CHAPTER 11. Prostate Cancer

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PROSTATE CANCER

IMPORTANCE OF PROSTATE CANCER FOR CANCER PREVENTION AND CONTROL

Prostate cancer is the most common cancer in U.S. men, accounting for about 29% of all newly diagnosed cancers, and the second leading cause of cancer deaths in U.S. men. One in six men will develop prostate cancer over the course of his life.[1] The American Cancer Society estimates that 218,890 cases of prostate cancer will be newly diagnosed in 2007 in the U.S.[1,2]

Risk factors that predispose men to prostate cancer are older age, black race, and a family history of prostate cancer (a history of having an affected first-degree relative at least doubles the risk).[3] Despite increasing research on the subject, the relationship between diet and obesity and risk of developing prostate cancer is as yet unclear. However, obesity and other related conditions, such as diabetes, have been associated with poorer post-surgical outcomes and increased mortality from prostate cancer.[4]

According to the American Cancer Society, more than 65% of all men with prostate cancer are 65 years of age or older.[2] Because prostate cancer usually occurs at an age when conditions such as heart disease and stroke cause death, many men die *with* prostate cancer rather than *from* it. Fewer than 10% of men with prostate cancer die of the disease within five years of diagnosis.[1] However, survival varies by stage at diagnosis and the characteristics of each individual case. Without treatment, men diagnosed with aggressive, or high-grade, prostate cancer have a significantly higher mortality than those with low-grade tumors, regardless of stage at diagnosis.[5] Black men develop prostate cancer at a higher rate than men in any other racial or ethnic group, but the reasons for the higher rate remain unknown. Black men are also far more likely than other men to die of this disease. In the years 1999–2003, 65 of every 100,000 black men died of prostate cancer compared with 27 of every 100,000 white men, 22 of every 100,000 Hispanic men, 18 of every 100,000 American Indian men, and 12 of every 100,000 Asian/Pacific Islander men.[1]

Although the risk factors for prostate cancer are inherent and therefore not preventable, certain tests can be performed for early diagnosis and screening. In 1986, the U.S. Food and Drug Administration approved the prostate-specific antigen (PSA) test as a method to monitor prostate cancer progression. The PSA test permitted the detection of latent and preclinical cancers that cannot be detected by clinical means. As a result, a large number of prostate cancers have been diagnosed that would never have been detected clinically (latent) or were detected earlier than clinical detection would have allowed (preclinical).[6] The prevalence of latent prostate cancers diagnosed at autopsy has decreased significantly with the advent of screening, especially in men over 70 years of age.[7] This suggests that prostate cancers that, in the past, went undiagnosed are now being diagnosed during the patient's lifetime.

Scientific consensus has not yet been reached on the effectiveness of prostate cancer screening in reducing deaths, and effective measures to prevent prostate cancer have not yet been determined. Prostate cancer screening by PSA or digital rectal exam (DRE) may, in fact, lead to the over-treatment of cancers that, if left undetected, would pose no threat to the health of the patient.[8]

Many physicians recommend screening to their patients, and in recent years a substantial proportion of men in the United States have been screened for prostate cancer with PSA, DRE, or both. Although screening detects some prostate cancers early in their growth, it is not yet known whether prostate screening saves lives or whether treatment reduces disability and death from this disease. A recent study conducted in Austria found a 19% reduction in mortality among men who received free PSA screening

compared to men who did not. Ongoing randomized trials in the United States and Europe will better evaluate the survival benefit of prostate cancer screening with PSA.[9]

Guidelines for prostate cancer are controversial primarily because of lack of evidence from randomized trials that early detection and aggressive treatment of prostate cancer can reduce mortality.[2,10,11] Other controversies exist because PSA testing frequently detects prostate cancer in older men, who may well die of other causes long before they are affected by the slow-growing prostate tumor that might otherwise have gone undetected. Additionally, as with other screening mechanisms, patients must contend with the possibility of false positives, anxiety over false positives, drawbacks to aggressive treatment, and the burden of dealing with a cancer that might never have been discovered or affected the patient during his natural life.[3,8]

A recent study published by the American College of Physicians recommends that all men begin prostate cancer screening at age 40 to establish a baseline PSA. PSA levels should be carefully monitored to identify rapid increases. The study also supports screening men older than 70 due to increasing life expectancy. All patients, regardless of age, should be counseled about the risks and benefits of undergoing prostate cancer screening and should discuss their options with a physician.[11]

The Centers for Disease Control and Prevention do not recommend prostate cancer screening but do recommend that men be provided with up-to-date information about screening, including the potential harms and benefits. Several organizations—including the American Cancer Society, the American Urological Association, the National Cancer Institute, and the U.S. Preventive Services Task Force—recommend offering information about the potential harms and benefits of screening in order that men, their physicians, and their families can make informed decisions about screening.[10,12]

For all of these reasons, it is important to educate the public and healthcare professionals about these issues concerning prostate cancer. Then, individuals should be able to make informed decisions about their prostate health in consultation with their doctors and families.

