The Prostate Net
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In The Know
Confronting Prostate Cancer

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American Association for Cancer Research
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**www.aacr.org**

**April 19**
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**www.canceradvocacy.org**

**April 28 - May 1**
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**www.ons.org**

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**May 21 - 26**
American Urological Association
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1.800.828.8225
**www.fitnessday.com**

# Chemotherapy with Taxotere Improves Survival over Other Chemo Combos

Taxotere (docetaxel), a chemotherapy drug approved by the FDA last year, has been shown to be more effective in improving survival over historical standard chemotherapy combinations. According to results from two clinical trials published in 2004 in the New England Journal of Medicine, and reported at the recent ASCO Prostate Cancer Symposium, chemo combinations based on Taxotere are more effective over standard chemo regimens in patients that are hormone-refractory, or those that have become resistant to traditional hormone therapy.

Dr. Daniel Petrylak (seen here), one of the key Principal Investigators for the Taxotere trials, provided a historical perspective on the treatment of prostate cancer. Hormone therapy is given to reduce levels of male hormones, which are responsible in part for the growth of prostate cancer. Unfortunately, patients ultimately stop responding to hormone therapy after being on treatment, and are then referred to as having hormone-refractory prostate cancer. Once they reach this level, patients have limited effective treatment options, and combinations of agents are used, such as the chemo agency mitoxantrone (Novantrone) and the steroid prednisone.

In the first clinical trial, a direct comparison of Taxotere/prednisone to the historical treatment of mitoxantrone plus prednisone was given to hormone-refractory patients. The NEJM reported that of the 1,006 patients, the average survival for the Taxotere combo was 19 months, compared to 16.5 months with the mitoxantrone-based regimen. In the second trial, Taxotere and the chemo agent estramustine was compared to chemo agent mitoxantrone and prednisone. In the Taxotere group, average survival was 18 months, compared to 15 months for those treated with the other regimen — a 20% decline in mortality and a 27% increase in Progression Free Survival (PFS). Equally important was the decline in PSA rates (50% vs. 27%) for the new treatment standard.

Since these studies were published, there have been other studies by researchers in the U.S. and elsewhere in the world that have shown that Taxotere (docetaxel) is a chemotherapy agent that continues to show promising activity in the treatment of prostate cancer. Taxotere works by inhibiting tubulin, a protein essential to cell division, thereby preventing cancer cells from dividing and growing in number. Taxotere is the only drug approved for breast, lung and prostate cancer, three of the most prevalent cancers. It was approved for combination use in prostate cancer in May of last year. Patients with hormone refractory prostate cancer should speak with their oncologist about the risks and benefits of using Taxotere for treatment of their disease state, as well as participating in one of the on-going trials using Taxotere and other agents in combination therapy. ♂

***Based on New England Journal of Medicine and Urology articles, Aventis Pharmaceuticals news release, and U.S. FDA press release.***

In The Know Confronting Prostate Cancer

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The Prostate Net, Inc.

