The Manitoba Prostate Cancer Support Group
NEWSLETTER

Vol. 222 – December 2009

The Manitoba Prostate Cancer Support Group encourages wives, loved ones, and friends to attend all meetings.

Feel free to ask basic or personal questions without fear of embarrassment. You need not give out your name or other personal information.

The Manitoba Prostate Cancer Support Group does not recommend treatment modalities, medications, or physicians. All information is however freely shared.

Want to reach us by email ?

manpros@mts.net

Thought For Today

Do as much research as you can
Proceed deliberately but without rushing
Choose the best doctor as you can find
Go with your best gut feeling
And never look back.

- Calm Men Sense

Web Resources:

www.hisprostatecancer.com

This site is especially good at covering the disease basics and treatment options. There is also information on after treatment topics such as your sex life, incontinence and nutrition. Another section deals specifically with treatment options for recurring prostate cancer. Overall, a worthwhile site to visit.

MOVING?

HELP US KEEP OUR RECORDS UP TO DATE

(204) 989-3433

Medical Advisors to The Manitoba Prostate Cancer Support Group

J. Butler M.D.
Radiation Oncologist

Paul Daeninck M.D.
Pain Management

Darryl Drachenberg M.D.
Urologist

Graham Glezerson M.D.
Urologist

Len Leboldus M.D.
Urologist
[Honorary]

Ross MacMahon M.D.
Urologist

John Milner M.D.
Urologist

Jeff Sisler M.D.
Family Practitioner

Gary Schroeder M.D.
Radiation Oncologist

Thanks!

Cancer Information Service

Call toll free:
1-888-939-3333 or
1-905-387-1153

When you call the toll free number of the Cancer Information Service, your questions will be answered by someone who understands how confus ing the subject of cancer can be. *All calls are kept confidential*

NEXT MEETING:

Thursday, December 17th, 2009 7 - 9 P.M.

Party Time: Don Swidinsky - guitarist.: Celtic Group
" Beggars Brawl " - Miriam, Darrell, Mike & D'Arcy

Location: AUDITORIUM of the Seven Oaks General Hospital - Leila & McPhillips

CHRISTMAS IS AROUND THE CORNER

WHICH SIGNALS THE END OF THE 2009 TAX YEAR.

We want to remind everyone planning to make a donation to the support group for a deduction on their income tax return, to do so soon. That way, Joseph, our Treasurer, will have time to issue your receipt **before December 31**.

Please act soon, because Joseph gets very busy cooking his Christmas turkeys in December!

WE REALLY APPRECIATE YOUR SUPPORT

The Manitoba Prostate Cancer Support Group operates on your donations

Have you used any of our services?

Newsletter - General Meetings - Hospital visits - One-on-one visits - Speakers

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Manitoba Prostate Cancer Support Group (MPCSG)

 # 705 - 776 Corydon Ave., Winnipeg R3M OY1

a tax deductible receipt will be issued.

Many Men 'Overdiagnosed' For Prostate Cancer, Study Finds

One million American men had needless treatment since PSA test became common

By Tom Spears, The Ottawa Citizen September 1, 2009

More than one million American men have gone through needless treatment for prostate cancer since the PSA test became common more than 20 years ago, a medical journal says.

And the study's author says Canadian men face the same problem of "overdiagnosis," causing them to have surgery and radiation treatment that can cause impotence, incontinence and pain.

This doesn't mean diagnosing cancer where none exists, says the study and editorial in Monday's Journal of the National Cancer Institute. It means that many men had a form of cancer that could have been left alone safely.

Doctors have long known this can happen with PSA tests, which measure a chemical in the body whose level increases when prostate cancer is present, the study says. But the author claims to have the first firm count of how many men are affected.

The PSA test (it stands for prostate-specific antigen) is designed as a way to detect cancer in an early stage.

But lead author Dr. Gilbert Welch of the U.S. Veterans Administration says having such a test shouldn't cause more cancers to be detected. It should, he says, allow doctors to find the same number of cancers - but find them earlier.

That's not what has happened. Since 1986, Welch estimates, American doctors have detected 1.3 million more prostate cancer cases than they would have found without the PSA test. Of those men, just over a million had cancer treatment.

