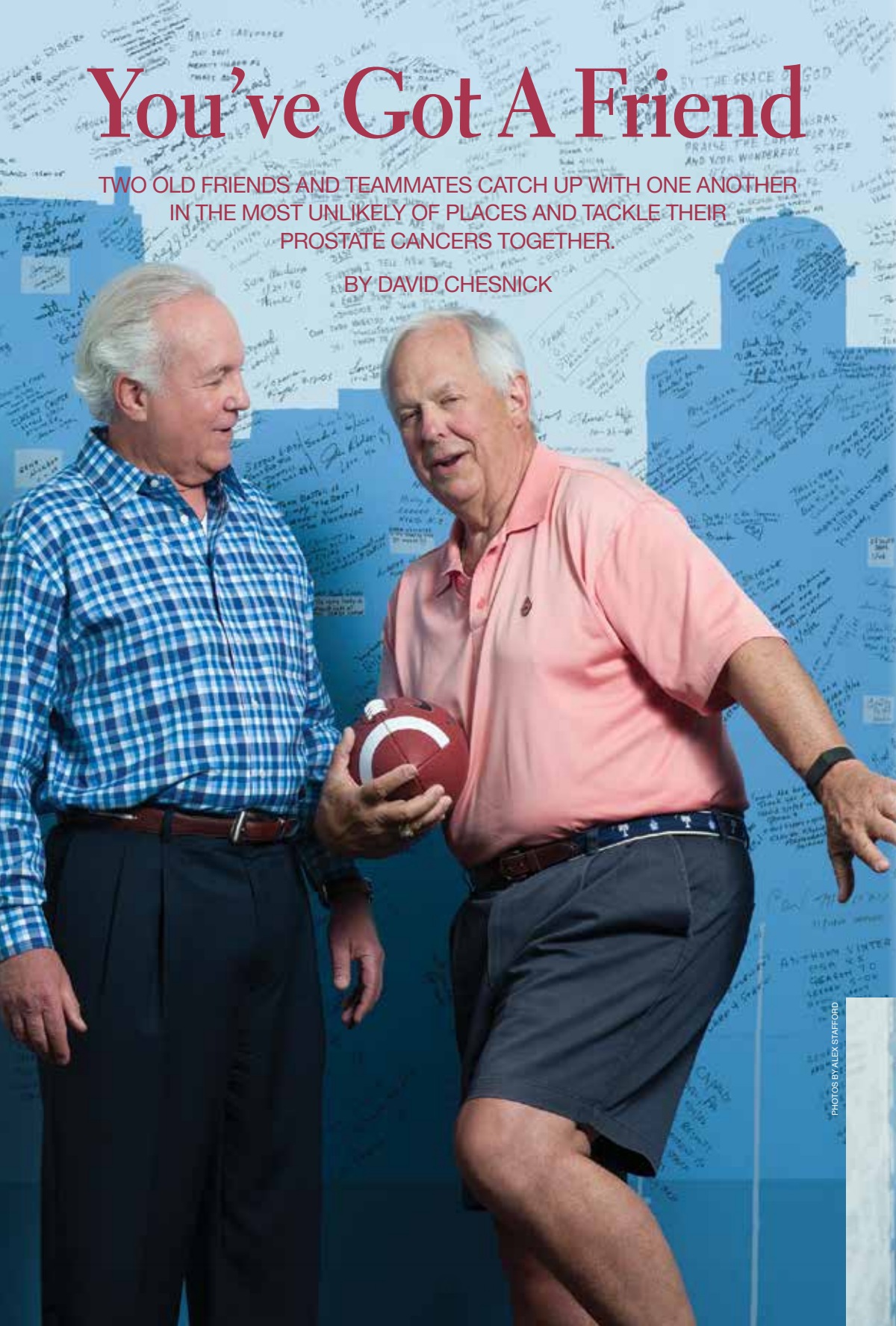
You've Got A Friend

TWO OLD FRIENDS AND TEAMMATES CATCH UP WITH ONE ANOTHER IN THE MOST UNLIKELY OF PLACES AND TACKLE THEIR PROSTATE CANCERS TOGETHER.

