The Manitoba Prostate Cancer Support Group

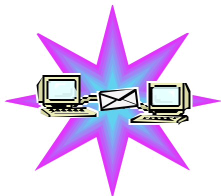
Vol. 215 – May 2009

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

WOMEN HAVE MORE IMAGINATION THAN MEN.
THEY NEED IT
TO TELL US HOW WONDERFUL WE ARE.

\- *KIRBY HAY*

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Urologist

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Urologist

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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, May 21st, 2009 7 - 9 P.M.

Dr. Janice Dodd, PhD, Physiology
"What's new in Prostate Cancer Research"

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

Help Wanted:

One of our members is being treated for both prostate cancer and Parkinson's disease.

Are you in a similar situation, or do you know someone who is? If so, please contact Jeannie: 253-1369.

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Routine PSA Tests Caught My Cancer

Here's another perspective on medical screenings - specifically the PSA blood test for prostate cancer, the value of which was questioned in a March 25 editorial. I am a six-year cancer survivor.

I know that anecdotal evidence and statistical analysis sometimes differ, but I'm so very glad both my personal physician and the urologist to whom he referred me had the good sense to realize that individual people are just that - people, not statistics.

A few weeks after my 59th birthday in 2003, my annual physical showed a significant increase in my PSA number. We'd been tracking it for several years. Forgoing those annual tests would have saved money, yes, but that pattern of regular tests enabled my doctor to catch the variation that signalled it was time for a specialist, which led to a biopsy, surgery and radiation.

"Just let it go; he'll probably die of something else anyway." Yes, sometimes that's true. How can any of us know for whom it's true?

As a nursing-home chaplain, I've seen lots of men in our facility who were dying from prostate cancer in their 70s and 80s. Because of routine medical screenings, I trust I won't be one of those men.

- *Pastor Keith Tomlinson, Waverly*

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Harvard Medical School Prostate Disease Website Guides Patients Through Decision-Making Process

BOSTON, April 23 /PRNewswire-USNewswire/ - Harvard Medical School today announced the launch of a new website to help men with prostate cancer and other prostate conditions understand the issues related to their condition and make smart, well-informed decisions regarding treatment. The website, www.HarvardProstateKnowledge.org, was created by Dr. Marc Garnick, an internationally-renowned expert in medical oncology and urologic cancer. This website is especially timely given all of the recent discussion on prostate disease and the complex information that men and their families have to sort through.

"Many men diagnosed with prostate cancer rush to a specific treatment," says Dr. Garnick, "but most men have time to learn about all of their options. There are many possible actions, including active surveillance, which involves watching the cancer to see if it progresses and treating it at a later time. Since there can be dramatic implications for both health and quality of life, it's important to be well-informed."

The new website provides multiple perspectives on how best to treat prostate disease, including prostate cancer, benign prostatic hyperplasia (BPH), and prostatitis, as well as erectile dysfunction and low testosterone levels.

"The public continues to be presented with conflicting medical and scientific data regarding many aspects of prostate diseases, including prostate cancer," Dr. Garnick notes. "We created www.HarvardProstateKnowledge.org as a tool to help men and their partners get the information they need to ask the right questions of their doctors."

The site draws upon the expertise of the extensive medical staff within Harvard Medical School and its teaching hospitals, as well as that of international thought leaders on prostate disease. It includes interviews and group discussions with faculty experts and first-hand accounts from patients and their families. The website also features video and interactive tools and will be updated regularly.

An open website, www.HarvardProstateKnowledge.org is available free to the public, made possible through funding from several philanthropic families. Dr. Garnick is a clinical professor of Medicine at Harvard Medical School and editor in chief of Perspectives on Prostate Disease, a quarterly publication for patients. He is also the author of A Patient's Guide to Prostate Cancer, and he maintains an active clinical practice at the Harvard-affiliated Beth Israel Deaconess Medical Center.