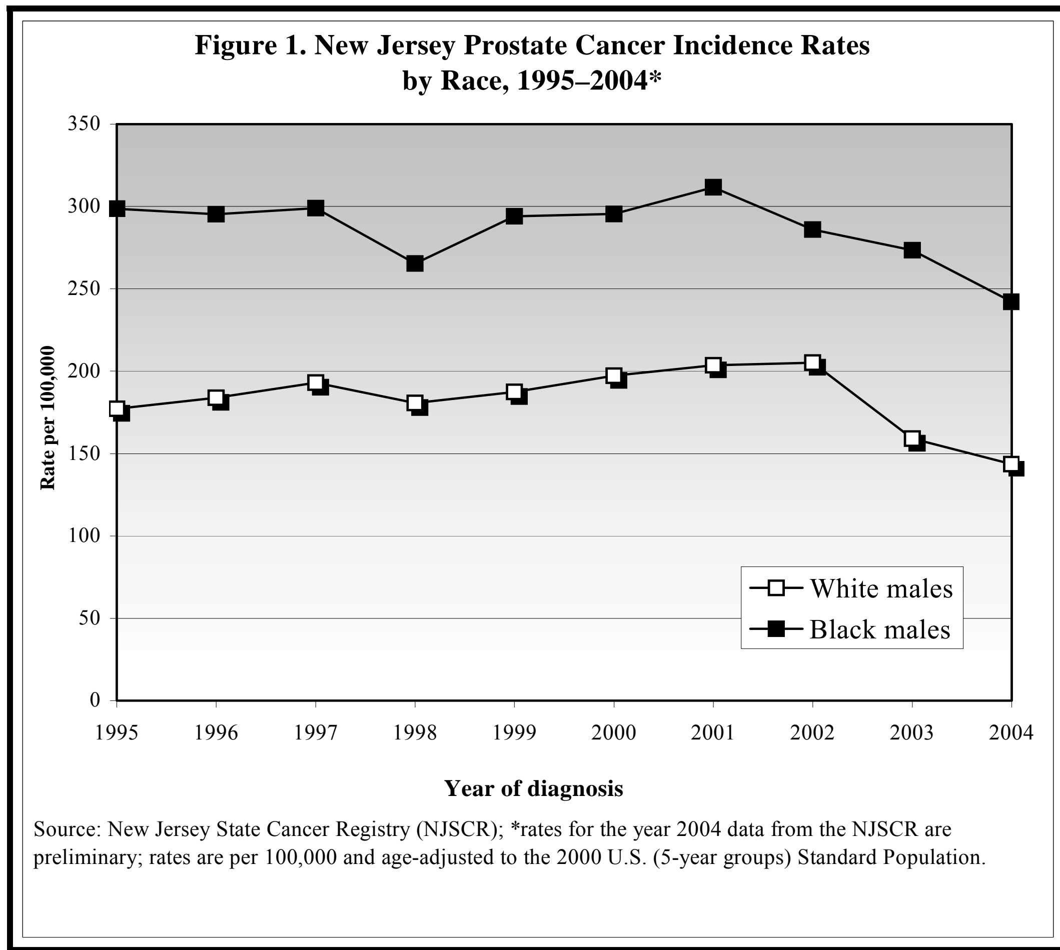
PROSTATE CANCER IN NEW JERSEY

In this section we discuss the status of prostate cancer in New Jersey, including incidence, mortality, prevalence, survival, and screening.

Incidence. Among New Jersey men, about 8,070 cases of prostate cancer will be diagnosed in 2007.[1] In 2004*, 157.7 men per 100,000** were diagnosed with prostate cancer in New Jersey; the rate was 143.6** among white men, 242.2** among black men**, and 157.7** among Hispanic men.[13] Black males have consistently had a higher incidence rate than white males in New Jersey, as well as in the nation (Figure 1).

