Welcome to Yale Cancer Center Answers with doctors Francine Foss and Anees Chagpar. Dr. Foss is a Professor of Medical Oncology and Dermatology, specializing in the treatment of lymphomas. Dr. Chagpar is Associate Professor of Surgical Oncology and she is Director of the Breast Center at Smilow Cancer Hospital at Yale-New Haven. If you would like to join the conversation, you can contact the doctors directly. The address is canceranswers@yale.edu and the phone number is 1-888-234-4YCC. This week you will hear a conversation about disparities in prostate cancer and PSA testing with Dr. Charles Walker. Dr. Walker is Assistant Professor of Urology at Yale School of Medicine. Here is Francine Foss.

Foss Charles, can you talk to us a little bit about how long you have been at Yale Cancer Center and about the position that you are in right now?

Walker I did my residency at Yale and I finished a residency in general surgery in urology in 2005, after which I was invited to join the Yale faculty, which is essentially the Yale Urology Group and I have been a practicing member of the urology group and an Assistant Professor at the School of Medicine for almost eight years now, and I have been doing prostate cancer work for much of that time. I was primarily at the VA in the earlier portion of my practice and I still have a very strong presence there and I did a lot of prostate cancer work. I had an opportunity to actually be principal investigator on several high risk prostate cancer clinical trials and I really sort of honed my expertise in the area of prostate cancer doing that work and also doing surgery with prostate cancer over that period of time. In the last really year, I have become a member of Yale of Cancer Center so I am relatively new to the center but I have been doing this work for a number of years.

Foss Can you talk with us a little bit about the Urology Department of Yale Cancer Center, who is in it, how many doctors, and what other kinds of folks are involved?

Walker We have an interesting sort of presence there because all of our adult urology practices for the most part are in the cancer center so that includes benign urology as well as malignant urology. So we do really everything there. Now, within that sort of the overall practice, there are a number of individuals who specialize in urologic cancer, which prostate cancer obviously is one of the big ones. So in all, I believe we have five urologic oncologists, which would include John Colberg, Preston Sprenkle, Simon Kim, Patrick Kenny, and Brian Shuch, and they solely do cancer and I do cancer among other things and actually the majority of my cancer practice is at the VA, but I am involved and interested in doing prostate cancer outreach and looking at disparity at Yale and that is my interest here.

Foss You also told me before the show that you do BPH and men in the audience might be confused about BPH and does BPH lead to cancer. Can you just give us a little primer on BPH?

Walker Absolutely, I do BPH and I do sexual health and sexual dysfunction and that is my main area of interest in my practice. BPH stands for benign prostatic hyperplasia and what it implies is a benign enlargement of the prostate and this is a process that happens as men get older and it is benign as

4:10 into mp3 file http://yalecancercenter.org/podcasts/2014_0112_YCC_Answers_-_Dr_Walker.mp3the name implies, which means it actually has nothing to do with prostate cancer and so one of the things that I think is confusing for men is that when we tell men to be on the lookout for certain symptoms that may suggest that they have prostate cancer, we are really talking about symptoms that are common to benign prostatic hyperplasia. You will see these brochures and often these informational resources telling men that if they have frequency of urination, difficulty urinating, waking at night to urinate, that they may have prostate cancer. In fact those symptoms are much more likely to indicate benign prostatic hyperplasia and so I often have men coming in with BPH who are very alarmed that they might have prostate cancer. Now the reason for that is that prior to the widespread use of the PSA test, men typically presented very late with prostate cancer and as a result they often did come in with symptoms and that is why we still tell man that if they have those symptoms they may have prostate cancer, so it is a little confusing.

Foss Can you back up a little and tell us how common prostate cancer is? We hear a lot about it and that the incidence increases as men get older. Can you just tell us a little bit about the incidence, how early does it start, how young, how old?