BY DAVID CHESNICK



PHOTOS BY ALEX STAFFORD

In the early '60s, both Frank Battaglia and Lynn Foltz played football for the Mt. Lebanon High Blue Devils in Pittsburgh, Pennsylvania. Lynn was All Western Conference. Frank was also on the varsity track and wrestling teams. Close friends, they lived in the same neighborhood and hung out with the same crowd of guys and girls.

After high school, they went on to college in South Carolina, Frank to Clemson University and Lynn to The Citadel. Both went into the service, married, had children, became grandparents and, at 71, are still working, enjoying successful business careers. But as it happens, they lost contact and hadn't spoken for 50 years – until they ran into each other one afternoon at the Dattoli Cancer Center, where each is waging a successful battle against prostate cancer.

FRANK'S JOURNEY

Frank's battle began with a PSA count that rose from 2.4 to 4.9 over a three-year period. While his urologist wanted to take a wait-and-see attitude, telling him he'd die before prostate cancer became a problem, his primary care physician took a more thorough approach, administering a Free PSA test.

This test provides a more accurate assessment of risk in men with a PSA over 4. Frank's revealed that he had a 35% chance of cancer, so he went back to his urologist who did a 12-core biopsy. Though one was cancerous, the urologist again advised doing nothing. For Frank, who had lost three family members to cancer, doing nothing wasn't an option.

"I felt like a deer caught in headlights. I started talking to other men, many of whom had had prostate cancer and had their prostates removed surgically. They were experiencing all kinds of problems.

"My brother, who still lives in Pittsburgh, talked to a client of his who recommended Dr. Dattoli's book, *Surviving Prostate Cancer Without Surgery*. I went on the Web and discovered he was in Sarasota, just down the road from where I live in Tampa. So I called."

"Within 24 hours, Dr. Sorace returned my call. He addressed every concern, answered every question, and explained treatment in detail.

"I visited the Center and after seeing the facility, meeting the staff, and seeing the technology, I was convinced that this is the best place on the planet. I felt I could believe in the people who were going to treat me. When you have cancer, that's crucial."

Beginning in July, Frank had radiation for 28 days. In September, Dr. Dattoli implanted 53 seeds. Three months later, on December 4, Frank returned for 10 days of booster radiation.

"Over the course of my treatment, I met 50 or 60 other men. We're like a family going through the same anguish, so there's

CONTINUED ON PAGE 8

Signing the wall: Lynn looks on as Frank takes his turn signing the "Wall of Fame" at Dattoli Cancer Center. The wall bears messages of gratitude, hope and encouragement expressed by Dattoli patients from all over the world.

You've Got A Friend

CONTINUED FROM PAGE 7

a real sense of camaraderie and a belief that we're all going to get better.

"And these men were from all over the world and the U.S.: Dubai, Peru, Texas, California, everywhere."

On December 4, there was even another guy from Pittsburgh.

LYNN'S JOURNEY

At his semi-annual checkup in June, Lynn's PSA was 2.6. Another blood work-up in July, necessitated by the removal of a small growth on his nose, revealed a PSA of 5.5. His primary care physician sent him to a urologist for a biopsy. The urologist told him he had a slow growing cancer and to come back in six months. In August, Lynn returned to his primary and his PSA was now at 7.2. His urologist still told him not to panic.

"That's when I knew to panic. I hung up and called Dattoli," Lynn recalls. Though he still lived in Pittsburgh, he'd had a condo on Longboat Key until 2008 and was aware of Dr. Dattoli by reputation and through a friend who'd been successfully treated at the Center. Lynn called and got a call back from Dr. Dattoli that evening. "I never felt hurried or rushed or that I was asking a stupid question.

"I felt good about being on top of it. A nurse called me to set up an appointment for a biopsy and to answer any questions I had about it. Over the couple of weeks between the first call and the biopsy, they called me three times to make sure I was comfortable with my decision. That put me at peace."