On-line version can be seen at:
www.theprostatenet.com/newsletter

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# From The Heart

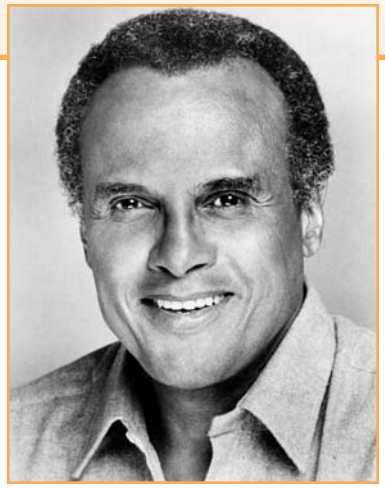
**Virgil Simons**
Publisher

It was a cold, snowy Saturday morning in Harlem. I was there to participate in a rally to bring the community together to heighten awareness of the risks they faced from cancer. Yet as I listened to the words of inspiration and information, swayed to the Gospel rhythms of joy and hope, I couldn't help but notice that the change we wanted the people to make was going to be more difficult than we could imagine. The choirmaster, blessed with a voice to stir the soul, was carrying at least 100 lbs of excess weight; the children in the group carried the curse of many underserved communities — obesity. Yet, the food being served was heavy on the staples of Southern cooking: fried bacon and eggs, biscuits with butter. Though signs of healthy eating — fresh fruit, juices, water — were present, guidance was needed to change the learned habits of a culture. Stepping outside for a moment I saw a few of my fellow participants who came out to get a quick cigarette break and noticed around the corner debris from a demolition site being dumped into containers with the resulting dust/pollutants spreading in the air. I began to resonate with the data that was delivered at the ASCO Prostate Cancer Symposium (see articles in this issue) showing that many of the root causes of cancer were related to environment and lifestyle. No longer is it enough to deliver information and hope that by educating a population, change will occur and health will happen. As an advocate it has become more apparent that fighting cancer and instituting community health is not an intellectual exercise, but really is a matter of changing hearts and minds — providing the motivation and means to adopt and/or adapt styles of living that will result in disease reduction and improved qualities of life. In my almost ten years as a prostate cancer survivor, I've seen major changes in the treatment of the disease — laparoscopic surgery, expansion of the types of radiation therapy and, most recently, drugs that can extend survival for those with advanced stage disease. Yet all of these advances are of little consequence if we don't find ways to better prevent disease or intervene earlier. This means moving away from traditional communication patterns, accepted healthcare delivery systems and distancing ourselves from the base element of curing cancer — the community. One of the leaders of the civil rights movement of the '60's said, "If the problem is in the community, then so is the solution." Truer words were never spoken. ♂

# A Letter From Home

***Publisher's Note: as a child and young man growing up, there were many occasions when I was alone wanting the guidance and support of my family, friends or mentors to help sort through a problem I faced. Oftentimes I got a letter from someone that gave me the counsel needed to move forward. This column will attempt to do the same for those faced with decisions on managing prostate cancer.***

***- VS***



## This month's "letter" is from

# Mr. Harry Belafonte

*Noted entertainer, actor and human rights activist.*

As a prostate cancer survivor of almost 10 years, the news being reported of drug discoveries that can prolong the life of someone with advanced stage disease is almost miraculous. Seeing the options that a newly diagnosed patient has for various radiation and laparoscopic treatments will only help remove some of the psychological barriers to care. Knowing that we can forestall the onset of bone pain and metastasis gives hope that this terrible disease can truly be managed as if it were a chronic condition like high blood pressure or diabetes.

But, despite this good news, I am still troubled to see facts that say prostate cancer is increasing in America; that if you're a black man you're more than 200% likely to die from prostate cancer than if you're a white male; that if you're poor, either white or black, you're more than 350% likely to succumb to the disease than if you're not; that if you're overweight, you are more likely to contract cancer and a whole host of other negative medical conditions. Yet, all this can be addressed: we can discover new drugs or ways to minimize these conditions; lifestyles can be modified for better health; government programs can be better utilized to educate and intervene. Why isn't it happening?

We have a serious lack of communication between our communities: consumer/patient, healthcare provider and pharmaceutical maker. We talk of the problems of racial health disparities and lack of minority participation in clinical trials; we say that we hold screening programs and no one comes; we produce millions of brochures that seemingly no one reads. How can we change the condition? In the words of Robert A. Humphrey, "An undefined problem has an infinite number of solutions."

If the "problem" of disease is in our communities, then the solution lies there also; only we are not, for the most part, working in the communities to make change happen. We cannot sponsor a Health Awareness Breakfast during Black History Month and think we've delivered a message; we can't provide funding for a golf tournament and think we'll get men into a clinic; we can't put our logos on a shirt and think we've communicated with the community. At the same time we've seen evidence of success such as the "Real Men Can Cook" multi-city cancer awareness program, Dia de la Mujer Latina which focuses on Hispanic/Latino family health programs, as well as The Prostate Net's "Going to the Barbershop to Fight Cancer" initiative. Successful? Yes! But why aren't they moving the elements of change forward and faster?

If communities are not responding to our messages, perhaps it is because we haven't invited them to be part of the process. Change starts from within, not without. If we want to solve the problems of our communities, we must be in the communities and be perceived by them with trust and credibility. It can be done; if you're not sure how to do it, just ask me. ♂

## Financial News Highlights

**Editors Note:** Financial analysts often report information on a company's research efforts well before the news appears in the general press and can give indications as to new drug or treatment protocol launches.