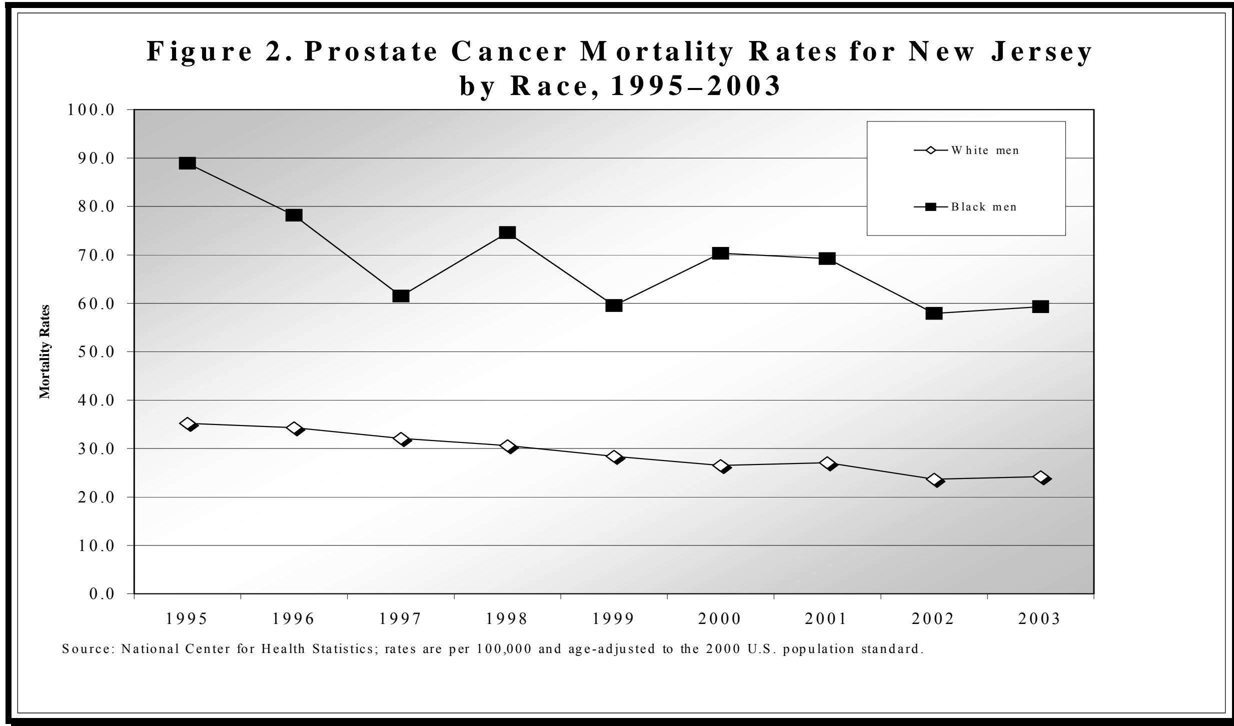
* Incidence rates for the year 2004 data from the New Jersey State Cancer Registry are preliminary.
** Rates are per 100,000 and age-adjusted to the 2000 U.S. population standard.

A significant decline in the number of deaths from prostate cancer has occurred since 1996, while the number of new cases has declined slowly. However, the burden is not equal. Among black men the toll of prostate cancer is particularly high, with a disease incidence approximately 50% higher than among white men. In addition, black men tend to experience the disease at an earlier age than white men, are diagnosed at more advanced stages of the disease, and die at a rate twice that of white men.[1] Men of all races with close relatives with prostate cancer are also at high risk for the disease. Between 1995 and 2004*, the annual proportion of cases diagnosed in the early stages of the disease (either in situ or localized) increased from about 61% in 1995 to about 85% in 2004*.[13,14,15]



Mortality. The American Cancer Society estimates that about 27,050 deaths due to prostate cancer will occur among men in the U.S. in 2007.[1] In New Jersey about 750 men will die of prostate cancer in 2007.[1] Prostate cancer mortality rates have decreased from 1995 to 2003. In whites in 1995 the New Jersey mortality rate was 35.2 per 100,000** compared to 24.2 per 100,000 in 2003; for blacks the rate was 88.9 per 100,000 in 1995 compared to 59.3 per 100,000** in 2003. The mortality rate for Hispanics has also decreased from 1995 to 2003. In 1995, the mortality rate for Hispanics was 26.4 per 100,000** compared to 20.1 per 100,000** in 2003 (Figure 2).[13] This is similar to decreases seen in the U.S. as a whole.[16]

* Incidence rates for the year 2004 data from the New Jersey State Cancer Registry are preliminary.
** Rates are per 100,000 and age-adjusted to the 2000 U.S. population standard.



Prevalence. Estimates indicate that on January 1, 2003, there were 61,483 or 1.5% of New Jersey men alive who had ever been diagnosed with prostate cancer. As with other cancers, the prevalence of prostate cancer increases with age and is highest in the 65+ age group (11.0%). The prevalence of prostate cancer is higher in whites than blacks (1.6% versus 1.2%, respectively).[17]

Survival. Similar to the U.S., the five-year relative survival rate for prostate cancer diagnosed in New Jersey (all races combined) from 1994–1997 is very high at 98.4%. Disparities in survival, however, exist between blacks and whites. In New Jersey, black men have a lower overall five-year survival rate than do white men (93.8% versus 99.2%, respectively) for the period 1994–1997 due to a higher proportion of black men being diagnosed at late stage.

