The Manitoba Prostate Cancer Support Group
NEWSLETTER

Vol. 220 – October 2009

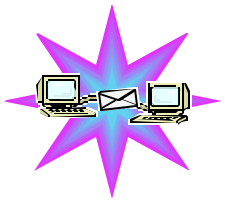
SHARING IS CARING

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

YESTERDAY IS HISTORY
TOMORROW IS A MYSTERY
TODAY IS A GIFT
THAT'S WHY IT'S CALLED THE "PRESENT".

- TOM BOOMER

Recommended Reading

Prostate Cancer:
A Patients Guide to Treatment
by Arthur Centeno and Gary Onik

THIS BOOK DISCUSSES 5 TYPES OF TREATMENTS. IT EXPLAINS HOW EACH TREATMENT WORKS, WHO IS A CANDIDATE, THE RISKS, COMPLICATIONS AND SIDE EFFECTS. IT IS A SHORT EASY TO READ 115 PAGE BOOK.

Web Resources

www.healthlinkbc.ca

www.uroinfo.ca

www.prostateinfo.com

www.procure.ca

www.phoenix5.org

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, October 15th, 2009 7 - 9 P.M.

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

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

About Prostate Cancer:

- 25,500 men will be diagnosed with prostate cancer this year alone (2009).
- 4,400 men will die of the disease this year.
- During his lifetime, 1 in 6 men will be diagnosed with the disease.
- Prostate cancer is the most common cancer to afflict Canadian men.
- Rates of prostate cancer in men are comparable to rates of breast cancer in women.
- The incidence of prostate cancer is increasing due to the aging of the population.
- It is a far greater threat for those with a family history of prostate cancer.
- Prostate cancer is turning up in men in their 40's.
- Over 90% of prostate cancer case are curable if detected and treated in their earliest stages.

Prostate Cancer Canada News - summer 2009 edition

"It seems to be effective so we're going to just keep milking you."

© Leo Cullum

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

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

_____

Address:_____

_____ Postal Code: _____

Card to be signed from: _____

✍

✍ This gift is IN MEMORY of:

_____

✍ This gift is IN HONOUR of:

_____

✍ Birthday ✍ Confirmation ✍ Get Well ✍ Wedding
✍ Graduation ✍ New Arrival ✍ Anniversary ✍ Bar/Bat Mitzvah

✍ Other:_____

✍ In appreciation for:_____

Please notify the following person of this gift:

Name:_____

Address:_____

_____ Postal Code: _____

✍ $25 ✍ $50 ✍ $100 ✍ $250 ✍ $500 ✍ $1000 ✍ $1000 +

Make cheque or money order payable to:

Manitoba Prostate Cancer Support Group (MPCSG)

 # 705 - 776 Corydon Ave., Winnipeg R3M OY1

a tax deductible receipt will be issued.

Study Explores Overdiagnosis of Prostate Cancer

September 10, 2009 Cancerconsultants.com

For every man who benefits from prostate cancer screening, many more are diagnosed and treated unnecessarily. The extent of this "overdiagnosis" of prostate cancer was explored in a study published in the Journal of the National Cancer Institute.

Each year in the United States, more than 192,000 men are diagnosed with prostate cancer and more than 27,000 die of the disease.

Men 50 years of age or older in the United States are often offered prostate-specific antigen (PSA) testing for the early detection of prostate cancer. The test may be offered at a younger age to men at high risk of prostate cancer. The PSA test measures proteins that are produced and shed by the prostate. PSA levels tend to be elevated when prostate cancer is present, but levels can also be elevated in benign (non-cancerous) conditions affecting the prostate.

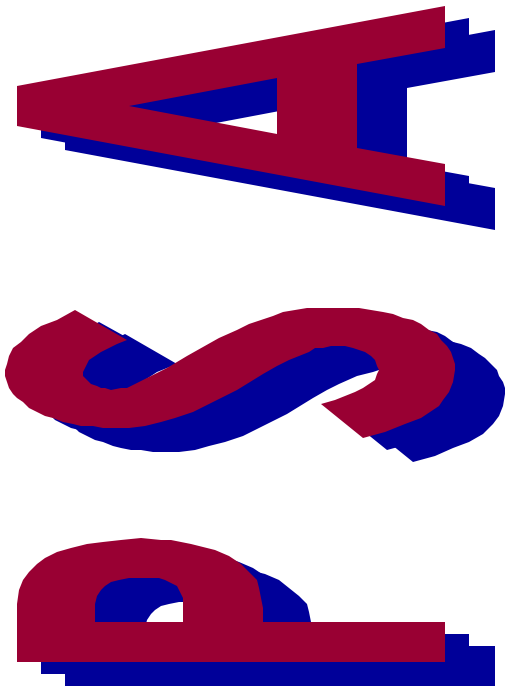
A concern with the use of PSA testing is that it may identify some cancers that do not require treatment. This is sometimes referred to as "overdiagnosis." Research suggests that some prostate cancers are very slow-growing and will not affect a man's health during his lifetime. Diagnosis and treatment of these cancers exposes men to the complications of cancer treatment without providing a benefit.