**Cytogen** Reports Record Revenues in 2004 — on the strength of sales of Quadramet, a non-opiod treatment for pain relief due to metastatic bone disease relating to various cancers, and Prostascint, the first and only commercial monoclonal antibody-based agent targeting prostate-specific membrane antigen (PSMA) to image the extent and spread of prostate cancer. Cytogen is traded on the NASDAQ, symbol — CYTO

- *Yahoo Financial News*

**Medarex** Reports Year End Loss — increased expenditures for research and development contributed to the increased losses for the period. The company still retains approximately $385 million in cash and equivalents which should help fund many of the their product development activities, including but not limited to: Phase II clinical trial of MDX-070, a fully-human anti-PSMA antibody for prostate cancer; a Phase I antibody trial with Eli Lilly for MDX-066; and a Phase I trial with Cell Genesys for MDX-010 in combination with GVAX, all for prostate cancer. Trades on the NASDAQ under MEDX.

- *Yahoo Financial News*

**GTx, Inc.** — reported net losses for the 4th Quarter and Year-end 2004 that exceeded comparable periods for 2003. The losses were attributed to increased R&D spending on clinical programs for its product Acapodene, which showed promising data in Phase II trial for the prevention of prostate cancer in high risk men and Phase III trial for the treatment of side effects associated with androgen deprivation therapy in advanced stage prostate cancer. The company trades on the NASDAQ — symbol GTXI.

- *Yahoo Financial News*

## Medical News Highlights

**Celebrex provides a two pronged attack against prostate cancer** — an article in the ***Clinical Cancer Research*** journal showed that celecoxib, a selective COX-2 inhibitor, marketed under the name Celebrex, not only has anti-cancer properties, but also exhibits a secondary mechanism that restricts the proliferation of prostate cancer cells. The researchers demonstrated that celecoxib worked in animals that had been implanted with human prostate tumors by reducing the proliferation of cancer cells and also reducing the growth of blood vessels at the tumor sites.

**Celgene Corporation** reported (*New York Times 3/8/05*) that its cancer drug, **Revlimid**, performed better than expected in two clinical trials for multiple myeloma proving so effective that the studies were being stopped early so that all patients could be offered the drug. Celgene also manufactures **Thalomid**, from which Revlimid is derived. Both products have been approved by the FDA for other medical conditions, but are currently being evaluated for the treatment of prostate cancer; a listing of trials and eligibility can be seen at www.prostate-online.com/astclinic.html

**Abbott Laboratories** reported that the U.S. Food and Drug Administration has agreed to file the New Drug Application for its oral agent Xinlay (atrasentan) targeted for the treatment of metastatic hormone-refractory prostate cancer. Preliminary results from Phase II and Phase III clinical trials indicate positive data on slowing disease progression and delaying in time to onset of bone pain.

# IN THE NEWS

There has been a lot of news coverage this winter about developments in treating advanced prostate cancer including a "vaccine" that helps improve survival, combinations of the chemotherapy agent Taxotere, and a drug currently being investigated by the FDA. "In the News" is a round up of recent news articles on promising therapies to help keep you informed.

## A Cancer First — Vaccine Offers Hope for Prostate Cancer

In February of this year, news articles reported that a new "vaccine" is the first success in prolonging the lives in men with prostate cancer by using a treatment that trains the immune system to fight tumors. The approach is called a cancer vaccine, although unlike typical vaccines, it treats the disease rather than preventing it.

The three-year University of California San Francisco study, lead by Dr. Eric Small (seen below), examined 127 men with advanced prostate cancer that had not spread to their bones, and who no longer responded to hormone therapy, the conventional treatment, but who had not yet experienced pain from the disease. Those who received the vaccine, (APC8015 - Provenge) — three doses over a six-week period - lived an average of 4.5 months longer than those given placebo. Researchers reported that survival was up 34 percent in the vaccine group, vs. 11 percent without. This means that after three years, three times are many vaccine patients were still alive (34 percent) compared with the placebo group (11 percent).

While reactions as reported in the press have been generally optimistic, some have also pointed out that the study didn't achieve its goal of delaying the time when men's disease worsened. Additionally, there is a concern that the initial studies showed benefit for men with Gleason scores < 7. Current studies in work have shown a positive benefit in slowing time to disease progression as measured by PSA Doubling Time.

The next step is to confirm these findings with a second independent study, planned for later this year, and the FDA has put the treatment on a "fast track" to speed up the normal study/review/approval process.