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Prostate Cancer Conundrum

Source: Boston Globe April 2, 2009

MORE MEN die from prostate cancer than from any other form of the disease besides lung cancer. The development of a PSA blood test, followed by biopsies for worrisome results from the test, was supposed to bring down this death rate. But two recent large studies, one in the United States and one in Europe, indicate that the screening is causing overdiagnosis and overtreatment - with little if any gain in lives saved. The National Institutes of Health and other funders of research should put a premium on supporting scientists looking for a marker that distinguishes between aggressive prostate cancers and what scientists call "indolent" cancers.

The human cost to overdiagnosis begins with anxiety and ends, in many cases, with surgery or treatment with radiation. Incontinence and impotence are common side effects. The cost to society is hundreds of millions of dollars spent on biopsies, treatments, and lost work time for handling cancers that in most cases would not become life-threatening. The researchers in the European study calculated that they would have to screen 1,410 men and treat 48 men for every one whose life was saved.

Granted, mortality rates for prostate cancer have fallen slightly in the decades since the PSA (prostate-specific antigen) screening became common. But researchers believe this might reflect not so much screening as improved treatment, including the use of hormones to keep the cancer at bay in older patients.

Despite the studies' finding of limited gains in lives saved by screening, many men will continue to ask for the test and put up with biopsies and treatment for the assurance of protecting themselves from a cancer that kills more than 28,000 Americans each year. "Some well-informed clinicians and patients will still see these trade-offs as favorable," wrote Harvard Medical School's Dr. Michael Barry in an editorial accompanying the studies in the New England Journal of Medicine. "Others will see them as unfavorable." He said the studies buttress the case for shared decision-making about the PSA test by men and their doctors.

But the studies also demonstrate the need for better tools to weigh the actual danger presented by the cancerous cells in a patient's prostate. An official at the National Cancer Institute in Bethesda, Md., says at least four new prostate tests are being studied in people, including a urine test that looks for an amino acid called sarcosine that rises when the prostate cancer is active. But it could be a decade before a better test than the PSA is in widespread use. Shortening that timetable would benefit not just men stricken with the disease, but also society as a whole as it tries to bring health costs under control.

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Facts To Consider In Prostate Cancer Cases

April 9, 2009

I APPLAUD the Globe's April 2 editorial "Prostate cancer conundrum." I was diagnosed with this disease at age 56 in 2001. I opted for treatment, and thanks to a superb surgeon, I have had no recurrence and have experienced minimal side effects.

The reporting of the studies that you cited, as with other press reports that I have read, seems to omit two critical facts. First, they do not mention the ages of the men who participated in the studies. That is critical because the older a man is, the less need he has for invasive treatment. (For me, at age 56, treatment was necessary I was otherwise in excellent health and had a life expectancy of 25 to 30 more years.)

Second, reporting on the studies has not mentioned Gleason scores, the current tool for evaluating the aggressiveness of the tumor. I had a Gleason score of 7, which is considered moderately aggressive, and I had three independent recommendations to proceed with either surgery or radiation. I chose surgery because radiation had greater side effects and, once you have radiation, surgery is precluded.

At any rate, it is essential, both for men and for managing healthcare costs, for studies to determine with greater accuracy the likelihood of the tumor to spread.

A. Eric Rosen
Framingham

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Prostate Cancer Risk Factors

Source: www.prostateline.com

Relatively little is known about the causes of prostate cancer; however, certain risk factors have been identified, including age, race, family history and levels of androgens (male sex hormones), while diet, sexual behaviour, environmental factors infections, exercise and body weight are also being investigated.

Age

Age is the single most important factor associated with the development of prostate cancer (Figure 1.3). Overt clinical disease is rare in men younger than 50 years of age; the incidence of the disease increases significantly in men older than 60 years, with more than 70% of all prostate cancers being diagnosed in men over the age of 65 years.

Race

The incidence of prostate cancer varies widely between racial groups. In some areas of the USA, the risk of the disease is 80% higher in blacks than in Caucasians; the black population also appears to develop the disease earlier in life. Chinese and Japanese men have the lowest incidence of prostate cancer, while men in North America and Northern Europe have the highest incidence. Despite the ethnic and geographical variations in the incidence of overt disease, the incidence of latent disease has been found to be similar in all populations, suggesting that environmental factors may influence the aggressiveness of prostate cancer.