"The results revealed 4 'hot spots.' Dr. Dattoli started to explain what alternatives I had. I stopped and asked him what he would tell his brother. He said he'd recommend 30 radiation treatments followed by seed implantation, and then booster radiation three months after that. I started in November and it ended in December.

"I was waiting to go in for one of my radiation treatments when Frank walked in."

"YOU'RE FROM PITTSBURGH, TOO?"

Back for booster radiation, Frank's PSA was 0.038. Lynn was nearing the end of his first round of radiation and was waiting to go into one of the radiation rooms when Frank walked in.

Neither recognized the other. It had, after all, been 50 plus years. But as men do at Dattoli Cancer Center, they began a conversation. It started with "Where are you from?"

"I asked where he was from, and he said Pittsburgh," Frank recalls. "I told him I was from Pittsburgh, too. He asked where I grew up and I said Mt. Lebanon. He said that's where he grew up."

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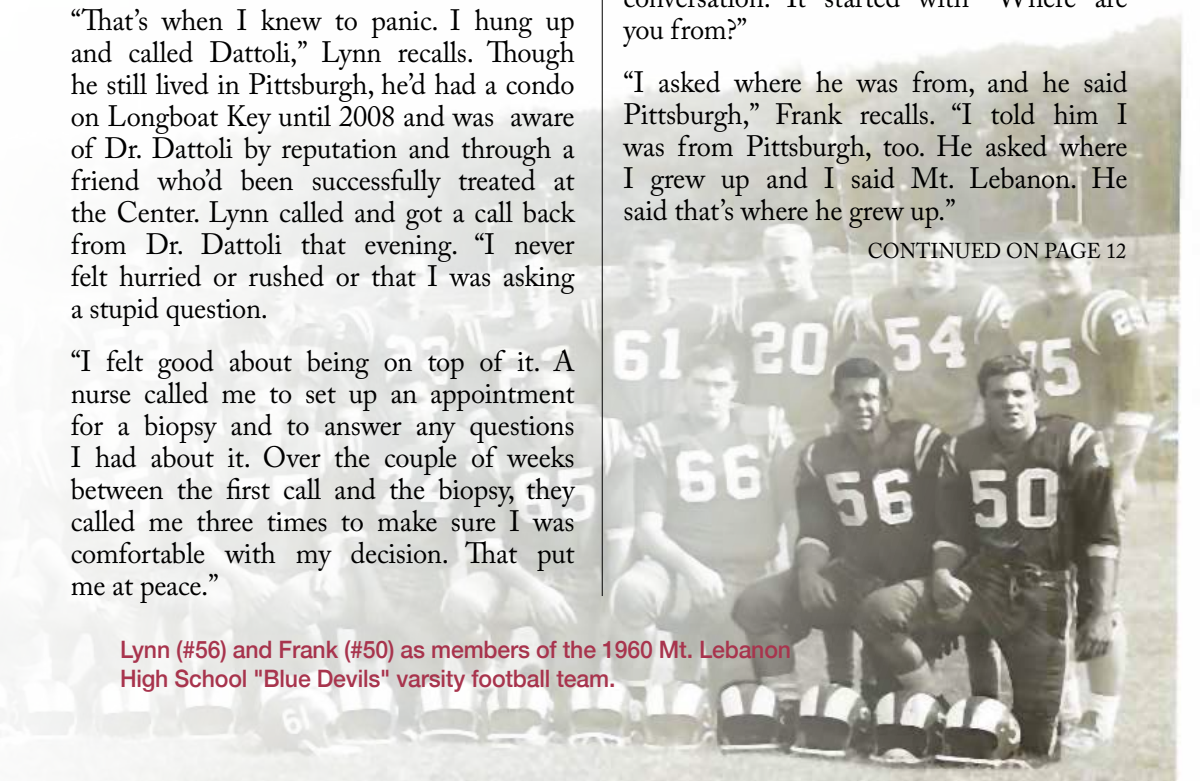
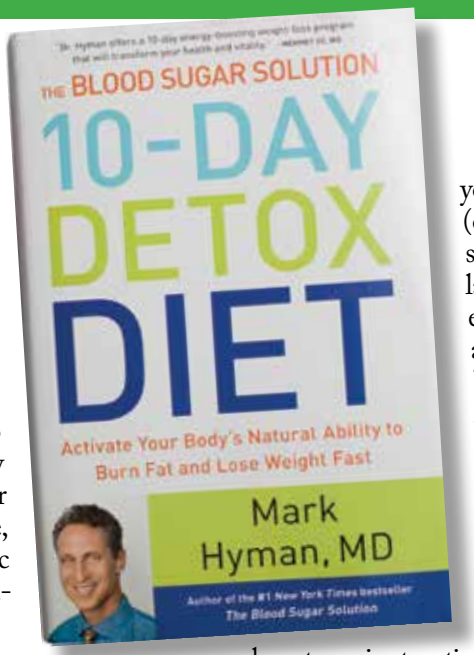