Many in the medical community believe that the study is an important validation for development of future vaccines, used in cancer to rally the immune system, rather than being able to totally prevent cancer, as vaccines in other diseases do. Some believe that cancer vaccines are emerging as a promising fourth way to combat cancer, complementing existing treatments of chemotherapy, radiation and surgery. In any event, the vaccine may not be appropriate for all, and patients should consult their oncologist. ♂

***Reported by Lindsey Bowman and compiled from CNN.com, Associated Press, New York Times Syndicate, San Francisco Chronicle news reports and Dendreon Corp. press release.***

# FDA is Reviewing New Treatment, Xinlay (atrasentan)

*A biological therapy for the treatment of metastatic prostate cancer, Xinlay (atrasentan), is under review by the FDA and could be approved toward the end of year or early in 2006.*

Details of this study were reported by Drs. Nicholas Vogelzang (see below), Joel Nelson, etc. at the recent ASCO Prostate Cancer Symposium. Their data showed that in men with metastatic, hormone-refractory prostate cancer, Xinlay appeared to slow the biochemical progression of the disease, delayed the time to onset of bone pain and decreased the incidence of bone pain, and produced an improvement in quality of life. Biological therapy involves using naturally occurring compounds that increase the body's natural immune defenses or interrupt the unnatural growth patterns of cancer cells. The objective of this study was to more precisely define the clinical benefit of atrasentan 10mg in this patient population.

Significant to patient consideration is the fact that this novel cytostatic agent could provide measurable benefit in reducing the time to disease progression, which is key to a patient population that had limited treatment options heretofore. Coupled with this are the results showing less likelihood of experiencing bone pain. Bone pain from metastases is one of the more disabling manifestations of advanced prostate cancer. It may severely affect quality of life, causing pain, increased risk of fractures, and other life-threatening complications.

Xinlay is an investigational, oral, once-daily, non-hormonal, non-chemotherapy, agent that belongs to a class of compounds known as selective endothelin-A receptor antagonists (SERAs). These agents are being investigated because of their potential to block endothelin activity, which is thought to be involved in the spread of cancer cells.

In studies separate from the Phase III clinical trial, Xinlay is currently being studied in several stages of prostate cancer. Trials are ongoing in men with prostate cancer that has not spread (non-metastatic), as well as in men with rising prostate specific antigen (PSA) following prostate cancer surgery. It is also being evaluated in combination trials with approved treatments for advanced prostate cancer. ♂

***Based on press releases from Abbott Laboratories and Journal of Clinical Oncology, and also 2004 ASCO Annual Meeting Proceedings.***

## Medical News Highlights

Results from the Prostate Cancer Prevention Trial (PCPT) showed that finasteride, sold commercially under the name Proscar, reduced the incidence of prostate cancer almost 25% in the trial group as compared to a placebo. There was no difference in mortality seen during the 7-year study. Concern exists as to the overall benefit of the drug's usage due to an increase in the number of high-grade tumors seen in those taking the drug. The results were published in the April 1, 2005 issue of Cancer. Merck manufactures Proscar.

News-Medical.net reported on a Finnish study of androgen-deprivation therapy (ADT) that showed a negative impact on thinking in men as a result of the drug therapy. Androgen-deprivation therapy is an effective treatment of prostate cancer that reduces the levels of testosterone, which stimulates tumor growth. It was noted that ADT also reduces levels of estradiol, a form of estrogen that is important in neurological development, learning and memory. Men were shown to have temporary but significant declines in several cognitive functions; the degree of change was related to the extent of estradiol reduction.

Dendreon Corp. stated, in a report filed by Bloomberg.com, that its experimental treatment, Provenge, improved the survival of men with prostate cancer, who took the drug, by an average of 4.5 months longer than those men receiving a placebo.

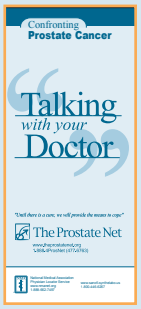
Obese and overweight men have lower levels of prostate-specific antigen (PSA) which "could mask biologically consequential prostate carcinoma" when the test for prostate cancer potential is given. This was the result of a study by Dr. Jacques Baillargeon at the San Antonio Center of Biomarkers of Risk for Prostate Cancer, as reported in the March issue of Cancer, involving 2779 men without prostate cancer whose blood serum PSA levels were correlated with their body mass index.

