



# Tex Us TOO, Inc.

## Prostate Cancer Education and Support

HOUSTON, TEXAS, CHAPTER (MEMBER OF US TOO INTERNATIONAL)  
**SOMEONE TO TALK TO... WHO UNDERSTANDS**

### MEETING ANNOUNCEMENT

**Date:** Monday, January 8, 2018

**Time:** 7:00 P.M.

**Place:** St. Luke's United Methodist Church, 3471 Westheimer at Edloe (between Buffalo Speedway and Wesleyan).

**Topic:** "Restoring Function: A Focus on Treating Urinary Incontinence."

**Speaker:** Ricardo Gonzalez, M.D.

**Agenda:** The speaker presentation will be followed by an informal meeting with chapter members to discuss personal prostate cancer questions and issues.

**Getting There:** *The monthly meetings are now in Room EN207.* Park behind the Church. Enter through the front center brick portico. Proceed ahead down Fellowship Walk to its end at front of Church. Turn left. Stairs to second floor immediately on left. Take corridor to Room EN 207 on left. For Elevator, on first floor continue down hallway past the Rotunda Room to corridor on left (sign indicates Elevator). A quick left again will bring you to Elevator. Room EN207 on your right." (Refreshments will be served).

Tex US TOO is a prostate cancer support group for the purpose of sharing information, education, experiences and mutual support. WE DO NOT DISPENSE MEDICAL ADVICE.

**Dr. Ricardo Gonzalez** is a diplomate of the American Board of Urology. A graduate of Stanford Medical School, completed his Urology Residence with a fellowship in Voiding Dysfunction at Cornell Medical School in NYC, focusing on voiding dysfunction and pelvic reconstructive surgery. He is an internationally-recognized expert in Green Light Laser Vaporization of the prostate for BPH, and has been invited to teach the operation throughout the U.S. and in 17 foreign countries. Is currently Medical Director for the Center for Voiding Dysfunction and the Clinical Research Center at Houston Metro Urology, and serves on the clinical faculty for Baylor College of Medicine and Methodist Hospital. His overall goal is to provide state-of-the-art urologic care to improve patients' quality of life.

### Tex Us TOO Information Sharing Message:

-----Original Message-----

From: Marissa Clifford <[mclifford@cancerresearch.org](mailto:mclifford@cancerresearch.org)>

To: pdsterlingco <[pdsterlingco@aol.com](mailto:pdsterlingco@aol.com)>

Sent: Fri, Dec 15, 2017 8:58 am

Subject: Upcoming Immunotherapy Patient Summit - Help get the word out

Dear Mr. Sterling,

Cancer Research Institute (CRI) is proud to offer our Immunotherapy Patient Summit program for the first time in Houston! This FREE educational event on January 27, 2018 will be hosted at Baylor College of Medicine, Texas Medical Center in Houston. People of all ages, cancer types, and stages are encouraged to attend this half-day Saturday event. Caregivers, friends, family, and advocates are also welcome to join us at this important educational summit.

See what attendees are saying about the summit: <http://bit.ly/2yFcrdO>

- Immunotherapy basics patients need to know
- Latest research update from the experts
- Patient experience with immunotherapy
- Clinical trials: what they are and how to access them (including on-site clinical trial navigator support)
- Cancer specific breakout sessions and networking opportunities, including a urologic cancer breakout with Dr. Sumit Subudhi

The program will begin at 10:00am and conclude at 3:30pm, including a catered lunch. Those interested in participating may register at: <https://cripatientsummit-hou.eventbrite.com>

We would appreciate your support in getting the word out among cancer patients and caregivers.

## **NOTES AND QUOTES**

**Hilarious Video from the Prostate Cancer Foundation, Promoting Prostate Cancer Testing. To see it, please visit: <https://www.pcf.org/today-show-psa/>**

**Yearly Biopsy Not Needed for Prostate Cancer Surveillance: From the Us TOO International Hot Sheet, January, 2018.** It is "acceptable" to biopsy men every two years instead of annually when they have low-risk prostate cancer and are managed with active surveillance (AS), concludes a new analysis that integrates individual patient data from four major studies. The new analysis was published online in *Annals of Internal Medicine* on 11/28/17. "The delay in detecting disease progression with biennial testing, relative to annual testing, ranges from three to five months, which is modest and is very unlikely to influence a patient's longterm outcome," said senior author Ruth Etzioni, PhD, a biostatistician at Fred Hutchison Cancer Research Center in Seattle, WA. The study examined data from the four biggest AS cohorts in North America: Johns Hopkins University (JHU); Canary Prostate Active Surveillance Study; University of California, San Francisco (UCSF); and the University of Toronto (UT). The sites differed in terms of biopsy schedules; periods ranged from every four years at UT to annually at JHU, although not all men at each center were managed as planned. Investigators compared PSA levels and biopsy Gleason scores for 2,576 men from all sites who were enrolled in an AS protocol between 1995 and 2014. All men had low risk disease: a Gleason score between 2 and 6 and T1 or T2 prostate cancer. Delays in detecting progression with annual vs. biennial biopsies were similar across the cohorts of men. The mean delay was highest at Johns Hopkins at about five months; the lowest delay was at the University of Toronto and UCSF at about three months. "Given the natural history of prostate cancer, a delay of six months or less in detecting disease progression is not going to change the final outcome in the vast majority of cases," Dr. Etzioni told *Medscape Medical News*. "Yet it halves the number of times a patient has to come for a biopsy [over the years]." The findings are important because there is no consensus about implementing the relatively new approach of AS, including the timing of the multiple-core needle biopsy, which is invasive and is associated with potential risks. She also pointed out that the cancer upgrades are "generally" from Gleason scores of 3+3=6 to 3+4=7, which would lead to a reclassification of a patient's disease from low-risk to intermediate-risk. Notably, in the new analysis, after the researchers accounted for variables in the protocols and competing treatments, risks for upgrading or progression differed among men in the four AS cohorts. Variables such as eligibility criteria and the indicators that trigger a recommendation for definitive treatment are complex, suggest the authors. The risk for cases being upgraded was highest in the UCSF cohort and lowest at Johns Hopkins. The risk at Toronto was similar to that reported in the Canary Prostate Active Surveillance Study. However, when the variable of competing treatments was removed the differences in upgrading rates emerged dramatically among the cohorts. For example, 10- year cumulative risk for upgrading in the absence of competing treatments ranged from 25% at Johns Hopkins to 65% at UCSF. The authors speculated that uncaptured differences in patient profiles among the four cohorts may be at play. For example, the Johns Hopkins patients all had very low-risk prostate cancer, with low PSA densities (<0.15 ng/mL/mL, which, in turn, may be due to a higher prostate volume. Thus, in men with larger prostates, it is likely that the chance of identifying high-grade foci is reduced. Overall, the authors caution that findings from a single active surveillance cohort may not reflect the risks for prostate cancer progression in another study population. Source: Medscape Medical News, 11/29/2017

***"The Night is Darkest Just Before the Dawn"***

***-- Thomas Fuller, English theologian and historian***

We welcome suggestions, criticisms and contributions to this publication. This is your newsletter. Please contact Manny Vazquez at 936-597-6646, or by e-mail at [manny@consolidated.net](mailto:manny@consolidated.net)