



Save The Dates...

April 2 – 8, 2007
National Public Health Week
Details at: www.nphw.org

April 12 – 14, 2007
31st Annual Symposium
American Society of Breast Disease
Hotel Nikko
San Francisco, CA
Details at: www.asbd.org

April 14 – 18, 2007
American Association of Cancer
Research
Annual Meeting
Los Angeles, CA
Details at: www.aacr.org

April 17 – 18, 2007
Word of Mouth Marketing Association
New Orleans, LA
Details at: www.womma.org

April 24, 2007
Understanding NCI: Teleconference
Resources for Understanding Cancer
Risk
1:00 – 2:00 EST
1.800.857.6584 – Passcode: RISK

April 28, 2007
3rd Annual Duke Prostate Cancer
Symposium
RTP Radisson Hotel
Research Triangle Park, NC
Details at: www.pccnc.org

April 28 – May 1, 2007
National Breast Cancer Coalition Fund
Annual Advocacy Training Conference
Hyatt Regency Crystal City
Arlington, VA
Details at: www.stopbreastcancer.org

May 16 – 19, 2007
National Conference for Nurse
Practitioners & Acute Care Clinicians
Nashville, TN
Details at: www.ncnpconference.com

May 17, 2007
Understanding NCI: Teleconference
NCI's Intramural Clinical Trials Program:
A National Resource for Patients
2:00 – 3:00 EST
1.800.857.6584 – Passcode: CCR

(continued on page 11)



CDC REVISED RECOMMENDATIONS FOR HIV SCREENING

Interview by Diane Johnson



Dr. Bernard Branson, M.D.
Associate Director for Laboratory Diagnostics
Centers for Disease Control—Division of HIV /
AIDS Prevention

DJ: As of the end of last year, the CDC is now recommending HIV testing and screening as part of all routine medical care for patients between the ages of 13 and 64. This seems like a radical departure from the past when patients had to request those tests. What are the key reasons for the change?

BB: *Actually it isn't such a radical departure. Since 1993, the CDC has been recommending that hospitals' in higher prevalence areas offer all patients HIV screening, particularly those at high risk. But, unfortunately, most institutions have not really implemented that recommendation. These recommendations build on that. People don't really know what the prevalence of HIV is or don't really know how much there might be in a patient population because they haven't been screening for it. Increasingly, we've been getting information that indicated there were a large number of people who were HIV infected but were never getting tested. That provided part of the basis for our recommendation. The other important developments were several cost-effectiveness studies published in 2005 and 2006 showing that screening for HIV was as cost-effective as many other health screening programs, including pap smears, colon cancer, mammography, etc. So with that combination: knowing people were being seen in healthcare settings and not being tested for HIV even though they were HIV-infected and knowing that the screening is cost-effective led to the change in the recommendations.*

DJ: Can you elaborate on cost-effective?

BB: *Well, cost-effectiveness is related to several things. The cost of the test, but also what the outcomes are in terms of the increase in life-expectancy, differences in disability, and reduction in subsequent transmission also play a role in cost-effectiveness.*

DJ: What advantages are there with early detection?

BB: *First of all, data show that about 40% of people overall get their first HIV test within one year of the time they are diagnosed with AIDS. The incubation period between getting infected and developing AIDS is about 10 years, so that means that many people have been infected, and have been potentially infectious to other people, for 10 years before they ever find out they are HIV infected. The advances in the therapies, especially since the mid-1990's when the highly effective antiretroviral therapy was introduced, has drastically reduced mortality and increased both the quality of life and life expectancy with HIV infection. And so early intervention, monitoring, and starting therapy before there's been severe damage to the immune system have a very important effect on extending life and improving health.*

DJ: So taking the antiretroviral can actually postpone the onset of the disease, but can't prevent its progression?

BB: *It postpones the onset of the severe immune deficiency which is a condition that leads to all the death and disability. It doesn't cure it. It's similar to the treatment of hypertension—you need to stay on the therapy.*

DJ: The recommended age range for screening is 13 to 64. At the youngest end of the spectrum, do you expect objections and controversy similar to the HPV vaccine controversy that's going on right now?

BB: *The CDC conducts something called the Youth Risk Behavior Survey. The 2005 survey indicated that 47% of high school students reported that they had had sexual intercourse at least once, and 37% of those sexually active students had not used a condom. So we looked at a lower age range for these recommendations. The evidence that we have regarding sexual activity, and in particular for younger women acquiring HIV infection, makes it important that it now become part of the repertoire for which people are screened. If it's caught early, lifesaving therapy can be provided and subsequent transmissions eliminated. This has also been endorsed by the American Academy of Pediatrics.*

DJ: And at the other end of the age range, I've been reading about HIV infections rapidly increasing in people in their 60's and 70's. Why was age 64 selected?

(continued on page 6)

“In The Know” is a publication of The Prostate Net, Inc.

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

P. O. Box 2192
Secaucus, NJ 07096-2192
phone: 201.342.3202
email: virgil@prostatenet.org

Publisher/Editor-In-Chief
Virgil Simons

Senior Editor
Diane Johnson

Contributing Editors
Lindsey Bowman
Maryann Porch
Lynne Scott-Jackson

Creative Director
Nato Rosado

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It's Spring and the world is blooming with new growth and potential. Well, it's no different here! The first thing you've probably noticed is that our Cover Story is not about prostate cancer, but rather HIV and AIDS. As we have thought about the complete picture regarding prostate cancer, we have seen that our society is not solely impacted by just one disease. Those families with a member facing prostate cancer may also have someone dealing with breast cancer or lung cancer; the man who survives prostate cancer may be faced later on with cardiovascular disease, diabetes or any other of a host of conditions. As the "Baby Boom" generation moves into their '60's, they are also moving into the prime years of first cancer diagnosis and/or the onset of other illnesses. We believe that it is our mission to be responsible in highlighting all of those issues that will affect our constituency because there is a co-morbidity of diseases at play in our society.

To that point then, the rationale for talking about HIV screening and the reasons why we believe it should be a front-of-mind for all of us. Some quick points that caught our attention:

- At least 40,000 people are infected with HIV annually
- Approximately 17,000 people die with AIDS annually
- Approximately 25% of the people with HIV are unaware of their infection
- Women account for 25% of the new HIV cases
- African-American women account for 61.4% of the women's totals
- Most women contract HIV from sex with men who are infected
- Men having sex with men represent about 67% of new HIV diagnoses
- 19% of all people with HIV/AIDS are over 50 years of age and this number is growing more each year

Looking at the rest of the newsletter we see the heart-warming story of Luther Vandross and his assistant Max Szadek, who together fought the battle against diabetes. This article also points up the need for knowing all you can about your health, getting regular check-ups/screening, etc.

Lastly, this issue is our latest thrust in the expansion of our Knowledge Net service matrix. Coming soon you'll see notice of our new Website, technological service offerings, programs to support public health professionals and much more. From the beginning our commitment was summed up as "Until There's a Cure, We'll Help You Cope!". From today forward it will be – "We Inform to Fight!" ♂

BOARD MEMBERS SPOTLIGHT

Board Member

Bobby Jefferson



This column exists to introduce you to our extraordinary board members. The spotlight this month is on Bobby Jefferson.

Bobby Jefferson is a man on the move. . . literally. In a typical year he will visit at least 10 developing countries as he directs technology and informatics programs for rural and community HIV health and hospital facilities. Bobby has more than 10 years experience in delivering information technology solutions to rural and resource-poor environments. He is currently associated with Constella Futures Group, LLC as the Senior Healthcare Management Information System Advisor on the President's Emergency Plan for AIDS Relief. He serves as an MIS technical advisor in several countries including Nigeria, South Africa, Tanzania, Zambia, Kenya, Rwanda, Haiti, Guyana and Uganda.

