



PCRI Insights

Patient & Physician in Co-Partnership

New Developments in Prostate Cancer Treatment

FEB 2006 VOL 9: NO 1

Executive Director Transition at the PCRI

Glenn Weaver has resigned his position as Executive Director and left the Prostate Cancer Research Institute to concentrate on his real estate investing business. The new Executive Director is Brad Guess, who brings to the PCRI a combination of strong leadership, an in-depth background in prostate cancer care and research, and more than 20 years of experience as a health care provider.

Meet Brad Guess

Guess graduated from the Primary Care Physician Assistant Program at Stanford University School of Medicine in 1998 and has worked in family medicine and medical oncology for the last seven years. Guess received his B.S. in Biology from Southern Utah University in 1985 (where he also played Varsity Basketball) and began his career in the medical field as a registered respiratory therapist working in a local community hospital. A humanitarian at heart, Guess completed a nursing degree in 1990 and

soon after, went to work as an international medical volunteer in Thailand where he spent three years at McCormick Hospital in the northern city of Chang Mai. While there, he not only taught courses in critical care nursing and respiratory care, but also organized community outreach programs on family planning, dental care, general medical care and immunizations in rural villages throughout the northern part of the country.

Prior to joining the PCRI in late 2005, he worked as a physician assistant with Dr. Mark Scholz (one of the co-founders of the PCRI) and Dr. Richard Lam at Prostate Oncology Specialists (POS) in Marina del Rey, CA, where he was involved in direct patient care and research. While at POS, he became quite familiar with the staff and workings of the PCRI. He was particularly complimentary to outgoing Executive Director Glenn Weaver.

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Promising New Developments

Not Ready for Prime Time

Commencing with this issue, *Insights* will be publishing articles that introduce emerging new treatments, pharmaceuticals, and novel therapies for prostate cancer. Many of these *promising new developments* are still in pre-clinical development, while some are in the early phases of research in men with PC. The first of these articles, which starts on page 2, introduces a novel new therapy that combines cryotherapy, which kills PC cells in the prostate with extremely cold temperatures, and the introduction of dendritic cells into the recently frozen tumors. It is theorized that once these dendritic cells are introduced into damaged PC tumors, they acquire antigen markers and activate the immune system's killer T-cells to search the body for other cancer cells bearing the same antigens and then kills these cells.

Can Diet Really Control Prostate Cancer?

Mark Scholz, MD and Ralph Blum

In December 2001 Thomas Mueller, a Los Angeles attorney, learned he had prostate cancer (PC). Thomas's disease was the contained variety of PC but at age 45 and newly married, he was alarmed to learn that the common treatments, surgery and radiation, frequently cause impotence. "I couldn't take that risk," he said. "I had to find another way."

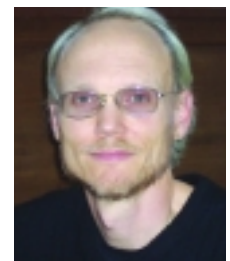
Thomas Mueller is of medium height and slight build, with close-cropped, wavy blond hair. He is soft-spoken, yet intense, with a self-deprecating, wry sense of humor. An intelligent, disciplined researcher, he quickly became knowledgeable about PC. There was another problem, however, a close call with melanoma when he was still in his 20s. Having had two cancers by age 45 convinced him that a change in lifestyle was necessary. With

the guidance of his wife, he decided to embark on a rigorous program of diet and exercise as his principal mode of therapy.

Just three months after Thomas began his macrobiotic regime; his weight plummeted from 157 lbs. down to 122. At that point, he was beyond lean. He was also exercising intensely, including running a marathon. "At the end of that ordeal, he reported, "I was so hypoglycemic that I was hallucinating. I definitely don't recommend marathons on such a stringent diet." Over that same time period, his PSA dropped from 4.0 down to 1.5 ng/ml, an encouraging sign that his cancer was being held in check.

Reliance on a macrobiotic diet and lifestyle as a form of treatment is not new. In the 1920s, Yukikazu Sakurazawa came to

Paris from Japan. He took the name "George Ohsawa," calling his teaching "macrobiotics." Ohsawa's teaching was brought to the United States by Mishio Kushi in



Thomas Mueller

1949.¹² These teachings espoused a belief that returning to the diet used in agrarian cultures throughout most of human history could prevent and counteract disease.

