



# The Manitoba Prostate Cancer Support Group



Vol. 212- February 2009

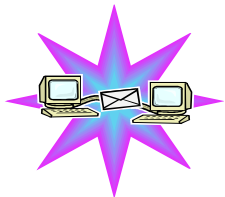


The Manitoba Prostate Cancer Support Group encourages wives, loved ones, and friends to attend all meetings.

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 YOU REALIZE THAT IN FORTY YEARS WE'LL  
HAVE MILLIONS OF OLD LADIES RUNNING ABOUT  
WITH TATOOS AND PIERCED NAVELS  
( NOW THAT'S SCARY ! )

- ANONIMOUS

## In This Issue

### page 2

PSA VELOCITY PREDICTS SURVIVAL  
IN HRPC PATIENTS

### page 3

'YOU HAVE CANCER'  
A CHEMICAL ENGINEER CHRONICLES  
HIS BATTLE AGAINST PROSTATE CANCER

### page 6

EXPERTS DEBATE CYBERKNIFE  
FOR PROSTATE CANCER  
SAFETY, EFFECTIVENESS OF DEVICE AT ISSUE

## 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 confusing the subject of cancer can be. *All calls are kept confidential*

## NEXT MEETING:

Thursday, February 19th, 2009 7 - 9 P.M.

**This program is usually one of the best of the year**

***Let's Share Some Of Our Stories (good and bad)***

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

## PSA Velocity Predicts Survival In HRPC Patients

By Liam Davenport 27 October 2008  
Urology 2008; 72: 903–907

MedWire News: Survival among patients with metastatic hormone-refractory prostate cancer (HRPC) is better predicted by prostate-specific antigen (PSA) velocity than any other PSA kinetics variable, Swedish study findings suggest.

Almost all responders to androgen deprivation therapy will eventually develop HRPC. As the increase in survival time is modest and toxicity is significant with current treatments, better predictors of patients who would benefit from treatment are required.

To determine the ability of PSA kinetics to predict survival in HRPC patients, David Robinson, from Ryhov County Hospital in Jönköping, and colleagues gathered baseline data on hemoglobin, PSA, alkaline phosphatase, Soloway score, and performance status pain analgesic score from 417 men with HRPC.

The patients were treated with either parenteral estrogen or total androgen blockade, and variables such as post-treatment PSA halving time, PSA level at nadir, interval to nadir, PSA velocity, and PSA doubling time after nadir were measured.

Fifty-seven per cent of patients had a baseline PSA value =200 ng/ml. The average follow-up period was 20.2 years, median

survival was 2.66 years after the start of treatment, and 32% of patients died within 9 months.

On univariate analysis, interval to PSA nadir, PSA doubling time, and PSA velocity had the greatest ability to predict death within 9 months.

A model incorporating the baseline variables was able to predict death within 9 months, with an accuracy of 67%. Of the post-treatment PSA variables, PSA velocity had the greatest impact, increasing the baseline model accuracy to 81%.

Combining the baseline model with PSA velocity, PSA doubling time, interval to nadir, and patient age at HRPC diagnosis had only a modest effect, increasing the predictive accuracy to 83%.

“Together with the other variables available before the start of treatment, the PSA velocity might be helpful in clinical decision-making, as well as stratification in clinical studies,” the team concludes in the journal Urology.

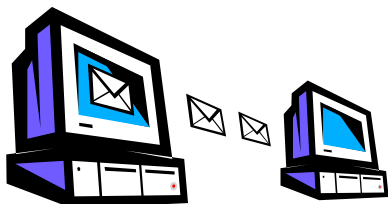
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### Ask The Doctor

If you have questions about Prostate Cancer ; Treatments ;  
etc., Send them to us and  
we'll try for some answers  
from our Advisory Board.

Reach us by email

**manpros@mts.net**



“I’m sure we’ll find a cure someday. Let me write you a postdated prescription.”

## 'You Have Cancer'

*A chemical engineer chronicles his battle against prostate cancer*

By GREG CAMPBELL

Watertown Daily Times SUNDAY, OCTOBER 26, 2008

Greg Campbell is professor emeritus of chemical and biomolecular engineering at Clarkson University in Potsdam.

"You have cancer." Three words that strike terror in your heart. In my case, at age 66, my urologist delivered the verdict: I had prostate cancer.

About 230,000 men are diagnosed each year with prostate cancer and 30,000 of them die eventually. More people die of prostate cancer than breast cancer, and I did not want to be one of them.

What's a man to do? Choices are stark — 190,000 have surgery each year, surgery that can lead to incontinence or impotence.