Bobby began his career after graduating from American University in Washington, D.C. He worked for the U.S. government on a team responsible for computer infrastructure in U.S. embassies overseas until 1998. Then he went to SETA, Inc., a USAID (U.S. Agency for International Development) contractor, where he was promoted to Deputy Program Manager and Team Lead. Over a four-year period of time he supervised a team of IT consultants here and in numerous foreign countries including the Ukraine, Georgia, Lithuania, Armenia, and many countries in Africa. Their projects varied from integrating six independent railway systems in Africa into a regional system to evaluating fifteen commercial banks for compliance in Armenia. His next career move was to CTIS, Inc., where he led a business development team developing clinical applications supporting agencies like the National Cancer Institute and expanded his international work to India.

As an invaluable member of The Prostate Net board, Bobby has lead the effort to become more involved in Government-supported activities on research and prevention to better assist those communities and groups disproportionately impacted by prostate cancer and other diseases of negative impact. His insight into navigating Washington's waters has been key in helping The Prostate Net to expand our service matrix.

Despite his demanding business schedule, he is equally committed to being a concerned father to his twins and sensitive husband. Given what he has accomplished in the first 16 years of his career, just imagine what Bobby Jefferson will get done in the next. We are grateful for his passion and expertise. ♂

SATRAPLATIN—Another Reason for Hope in the Fight Against Advanced Pca

Up until just two years ago there had been no hope for those men dealing with advanced stage prostate cancer. Then, we saw the approval and wide spread usage of Taxotere, which was the first chemotherapy drug that showed proven survival benefit for those who have failed the previously accepted treatment protocols. Dr. Daniel Petrylak (seen here), who was one of the key investigators in the trials leading up to that approval, is now involved in another potential major therapeutic breakthrough that could offer hope – and longer term survival – for that group of patients that have failed primary chemotherapy treatment.

In an interview with Dr. Petrylak, he told us that Satraplatin is an oral compound being investigated for patients who have failed a prior treatment of chemotherapy and have begun advancing while on androgen ablation therapy, otherwise known as hormone-refractory prostate cancer. The clinical study, in which Dr. Petrylak has teamed with other leading cancer researchers: Drs. Oliver Sartor, Fred Wittes and Cora Sternberg, was designed in conjunction with the FDA to insure positive research outcomes. The trial was designed to measure disease Time-To-Progression (TTP) as its primary endpoint. Preliminary findings show a lower toxicity than other drugs typically used and, most importantly, showed excellent TTP in the main areas of concern: pain, skeletal events, resistance to drug effectiveness and death. Overall there was a 40% reduction in the rate of progression.

Satraplatin is a novel platinum compound that has shown anti-tumor activity in several cancers including advanced hormone-refractory prostate cancer. Preliminary results of a phase III randomized trial comparing Satraplatin + prednisone (a steroid) to placebo + prednisone, showed a 33% reduction in the risk of disease progression with increasing improvement noted over time. At 6 months, 30% of the patients taking Satraplatin had no disease progression compared to 17% of the patients taking the placebo. At 12 months, 16% of the Satraplatin group had no disease progression compared to 7% of the placebo group. The reported side effects were mild to moderate and included low white blood cell and platelet count, nausea, vomiting, and diarrhea. The ideal candidate for the drug is that patient who has failed primary chemotherapy.

The manufacturer, GPC Biotech, Inc., is making Satraplatin available on a limited basis through an Expanded Access Program. If you are interested in this program, your physician can get further information about enrollment at www.speratrial.com or by calling 800.349.8086. ♂



Medical News Highlights

Cell Therapeutics (NASDAQ: DBLE) reported positive data on its drug, Xyotax, for the treatment of lung cancer and androgen independent prostate cancer. The hope for the drug is that it will benefit patients who have failed prior taxane therapy.

Smoking increases your risk for oral cancer more than 6 times versus a non-smoker. Smoking and the use of alcohol increases it more than 15 times; and if you use smokeless tobacco (chewing or snuff), you become 50 times more likely to develop oral cancer, dental cavities, periodontal disease as well as partial or complete tooth loss.

Androgen Deprivation Therapy (ADT) for prostate cancer treatment may make men more susceptible to diabetes and heart disease according to a report in the *Journal of Clinical Oncology* (2006;24:4448-4456) based on a research study done at Harvard Medical School. The use of GnRH agonists suggests that patients should discuss the potential risks with their physicians

Dendreon announced that the FDA's Cellular, Tissue and Gene Therapies Advisory Committee would review the Biologics License Application (BLA) for its immunotherapy drug, Provenge, on March 29, 2007. Final FDA ruling is expected by May 15, 2007.

Cytogen Corp., a maker of cancer-detection products, said an eight-year study showed that its system for tracking prostate cancer cells can determine whether the disease has spread and predict patients' chances of survival. The results may encourage doctors to use Cytogen's Prostascint test to more precisely spot prostate cancer cells, said Rodney Ellis, a radiation oncologist with the Case School of Medicine in Cleveland, who was lead investigator of the company-sponsored study.

Medical device manufacturer, **Verathon**, is offering \$10,000 for the best proposal for a study that would examine the relationship between bladder mass and certain bladder dysfunctions. Details can be seen at: http://seattletimes.nwsources.com/html/business/technology/200356656_2_sundaybuzz11.html

(continued on pg. 4)



UNITED STATES
DEPARTMENT OF VETERANS AFFAIRS

ARE YOU A VIETNAM VET WITH PROSTATE CANCER?

Check out the V.A.'s Agent Orange Program

If you are a veteran of the Vietnam war and served time in-country, you might have been exposed to Agent Orange, an herbicide used there between 1962 and 1971 to remove vegetation that provided cover for enemy forces. Following military service in Vietnam, some veterans began reporting health problems that have since been attributed to their exposure to Agent Orange and other herbicides.

If this applies to you and you have been diagnosed with prostate cancer, you might qualify for a comprehensive benefit program that the Department of Veterans Affairs has developed. Quality healthcare, disability compensation, research, outreach, and education is available.

In addition to prostate cancer, the Veterans Administration currently lists several other illnesses caused by exposure to such herbicides, including: Type II diabetes, Hodgkin's disease, non-Hodgkin's lymphoma, respiratory cancers, multiple myeloma, and soft tissue sarcoma. These illnesses must be at least 10% disabling; some have a specific timeline for development to qualify.

To get more information about Agent Orange and benefits for Vietnam veterans, go to their website: www.va.gov/agentorange. You can also call 800-749-8387.

You must provide your name, e-mail address, telephone and/or fax number, and your VA file / social security number. ♂

Medical News Highlights

(continued from pg. 3)

Obesity, according to a report by the Millennium Research Group, will contribute to an increase in diseases or conditions that lead to surgical intervention. The report finds that 11 million Americans are considered morbidly obese, with that number expected to increase to 13 million by 2011. Details can be viewed at: http://www.mrg.net/news_newwin.php?news_id=216

Dermatologist's say, "almost all of us will get **moles on our bodies**, someday" it's a part of growing older. Usually after 40 these skin growths appear, most often on the torso. Some of these moles become cancerous or turn into what is called "Melanoma". "If you think you have melanoma or some other type of skin cancer, see your doctor immediately." Read the complete article at: <http://www.emediawire.com/releases/2007/3/emw510385.htm>

A trial testing whether the chemotherapy drug **mitoxantrone** would benefit men with prostate cancer has been stopped because three of the 488 patients who received the drug developed leukemia. Details can be read at: <http://www.forbes.com/forbeslife/health/feeds/hscout/2007/01/19/hscout601168.html>

At least half of American adults take **vitamin and mineral supplements** regularly, spending more than \$23 billion dollars a year. Many people believe these supplements can help prevent disease and improve health, but is there scientific evidence that proves these supplements, herbs and "natural" or homeopathic remedies really work? Read the complete article at: <http://www.clarionledger.com/apps/pbcs.dll/article?AID=/20070123/COLORADO/701230314/1292/health>

Diabetes is a very sneaky disease that can be active in the body for many years before it is diagnosed. There are some telltale signs of diabetes most people can ignore or explain away so they don't seek treatment. By the time a diagnosis is finally made, diabetes may have already caused damage to fragile blood vessels in the eyes, heart, kidneys and feet. See the full story at: <http://www.clarionledger.com/apps/pbcs.dll/article?AID=/20070130/COLORADO/701300316/1292/health>

An increase in **insulin-like growth factor (IGF-1)** found in milk may lead to increased rates of colon, breast and prostate cancer. Read the full story at: <http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2007/03/25/BUGBROQASE1.DTL>

HEALTHY BODY = HEALTHY PROSTATE

Mark Moyad, MD, MPH

by Diane Johnson



Dr. Mark Moyad is the Phil F. Jenkins Director of Preventive & Alternative Medicine at the University of Michigan Medical Center in the Department of Urology. Alternative and complementary therapies include nutrition, herbs, supplements, and lifestyle and environmental approaches to holistic cancer treatment. Uniquely, his position has been fully funded and endowed by his patients. He is the author of over 80 medical articles and papers, and has written or co-authored five books, including The ABC's of Prostate Cancer.

