Prostate Cancer Support Association of New Mexico

LIFELINE

Supporting those with prostate cancer and their families since 1991

Quarterly Newsletter
April 2025
Volume 32, Issue 2

Issue Highlights

Scan to learn more about PCSANM

Support Group Meetings

Meetings are held at Bear Canyon Senior Center, 4645 Pitt St. NE in Albuquerque, from 12:30 p.m. to 2:45 p.m. on the first and third Saturdays of most months.

Meeting topics and information may be found at:

https://www.pcsanm.org/meetings/

Please call 505-254-7784 or email pchelp@pcsanm.org with questions.

In Five Cancer Types, Prevention and Screening Have Been Major Contributors to Saving Lives

National Cancer Institute press release, December 5, 2024

Improvements in cancer prevention and screening have averted more deaths from five cancer types combined over the past 45 years than treatment advances, according to a modeling study led by researchers at the National Institutes of Health (NIH). The study, published Dec. 5, 2024, in *JAMA Oncology*, looked at deaths from breast, cervical, colorectal, lung, and prostate cancer that were averted by the combination of prevention, screening, and treatment advances. The researchers from NIH's National Cancer Institute (NCI) focused on these five cancers because they are among the most common causes of cancer deaths and strategies exist for their prevention, early detection, and/or treatment. In recent years, these five cancers have made up nearly half of all new cancer diagnoses and deaths.

"Although many people may believe that treatment advances are the major driver of reductions in mortality from these five cancers combined, the surprise here is how much prevention and screening contribute to reductions in mortality," said co-lead investigator Katrina A. B. Goddard, Ph.D., director of NCI's Division of Cancer Control and Population Sciences. "Eight out of 10 deaths from these five cancers that were averted over the past 45 years were due to advances in prevention and screening."

A single prevention intervention, smoking cessation, contributed the lion's share of the deaths averted: 3.45 million from lung cancer alone. When considering each cancer site individually, prevention and screening accounted for most deaths averted for cervical, colorectal, lung, and prostate cancer, whereas treatment advances accounted for most deaths averted from breast cancer.

"To reduce cancer death rates, it's critical that we combine effective strategies in prevention and screening with advances in treatment," said W. Kimryn Rathmell, M.D., Ph.D., director of NCI. "This study will help us understand which strategies have been most effective in reducing cancer deaths so that we can continue building on this momentum and hopefully increase the use of these strategies across the United States."

"The Biden Cancer Moonshot is making real progress towards its bold goal to reduce the cancer death rate by at least 50% by 2047," said Danielle Carnival, Ph.D., deputy assistant to the President for the Cancer Moonshot and deputy director, Health Outcomes, White House Office of Science and Technology Policy.

Continued on page 5

PLEASE SUPPORT PCSANM

Scan to donate, visit www.pcsanm.org/donate,
or send a check payable to:
PCSANM
2533 Virginia St. NE, Stuite C
Albuquerque, NM 87110

Board of Directors

Prostate Cancer Support Contacts Around the State

City	Contact	Phone
Clovis	Kim Adams	(575) 769-7661
Farmington	Deb Albin	(505) 609-6089
Los Alamos	Michael Smith	(505) 709-5021
Las Cruces	John Sarbo and	(915) 503-1246
Santa Fe	Guy Dimonte	(505) 699-2139

DISCLAIMERS:

PCSANM gives education, information and support, not medical advice. Please contact your physician for all your medical concerns.

No copyrighted material belonging to others is knowingly used in this publication. If any is inadvertently used without permission, please contact our office.

PCSANM does not endorse or approve, and assumes no responsibility for, the content, accuracy, or completeness of the information presented.

In Memory

With deep sympathy and regret, we list this name:

John Guth

PCSANM *Lifeline*
A quarterly newsletter addressing issues of prostate cancer

Published:

January April
July October

PUBLISHER
Prostate Cancer Support Association of New Mexico
2533 Virginia St. NE, Suite C
Albuquerque, NM 87110

(505) 254-7784
(505) 254-7786 (fax)
(800) 278-7678 (toll free in NM)

Office is open
Monday-Thursday
10 a.m. - 2 p.m.