"This is definitely a problem in Canada as well," he said, though he does not use Canadian statistics in his study. "Most of this excess incidence (number of cases) must represent overdiagnosis," his study concludes.

"I don't think it's widely understood yet," said Welch, an internal medicine specialist. "Many people don't understand the human cost of being overdiagnosed — being told you have cancer" even though "that cancer will never cause symptoms or death in your lifetime. We don't know which patients are overdiagnosed, so we treat them all."

Men in their 50s are now 3.6 times more likely to be diagnosed with prostate cancer than before the PSA test. Men younger than 50 are now 7.2 times more likely to be diagnosed.

"We appear to be taking what used to be a disease of older men and turning it into a disease of younger men," he said.

In an editorial in the same journal, the chief medical officer of the American Cancer Society argues that while the death rate from prostate cancer is dropping (down 40 per cent since 1993), "the reasons are not known" and the PSA test may not be responsible.

Dr. Otis Brawley says an American survey shows no benefit of screening, while a European study shows the PSA test does save lives.

But even the European study shows "substantial overdiagnosis," he says.

"More than 1,400 men have to be screened and 48 additional men diagnosed and treated to avert one prostate cancer death."

He adds: "Prostate cancer screening has resulted in substantial overdiagnosis and unnecessary treatment. It may have saved relatively few lives.

"We desperately need the ability to predict which patient has a localized cancer that is going to metastasize and cause suffering and death and which patient has a cancer that is destined to stay in the patient's prostate for the remainder of his life."

In Canada, "we have been seeing similar trends in the increase of the rates of cancers being diagnosed," said Heather Chappell, acting director of cancer control policy at the Canadian Cancer Society.

"It's our inability to tell the dangerous cancers from the cancers that you would have lived with all your life and not even known about."

Research continues into trying to learn the difference, she said. Meanwhile, "we firmly believe that it (screening) should be a personal choice" for patients.

In Canada, about 23,500 men are diagnosed with prostate cancer each year, and 4,400 die from it.

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Cancers Can Vanish Without Treatment, but How?

By GINA KOLATA October 27, 2009

Call it the arrow of cancer. Like the arrow of time, it was supposed to point in one direction. Cancers grew and worsened.

But as a paper in The Journal of the American Medical Association noted last week, data from more than two decades of screening for breast and prostate cancer call that view into question. Besides finding tumors that would be lethal if left untreated, screening appears to be finding many small tumors that would not be a problem if they were left alone, undiscovered by screening. They were destined to stop growing on their own or shrink, or even, at least in the case of some breast cancers, disappear.

"The old view is that cancer is a linear process," said Dr. Barnett Kramer, associate director for disease prevention at the National Institutes of Health. "A cell acquired a mutation, and little by little it acquired more and more mutations. Mutations are not supposed to revert spontaneously."

So, Dr. Kramer said, the image was "an arrow that moved in one direction." But now, he added, it is becoming increasingly clear that cancers require more than mutations to progress. They need the cooperation of surrounding cells and even, he said, "the whole organism, the person," whose immune system or hormone levels, for example, can squelch or fuel a tumor.

Cancer, Dr. Kramer said, is a dynamic process.

It was a view that was hard for some cancer doctors and researchers to accept. But some of the sceptics have changed their minds and decided that, contrary as it seems to everything they had thought, cancers can disappear on their own.

"At the end of the day, I'm not sure how certain I am about this, but I do believe it," said Dr. Robert M. Kaplan, the chairman of the department of health services at the School of Public Health at the University of California, Los Angeles, adding, "The weight of the evidence suggests that there is reason to believe."

Disappearing tumors are well known in testicular cancer. Dr. Jonathan Epstein at Johns Hopkins says it does not happen often, but it happens.

A young man may have a lump in his testicle, but when doctors remove the organ all they find is a big scar. The tumor that was there is gone. Or, they see a large scar and a tiny tumor because more than 95 percent of the tumor had disappeared on its own by the time the testicle was removed.