Family history

Men who have at least one first-degree relative with a positive diagnosis of prostate cancer are twice as likely to develop the disease than those without a family history. If both a first and second degree relative has the disease then the risk can increase nine fold. It is estimated that about 10% of all prostate cancers have some form of genetic basis. Genetic analysis has identified the hereditary prostate cancer (HPC) gene, and a point in the gene that is susceptible to mutation (a susceptibility locus), HPC1, located on the long arm of chromosome 1. A second susceptibility locus resides on the X chromosome - one of the chromosomes determining sex - suggesting an X-linked mode of inheritance.

Most prostate cancers do not develop solely as a result of inheriting a mutant hereditary prostate cancer, gene, but this gene may be involved in sporadic (random) prostate cancers.

Hormones

The main male sex hormone, testosterone, and its active metabolite, dihydrotestosterone (DHT), are essential for the normal growth of the prostate gland and therefore play a role in the development and progression of prostate cancer. Prostate cancer is rare in men castrated before puberty or in individuals with reduced levels of 5 alpha-reductase, the enzyme that converts testosterone to DHT.

In addition, Asian men have lower average testosterone levels than Caucasian or African-American men and have a lower incidence of prostate cancer.

Other hormonal factors have also been linked to the risk of prostate cancer e.g. low levels of sex-hormone-binding globulin (SHBG) may increase risk and high levels of oestradiol may decrease the risk.

Diet

Several dietary factors may affect prostate cancer risk:

=> Fat - consumption of fat, especially saturated fats (found in red meat and dairy products) show a correlation with an increased risk of prostate cancer.

=> Calcium/Fructose - a high calcium/low fructose diet may increase prostate cancer risk.

=> Lycopene - a high intake of this antioxidant pigment found in fresh tomatoes and tomato sauce may reduce the risk.

=> Selenium - an increased intake of this mineral may also reduce risk.

=> Vitamin E (alpha-tocopherol) - long-term use of a moderate dose of this anti-oxidant may have a risk-reducing effect.

=> Soy - the ingestion of soy-based product may protect against the development of prostate cancer

=> Alcohol - high alcohol intake may increase the risk.

Some or all of these may, as previously identified be involved in the large variation in incidence that occurs between different races.

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Sexual behaviour
There is some suggestion that the risk of prostate cancer may be increased in men who become sexually active at a young age, who have multiple sexual partners, or who contract a sexually transmitted disease. However, the evidence for this hypothesis is inconclusive and the finding could represent a hormonal effect.

Environmental factors
The most convincing evidence for the involvement of environmental factors in increasing the risk of prostate cancer comes from migration studies. These studies show that the incidence of prostate cancer in immigrants moving from low-risk to high-risk countries can increase with successive generations. An environmental factor that has been proposed as possibly responsible for the changes in incidence is exposure to industrial chemicals (such as cadmium).

Occupational exposure to high levels of cadmium or radiation appear to be associated with increased risk, although these factors are likely only to contribute in a relatively small number of cases. A higher risk has also been suggested in farming â possibly due to exposure to chemicals used as fertiliser or in pest control.

There is evidence to suggest that vitamin D status may affect cancer risk.

Prostate cancer mortality rates in the USA are inversely proportional to exposure to ultraviolet light, which is essential for the formation of vitamin D.

Infections
Viruses, such as herpes simplex virus type-2 (the cause of genital herpes), have been implicated in the development of prostate cancer although the positive association of these viruses with the disease has not yet been confirmed.

Physical Activity/Body Weight
Exercise may decrease prostate cancer risk, whereas being overweight may increase the risk.

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VOLUNTEERS NEEDED TO HELP

Safeway is once again campaigning in aid of awareness and a cure for prostate cancer.

We need volunteers to help serve cake and pass out pamphlets on June 6th, 2009.