Thomas's "healing version" of the diet, tailored specifically for cancer patients, was particularly restrictive, consisting mainly of whole grains and vegetables. Staples include Miso soup, brown rice, lentils, and "sea vegetables" like nori and kelp. Strictly forbidden

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Cancer Cryo-Immunotherapy

A Battle Between the Immune System and Cancer

Haakon Ragde, MD *The Haakon Ragde Foundation for Advanced Cancer Studies, Seattle, WA* and Duke K. Bahn, MD *The Prostate Institute of America of Community Memorial Hospital, Ventura, CA*

As most of us know, the immune system plays a critical role in controlling and eliminating infectious organisms, including many bacteria and viruses. More controversial has been the question of whether the immune system can effectively control cancer growth and metastases. The last several years have provided new insights into how the immune system works, along with possible means to activate the system so that immune cells will recognize markers on cancer cells and destroy these cells. These advances have led to the emergence of a new and promising therapeutic strategy in cancer treatment, referred to as tumor immunotherapy, which can successfully treat and possibly cure selected patients.^{1,2}

A potentially key weapon is the **dendritic cell (DC)**, a scarce white blood cell that can now be generated by the millions in the laboratory, where they are cultured from precursor cells that circulate in the blood. Dendritic cells are the body's scavengers, constantly prowling our bodies in an effort to communicate to the immune system the various biological goings-on in the cells throughout the body. In the case of disease states involving bacteria, virally infected cells, and cancer cells, distinct molecular markers, called antigens, reveal the problematic nature of these cells. Dendritic cells gobble up these cells and break them down into smaller protein fragments which they prominently display on their cell surfaces (Figure 1). The dendritic cells then migrate to the nearest lymph node, rather like detectives

returning with evidence to the forensic lab at the local precinct station, in this case bringing biochemical evidence of disease with them.

In the lymph node, the dendritic cells present the biochemical evidence to lymphocytes known as "naïve T cells" (Figure 2). If the presented antigen is identified as "problematic" – i.e. related to infection or cancer – certain naïve T cells are capable of undergoing activation, wherein their numbers increase greatly. These activated T cells migrate out of the lymph node and search the body for cells bearing the same antigens and kill them (Figure 2). Among these T cells are the same type of killer T cells that will attack and unleash torrents of strikingly powerful substances in an attack that can completely destroy organs weighing several pounds (such as the kidney, liver, or heart) in mismatched human transplants.

Strategies using dendritic cells to fight cancer (dendritic cell vaccination) have entered clinical testing in the past decade.³ Most of these methods administer patients' own dendritic cells after first "arming" them with a synthetic cancer antigen in the laboratory. Patients' T cells specific for the chosen cancer antigen are activated and can in theory kill cancer cells bearing the antigen (Figure 3). These studies have shown that dendritic cell injections were well tolerated with minimal side effects. Clinical responses were observed in approximately half of the trials.⁴

An alternative strategy for dendritic cell vaccination is to introduce a patient's dendrit-

ic cells into the cancerous tissue⁵, thus allowing these dendritic cells to acquire antigens directly from that patient's own cancer cells ("intra-tumoral dendritic cell injection"). Since cancer is generally composed of a heterogeneous (highly variable) population of cancerous cells expressing numerous antigens, multiple cancer antigens can, in theory, be acquired by dendritic cells using this strategy. Vaccines that target multiple antigens may be a superior choice for eliciting a more complete immune response against cancer than those that target only one antigen.

Releasing Antigens from a Tumor

It has been speculated that an even more efficient means of obtaining the antigenic components of a cancerous mass in the body might involve first damaging the tumor - thereby causing it to release some or all of its antigens - and then introducing the dendritic cells into the damaged tumor environment. These dendritic cells may then be able to better acquire the tumor antigens (as in Figure 1) than if the tumor cells had not been damaged before the injection of the dendritic cells into the tumor mass.

This speculation has found support in several recently reported studies. For instance, when mice with implanted experimental tumors were treated with chemotherapy followed by injection of dendritic cells into the growing tumor, complete regression of these tumors was observed.^{6,7} No such regression

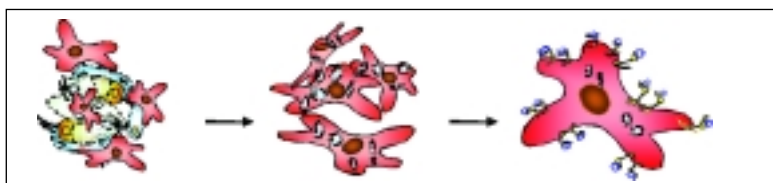


Figure 1. Dendritic cells uptake antigens, process them, and display them on their surfaces.

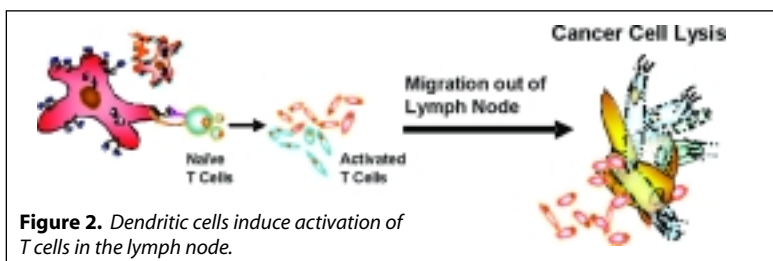


Figure 2. Dendritic cells induce activation of T cells in the lymph node.