## Resources

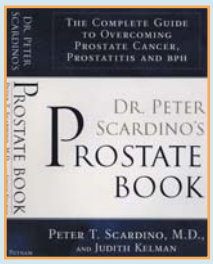
**Virgil's Prostate On-line**
patient information site
www.theprostatenet.com

**Prostate Net Patient Hotline**
1.888.4ProsNet (477.6763)
24/7 live operator (in English and Spanish) intake for counselor follow-up


**Know Your Options**
informational brochure on understanding the process of diagnosis and treatment - in English and Spanish




**Talking With Your Doctor**
informational brochure for patients and physicians to encourage effective communication between doctor and patient to achieve best treatment protocols




**The Complete Guide to Overcoming Prostate Cancer, Prostatitis and BPH**
A definitive new book by Dr. Peter Scardino of Memorial Sloan-Kettering Cancer Center in New York

# Does Race Matter?

The numbers relating to prostate cancer are staggering on their own: 230,000 new cases in the United States in 2004; nearly 30,000 deaths from prostate cancer in 2004; 82 men die every day from this disease, and we are seeing a steady rise in these rates. Yet when we look at our minority populations, the numbers show an even more sobering picture:

| Age-Adjusted Prostate Cancer (rates per 100,000) – 1997 - 2001 | | |
|---|---|---|
| RACE | INCIDENCE | MORTALITY |
| White | 167.4 | 28.8 |
| White Hispanic | 166.7 | 29.1 |
| Black | 271.3 | 70.4 |

The issue of racial health disparity is one of paramount importance to Government agencies, medical centers and advocacy groups such as The Prostate Net; but are we focused on the correct criteria. Is it really "race" that's the key factor or is it something else?

At the recent Prostate Cancer Symposium, sponsored by the American Society of Clinical Oncology (ASCO), two leading clinicians and cancer researchers engaged in a point / counterpoint discussion that proved to be illuminating and directional in moving the focus. Though the discussion was themed to create positions of pro versus con, the reality of their arguments really showed more agreement than not.

Dr. Otis Brawley of Emory University lead the discussion by creating a historical perspective of "race" and its position, or lack of it, in cancer research and treatment. The concept of "race medicine" was one that held strength in the first three decades of the 20th Century and saw its nadir in practice with the infamous Tuskegee experiments that permitted over 300 men with syphilis to go untreated on the belief that the disease was different in African-Americans versus Caucasians. However, to dismiss that concept, he illustrated that geographic origin was more relevant to certain disease prevalence than "race". Sickle Cell Disease is normally viewed as a "black" disease, yet the primary areas of geographic origin of the disease are the Mediterranean Basin and Central Africa, regions that are primarily "white". Race in America Dr. Brawley posited is really more of a social construct than a true biological reality.

Further to the point, in an analysis of all-cancer mortality among U.S. men, those who were in the **lowest socio-economic** categories, regardless of their race, had the **highest mortality** percents.

The reality of cancer in America is that poor people die more from the disease than those designated solely by race.

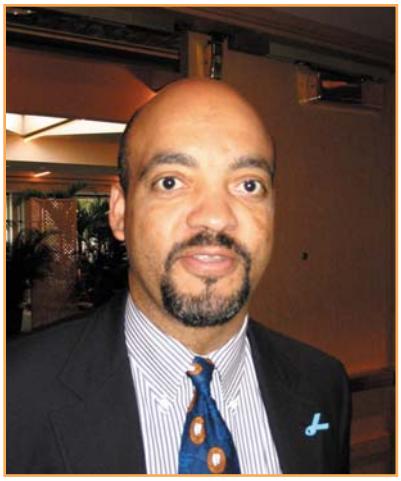
In looking at the "new" factors of racial health disparity, those with the greater relevance, and more scientific correlation, than race are:

* Socio-economic status
* Diet
* Body mass index (BMI)
* Access to care

*(continues on next page)*

Given that black people and poor people suffer disproportionately, we must expand our focus past race and address the question posed by Dr. Brawley, "how can we provide adequate high quality care to a population that has so often not received it?"

Taking the not-really-opposing point of view was Dr. Mack Roach III of the University of California at San Francisco, who supported many of Dr. Brawley's points that race does matter but **"WHY"**.