Fortunately, my friend Russ, who has been fighting prostate cancer for 10 years and is director of a national prostate cancer support group, US-Too, urged me to "read and use the Internet to get as much information as you can."

Wise advice. Coupled with a box of materials, including books that Russ sent me, I began my quest to find a way out of this nightmare.

*But back to the beginning.*

My prostate specific antigen (PSA) numbers — a guide my family physician used to determine the extent of the cancer in the prostate gland — had been established at a normal 2.6, meaning no cancer. After 20 years, in spring 2005, the number suddenly jumped to 4.6. On my next visit, the PSA number dropped back to 2.8. My doctor and I decided against a follow-up with a urologist.

*Not a smart move, as it turned out.*

In spring 2007, my PSA jumped again — to 4.6. Time to see a urologist. He reviewed my medical history, did a digital rectal exam, felt an abnormality in the prostate gland and ordered a biopsy.

Two weeks later, I got the three dreaded words: You have cancer.

Four of the eight biopsies turned up cancerous tissue. Now the PSA was at 4.8.

The urologist also threw out some new numbers — my Gleason Score (a measure of how much the cancer cells had mutated from normal cells) stood at 7 for one of the biopsy cores and 6 for three others from the gland's right side. The left side was cancer-free.

Like most men hearing this verdict and these numbers for the first time, I knew nothing.

My urologist recommended surgery to remove the cancerous prostate gland.

He also scheduled a computed axial tomography (CAT) scan of my pelvic area to determine if the cancer was spreading.

*What to do?*

I searched for some answers: Should I have surgery? Are there other ways to tackle my cancer?

Among the books I checked were two from US-Too that Russ recommended:

- "A Primer On Prostate Cancer" by Stephen B. Strum and Donna Pogliano (2002, The Life Extension Foundation, Hollywood, Fla.).
- "Surviving Prostate Cancer Without Surgery" by Dr. Michael J. Dattoli, Jennifer Cash and Donald Kaltenbach (2005, Seneca House Press, Dattoli Cancer Foundation, Sarasota, Fla.).

The primer was not easy to read but it had some eye-opening information.

For example, there are about 12 bad choices facing someone with prostate cancer, and major complications from those choices include high rates of incontinence, impotence and rectum damage.

Even worse is the high probability that surgery would not get all the cancer. This is an aspect not normally part of the discussion by the urologist. Remember, all urologists are surgeons.

Watchful waiting might be in order for some men diagnosed with prostate cancer — those whose PSA numbers are monitored regularly and aren't doubling rapidly. With my

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PSA now at 5.8, I was among the 10 percent to 20 percent of men whose PSA numbers indicated the cancer was aggressive. Watchful waiting was not an option.

I discovered the Partin Tables, which provide probabilities of the outcome of radical surgery. For me, there was only a 35 percent chance surgery would get all my cancer.

This meant I was reduced to radiation therapy, which often holds risk for bladder and rectum damage.

But the more I read, I realized there was another option — the use of beam and seeds, an approach successfully pioneered by Dr. Dattoli, co-author of "Surviving Prostate Cancer Without Surgery," at his clinic in Sarasota.

I elected to pursue this strategy. And thus began my journey from Northern New York to sunny Florida and the road to treatment.

■ ■ ■

Like all engineers, I tend to ask a lot of questions. I already had found answers to lots of them. I now needed to know what the Dattoli Clinic was going to do to treat my cancer.

The clinic team is efficient. After I faxed my medical records to them, I had a 40-minute, long-distance phone conversation with Dr. Richard Sorace, Dr. Dattoli's partner, telling him I wanted to be a patient. The next day, a nurse, by phone, reviewed more of my medical history.

Once accepted as a patient, I had more forms to complete, and they scheduled two more tests before my office visit with Dr. Sorace.

The first test was a ProstaScint, using a radioactive monoclonal antibody that binds only with prostate cancer cells. The other was a positron emission tomography (PET) scan, conducted at a clinic in Sarasota near the Dattoli facility.

My wife, Sue, and I headed for Florida, where we occupied an efficiency apartment for the lengthy run of tests.

For the ProstaScint exam at Orlando Regional Health Care in Florida, I was given radioactive injections and sent away for five days while my body absorbed this material.

In the meantime, I underwent a PET scan of soft tissue and bone. Before the scan, I was injected with radioactive fluorine, which is attached to a sugar molecule. In the soft

tissue, cancer cells need more energy than normal cells, so more fluorine is left in the cancer cells and will show up as "hot spots" during the PET scan.