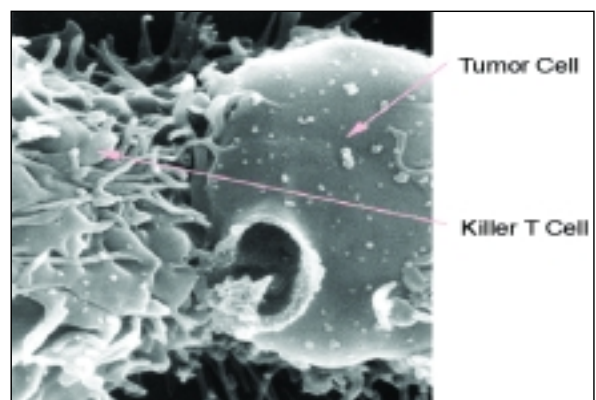


Figure 3. Scanning Electron Micrograph of a Killer T Cell Engaging a Tumor Cell.

was noted when the mice were treated with chemotherapy alone or dendritic cell injection alone. In these cases, chemotherapy hypothetically resulted in cellular death of part of the rapidly growing tumors.

Similar observations have been noted when the “damaging” treatment was hyperthermia (heat)⁸, radiation⁹, or cryotherapy^{10,11} of the tumor. In these cases, the mice that received the combination of the damaging therapy and the injection of dendritic cells into the damaged tumor fared significantly better – as measured by either the growth of the tumors, the number of new tumors, or the survival of the mice – than the mice that received the damaging treatment or dendritic cell injection alone.

Taken together, these observations suggest that there may be a therapeutic approach to human cancers that combines a tumor damaging strategy followed by the injection of autologous, or self-derived, dendritic cells into the treated tumor. An example of such an approach is a Stanford University clinical trial that damages liver tumors with thermotherapy (heat), followed by dendritic cell injection.⁵

Dendritic Cell-Based Cryo-Immunotherapy

In the spring of 2004, the Seattle-based

Haakon Ragde Foundation partnered with Sangretech Biomedical, a Seattle biotech company, and the Prostate Institute of America in Ventura, California, to study a similar immunotherapeutic modality.¹² This therapeutic approach entails the use of cryotherapy (freezing) of prostate tumors followed by intra-tumoral dendritic cell injection. This combination is known as “dendritic cell based cryo-immunotherapy.” In this case, tumor damage and antigen liberation is achieved via cryotreatment of the prostate and/or metastases. (See Figure 4.) An investigation of this combination in PC patients is currently underway at the Asian Hospital and Medical Center in Manila, the Philippines.

The primary objective of this study is to explore the safety of a potential cancer treatment that first freezes the prostate, and follows with an injection of millions of the patient’s own dendritic cells into the gland. As stated above, this process may allow dendritic cells to capture tumor antigens released by the dying PC cells in response to the cryotherapy. As illustrated schematically in Figures 1 and 2, the process is designed to result in a system-wide immune assault upon remaining tumor cells that have spread - or may have spread - from the original, primary PC.

In contrast to other tumor-damaging approaches such as chemotherapy and radiation, cryotherapy may be a superior means of damaging the tumor and releasing tumor antigen. There is strong biological evidence to support this hypothesis: first, cryotherapy will not damage the immune system as chemotherapy and radiation do. Second, it is well established that immunotherapy works best with smaller tumor volumes, and cryo-destruction results in a swift reduction of most of the cancerous mass (along with a predictable release of antigen).

Seven PC patients have traveled to the Philippines to take part in this trial in 2005. Although additional clinical evidence will be necessary before any conclusions regarding Cryo-Immunotherapy’s safety and effectiveness may be reliably ascertained, early labs results (including PSA) in these seven patients are encouraging. Additional labs tests, imaging studies, and physical evaluations in the seven patients treated thus far are ongoing. Based on these early results, a U.S. trial, to take place at the Prostate Institute of America in Ventura, California, is in the planning stages. Studies are also being contemplated in other cancer types, as the technique is applicable in theory to most solid tumor cancer.

No significant toxicity issues related to dendritic cell administration have been encountered to date. Cryoablation of the prostate has led to some common and expected side effect, specifically some fatigue and some non-febrile sweating during the first 24-48 hours after treatment, though these were temporary. Overall, dendritic cell-based cryo-immunotherapy has been well tolerated by the first seven patients.