DJ: You advocate a holistic approach to prostate cancer treatment. What does that mean?

MM: *Men must begin to look at their total health, not just their prostate's. Drastic lifestyle intervention is required. If they don't concentrate on things like controlling their blood pressure or stopping smoking, any cancer treatment will be a waste of time. What if they are successfully treated for prostate cancer, but because their cholesterol is too high, they have a stroke and die? It would be like driving toward a cliff with your foot on the gas and worrying about a mosquito in the car. People need to do whatever it takes to be heart healthy, because heart disease is still the #1 cause of death. But this kind of approach to cancer treatment can be frustrating for patients.*

DJ: What do you mean?

MM: *In this country, we tend to be disease-specific and focused on the quick fix. Patients are treated for individual diseases ignoring the state of their health in general. People want easy answers: 'low fat diets reduce breast cancer' or 'high fiber intake decreases colon cancer', neither of are true. Too many promises are being made that can't be kept. When people find out these theories are false, they get confused and lose trust in healthcare. If you focus on changing your lifestyle for the better, it may affect your prostate cancer, but it will increase your overall health and longevity. A high level of cholesterol is a greater predictor of death than the kind of prostate cancer treatment you receive. It's crazy to exercise just to reduce your cancer risk. You should be doing it to get healthy....period.*

DJ: Is it the same for everyone?

MM: *Not really. Some people are Cadillac--they can do a little and get away with a lot. And some are Pintos--they just have bad genetics. But the primary risk factor for prostate cancer is the same for everyone--getting older. People are living longer now, so the incidence of prostate cancer is increasing. If we take care of ourselves, we can live out our maximum lifespan.*

DJ: Are there specific foods or supplements we can take to keep from getting cancer?

MM: *No, but some are still good for you. We just need to be more precise. For example, green tea is being touted as a cancer preventative. But when we study people who drink large quantities of green tea like the Japanese, it's not just the tea. They have diets low in saturated fats, they walk one hour a day, they don't tend to be overweight, etc. Countries with the longest life spans are practicing multiple moderate lifestyle changes, instead of one or two things in extreme. Most of the recommendations are good for something, but maybe not what they're being linked to. Vitamin D is hot right now in relation to prostate cancer. Even if it turns out to have no impact there, it still reduces osteoporosis. Others may be worthless or even dangerous. Five servings of fruits and vegetables a day do not prevent cancer. Vitamin E is actually heart unhealthy. The point is to weed out the hype and senseless recommendations. Use your common sense.*

DJ: It's a tremendous vote of confidence that some of your patients created a fully endowed position for you in this field. One of them, Phil Jenkins, said, "He's a brilliant guy doing a great job for breast and prostate cancer around the country and around the world." How is your practice different from others?

MM: *Thanks to their generosity, I am able to practice what I call "old-fashioned medicine in a modern time." I see patients regardless of their income or whether they have insurance, and I can spend as much time with a patient as necessary, visiting with them over the phone or in their homes. I don't have to spend up to 1/3 of my time filling out paperwork like other practitioners do. I certainly can't get to everyone who needs help, but it shows what can be accomplished when a patient and health professional get together and share a vision of making healthcare better. I am not funded by the pharmaceutical industry. I never speak for a company that requires me to do an ad for them. I am able to practice free of business bias. When money limitations are removed from the equation, it changes completely the way I can deal with patients.*

DJ: You've been dedicated to the study and practice of alternative medicine for over 20 years. Have you seen the practice of urology change in that time?

MM: *There is a totally different environment in urology now. Physicians all over the world are adapting a new philosophy. Ten years ago, most physicians didn't know what nutrition was. Now they incorporate it into their practice. But I'm still frustrated that we aren't further along. We've been treating prostate cancer with the same drugs for 20 years now. What about the impact of hormone therapy on cardiac risk? Do statin drugs also reduce prostate cancer risk? And we're still removing the whole prostate, unlike lumpectomies available for breast cancer patients. Robotic laparoscopic prostatectomy is an example of minimally invasive therapies that have the same effect as more drastic treatments. I am dedicated to pursuing more of those.*

(continued on page 10)

LETTERS FROM HOME: THE LUTHER VANDROSS STORY

by Diane Johnson



Max Szadek was part of beloved singer Luther Vandross' life for over 15 years, as his personal assistant, caregiver, and friend. He learned valuable lessons about getting and being healthy through Luther's struggles and eventual death. We talked to him about how he is passing along those lessons and his determination to carry on Luther's legacy.

DJ: What was your relationship with Luther?

MS: Before I worked for Luther, I worked at the American Conservatory Theater in San Francisco as a costume designer. I started out in the wardrobe department for Luther's tour, *Never Let Me Go*. About a year and a half later, I became his personal assistant. We worked together for about 14 years.

DJ: Luther's struggles with his weight and his health were well publicized over the years. How did his lifestyle affect his health?

MS: Luther was a big man. He was over 6 feet tall. I always considered his ongoing personal battle with weight to be public knowledge. In the time I worked for him, Luther lost and gained the same 100 pounds several times. It was painful to watch because the music industry is so geared toward the visual. There is a photo shoot for every new album and a video shoot with every new single. You can't hide a weight gain, no matter how small. The amazing thing about Luther was that he was always incredibly disciplined--about his music and about his food intake when he was on a diet. He wouldn't waiver until he hit his goal weight. No exceptions. But a little 'bump' in the road would trigger something and he could not stop a 5 or 10-pound weight gain from turning into 100 pounds.

DJ: Was his diabetes public knowledge?

MS: I was aware he was living with Type 2 diabetes, because I would pick up his medications, but we never really discussed it. In fact, that was the extent of our conversation about diabetes until he suffered a stroke. I regret not talking to him about his diabetes and how it might be affecting his life. Luther was very headstrong and determined, so even if I had pushed, we might not have discussed it. He was my friend, but he was also my boss. I deeply regret the fact that he suffered a stroke. I was very naïve to diabetes and its related health risks. I had no idea that something like that could happen.

DJ: What about exercise?

MS: I did introduce him to step-aerobics--he loved music and dancing, so it was a natural fit. It was the first time he had added exercise to his diet routine and he was shocked at how much more he could eat and still lose weight. However, Luther was not in love with exercise. At some point, no matter how good things were going, he would eventually fall off the wagon and begin to gain the weight back. It was a very vicious cycle to witness. You had to be careful when discussing weight because it was such a personal issue for him. He was wrestling with his demons 24/7, so he didn't want the people closest to him continually bringing it up. No one was more aware or upset about his weight gain than he was. When I look back, he might have thought to himself that he was a failure. Here was a man who not only lived his dream, but also achieved enormous success. Yet he couldn't succeed at something so many people take for granted: managing your weight. It is so sad because I know this scenario is playing out all over the country as we talk.

DJ: After Luther's stroke how did his life, and yours, change?