Prostate cancer survival rates are much higher for cancers diagnosed at the local and regional stages than at the distant stage. In New Jersey from 1994–1997, the five-year relative survival rate for local- and regional-stage prostate cancer was almost 100%, whereas that for distant-stage prostate cancer was only 28.6%. From 1984–1997 prostate cancer diagnosed at the local stage has increased from 58% to 71% for white men and from 53% to 70% for black men. The five-year survival rate for black men and white men is the same for local disease (100%). However, the survival rate for regional and distant disease is slightly higher for black men than white men (100% versus 97.5% for regional disease and 30.1% versus 27.8% for distant disease, respectively).[18]

Screening. According to 2004 data from the New Jersey Behavioral Risk Factor Survey, approximately one-half of men aged 40 years and older reported having had a PSA test within the past two years. The number of men who reported having had a PSA test increased with age; 27.4% for the 40- to 49-year-old age group, 61.8% for the 50- to 59-year-old age group, 78.2% for the 60- to 64-year-old age group, and 77.5% for men 65 years of age and older. The rate of screening in New Jersey is highest in the black population; 58.0% of blacks reported PSA testing within the previous two years, followed by 56.5% of whites, and 44.9% of Hispanics (Figure 3).[19]

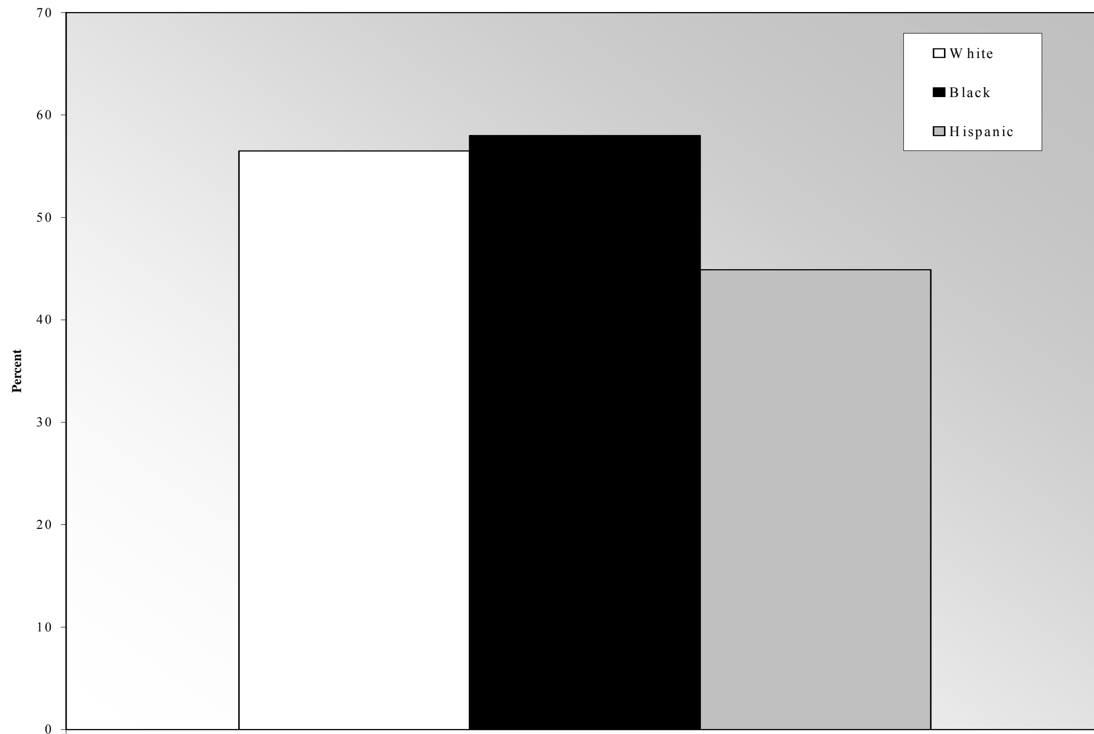


Figure 3. 2004 NJ Behavioral Risk Factor Survey,
Percent of Men aged 40+ who have had a PSA test within the past two years
70
60
50
40
30
20
10
0
Percent
White
Black
Hispanic
Men aged 40+ who have had a PSA test within the past two years
Source: Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, [appropriate year]

HEALTHY NEW JERSEY 2010 GOALS

Healthy New Jersey Goal	Reduce the age-adjusted death rate of males from prostate cancer per 100,000 to 23.0 for total males, 23.0 for white males, and 46.0 for black males, ensuring that all efforts are appropriate culturally, linguistically, and at the proper literacy level, by 2010.

Table 1. Age-adjusted death rate from prostate cancer, New Jersey, 1999–2002 and Healthy New Jersey 2010 projected target rates.[20]

Population	1999	2000	2001	2002	Target	Preferred 2010 Endpoint
Total	30.4	29.6	30.0	25.9	23.0	14.0
White	28.4	26.7	27.1	23.8	23.0	13.0
Black	58.4	69.1	68.3	57.5	46.0	25.0
Hispanic	17.5	21.4	14.8	27.1	***	***
Asian/Pacific Islander*	**	**	**	**	***	***

* *The number of Hispanic and Asian/Pacific Islander deaths is known to be understated.*
** *Figure does not meet standard of reliability or precision; based on fewer than 20 cases in numerator.*
*** *A target was not set because the baseline data for this subpopulation were statistically unreliable.*
Note: Data for white, black, and Asian/Pacific Islander include Hispanics and non-Hispanics.