Therapeutic cancer vaccines are attractive because of their negligible side effects that allow patients to maintain their quality of life – a privilege rarely possible with conventional cancer treatments. As clinical responses to vaccine therapy continue to advance as a result of new knowledge and improved techniques, there will be an increasing use of this modality in the management of all solid cancers, both for clinically localized cancers and for cancers that have spread. ■

Editor’s Note: As the authors make clear, Dendritic cell-based Cryo-Immunotherapy is still continued on page 7

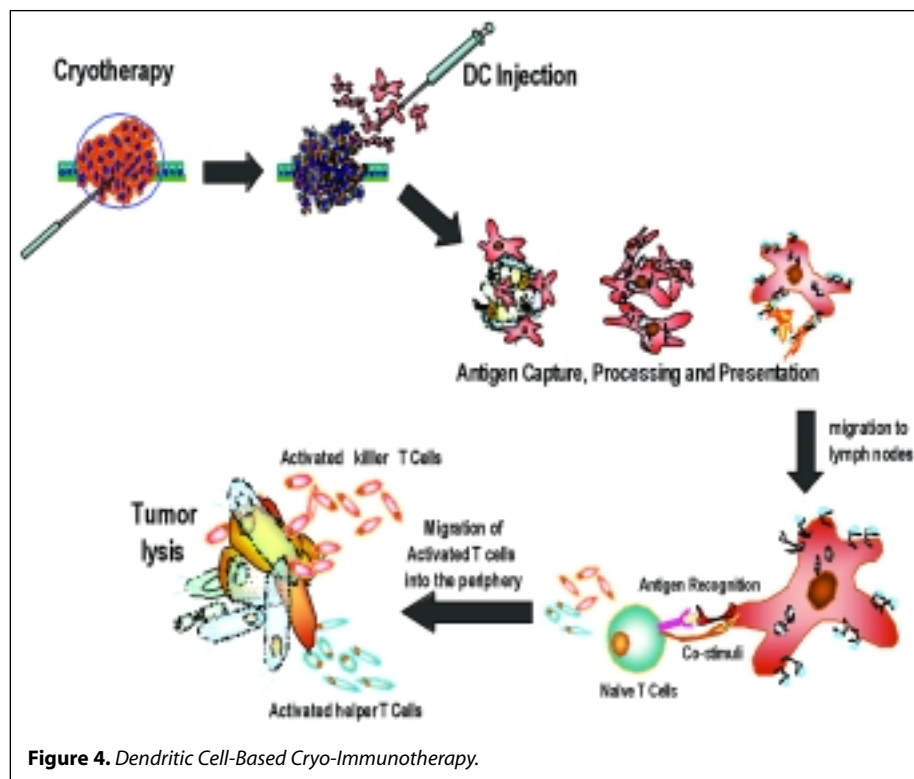


Figure 4. Dendritic Cell-Based Cryo-Immunotherapy.

are all sugars, fats, meats, dairy, oils (with some allowance for cooking), and even most fruits. Processed foods like breads and pasta are also rigorously avoided.

Clearly Thomas's diet is not for the faint of heart. Moreover, he believes that the healing process is enhanced by preparing his own food—the antithesis of our pre-packaged, microwave culture. What's more, the macrobiotic preference is always for food that is in season and locally grown. "The time for food gathering and preparation was so demanding," he reports, "that I resigned from my law firm and committed all my energy to healing myself."

There is now growing medical evidence for the effectiveness of diet in counteracting PC. Dr. Dean Ornish, of cardiac diet fame, has now moved boldly into the arena of diet therapy for treating PC. In the September 2005 issue of *The Journal of Urology*, Ornish published a study

testing the effectiveness of an intensive dietary and lifestyle program. The program consisted of a vegan diet (vegetarian, non-dairy diet), supplemented with antioxidants (such as lycopene, selenium and vitamin E), moderate aerobic exercise, and stress management techniques. Ornish studied 93 men who, like Thomas Mueller, had chosen not to undergo conventional invasive treatment for their PC. Half these men were randomly allocated to the Ornish program, while the remainder served as a non-treated comparison group. After 12 months, the PSA of the treated group of men decreased an average of 0.25 ng/ml or 4%, and the PSA of the non-treated group of men increased an average of 0.38 ng.ml or 6%.³

Ornish did additional laboratory studies using the blood of his participants, with dramatic results. Extracting serum from the men in both groups, he fed it to PC cells lines kept alive in Petri dishes. The cells that were fed serum from men **not** on the Ornish program grew **eight times faster** than those cells receiving serum from men in the treatment group.