EMAIL
pchelp@pcsanm.org

VISIT OUR WEBSITE
http://www.pcsanm.org

EDITOR
Rod Geer

MEETING MODERATORS
Jonathan Brown
Dave Turner

FACEBOOK

MedPage Today: February 4, 2025

Hydroablation Device Shows Promise for Early Prostate Cancer

Charles Bankhead, Senior Editor

A hydroablation device developed for benign prostatic hyperplasia (BPH) showed promise as a potential treatment aid for early prostate cancer, according to results of a preliminary study from China.

Men in active surveillance for prostate cancer with symptomatic lower urinary tract symptoms (LUTS) had an early spike in circulating tumors cells (CTCs) after treatment, followed by a decrease to below baseline levels. MRI-detected prostate lesions had disappeared 6 months after Aquablation treatment.

In addition, prostate symptoms improved and sexual function remained stable or improved, reported Jeremy Yuen Chun Teoh, MD, of the Prince of Wales Hospital and the Chinese University of Hong Kong. "In an active surveillance population, Aquablation resulted in improved urinary function, stable or improved sexual function, and a transient spike in CTCs lasting less than 2 days that did not result in any oncologic concern," the authors noted. "Aquablation may be considered a safe option for men with localized prostate cancer who require treatment for LUTS due to BPH."

Noting that the study involved only five patients, the authors of an accompanying editorial nonetheless were impressed by the results and called for further investigation of the hydroablation device in prostate cancer.

"While the significance of CTCs remains debatable, these results suggest that Aquablation among this cohort does not worsen oncologic symptoms," wrote Greg Raster, MD, of the University of Chicago, and Brian T. Helfand, MD, of Endeavor Health in Evanston, Illinois. "Rather, Aquablation appeared to also eliminate MRI lesions in all patients, suggesting this therapy may also be a suitable treatment for these types of cancer patients. The data support further exploration into this exact question, whether Aquablation can be used as treatment for both BPH and prostate cancer."

"If Aquablation ultimately becomes a viable treatment for prostate cancer, it would be different from almost all other focal therapy," Raster and Helfand added. "Specifically, Aquablation has the potential to treat increasing amounts of tissue bilaterally within the prostate without a proportional increased risk in side effects. This makes Aquablation a very attractive candidate for this dual purpose."

The Aquablation system initially received FDA approval in 2017 for treatment of LUTS secondary to BPH. The FDA cleared the AI-assisted robotic Hydros system for water ablation last year. The system uses a high-intensity waterjet to remove tissue, as compared with other technologies that ablate tissue in situ, Teoh and colleagues noted.

A theoretical concern is the potential for spillage of CTCs.

"Any physical manipulation of the prostate, be it digital rectal exam, biopsy, surgery, TURP [transurethral resection of the prostate], or enucleation, has the theoretical potential to cause tumor cells to shed for a transient period of time," the study authors wrote. "The magnitude of actual CTC release is minute and inconsequential in comparison to the integral release of naive localized prostate cancer and there is a substantial body of evidence supporting the lack of metastatic risk posed by physical diagnostic or treatment manipulation of the prostate." A recent meta-analysis of 12 studies involving a total of 1,917 men with prostate cancer showed no significant association between pretreatment levels of primary CTCs and biochemical recurrence. Teoh and colleagues conducted a pilot study to determine whether Aquablation could lead to metastatic seeding by means of CTCs released into the circulation.

The five patients enrolled in the trial had a mean age of 63.4, a baseline prostate-specific antigen (PSA) level of 8.9 ng/mL, and a mean prostate volume of 60.3 mL. All of the men had visible prostate lesions by multiparametric MRI (grade group 1) and were considered candidates for active surveillance. They also had LUTS, with an International Prostate Symptom Score (IPSS) of 18.2. Treatment was by robotic-assisted bilateral hydroablation of the prostate. The primary outcome was CTC counts in serial blood sample draws.

Four patients had detectable CTCs before treatment. All five had detectable CTCs immediately after treatment, two had detectable CTCs on post-treatment day 2, and three on day 7. The CTC count per patient was 1.2, 3.2, 0.2, and 1.0 on the four assessment days. Prostate volume decreased to a mean of 37.1 mL at 3 months and was 37.8 mL at 6 months ($P<0.05$ vs baseline). PSA level declined to 4.6 ng/mL at 3 months ($P<0.01$) before rebounding slightly to 5.6 ng/mL at 6 months ($P<0.05$ vs baseline).