Walker Absolutely, I am happy to talk about that. Prostate cancer is very common, it is estimated that one in six men will be diagnosed with prostate cancer in their lifetime, and actually that is one in five for African-American men who are at greater risk for prostate cancer. In 2013, it is estimated that roughly 236,000 men will be diagnosed with prostate cancer and close to 30,000 will die of prostate cancer, which obviously is significant. It is the second most common cancer in men and also the second most common cause of cancer death in men. So, it is a very prevalent disease, many men will be diagnosed with prostate cancer, but I think what is reassuring is that of those men, the great majority of them will have cancer that is not likely to be lethal.

Foss How many of those men actually present with symptoms and how many present because we do a blood test like a PSA?

Walker That is a good question and I do not know the actual statistics on how many men present with symptoms, what I can tell you is that prior to the PSA era, which is really about 20 years ago, a little bit more maybe, there was a 75% higher incidence of men presenting with very late stage prostate cancer and PSA testing has reduced the incidence of men presenting with metastatic prostate cancer by 75% and so we would assume that many of those men had symptoms and so today it is a much lower percentage of men and we very rarely see men in our clinical practice who present with symptoms related to prostate cancer. Now, PSA really is the mainstay for diagnosis and we can talk about it now or later, the controversy behind the PSA test, which is a discussion in and of itself.

7:49 into mp3 file http://yalecancercenter.org/podcasts/2014_0112_YCC_Answers_-_Dr_Walker.mp3

Foss That was going to be my next question. As you know, and the audience may have heard, is that there have been differing recommendations about whether or not men need to actually get the PSA test and some of the insurance plans may not be paying for it anymore. Can you talk with us about that whole controversy and where you stand on it?

Walker Absolutely, this is a very hot area of discussion and I am always happy to talk about. I will start by saying that personally I believe in PSA screening and I will come back to that. The United States Preventative Service Task Force came out with a recommendation against prostate cancer screening in 2012. They actually gave it a level D recommendation and the reason that is important is that the Affordable Care Act has mandated that the USPSTF actually inform reimbursement for diagnostic and screening tests like the PSA. So, a level D recommendation typically will not to be reimbursed by Medicare and other commercially available insurance policies. However, President Obama has, at least provisionally, for the time being, indicated that the PSA test would be covered and so PSA testing in large part is still covered. Although I have recently seen men whose policies have not covered it, so clearly there are some policies that may not be covering the test and the reason for that is because of this recommendation and we as urologists are tremendously concerned about this because a PSA test, although it is not a perfect test, it is far from perfect in fact, but it is the only way that we have to identify men

with potentially lethal prostate cancers at a stage early enough to cure them and so without the test we simply do not find these men and they present with metastatic disease. There were a number of reasons that they came up with this recommendation and there were three large randomized clinical trials looking at prostate cancer screening, two in Europe and one in the United States, and it turns out that the one in the United States did not find a benefit from the standpoint of reducing death due to prostate cancer, or prostate cancer specific mortalities we call it. However, the other two trials, one was called the European Randomized Study for Prostate Cancer Screening and the second the Goteberg trial, which was another European study, both very large studies, I think 160,000 and 20,000 men respectively, and those trials both actually demonstrated a clear reduction in prostate cancer related death as a result of screening, with 44% in the Goteberg trial and 21% in the European Randomized Trial and so clearly there is a benefit and those studies also found that there was a reduction in the number of patients, or the proportion of patients presenting with metastatic disease, so for many of us that provides the impetus to strongly recommend PSA screening. A couple of caveats were that they did not find a benefit for screening in men over age 70 and so that has to be taken into consideration and clearly there was the risk of over diagnosing men, which was common in every trial and so that is something that has to be taken into consideration as well and many of the organizations that are relevant in the discussion of prostate cancer screening, the American Urologic Society, the American Cancer Society and the National Comprehensive Cancer Network of the NIH, have essentially come out with their own guidelines about prostate cancer screening, and although they differ a little bit, all of them agree that an informed discussion with your doctor, what we call shared decision making, should be offered with a discussion of prostate cancer screening and the option for a prostate cancer biopsy if they happen to have an abnormal screen for men between the ages of 55 and 69. There is some disagreement about when you should start, but most of the organizations that I just mentioned