The Impact of Suppressed Blood Sugar Levels

Ground breaking as these results are, Ornish's article did not offer any theory as to why his program is working. A review of Thomas Mueller's medical history however,

provided a clue concerning the underlying mechanism that may explain why dietary intervention works. Whenever Thomas came into our office, even if it was right after breakfast, his serum blood sugar was in the 70s, which is unusually low. Blood sugars in most patients, when checked after breakfast, can run as high as 120-150. It seems logical that there is a direct connection between low blood sugar levels and retarded cancer growth.

We should not be surprised that suppressed blood sugar levels could have a major impact on cancer growth. First, sugar (glucose) is like gasoline, fueling all the cells in the body. Cancer cells divide rapidly and therefore are greedy for sugar, because it is necessary for their growth. This fact is dramatically illustrated by Positron Emission Tomography, or PET scan. The PET scan uses radioactive sugar injected into the bloodstream to locate tumors throughout the body. PET can so effectively pinpoint growing active groups of cancer, that with a matter of minutes, the areas of high sugar uptake can be clearly seen in the scan images (see Figure 1.)

Cancer cells require dramatically more glucose to survive and proliferate than normal cells. This is because cancer cells run on a primitive energy metabolism called anaerobic glycolysis that burns sugar without oxygen.

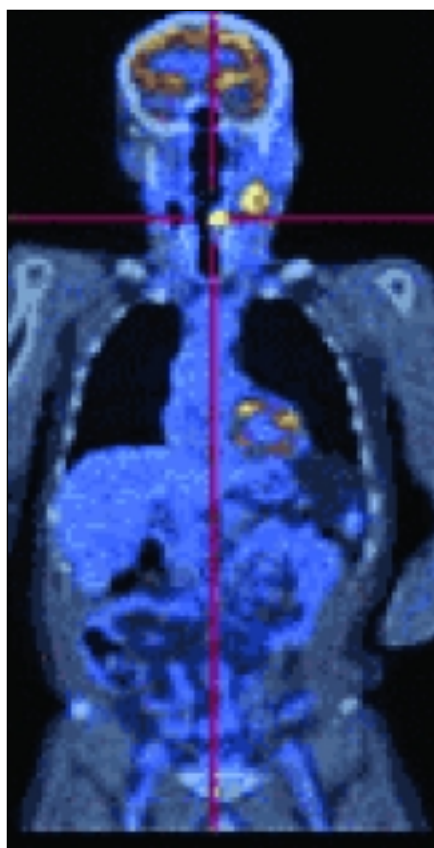


Figure 1. PET Scan image using FDG (¹⁸Fludeoxyglucose) of a 63-year-old male with hypo-laryngeal (neck) cancer on the left. FDG provides a signal that the PET scanner detects (gold colored mass in the neck) in tissues that are using large amounts of glucose. The uptake of glucose seen in the heart and brain are normal.

Image used with permission:
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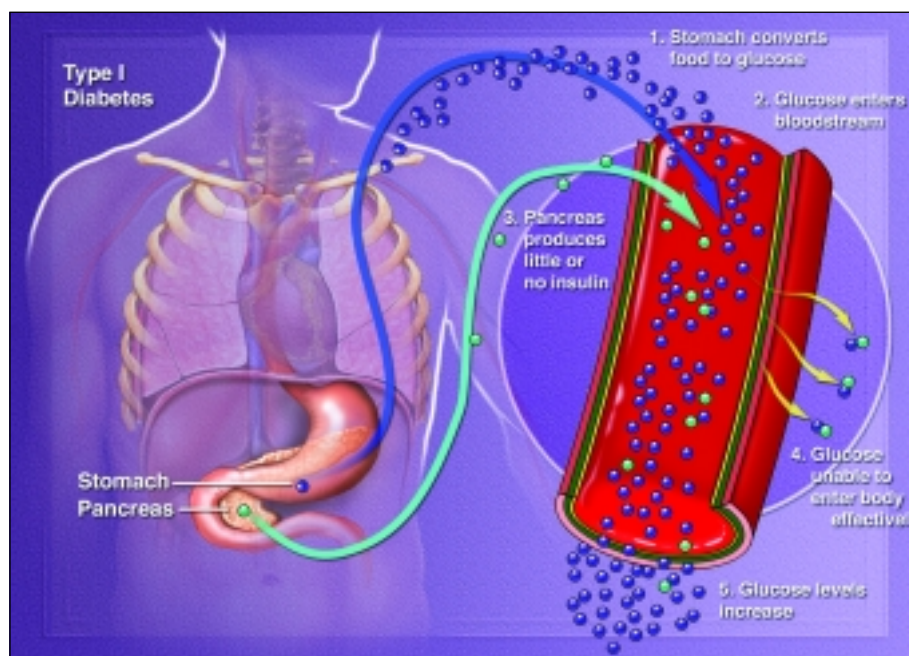


Figure 2. Regulation of glucose in Type 1 Diabetes. Medical Illustration Copyright © 2006 Nucleus Medical Art, All rights reserved. www.nucleusinc.com (Illustration used with permission.)