MS: Our lives changed tremendously. Personally, I spent more time in the hospital in the first week after Luther's stroke than I had in my entire life. Luther needed around-the-clock care. Because I found him after his stroke, I stayed with him and managed his care. After he survived his stroke, he needed help with every part of his life. So I started picking up the pieces and never stopped until he died. My boss was my mentor and one of the most influential men in my life. He taught me to go after my dreams and not let fear get in the way.

After his stroke, I took a minute everyday to acknowledge just how grateful I was to know him and work for him. Traveling around the world helping a world-famous singer was not only a great job, but also a great life. I am so thankful that I was able to continue to be part of his life and help ensure that he received the best care and quality of life possible.

DJ: Regrettably, Luther died at the age of 54. It must be very difficult for his family and you.

MS: When diabetes stopped his voice, the silence was deafening to me. I love hearing the records, but I will never forget the live concerts. I couldn't go back to working in show business after the experience. It changed me. I really regret not having known more about diabetes and its complications. I now consider myself a passionate advocate for diabetics. I'm practically a walking encyclopedia. I have formed a community-based organization called Divabetic, because I wanted to help others learn more about diabetes in a fun, effective way without feeling scared or overwhelmed. Divabetic is 'diabetic' with a 'v' for Vandross. I was inspired by my boss' fight after his stroke to regain his life. I was also inspired by Luther's love of divas like Diana, Aretha, Dionne, and Whitney. Divas inspired him to sing.

DJ: Tell us more about Divabetic.

MS: His stroke generated so much awareness in the press, I felt I had to jump in and try to help Luther's fans who were struggling with their own diabetes. And I thought we could help people get healthy before they suffer a stroke, kidney failure, or blindness. Trust me, when I first started, I didn't have such a lofty goal. But so many people told me that the word 'DIVAbetic' inspired them to take charge of their



(continued on pg. 9)

Financial News Highlights

Cytogen Corporation (NASDAQ: CYTO) reported a net loss of \$15.1 million for fiscal year 2006 versus a net loss of \$26.3 million for the comparable period in 2005. The loss is associated with the launch of new oncology products, **Caphosol** and **Soltamox**. The company reported positive issues related to a Phase I clinical trial of CYT-500, a radiolabeled monoclonal antibody targeted to prostate-specific membrane antigen (PSMA). Details at: http://home.businesswire.com/portal/site/google/index.jsp?ndmViewId=news_view&newsId=20070228005988&newsLang=en

GTx, Inc. (Nasdaq: GTXI) announced that it has entered into agreements with selected institutional investors to purchase approximately \$60.8 million of its common stock at a price of \$16.00 per share, which represents a 4.7% discount to the closing price on December 12, 2006. GTx is developing **ACAPODENE®** (toremifene citrate), a selective estrogen receptor modulator, or SERM, in two separate clinical programs in men: first, a pivotal Phase III clinical trial for the treatment of serious side effects of androgen deprivation therapy for advanced prostate cancer, and second, a pivotal Phase III clinical trial for the prevention of prostate cancer in high risk men with high grade prostatic intraepithelial neoplasia, or PIN.

- [PRNewswire](http://www.commercialappeal.com/mca/business/article/0,1426,MCA_440_5374370,00.html)
Additional details at: http://www.commercialappeal.com/mca/business/article/0,1426,MCA_440_5374370,00.html

Indevus Pharmaceuticals Inc. (IDEV) and **Valera Pharmaceuticals Inc.** (VLRX), revealed that they entered into a definitive agreement under which Indevus will acquire Valera in a stock transaction for \$7.75 per share or an aggregate value of approximately \$120 million. Valera is a specialty pharmaceutical company that markets Vantas for advanced prostate cancer. Indevus specializes in products to treat urological, gynecological and men's health conditions.

- [TradingMarkets.com](http://www.TradingMarkets.com)

Merck (nyse: MRK) reaffirmed its outlook for 2006 and forecast higher 2007 profit. In a statement, chief executive Richard Clark said investors could look to Merck to return to compound double-digit earnings growth in 2010. "Beyond 2010 we expect to deliver sustained revenue and earnings growth fueled by our growing pipeline".

EDAP TMS S.A. (EDAP - Nasdaq) concluded a private placement of 961,676 shares, in the form of American Depository Shares that resulted in net proceeds of approximately \$6.5 million. The company is the global leader in High Intensity Focused Ultrasound (HIFU) equipment for the treatment of prostate cancer. The

(continued on pg. 6)

Financial News Highlights

(continued from pg. 5)

company has utilized a new business model (Ablatherm RPP) that places equipment and provides specialist training to enhance short-term proficiency. Additional information can be viewed at:

<http://biz.yahoo.com/prnews/060803/dath045.html?.v=43>

Forbes.com predicted that the aging baby boomer population, increased pharmaceutical usage, the new Medicare prescription drug benefit plan and more generic drug introductions would drive the revenue and growth potential for the **CVS** and **Walgreen** drug chains. The story can be seen at: <http://www.forbes.com/2006/08/04/cvs-earnings-0804markets04.html?partner=alerts>

Merck, on the strength of the FDA approval of **Gardasil** for the prevention of cervical cancer, has a revenue potential worldwide of \$2 to \$4 billion. Gardasil protects against the sexually transmitted human papillomavirus (HPV) by vaccinating young girls prior to the time they might become sexually active.

Cell Genesys, Inc. (NASDAQ: CEGE) reported a fiscal year 2006 net loss of \$64.9 million versus a net loss of \$82.9 million for the comparable 2005 period. The loss was contributed by, for a significant part, research and development costs associated with the expansion of Phase III clinical trials for its product, GVAX, in the treatment of prostate cancer. Details can be viewed at: <http://sev.prnewswire.com/health-care-hospitals/20070301/SFTH05801032007-1.html>

Pharmion Corporation (NASDAQ: PHRM) announced an increase in net sales for the fiscal year 2006 of 7.9% over fiscal year 2005 primarily on the strength of reported trial data on several oncology products. Details can be read at: <http://www.prnewswire.com/cgi-bin/stories.pl?ACCT=104&STORY=/www/story/02-21-2007/0004532062&EDATE=>

Sanofi-Aventis SA, France's biggest pharmaceutical company, and Canadian drugmaker QLT Inc. agreed to pay a total of \$157.5 million to end

(continued from page 1)

BB: *The basis for routine screening at that age is that persons age 50-64 account for about 13% of new HIV diagnoses that are reported to the CDC. People older than 65 so far comprise less than 2% of new HIV diagnoses. So the cut-off is based on the likelihood of being infected, as well as the cost-effectiveness analysis. But I was at a briefing in Washington recently. There was a person there from Howard University Hospital where they started doing routine screening. They mentioned they had diagnosed unsuspected HIV in an 82 year old person. Clearly it occurs.*

DJ: Are there any risks or side effects from HIV screening tests?

BB: *There's no risk. It's a simple blood test like other blood screening tests. You might have a little bruise where the blood is drawn. There is virtually no risk associated with the test.*

DJ: Are the tests expensive? I understand there are different kinds of tests, including a home testing kit.

BB: *The routine or conventional test, called an EIA, is inexpensive. It depends on what the lab charges--and of course we have no control over that—but it usually costs about \$8. The big difference is in the time to get results. Because the EIAs are run in batches (the typical EIA procedure uses a plate that can perform 90 tests in a batch) most laboratories run them only once a day. (Some hospital labs with lower volume may run them only once or twice a week.) Therefore, the time necessary to get results depends not only on the procedure, but the processing. In general, however, labs do not report positive EIA test results until they have been repeated, and if positive, followed by a confirmatory test. Thus, it may take from several days to a week before the laboratory reports a positive test result.*

The rapid test, which gives you immediate results, costs between \$12 to \$15. So we don't consider it a particularly expensive test. As for the home kit, the only thing that's currently available is a home sample collection kit, where a person pricks their finger, puts blood onto a specimen card, and sends it in to a laboratory where they use a conventional test. That is just as accurate as when a sample is collected in a doctor's office.