12:56 into mp3 file http://yalecancercenter.org/podcasts/2014_0112_YCC_Answers_-_Dr_Walker.mp3

agree that screening should start either at age 40 or 45 and the American Urologic Association recommends that it begin at 40 for men at risk, and that would include African-American men and men with a family history of prostate cancer. The American Cancer Society also has a similar recommendation and the National Cancer Comprehensive Network recommends that all men have a baseline PSA at age 40.

Foss That gives us a lot of information and after we take a break we will talk a little bit more about some of the specifics about prostate cancer. This is Dr. Francine Foss with Dr. Charles Walker talking about prostate cancer and

disparities and will be back after this Medical Minute.

Medical

Minute The American Cancer Society estimates that the lifetime risk of developing colorectal cancer is about one in twenty and that risk is slightly lower in women than in men. When detected early, colorectal cancer is easily treated and highly curable. Men and women over the age of 50 should have regular colonoscopies to screen for the disease. Each day more patients are surviving colorectal cancer due to increased access to advanced therapies and specialized care, which is giving colorectal cancer survivors more hope than they have ever had before. Clinical trials are currently underway at federally designated comprehensive cancer centers like the one at Yale to test innovative new treatment for colorectal cancer. New options include a Chinese herbal medicine being used in combination with chemotherapy to reduce side effects of treatment and help cancer drugs work more effectively. This has been a medical minute and more information is available at yalecancercenter.org. You are listening to the WNPR Health Forum on the Connecticut Public Broadcasting Network.

Foss Welcome back to Yale Cancer Center Answers. This is Dr. Francine Foss and I am joined tonight by my guest, Dr. Charles Walker and we are discussing the issue of prostate cancer and disparities. Before the break we talked a lot about the recommendations for PSA screening and the controversy there. I wonder if we could just wrap up that discussion by hearing again what your recommendations are and also I just wanted to touch on the issue of disparities here as well because you talked about how this study did not really show any difference in mortality, but I am wondering in those specific populations, like African Americans, if in fact the study looked at that directly and if there may have been a benefit there?

Walker Those are great questions, just to sum it up, I am in favor of prostate cancer screening. I believe that all men should have a baseline screening test at age 40. I think that subsequent screening should depend on what the level of that test is. There is evidence that if your PSA is less than 1 in your 40s, then you are at very, very low risk for having cancer develop at a later point of your life. I strongly recommend that men at risk, either with a family history or African American heritage, be screened annually beginning at age 40, and I think that for all men it should involve informed

16:18 into mp3 file http://yalecancercenter.org/podcasts/2014_0112_YCC_Answers_-_Dr_Walker.mp3

decision making with their doctor where they discuss the risks and benefits and

also the potential harms of treatment if they are diagnosed with prostate cancer and the last thing I would say is that I do not necessarily agree with some of the recommendations that men over 70 should not be offered screening. I think if men over 70 have good life expectancy, of greater than 10 years, and they have an informed discussion with their urologist that they should potentially be able to partake in screening. So that is my opinion on it and I think most of my colleagues would agree with that.

Foss And how about this issue of disparities with African American patients?

