Evansville Cancer Center kicked off its fifth annual prostate cancer awareness program ‘Tackling Prostate Cancer with Len Dawson and Bart Starr’ on Thursday, August 24th, 2006 at the Evansville Marriott. The evening’s events opened with a reception for VIPs and sponsors followed by a presentation for the public. A video was shown spotlighting local prostate cancer survivors, their families and a man who had lost his father to prostate cancer. Len Dawson, prostate cancer survivor and Hall of Fame quarterback with Kansas City Chiefs, and Bart Starr, Hall of Fame quarterback for Green Bay Packers, teamed up to play against each other in the first SuperBowl. Len Dawson addressed his own battle with prostate cancer urging men to be screened annually for this disease, stressing the importance of having both a digital rectal exam and a PSA blood test when being screened. Mr. Dawson’s PSA blood test was normal but a DRE led to the diagnosis of prostate cancer.

‘Understanding Prostate Cancer’ One-Hour Television Program

On Tuesday, August 29th from 8 to 9 p.m. Mike Blake of 14 WFIE hosted ‘Understanding Prostate Cancer: A Live Call-In with Physicians’ produced by the Evansville Cancer Center. This year’s program featured prostate cancer survivors Tim Mahoney, George Flowers, Bob Ensner and wife Barb, Dan Kieffer and Keith Wagner who lost his father to prostate cancer. In addition, viewers had the opportunity to call into WFIE’s studios and have their questions answered live by a panel of urologists from the Tri-State area and the oncologists and psychologist from Evansville Cancer Center.

Free Prostate Cancer Screenings Offered to Area Industries

This is the fourth consecutive year that Evansville Cancer Center has coordinated several prostate cancer screenings at area industries. The screenings were provided free of charge compliments of a grant from AstraZeneca, assistance by LabCorp, who processed the PSA blood tests, and several urologists who generously donated their time to provide digital rectal exams.

Evansville Cancer Center screened 181 men for prostate cancer at area industries such as Alcoa, Berry Plastics, Industrial Contractors, Inc., Mead Johnson Nutritionals, and PPG Industries just to name a few. Of the men screened, 17 were found to have PSA’s of 4.0 or higher or had irregular DRE. They were instructed to schedule an appointment with their primary care physician or a urologist for further evaluation or testing. Even though guidelines recommend men to have annual screenings, 102 men who participated had never had a PSA blood test before or had not been screened annually.

Results from questionnaire men filled out prior to being screened.

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<th>When did you last have a digital rectal exam?</th>
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| 59  | 54  |
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| 28  | 39  |

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The Evansville Cancer Center would also like to thank the urologists in the Tri-State area, AstraZeneca & LabCorp for teaming with us to provide educational awareness of prostate cancer and free prostate cancer screenings.

William Fisher, MD, Phillip M. Gilson, MD, Barney Maynard, MD, Todd Renschler, M.D., Bruce Romick, MD, Bill Samm, MD & Michael Zenni, M.D. of Urological Associates, Inc.

Thomas Gadient, M.D. of Urology Consultants & Paul F. Siami, MD of Welborn Clinic.

Evansville Cancer Center, A Vantage Oncology Facility

700 N. Burkhardt Road ■ Evansville, Indiana 47715 ■ 812-474-1110
The National Screening Trial NLST is a clinical trial to assess whether screening individuals at high risk for lung cancer with spinal CT or standard chest x-ray can reduce lung cancer deaths.

**Work-Up and Treatment Options**

Work-up after you obtain a biopsy which shows non small cell lung cancer would include history and physical including performance status and weight loss with CT of the chest and upper abdomen including the adrenal glands, CBC, platelets, chemistry profile, and smoking cessation counseling. In addition, patient should have pulmonary function test, bronchoscopy, mediastinoscopy to evaluate the mediastinum, PET scan and MRI of the brain.\(^{8,9,10,11}\) Mediastinal staging with PET has shown sensitivity from 64% to 88% with specificity of 77% to 91% in different studies.\(^8\) Mediastinal staging with PET has an overall accuracy of 74% according to a Duke’s study. Stage IB-IIIA with resectable tumors should go on to have surgery with negative margins followed by postoperative adjuvant chemotherapy if medically able.\(^{12,13}\)

One technique in surgical resection is video assisted thoracoscopic lobectomy which has shown less postoperative pain, preservation of pulmonary function and less cytokine production.\(^{14,15,16,17}\) Postoperative adjuvant platinum based chemotherapy after surgical resection has shown survival benefit.\(^{18,19,20}\) Stage IIIA patients with mediastinal adenopathy, N2 disease have a survival advantage with preoperative chemotherapy followed by surgical resection versus surgery alone.\(^{21}\) Induction chemotherapy prior to surgical resection is associated with more side effects. Lobectomy was associated with less surgical mortality versus pneumonectomy.\(^{22}\) Intergroup trial 0139 a randomized trial of definitive chemotherapy with Cisplatinum, VP-16 with radiation treatments to 61Gy versus induction chemotherapy with Cisplatinum, VP-16 with radiation treatments to 45Gy followed by re-evaluation, if no progression of disease then surgical resection. The trial showed no survival difference between the two arms. Patients in the radiation arm had more esophagitis than the surgical arm. The surgical arm had significant postoperative mortality of 8% with 30 day postoperative mortality 5%. The patient that had a lobectomy had a significantly lower morality rate than patients who had a pneumonectomy. Currently there is an Intergroup trial, S0332 of induction chemotherapy plus or minus radiation therapy followed by surgery for resectable IIIA, N2 non small cell lung cancer. In the trial patients received Cisplatinum and Docetaxel two cycles with radiation to 45Gy followed by surgery followed by three cycles of Docetaxel versus Cisplatinum and Doctaxel for two cycles prior to surgery followed by three cycles of Docetaxel. Future trials are going to look at Tarceva or Iressa with chemotherapy as induction therapy prior to surgery particularly in patients who have never smoked or have limited smoking history.\(^{23}\) Another future development is use of Bevacizumab and chemotherapy for non squamous cell non small cell carcinomas of the lung because of improvement in complete response and partial response rate and median survival compared to chemotherapy alone.\(^{24,25}\) In unresectable stage III non small cell lung cancer, concurrent radiation and chemotherapy have shown improvement in survival.