The investigators observed no disease progression by MRI, and none of the patients had visible prostate lesions at the 6-month assessment by MRI. Three patients had negative prostate biopsies, and two had grade group 1 disease.

The mean IPSS score decreased to 8.2 at 3 months and was 9.2 at 6 months. Sexual function assessments showed no significant change or improvement from baseline at 3 and 6 months.

The FDA has approved a pivotal randomized clinical trial to compare Aquablation and radical prostatectomy in men with grade group 1-3 localized prostate cancer.

MedPage Today: February 5, 2025

Implant Shows Promise for Tumor-Specific Treatment in Prostate Cancer

Charles Bankhead, Senior Editor

An implantable, drug-eluting microdevice showed promise for informing decisions about systemic therapy for prostate cancer prior to radical prostatectomy for high-risk disease, according to results of a pilot study.

Percutaneously inserted directly into a prostate cancer lesion, the implantable microdevice (IMD) caused no severe adverse events. Pathology studies of tumor and adjacent tissue showed differential responses to the same drug within and between patients. All 14 patients underwent uneventful, successful, robot-assisted prostatectomy.

The study showed the feasibility of simultaneous assessment of tumor-specific responses to multiple drugs to guide targeted systemic therapy for high-risk prostate cancer, reported Benjamin V. Stone, MD, of the Medical University of South Carolina in Charleston, and co-authors in the *Journal of Urology*.

"Our ability in this study to place the IMD preoperatively using MR-guided percutaneous methods represents an important innovation and is critical to assessing drug response," the authors stated in their discussion of the study. "Given the safety and feasibility demonstrated in this pilot study, next steps include assessment of the feasibility of MR-guided percutaneous IMD retrieval, which would enable use in patients not undergoing surgery. The results could then be used to guide neoadjuvant systemic therapy and inform treatment choices in men undergoing radiation or no local treatment."

The prostate cancer study followed a similar one in non-small cell lung cancer, wherein an IMD was placed intraoperatively into tumors, they noted.

Despite marked expansion of systemic therapy options for prostate cancer over the past 20 years, genomic variation and the multifocal nature of prostate cancer continue to pose a challenge to optimizing systemic therapy, noted Madison K. Krischak, MD, and Arnav Srivastava, MD, both of the University of Michigan in Ann Arbor, in an accompanying commentary.

"In this context, there is a growing need to tailor systemic therapy regimens to the genomic signatures of a patient's tumor," they stated.

Despite the small sample size and logistical issues that may limit applicability, "this study holds tremendous promise," Krischak and Srivastava added. "As the prostate cancer field moves toward precision medicine, future work is needed to inform IMD length of exposure, evaluation of biomarker response, and IMD retrieval techniques to expand this technology's utility."

Need for Better Treatment Options

As the incidence of prostate cancer has increased in the U.S., so has the need for better options for patients at high risk of treatment failure. The rationale for systemic therapy in high-risk localized disease revolves around the hypothesis that many patients likely harbor micro-metastatic disease that eventually will require systemic drug combinations, Stone and colleagues pointed out.

"Earlier treatment should improve survival while tumor burden is low," they wrote. "However, given the genomic and epigenetic heterogeneity of prostate cancer and the mixed treatment responses to systemic agents, the optimal therapy for each individual patient with newly diagnosed high-risk disease remains unknown."

Recent studies have shown that specific mutations and gene expression profiles correlate with differential response to systemic therapies, they continued. As an example, *BRCA* mutations correlate with sensitivity to platinum chemotherapy and PARP inhibitors.

Preclinical studies of several tumor types, including prostate cancer, have shown that local response to chemotherapy correlates with systemic response. The observations imply that identifying patient-specific local response to systemic agents might inform treatment sequence in neoadjuvant, adjuvant, and salvage settings.

Stone and colleagues evaluated the feasibility of using an IMD to assess in situ intra-tumoral response to therapeutic agents in intermediate- and high-risk localized prostate cancer. Information gleaned from the pilot study might offer guidance toward development of individualized therapy and simultaneously facilitate testing of novel agents.

