Will America Have Affordable Healthcare? A Physician’s Perspective

by Virgil Simons

The Patient Protection and Affordable Care Act of 2010 was designed to ensure that all Americans will have access to quality, affordable health care and was further intended to make necessary structural and procedural transformations of the health care system necessary to contain costs. There has been much discussion and controversy arising from the nine components of reform in many cases without knowing the key elements of the legislation. A Summary of the Act can be found by clicking here.

Much of the contentious debate centered on the individual mandate that said everyone had to buy health insurance or face paying a tax penalty. Basically, according to Bloomberg Businessweek, the Affordable Care Act tells people to buy coverage on the private market and taxes them if they don’t. Despite the onerous idea of additional taxes, the Supreme Court upheld the legislation and the Act is moving forward to its full implementation in 2014, barring any changes that may arise from the results of the 2012 Presidential election. A discussion of the economic impact from the Supreme Court’s decision can be viewed here.

Thus far there is logic to the issue: 94% of Americans will be covered for health insurance; the individual mandate insures the minimization of “free riders” or having the majority of society paying the costs for those who don’t buy insurance; eliminating denial of coverage for pre-existing conditions; allowing children to be covered under their parent’s policies; providing coverage for preventive care; creating a tax credit which will allow lower income families to purchase health insurance; creating incentives for employers to provide health insurance to their employees; and capping out-of-pocket costs for families.

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Getting the Care We Need

by Virgil Simons

Starting in 2014 we will see the full implementation of the Affordable Care Act of 2010, barring any changes resulting from legislative initiatives after the November elections. One of the key components of the Act, and a major point of controversy, is the mandate that every American will have to be covered under a health insurance plan or pay a penalty. That element was confirmed in the Supreme Court’s decision in June.

Looking at models from other countries with universal healthcare plans, the mandate to have insurance ensures that individuals will no longer be shortsighted in their personal health responsibility. The legislation protects people from the risks and results of being uninsured, but it also protects the rest of us from having to pay for the care of those who have been heretofore, “free riders”, having their healthcare paid for by taxes on the balance of the community.

This concept of an insurance mandate should not be foreign to us; states mandate that you must have liability insurance if you own an automobile, mortgage underwriters require you have flood insurance if you live in a flood plain, Social Security and unemployment insurance are mandates that get deducted from our paychecks, etc. So, why not a mandate for health insurance? Theoretically, if everyone participates then the costs should go down. That may be an illusory goal as detailed by Dr. Peter Albertsen in our feature story.

Already we’ve seen some key provisions that point toward better care for more of our citizens:

• Elimination of pre-existing conditions in obtaining insurance
• Coverage of children to the age of 26 on parents’ policies
• Expansion of cost-free preventive services in healthcare policies and Medicare
• Drug discount for brand-name drugs in the Medicare “donut hole”
• Increase in the number of Accountable Care Organizations

But the one that is still a question mark, but with the potential for major consumer benefit is the Health Insurance Exchanges option. This program is intended to help individuals without employer insurance and small businesses compare health plans, and their costs, on a “level playing field.” All plans will include the same basic package of core benefits, but that’s where the concurrence ends.

The plans will have four different levels of “Actuarial Value”, or the percent of healthcare costs that will be paid by each plan. However, as the authors of a recent Commonwealth Fund study (see below) have found, “average out-of-pocket expense declines as actuarial values rise, but two plans with similar actuarial values can produce very different outcomes for a given person. The overall affordability of a plan also will be influenced by age rating, income-related premium subsidies, and out-of-pocket subsidies. Actuarial value is a useful starting point for selecting a plan, but it does not pinpoint which plan will produce the best overall value for a particular person.”
The War Against Cancer has been on-going for almost 40 years since President Nixon's declaration. We've yet to see its demise, but the past few years have seen dramatic wins against prostate cancer. Research has brought us drugs that provide additional months of survival, slow the spread of the disease by years in many cases, and improvements in the quality of life for those with metastatic prostate cancer. In the forefront of these positives has been the gains made through research. One of the leaders in this research is our featured guest, William Nelson M.D., Ph.D., professor of oncology and director of the Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins. We are speaking with Dr. Nelson today regarding his involvement with another research-driven initiative, Stand Up To Cancer or as its known in the community of patients and professionals, SU2C.

Virgil Simons: Dr. Nelson, what is SU2C?

William Nelson: Stand Up To Cancer is an organization launched by leaders of the entertainment and news industry to increase awareness and raise funds for cancer research and treatment innovation. We see it as a groundbreaking initiative created to accelerate innovative cancer research that will get new therapies to patients quickly and save lives now.

VS: Research as a concept has been talked about for decades and, while patients see this as an important issue, what makes the SU2C initiative different?

WN: There are three key elements that provide uniqueness to the program:

1. The funding model requires the breakdown of traditional barriers/impediments to collaborative research, promoting the development of “Dream Teams” composed of the best people regardless of where they reside, be it medical center, university, department or country.