I returned to Orlando for the ProstaScint scan, which can detect the presence of cancer cells in the prostate gland and determine whether they have spread into nearby lymph glands.

Test outcomes from both the ProstaScint and the PET scan were merged to give the Dattoli staff a good picture of my situation.

Then came my first appointment with Dr. Sorace. My wife accompanied me. After a nurse checked my blood pressure (106 over 59 — the nurse offered the ironic observation, "Some people would kill for those numbers.") I finally met Dr. Sorace.

He discussed my family medical history, and when I told him the Partin Tables indicated I would, on average, have a 35 percent success rate with surgery, he countered that the Dattoli radiation protocols had an 85 percent chance of keeping me cancer-free for 10 years. He prescribed Avodart and Cosodex, both hormones to inhibit cancer growth in the body.

Turning to my ProstaScint and PET scans, he said both tests were negative — on the surface, good news. But I also knew by now that a relatively large tumor — 0.8 centimeter in diameter — could be present and not detected by these tests.

Dr. Sorace agreed that he could not rule out the growth of smaller cancer tumors elsewhere in my lymph system and bones. But he reassured me that Dattoli procedures result in a less than 1 percent chance of incontinence (compared with 15 percent to 20 percent with surgery) and 25 percent chance of impotence (60 percent to 70 percent with surgery).

The next step was a visit to the Doppler ultrasound room. I was installed on a table, flat on my back, my feet in stirrups, and a Doppler probe was inserted in my rectum to take 5-millimeter color images of the prostate. There was a computer screen that both my wife and I could view — seeing the same things the Doppler operator was viewing.

What we could see was not much different than what I'd seen a while back in my urologist's office in upstate New York. The digital images of the rectum and prostate gland were integrated to reveal a prostate gland that was 42 centimeters cubed.

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The operator turned on the color Doppler, and suddenly large areas of red popped up on the screen — these were the cancer tumors. The images showed Dr. Sorace that cancer "fingers" had already moved into the fatty tissue around the prostate and that surgery was not guaranteed to get them.

The Dattoli Clinic has a special computer software program that allows them to create a three-dimensional image of the prostate and the cancer sites — helping them pinpoint exactly where to plant the radiation seeds.

Then came the "fun" part — a catheter was inserted in my penis to send iodine dye into my bladder, while simultaneously another catheter was pushed into my rectum for a barium enema.

Then, they ran me through a CAT scan — a "simulation" or dry run for the real thing, which would come later. They just wanted to have a good picture of where everything was for the later radiation seed planting.



And I said this was "fun"? Well, the aftermath was — Dr. Sorace told me to drink lots of liquids to get the iodine dye out of my system. As a matter of fact, he suggested a six-pack of beer would do the trick. Done!

This was on a Thursday. I returned to the clinic the following Monday for X-rays in the e-beam accelerator, which would be used as a baseline analysis.

With all the tests and analysis done, the clinic began the real work: 25 sessions of guided and intense radiation therapy — one session a day for five days, then a weekend break. This went on for five weeks.

This technique, unique to the Dattoli Clinic, is designed to target the radiation where it will kill the cancer cells and minimize radiation exposure to the bladder and rectum.

I would show up daily at 2:20 p.m. for my date with the beam accelerator.

After those treatments, I got a two-week break, allowing my body to recover. And then Dr. Dattoli, in an outpatient surgical procedure at the Sarasota hospital, inserted 69 radiation seeds near my prostate in a 23-hour ordeal — 45

minutes to plant the seeds and then monitoring me to make sure everything was OK.

Then it was back to Canton at the end of March.

I returned to the Dattoli Cancer Clinic in late June for eight more "cleanup" beam treatments on the outer part of the prostate area.

One of the first things they did was order another PET scan.

In January, when they did the first one, Dr. Sorace indicated they had found some activity in my chest — even I understood that this could mean some type of cancer there. When I was told a couple of days later the PET scan showed no signs of cancer, my wife saw the tension disappear from my body.

I finished the "cleanup" on July 8. Dr. Sorace told me everything looked fine and I could stop taking the hormone supplement at the end of these treatments. I did. I hope never to take them again.

My current hormone-depressed PSA is 0.039 and I'm hoping it will stay there. I am one of the 85 percent of Dattoli patients who are cured.

Incidentally, Dr. Dattoli allows one of his team to score him on how well he places the radiation seeds around a patient's prostate. In my case, he scored a 99.2. Not bad. I wonder how many times he's perfect!

There were no side effects from the cleanup treatment. And I can say clearly: "I am now a surviving cancer patient."