GOALS, OBJECTIVES, AND STRATEGIES

Prostate Cancer Summits were held—most recently in April 2001—to gather New Jersey physicians, researchers, health professionals, patients, advocates, and various organizations to address the serious healthcare crisis in prostate cancer. Four areas for action were identified for New Jersey: public education and awareness, patient/client education for screening and follow-up, access to care, and research and surveillance. Therefore, the Prostate Cancer Workgroup has used these four areas as a basis for addressing prostate cancer in this report.

In support of the Healthy New Jersey 2010 goal for prostate cancer, the recommendations of the Prostate Cancer Workgroup are summarized below for the following focal areas:

- Public awareness and education
- Patient/client education for screening and follow-up
- Access to care
- Research and surveillance

PUBLIC AWARENESS AND EDUCATION

As described earlier in this chapter, scientific consensus has not been reached on the effectiveness of prostate cancer screening in reducing deaths, and effective measures to prevent prostate cancer have not yet been determined. Education and early detection, therefore, represent the two prongs of our approach to addressing prostate cancer in New Jersey. Because there is no consensus on screening for this disease, the public must be educated on the risk factors for prostate cancer, the screening methods, and the options for treatment if cancer is found. The public should be educated about the pros and cons of prostate cancer screening to facilitate informed decision-making.

New Jersey is fortunate in that the New Jersey Cancer Education and Early Detection Program (NJCEED) has a state appropriation of 5.4 million, $900,000 of which is allocated to provide prostate cancer education, outreach, and screening to medically underserved men (Appendix B). If an individual consents to being screened, he is given the PSA and DRE screening tests. If a screening test result is found to be suspicious, the patient is then referred for further examination and work-up. It is hoped that such education and access to screening and treatment services will be instrumental in fighting prostate cancer in New Jersey.

However, the NJCEED program targets only those individuals living at or below 250% of the Federal Poverty Level. Dissemination of prostate cancer information should be broadened to reach all New Jersey residents in order to more widely influence knowledge, attitudes, and practice related to adherence to prostate-healthy behaviors, prevention, and early detection.

Educational and community-based programs can play an integral role in contributing to the improvement of health outcomes related to prostate cancer, specifically in high-risk populations. These programs, when developed to reach those outside of traditional healthcare settings, can be critical to enhancing health promotion and quality of life for New Jersey residents. Interventions that will elicit and ensure participation from populations at high risk for prostate cancer should be a high priority.

One such intervention that has been successfully implemented in New Jersey under the first edition of this *Plan* is the Prostate Net's *Going to the Barbershop to Fight Prostate Cancer* initiative. With the support of the Prostate Cancer Workgroup, the Prostate Net brought this innovative national initiative to New Jersey in 2004. The objectives of the Barbershop Initiative are to:

- Address the situation of racial health disparity prevalent within minority communities through education on disease risk leading to informed disease screening.
- Establish a network of barbershops, medical centers, and other concerned stakeholders (**The Barbershop**) for providing to those at greatest risk consistent, ongoing healthcare communication and motivation to participate in the healthcare system.
- Establish and validate a credible peer educator/communicator (**The Barbershop**) to facilitate delivery of the healthcare messages and to motivate the audience to participate in the healthcare system.
- Address other medical conditions with a negative impact on these communities.

To date, the Barbershop Initiative in New Jersey encompasses 73 barbers and 16 healthcare centers.

In 2005 and 2006, the Prostate Net awarded the Prostate Cancer Workgroup and the Task Force an Honorable Mention at the first annual "In the Know" Awards for Eliminating Health Disparities for its work in implementing the Prostate Cancer chapter of the *Plan*.

The Prostate Cancer Workgroup recommends the continued implementation of such public awareness and education interventions.

GOAL PR-1	To promote a public health message regarding prostate cancer screening and the benefits and risks of early detection, symptoms, and follow-up for normal and abnormal screening and treatment.

Objective PR-1.1

To increase public knowledge among **all** people about the risk factors associated with prostate cancer and the benefits of early detection, especially for men aged 40 years and older who are at high risk, men of African descent, and men with a family history of prostate cancer.

Strategies

PR-1.1.1 Promote educational programs that comprehensively describe prostate cancer screening, the risks involved in screening, symptoms, follow-up, and treatment for all men, including participation in clinical trials.

PR-1.1.2 Monitor to ensure that the educational materials list the pros and cons of prostate cancer screening.

PR-1.1.3 Promote educational programs that describe the issues related to barriers, myths, access, funding for prostate cancer screening, follow-up, and treatment for high-risk individuals throughout the age continuum, especially men of African descent. Promote the provision of these educational programs by partnering with national, local, and statewide organizations.

PR-1.1.4 Identify and partner with community-based organizations for prostate cancer educational programs to further implementation.

PR-1.1.5 Develop and distribute a prostate cancer resource guide for New Jersey residents, as well as a communication plan for public education on prostate cancer.