To explore how frequently overdiagnosis has occurred since PSA screening became widespread in the United States, researchers evaluated information from a large, national cancer registry. They assessed prostate cancer trends from 1986 (the year before an influential PSA study was published) to 2005.

* During the 30 years since the introduction of PSA testing, PSA testing has resulted in 1.3 million more prostate cancer diagnoses than would have occurred otherwise. Roughly one million of these men received treatment for prostate cancer.
* The increase in prostate cancer diagnoses after the introduction of PSA testing was most apparent in younger men. Prostate cancer incidence rates have tripled in men in their 50s and increased by more than seven-fold in men younger than 50.
* There has been a decline in prostate cancer mortality during the PSA screening era, but it's unclear how much of this decline is due to screening (improvements in treatment are likely to have played a role as well). Nevertheless, even if all of the decline in mortality is due to screening, the results of this study suggest that relatively few men have benefited from early detection.

This study highlights the importance of an informed decision-making process about prostate cancer screening, in which men who are considering being screened fully understand what is known about the potential risks and benefits.

• • •



Prostate Cancer Canada's Position on the PSA Test

Age 40: At age 40, it is imperative to establish a baseline PSA score. While the threat of prostate cancer is minimal at this age, it also precedes the onset of benign prostatic hyperplasia (BPH), the natural enlargement of the prostate that commonly occurs with age. The onset of BPH often results in rising PSA over time, and can be confused with the onset of prostate cancer. Unless your resulting baseline PSA score is of concern to your doctor, the PSA need only be repeated every 5 years until age 50.

Age 50: At age 50, all men should begin annual or semi-annual PSA testing if they have not yet done so. Results that show minimal increase in PSA against your baseline score (at the discretion of your physician) require no further action until your next annual test. Those with significant increases should prompt a consultation with your doctor about follow up PSA tests and possibly biopsy to test for cancer.

Prostate Cancer Canada News - summer 2009 edition

• • •

Turn Down The Heat

OurVoice Vol.14 - No.2 by Dr. Fabio Cury

Managing hot flashes, bone risks and more side effects of hormonal therapy

Androgen deprivation therapy, also known as hormonal therapy, is commonly used at various stages of prostate cancer treatment. It is usually administered in the form of medications (e.g., luteinizing hormone-releasing hormone [LHRH] analogues or agonists) that inhibit the production of testosterone — this is called chemical or medical castration. In some cases, androgen deprivation can also be performed by removing both testicles (surgical castration). Whatever the approach chosen, the objective of androgen deprivation therapy is to abolish blood-circulating levels of testosterone, which feeds prostate tumours.

Alongside its proven benefits for prostate cancer, hormonal therapy is associated with a spectrum of secondary effects; the lack of testosterone and the resulting changes in physiological functions that depend on this hormone often have a negative impact on quality of life. This article focuses on management of side effects secondary to the use of androgen deprivation therapy in general (another class of drugs used during hormonal therapy is known as antiandrogens, but these medications are not often used alone). While these side effects can be distressing, knowing what they're up against when they start hormonal treatment can help men — and their partners — be better prepared to deal with them.

Sexual symptoms

Most men who are sexually active prior to treatment will develop sexual dysfunction once they start hormonal therapy. Even if the erectile dysfunction is not complete, the accompanying loss of libido (sexual desire) will negatively affect one's sexual life. This is a direct consequence of the lack of testosterone, and only the recovery of usual testosterone levels will normalize sexual ability. In clinical practice, we are often asked if the use of oral medications for erectile dysfunction (e.g. Cialis®, Levitra®, Viagra®) can solve the problems induced by hormonal therapy. Unfortunately, these drugs are not extremely helpful, since the presence of circulating testosterone is crucial for a normal sexual life. The management of this secondary effect usually involves psychological preparation to help patients and their partners adapt to this change during treatment. If necessary, counselling with sex therapists can be a valuable aid. Once a temporary course of hormonal therapy is finished, testosterone levels are likely to return to normal and regaining erectile function is possible, although the time it takes can vary. Recovery can sometimes be delayed and incomplete, depending on important factors such as: the length of time one is on hormonal therapy, the patient's age, other therapies being used, and pretreatment testosterone levels.