Continued on page 5

MedPage Today: February 5, 2025

Implant Shows Promise for Tumor-Specific Treatment

Charles Bankhead, Senior Editor

Continued from page 4

Investigators enrolled men with intermediate- or high-risk localized prostate cancer (defined as ≥Gleason score 3 + 4, >3 positive biopsy cores, and >50% positivity in a single core). All patients underwent multiparametric MRI that detected at least one lesion in the region of a positive biopsy.

Device, Study Characteristics

The IMD consists of a biocompatible cylinder with 20 drug reservoirs, each of which releases a unique drug or drug combination into non-overlapping regions of the tumor, enabling assessment of activity in the native microenvironment, the authors noted. Drugs used in the study included second-generation androgen inhibitors, PARP inhibitors, PD-1 inhibitors, and chemotherapy.

Each IMD has a fluorescent-tagged marker to aid orientation in postoperative analysis and is implanted via trans perineal insertion of an 18-gauge biopsy needle. Radical prostatectomy occurred 2 days after IMD placement. Investigators inserted a total of 53 IMDs and retrieved 49. Missing IMDs were thought to have been displaced during specimen handling or transport.

A variety of pharmacodynamic assessments were performed and demonstrated differential tumor responses across treatments. The authors noted both intra- and inter-patient variability in response to the different therapies evaluated. They also used pathway signaling markers to study the drugs' effects on known prostate cancer-specific signaling pathways.

"A clear strength of this technique is to evaluate tumor response to systemic therapy in situ," the authors stated. "Therapeutic response from all agents is likely a complex interaction between the normal stroma, immune system, and tumor."

"Placing multiple IMDs into multiple MRI-visible tumors, if present, enables us to assess both inter-tumor and intratumor drug response across different regions of the same tumor and between different tumor foci," they added. "Importantly, the IMD may facilitate a safe and novel methodology for drug discovery with intratumor testing of new and emerging therapies using microdoses that are a small fraction of therapeutic systemic doses with no apparent systemic toxicity."

National Cancer Institute (press release): December 5, 2024

In Five Cancer Types, Prevention and Screening Have Been Major Contributors to Saving Lives

Continued from front page

The researchers used statistical models from the Cancer Intervention and Surveillance Modeling Network (CISNET) and cancer mortality data to estimate the relative contributions of prevention, screening, and treatment advances to deaths averted from breast, cervical, colorectal, lung, and prostate cancers between 1975 and 2020.

In total, the modeling showed, 5.94 million deaths were averted from these five cancers between 1975 and 2020. Of these, prevention and screening interventions accounted for 4.75 million, or 80%, of the averted deaths. The individual contributions of prevention, screening, and treatment varied by cancer site:

- In breast cancer, 1 million deaths (out of 2.71 million that would have occurred in the absence of all interventions) were averted from 1975 to 2020, with treatment advances contributing to three-quarters of the deaths averted and mammography screening contributing to the rest.
- In lung cancer, prevention through tobacco control efforts accounted for 98% of the 3.45 million deaths averted (out of 9.2 million), and treatment advances accounted for the rest.
- In cervical cancer, the 160,000 deaths averted (out of 370,000) were entirely through cervical cancer screening (i.e., Pap and HPV, or human papilloma-virus, testing) and removal of precancerous lesions.
- In colorectal cancer, of the 940,000 deaths averted (out of 3.45 million), 79% were due to screening and removal of precancerous polyps, with treatment advances accounting for the remaining 21%.
- In prostate cancer, of the 360,000 deaths averted (out of 1.01 million), screening via PSA testing contributed 56% and treatment advances contributed 44%.

“These findings suggest that we need to continue to have strong strategies and approaches in all of these areas,” Dr. Goddard noted. “It's not just treatment advances alone, or prevention and screening alone, that is helping us to reduce cancer mortality.”

The authors acknowledged that the five cancer sites included in the study account for less than half of all cancer deaths and that the findings for these cancers may not necessarily apply to other cancers.

National Cancer Institute: February 18, 2025

Many Men with Metastatic Prostate Cancer Are Not Getting the Recommended Treatments, Study Finds

Sharon Reynolds

Since 2017, recommendations for the treatment of metastatic prostate cancer that can be controlled by shutting off its supply of hormones, often called hormone- or castration-sensitive prostate cancer, have shifted radically.