2. The financial support, which has been multi-millions of dollars over three years. The idea is that the funding be adequate to accomplish something bold and that the Dream Teams be held to aggressive timelines for delivering new treatments/diagnostics to the clinical setting.

3. Active management of Dream Teams by the SU2C Scientific Advisory Committee. The Committee meets with the teams every six months and, depending on the progress made and opportunities arising, can redirect research activities.

VS: We hear about many new drugs recently approved, or in final development, for advanced stage prostate cancer treatment; how can SU2C help make this process more rapidly achievable?

WN: The new Dream Team focused on prostate cancer, jointly supported by SU2C and the Prostate Cancer Foundation, is specifically oriented to understanding prostate cancer that has progressed despite conventional hormone therapy, chemotherapy, abiraterone acetate, and enzalutamide (if it receives FDA approval); i.e., each of the Teams will focus on understanding how/why prostate cancer progresses to threaten life despite current treatments and how the disease can be better stopped.

We now have the best people working synergistically under a shorter timeline to bring meaningful translational research to patients within 3 years. For the first time in history, we can envision the possibility of stopping cancer in its tracks. Now more than ever, as government funding for cancer research is disappearing from the national agenda, every single one of us affected by cancer must stand up and be heard.

VS: On September 7th the Stand Up To Cancer “roadblock” fundraising special will be televised; what is it and why is it important?

WN: The SU2C television program captures the energy and popularity of leading entertainment figures at their most socially responsible- sharing their commitment and passion for solving the cancer problem for everyone.

VS: What can we do from the patient community to support SU2C?

WN: The patient and patient advocacy communities have led the way in disseminating valuable disease education, therapeutic information, supporting research trial participation, and energizing the population at large. . . . hopefully, the SU2C program will provide an opportunity to help them in galvanizing excitement for their efforts.

For more information on Dr. Nelson, see:
http://www.hopkinsmedicine.org/kimmel_cancer_center/our_center/leadership.html

For more information on Stand Up To Cancer, visit the website at:
http://www.standup2cancer.org/

For details on the nationally broadcast television show on September 7, 2012, see:
http://www.standup2cancer.org/the_show
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parents’ policies until the age of 26, etc. What could be wrong?

In short, the answer to that question poses another, Can we afford it? Our
guest commentator on this issue, Dr. Peter Albertsen, Chief and Program
Director of the University of Connecticut Health Center, provided a very cogent
insight into the problems we face in a recent article in European Urology
(Volume 62, Issue 3, Pages 365-367, September 2012). While addressing
the viability of robot-assisted radical prostatectomies, Dr. Albertsen talked about
the new equation for health care in America: cost versus value received.

Virgil Simons: In your article you indicated that the for prostate cancer care in
the U.S. is approximately $11.9 billion and, because we have an aging
population that will soon have access to more healthcare, that figure will
dramatically increase. What’s really driving healthcare costs today?

Peter Albertsen: Health care costs are rising due to multiple factors.

Americans are living longer and therefore there are more patients to treat. As
the baby boomers age there are more elderly patients. The elderly usually
consume more health care resources than the young. With each passing year
we have more diagnostic tools to offer. There has been an explosion in imaging
tools including CT scans, MRI scans, PET scans and other nuclear medicine
studies. Individually, each of these modalities has a great deal to offer, but if
not used wisely they can add enormous new costs to the health care system.

New genetic markers that offer the potential to screen for disease and direct
cancer therapy have recently appeared. New devices in orthopedics and general
surgery can relieve pain and suffering, but do not come free. All add to the
total cost of health care. Unfortunately, health care delivery is still very
inefficient and labor intensive. As a consequence our delivery systems become
increasingly expensive to operate. Americans spend about twice as much per
capita for health care when compared to other Western Countries. Much of this
can be attributed to the lack of incentives to use health care resources
efficiently. By eliminating services that provide little or no value we could
dramatically lower health care expenditures.

VS: You detailed the global impact of prostate cancer in countries around
the world, how are other countries managing the problem given that they
spend approximately the same 5-6% of their budgets on cancer care, as
we do?

PA: Most other western democracies offer single payer health care systems
that cover all citizens. As a consequence they have been able to organize
health care delivery much more efficiently. Health care budgets are established
and health care workers within the system derive methods of maximizing value
for the health care dollar spent. In Canada, for example, each province controls
health care costs within the province. The province develops the operating and
capital budgets for the year. This in turn controls the number of hospitals and
expensive diagnostic and treatment tools that are available to the public. The
provinces have an incentive to invest only in health services that provide the
greatest public health gain. While the waiting lines may be a bit longer in
Canada, most Canadians are happy with their health care system and receive
care promptly for care that is needed urgently. In the United Kingdom, the

government, however, also works closely with the NHS to fund
clinical research to determine what
health care services work best in
which situations.

VS: In your editorial you refer to “…distorted health care
market forces often encourage
the use of therapies with
marginal benefit.” Can you give
us some examples?