DJ: Do you know if insurance would cover these tests?

BB: *Well, the way insurance works right now is that they pay for recommended screening tests and they pay for tests that are associated with a diagnosis. So if someone came in and they had something that might be related to HIV, I think there is no question that insurance would pay for it. The issue of insurance paying for screening tests is always one that takes a while to develop. When the CDC issues recommendations and other medical societies endorse them (so far the American Medical Association and the American College of Obstetrics and Gynecology have issued the same recommendations), they become standard of care and insurance companies pay for them. At the current time, certain insurance companies have already said they would pay for screening. Others are saying paying for it as a screening test is 'under consideration.' But we anticipate that most insurance companies will begin to pay for HIV screening.*

DJ: Is there a difference in efficacy between the EIA and the rapid test?

BB: *No, both tests are screening tests and they're both very accurate. Accuracy of the rapid test and the conventional test are both well over 99%. In addition, if there is a positive test you do have to have confirmation, not dissimilar to a PSA test, which is a screening test but does not diagnose cancer until you do further kinds of testing. But to be absolutely certain after the screening test, you need a confirmatory blood work to clinch the diagnosis.*

DJ: How often should the testing be done?

BB: *We're recommending at the current time that everyone should know their HIV status. We don't recommend that people get tested more than once unless they have some kind of risk for HIV, such as multiple sexual partners or men having sex with men. In those cases we recommend people get screened at least every year. The big problem in terms of older people is that data shows that they don't think they have a chance of being infected, so they get diagnosed later in the course of the disease. Because they are diagnosed later, they respond less well to the therapy since their disease is already further along. It's a part of the reason that we are recommending screening up age 64 on a routine basis--to try to catch people before they go on to develop HIV disease.*

DJ: Screening people for this disease is sensitive and, in case they had it, potentially a discriminatory one. How will clinicians handle suggesting this screening? Will they get supplemental training or is it something they are already comfortable with?

BB: *Well there are two sides to what you're talking about. One of the problems in the past for a lot of people was that HIV was perceived as something you only had to worry about if you were in a high-risk behavior group--injection drug users, homosexual men, or something like that. So just getting an HIV test was associated with some degree of stigma. It was like admitting that you'd had some kind of past indiscretion that you might prefer not to admit. So we think that recommending the screening for everybody is going to reduce the stigma associated with testing.*

The other issue is the persistent stigma that is associated with having HIV disease itself, because there's a lot of fear and concern around that. There are programs that are working with that and treating it in primary care settings. Of course people who have more experience in taking care of people with HIV disease are providing the initial training. So, in response to your question, we don't think clinicians will need additional training to do the screening itself, but it may be that some clinicians are less familiar with how to actually monitor and manage HIV disease. They may need to acquire a consultation or referral to a specialist, similar to sending someone to an oncologist after they're diagnosed with cancer.

DJ: Is it common for clinicians to refer to an HIV specialist?

BB: *It's increasingly common because there are a very large number of drugs that are available--there are now about 29 first-line drug combinations available. So it might require getting advice from an HIV specialist. There are two organizations of HIV specialists that also provide information about referrals resources. One is the American Academy of HIV Medicine and the other is the HIV Medicine Association. They both have referral and consultation services to help clinicians who may not be familiar with an HIV specialist.*

DJ: If a person is diagnosed with HIV, what should they expect from their doctor? What would the next steps be?

BB: *Well they do need to confirm the diagnosis, but because the tests are really accurate, it's very rare that the test result is not confirmed. So you then need to get some additional testing to figure out what stage the disease is in. Depending what that shows, you would have to have periodic monitoring to determine the course of the disease and when you might need to get started on the antiretroviral therapy. Recommendations for exactly when therapy should be started are updated about*

(continued on pg. 7)

twice a year. The primary recommendation is to evaluate a person by doing blood tests, including a viral load test and a CD4 lymphocyte count. The lymphocytes are the part of the immune system that HIV damages. When the CD4 count starts to drop, that's when you start to think about initiating the antiretroviral therapy.

DJ: Which groups are most at risk now and has that changed since the 1980's?

BB: As a transmission category, men who have sex with men still comprise the largest proportion of HIV infected people. Among women, heterosexual contact is the most common source of HIV infection. We think that certainly has changed since the 1980's when this was primarily a disease among men who have sex with men and injection drug users.

DJ: In December, the National Institutes of Health reported that, "...given similar patterns of risk behaviors across racial groups, young African American adults are more likely to become infected [with HIV]." Even those people without high risk behavior (multiple sexual partners, alcohol, tobacco, or drug abuse) they "were more than seven times as likely as young white adults in the same category to harbor STD/HIV infection." Can you comment on this?

BB: The big message for people to recognize is that HIV is a sexually transmitted disease. Since the proportion of infections among injection drug users is decreasing and transmission as a result of blood transfusions has been eliminated in this country, the primary way HIV infection is currently spread is through sexual activity. So if you talk about African Americans with no risk factors, I think what you're talking about is the absence of traditional risk factors related to injection drug use or potentially men having sex with men. Their infections are more often a result of heterosexual contact.

DJ: What kind of outreach is recommended for those who do not seek out routine healthcare?

BB: There are two circumstances here. One, the CDC and other public health agencies have for a long time maintained specific outreach programs. We try to get people who are at high risk into programs and into HIV care. An important goal of the new recommendations is directed toward the population that only receives medical care from emergency departments. They don't have a source of primary care, so we want to make sure that these people can have the opportunity to get an HIV test wherever they encounter the healthcare system.

Recently in the MMWR (Morbidity and Mortality Weekly Report) we published an analysis from South Carolina where they were able to link everyone that was reported with HIV and AIDS to data on health care visits. What they found is that 73% of the people who were diagnosed with HIV or AIDS had had multiple (an average of 4) healthcare visits before they got diagnosed with HIV, when it could have been found earlier. And almost 80% of those healthcare visits were made to emergency rooms. So the issue is not only people who have routine healthcare, but people who access healthcare and rely on emergency departments as their main source of healthcare. That's a place we are particularly interested in focusing some of our screening efforts.

DJ: Did I leave anything out that we should know?

BB: I think that you covered everything. I think our key message is that finding out that you have HIV does give you access to lifesaving treatment. In the early days when the CDC made its first recommendations in 1993 for more wide spread screening, therapy was not nearly as effective. So there was much less benefit in finding out whether you were HIV infected. The second thing that we haven't talked much about is the issue of what this might do for the whole epidemic. Because it's been shown that people who are unaware that they are HIV infected are about 3 1/2 times more likely to transmit HIV than people who know about it. So in addition to the benefit for individual patients, there is a considerable benefit for their loved ones and for the people around them in reducing the chance of transmitting HIV to someone else.

Also I want to reiterate that we need to communicate even to people in the older range.

It's of concern to us that survival for older people is shorter, because HIV is usually diagnosed later. So we'd like to make sure that older patients benefit from advances in treatment as much as younger people and that they are getting tested. Make sure the guys over 60 get the message as well.

DJ: Thank you so much for your time, Dr. Branson, and for bringing us up-to-date on this epidemic and how people can take care of themselves. ♂

Editor's Note: To find the nearest location where the test can be provided,

- Call: 1.800.CDC-INFO
- On the Web: www.hivtest.org

A Pass for Provenge!?

On March 29th an advisory panel to the U. S. Food and Drug Administration (FDA) voted to recommend that the immunotherapy vaccine, **Provenge**, be approved for the treatment of advanced stage prostate cancer. With votes of 17-0 and 13-4, the group believed that the drug was safe and "substantially effective" respectively, based on clinical trial results seen thus far. The shares of the manufacturer, Dendreon, soared on news of the recommendation.

