

Diagnosed with prostate or breast cancer: Now what?

Each year nearly 218,000 men learn they have prostate cancer, and about 207,000 women are told they have breast cancer. In most cases the condition is diagnosed early, when it's most treatable. And the death rates for each are on the decline, probably because of better detection and treatment.

But the combination of early diagnosis and multiple treatments also forces patients and doctors to make a difficult decision: How aggressively should they treat early-stage cancer?

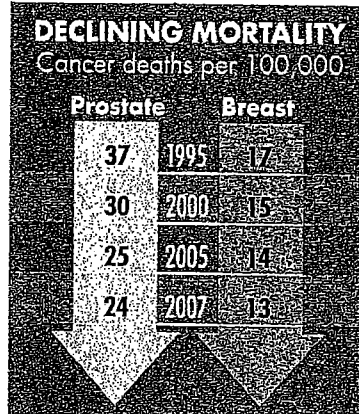
Most prostate cancers are so unaggressive that one option is to simply monitor

the tumor and start treatment if it progresses. But in a study of 124,000 men in the July 26, 2010, issue of the Archives of Internal Medicine, three of four of those with early-stage cancer chose radiation or surgery, each of

which can cause impotence, incontinence, or both.

For breast cancer, the percentage of women who choose a mastectomy (which removes the entire breast) over a lumpectomy (which preserves most of the breast) is actually on the rise. One study found that from 2004 to 2007, 44 percent of women chose to

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Screening recommendations

While most women undergo mammography and most men get their prostate-specific antigen (PSA) level measured, the advice for each is actually quite controversial. Here's our take.

Prostate

- Men 50 and older should decide based on their risk of prostate cancer, as well as whether they are more concerned about cancer than the risk of false-positive test results and the possible side effects of treatment.

- Men who are older than 75 or have a life expectancy of less than 10 years should avoid PSA testing, since the cancer typically progresses so slowly they are more likely to die with the cancer than of it.

Breast

- Women 40 to 49 should decide based on their risk of breast cancer, as well as whether they are more concerned about cancer than the risk of false-positive test results and the possible side effects of treatment.

- Women 50 to 75 should undergo routine mammography. The benefits for women older than 75 are less clear. Regardless of age, screening every two years appears to be as effective as annual screening.

Now what?

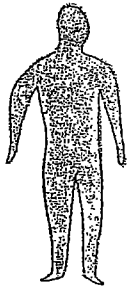
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have a mastectomy, compared with just 33 percent from 1994 to 1998. And the percentage of women who decide to have both breasts removed, not just the one with the tumor, has more than doubled since 1998.

Patients often choose aggressive treatments for good reasons, including reassurance. But incomplete, confusing, or in some cases biased information from their doctors also influences their decision. Here's what you should know to get the care that's best for you.

PROSTATE CANCER

Get informed



Few medical decisions are as tough as those facing a man diagnosed with prostate cancer. There's no shortage of treatments, including surgery performed with or without robotic assistance, and radiation delivered by an external beam or by radioactive seeds implanted inside the body.

But it's hard to compare safety and effectiveness. And because experts say that most prostate cancers are extremely slow-growing and might not pose a serious threat, many men might be better off deferring treatment.

Unfortunately, doctors often provide falsely optimistic descriptions of a treatment's effectiveness, downplay side effects, and gloss over watchful waiting as an option, according to a review of 69 studies that investigated how men with prostate cancer make treatment decisions. The table below compares the most established treatments for prostate cancers that have not spread beyond the gland. (Survival rates are lower for people with tumors that have spread, and most cases require more aggressive treatments that increase the risk of complications.)