Dr. Roach related several other examples of healthcare disparity: greater utilization of coronary revascularization procedures among Medicare Part A enrollees was higher for whites; Blacks were 33% to 54% less likely to receive enhanced cardiac therapies than whites in Veterans Administration hospitals; and living in a disadvantaged neighborhood is associated with increased coronary heart disease. All of the above examples have been reported in the *Journal of the American Medical Association* and the *New England Journal of Medicine*. In trying to understand the differentials based on genetic factors, studies of the polymorphism Cyp3A4, which is important in androgen metabolism in prostate cancer, would have suggested that the presence of this polymorphism is a factor; however, the reality is that there wasn't correlation with disease outcomes. In reality, the preponderance of all data suggests that there are **NO** differences in outcomes based on race. The fact is African-American men have the 2nd highest five-year survival rate in the world, after U.S. white men. If race then does not matter, then why do Blacks still have a higher incidence and mortality from prostate cancer?

We can break the factors into categories related to incidence and/or mortality:

**Incidence**
- Dietary Factors
  - Food types
  - Quality of food
  - Obesity
- Environmental
  - Employment
  - Inner City
  - Pollution

**Mortality**
- Lack of access to care
- Lower utilization of services
- Lower quality of care
  - Patient related
  - Insurance related
  - Physician related
- Less screening

While mortality among minorities and the poor remains the highest, declines have been noted based on advances in screening and treatment; but we must insure that equality in treatment exists to provide for equality of outcomes. ♂

# ASCO - first Multidisciplinary Prostate Cancer Symposium

The American Society of Clinical Oncology held in February the first Prostate Cancer Symposium. The information presented at the Symposium is available in audio/slide format.

Visitors can browse or search presentations within the Virtual Meeting Section categorized by topics as risk factors and epidemiology; prevention, screening, localized disease; high-risk disease; androgen-deprivation therapy; hormone-refractory disease; and developmental therapeutics.

You can begin review of this valuable resource by going to:
**www.asco.org/ac/1,1003,_12-002517-00_18-0037,00.asp**

## Did You Know...

***Did You Know?***
Eat more AVOCADOS! They have had a bad rap because of their high fat content; however:
*Avocados are rich in lutein, an antioxidant linked to a reduced risk of prostate cancer
*Avocados are high in Vitamin E, again linked to lower risk of prostate cancer
*Avocados are low in carbohydrates and high in fiber
*Avocados have high content of glutathione, another anti-oxidant; beta-sitoserol which helps lower blood pressure; as well as being rich in thiamin, riboflavin, niacin and folate and back to the fat, avocados have "good", monounsaturated fat as in canola or olive oils
- ***Cincinnati Enquirer***

***Did You Know?.***
Greater levels of selenium, Vitamin E and the tomato nutrient, lycopene, have been shown to reduce prostate cancer in a group of men possessing a specific genetic variation with sensitivity to oxidative stress. Conversely, it was shown that if carriers of this genetic variation had low levels of these vitamins and minerals, their risk for aggressive prostate cancer increases as much as 10 times over those men who maintain higher levels of these substances.

These results were published in the March 15, 2005 issue of Cancer Research and were based on data derived from the Physicians Health Study.
- ***Medical Research News — 3/15/05***

***Did You Know?***
African-American men who receive a false-positive in a baseline screening for prostate cancer were 1.9 times less likely to return for subsequent screenings compared to those who tested negative.

The details of this study were published in the January issue of Cancer Epidemiology Biomarkers & Prevention. The authors concluded that there was a need for physicians to better inform their patients in greater detail all elements of the test, including the possibility of false positives, the meaning of test results, the relationship between screening and mortality, etc. This information sharing should have the effect of increasing doctor/patient shared decision-making and greater physician understanding of the patient's attitudes and perceptions.
- ***NCI Cancer Bulletin — 2/8/05***

Questions Q&A Answers

**The Prostate Net's Board of Medical Advisors will answer questions of general interest sent to "In The Know"; they cannot make specific diagnoses nor recommend treatment. Questions should be sent to: vhsimons@prostate-online.org**

**Q.** My doctor says that I may be a candidate for a clinical trial, but I want to be sure that if I go into a trial I will get the treatment and not a placebo. How can I be certain?

**A.** Clinical trials are often referred to as being of a specific phase. A Phase I trial is constructed to determine the safety and proper dosing of a particular therapy. A Phase II trial is set up to determine the effect or response of that particular therapy. A Phase III trial is usually done to randomize someone to the new therapy or the older, more standard approach. It is typically the Phase III trial that could have a placebo, but it will usually only have a placebo if taking the placebo, or no therapy at all, is a reasonable standard approach at that time.