Concurrent treatment has increased toxicity especially of esophagitis. SWOG 9504 of concurrent chemoradiotherapy with consolidation in stage IIIB non small cell lung cancer, T4 or N3 has shown improvement with consolidative Docetaxel chemotherapy.\(^{26}\) Future studies of the RTOG are looking into concurrent Cetuximab with chemo radiation therapy, as well as Thalidomide with chemo radiation therapy. The preferred treatment is concurrent chemotherapy and radiation therapy followed by adjuvant chemotherapy with induction chemotherapy followed by concurrent chemoradiotherapy as an option in selected patients to reduce toxicity. The multi-disciplinary team approach with multi-modality therapy have improved survival in lung cancer.

- Jon D. Frazier, M.D., Radiation Oncologist, Evansville Cancer Center

REFERENCE

Venous thrombosis (30-70%)
Skin lesions at heparin injection sites (10%)
Cerebral venous (sinus) thrombosis
Myocardial infarction
Venous limb gangrene (VKA)
Erythematous plaques
Pulmonary embolism (PE)
Stroke

Heparin Induced Thrombocytopenia (HIT) is an immune-mediated adverse effect of heparin that paradoxically increases risk of thrombosis. HIT is associated with: thrombocytopenia, the generation of heparin-dependent antibodies (typically IgG), as well as a high risk for thrombosis causing significant morbidity and mortality. The thrombosis sites are typically:

- Venous thrombosis (30-70%)
  - Deep vein thrombosis (DVT)
  - Pulmonary embolism (PE)
  - Adrenal necrosis (adrenal vein thrombosis)
  - Cerebral venous (sinus) thrombosis
  - Venous limb gangrene (VKA associated)
- Arterial thrombosis (“white clots”) (15-30%)
  - Limb artery thrombosis
  - Stroke
  - Myocardial infarction
- Skin lesions at heparin injection sites (10%)
- Skin necrosis
- Erythematous plaques
- Acute reactions after i.v. heparin bolus (10%)
- Disseminated intravascular coagulation (DIC) (10%)

The diagnosis of HIT is based upon clinical suspicion and treatment should not rely on laboratory confirmation alone.

Management includes: discontinuation all types of heparin, checking other potential causes of thrombocytopenia, assessing risk of thrombosis and if indicated, initiating alternative anticoagulant therapies. (Agraban, Danaparoid, Lepudrin.)

Above is a brief summary of Dr. Hadad’s presentation. If you would like a complete copy of his presentation on Heparin Induced Thrombocytopenia, please call 812-474-6000 or you may E-mail Dr. Hadad at hhadadrc@yahoo.com.

Dr. Hadad Presents at Methodist Hospital’s Grand Rounds on Heparin Induced Thrombocytopenia

The American Board of Radiology in prostate. He is certified by the therapy of the head and neck, lung, esophagus, pancreas, uterine, cervix, kidney, bladder, stomach and acute myeloid leukemia. The risk of lung cancer is no different in smokers of “light” or low tar yield cigarettes.

Numerous tests such as low dose spiral computed tomography (CT) scans and molecular markers in sputum have produced promising results in detecting lung cancer at early, more operable stages when survival is better. However, there are considerable risks associated with lung biopsy and surgery that must be considered when evaluating the risks and benefits of screening.

Lung Cancer

According to the American Cancer Society an estimated 174,470 new cases of lung cancer are expected in 2006 with an incidence rate declining significantly in men since 1984 and stabilizing in women since 1998. Lung cancer is classified clinically as small cell (13%) or non small cell (87%). Lung cancer is the most common cancer related death in both men and women. An estimated 162,460 deaths accounting for about 29% of all cancer deaths are expected to occur in 2006. Since 1987 more women have died each year from lung cancer than from breast cancer. Death rates have continued to decline significantly in men from 1991 through 2002. Female lung cancer death rates are approaching a plateau after continuously increasing for several decades. These trends in lung cancer mortality reflect decreased smoking rates over the past 30 years. Cigarette smoking is by far the most important risk factor for lung cancer. Smoking accounts for at least 30% of all cancer deaths and 87% of lung cancer deaths. Genetic susceptibility plays a role in the development of lung cancer especially in those who develop the disease at a younger age. Early detection has not yet been able to reduce mortality. Sixteen year follow-up of the Mayo lung project showed no difference in lung cancer mortality between arms, but significantly more lung cancers were diagnosed in the screening arm. Smoking is associated with increased risk for at least 15 types of cancer: nasopharynx, nasal cavity and paranasal sinuses, lip, oral cavity, pharynx, larynx, lung, esophagus, pancreas, uterine, cervix, kidney, bladder, stomach and acute myeloid leukemia. The risk of lung cancer is no different in smokers of "light" or low tar yield cigarettes.

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