Patient/Client Education for Screening and Follow-up

Although PSA levels alone do not supply doctors with sufficient information to distinguish between benign prostate conditions and cancer, the doctor will take the result of this test into account in deciding whether to check further for signs of prostate cancer. While there is no definitive PSA level above which the test is considered diagnostic, PSA velocity (the rate at which a patient's annual PSA level increases) and PSA doubling time (the length of time it takes for a patient's PSA level to double) can be used as an indicator to recommend further testing. For this reason, it is important that a baseline PSA be established and followed for any change.[11] Men should discuss PSA or DRE results with their doctors, especially since it is not clear that all men need to be treated immediately for prostate cancer. Men should receive information regarding possible risks and benefits of detecting and treating prostate cancer early. Men who ask their doctors should receive education and information about testing.

According to the American Cancer Society, many factors may cause an individual to refrain from seeking out available screening and educational programs. Personal beliefs and practices, fear, lack of physician recommendation, and lack of access to medical care have all been identified as barriers to cancer screening. Low cancer-screening prevalence is found particularly among adults who have little or no access to medical care, are uninsured or underinsured, have lower education levels, live in rural areas, have language barriers, are members of ethnic minorities, or lack referrals from their physicians. Additionally, people with unhealthy lifestyle practices, such as smoking, are less likely to seek out cancer screening than those with healthy lifestyles.[10]

Currently, men in New Jersey who are eligible can be screened for prostate cancer through the NJCEED program (Appendix B). Yet additional efforts will be required to increase the number of men who seek out screenings. These efforts will demand improved collaboration among government agencies, private companies, non-profit organizations, healthcare providers, policy-makers, insurance companies, survivors, and the general public. No formal state mechanism currently exists to ensure downstream care if prostate cancer is diagnosed through the NJCEED program.

Providing education is the first step to increasing the number of New Jersey residents accessing prostate cancer screening. Increasing knowledge, improving physician recommendations, and creating access to affordable cancer screening tests are important ways to lower barriers to cancer screening. For example,

when offices and/or insurance companies use methods such as computerized reminders for screening appointments, screening rates tend to increase.

GOAL PR-2	To improve client/patient education about prostate cancer screening, risk factors, symptoms, follow-up, and treatment.

Objective PR-2.1

To increase knowledge among men with normal screening results about the need to annually discuss prostate cancer screening, using nationally recognized screening guidelines, with a medical professional.

Strategies

PR-2.1.1 Promote educational materials and resources that provide information on prostate health and screening.

PR-2.1.2 Ensure that distributed materials on prostate health and screening are up to date.

PR-2.1.3 Develop a communication plan for client/patient education on prostate cancer.

Objective PR-2.2

To increase knowledge among men with screening abnormalities about the benefits and risks associated with nationally recognized prostate cancer diagnostic and treatment procedures by providing information and resources.

Strategies

PR-2.2.1 Investigate available prostate cancer educational materials and resources that explain in detail the next steps to be taken following an abnormal screening, the available procedures, and the benefits and risks of each procedure. Develop these materials if needed.

PR-2.2.2 Distribute the above-mentioned materials to men with abnormal screening results for prostate cancer.

ACCESS TO CARE

One of the major barriers to cancer prevention and early detection is lack of access to proper screening. Although screening programs are available, access to care is a problem in medically underserved areas. Studies have shown that those with less than optimal access to care are generally ethnic minorities, unemployed, and have lower levels of education and income, usually below the poverty line.[21]

In New Jersey, challenges within the healthcare delivery system have been identified as a major access issue, along with language and transportation barriers.[21]

A variety of community-based organizations, especially faith-based organizations, specifically design their programs for underserved populations. Local, state, and federal agencies also need to expand their programs to underserved populations.

Partnerships with healthcare providers are essential to facilitate prevention, and selected healthcare providers based on their location should target underserved populations. Establishment of a public announcement system available throughout the state that includes sites, times, availability of transportation, networking system, etc. is also essential.

Currently, eligible men and women have access to screening for breast, cervical, colorectal, and prostate cancers through the NJCEED program. If diagnosed through the program, women may be eligible to receive Medicaid coverage of treatment for breast and cervical cancer. However, there is no program currently in place to provide treatment for those diagnosed with prostate or colorectal cancer. It is essential that funds be allocated to provide treatment to these individuals.

To improve access to care for prostate cancer, the Prostate Cancer Workgroup proposes the following goal, objectives, and strategies.

GOAL PR-3	To increase access to prostate cancer services for all New Jersey men, including education, screening, treatment, and palliative care.

Objective PR-3.1

To increase the number of contacts, e.g., prostate cancer screenings, education, support groups, etc. made available by healthcare practitioners and advocates for targeted populations.

Strategies

PR-3.1.1 Partner with community leaders/community-based organizations, including faith-based organizations, on prostate cancer education and screening programs to create incentives that attract underserved populations.

PR-3.1.2 Identify underserved populations in need of prostate cancer education and screening using credible data available through local, state, and federal agencies.

PR-3.1.3 Identify prostate cancer education and screening services in convenient sites or areas within communities.