Given the possibility of a benefit of the new therapy, many Phase III trials now have a crossover, giving the new therapy at some later time, so that everyone gets a chance to have the therapy. Phase I and II trials do not usually have a placebo because these trials are determining a direct measurement of the new therapy. Most importantly, all trials require a consent form, which describes the process specific to the particular trial; therefore, consideration of participation in clinical trials should include a careful reading of the consent form and an in-depth discussion with your doctor and the investigator.

**Dr. Robert DiPaola**
Associate Professor of Medicine
The Cancer Institute of New Jersey

## Information on Clinical Trials

**Understanding Clinical Research**
www.prostate-online.com/research.html

**Locating a Clinical Trial**
www.prostate-online.com/astclinic.html

**National Cancer Institute**
1.800.4.Cancer
www.cancer.gov/clinical_trials/

**The Prostate Net "Hotline"**
1.888.477.6763

**Data Sources of Clinical Research**
www.prostate-online.com/clinicresearchdata.html

The Prostate Net
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**Visit Our Booth #2101 at ASCO**

**May 13-17**
American Society of Clinical Oncologists
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**www.asco.org**

The Prostate Net

www.prostatenet.org

# Fighting Cancer at the *Barbershop!*

In February 2004 The Prostate Net launched its ***Barbershop Initiative*** in conjunction with MGM Studios and their release of the movie sequel, "Barbershop II". Our program set the foundation for developing a network to provide culturally credible, disease-specific, information within minority communities manifesting high levels of negative impact from prostate cancer.

From 2/15/04 through 4/30/04, we enrolled 21 medical centers around the country that, in turn, recruited and trained over 400 barbers to disseminate educational materials from The Prostate Net and the National Cancer Institute's Cancer Information Service to effectively inform the target populations. These materials were supplemented by in-shop information meetings, hosted by the barbers, with the community outreach teams of the medical centers as a way of presenting an active, and positive, face within the community to gain credibility and trust for on-going intervention efforts.

Coupled with this was the commitment by the medical centers **to provide free prostate screenings** to consumers via the barbershop effort and the agreement **to insure care for any, without insurance**, who tested positive for the disease.

As a result, **10,034 men** (as of 10/15/04), who had never been in the healthcare system, have been informed, educated and screened for the disease.

The strength, and credibility, of our mission is aided by the organizations with whom we are participants and/or collaborators: MGM Studios, the National Medical Association, The National Cancer Institute's Cancer Information Service, National Black Leadership Initiative on Cancer, American Airlines, Aventis Oncology, Celgene Corp., Purdue Pharma, Abbott Foundation, American Cancer Society local chapters and many others. The network of information dissemination and patient motivation will be expanded through our recent alliance with the **National Association of Barber Boards of America**, whose membership of more than 200,000 barbers will create opportunities for greater medical center/community partnerships.

The ***Barbershop Initiative*** has proven to be an effective vehicle, when appropriate local commitment is present, in:

1. Create an on-going culturally credible conduit for dialogue on disease intervention between the patient and healthcare communities
2. Developing a cadre of community health communicators / patient navigators with leadership ties to those affected by racial/socio-economic health disparities
3. Establishing the basis for clinical trials recruitment
4. Creating opportunities to interdict other disease conditions, e.g. cardiovascular, diabetes, etc.

For 2005, we will commence the effort in May and continue through October, then consolidate the base for further expansion in 2006. As of today, we have over 60 medical center partners and more than 800 participating barber/lay health motivators with more joining the network weekly. Additionally in June of 2005 we will roll out the pilot of the enhanced educational system, called **The Wired Barbershop**, which will place interactive computers in the barbershops for consumer self-education as well as guided instruction from the medical center community outreach teams. We will preview the concept at the **ASCO Convention on May 13-17, 2005 in Orlando.**

## New Program Partners

The success of the Barbershop Initiative has been realized in no small part because of the support of many diverse partners, who have all come together to wage the fight against prostate cancer and other diseases of negative impact on underserved communities.