Oxygen metabolism (aerobic glycolysis) allows the healthy cells of the body to extract many more molecules of energy from glucose than with anaerobic glycolysis. In other words, the cancer cell's demand for glucose is enormous.

Insulin: The Connection Between Diet and PC

All this would seem to indicate blood sugar levels are the driving force in cancer growth. But this does not explain the fact that diabetics—men with chronically high blood sugar—have less prostate cancer than normal men.⁴ How can we explain this? *Diabetes is a disease of low insulin levels.* We know that sugar in the blood is unable to enter the cells without the aid of insulin. Insulin is manufactured and stored in the pancreas until released into the blood *in response to high glucose levels.* As blood sugar levels rise, insulin release accelerates (see Figure 2).

The connection between diet and PC, therefore, appears to hinge only indirectly on blood sugar levels. It is not high blood sugar per se, but rather the high level of insulin, triggered by high blood sugars, that simulates rapid PC growth. There are several reasons why this makes sense. Insulin is one of the most potent growth hormones in the body. Several studies have reported a connection between insulin and PC. Two of these studies show that high insulin levels, or a high sugar diet (which causes high insulin levels), are connected with a higher incidence of PC.^{5,6} A third study has reported that increased insulin levels are associated with more high grade PC.⁷ All this reinforces our conclusion that *it is insulin, and not glucose, that is driving PC.*

How to Suppress Insulin Levels

With such compelling evidence that insulin suppression is vital, the real question is how to best control and suppress insulin. Diet is the only effective method for manipulating insulin levels. The dietary model for controlling insulin already exists, worked out many years ago for diabetics, in what is termed a low-glycemic-index diet. The glycemic index (GI) is a ranking of the carbohydrates in different foods on a scale from 0 to 100 according to the extent to which they raise blood sugar levels after eating (see Tables 1 and 2 for the GI range and value for selected foods).⁸ High-glycemic-index food results in higher and more rapid

increases in blood glucose levels than the consumption of low-glycemic index food. Rapid increases in blood glucose are potent signals to the beta-cells of the pancreas to increase insulin secretion.⁹ In contrast, the consumption of low-glycemic food results in lower blood glucose and lower insulin demands on pancreatic beta cells.¹⁰ Thus, it is basically a low-glycemic index or a diabetic's diet that will most benefit men with prostate cancer.

Low GI	55 or less
Medium	GI 56-69
High GI	70 or more

Thomas's choice of a macrobiotic diet has been remarkably effective. A repeat prostate biopsy in late 2004 showed less extensive disease than when he was originally diagnosed, and his PSA has remained low and stable. Periodically, he has undergone both high-resolution prostate scanning with spectrographic endorectal MRI and color doppler ultra-

sound. There has been no evidence of cancer progression.

Thomas's decision to forgo radiation or surgery at such a young age may seem reckless to members of the medical establishment. But he offers the following rationale: "The pace of advancing medical technology encourages me to wait as long as possible before undergoing any treatment with potentially irreversible consequences. I expect less toxic treatment alternatives will eventually become available. It's only a matter of time. In the last few years, I have already seen substantial advances—in the area of prostate imaging, for example. I plan to use my diet as my primary therapy as long as my cancer remains stable."

Conclusion

There are a number of studies confirming that being overweight and overeating contribute significantly to increased incidence and aggressiveness of PC.^{11, 12,13,14}

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Food	Glycemic Index (Glucose = 100)	Serving Size	Carbohydrate per serving (g)
Dates, dried	103	2 oz (60g)	40
Cornflakes	81	1 cup (30g)	26
Jelly beans	78	1 oz (30 g)	28
Puffed rice cakes	78	3 cakes (25g)	21
Russet potato	76	1 medium (150g)	30
Doughnut	76	1 medium (47g)	23
Soda crackers	74	4 crackers (25g)	17
White bread	73	1 large slice (30g)	14
Table sugar (sucrose)	68	2 tsp (10g)	10
Pancake	67	6" diameter (80g)	58
White rice (boiled)	64	1 cup (150g)	36
Brown rice (boiled)	55	1 cup (150g)	36
Spaghetti, white; boiled 10-15 min	44	1 cup (140g)	33
Spaghetti, white; boiled 5 min	38	1 cup (140g)	40
Spaghetti, whole wheat; boiled	37	1 cup (140g)	37
Rye, pumpernickel bread	41	1 large slice (30g)	12
Oranges, raw	42	1 medium (120g)	11
Pears, raw	38	1 medium (120g)	11
Apples, raw	38	1 medium (120g)	15
All-Bran™ cereal	38	1 cup (30g)	23
Skim milk	32	8 fl oz (250ml)	13
Lentils, dried; boiled	29	1 cup (150g)	18
Kidney beans, dried; boiled	28	1 cup (150g)	25
Pearled barley; boiled	25	1 cup (150g)	42
Cashew nuts	22	1 oz (30g)	9
Peanuts	14	1 oz (30g)	6