Or a young man will show up with a big tumor near his kidney. Doctors realize that it started somewhere else, so they look for its origin. Then they discover a scar in the man's testicle, the only remnant of the original cancer because no tumor is left.

Testicular cancer is unusual; most others do not disappear. But there is growing evidence that cancers can go backward or stop, and researchers are being forced to reassess their notions of what cancer is and how it develops.

Of course, cancers do not routinely go away, and no one is suggesting that patients avoid treatment because of such occasional occurrences.

"Biologically, it is a rare phenomenon to have an advanced cancer go into remission," said Dr. Martin Gleave, a professor of urology at the University of British Columbia.

But knowing more about how tumors develop and sometimes reverse course might help doctors decide which tumors can be left alone and which need to be treated, something that is now not known in most cases.

Cancer cells and precancerous cells are so common that nearly everyone by middle age or old age is riddled with them, said Thea Tlsty, a professor of pathology at the University of California, San Francisco. That was discovered in autopsy studies of people who died of other causes, with no idea that they had cancer cells or precancerous cells. They did not have large tumors or symptoms of cancer. "The really interesting question," Dr. Tlsty said, "is not so much why do we get cancer as why don't we get cancer?"

The earlier a cell is in its path toward an aggressive cancer, researchers say, the more likely it is to reverse course. So, for example, cells that are early precursors of cervical cancer are likely to revert. One study found that 60 percent of precancerous cervical cells, found with Pap tests, revert to normal within a year; 90 percent revert within three years.

And the dynamic process of cancer development appears to be the reason that screening for breast cancer or prostate cancer finds huge numbers of early cancers without a corresponding decline in late stage cancers.

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If every one of those early cancers were destined to turn into an advanced cancer, then the total number of cancers should be the same after screening is introduced, but the increase in early cancers should be balanced by a decrease in advanced cancers.

That has not happened with screening for breast and prostate cancer. So the hypothesis is that many early cancers go nowhere. And, with breast cancer, there is indirect evidence that some actually disappear.

It is harder to document disappearing prostate cancers; researchers say they doubt it happens. Instead, they say, it seems as if many cancers start to grow then stop or grow very slowly, as has been shown in studies like one now being done at Johns Hopkins. When men have small tumors with cells that do not look terribly deranged, doctors at Johns Hopkins offer them an option of "active surveillance." They can forgo having their prostates removed or destroyed and be followed with biopsies. If their cancer progresses, they can then have their prostates removed.

Almost no one agrees to such a plan. "Most men want it out," Dr. Epstein said. But, still, the researchers have found about 450 men in the past four or five years who chose active surveillance. By contrast, 1,000 a year have their prostates removed at Johns Hopkins. From following those men who chose not to be treated, the investigators discovered that only about 20 percent to 30 percent of those small tumors progressed. And many that did progress still did not look particularly dangerous, although once the cancers started to grow the men had their prostates removed.

In Canada, researchers are doing a similar study with small kidney cancers, among the few cancers that are reported to regress occasionally, even when far advanced.

That was documented in a study, led by Dr. Gleave that compared an experimental treatment with a placebo in people with kidney cancer that had spread throughout their bodies. As many as 6 percent who received a placebo had tumors that shrank or remained stable. The same thing happened in those who received the therapy, leading the researchers to conclude that the treatment did not improve outcomes.

The big unknown is the natural history of many small kidney tumors, many of which are early kidney cancers. How often do small tumors progress? Do they ever disappear? Do they all need surgical excision? At what stage do most kidney cancers reach a point of no return?

These days, Dr. Gleave said, more patients are having ultrasound or CT scans for other reasons and learning that there is a small lump on one of their kidneys. In the United States, the accepted practice is to take those tumors out. But, he asks, "Is that always necessary?"

His university is participating in a countrywide study of people with small kidney tumors, asking what happens when those tumors are routinely examined, with scans, to see if they grow. About 80 percent do not change or actually regress over the next three years.

With early detection, he said, "our net has become so fine that we are pulling in small fish as well as big fish." Now, he said, "we have to identify which small fish we can let go."