Lynn (#56) and Frank (#50) as members of the 1960 Mt. Lebanon High School "Blue Devils" varsity football team.

The Blood Sugar Solution 10-Day Detox Diet

by Dr. Mark Hyman

BOOK REVIEW BY MEG BROCKETT, MPH



This book promises: "Lose weight and revolutionize your health in just days!" As big of a fan as I am of New York Times Best Selling author Dr. Mark Hyman, I was skeptical, because I already ate healthfully. Following the program outlined in the book, I discovered two things: 1) yummy new recipes and 2) I am a sugar addict – a gluten-free, nearly vegan, organic vegetables and super food-eating sugar addict.

Apparently I'm not alone. Dr. Hyman's assertion is that sugar, dairy and grains cause many to suffer from diabetes, obesity and a number of other health problems. In preparation for the book, Dr. Hyman launched an online version with 600 members. The group lost an average of seven pounds in 10 days. In addition, 62 percent had improvements in medical issues (irritable bowel, acid reflux, fatigue, migraines, anxiety, joint pain, binge eating, etc.). Remember that this is within just 10 days!

Dr. Hyman's 10-Day Detox is set up to give you a taste of what you feel like without sugar, dairy, grains and caffeine. Don't panic – the food is fabulous. It's only 10 days, and you really do feel great. After the 10 days, you decide whether to continue or go back to your previous diet. However, if you haven't tried this (or another dairy/grain/sugar-free diet), you will lack an invaluable experience that gives you the ability to make a choice based truly on how you feel. Without such an experience, all you know is what you won't have. You have yet to discover all you will have. Don't worry, the cravings go away.

NOTE: I don't advise the Kindle version. You'll want a hard copy for handy access to the recipes.

The book includes step-by-step instructions, shopping lists and delicious recipes.

My only complaint is that the book was repetitive at times. Online book reviews are generally as enthusiastically positive as mine. Those that aren't take issue with the cost of food and supplements; that you can buy the supplements from Dr. Hyman; "extras" you can buy such as a journal; and that it takes actual time to cook, etc.

For me, I already cook and had many of the supplements. As for the cost of the program, there is an initial investment in some non-perishables, a journal and supplements, if you don't already have them. I'm not so sure it's more expensive to eat this way, though. After all, I'm saving tons by eliminating chocolate-covered bananas and Starbucks lattes.