Like most men who get the prostate cancer diagnosis, I asked, "Why me?" This was quickly followed by, "I will fight this until I win or die of other causes."

Luckily, prostate cancer is treatable if detected early. It was for me. I look forward to a long and active life, and at the end I hope to be able to say — to quote an Irish friend — "As I slide into the grave I want to be shouting, 'It's been a hell of an interesting ride.'"

• • •

## Experts Debate CyberKnife for Prostate Cancer

*Safety, Effectiveness of Device at Issue*

By Rob Stein Washington Post Staff Writer  
Friday, November 28, 2008; A03

When Georgetown University Hospital bought a new high-tech system in 2001 to treat patients with radiation, doctors at first used the computerized, robotic device only for brain and spinal tumors that would be difficult if not impossible to fight any other way.

But Georgetown, along with Virginia Hospital Center and others around the country, is now aggressively marketing the \$4 million machine, known as the CyberKnife, for early prostate cancer, one of the most common cancers. That trend has sparked an intense debate about whether it represents an important advancement or the latest example of an expensive and potentially profitable new technology proliferating too soon.

While its advocates say the CyberKnife offers prostate cancer patients a safe and effective -- and much more convenient -- alternative to traditional radiation treatment, many experts fear that it could leave many men unnecessarily vulnerable to recurrences or potentially serious complications.

"This is really pushing the envelope," said Anthony L. Zietman, president-elect of the American Society for Therapeutic Radiology and Oncology (ASTRO). "It might be as good and more convenient. It may be better and more convenient. But it could turn out to be a disaster. No one knows."

Proponents argue that enough evidence has accumulated to make them confident that the approach is at least as good as standard therapies and that it can prevent unnecessary deaths by making treatment less daunting. Because the CyberKnife can more precisely target tumors with higher doses of radiation, it could prove even safer and more effective, they say.

"I'm very excited about this," said Sean P. Collins, a Georgetown radiation oncologist. "I think it's an important addition to the treatment of prostate cancer. We'll definitely save more lives."

Some critics worry, however, that the push to expand the use of the CyberKnife may be motivated in part by financial incentives: The manufacturer wants to sell more machines, hospitals and private practices want to recover the cost of the systems, and urologists can receive a Medicare payment of about \$1,200 for each patient who opts for the therapy.

"Unfortunately, it often comes down to the money," said Louis Potters, who chairs ASTRO's Health Policy Council. "Prostate cancer is so common that it represents low-hanging fruit in terms of revenue opportunities."

The debate illustrates the issues that can arise when costly new medical technologies arrive before researchers have thoroughly evaluated their risks and benefits.

"You have a lot of factors that converge to make something take off," said Diane C. Robertson of the ECRI Institute, an independent, nonprofit organization that evaluates medical technologies. "If you have a promising technology coupled with favorable reimbursement coupled with hospitals' need to be competitive, that's enough to give something a push."

Prostate cancer strikes more than 186,000 American men each year and kills more than 28,000, making it the second most common cancer after skin cancer and the second leading cancer killer after lung cancer among men.

Because the tumors often grow slowly, many men can choose to have doctors closely monitor them. For those who decide to treat the cancer, the most common approaches are surgery to remove the prostate or various forms of radiation, including radioactive "seeds" that are implanted in the gland or "external beam" radiation that subjects the tumor to relatively low doses spread over about 40 fifteen-minute sessions. All the treatments can produce complications, including incontinence, bleeding, problems urinating and impotence.

The CyberKnife enables men to complete treatment in just four or five sessions by much more accurately delivering about quadruple the usual dose of radiation each time. Doctors inject four tiny gold cylinders into the prostate to create a precise target. The patient lies on his back for each one-hour session as a robotic arm swivels around to shoot dozens of beams from multiple angles.

"You are able to give very high doses and sculpt those doses to the tumor," said Omar Dawood of Accuray Inc. in Sunnyvale, Calif., which has installed more than 90 systems in the United States as doctors have started using the machine for other cancers. "It could revolutionize the way prostate cancer is treated."

Dawood said that more than 2,000 prostate cancer patients have been treated, and that the approach seems to work as well as standard treatment with about the same, or perhaps even fewer, short-term side effects. At least one study that followed patients for several years indicates that it continues to be safe and effective, and the company is sponsoring two new studies at multiple sites nationwide.

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"We've been getting very good outcomes," said Georgetown's Collins. "Prostate cancer is a real killer, and people are not getting treated because it's inconvenient for them. This offers them a much more convenient option."

At the Virginia Hospital Center, the CyberKnife is quickly becoming the most popular option.