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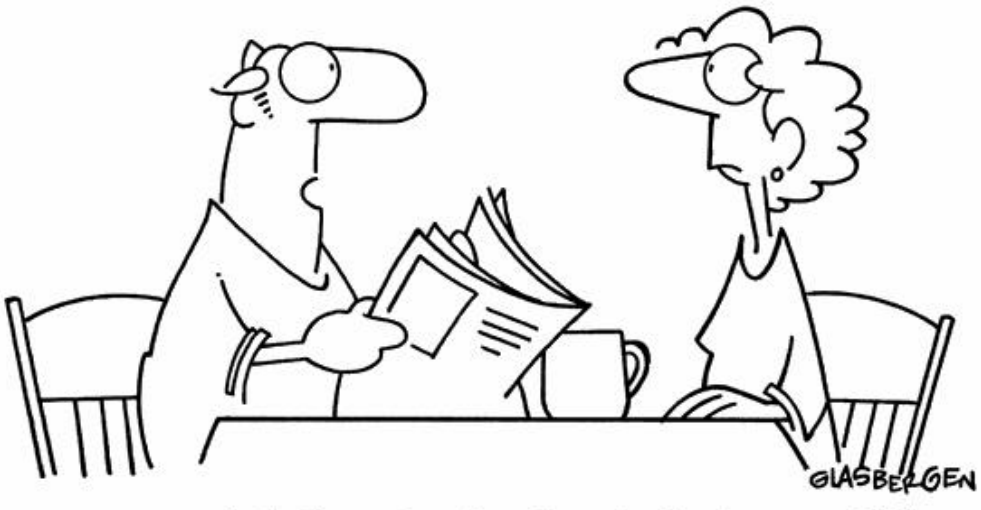

"Many people believe that laughter is the best medicine, so the government has declared a ban on all laughing until further studies can be done.

Study Finds Pro and Cons to Prostate Surgeries

By RONI CARYN RABIN

Prostate cancer patients who chose minimally invasive surgery rather than more extensive operations to remove the prostate were less likely to experience complications like pneumonia, but reported higher rates of long-term problems, including impotence and incontinence, according to one of the largest studies to compare outcomes to date.

Patients achieved similar rates of cancer control regardless of which surgery they had, the analysis found.

The study, in Wednesday's Journal of the American Medical Association, is not considered the last word on the subject, several experts agreed. But it raises questions about claims of superiority of minimally invasive laparoscopic and robotic-assisted surgeries, which have led to a surge in their popularity.

"People intuitively think that a minimally invasive approach has fewer complications, even in the absence of data," said Dr. Jim C. Hu, the study's lead author, who is director of urologic robotic and minimally invasive surgery at Brigham and Women's Hospital in Boston. "Men who were well educated and had higher incomes were actually more likely to embrace this approach, often due to aggressive marketing by hospitals that had spent $1.5 million to acquire the robots. I think the technology has been oversold."

In one version of prostate removal, called open surgery, a surgeon makes an incision that is several inches long. With minimally invasive surgery, also called laparoscopic surgery, the surgeon operates through a series of small incisions using tools and a camera for the operation. With robotic surgery the surgeon sits at a computer and manipulates a robot to do the operation through the small openings.

In 2003, minimally invasive radical prostatectomies, which include robotic surgeries, made up fewer than 10 percent of prostate removal surgeries. By 2006-7, they constituted 43 percent of procedures.

The Harvard researchers who did the study assessed the outcomes of 1,938 men who had minimally invasive prostate surgery from 2003 to 2007 and 6,899 men who had open surgery. They used Surveillance, Epidemiology and End Results, or SEER, data from the National Cancer Institute representing 26 percent of the American population, linking it with Medicare data.

The men in the study — all of them 65 or older — who underwent minimally invasive surgery had shorter hospital stays, fewer respiratory complications and other surgical complications, and were far less likely to receive a blood transfusion. But they had more complications involving the genital and urinary organs immediately after surgery, with 4.7 percent having those complications, compared with 2.1 percent of open surgery patients.

When the researchers looked at lasting complications more than 18 months later, they found that men who had minimally invasive surgery were at greater risk of suffering from incontinence and erectile dysfunction than those who had open surgery.