PR-3.1.4 Develop strategies to empower significant others to encourage males to seek prostate cancer education and screening services.

PR-3.1.5 Provide advocacy services to help clients with prostate cancer navigate the healthcare system.

PR-3.1.6 Develop strategies to encourage payers to support community-based prostate cancer prevention services since early detection may be more cost effective.

PR-3.1.7 Partner with community-based organizations to address language, education, literacy, cultural, and economic barriers to receipt of prostate cancer education and screening services.

PR-3.1.8 Partner with community-based organizations to develop and offer culturally relevant programs located within easily accessible community sites, e.g., take prostate cancer education and screening programs to community events, bring programs to the people.

PR-3.1.9 Evaluate funding sources through government agencies, insurance and pharmaceutical companies, and foundations to assist in finding ways to increase access to prostate cancer education and screening services.

Objective PR-3.2

To ensure that all men diagnosed with prostate cancer through the NJCEED program have access to follow-up and treatment services.

Strategy

PR-3.2.1 Advocate for funding to be allocated to provide treatment for all men diagnosed with prostate cancer through the NJCEED program.

RESEARCH AND SURVEILLANCE

Prostate cancer is characterized by a wide range of treatment options depending on a patient's age, overall health, status of the cancer, and personal choice. In addition, knowledge about the disease, its

detection, and its treatment is constantly evolving. Physicians, particularly primary care doctors, may find it difficult to remain apprised of new developments and subsequently advise or treat individual patients in an efficient and comprehensive manner.

The Prostate Cancer Workgroup will closely monitor new and emerging research in prostate cancer and partner with organizations to ensure that both patients and physicians remain up to date on currently available technologies and resources.

New research into prostate cancer prevention, early detection, and treatment is ongoing. In order to ensure that research outcomes are applicable to diverse populations, it is important to recruit racial and ethnic minorities to participate in clinical trials. However, significant barriers have been identified that lead to under-representation of minorities in clinical research. A recent study identified barriers to research participation among Latinos and blacks. These included fear of experimentation/harm, lack of transportation, lack of financial resources, time conflicts, mistrust of the healthcare system and medical research, fear of deportation, poor communication, and language barriers. Several factors were also found to motivate minorities to participate in research, including having medical staff from the same racial/ethnic group and having childcare and transportation provided.[22]

Strategies to improve minorities' participation in clinical research should include: (1) effective communication and interaction between research teams and the community; (2) developing culturally sensitive research teams to build trust; (3) planning to eliminate the burden of cost associated with transportation, childcare, and time off from work; (4) improve effective communication regarding the business of research and the benefits to the participant and the community; (5) improve the participant-research team relationship by creating a research environment in which the patient feels valued and respected.[23] Addressing these barriers and providing appropriate motivation is an important step in increasing minority representation in clinical research studies.

GOAL PR-4	To expand a research agenda specific to prostate cancer issues in New Jersey.

Objective PR-4.1

To develop a plan to incorporate men, in demographic groups that are underrepresented, in prostate cancer screening and clinical trials.

Strategies

PR-4.1.1 Identify and develop community leaders as intermediaries between organized medicine and the individual client concerned about prostate cancer.

PR-4.1.2 Develop outreach programs with community leaders to improve client participation in screening and clinical trials.

PR-4.1.3 Increase the quality and the amount of information patients receive to facilitate making informed decisions to seek prostate cancer screening.

PR-4.1.4 Partner with the New Jersey Commission on Cancer Research to encourage researchers to seek out grants in prostate cancer research.

Objective PR-4.2

To facilitate collaboration between institutions providing prostate cancer clinical trials and underrepresented populations.

Strategies

PR-4.2.1 Encourage the physicians of underrepresented populations to refer their prostate cancer patients to clinical trials in New Jersey.

PR-4.2.2 Encourage the physicians of underrepresented populations to participate directly in clinical trials for prostate cancer in New Jersey.

PR-4.2.3 Educate physicians about clinical trials for prostate cancer so that this information can be disseminated to men who may be eligible to participate.

GOAL PR-5

To ensure that New Jersey residents and physicians remain up to date on currently available prostate cancer technologies and resources.

Objective PR-5.1

To continue to monitor and disseminate current advances in prostate cancer prevention, screening, diagnosis, and treatment.

Strategies

PR-5.1.1 Conduct periodic literature reviews to determine the state of the science in prostate cancer research and to identify potentially promising new technologies.

PR-5.1.2 Work with stakeholders to disseminate, as they become available, evidence-based advances to healthcare providers through CME offerings.

Objective PR-5.2

To continue to monitor trends in prostate cancer incidence, mortality, and survival.

Strategy

PR-5.2.1 Request appropriate data, as needed, from the New Jersey State Cancer Registry and other applicable sources.