PA: The United States health care
system is unique in that virtually
any and all health care therapies
are reimbursed provided that they
are proven safe and in the case of
drugs, efficacious. As a

consequence the health care industry has been extraordinarily creative in
developing new devices and drugs that can improve health and longevity. This
is a good thing, however, the business model is predicated on the assumption
that society will continue to pay virtually any price to deliver a service that has
been proven effective, no matter how marginal, to any patient. Many cancer
therapies now cost over $100,000 to extend life for just a few months. Often
the doctors, hospitals and corporations promoting these therapies receive
significant financial gain by delivering them. This may be fine if we had
sufficient funds, but the growing number of uninsured who are unable to access
basic health care services that have been proven to be very effective is a major
political issue. Who should be responsible for these costs? Could you imagine
what would happen if we all paid the same premium for home owner’s
insurance and anyone who suffered damage from a storm or a fire could obtain
temporary housing in any hotel, condominium or rental unit of their choosing?
I suspect the demand for the luxury units would quickly outstrip the insurer’s
ability to pay, which would then lead to continually rising premiums.

VS: You say that the Institute of Medicine in the U.S. has made the
“appropriate treatment of prostate cancer” a priority in determining value
through comparative effectiveness research. How do we get to a point of
establishing comparative analyses when we don’t yet have standardized
guidelines for the management of prostate cancer: surgery vs. radiation;
when to chemotherapy vs. hormonal maintenance; timing for use of
emerging drug agents, etc.?

PA: It is actually the other way around. Standardized guidelines can only be
developed after competing medical therapies have been analyzed and
compared. We cannot make standardized recommendations concerning which
patients should receive surgery or radiation for prostate cancer until we have
done the basic medical research to determine which works better in which

situations. Medicare and the large insurance companies have been either
prohibited from or have been unwilling to fund this type of research. Those

companies that provide health specific treatments now are reluctant to fund

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Continuous Androgen Deprivation Therapy vs. Intermittent: Does It Matter?

Androgen deprivation therapy has been the prevailing standard of care for men who have failed primary treatment (surgery, radiation) for prostate cancer and the disease has recurred. That accepted protocol involved continued administration (CAD) of hormonal or antianandrogenic agents over a period of time usually greater than 6 months.

However, utilization of this therapy often has side-effects impacting quality of life, such as, loss of libido, reduction in muscle mass, enlarged breasts, hot flashes, etc., as well as clinically significant side-effects of increased risk for diabetes and skeletal adverse events. Because of these factors many clinicians recommended a protocol of intermittent androgen deprivation (IAD) in the belief that the disease could still be impeded while improving the patient’s quality of life.

However, a presentation at this years Annual Meeting of the American Society of Clinical Oncology (ASCO) by Dr. Maha Hussain, reporting on the preliminary results of the SWOG (Southwestern Oncology Group) 9346 clinical trail, brought into question whether intermittent androgen deprivation therapy was a viable protocol for the management of advanced stage prostate cancer. Dr. Hussain reported the findings of this 17-year study involving more than 1,500 patients:

- At a median follow-up of 9.2 years, median overall survival (OS) was 5.8 years for men in the continuous arm vs. 5.1 for those on intermittent therapy
- For men with minimal spread of prostate cancer (PCa), continuous therapy showed median survival of 7.1 years vs., 5.2 for those in the intermittent arm.

Again, as with much of the information produced, patients are left to wonder, “What do I do?” To help answer this question we are speaking in this issue with William Oh, MD, Chief of the Division of Hematology and Medical Oncology; Professor of Medicine and Urology; and Ezra M. Greenspan, MD Professor in Clinical Cancer Therapeutics at the Mount Sinai School of Medicine and Associate Director for Clinical Research, The Tisch Cancer Institute. Dr. Oh participated with Dr. Hussain in a special post-plenary “sidebar” discussion on the SWOG 9346 findings wherein Meeting attendees could voice their concerns on the recommended practice change.

Virgil Simons: Dr. Oh, at the session you were quoted as saying: “These results are difficult to interpret. We want the best for our patients. But there is a risk of looking for information in a subset analysis. That guidance would be wrong.” If you as an experienced clinician and cancer researcher have difficulty in finding the actionable essence from this study, how is the average patient supposed to make an informed choice?

William Oh: It’s true that the results of this important study are controversial and can be interpreted in more than one way. In the end, however, I believe that the right conclusion of this study is that IAD is inferior to CAD in terms of survival. While the effect was not dramatic, it is my basis for stating that the standard of care remains CAD for men with metastatic prostate cancer. That doesn’t mean that all patients with metastatic prostate cancer should always get CAD, though, but it is where the discussion should start, in my opinion.

VS: There were comments from the audience, and subsequent publications, questioning the finding that IAD was inferior to CAD. One of the Aims of the study was to determine if IAD is non-inferior. Again, as a patient, I’m caught up in medical semantics; is “not non-inferior” equivalent to “inferior”; and what does it mean clinically?