For each 100 men who had minimally invasive surgery, some 15.9 percent were at risk of being incontinent each year, while 26.8 percent experienced erectile dysfunction, compared with 12.2 percent and 19.2 percent, respectively, each year for every 100 men who had open surgery, the study calculated.

Several surgeons who specialize in robot-assisted procedures said the study was limited because it was unable to distinguish between those using robot technologies and older minimally invasive techniques.

Many experts said the outcomes of experienced surgeons were better than those reported in the study.

"I almost exclusively do robotic prostatectomy now because I think that, despite this manuscript, there is clear evidence that it is comparable, in terms of continence, potency and tumor control," said Dr. Joseph Smith, the chairman of urologic surgery at Vanderbilt University School of Medicine.

But Dr. Smith added, "I don't think there's anything demonstrating it to be superior."

Dr. Peter Scardino, chief of surgery at Memorial Sloan-Kettering, said the study was important because it reported on data that did not come just from one medical center or one region.

"At the end of the day," Dr. Scardino said, "what all the studies will show is that it's not the tools the doctor uses, but the experience and skill of the surgeon. There's nothing magical about the laparoscopic or robotic."

New York Times October 14, 2009

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Few Side Effects Found From Radiation Treatment Given After Prostate Cancer Surgery

ScienceDaily (Sep. 29, 2009) — The largest single-institution study of its kind has found few complications in prostate cancer patients treated with radiotherapy after surgery to remove the prostate. Men in this study received radiotherapy after a prostate-specific antigen (PSA) test following surgery indicated their cancer had recurred.

Researchers say the findings from Mayo Clinic's campuses in Florida and Minnesota suggest that patients and their physicians should not overly worry about toxicity and side effects from the treatment, known as salvage external beam radiotherapy. The study findings will be published in the October issue of Radiotherapy and Oncology.

"There is a general fear of this kind of radiation treatment on the part of some patients and their physicians, but this study shows that it not only effectively eradicates the recurrent cancer in a substantial number of patients, but that there are few serious side effects," says the study's lead investigator, Jennifer Peterson, M.D., from the Department of Radiation Oncology at Mayo Clinic in Florida.

"It is really important that patients and their doctors watch PSA levels after a radical prostatectomy, which is a complete removal of the prostate," she says. In men who have an intact prostate, a PSA test can indicate either an enlarged prostate gland or development of cancer in the prostate, says Dr. Peterson. "But in men without a prostate, a rising PSA level indicates that cancer has recurred. After a recurrence is detected, there is only a narrow window of time during which radiotherapy will be beneficial in controlling their cancer."

"No other therapy besides salvage external beam radiotherapy has been shown to cure these patients," she adds.

In 2009, an estimated 192,000 American men will have newly diagnosed prostate cancer. Approximately one-third (about 64,000 men) will choose radical prostatectomy as their primary treatment, according to the National Cancer Institute. Large studies have shown that one-third of those men, about 21,000 patients, will experience a rising PSA — a recurrence of their cancer — within five to 10 years, says Dr. Peterson. "Two-thirds of these men, if left untreated, will have metastatic disease within 10 years, but the chances of that occurring are greatly reduced in patients given salvage radiotherapy," she says.

Lingering uncertainty about the effectiveness of salvage radiotherapy and its side effects have led many urologists not to recommend the treatment, says co-author Steven Buskirk, M.D., from Mayo Clinic in Florida.

This study, which lasted two decades, was undertaken to specifically document those side effects. It studied 308 patients with a median follow-up of 60 months after salvage external beam radiotherapy. Only one patient had a serious (grade 4) complication and three patients had a less serious (grade 3) side effect. None of these effects were fatal, and all were treated. Milder side effects were seen in an additional 37 patients, the researchers say, and all were successfully treated for these complications. Urinary leakage, a concern of many patients who choose not to use radiation, was not a common side effect of treatment.

Improved techniques in the administration of salvage external beam radiotherapy since the study began in 1987 likely would mean the rate of side effects today, compared to those in the study, would be much lower, says Dr. Buskirk.

"We can do a better job today with delivering radiation precisely where we want to, while minimizing dose to surrounding normal tissues," he says.