Giving a single drug to suppress testosterone production—for years, the standard of care—is no longer considered enough. Guidelines in the United States now recommend giving a combination of two different drugs to block hormones in two different ways. For people at the highest risk of their cancer getting worse, guidelines recommend adding chemotherapy as well. In clinical trials, both approaches have shown that they help people live longer.

However, results from a new study indicate that these guidelines have largely not trickled down into practice. In a survey of U.S. doctors who care for patients with prostate cancer, almost 70% reported not using this combination therapy up front for patients with hormone-sensitive metastatic prostate cancer.

The findings, published December 9 in *JAMA Network Open*, are very concerning, said the study's lead investigator, Neeraj Agarwal, M.D., of the University of Utah's Huntsman Cancer Institute.

"In the United States, the majority of patients aren't receiving life-prolonging [combination therapies], despite the fact that [clinical] trials have shown that they lead to a really meaningful improvement in overall survival," Dr. Agarwal said.

In their survey responses, almost 60% doctors who did not prescribe combination treatments for most of their patients expressed concerns that giving more than one drug at a time would have too many side effects. However, in clinical trials, researchers actually saw the opposite effect: People who received the recommended combination treatments reported having a higher quality of life overall than those who got only a single drug.

The improved quality of life may reflect the ability of the combination treatment to better reduce symptoms, such as the pain and fractures caused by the spread of prostate cancer to the bones, explained NCI's Fatima Karzai, M.D., who studies new treatments for prostate cancer but was not involved in the study.

"When somebody has a lot of disease [in their body], and they have symptoms from the disease, if you put these drugs together, people actually feel better, because their symptoms get better sooner," Dr. Karzai said.

Many doctors also weren't up to date on the current guidelines, reporting that they thought use of a single drug remained the standard of care.

"One drug alone is no longer sufficient" for these patients, said Dr. Agarwal. "Combining two [or more] really improves survival without compromising quality of life. But, if you look at the implementation of these data in the real world, we see a real disconnect."

Some of the guidelines in question were only updated within the past 2 years, explained Gurvaneet Randhawa, M.D., M.P.H., of NCI's Healthcare Delivery Research Program, who was not involved with the study. This may not be enough time for new knowledge to spread widely among physicians.

However, Dr. Randhawa added, it highlights the need for research into understanding how best to provide the information from the latest guidelines to clinicians. "There are likely differences in the [best] ways to integrate the guidelines into the workflow and decision support for providers in different specialties," he said.

A one-two-three hit

In men with metastatic hormone-sensitive prostate cancer, intensified treatment with the recommended drug combinations delivers a one-two hit to hormone-sensitive cancer cells.

The first hit, standard androgen deprivation therapy with drugs like goserelin and leuprolide, suppresses the production of testosterone by the testes. The second hit is a newer class of drugs, called androgen receptor pathway inhibitors (ARPIs). These drugs—which include abiraterone, apalutamide (Erleada), darolutamide (Nubeqa), and enzalutamide (Xtandi)—stop cancer cells from using any testosterone that remains in the body.

And for people with the most aggressive disease, a third hit, chemotherapy (specifically a drug called docetaxel) can directly kill prostate cancer cells.

Previous studies from Dr. Agarwal's team and others have found that, despite clinical trials demonstrating the superiority of more intensified treatment with combination therapies in clinical trials, these findings were largely not changing real-world practice.

Continued on page 7

National Cancer Institute: February 18, 2025

Many Men with Metastatic Prostate Cancer Are Not Getting the Recommended Treatments, Study Finds

Sharon Reynolds

Continued from page 6

"So we wanted to delve into why," he said. "What are the reasons for this?"

The researchers used data collected between July 2018 and January 2022 by the Adelphi Real World retrospective survey, which regularly asks representative samples of doctors across the country detailed questions about the treatments they prescribe for their patients and why they chose those treatments. The survey also links doctors with their respective patients' medical records, to let the researchers verify the treatments received.

The survey collected answers from 107 doctors and covered the treatment of 617 people with metastatic hormone-sensitive prostate cancer over the three-and-a-half -year window of the study. Doctors included medical oncologists and urologists from both community hospitals and academic cancer centers.