If you can help, please contact:
Tom Boomer at 663 - 1351

Sex after Prostate Cancer Surgery - What Can You Expect? Comments by Motivational Speaker and Cancer Survivor

Chuck Gallagher

Before reading this post…if you have been diagnosed with Prostate Cancer or are a Prostate Cancer survivor, I would appreciate your help. I am writing a book, from a layman's perspective, about Prostate Cancer and how to find solutions to improve our lives. I am conducting interviews during the months of October 2008 through November 2008. The interviews are confidential and your name will not be revealed. If you are willing to discuss your experience… please contact me at chuck@chuckgallagher.com. From there we can set up a time for a phone interview. Likewise, this disease no only affects the man diagnosed but also his family, so I am interviewing spouses and/or significant others. Thank you in advance for your help. Now I hope this article is of some benefit to you.

Let me begin by saying, this is written with the intent to help those men who have dealt with or are dealing with the issues surrounding prostate cancer. I am not a physician. My perspective is my own and born from my personal experience with prostate cancer at a "relatively" young age.

Background: I was diagnosed with prostate cancer at age 47. There were no warning signs. To all around me I was the picture of health and as far as I was concerned they were right. I had no symptoms. In fact, I felt great.

I went to my family doctor in order to get a prescription for Propecia (a pill to keep your hair from falling out). My hair line was beginning to recede and I wanted to stop its progress. My physician (who in retrospect saved my life) required that I have a blood test before she would prescribe the hair loss drug. As I recall, she said that the drug would artificially lower my PSA and I needed to have it checked first.

Honestly, at the time I didn't know what a PSA was - the only thing I did know was - I hated needles and the thoughts of giving blood repulsed me. But vanity won and I had the test. Frankly, the rest was history, as the tests revealed an elevated PSA which ultimately lead to the prostate cancer diagnosis.

Treatment Method: While considering many methods, ultimate I selected surgery using the da Vinci method. I could not have been more pleased. The skill of the surgeon from Johns Hopkins and the method used were both outstanding. I highly recommend that men considering surgery consider this method. The recovery time following surgery was substantially reduced and the side effects were non-existent.

Following surgery there were several issues that were of immediate concern:

1. What was in the pathology report (if that was good then the other issues were important)?
2. Were the nerve bundles saved around the prostate (if not, no erection)?
3. How difficult would it be to recover - move, walk, have a bowel movement, etc.?
4. How long would the catheter stay in and would it cause problems?
5. What would the reported incontinence be like (really) and would it last a long time?
6. When could I expect some normalcy in sexual performance?

#1 = great pathology report (whew…that was a relief!)

#2 = nerves were saved; however, the doctor cautioned about expecting too much too soon.

#3 = no great surprise, the hospital got me moving quickly. It was not comfortable, but in the end they were right. Suck it up and get on with it they told me. You'll appreciate how quickly you'll recover when you get out of bed and get on with life. They were right. Within three days, I was prepared (moving a bit slowly I might add) to get on a plane and fly back home from Baltimore to North Carolina.

#4 = That was (at the outset) the biggest challenge. While most catheters stay in a week or maybe two, mine was in for three weeks. The physician stated that he wanted to make sure due to my psychology that it healed well, so I got the pleasure (NOT) of an extra week. Frankly, that was annoying and one of the happiest days of my life was when it was removed. Frankly, it was somewhat painful, unpleasant, difficult to keep comfortable, and all around a real pain (both figuratively and literally).

#5 = Considering I took a good six months from diagnosis to surgery, I had time to work with Kegel exercises. Kegel exercises may be beneficial in treating urinary incontinence in both men and women. Having received wise advice from the folks at Johns Hopkins, I was told that men would be wise to exercise those pubococcygenus muscles in advance of surgery so that they have "muscle memory" after surgery. I was told issues with incontinence would be dramatically

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reduced and they were right. Within 5 - 6 weeks I was 99% continent.

#6 Sexual Function: Candidly, that returned much slower than I expected.