References

1. Jemal A, Siegel R, Ward E, Murray T, Xu J, and Thun MJ. Cancer statistics 2007. *CA: a Cancer Journal for Clinicians* 2007;57;43–66.
2. American Cancer Society. *Cancer Facts and Figures 2007*. Atlanta, GA: American Cancer Society, Inc, 2007.
3. Barry MJ. Prostate-specific-antigen testing for early diagnosis of prostate cancer. *New England Journal of Medicine* 2001;344(18):1373–1377.
4. O'Malley RL and Taneja SS. Obesity and prostate cancer. *Canadian Journal of Urology* April 2006;13(Suppl 2):11–17.
5. Albertson PC, Hanley JA, and Fine J. 20-year outcomes following conservative management of clinically localized prostate cancer. *JAMA* 2005;293(17):2095–2101.
6. Merrill RM and Stephenson RA. Trends in mortality rates in patients with prostate cancer during the era of prostate specific antigen screening. *Journal of Urology* 2000;163(2):503–510.
7. Konety BR, Bird VY, Deorah S, and Dahmoush L. Comparison of the incidence of latent prostate cancer detected at autopsy before and after the prostate specific antigen era. *Journal of Urology* 2005;174(5):1785–1788.
8. Harris R and Lohr KN. Screening for prostate cancer: An update of the evidence for the U.S. Preventive Services Task Force. *Annals of Internal Medicine* 2002;137(11):917–929.
9. Oberaigner W, Horninger W, Klocker H, Schönitzer D, Stühlinger W, and Bartsch G. Reduction of prostate cancer mortality in Tyrol, Austria, after introduction of prostate-specific antigen testing. *American Journal of Epidemiology* 2006;164(4):376–384.
10. American Cancer Society. *Cancer Prevention and Early Detection Facts and Figures 2006*. Atlanta, GA: American Cancer Society, Inc., 2006.
11. Catalona WJ, Loeb S, and Han M. Viewpoint: Expanding prostate cancer screening. *Annals of Internal Medicine* 2006;144:441–443.
12. U.S. Preventive Services Task Force. *Screening for Prostate Cancer: Recommendations and Rationale*. Rockville, MD: Agency for Healthcare Research and Quality. Available at http://www.ahrq.gov/clinic/3rduspstf/prostatescr/prostaterr.htm. Accessed October 2, 2006.
13. New Jersey State Cancer Registry. *January 2007 Analytic File.* Trenton, NJ: New Jersey Department of Health and Senior Services, 2007.
14. Burger SS, Klotz JB, Weinstein RB, Abe T, and Van Loon S. *Cancer Incidence in New Jersey 1995–1999: Implementation of the Year 2000 Population Standard*. Trenton, NJ: New Jersey Department of Health and Senior Services, Cancer Epidemiology Services, New Jersey State Cancer Registry, 2001.
15. Aloyets N, Klotz J, Roche LM, Van Loon S, and Kohler BA. *Prostate Cancer in New Jersey, 1979–1996*. Trenton, NJ: New Jersey Department of Health and Senior Services, Cancer Epidemiology Services, 2000.
16. Surveillance, Epidemiology, and End Results (SEER) Program (http://www.seer.cancer.gov) SEER*Stat Database: Mortality – All COD, Public-Use With State, Total U.S. (1969–2003),

National Cancer Institute, DCCPS, Surveillance Research Program, Cancer Statistics Branch, released April 2006. Underlying mortality data provided by NCHS (http://www.cdc.gov/nchs).

17. Niu X, Roche LM, Pawlish K, Kohler BA, and Van Loon S. *Cancer Prevalence in New Jersey on January 1, 2003*. Trenton, NJ: New Jersey Department of Health and Senior Services, Cancer Epidemiology Services, November 2006.
18. Niu X, Agovino PK, Roche LM, Kohler BA, and Van Loon S. *Cancer Survival in New Jersey, 1979–1997*. Trenton, NJ: New Jersey Department of Health and Senior Services, Cancer Epidemiology Services, September 2006.
19. Centers for Disease Control and Prevention. *Behavioral Risk Factor Surveillance System Survey Data*. Atlanta, GA: Centers for Disease Control and Prevention, 2007.
20. New Jersey Department of Health and Senior Services. *Healthy New Jersey 2010: Update 2005*. Trenton, NJ: New Jersey Department of Health and Senior Services, Center for Health Statistics, 2005.
21. Vali FM. *Access to Primary Care in New Jersey: Geographic Variation of Hospitalizations for Ambulatory Care Sensitive Conditions in 1995 and 1997.* Princeton, NJ: Health Research and Educational Trust of New Jersey, 2001.
22. Calderon JL, Baker RS, Fabrega H, Conde JG, Hays RD, Fleming E, and Norris K. An ethno-medical perspective on research participation: A qualitative pilot study. *Medscape General Medicine* 2006;8(2):23.
23. BeLue R, Taylor-Richardson KD, Lin J, Rivera AT, and Grandison D. African Americans and participation in clinical trials: Difference in beliefs and attitudes by gender. *Contemporary Clinical Trials* 2006, doi:1016/j.cct.2006.08.001.