



# VIRGINIA PROSTATE CENTER *Newsletter*

A PARTNERSHIP PROGRAM OF EASTERN VIRGINIA MEDICAL SCHOOL AND SENTARA CANCER INSTITUTE  
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Paul F. Schellhammer, M.D., Editor

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A word of explanation concerning our new letterhead and new name: the Virginia Prostate Center. Over the past five years, as the Center for Urologic Oncology, we have coordinated and welded the efforts of urology, radiation oncology, medical oncology and basic science towards the improved care of patients with urologic malignancy. We will continue to do just that in 1996 and beyond.

We have decided, however, to sharpen the focus of our efforts under the name Virginia Prostate Center in response to the marked increase in the diagnosis of prostate cancer and the controversies swirling about the subjects of PSA, screening and treatment options. This in no way lessens our dedication to improving treatment of cancers of the kidney, bladder, and testes.

Because of the continued increase in newly diagnosed prostate cancers, we are investigating various means of suppressing the growth of the cancer so that it never becomes an issue in the life of a male. One concept that has been taken to clinical application through a prospective randomized trial is the ability of the drug Proscar (Finasteride) to do just that. As mentioned in an earlier newsletter, a Proscar treatment group is being tested against a placebo control group in approximately 20,000 men throughout the United States. The VPC is participating in this trial, and we have enrolled 233 patients since the trial's initiation one year ago.

We have also been selected as one of five sites (from a total of more than 200 sites in the U.S.) to concentrate efforts on enrolling African American men in the study. We were chosen because our statistics show that approximately 10% of men entering the trial in our center are African American, an incidence equal to the race distribution in the United States. African American men have a higher incidence of and mortality from prostate cancers than do Caucasian males.

In addition to race, the other significant risk factor for prostate cancer is a family history of the disease, so it is obvious that brothers of prostate cancer

patients are at higher risk and may wish to avail themselves of the regular examinations and PSA determinations that are part of this trial. We are encouraging our patients to notify brothers who are over the age of 55 of the trial. The PCPT trial will remain open for enrollment for approximately six more months.

A great deal of uncertainty remains as to the most appropriate treatment once prostate cancer is diagnosed. A trial sponsored by the National Cancer Institute is being generated to test this question, and our center will participate in this trial. The trial is

## The VPC Leadership

The Virginia Prostate Center, a joint program of Eastern Virginia Medical School and the Sentara Cancer Institute, brings together physicians and basic scientists from the disciplines of microbiology and immunology, urology, radiation oncology, pathology, and pharmacology. The VPC combines basic and clinical research and patient care to provide improved diagnostic techniques and expanded treatment options for prostate cancer and other urologic diseases.

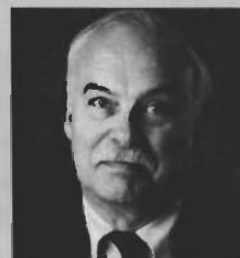
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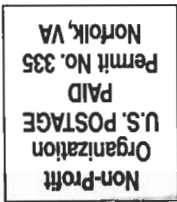


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called PIVOT (Prostate Intervention Vs. Observation Trial) and is constructed to assess the benefit of active therapy by radical prostatectomy versus observation or surveillance, along with the institution of therapy (usually hormone therapy) only when evidence of progression is seen.

While this trial will not be appropriate for all patients with prostate cancer, the information, video and literature that will be associated with the trial will provide a valuable resource to patients with newly diagnosed prostate cancer as they struggle to decide on the best treatment for them.

To evaluate the outcome and side effects of treatment, we have sent our patients a questionnaire which will shortly be processed and tabulated. When the analysis is compiled, we will report the results to you.



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## Treatment Options

There are several options available to patients for the management of localized prostate cancer: surgical removal of the cancerous prostate (radical prostatectomy); definitive radiation therapy (external beam therapy); implantation of the prostate with radioactive seeds; cryotherapy (freezing the prostate); and surveillance with no active treatment.

Before deciding on a treatment approach, the patient must weigh potential benefits against potential harm, side effects, or after-effects. Potential benefits include avoiding morbidity from disease progression or death from cancer. Each form of therapy has its benefits, but each also has its own set of potential complications and side effects. Because the severity of potential side effects and after-effects varies with the form of treatment, certain treatments may be more appropriate for some patients than others. For example, older patients with coexisting medical problems (heart disease, diabetes, emphysema) may be at greater risk of complications than younger, healthier patients.

Through the urologist's examination and communication with the patient and his primary care physician, we gather information regarding the status of the patient's overall health. This enables us to estimate and discuss the patient's risk of complications prior to the patient selecting treatment.

Most localized prostate cancer is either well-differentiated or moderately well-differentiated, and the progression of the disease is very slow. The risk of morbidity or death from prostate malignancy is low for the first 10 years after diagnosis. Men with a relatively short life expectancy — less than 10 years — will therefore have little risk of cancer-related death or disease progression. These risks increase after 10 years, so active treatment may be appropriate in men expected to live longer.

While average life expectancy for a 74-year-old

man is 10 years, age alone cannot be the sole predictor in treatment outcome. Family longevity and coexisting illnesses often influence these estimates and decisions. Exceptionally good health and family history may improve the outlook for an older patient, while significant heart, lung, or vascular disease may adversely affect the outlook for a younger patient.

Surveillance is the term used to describe the practice of close follow-up of a cancer patient without active treatment of his disease. Such follow-up generally includes a thorough physical examination and assessment of PSA levels. Treatment is initiated only if clear progression of the cancer is observed.

While this approach to the management of prostate cancer has the benefit of sparing the patient treatment he may not immediately need and the potential side effects of that treatment, not all men are emotionally prepared to allow a malignancy to go

untreated when some treatment is available. Ongoing surveillance in these men may be difficult to conduct or justify.

In summary, the patient's overall condition, including his attitude towards his disease and his emotional status, must be carefully assessed, along with the stage and grade of his tumor and his access to various treatment options, before a decision is made regarding a specific treatment. The optimal candidate for management of localized prostate cancer by surveillance is a patient with a life expectancy of 10 years or less and a small, well- or moderately well-differentiated tumor. He should be comfortable with the prospect of having a tumor which will almost certainly progress, albeit very slowly, and should understand that treatment of such progression, while not curative, is quite effective in delaying the effects of such disease progression. It is important that a physician who is trained in the management of prostate malignancy be available to perform follow-up care at a facility easily accessible to the patient. ♦

**"The most important factor in deciding treatment for localized prostate cancer is not time to treatment, but rather time spent on careful consideration, discussion and understanding of the relative risks and benefits of the various options."**

**Dr. Paul Schellhammer**