* Within three weeks of the catheter being removed I wanted to test sexual function. To my pleasant surprise with physical and visual stimulation I was able to achieve a marginal erection and orgasm. I was elated. However, I soon found out that my first experience was not sustainable on a regular basis.
* Like most men, I was given prescriptions for Viagra and informed about other alternatives.
* Within three to six months, I found that achieving an erection was difficult and that any mental distraction would prove to be an impairment.
* Viagra would provide some help, but the side effects were bothersome - especially the flushed feeling I felt in my chest and nasal cavity. Even with Viagra or the other alternatives, I did not feel that the result was successful.
* By the seventh month I was concerned about the lack of consistence in sexual function. That took it's toll emotionally. While women may not completely understand, men will get it. We are sexual beings and, while we don't define ourselves by sex, we certainly understand the important role sexual function has in our lives. Inability to perform can have direct effects in other areas of ones life.
* I was told there would be no ejaculate. That was true and false. There was no ejaculate as men generally know it. However, I did leak a fair amount of urine. I think the urine leakage surprises and disturbed me more than it did my partner She understood that urine is harmless. I soon learned that I should empty my bladder before sex otherwise, there would generally be urine leak when orgasm was reached.
* By the ninth month I woke to a nocturnal erection. I must admit I was surprised and elated. However, the natural erection was still missing.
* There had been no significant change from the sixth month through the tenth month, so I was becoming a bit concerned. I sought help in an unusual way, I sought Hypnotherapy as a possible solution. Wow…now that was worth it.

Hypnotherapy: Perhaps for the skeptics I had just healed enough to experience a change, but when I sought help I had the same results. Not knowing what to expect, I was open to anything that would provide some normalcy. I had come to know that things would never be the same. For one thing, I wasn't 17 years old any more. I had to know that with age sexual performance will change. Likewise, I knew that without a prostate (the old plumbing if you will) I would never have an ejaculation - although an orgasm is quite normal without ejaculation. In any event, I elected this alternative form of therapy. What did I have to lose?

I went through the process feeling quite relaxed. The female hypnotherapist wasn't sure that it would be comfortable for a man. Frankly, in my mind, if I got the result I didn't care who provided the service. The process lasted and hour to and hour and one-half.

Within three days it was time to test the program. To my great surprise, I had an erection with less effort than it took over the prior 10 months and the orgasm was powerful. Since that point, there has been a marked difference in sexual function. Why? I'm not sure I know. I feel that two things converged at the same point. One - I had taken time to heal physically and with practice one can achieve a return to normalcy. Two, I feel the hypnotherapy allowed me to by pass my conscious emotional fears and empower my subconscious to know that I was fine and fully functional (within the physical confines of surgery). Either way…the process worked.

Three Years Later: Sexual function is normal - for a 50 year old prostate cancer survivor.

1. I understand that sex will never be the same as before. I accept that knowing that I am living as a result of early detection and appropriate treatment.
2. With the prostate gone, there will not be normal ejaculate during sex. Strange, but as a man I miss that - but I must say, my wife doesn't.
3. As time goes on natural erections (unassisted) are possible. They are not as frequent as they used to be, but from time to time I will have a nocturnal erection.
4. Orgasm is quite natural, with or without ejaculate. However, expect some urine leakage during sex. Especially early on one might want to keep a towel handy.
5. Libido did not change even right after surgery.

As a motivational speaker, I have become accustom to sharing personal experiences in order to share more universal truths. This entry, however unusual, is not about personal sexual performance, but rather written in order to help other men understand from a first hand perspective what to expect and perhaps to provide hope that sexual performance, so important to most men, can return after experiencing surgery.

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Publications Agreement #40037332 Return Undeliverable Canadian Addresses to: Manitoba Prostate Cancer Support Group #705 - 776 Corydon Ave Winnipeg, Manitoba R3M 0Y1

Manitoba Prostate Cancer Support Group
705 - 776 Corydon Ave.,
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Publications Agreement
40037332

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 Social 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

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Tom Boomer, Executive Member	663-1351
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www.misterpete.com

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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

Name: ✍ Mr. ✍ Mr. & Mrs. ✍ Mrs. ✍ Ms ✍ Miss

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 # 705 - 776 Corydon Ave., Winnipeg R3M OY1

****a tax deductible receipt will be issued.***