Walker This is a tremendously important issue and obviously one that is of interest to me and hopefully something that will help define part of my career. This issue of disparity is tremendously important and I think that what we are really trying to do when we talk about disparity is understand what the factors are that create an environment where the men who are most at risk are perhaps falling through the cracks and this would I think adequately describe the African American population in the prostate cancer discussion and so when we talk about prostate cancer in African Americans a couple of things need to be clearly established. One is that African American men are one and a half times as likely to be diagnosed with prostate cancer as their Caucasian counterparts and they are almost two and a half times as likely to die of prostate cancer. That is pretty sobering, and I think is the reason that so many people that are involved in prostate cancer feel that it is important that these men be screened at an earlier age. That is the first issue. The other issues really pertain to, how do we eliminate the disparity? There appears to be a disparity on every level of prostate cancer care. So African American men with prostate cancer typically present at later stages of the disease where it is more difficult to cure the disease. They typically experience a greater delay in having definitive care after they have been diagnosed. They are less likely to be treated at high volume centers by high volume surgeons and they are less likely to be offered surgery, and we have not talked about that yet but for younger men with prostate cancer surgery is often felt to be the first line, and finally, they are less likely to be aware of what their options are when they have aggressive or high risk prostate cancer, and so we have a lot of disparity there to deal with and there are a lot of reasons for that, there are issues of access to care, there are issues of education, there are issues of health seeking behaviors, which are typically poor in the African American community, and so there are many, many issues I think that are relevant to the discussion of disparities and why they exist.

Foss Can you talk a little bit about the representation of African American patients in some of these studies do these data really represent, what

is happening in African Americans verus Caucasians?

Walker I am really glad you brought that up, because it was actually something that I should have pointed out and it is a tremendously important issue. In these studies, African Americans were tremendously under represented, particularly in the European studies, and so one of the biggest concerns about the recommendation against prostate cancer screening is that it would create undo harm to African American men and men with a family history as well. Because the men that were

20:33 into mp3 file http://yalecancercenter.org/podcasts/2014_0112_YCC_Answers_-_Dr_Walker.mp3at the highest risks were not well represented in these studies and so the study outcomes really were not generalizable to these men. So when you look at the American study or the US study that shows no benefit in terms of reducing prostate cancer mortality, it really does not apply to African American men who tend to have more aggressive disease and who die at a higher rate of prostate cancer, because they were not represented well in the studies.

Foss What are we doing as far as community outreach as far as addressing this whole issue of disparities in men from African American background?

Walker As you may be aware, we recently held a prostate cancer screening event in New Haven, sponsored by Yale Cancer Center at Smilow Cancer Hospital, and we also had tremendous support from Yale-New Haven Hospital. It was really a fantastic event. It was well staffed and attended by everybody in my department and we had a good turnout of men in the community. This type of thing is really only the first step. I talked briefly about some of the different areas that we need to address in disparity, education, outreach, promoting health seeking behaviors, access to care, all of these things are important and to me the first thing that has to happen is that those of us who are in a position to make a difference, and you could argue that everybody can make a difference, but certainly those of us who practice in a tertiary academic center where we have the benefit of having a world-renowned cancer center like Yale Cancer Center, we have to get ourselves together and we have to form collaborations that are multidisciplinary and we have to take advantage of our colleagues in public health and take advantage of our colleagues that are doing outcome research and we have to bring all these people together and create meaningful initiatives that really can make a difference in the community. An example of this is the barber shop initiative which has taken place across the country in several big cities and what the barber shop initiative did was it actually brought educators and physicians and folks interested in community outreach into the barber shop

which provided resources and education to African American men in an environment where they were comfortable, and they educated these men about the importance of screening and then offered them screening and established the means of follow-up for these men and so that is an example of a really meaningful initiative that can have a tremendous impact in the community and really brings together all of those different things that I have talked about. Those are the kinds of things that we need to do and prostate cancer screening is the first step. I am excited that we now have a growing core of people here between the Cancer Center and Yale-New Haven Hospital and in the community that are really committed to this cause and I think they are going to do some good things in the near future in terms of outreach.

Foss It sounds great that we can start getting people screened and hopefully pick those cases up early.

Walker Absolutely.

24:11 into mp3 file http://yalecancercenter.org/podcasts/2014_0112_YCC_Answers_-_Dr_Walker.mp3

Foss Can you tell us what happens when a patient comes to you with prostate cancer and they have already been diagnosed, can you step us through some of the tests that need to be done, and then the treatments?