Overall, only about 30% of patients got the recommended intensified treatment. The reasons given for not prescribing intensified treatment were usually not based on up-to-date data. For example, for about 19% of patients who didn't receive intensified treatment, doctors reported that a single drug was more effective. For another 31% of patients, doctors stated that clinical trials hadn't shown improved survival with treatment intensification.

Doctors who reported more aggressive goals for lowering PSA levels, in hopes of eradicating as much prostate cancer as possible, were more likely to prescribe the recommended drug combinations.

Other factors didn't seem to make much of a difference. For example, concerns about insurance coverage were rarely cited as a reason for not prescribing combination therapy.

Doctors: Don't save combination therapy for later

Dr. Agarwal suggested one potential reason for why some clinicians still use single-drug androgen deprivation therapy for patients with hormone-sensitive disease. In most people with metastatic hormone-sensitive prostate cancer, the cancer eventually changes so that it can grow without being reliant on testosterone from the testes, known as hormone-resistant (or castration-resistant) disease.

Hormone-resistant disease is harder to control, with only about 30% of people with this form of prostate cancer surviving more than 5 years.

However, many of the same drugs are used to treat hormone-sensitive and hormone-resistant disease. So, providers may be thinking that if they use the more intensified treatment for patients with hormone-sensitive disease, he said, "'What will [I] have left for future use when the disease progresses?'" In other words, they want to keep some of these therapies in reserve "for when castration resistance happens."

And in the study, he noted, about 16% of men who initially got single-drug androgen deprivation therapy went on to get more intensified treatment when they developed hormone-resistant disease. Other recent studies have also found that reserving treatment intensification for this scenario is one of several common reasons for not using it in patients with hormone-sensitive disease.

Nevertheless, Dr. Agarwal added, "that's not the right way to treat patients." Multiple clinical trials have shown that people who receive combination therapy when their disease is still hormone sensitive live longer than those who get it later, after their disease becomes hormone resistant.

"So the message here is: Don't wait for disease progression," he said. But that message needs to be spread much farther and wider than it has to date, he added.

Patients: Understand your disease

For now, explained Dr. Karzai, patients who have a new diagnosis of metastatic hormone-sensitive prostate cancer may have to advocate for themselves to get the highest quality care.

"I'm not suggesting that patients read all these clinical trial data and try to figure them out on their own," she said. "But really understand your disease. If it's hormone-sensitive, talk to your doctor about what that means, and how the amount of cancer in your body affects your treatment choices. Talk about side effects. Ask about two- and three-treatment combinations and how they will make you feel. Ask: 'What are the benefits? What are the risks?'"

It can help to have a trusted person help you take notes and ask questions, Dr. Karzai continued. "A lot of times, to be a patient by [yourself] in a room with a doctor, it's just too much information [to take in]. And I also highly recommend getting a second opinion," she said.

Prostate Cancer Support Association of New Mexico

PCSANM *Lifeline* Newsletter
Celebrating 34 years of supporting individuals with prostate cancer and their families

Prostate Cancer Support Association of New Mexico, Inc.
2533 Virginia St. NE, Suite C
Albuquerque, NM 87110

A Message From the Chairperson

April 2025

Dear Readers,

I appreciate you taking the time to read our newsletter. I hope you've found it both informative and valuable.

As you may remember, our January 2025 edition featured a contest, offering a prize to the first reader who responded with something they learned from the newsletter. I'm excited to announce that the winner of that challenge is Joseph Warner.

Joseph was particularly interested in our feature on the National Cancer Society's study that supports Stereotactic Body Radiation Therapy (SBRT) as a standard treatment for certain prostate cancers. What stood out to him was the finding that the incidence of side effects from this treatment may actually be lower in the U.S. compared to Europe—thanks to advancements in protective equipment, such as rectal spacers, that help reduce potential damage during SBRT.

Joseph's thoughtful insights reminded me of the impact that sharing knowledge can have, and I'm pleased to see active engagement from our readers.

A huge thank you to everyone who continues to be part of our community. Your feedback and contributions are what make this newsletter so special. We look forward to bringing you even more valuable information in upcoming issues.

Warm regards,

Rod Geer

Rod Geer
Chairperson of the Board, PCSANM