The panel's recommendation was a victory on many fronts: for patients, it offers hope for those who have failed hormonal therapy; for advocates, it was a watershed moment in coalescing behind an agenda to effect policy change in the drug approval process; for the pharmaceutical industry, it signals a possible shift in FDA policy relative to drug approvals given that Provenge had failed in two other clinical trials; and, lastly, it could be a potential financial bonanza for Dendreon with estimated U.S. sales of the drug as much as \$1 billion.

However, despite the panel's recommendation, there still remains a cloud that could yet rain on the parade based on some cautionary comments emanating from several sectors. Scientific concerns point to the fact that the number of trial participants was only 127 patients versus the 1,000 men tested in the Taxotere trial. Additionally, like the cancer drug Iressa, concern suggests that early data approval may be reversed based on results from a larger trial study. There is a 500-patient study under way now, but it isn't expected to finish until 2010. There is also concern surrounding the significant "buzz" in the media from the drug's inception that has fueled much of the financial movement and speculation on the stock.

The FDA is under pressure to insure drug safety, asking for more and more data before a drug is approved. At the same time, it is under pressure from consumers who want access to those drugs that appear to have a positive therapeutic benefit without necessarily waiting for full FDA approval. The key question therefore is "If a cancer therapy seems to work, should the FDA risk giving it an early approval?"

May 15th, which is the deadline set for the FDA to act on the Provenge application, will be a watershed moment on many fronts. ♂

Financial News Highlights

(continued from pg. 6)

a patent suit so they can continue to sell the prostate cancer drug Eligard. Details can be seen at:

<http://www.bloomberg.com/apps/news?pid=20601082&sid=aONsWFA67DkY&refer=canada>

The stock of **Dendreon** began to move upward in anticipation of the FDA Advisory Committee's meeting scheduled for the week of March 26th to discuss approval of the drug **Provenge**. Positive comments could set the stage for a major win by the company; the opposite could be the death knell for the company. Further information can be seen at: http://www.247wallst.com/2007/03/dendreon_stock.html

GPC Biotech gave additional details about the Phase III trial of **satraplatin** at a scientific meeting in Germany. In the test, satraplatin was administered along with prednisone as a second-line treatment to 950 patients with hormone-refractory prostate cancer. The oral drug provided pain relief and extended progression-free survival. Satraplatin has been under FDA review since February. Spectrum Pharma (SPPI) licensed the drug to GPC in 2002, and GPC sold the European rights to Pharmion (PHRM). GPC rose 45 cents to \$28.57. Excerpted from: <http://biotech.seekingalpha.com/article/30529>

GPC Biotech made a net loss in the fourth quarter because of higher research and development costs for its key drug satraplatin, despite a 79 percent increase in sales. GPC said it expects 2007 sales, research and development costs and cash burn to be higher than in the previous year, but did not give a more specific outlook. The full article can be read at: http://investing.reuters.co.uk/news/article/investing.aspx?type=health&storyID=2007-03-15T120239Z_01_L15591807_RTRIDST_0_SP_PAGE_015-L15591807-OISHE.XML

Hollis-Eden Pharmaceuticals, Inc. (NASDAQ:HEPH) today announced financial results for the fourth quarter and year ended December 31, 2006. For the fourth quarter, the Company reported a net loss of \$7.9 million (or \$0.29 per share), compared to a net loss of \$10.4 million (or \$0.50 per share) in the fourth quarter of 2005. For the full year, the Company reported a net loss of \$30.2 million (or \$1.20 per share), compared to a net loss of \$29.4 million (or \$1.46 per share) for full-year 2005. During 2006, Hollis-Eden focused heavily on advancing next-generation drug candidates from its Hormonal Signaling Technology Platform towards clinical development. Another next-generation drug candidate, HE3235, has demonstrated impressive activity in preclinical models of hormone driven prostate and breast cancer. The complete report can be seen at: http://home.businesswire.com/portal/site/google/index.jsp?ndmViewId=news_view&newsId=20070316005211&newsLanguage=en

Constella Group Supports Prevention of Prostate Cancer through Enhancing Human Health Grants



Bobby Jefferson, on left; Jesse Milan, Constella VP, Corporate Philanthropy

Constella Group, a leading global provider of professional health services, today announced that it has awarded, through its Constella Group Corporate Giving Fund of Triangle Community Foundation, \$10,000 to The Prostate Net's, Going to the Barbershop to Fight Prostate Cancer, a campaign that enlists local barbers as health educators so they can, in turn, educate African American men about risk factors, prevention, early detection and treatment of prostate cancer.

Through its grant, Constella will support The Prostate Net's recruitment of barbers into the campaign. The grant will also be used to expand linkages to medical centers for free screening programs for patients and to expand community outreach activities, all to address the hidden health issue of prostate cancer among African American men.

"Constella has played a vital role in cancer research, in children's health, and in violence prevention programs as part of our vision of enhancing human health around the world, every day," said Donald A. Holzworth, Constella Group chairman and CEO. "I am honored that Constella is supporting this organization — which shares our passion for educating people about the treatment and prevention of prostate cancer.

"Constella is helping The Prostate Net achieve its goal through this generous grant," said Virgil Simons, founder and president of The Prostate Net. "Fighting cancer necessitates communicating with family, doctors, friends and community to achieve the best chance for a cure, but more importantly to minimize the risk for those yet undiagnosed. We are honored

that Constella employee, Bobby Jefferson, a member of our Advisory Board, nominated us for this grant."

Constella Group is a leading provider of professional health services worldwide, dedicated to enhancing human health around the world, every day. Through its work in health sciences, international development, and pharmaceutical product development, Constella creates and provides health intelligence to help industry and government clients identify and solve critical problems affecting human health. For more information, visit www.constellagroup.com

In 2006, Constella established its Corporate Philanthropy Program to support non-profit organizations across the world that share the company's goal toward achieving a healthy and disease free world. The program encourages employee volunteerism and community service by limiting Enhancing Human Health Grants only to organizations where employees actively volunteer. Under the leadership of its corporate philanthropy officer, Constella established a company-wide representative committee responsible for reviewing grant applications and deciding which grants, and at what amount, Constella should fund. For more information on Constella's Corporate Philanthropy Program contact Jesse Milan, corporate philanthropy officer, at 202.777.0945 or at jmilan@constellagroup.com ♂

At Your Service.....

One of the most important features in our matrix of services to our readers is our **Peer Survivor Counselor** program. With this effort, we provide a "Been there, done that" human support that specifically details the "need to know" information that will get you through whatever phase of the disease you're in.

If you're trying to decide whether to have an open prostatectomy versus the robotic laparoscopic version, we have counselors that have been through each one and can comment on what to expect and, more importantly, what to ask of your doctors. We have a team that can comment on:

- surgical techniques
- radiation therapies
- hormonal options
- chemotherapy protocols
- clinical trial participation
- side effects issues
- end-of-life concerns

To reach one of our counselors you can:

- email us – support@prostatenet.org
- call us – 1.888.4ProsNet(477.6763)

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This month we put the spotlight on our "First Family" of counselors, **Manuel and Mary Vazquez**.

Manuel has been an integral part of The Prostate Net's existence because he counseled our Founder, Virgil Simons, through his encounter with prostate cancer and has been by his side for the thirteen years since. Manuel had been an IT executive in the oil industry until he came face-to-face with prostate cancer. After he beat the "beast" he became passionate about changing the lives of others through education and personal support; over the years, he has been a mentor and support for hundreds of men and their families.

Though blessed with a great family and life, and having fought the disease once, he had to go on to face subsequently many years of after-effects from his therapy and complications from the treatments to correct the side-effects issue. He has therefore accumulated experiences and knowledge that he passes on to others going down the path he's walked. Manny has gone through several counselor training programs and still participates in many American Cancer Society and Man-To-Man patient support efforts.

Mary is not someone who sits on the sidelines either; her sage and grandmotherly words have helped many partners of men facing the disease understand how they can best support the men in their lives to get through the process and to hold themselves together as well.