WO: I spent a lot of time trying to understand this distinction, and spoke with many biostatisticians. When the study was designed many years ago, there was an agreement of what would be considered a non-inferior result between IAD and CAD. However, this study did not show that IAD was non-inferior. But I struggled with explaining to doctors and patients what exactly “not non-inferior” meant. The chance of dying was 9% higher in the group receiving IAD, but the range of possibilities included a chance that the 2 approaches are equivalent but also a chance that IAD could be up to 24% worse. From a common-sense perspective, I believe that the study demonstrated that IAD was inferior to CAD, and that is how I chose to convey this complicated statistical message.

VS: The researchers found, in additional analyses, that men with “minimal disease” (disease that had not spread beyond the lymph nodes or the bones of the spine or pelvis) did significantly better on continuous therapy, while men with “extensive disease” (disease that had spread beyond the spine pelvis, and lymph nodes or to the lungs or liver) seemed to do about as well using either treatment approach. Again, the data showed that men on continuous therapy had a median overall survival time of 5.8 years, with 29% of these men surviving at least 10 years. Those on intermittent therapy had a median overall survival time of 5.1 years, with 23 percent surviving at least 10 years. What can these differences be attributed to, and what should be the “trigger” to choose one protocol vs. the other?

WO: I do not agree with the designation of minimal and extensive disease being relevant categories to decide who should or should not get IAD. In fact, it does not make much biological sense that patients with minimal disease would do so much worse with IAD. Also, the definitions of disease extent were unusual—a single rib or skull metastasis put you into an extensive disease category. It was also a “post-hoc” analysis, meaning it was not preplanned. If you look at enough variables, occasionally some will be positive.

VS: Dr. Lawrence Einhorn at the sidebar session said that this study’s findings were a “scare tactic” and that “minimal-risk disease is an artificial designation”. How would you respond?

WO: He was referring to the fact that there was a nearly 2 year difference in survival in the minimal disease groups as defined in the trial, and that this would be considered significant by most people. As I noted above, I agreed that the division into minimal and extensive disease was artificial, and should not be used by clinicians or patients as a reason to consider IAD or CAD.

VS: At the same ASCO meeting, a separate poster discussion suggested that IAD provided better quality of life endpoints — impotence, libido,
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research that may prove that their product is inferior or doesn’t work at all. It is no surprise that the United Kingdom rather than the US has invested heavily in a clinical trial to determine what works better: surgery, radiation or watchful waiting with delayed hormonal therapy for men with newly diagnosed prostate cancer. This study is called the PROTECT trial and should provide answers to these questions by 2015. Most companies invest at least 5% of their revenues in research and development; some invest considerably more. In health care, other than for new pharmaceuticals, there is minimal incentive to prove what really works and what does not.

VS: We’ve seen the rapid introduction of new protocols, e.g. proton beam radiation, robot-assisted surgery, as well as new drug/chemical agents such as, abiraterone, sipuleucel-T, etc. all of which come with staggering costs, much of which is now covered by Medicare. The value of all of this innovation comes down to your “big question”: how much of their cost will be borne by society and how much will be paid for by the individuals demanding these services? Do you see the Affordable Care Act leading us to a value based system or a perpetuation of what we now have?

PA: Health care reform will happen whether the Affordable Care Act remains in place or is repealed. We simply can no longer afford the path we are on. If we do not make the investments to determine what works and what does not, the government will have only one option: limit the budget devoted to healthcare services. Whether copays will be dramatically increased or access to some services curtailed will depend upon which party gains dominance after the election this fall. The Affordable Care Act does have some resources devoted to conducting patient outcomes research. Whether this section will survive political attack remains to be seen. These same concepts drove the development of the Agency for Health Care Policy and Research over a decade ago. Unfortunately, some segments of the health care industry were unhappy with research reports that determined that procedures in their area offered minimal value. The Agency was subsequently restructured and the budget reduced.

VS: Thank you, Dr. Albertsen, for sharing your insights.

Additional sources of information for our viewers:
http://dpc.senate.gov/healthreformbill/healthbill04.pdf
http://www.healthcare.gov/law/timeline/full.html
http://www.businessweek.com/articles/2012-07-05/the-case-for-way-more-mandates

Women at Risk: The Necessity for Healthcare Reform

The Commonwealth Fund recently published a study that showed the higher cost for healthcare in the U.S. was preventing women from seeking medical services compared to women in 10 other industrialized countries. The study estimated that 18.7 million U.S. women ages 19 to 64 were uninsured in 2010, up from 12.8 million in 2000. An additional 16.7 million women had health insurance but had such high out-of-pocket costs relative to their income that they were effectively underinsured in 2010. The graph shown here highlights the implications of poor coverage for women in the United States by comparing their experiences to those of women in the other nations, all of which have universal health insurance systems. The key finding of this study is “…that women in the United States—both with and without health insurance—are more likely to go without needed health care because of cost and have greater difficulty paying their medical bills than women in the 10 other countries.” Though dismal in its facts, the study does offer hopeful potential through current healthcare reform. They posit that, “In 2014, the Affordable Care Act will substantially reduce health care cost exposure for all U.S. women by significantly expanding and improving health insurance coverage.” A graphic that can be found here shows the current (2009-2010) percent of women, aged 19 — 64, that are uninsured by state versus the percentage that would be covered under a Fully Implemented Affordable Care Act. For example, here in our home State of New Jersey, 17.6% of women lack coverage; under the Affordable Care Act that number drops to 6.7%.