Research Update

Prostate Biopsies Using Both Power Doppler Ultr

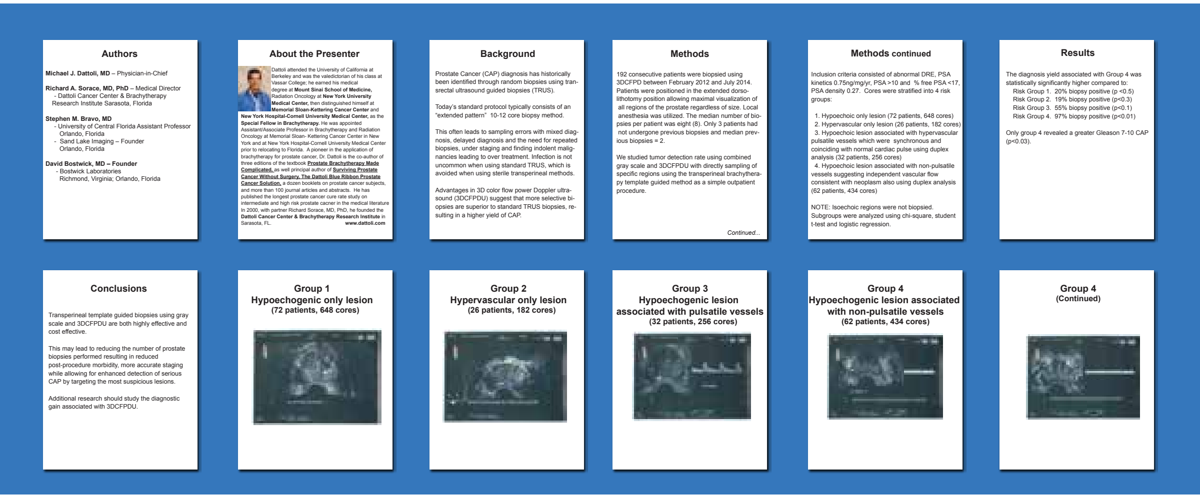
ASCO 2015 GENITOURINARY

At the annual American Society for Clinical Oncology Genitourinary Cancer Symposium in Orlando in February, thousands of physicians who treat these cancers gathered to learn about the newest diagnostic and treatment breakthroughs. Among these were several hundred who submitted their current research for review by the society's august panel, in hopes of being accepted for a "poster presentation" at the meeting.

Dr. Michael Dattoli prepared a paper reporting the success of using 3D color-flow power Doppler ultrasound for biopsy guidance, and it was accepted for this important and widely attended International Genitourinary Symposium.

As all Dattoli Cancer Center patients know, color-flow Doppler ultrasound has always been a cornerstone of the diagnostic work-up here. While other physicians have been slow to adopt this tool, we have determined over time that it can provide important information that is not available through any other source.

The recent poster presentation, co-authored by Richard Sorace, MD, PhD; Stephen M. Bravo, MD; and David Bostwick, MD, looked at 192 consecutive patients who were biopsied using the 3D color-flow power Doppler ultrasound for guidance. Only three of these patients had not undergone a previous biopsy. Comparisons were made between gray-scale imaging and the 3D