We are truly blessed to have Mary and Manny as part of our team! ♂



EXPLORING NEW HORIZONS IN HEALTHCARE

by Diane Johnson

The face of America is changing...literally. Due to a number of trends--for example, the declining white birthrate vs. higher birthrates in minority and immigrant populations--the U.S. will soon be "a majority of minorities", according to the Strategic Research Institute (www.srinstitute.com). The Institute hosts an annual Multicultural Healthcare Conference that focuses on market development and outreach.

According to Rupa Ranganathan, Ethnic Strategist at the SRI, this conference is designed to help "find solutions and insights to unlocking under-tapped segments of diverse ethnic and culturally different populations." She began this conference eight years ago after noting both increasing interest from healthcare representatives and glaring racial and ethnic disparities in healthcare. She decided to bring together "folks who are in the industry with experts who can help bridge these gaps. "

From grassroots and faith-based strategies to cultural insights into health behaviors to website content management, the conference will address the healthcare issues that are emerging as the country's racial and ethnic groups grow. Some topics include:

Reaching the Hispanic Community through Cultural Connections
Emerging Opportunities and Challenges in Asian American Healthcare
Tapping into Gay and Lesbian Media
Best Practices in Multicultural Event Marketing
Identifying Needs of the Physician Community

Presenters this year included Virgil Simons, the Founder and President of The Prostate Net, who discussed the successful national health education and advocacy program, the Barbershop Initiative, and Thomas A. LaVeist, PhD, from the Center for Health Disparities Solutions in the Johns Hopkins Bloomberg School of Public Health, who spoke on the ethnic demographic transitions occurring in this country and its ramifications on the healthcare system.

"Serious disparities in the health status of these population groups increase the importance of cultivating stronger relationships," Ms. Ranganathan added. "Healthcare companies must connect closer with multicultural populations."♂

LUTHER

(from page 5)

diabetes like a diva, that I decided to get more involved. I now present monthly diabetes motivational support meetings in Manhattan and Harlem, ongoing annual programming, and online support (www.divabetic.org).

This year one of my programs, Divabetic--Makeover Your Diabetes, is being presented in seven major cities--Philadelphia (January 1), New York City (February 22), New Orleans (March 31), Los Angeles (June 16), Cleveland (September 29), with Dallas and Washington, D.C. to be announced. We work with certified diabetes educators, registered dietitians, and certified life coaches to help people make game plans for better care. We throw in things like knitting classes, tea tastings, and image consultations to keep it upbeat and fun. And we mix in some glamour, fashion, music, education and fitness. We try to make our programming as entertaining as a live Luther show. And, thanks to the sponsorship of Novo Nordisk, it's all free. I do provide programming for all family members, but I focus on the 'divas'. I believe if I reach the women, the women will in turn take what they learned back to their families and 'share the care.'

DJ: We all know and love people who have diabetes. What can we do to help them?

MS: I think people can start asking questions and stop being polite or distant. I recently heard a story of a man who was living with diabetes his whole life. One day he unfortunately developed cancer. Everyone he knew wanted to know how they could help with his cancer, but no one had ever offered help with his diabetes. For some reason there is a lot of blame and shame associated with this disease. In fact, many people share in our meetings how family members sabotage their efforts to get back on track with their care!

Don't make fried chicken every night and assume someone can 'just say no.' Refuse to cook it in the first place. Buy more fruits and vegetables. Learn about diabetes. My grandmother was living with diabetes, but she died when I was very young. I knew the words 'diabetes' and 'touch of sugar', but I had no idea what serious complications can be associated with it. Grandparents can teach their grandchildren important lessons about this. Have your loved ones show you how to inject their insulin and/or what to give them if they're experiencing a high or a low. Don't wait for them to be lying on the ground to learn. Learn now. And one more thing: many people with diabetes are battling depression. I don't think people are aware of this. Depression can really play havoc with someone's ongoing care. We need to stop blaming people for not taking better care of themselves and lead by example. Just listening and letting them talk about their diabetes is probably the greatest way to unmask the silent killer.

DJ: Anything else you want our readers to know?

MS: I don't want what happened to Luther to happen to anyone else. Everyday I wake up with one goal in my mind: to prevent someone else from suffering a stroke. I am so grateful that I'm helping further my boss' legacy by helping others stay healthy and upbeat about their daily diabetes care. I feel driven to bring diabetes education to the community and teach people in a language they will understand.

And I want to thank all of Luther's fans out there for being so supportive and kind to the Vandross family, friends, and staff after his stroke. You can see a letter from Luther's mother, Mary Ida Vandross, on our website. She writes very movingly of how diabetes has devastated her family. We read every letter the fans write and respond to as many as we can. We always end our meetings with a line from one of Luther's most popular songs--"Believe in the power of love!" That says it best.

DJ: Thank you so much for sharing what you've learned and what you're hoping to accomplish. We wish you nothing but success in this terribly important mission.♂

Editor's note: More information on Max and his programs can be found at:
www.divabetic.org

Improving Access to Prostate Cancer Treatment

Free Program Helps Uninsured Americans Save on Prescription Medicines and Products

The most common cancer (aside from skin cancer) found in American men is prostate cancer. According to the American Cancer Society, approximately 218,890 new cases of prostate cancer will be diagnosed in the United States in 2007. While the disease remains the second leading cause of cancer death in men, the death rate for prostate cancer is on the decline due to early detection and treatment. When prostate cancer is found early and treated effectively, there is nearly a 100 percent chance of a cure.

Thus, access to medications for the treatment of prostate cancer should never become a barrier to care. However, an estimated 46 million people across the United States do not have healthcare coverage. That's why it's important to know about a free prescription savings program called **Together Rx Access**.

Individuals may be eligible for the Together Rx Access™ Card if they do not qualify for Medicare, do not have public or private prescription drug coverage, have a household income of up to \$30,000 for a single person or \$60,000 for a family of four (income eligibility is adjusted for family size) and are a legal resident of the United States or Puerto Rico.

Most cardholders save 25 to 40 percent (Editor's Note: Each Cardholder's savings depend on such factors as the particular drug purchased, amount purchased, and the pharmacy where purchased. Participating companies independently set the level of savings offered and the products included in the program. Those decisions are subject to change.) on brand-name prescription drugs and products. Over 300 brand-name prescription products are included in the program; visit the program's Website for the most current listing of medicines and products. Savings on a range of generics are also available. The program is accepted at a majority of pharmacies nationwide and in Puerto Rico. Cardholders simply go to their pharmacist with their prescription, and the savings are calculated right at the pharmacy counter. There are no enrollment costs, monthly dues or hidden charges.

Together Rx Access was created by leading pharmaceutical companies to help patients and their families gain access to meaningful savings on needed prescriptions right at the pharmacy counter. The program also directs individuals to the Partnership for Prescription Assistance (PPA), a clearinghouse for more than 475 public and private assistance programs, including 180 offered by pharmaceutical companies.

There are three easy ways to enroll in the Program:

- o Call the toll-free phone number 1-800-250-2839.
- o Complete a short paper application and return it by mail.
- o Visit www.TogetherRxAccess.com to instantly enroll online.

A quick start savings card is available that can be activated over the phone in less than one hour if the eligible enrollee calls within call center hours and two business days at all other times.

"We firmly believe increasing access to and utilization of quality prostate cancer care can reduce prostate cancer deaths," says Virgil H. Simons, founder and president of The Prostate Net. "The Together Rx Access Card offers a necessary resource for patients with prostate cancer who need help paying for the treatments they so desperately need." ♂

Patient Assistance Programs

Many of these programs will require request through your doctor as well as various proofs of income and financial need; however, they can be effective in getting the treatment that you require but can't afford:

CancerCare

800.813.4673

www.cancercare.org/get_help/assistance

Partnership for Prescription Assistance

888.477.2669

www.pparx.org

Patient Advocate Foundation

866.512.3861

www.copays.org

RxAssist / RxOutreach Patient Assistance Programs

www.rxassist.org

RxHope

877.979.4673

www.rxhope.com

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Amgen Reimbursement Connection

800.272.9376

www.amgen.com/patients/assistance.html

Bristol-Myers Squibb Patient Assistance Foundation

800.736.0003

www.bmspaf.org

Sanofi-Aventis PACT Plus

800.996.6626

<http://oncology.sanofi-aventis.us/reimbursement>

HEALTHY BODY

(from page 4)

DJ: How can we get your message out to men at risk?