Here are a few of the most recent participants in the program:

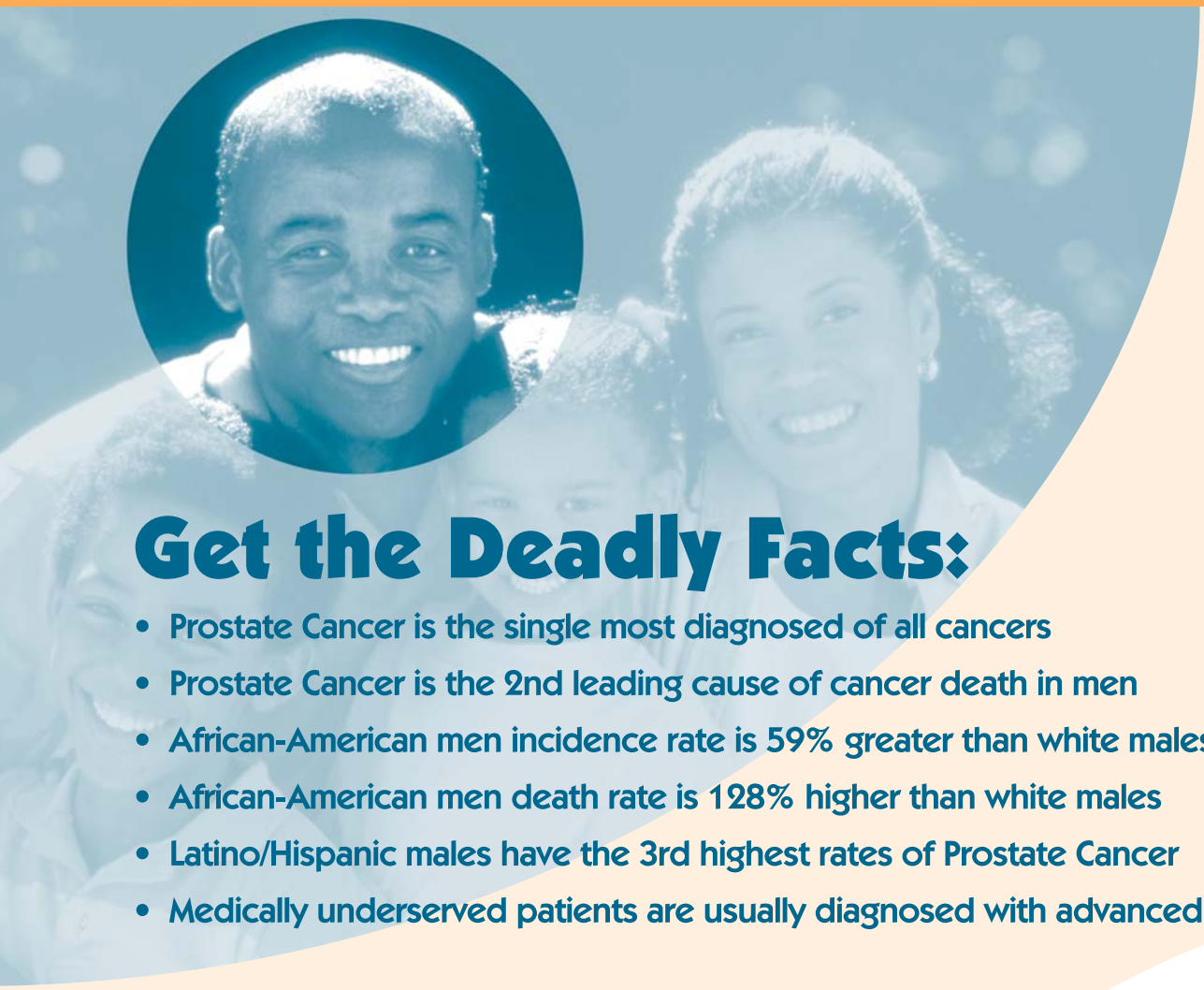
**National Association of Barber Boards of America**
www.nationalbarberboards.com

**Fannie E. Rippel Foundation**
www.fdncenter.org/grantmaker/rippel

**Safe At Home Prostate Awareness Network**
www.safe-at-home.net

# "Going to the *BARBERSHOP* to Fight Prostate Cancer"

A national initiative to promote disease risk education and Prostate Cancer Screening



## Get the Deadly Facts:

- Prostate Cancer is the single most diagnosed of all cancers
- Prostate Cancer is the 2nd leading cause of cancer death in men
- African-American men incidence rate is 59% greater than white males
- African-American men death rate is 128% higher than white males
- Latino/Hispanic males have the 3rd highest rates of Prostate Cancer
- Medically underserved patients are usually diagnosed with advanced stage disease

## Become Part of the Solution...

For more information on how to become a part of our program, please visit us online at **www.prostatenet.org/barbershop**

The Prostate Net

www.prostate-online.org
1.888.4PROSNET (477.6763)

*"Until there is a cure, we will provide the means to cope"*