Authors
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About the Presenter
Dattoli attended the University of California at Berkeley and was the valedictorian of his class at Vassar College; he earned his medical degree at Mount Sinai School of Medicine, Radiation Oncology at New York University Medical Center, then distinguished himself at Memorial Sloan-Kettering Cancer Center and New York Hospital-Cornell University Medical Center, as the Special Fellow in Brachytherapy. He was appointed Assistant/Associate Professor in Brachytherapy and Radiation Oncology at Memorial Sloan- Kettering Cancer Center in New York and at New York Hospital-Cornell University Medical Center prior to relocating to Florida. A pioneer in the application of brachytherapy for prostate cancer, Dr. Dattoli is the co-author of three editions of the textbook Prostate Brachytherapy Made Complicated, as well principal author of Surviving Prostate Cancer Without Surgery, The Dattoli Blue Ribbon Prostate Cancer Solution, a dozen booklets on prostate cancer subjects, and more than 100 journal articles and abstracts. He has published the longest prostate cancer cure rate study on intermediate and high risk prostate cacner in the medical literature In 2000, with partner Richard Sorace, MD, PhD, he founded the Dattoli Cancer Center & Brachytherapy Research Institute in Sarasota, FL.
www.dattoli.com
Background
Prostate Cancer (CAP) diagnosis has historically been identified through random biopsies using transrectal ultrasound guided biopsies (TRUS).
Today's standard protocol typically consists of an "extended pattern" 10-12 core biopsy method.
This often leads to sampling errors with mixed diagnosis, delayed diagnosis and the need for repeated biopsies, under staging and finding indolent malignancies leading to over treatment. Infection is not uncommon when using standard TRUS, which is avoided when using sterile transperineal methods.
Advantages in 3D color flow power Doppler ultrasound (3DCFPDU) suggest that more selective biopsies are superior to standard TRUS biopsies, resulting in a higher yield of CAP.
Methods
192 consecutive patients were biopsied using 3DCFPD between February 2012 and July 2014. Patients were positioned in the extended dorsolithotomy position allowing maximal visualization of all regions of the prostate regardless of size. Local anesthesia was utilized. The median number of biopsies per patient was eight (8). Only 3 patients had not undergone previous biopsies and median previous biopsies = 2.
We studied tumor detection rate using combined gray scale and 3DCFPDU with directly sampling of specific regions using the transperineal brachytherapy template guided method as a simple outpatient procedure.
Continued...
Methods continued
Inclusion criteria consisted of abnormal DRE, PSA kinetics 0.75ng/mg/yr, PSA >10 and % free PSA <17, PSA density 0.27. Cores were stratified into 4 risk groups:
1. Hypoechoic only lesion (72 patients, 648 cores)
2. Hypervascular only lesion (26 patients, 182 cores)
3. Hypoechoic lesion associated with hypervascular pulsatile vessels which were synchronous and coinciding with normal cardiac pulse using duplex analysis (32 patients, 256 cores)
4. Hypoechoic lesion associated with non-pulsatile vessels suggesting independent vascular flow consistent with neoplasm also using duplex analysis (62 patients, 434 cores)
NOTE: Isoechoic regions were not biopsied. Subgroups were analyzed using chi-square, student t-test and logistic regression.
Results
The diagnosis yield associated with Group 4 was statistically significantly higher compared to:
Risk Group 1. 20% biopsy positive (p <0.5)
Risk Group 2. 19% biopsy positive (p<0.3)
Risk Group 3. 55% biopsy positive (p<0.1)
Risk Group 4. 97% biopsy positive (p<0.01)
Only group 4 revealed a greater Gleason 7-10 CAP (p<0.03).
Conclusions
Transperineal template guided biopsies using gray scale and 3DCFPDU are both highly effective and cost effective.
This may lead to reducing the number of prostate biopsies performed resulting in reduced post-procedure morbidity, more accurate staging while allowing for enhanced detection of serious CAP by targeting the most suspicious lesions.
Additional research should study the diagnostic gain associated with 3DCFPDU.
Group 1
Hypoechogenic only lesion
(72 patients, 648 cores)
Group 2
Hypervascular only lesion
(26 patients, 182 cores)
Group 3
Hypoechogenic lesion associated with pulsatile vessels
(32 patients, 256 cores)
Group 4
Hypoechogenic lesion associated with non-pulsatile vessels
(62 patients, 434 cores)
Group 4
(Continued)

The ASCO Symposium poster contains color Doppler images to illustrate each of the four groups. Please call us at 941.365.5599 if you would like us to send you a copy of the poster.

Gray Scale and 3D Color-Flow asound (3DCFPDU)

CANCER SYMPOSIUM, FEBRUARY 26-28, 2015

color-flow power Doppler images in finding active disease in the gland.