While this study focused solely on women, it would be safe to assume similar numbers for men as well with a concomitant benefit under the Affordable Care Act. We must engage our legislators to provide the care that we need.


Here - http://www.commonwealthfund.org/usr_doc/site_docs/slideshows/WomenAtRisk/WomenAtRisk.html
Continuous Androgen Deprivation Therapy… continued from page 5

energy/vitality, physical function, and emotional function — for patients than CAD. With these findings from SWOG 9346, are we asking patients to choose between survival (OS) and living (QOL)?

WO: If you look closely at the information presented in that poster, the differences in quality of life were modest. For instance, at 3 months, impotence rates were reduced by 9% for IAD while there was a 2% increase in impotence in CAD. There was a 7% increase in libido for IAD compared to a 1% increase in CAD. I made the point in my discussion that in fact, most of the time spent in the IAD arm (61%) was spent on hormones, and that recovery of testosterone often takes 4 or more months.

That said, I know patients feel better off of hormone therapy. I have used a lot of IAD in my patients over the years, primarily in men who have a rising PSA alone and no visible metastases, but also in some men with metastases who could no longer tolerate the hormones and wanted a break. At that time, though, no randomized trials were available regarding the survival difference. Now that SWOG 9346 is available, patients and their physicians can decide whether the side effects that they are having are bad enough that they would like to take a break, knowing that the IAD could be inferior in terms of survival.

VS: Several commentators have said that they would be reluctant now to offer intermittent therapy to patients who are doing well on CAD. Is this a case where physicians don’t want to make a change notwithstanding “evidence-based medicine guidelines”?

WO: I agree with the idea that men with metastatic prostate cancer, who are doing well on CAD, with disease controlled and tolerable side effects, should continue on CAD. The evidence supports this. The more difficult situation is men who have been doing well on IAD over the years but now have this data in front of them. Should they stop the IAD process? This is more difficult to say, but my practice now is to make sure that the patient understands that IAD could be worse in terms of long-term disease control, but still make a decision together based on their personal history.

VS: At the end of the day, Dr. Oh, what information, guidelines, biometric indicators, etc. can we give a patient to be able to have the appropriate dialogue with his doctor to make an informed decision?

WO: For patients with newly diagnosed metastatic prostate cancer, I recommend CAD as the standard of care, but I clearly point out to them that we will reassess both their disease response and side effects along the way. I do not rule out the possibility that we could switch to IAD, but I tell them that IAD is not my preferred approach, since it appears to be worse in terms of survival. I tell them that the difference in the trial was modest (9%) but enough that I believe the standard of care is CAD. For patients with rising PSA who go on hormone therapy, I usually use IAD as my preferred standard of care, given the results of the PR7 study, which showed that CAD and IAD are equivalent in non-metastatic rising PSA patients.

VS: Thank you, Dr. Oh, for your cooperation and assistance in understanding this important issue.

WO: Thank you for the opportunity, Virgil. I know it’s a difficult choice, and I encourage consultations to discuss the issues in more detail.

Additional sources of information:
http://www.asco.org/ASCOv2/Meetings/Abstracts?vmview=abst_detail_view&confID=114&abstractID=101068
http://www.asco.org/ASCOv2/Meetings/Abstracts?vmview=abst_detail_view&confID=104&abstractID=72503

CancerCare’s Connect Workshops

Diane Johnson

August, 2012

CancerCare offers free educational workshops by leading experts for those who are fighting cancer, their families, caregivers and friends. One-hour telephone workshops on a wide range of topics are presented on a regular basis, each followed by a question and answer session. Some of the recent workshops include, ‘Caring for Your Bones When You Have Prostate Cancer’, ‘Stress Management for Caregivers’, and ‘Communicating with Your Doctor.’

Workshops can be accessed from all over the world and are free of charge. Pre-registration is required. One week before each workshop, an email will be sent to you with detailed information and instructions, including a toll-free number to call and a link for online access. You can find a complete schedule of upcoming workshops and events and over 50 archived workshops at www.cancercare.org.

UPCOMING WORKSHOPS OF INTEREST:

September 28, 2012, 1:30 to 2:30 pm (EST)—‘Advances in the Treatment of Prostate Cancer (Living with Prostate Cancer, Part 1)

October 12, 2012, 1:30 to 2:30 pm (EST)—‘Dealing with the Side Effects of Prostate Cancer Treatments’ (Living with Prostate Cancer, Part 2)

Register at www.cancercare.org/connect or by calling 1-800-813-HOPE (4673).
To Infinity, and Beyond: The Story of “Team Chema”

By Virgil Simons

We speak casually of how the Internet has made the world smaller, but this story has made it even more so for me. I recently received one of those posts on LinkedIn suggesting a possible connection. In this case it was a woman who taught at my old grammar school back in Chicago! Definitely it was worth an email to reach out to her.