KNOW YOUR RISK

To guide your decision, it's important to understand whether you have a low-, medium-, or high-risk tumor. Risk is typically based on three factors: levels of prostate-specific antigen (PSA) in your blood, the size and extent of the tumor, and a rating of the tumor pathology called the Gleason score. Small tumors that are confined to the prostate gland combined with low PSA levels (10 nanograms per milliliter or less) and low Gleason scores (six or less) indicate a low-risk tumor that can make watchful waiting, also called active surveillance, a reasonable choice. If you have a medium- or high-risk tumor, treatment might be more appropriate—if you understand and accept the likely adverse effects of both radiation and surgery.

Robotic surgery provides no guarantee of fewer complications. And marketing hype might fuel unreasonable expectations. In a Duke University study, dissatisfaction was three to four times higher among those treated by robot-assisted surgery compared with those treated by traditional surgery, even though rates of troublesome side effects were about the same.

Prostate-cancer treatments compared

Treatment	10-year cancer death rate	Long-term adverse effects	Test description and common results	Good candidates
Watchful waiting (active surveillance)	About 3% for low-risk tumors; about 5% for intermediate-risk tumors.	Anxiety from uncertain cancer status.	<ul style="list-style-type: none"> PSA testing 2 to 3 times a year and repeat prostate biopsies once a year. Half to two-thirds of patients can expect at least five years without need for treatment. 	<ul style="list-style-type: none"> Men with low-risk tumors who highly value sexual activity and freedom from treatment side effects. Men with life expectancy of 10 years or less.
Surgical removal (prostatectomy)	Less than 1% for low-risk tumors; about 3% for intermediate-risk tumors.	<ul style="list-style-type: none"> Poor sexual function: 53% Urinary leakage more than once a day: 14% Frequent, urgent, bloody, or painful bowel movements: 1% 	<ul style="list-style-type: none"> Requires 1 to 3 days in a hospital and a week or two with a urinary catheter. Removal of gland means less chance of recurrence. 	Otherwise healthy men who have the longest life expectancy and the least surgical risk.
External-beam radiation	About 2% for low-risk tumors; about 4% for intermediate-risk tumors.	<ul style="list-style-type: none"> Poor sexual function: 58% Urinary leakage: 7% Frequent, urgent, bloody, or painful bowel movements: 11% 	<ul style="list-style-type: none"> Requires 7 to 8 weeks of daily treatments. Because prostate isn't removed, lingering cancer cells may prompt recurrence. Sexual problems tend to worsen over time. 	Men who want to avoid major surgery or whose poor health or advanced age makes surgery too risky.
Internal-seed radiation (brachytherapy)	Long-term data not available; potentially similar to external-beam radiation.	<ul style="list-style-type: none"> Poor sexual function: 46% Urinary leakage: 10% Frequent, urgent, bloody, or painful bowel movements: 8% 	<ul style="list-style-type: none"> Requires one outpatient operation in which doctors implant radioactive seeds in prostate using hollow needles. Because prostate isn't removed, lingering cancer cells may prompt recurrence. Sexual problems tend to worsen over time. 	Same as external radiation but more practical for those who can't easily make daily trips to the hospital.

¹¹ Death rates are based on an observational study in 2010 of 6,849 Swedish men diagnosed with localized prostate cancer. ¹² Adverse effect rates are for two years after completion of treatment, as reported in a 2008 study in which researchers surveyed 1,201 men about quality of life before and after brachytherapy, external-beam radiation, or prostatectomy.

Take your time



Women who learn they have breast cancer often choose a treatment during their first visit to a cancer doctor. But "taking a week or two to decide is usually not going to hurt," says Alison Conlin, M.D., a breast-cancer specialist at the Providence Cancer Center in Portland, Ore. "The important thing is to feel like you've made the right decision for you."

SURGERY: AGGRESSIVE VS. MINIMAL

Most women with breast cancer receive a diagnosis of either an early-stage tumor or ductal carcinoma in situ (DCIS), in which abnormal cells remain confined to the ducts in the breast and pose little threat of spreading.

Some experts question the need to treat DCIS at all, since the abnormal growths usually pose no long-term risks. But because doctors can't predict which growths might later prove invasive, most treat it like a more clearly dangerous tumor.

