

Newsletter for the Month of Oct. 1-31

One of the large problems facing men either HIV+ or - is the treatment of localized prostate Cancer in the era of PSA Screening.

In an online study titled "Treatment of localized Prostate Cancer in the era of PSA screening" Thomas L. Schwenk, MD in Journal Watch General Medicine, addresses this problem. The article starts out with what many people in the cancer field are concerned about is the overly aggressive treatment of clinically insignificant prostate cancer that is detected by Prostate-Specific antigen (PSA) screening. Researchers used linked Medicare and cancer registry databases to assess mortality in 14,416 older men age >65 median age 78 with diagnosis of localized stage T1 or T2 prostate cancer. During the early era of PSA testing (1992-2002) who did not die or receive prostatectomy or radiation during the first year after their diagnoses (median follow-up, about 8 years.)

For patients with highly, moderately, and poorly differentiated cancers, 10 year prostate cancer-specific mortality was 8%,9%, and 28% respectively; mortality from all other causes was about 80% in all three groups. Most men received androgen-deprivation therapy, but only about 2% received chemotherapy, and about 1% underwent spinal surgery or radiation therapy during follow-up.

The conclusion of this study after all the variables are considered is watchful waiting for about a year appears to be appropriate treatment.

Selective Estrogen Receptor modulators (SERMs) Nelsen HD et al, Ann intern Med 2009.

The selective estrogenic receptor modulators, tamoxifen and raloxifene are associated with lower risk from primary invasive breast Cancer. These agents are approved in the US for chemoprophylaxis in high-risk women (in postmenopausal women only). These agents have been proven successful as adjuvants to primary breast cancer therapy. But there are side effects of these agents namely increased risk for abnormal uterine bleeding and hysterectomy for benign diseases. Both of the above drugs were associated with greater likelihood of hot flashes. So what should a woman who is premenopausal high risk do? Take either tamoxifen or raloxifen and know the risk, or wait for the aromatase inhibitors which are a potential alternative that are now being evaluated. That is the choice that a physician dealing with the woman who has this problem must explain. The choice must be left to the woman.

The Peter Schick Foundation is now entering an exciting phase of its growth. We are studying clinical trials for HIV, and Type 2 Diabetes with Alpha Sun, a bone marrow stem cell stimulator that increases the circulating effective bone marrow stem cells 30 % 2 hours after ingestion. We are also forming a company with Simplicity Health who manufactures the alpha sun compound which is AFA or the blue green algae. To donate to these trials or to receive information about participating in the private placement of the new company PSUN, write to The **Peter Schick Foundation, 1223 Wilshire Blvd. #1007, Santa Monica Ca. 90403**. Inquires about the company, and donations to the foundation for the clinical trials is appreciated. You can make a difference.

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