Maria Teresa Buendia-Fahy is a microbiologist born and raised in Colombia, lived in France and Switzerland, and settled in Illinois just two years ago, but, as she says, “I feel at home here.” Her story is particularly relevant to us because she lost her father almost a year ago to kidney cancer, after he fought prostate cancer 3 years previously, and an uncle, also a victim, of prostate cancer. Because of her scientific background, Maria Teresa became the family’s information gatherer and researcher as they tried to learn all they could about the disease.

Maria Teresa’s father, José María Buendia, nicknamed “Chema”, died after valiant efforts of his doctors and family, but left a legacy in “Team Chema” — Maria Teresa, her husband, children, mother, sisters and other family members — to become involved as “a way of contributing and fighting for my Dad, even though I couldn’t be with him.” Maria Teresa has been very active with the Kidney Cancer Association in fundraising as well as being an advocate for education about the disease, particularly in the Latino/Hispanic communities.

The source of her passion and commitment started from her father’s illness: “When he was diagnosed, it was the worst moment of my life. You never think it’s going to happen to you or someone you love. After an experience like this, you truly live with a hole in your soul. But I’m so grateful for my father. Team Chema is our way to keep him alive. I’m very happy to be able to help more people through my job; it is not easy, it hurts but I do not want it any other way. I need to find ways to use my life and my environment to educate about kidney cancer. My Dad and my children always told each other, ‘I love you infinite and beyond’; from the Toy Story movies, so the infinity symbol is in our Team Chema logo. In April of this year, I participated in a poster session at the American Association for Cancer Research” advocate session and it’s message summed up my life’s work now in carrying on with Team Chema, “Advocacy is a mission for life inspired in the infinite power of love.”

Note: excerpts of Maria Teresa’s story were taken from: https://secure.kidneycancer.org/neon/resource/kca/files/WHKCSurvivors.pdf

The Distress of Cancer Care

By Virgil Simons

Cancer of all kinds has been a prevalent element in the utilization of healthcare resources and is expected to be a continuing one. The Institute of Medicine projects that the prevalence of cancer will double in the next 15 years, which will place even greater strain on a system currently being tested. We have hopes in the emerging matrix of drug therapies and treatment protocols, but these all come with a price that will limit their broad scale utilization, further taxing the insurance and government reimbursement structures, and further increase the suffering of those impacted by a diagnosis of cancer.

However, in looking at how the disease is managed, the psychosocial aspects of a patient’s life and medical condition are often overlooked. The basic Vital Signs that are assessed are: temperature, blood pressure, pulse rate, and respiratory rate. Quality of life situations need also to be incorporated into this assessment and this is why the International Psycho-Oncology Society has incorporated two additional vital signs into their International Standard of Quality Cancer Care. This step was taken based on the United States Institute of Medicine’s report that there was strong evidence for the efficacy of psychosocial intervention in cancer care. The National Institute of Health and Clinical Excellence in the UK and the Canadian Strategy for Cancer Control concurred with the IO M and stressed that the two new vital signs be added to the protocol of vital sign acquisition. Those two new indicators are: Pain and Distress.

Prevalence rates of distress in cancer patient populations have been well documented, as has the incidence of pain in advanced stage disease patients. The negative impact of these conditions on patients, their families and their community should be of primary concern for clinicians, disease investigators, health service professionals and patient support organizations. The International Psycho-Oncology Society believes that focusing on these two new vital signs, particularly distress is essential to supporting the well being of the patient.

Further information can be found at:
http://www.ipos-society.org/
http://jco.ascopubs.org/content/23/26/6440.long

Maria Teresa and “Chema”
Global Perspectives On Prostate Cancer Therapies

A recent article in *European Urology* (1) reported that prostate cancer is now the most frequently diagnosed cancer in men in Europe, North and South America, and Australia and the leading cause of cancer death in Sweden, the second-leading cause of cancer death in the United States, and the third-leading cause of cancer deaths in Europe.

Given this global phenomenon, it is important that we seek to gain information from as broad a spectrum of sources as possible. The following are selected articles, presentations, etc. that can help inform the desired standards of care:

**ESMO (European Society of Medical Oncology) 2011 – September 23 –27; Stockholm, Sweden**

Interview with Karim Fizazi, MD, PhD about the Overall Survival Benefit of Radium-223 Chloride in the treatment of patients with symptomatic bone metastases in castration-resistant prostate cancer - a Phase III randomized trial (ALSYMPCA).

http://www.youtube.com/watch?feature=player_embedded&v=LZ_LS5vdbP4

**ECCO (European CanCer Organization) – September 24 – 26; Stockholm**

The Patient Advocacy/Ethics Track at the 2011 European Multidisciplinary Cancer Congress in Stockholm.