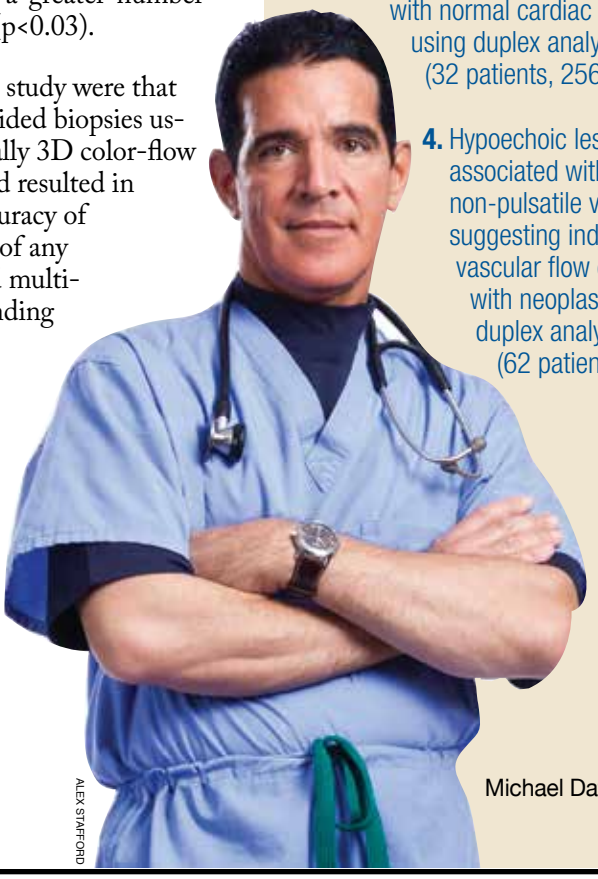
Criteria for participation in this study included: abnormal digital rectal exam, PSA velocity of .75 per year, PSA higher than 10, percent free PSA less than 17, or PSA density of 0.27.

Results of the comparison study revealed a statistically significant increase in finding active cancer cells in group #4 (97%, $p<0.01$). This group also revealed a greater number of Gleason 7-10 cancers ($p<0.03$).

The conclusions from the study were that transperineal template guided biopsies using gray-scale and especially 3D color-flow power Doppler ultrasound resulted in the highest predictive accuracy of detecting prostate cancer of any modality (including fused multi-parametric MRI). This finding may lead to reducing the number of random sample prostate biopsies performed, resulting in reduced post-procedure morbidity and more accurate staging, while allowing for enhanced detection of serious prostate cancers by targeting the most suspicious lesions.

Biopsy cores were stratified into four risk groups:

1. Hypoechoic only lesion (72 patients, 648 cores)
2. Hypervascular only lesion (26 patients, 182 cores)
3. Hypoechoic lesion associated with hypervascular pulsatile vessels which were synchronous and coinciding with normal cardiac pulse using duplex analysis (32 patients, 256 cores)
4. Hypoechoic lesion associated with non-pulsatile vessels suggesting independent vascular flow consistent with neoplasm, also using duplex analysis (62 patients, 434 cores)



ALEX STAFFORD

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Prostate Cancer ↔ Bladder Cancer:

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literature that suggests a higher risk of developing bladder/rectal cancer following prostate radiation. The risk, however, is quite small and does not take into account the fact that the patients who have been treated with radiation to the prostate are already predisposed to developing bladder malignancies (the "genitourinary tract"), while men who develop rectal cancers are of the correct median age for developing that malignancy. Interestingly, there is even data suggesting a reduced rate of developing rectal cancer in men who have received prostate radiation.

Today's radiation therapy, especially the exquisitely focused micro-beam therapy pioneered at our Center (DART), does not cause cancer in the bladder (or rectum or any other genitourinary organ). Rest assured that your treatment here would not be the cause of a second primary cancer! The only cause that can be suggested is the privilege you have had to age, the environment in which you live and work, your own lifestyle choices and the genetics that you inherited from your parents.

You've Got A Friend

CONTINUED FROM PAGE 8

Soon the two men had narrowed things down to a street. Lynn asked Frank his name and when Frank responded, Lynn said, "One of my best friends in high school was Frank Battaglia. My name is Lynn Foltz."

"I looked in his eyes. They never changed," Frank says, and the years melted away.

At that, the two old friends stood and embraced. Frank recalls a hug; Lynn, a great kibitzer who can't resist a joke, got serious remembering the meeting.

"There was a tear or two."

MOVING FORWARD

The two have been texting regularly since their reunion. "Frank has been lending terrific support and explaining everything that's happening and that's going to happen as I move forward," Lynn says. "He's been there for me. We want nothing but the best for one another."

Some stories just do get better with time. This is one of them.