However, it appears that insulin may be the real culprit, an idea that has been poorly understood and has not received the attention it deserves. This failure has resulted in diverse theories and conflicting medical recommendations about the impact and efficacy of diet for PC patients. If medical professionals can agree that insulin-stimulating foods are taboo, we can begin working together to educate patients, speaking with one voice. ■

Editor's Note: *Both the PCRI and the authors stress that the treatment described in this article should only be used under the direction of a physician.*

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EXECUTIVE DIRECTOR TRANSITION AT THE PCRI FROM PAGE 1

The PCRI Today

"Under Glenn's leadership, the PCRI staged both national and regional conferences, attracting many of the leading experts in the PC field both to speak at the conferences and to submit articles for publication in *PCRI Insights*," Guess said. "During this period, the PCRI Helpline and website became widely recognized as important sources of information for PC patients, caregivers and physicians. This has supported a fundamental mission that I wholeheartedly endorse.

"To improve the quality of men's lives by supporting research and disseminating information that educates and empowers prostate cancer patients, families, and the medical community."

Plans for the Future

Guess has specific plans for carrying out this mission by adding new programs and focuses that will expand the scope of these services. He summarizes these plans as follows.

"We will, of course, continue the publication of *Insights*, which has been one of the cornerstones of our mission to educate and empower PC patients. We will continue to offer patient conferences, which have been so popular. Our next regional PC conference is scheduled for September 9th of this year.

Our Helpline and website will continue to be available to those seeking information about PC and its treatment options.

"What will be new is an expanding of the programs we offer. We will, for example, try to better serve those men with advanced PC through articles, educational materials and meetings on advanced PC treatments and supportive care. One of the ways we will do this is with the hosting of "Town Hall Meetings", in which we plan to bring together men with advanced PC and physicians who are PC experts. These meetings will provide a unique opportunity for these men to interact with experts on the latest developments in their disease. Our first meeting is scheduled for April 8 in Los Angeles. We have also begun work on a research project concerning advanced PC and pain, which we hope to have completed next year. The results of this research should give us a better understanding of PC pain and the best methods to treat it, so that we can educate advanced PC patients about pain more effectively.

"We also intend to increase our interaction with primary care physicians, urologists and medical oncologists. There is a tremendous need, now more than ever, for up-to-date information and collaboration between these three specialties when it comes to the screening, diagnosis, treatment, management and follow-up for PC.

Specifically, we plan to publish articles and provide educational materials and opportunities to these physicians that will be relevant and useful in their daily practice. For example, we have written an article entitled "Preventing and Treating the Side Effects of Testosterone Inactivating Pharmaceutical in Men with Prostate Cancer" that is scheduled to be published soon in the journal, *Seminars in Preventive and Alternative Medicine*.

"In addition to developing new programming at PCRI, a major part of my role as the executive director of the PCRI will be fund development. Since we are a mission-based non-profit organization, our financial support comes from individuals and groups within the community who believe that the work we do is important and worth supporting. It will be my job to encourage past financial supporters of the PCRI to continue their support or even go beyond what they have given in the past. Additionally, we have to spread the word about our work and mission, so that others in the community will want to see it continue, and therefore provide further financial support.

"I am excited to join with the dedicated staff, board members and supporters of the PCRI in continuing to fulfill their mission to the PC community, and expect to have a long and successful relationship." ■

Winning Despite Prostate Cancer

If you're letting your bout with PC get you down, you might want to compare notes with Alan Carlisle.

Carlisle, who is 76 years old, is a lawyer who has always loved to run, and has been doing so competitively for 40 years. In that time, he has competed in 81 marathons. His first triathlon competition was in 1979, but that wasn't challenging enough for him. In 1985, when he was 55, he progressed to the Ironman Triathlon World Championship race in Hawaii. By the time he was 60, he was rated #1 in the nation.

These grueling races begin with a 2.4-mile swim in the ocean, are followed by a 112-mile bike ride, and end with a 26.2-mile marathon run. To be successful, a competitor must finish in less than 17 hours. To quote Dr. P.Z. Pearce, "If God invented marathons to keep people from doing anything more stupid, triathlons must have taken Him completely by surprise."

PC Slowed Him Down

Carlisle's performance in these demanding races steadily improved, but in 1997 he was diagnosed with PC and underwent seed implant therapy that threatened to end his competitive racing career. "It effectively put me down for almost two years," he says, "but I was determined not to let it keep me down."