"About half of our patients are CyberKnife now," said Timothy Jamieson, medical director of radiation oncology.

Robert Blythe, 56, of Sterling was treated with the CyberKnife at Virginia Hospital Center this summer after his early prostate cancer was diagnosed.

"It sounded great to me," said Blythe, who did not want to face two months of driving more than an hour each way from the auto body shop he runs in Winchester to be treated.

"Being new and on the cutting edge, it seemed like the right thing to do. This would be much more convenient."

While there is a biological reason to think that fewer high doses of radiation may work well for prostate cancer, skeptics said the studies done so far have been too small and followed patients for too short a time.

"We just don't have the data to support treating prostate cancer with five days of radiation," said Kevin A. Camphausen of the National Cancer Institute, noting that prostate cancer can recur many years or even decades later. And high-intensity radiation, even though it is more precisely focused, might still damage the rectum, bladder and urethra, potentially causing complications years later.

"What I'm worried about is that we might not be curing patients who we know are curable," he said.

Although several systems can perform similar procedures, CyberKnife has been promoted most aggressively. In the Washington area, Georgetown has bought radio ads and Metro signs and sent direct mailings to doctors, while Virginia Hospital Center has been running ads in local newspapers and mailing brochures to nearby homes. In other areas, billboards prominently tout the treatment.

"There are places in Florida you can't go a mile without seeing a billboard for a CyberKnife," said Paul E. Wallner, a radiation oncologist who co-chairs ASTRO's emerging technology committee.

Wallner and others said patients and many doctors tend to

assume that just because something is new, it is better.

Despite the reservations, Medicare and private insurers in many parts of the country are paying for the treatment, which costs about the same as more traditional radiation therapy -- about \$20,000 to \$30,000. Some insurers, however, have decided against covering the treatment until more evidence is available, and Medicare, concerned that it was inadvertently creating a financial incentive to use the CyberKnife, next year will make doctors justify being reimbursed for referrals.

Some experts also worry that the CyberKnife may exacerbate concerns that patients who could avoid treatment or have surgery instead are being steered toward standard radiation therapy by urologists who have a financial interest in the machines used for that.

"It's the dark side of medicine," Zietman said. "Self-referral is already a big issue. CyberKnife could have a similar problem."

Proponents, however, suggest that the criticism of the CyberKnife is driven by doctors who are wedded to existing treatment, resistant to change and fearful they will lose patients to a superior alternative.

"There's big money in this field, so people are bound to be interested in preserving their turf," said Robert Meier, co-founder of the CyberKnife Center at the Swedish Cancer Institute in Seattle.

Dawood says the company encourages doctors to offer the treatment as just one option, to tell patients about the limitations of existing research and to collect detailed data to validate the long-term safety and effectiveness of the device.

In the meantime, proponents say, it would be wrong to deny patients the care.

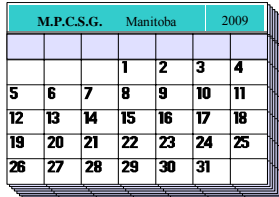
"To me, waiting 20 years to prove it's as good as our old way of doing it doesn't make sense. You are withholding it from many people who might benefit from it," Collins said.

Blythe, meanwhile, remains happy with his choice.

"I'm glad I did it," he said. "It was efficient and fast, and from everything I've read, it doesn't sound like people are having problems with it. I'm not worried."

• • •

**FUTURE MEETINGS:**



*February 19th, 2009  
 March 19th, 2009  
 April 16th, 2009*

**Executive Committee:**

	(204)
Pam Boomer, Executive Member	663-1351
Tom Boomer, Executive Member	663-1351
Joseph Courchaine, Treasurer	257-2602
Laurette Courchaine, Executive Member	257-2602
Michael Doob, Newsletter Editor	488-0804
Darlene Hay, Executive Member	837-6742
Kirby Hay, Information Coordinator	837-6742
Jim Leddy, Secretary	831-6119
Ken Kirk, New Member Chairman	261-7767
Norm Oman, Chairman, Events Coordinator	487-4418
Brian Sprott, Media Coordinator	668-6160
June Sprott, Executive Member	668-6160
Lorne Strick, Videographer	667-9367
Arthur Wortzman, Speaker Chairman	287-8621
Our Answering Machine	989-3433

This newsletter is a **Bottom Line Computer Services** publication

[www.misterpete.com](http://www.misterpete.com)

**CAN YOU HELP?**

The Manitoba Prostate Cancer Support Group operates on your donations  
**We need your contributions**

Have you used any of our services?

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

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