In those cases, as well as with early-stage tumors, the first tough decision is choosing between a lumpectomy and a mastectomy. While up to 80 percent of women are candidates for the less aggressive surgery, in this country only about 40 percent of them choose that option, compared with 55 percent in Japan, 63 percent in Germany, and 81 percent in France.

Lumpectomy is not a good option if the tumor is too large or diffuse or the patient can't tolerate radiation. But in other cases it's as effective as a mastectomy, so the choice depends on individual concerns. A lumpectomy spares most of the breast, leaves a smaller scar, and eliminates the need to wear a false breast or have reconstructive surgery. But it usually entails two to six weeks of daily radiation treatments. That might be impractical if no treatment center is nearby.

Radiation can cause significant fatigue, but many patients fare well enough that they can continue to remain active. It can also cause some permanent shrinking and hardening of breast tissue, as well as itchy and tender skin. In about 25 percent of patients, the skin can temporarily break down and take about a week to fully heal.

Mastectomy usually requires radiation only when the tumor is very large or cancer

cells have spread to nearby lymph nodes. The surgery removes all the breast tissue from the side of the chest that has the tumor. That improves the chance of removing all the cancer and makes it less likely that you'll need a repeat procedure in the future. But losing a breast makes some women feel disfigured. Improved plastic surgery and advances in surgical techniques, such as a skin-sparing mastectomy and simultaneous breast reconstruction, might be part of the reason more women are choosing to have a mastectomy.

Prophylactic mastectomy, or having a healthy breast removed along with a diseased one, does reduce the risk of developing a future breast cancer. But that is rarely necessary, since the chance of developing cancer in the unaffected breast is low. It's much more likely for the cancer to spread instead to the lymph nodes or other parts of the body, and prophylactic mastectomies don't prevent that from happening. Our medical consultants say that women should first consider nonsurgical options, including frequent checkups and possibly taking a drug to reduce any risk of cancer in the other breast.

DRUGS: GET THE RIGHT ONE

Several medications can reduce the risk of cancer returning after surgery. But which one depends on your age and the kind of breast cancer you have.

Tamoxifen (*Nolvadex* and generic) can cut the risk of breast-cancer recurrence when taken for up to five years after surgery, but only if the cancer is fueled by the female hormone estrogen. And because the drug blocks some of estrogen's effects on the body, it can bring on symptoms similar to those of menopause, including hot flashes, irregular periods, and vaginal dryness. Tamoxifen might also cause indigestion or make you feel nauseated.

Aromatase inhibitors, a newer class of drugs, cause fewer problems than tamoxifen. But they can still cause bone loss, and only postmenopausal women should take them since they shut down estrogen production entirely. Three are now available: anastrozole (*Arimidex*), exemestane (*Aromasin*), and letrozole (*Femara*). Side effects such as aching joints and weak bones seem to be more common than with tamoxifen.

Targeted therapy with trastuzumab (*Herceptin*) can help the 20 percent of breast-cancer patients who have a protein called human epidermal growth factor receptor 2 (HER-2). People with that protein are more likely to experience fast-growing, treatment-resistant tumors. ■

Cancer decision-making checklist

- ① Learn about all the options—including no treatment.
- ② Ask questions until you're sure you understand.
- ③ Compare the risks and side effects of treatments, not just their effectiveness.
- ④ Ask how many cancer patients the doctor and hospital have treated in the past year, and how that compares with other doctors and hospitals. Also ask about success and complication rates. Avoid providers that have treated very few or won't share their results.
- ⑤ Get coordinated care from a team that includes medical, radiation, and surgical oncologists. Check to make sure that members of the team share information with each other.
- ⑥ Consider a second opinion. That changed the original recommendations for more than half of the breast-cancer patients in a 2006 study, and also uncovered problems missed by the original caregiver.