Walker Absolutely, to take one quick step back, the screening itself includes the PSA test and what we call a Digital Rectal Examination where we examine the prostate. Once we are able to establish that a man is at risk either because the PSA is elevated or the examination is abnormal, we send him for a biopsy. The biopsy will then demonstrate whether or not cancer is present and it will also tell us how aggressive that cancer is biologically and so I often have to explain to patients that it does not necessarily tell me whether it is advanced or not. It just tells me what the potential for that cancer is to grow and potentially become advanced and so based on the biology of the biopsy we then stratify men into risk groups, and we have low risk, intermediate risk and high risk and how you treat prostate cancer, how you manage prostate cancer, ultimately is dependent upon that risk stratification. Men at low risk can overwhelmingly be given the option of active surveillance which is basically a management protocol where we do not treat men but we follow them very closely and we rebiopsy them after a year, and at subsequent intervals after that and provided they do

not show any clinical evidence that they are progressing we can follow them indefinitely and we know that this is something that we can do because a great majority of men with prostate cancer have indolent disease. Now if they have intermediate or higher risk disease or they are younger men, we often will offer them more aggressive treatments and in those treatments there are a number that can be offered. The mainstay of treatment has always been surgery and external beam radiation. Those are the two sort of core treatments and then there is a variety of other things that I certainly am happy to talk about it if you like but those are the mainstays for intermediate and certainly progressive disease.

Foss Can you talk about some of the complications of surgery, men are worried about erectile dysfunction for instance and other complications related to that type of surgery.

Walker Absolutely, part of that shared decision making is talking about these treatments and explaining what the potential side effects are and so for surgery, erectile dysfunction and urinary incontinence are two of the big ones. Not all men will suffer from these side effects, in fact, it is estimated that about 50% of men in general will have erectile dysfunction after prostate cancer surgery and anywhere from 5% to 15% of men will have urinary incontinence. The actual number varies depending on what study you are looking at but that is a reasonable estimate. The other thing I think that is important is to tell these men that there are treatments for erectile dysfunction and for urinary incontinence that are effective and they have to be aware that surgery does not necessarily mean an end to their sexual function and it does not mean that they are going to have to live with incontinence for the rest of their life. But they are significant and they are potentially devastating for one's quality of life.

Foss Would you say that for most men those are reversible, or is there a percentage there?

28:02 into mp3 file http://yalecancercenter.org/podcasts/2014_0112_YCC_Answers_-_Dr_Walker.mp3Walker I do not know if reversible exactly is the word I would use but they are treatable and for most men you can offer them treatments that will allow them to regain function and I believe that to be the case. Radiation on the other hand, also has a side effect of erectile dysfunction but it tends to have less of an evidence of urinary incontinence. Other symptoms that can be experienced with radiation therapies though include adverse effects to the GI tract, the gastrointestinal tract, and also symptoms related to irritation of the bladder and so those were some other common symptoms that can happen.

Foss Can you briefly tell us what the role is, if there is a role, of hormonal therapy or chemotherapy?

Walker Hormonal therapy traditionally has been reserved for men who present with advanced disease. This is prostate cancer that has spread outside of the prostate and so these men are not candidates for curative therapies like surgery or radiation. However, studies have shown that when you administer radiation to men, if you also give them a short-term course of hormone therapy along with that, you can improve their survival. Chemotherapy also classically has been reserved for men who have the most advanced metastatic disease; it is not responsive to any other treatments. However, in the study that I do at the VA, we are one participating site, it is a multicenter study. We are looking at giving chemotherapy prior to surgery in an effort to improve outcomes for men with higher risk prostate cancer so there are some protocols and research where chemotherapy and hormone treatments have been used in a non-standard fashion.

Dr. Charles Walker is Assistant Professor of Urology at Yale School of Medicine. If you have questions or comments we invite you to visit yalecancercenter.org where you can also get the podcast and find written transcripts of past programs. You are listening to the WNPR Connecticut's Public Media Source for News and Ideas.