MM: *I approach it from a probability standpoint. We use probability in every aspect of our lives: wearing a seatbelt may help but may not, for example. Physicians are practicing probability in medicine everyday. If there is a high probability of a cure, then that treatment is chosen. If it has a low probability of success, it is rejected. It makes sense then to choose the highest probability items to fix your health. If you focus on what you can control now, it will have a profound effect on your cancer risk in the future.*

DJ: How can people find out more about alternative medicine?

MM: *One resource is a quarterly journal that I edit called "Seminars in Preventive and Alternative Medicine". It presents reviews of treatment options, nutritional therapies, preventive measures, etc., all based on reports from clinical trials. It is a valuable resource for practitioners and patients dealing with cancer and other chronic diseases. It's available at www.seminarsprevaltmed.com.*

DJ: Thank you so much, Dr. Moyad, for your time and insights. Your dedication to your patients is an inspiration. ♂

Visit us at ASCO – Booth #4003
June 1 – 5, 2007
McCormick Place, Chicago



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(continued from page1)

www.prostatenet.org

The Prostate Net / The Knowledge Net will present its full matrix of services at the Annual Meeting of the American Society of Clinical Oncology.

Please stop by our booth to review our range of educational and communication solutions:

- **The Knowledge Net** interactive computer educational system for:
 - o Consumer/patient passive or interactive learning
 - o Specific product/protocol presentation
 - o Embedded consumer research capability
- **The Barbershop Initiative** for clinical and/or research interventions in minority and/or medically underserved communities
- **In The Know activities:**
 - o Health disparity awards programs
 - o Newsletter and educational modules
 - o PodCasts and Cell Casts capabilities for enhanced education
 - o **New Nurse recognition program**
- **“Crowns Against Cancer”** faith based educational and intervention programs



“Master Barber of the Year” Award

CALL FOR ENTRIES

DEADLINE— June 22, 2007

Criteria

Licensed for 10+ years with no state barber board violations

Documented commitment to the profession

Documented commitment to the community

Documented committed to barber training

Send one page (maximum) letter of nomination stating why your nominee deserves this honor; include copy of nominee’s barber license, photo and 3 letters of endorsement documenting commitment to community service to:

**Master Barber of the Year Contest
Barbers International, Inc.
2708 Pine Street
Arkadelphia, AR 71923**

Details at: www.barbersinternational.com

**Finalists and Winner recognized August 4-6, 2007 during
2nd Annual Barbers International Conference
B 'Ej keci qu'Y gurlp'Qu' ctg'J qvgr#**

June 1- 5, 2007

American Society of Clinical Oncology
McCormick Place
Chicago, IL
Details at: www.asco.org/annualmeeting

July 29 – August 2, 2007

Emory – Winship Cancer Institute
Future Directions in Hematology and Oncology
The Cloister
Sea Island, GA
Details at: www.cancer.emory.edu/events

August 4 – 6, 2007

Barbers International Annual Meeting
Details at: www.barbersinternational.com

August 13 – 16, 2007

CDC Cancer Conference: Meeting
Future Challenges
Hyatt Regency
Atlanta, GA
Details at: www.cdccancerconference.net

August 27 – 31, 2008

UICC World Cancer Congress
Geneva, Switzerland
Details at: www.uicc.org/congress08

September 5 – 8, 2007

Department of Defense Prostate Cancer Research Program
IMPACT: Innovative Minds in Prostate Cancer Today
Hyatt Regency
Atlanta, GA

September 7 – 8, 2007

The 2007 Breast Cancer Symposium
San Francisco, CA
Details at: www.breastcasyposium.org

Qevqdt '53'6'Pqxo dgt '5.'4229

Society for Public Health Education
58th Annual Meeting
Alexandria Mark Hilton
Alexandria, VA
Details at: www.sophe.org

Pqxo dgt '5'6'9.'4229

American Public Health Association
Annual Meeting
Washington, DC
Details at: www.apha.org

Did You Know?

The Centers for Medicare and Medicaid Services is now posting information on its Websites that shows hospital-specific treatment detail on 30 procedures, along with Medicare payment data that can help you make informed decisions on the quality of hospital care. Details can be seen at: www.cms.hhs.gov/HealthCareConInit/

Drinking 48 ounces of Water daily for men (32 ounces for women) can lower the risk for bladder, colon and breast cancer as well as improve your memory and mood.

A Tufts University study has shown that music can have a comparable effect of a 325-mg dose of acetaminophen in lowering pain after surgery. Hmm...I wonder if it could work with diagnostics as well: take your iPod with you for your DRE!

Mortality rates for African-American women are higher than any other racial/ethnic group for nearly every major cause of death including heart disease, lung cancer, cerebrovascular disease, breast cancer and chronic obstructive pulmonary diseases.

- Making the Grade on Women's Health: National Women's Law Center

The frequency of premenopausal breast cancer in African-American women is twice the rate of Caucasians. Studies show that in most instances, that in African-American women, by age 40, the cancer has already spread. Details of this report by the U.S.

Department of Health and Human Services, Office of Minority Health are available at: www.omhrc.gov/ctg/ctg_cancer_issue.pdf

While Hispanic women have almost 50% higher incidence rates of cervical cancer than Black women, Black women are 75% more likely to die from the disease. Details can be seen at: http://seer.cancer.gov/csr/1973_1999

Heart disease is the leading cause of death for Black women in the U.S. The higher mortality rates seem to be the result of a higher proportion of Black women exhibiting the risk factors associated with increased mortality: cigarette smoking, hypertension, diabetes, high cholesterol, inadequate physical activity and obesity.

- JAMA.1998;280(4):356-362
- Urban and Rural HealthChartbook. National Center for Health Statistics, 2001

The Association for Black Cardiologists has developed an educational video on preventing heart disease for African-American women, featuring Maya Angelou. It can be ordered from: www.abcardio.org/womensCenter/heartHealth.htm

71% of the 4,500 newly diagnosed cases of HIV is found among African-American women.

- American Journal of Public Health. 2001;91(7):1060-1068

Call for Applications for the NCI's DCLG

An opportunity for Advocates voices in Cancer Care

The National Cancer Institute's Office of Liaison Activities (<http://ola.cancer.gov>) is

extending an open invitation to all interested and eligible advocates, consumers and survivors to apply for 4 vacancies on the National Cancer Institute (NCI)

Director's Consumer Liaison Group (DCLG) with terms beginning July 2007. More information on the program can be found at: <http://dclg.cancer.gov>

The DCLG is a Federal Advisory Committee of 16 cancer advocates and consumer members who are appointed by the Director of the NCI.

As a group the DCLG reflects the breadth and diversity of the cancer consumer advocacy community in expertise, cultural, ethnic, gender and regional distribution. DCLG members provide broad-based recommendations to the NCI Director, and serve as a forum to receive feedback and input

from all areas of the cancer advocacy community.

The NCI Director has identified eliminating cancer disparities and research issues in cancer care delivery as two focus areas for the DCLG in 2007.

DCLG applications are now being accepted and must be postmarked by March 30, 2007 in order to be considered.

Application instructions can now be downloaded from: <http://deainfo.nci.nih.gov/advisory/dclg/applications/2007DCLGApplication.pdf>

Information on completing the application package can be obtained from:

Palladian Partners, Inc.
ATTN: DCLG 2007 Selection Process
Phone: 1.301.650.8660
Email: dclg2007@palladianpartners.com



The Prostate Net, Inc. P. O. Box 2192, Secaucus, NJ 07096-2192

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