Advocacy in Action: A guide for patients with advanced cancer:

http://www.youtube.com/watch?v=s2coBAGGdho&list=PL0E6FF073E3300B82&index=7&feature=plpp_video

Advocacy in Action: The educated patient and the Internet:

http://www.youtube.com/watch?v=fnEoWwXpVeQ&list=PL0E6FF073E3300B82&index=6&feature=plpp_video

**EMUC (European Multidisciplinary Meeting on Urological Cancers) 2011 – November 4–6; Barcelona, Spain**

State-of-the-art lecture: Differences in time to disease progression cannot be used as surrogate endpoint for survival in patients under immediate or deferred androgen deprivation. Final results from EORTC trial 30891:


State-of-the-art lecture: Radiotherapy trials in prostate cancer - interpretation and challenges:


November 5th Prostate Cancer Plenary sessions; videos available on:

- Screening — Pro and Con
- Pathology of prostate cancer - What is new?
- Debate: Focal treatment instead of active surveillance


Prostate Cancer Plenary Sessions continue; videos available on:

- The role of brachytherapy in low, intermediate and high risk prostate cancer
- When is lymphadenectomy needed?
- Robot, laparoscopic and open surgery - what do studies show?


Prostate Cancer Plenary Sessions continue; videos available on:

- Why robotic RPE will stay
- Debate: Best treatment of high risk prostate cancer?
- Radiotherapy and hormonal treatment
- Radical prostatectomy with/without adjuvant radiotherapy


November 6th: Updates on Medical Treatment; videos available on:

- New hormonal treatment opportunities in prostate cancer
- Update on bisphosphonates and RANKL inhibitors

http://emucbarcelona2011.org/?id=28&ListMode=&SDAY=2011-11-06&SS=3388&f_SS=s&f_PS=s&f_PL=s&f_Os=s&f_SES=s

Update on Imaging of Urological Tumours; videos available on:

- CT/MRI
- PET scan
- Sonography

http://emucbarcelona2011.org/?id=28&ListMode=&SDAY=2011-11-06&SS=3389&f_SS=s&f_PS=s&f_PL=s&f_Os=s&f_SES=s

Take Home messages on Medical Oncology, Radiotherapy and Urology:

http://emucbarcelona2011.org/?id=28&ListMode=&SDAY=2011-11-06&SS=3390&f_SS=s&f_PS=s&f_PL=s&f_Os=s&f_SES=s

**EAU (European Association of Urology) 2012 – February 24-28; Paris France**

Plenary Session: Personalised Treatment for Low and Intermediate Risk Prostate Cancer

Global Perspectives on Prostate Cancer  continued from page 9

EAU Paris 2012 Congress Report from the Pharma Strategy Blog:
http://www.youtube.com/watch?v=2cfkytKxaTc

Medical Journals
Intensity-Modulated Radiation Therapy, Proton Therapy or Conformal Radiation Therapy and Morbidity and Disease Control in Localized Prostate Cancer.
Pathologic Prostate Cancer Characteristics in Patients Eligible for Active Surveillance: A Head-to-Head Comparison of Contemporary Protocols.
Robot-assisted Radical Prostatectomy — Fake Innovation or the Real Deal?

References:

Patient Power and The Prostate Net® Announce Partnership

In an effort to address the problems impacting patients, their families and caregivers, as well as the physicians who manage their health, Patient Power and The Prostate Net have announced their partnership in a global initiative of patient information and education.

Patient Power is a one-of-a-kind resource bringing in-depth information to patients with cancer and chronic illness. Audio and video interviews, with transcripts, help patients make informed decisions in partnership with their medical team. Founded by patient-advocate, medical journalist, author (of the acclaimed book “The Web-Savvy Patient”) and cancer survivor Andrew Schorr, Patient Power goes far beyond basic health information. Patient-centric programs focus on delivering the most credible, authoritative and up-to-date health information. More than 3,000 on-demand programs feature leading medical experts, inspiring patients, unforgettable stories and actionable medical guidance on serious health concerns. Connect with Patient Power on Facebook, YouTube, Twitter and Vimeo, and view the entire library of audio and video interviews at http://www.PatientPower.info.

The Prostate Net® is a non-profit patient education and advocacy organization founded 16 years ago by Virgil Simons, a 17-year survivor of prostate cancer, who has built an international organization using a matrix of informational techniques, disease intervention programs and key public/private stakeholder partnerships to address issues of risk awareness, disease treatment decision-making and advanced stage management of prostate cancer.

The core objective of The Prostate Net is to:
1. Educate consumers most at-risk from prostate cancer
2. Inform the community on other diseases of negative impact
3. Motivate consumers to make informed choices as to healthcare

Dr. Eddie Reed Named Clinical Director For National Institute On Minority Health and Health Disparities

Dr. Eddie Reed, who developed the cancer-fighting drug Taxol, is leaving his post as an oncologist and scientific researcher in Mobile for a job with a newly formed National Institutes of Health agency in Maryland, his colleagues said this week.