He instituted a grueling training program of his own to get back into competitive shape, and he continues it to this day. Every morning, he gets up at 5:30 a.m. to "bike, run, swim, or sometimes, all three." He also bikes the 50 miles to the beach and back each Saturday with friends, many of them about half his age, from a group called the "Inland Inferno." And he does it for fun.

As he says, "it's fun to get out with people who want to live right and be competitive. It's not only hard exercise, it's a social endeavor."

Back to the Ironman Triathlon

As his conditioning program brought back his stamina and skills, his competitive urge led him back to Ironman Triathlon competition in a remarkably short time after his PC seed therapy. He became progressively more competitive, and in 2004, at the age of 75, he won the Western Australian Ironman Triathlon in the over-70 class with a time of 15 hours, 51 minutes.

Carlisle wanted more. The Australia win had qualified him to compete in his fifth 2005 World Championship Ironman Triathlon in Kona, Hawaii. Competing in the 75-79 age category, he knew that this race would be more difficult and he trained accordingly. And on

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Carlisle being greeted by his wife at the Kona finish line.

CANCER CRYO-IMMUNOTHERAPY FROM PAGE 3

in an early stage of testing, and significant time and effort is still required before conclusions can be reached. Since this article was written, the Manila-based cryo-immunotherapy trial has continued to recruit patients. Preparations are now underway for the planned U.S. trial at the Prostate Institute of America in Ventura, California. For more information, contact The Prostate Institute of America at 888-234-0005 or The Haakon Ragde Foundation for Advanced Cancer Studies at 206-273-7919.

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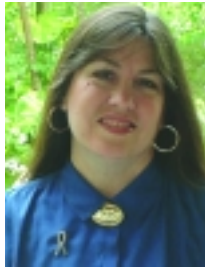
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Prostate Cancer Forum Held in Florida



Dr. Charles "Snuffy" Myers



PCRI's Jan Manarite of Florida

The PCRI continues to organize and stage innovative events to increase the understanding of PC and its treatments. A good example was the PC Forum entitled **Clinical Issues in Prostate Cancer**, which was produced on January 22, 2006 in Fort Myers, FL by the PCRI in conjunction with the Foundation for Cancer Research and Education (FCRE). Organizer Jan Manarite, the PCRI Educational Facilitator in Florida, brought together the FCRE's Dr. Charles "Snuffy" Myers and a cross-section of the Florida medical community to share the latest information on PC treatments.

Dr. Myers, who specializes in PC treatment and research, traveled from his practice in Charlottesville, VA to meet with a select group of Florida medical professionals who have a direct interest in PC and its treatment. In all, ten different organizations were represented. Attendees included Dr. Robert McDonald from Radiology Regional, Dr. Geoffrey Negin from Florida Radiology Consultants, Dr. Jim Reeves from Florida Cancer Specialists, Dr. Michael Katin from 21st Century Oncology, Dr. Bert van Beever from Florida Urology, Dr. Jay Friedland from Naples Radiation Oncology, and Janice Chase, R.N. from the Sanibel Medical Clinic.

"I was the so-called moderator for this group, but there really wasn't much moderating to be done," Manarite recalls. "Before the

luncheon was served, an animated discussion between Snuffy and the other medical professionals was already underway. Facts, ideas, and questions were readily exchanged. It was a formal setting with a wonderfully informal feeling. After lunch, Snuffy took the podium and presented some of his clinical observations, pharmaceutical insights, and interesting case studies, which stimulated questions regarding clinical challenges in PC. A selection of full text articles pertaining to contemporary subjects was provided to the physicians for future reference.

"Although this was our first such forum, everything went very smoothly. Much of the credit for this smoothness should be given to the Sanibel Harbour Resort & Spa that catered the event and to the forum's sponsors: Berlex Laboratories (unrestricted educational grant), Florida Radiology Consultants, Radiology Regional, and Bostwick Laboratories. Everyone who attended agreed that this first forum was very valuable, and preliminary discussions are now underway for a second, 'similar' event with Dr. Myers for Florida medical professionals. Contact me at (239) 395-0995, or jmanarite@pcri.org." ■

WINNING DESPITE PC FROM PAGE 7

October 15, 2005, Alan Carlisle overcame gusty winds and high humidity and finished a remarkable fourth.

"I feel that I'm racing as well as I ever did," he says. "Age has slowed me down, but not cancer. I'll be competing in my eighth Ironman in Brazil in May, and I certainly don't regard it as my last race. Not only do I want to win the 75-79 Brazil Ironman, but I can hardly wait to become 80 so that I can win the World Championship in Kona as well. It will be fun." ■

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