"In our experience at Mayo Clinic, the side effects of salvage radiotherapy in patients treated after a radical prostatectomy are minimal," says Dr. Peterson. "Even more importantly, it is the only potential curative treatment possible in these patients once cancer has recurred."

The study was funded by Mayo Clinic.

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Swiss Study Finds Income Affects Prostate Cancer Patients' Survival

American Cancer Society 28-Sep-2009

Prostate cancer patients of low socioeconomic status are more likely to die than patients with higher incomes. That is the finding of a new study from Swiss researchers to be published in the December 1, 2009 issue of Cancer, a peer-reviewed journal of the American Cancer Society. The study's findings indicate that poor prostate cancer patients receive worse care than their wealthier counterparts.

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Many of the previous studies on socioeconomic status (SES) and prostate cancer mortality are from North America, particularly from the United States. Researchers wanted to know how disparities affected prostate cancer mortality in Switzerland, a country with an extremely well developed health care system and where healthcare costs, medical coverage, and life expectancy are among the highest in the world, Elisabetta Rapiti, M.D., MPH, of the University of Geneva and her colleagues conducted a population-based study that included all residents of the region who were diagnosed with invasive prostate cancer between 1995 and 2005.

The analysis included 2,738 patients identified through the Geneva Cancer Registry. A patient with prostate cancer was classified as having high, medium, or low socioeconomic status on the basis of his occupation at the time of diagnosis. The investigators compared patient and tumor characteristics, as well as treatments among the different socioeconomic groups.

Compared with patients of high socioeconomic status, those of low socioeconomic status were less likely to have their cancer detected by screening, had more advanced stages of cancer at diagnosis, and underwent fewer tests to characterize their cancer. These patients were less likely to have their prostates removed and were more likely to be managed with watchful waiting, or careful monitoring.

Patients with low socioeconomic status also had a 2-fold increased risk of dying from prostate cancer compared with patients of high socioeconomic status. "The increased mortality risk of patients of low socioeconomic status is almost completely explained by delayed diagnosis, poor work-up, and less complete treatment, indicating inequitable use of the health care system," said Rapiti. The authors say lead time and length time biases linked to early detection through PSA screening may partially explain the survival advantage observed among high SES patients. However, they found that the differences by SES in prostate cancer mortality were limited to patients with advanced disease, for whom the impact of such biases is not as strong, and that treatment choice probably played a more important role. The authors say reducing health inequalities linked to socioeconomic status should receive high priority in public health policies, and that improving patients' access to prevention and early diagnostic tests and ensuring that they receive standard treatments could help reduce the socioeconomic differences seen in this study.

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2009 MEETINGS:

Jan. 15.....Dr. Paul Daeninck, Pain Management specialist -
" Supportive Care for The Prostate Cancer Patient and his Family "

Feb. 19.....MPSGC member stories -
" Let's Share Some of our Stories (Good & Bad) "

Mar. 19.....Dr. John Milner, Urologist -
" Prostate Cancer : What Does "Cure" Mean for This Disease? "

April 16.....Dr. H. R.Wightman, Pathologist -
" Explaining the Role of The Pathologist "

May 21.....Dr. Janice Dodd, PhD, Physiology -
" What's New in Prostate Cancer Research "

June 18.....Tom Roche, Social Work -
" So You've been referred to a Soc ial Worker: Now What? "

July 16.....Jason Bachewich, Naturopath -
" New Science & Nutritional Breakthroughs in Prostate Cancer Support "

Aug. 20.....Robin Chambers, Oncology Dietician -
" Common Myths About Diet and Cancer "

Sept. 17.....Dr. Jeff Sisler, Family Physician -
" Prostate Cancer : Post Treatment Concerns "

Oct. 15.....Kim Hodgins, Physiotherapist -
" Incontinence and The Pelvic Floor Muscle "

Nov. 19.....Greg Harochaw, Pharmacist -
" Treating Erectile Dysfunction after Prostate Cancer Treatment "

Dec. 17.....Party Time: Don Swidinsky - guitarist.: Celtic Group
" Beggars Brawl " - Miriam, Darrell, Mike & D'Arcy