Reed, who has worked at the University of South Alabama Mitchell Cancer Institute for four years, was recently named clinical director of the National Institute on Minority Health and Health Disparities, an agency created through President Obama’s Affordable Care Act.

“In this pivotal role, Dr. Reed will be strategically placed to have major impact on federal programs that will shape our national healthcare systems for the foreseeable future,” said Dr. Mike Boyd, who leads the USA Mitchell Cancer Institute.

“It is particularly comforting to know that a person of Eddie’s piercing intellect, impeccable character and quiet wisdom will be so critically positioned” as the implementation of the act continues, Boyd said.

The mission of the newly created national institute, located in Bethesda, Md., is to lead scientific research to improve minority health and eliminate health disparities, officials said.

Reed will remain on the MCI staff as an adjunct distinguished professor, likely returning for guest lectures and offering second opinions on complex medical cases, MCI officials said.

4. Provide on-going health care interaction between patients and professionals
5. Create an interactive network to maximize actionable healthcare messages

Interaction with The Prostate Net can be had through Facebook, YouTube, LinkedIn, Twitter, as well as through their websites in English - http://theprostatenet.org/ - and Spanish - http://www.theprostatenet.org/espanol/

Both organizations have expanded their service matrices globally and both have offices in Barcelona, Spain to better serve the international community. For further information, contact Andrew Schorr - andrew@patientpower.info - or Virgil Simons – virgil@prostatenet.org.
Symposium Registration Information

Please complete this form, save it and email it as an attachment to support@prostatenet.org or complete it, print and mail to:
Prostate Net, P. O. Box 10188-#77550, Newark, NJ 07101-3188

Name (Please list name as you wish it to appear)
________________________________________________________________________________________

Address  ________________________________________________________________________________

City, State and Zip  ____________________________________________________________________

Contact Telephone # (Required)  ____________________________________________________________________

Contact Email (Required)  ____________________________________________________________________

Category (Please circle all that are applicable):
PATIENT / SURVIVOR / SPOUSE / PARTNER / CAREGIVER / PATIENT ADVOCATE
UROLOGIST / MEDICAL ONCOLOGIST / RADIATION ONCOLOGIST
NURSE PRACTITIONER / NURSE / HEALTH SERVICE PROFESSIONAL / STUDENT / FACULTY

Registration for the Symposium is Free! Please indicate the location for which you are registering
(NOTE – a separate registration form is required for each person attending):

September 8 – PROSTATE CANCER SYMPOSIUM –
Chicago, IL; Northwestern University Lurie Cancer Center  

September 22 – PROSTATE CANCER SYMPOSIUM –
Detroit, MI; Karmanos Cancer Center  

October 27 – PROSTATE CANCER SYMPOSIUM –
New York, NY; The Prostate Net - NYU Kimmel Center  

November 3 – PROSTATE CANCER SYMPOSIUM –
Nassau, Bahamas; The Superclub Breezes Resort  

November 10 – PROSTATE CANCER SYMPOSIUM –
Jacksonville, FL; Mayo Clinic  

November TBD – PROSTATE CANCER SYMPOSIUM –
Philadelphia, PA; Kimmel Cancer Center at Jefferson  

Please return completed forms to:
The Prostate Net
Email: support@prostatenet.org  Fax: 270-294-1565
For more information: 1-888-477-6763
3rd Annual
Prostate Cancer Symposium
An Educational Initiative for Patients/Spouses, Advocates and Healthcare Professionals

Hot Topics in Prostate Cancer:
- PSA controversy
- Sexual dysfunction after therapy
- Active Surveillance
- Racial disparities and prostate cancer

Date: Saturday, Sept 8, 2012
Time: 8:00 am - 2:00 pm
Location: Robert J. Lura Medical Research Center
Haywood Auditorium, 321 S Superior St, Chicago

FREE registration for all attendees
FREE Breakfast and Lunch
Discounted parking is available at Northwestern Memorial Hospital Parking Garage.

P. O. Box 10188-27550
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Tel: 1.888.477.6763
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Call us: 1.888.477.6763, or email us at: support@prostatenet.org
Mailing/Delivery address:
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The Prostate Net and The Robert H. Lura Cancer Center in conjunction with the Prostate SPARC, a collaboration of Northwestern University, University of Chicago, and NorthShore University Healthsystem present:

An Educational Initiative for Patients/Spouses, Advocates and Healthcare Professionals

2nd Annual Prostate Cancer SYMPOSIUM

Hot Topics in Prostate Cancer:
- What’s New in Radiation Oncology?
- Treatment Strategies for Patients with Contraindication Prostate Cancer
- Understanding and Responding to the Legal and Psychosocial Needs of Prostate Cancer Patients and Their Families
- Sexual Dysfunction After Therapy

Date: Saturday, Sept 22, 2012
Time: 8:00 am - 1:00 pm
Location: Charles E. Wright Museum of African American History
315 East Warren Avenue
Detroit, Michigan 48201

Registration call (800) KARMANOS or 1-800-557-6346 (www.karmanos.org)

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