Hot flashes

Approximately 80% to 90% of men undergoing hormonal therapy will experience hot flashes, usually described as a feeling of intense heat that begins in the face or face and chest. The sensation may spread to the whole body and be associated with sweating, accelerated heartbeat and, sometimes, nausea. Hot flashes can last from two to 30 minutes and may recur constantly throughout the day and night. Their intensity varies from mild to severe. Hot flashes can cause insomnia, affect mood and impair concentration. There is no "standard" therapy for reducing the intensity of hot flashes, but several drugs have been studied that provide a wide range of responses. Medications that can be helpful in some cases include megestrol acetate, transdermal estrogen, gabapentin, and selective serotonin uptake inhibitors (a type of antidepressant); these are available only by prescription from your doctor. Some natural products are also reported to improve this side effect, for example soy products, vitamin E and herbal remedies, but their true effect is variable and not tested in prospective randomized trials. Also, it is suggested that people who suffer from hot flashes avoid potential triggers such as caffeine, hot drinks and spicy foods. Of course, this is very personal, as these triggers do not all have the same effect on all patients who are taking hormonal therapy.

Osteoporosis

The risk of osteoporosis and consequent bone fractures increases with prolonged androgen deprivation therapy. This happens because hormonal therapy generally decreases bone density, and weaker bones are at higher risk for fractures. This is a situation in which the best "treatment" option is prevention: Lifestyle changes, including smoking cessation, exercising (especially resistance exercises such as weight training), calcium and vitamin D supplementation, and limiting caffeine and alcohol consumption are beneficial to reduce or slow down the risk of developing osteoporosis. A new class of drugs known as bisphosphonates increase bone density and, therefore, have the potential to lower the risk of osteoporosis and fractures associated with prolonged hormonal therapy. However, the ideal timing for starting these drugs, as well as the optimal dose and schedules are still a subject of controversy; ongoing clinical trials are targeting these questions.

(Continued on page 5)

(Continued from page 4)

Body and metabolic changes

Gynecomastia, the abnormal enlargement of mammary glands (breasts) in men, is usually associated with the use of antiandrogens given as monotherapy. Although generally linked with the psychological burden of changes in body image, it may sometimes be accompanied by breast tenderness. Medical interventions to treat gynecomastia include radiation therapy, surgery or use of medications such as tamoxifen or aromatase inhibitors.

A certain percentage of patients undergoing hormonal therapy notice other less common — but not irrelevant — secondary effects, including: diabetes, cardiovascular (heart) disease, metabolic changes (especially related to fat metabolism, with changes in body composition and weight gain), and fatigue.

Find your healthy balance

It's important to remember that any type of therapy has to be oriented and/or followed by your treating physician, and the options described above may not be suitable in all cases.

While there is no known "magic pill" to cure these symptoms, a healthy lifestyle with a well balanced diet and regular exercise and, of course, close follow-up with your physician (especially if you already have elevated cholesterol, high blood pressure or diabetes) are critical to keeping your system well balanced and helping you go through hormonal therapy with no major complications.

Dr. Fabio Cury is an Assistant Professor in the Department of Oncology, Division of Radiation Oncology, at McGill University in Montreal (Québec).

• • •

Winnipeg Tests Treatment For Prostate Cancer

By Kevin Rollason, Canwest News Service
September 20, 2009 Winnipeg Free Press

WINNIPEG - Diagnosed with prostate cancer, Martin Hiebert was facing surgery and a weeklong painful recovery in hospital

Instead, Hiebert, 62, went in for treatment and was on his way home eight hours later.

``There was no pain," he said recently about his experience almost a year ago.

``I had a catheter on for eight days and I had some discomfort because of that, but then I was back to normal," he said. ``It was amazing."

Instead of using a scalpel and radiation to attack the prostate cancer, Hiebert took part in a test treatment using High Intensity Focused Ultrasound with the Sonablate 500.

Almost a year after undergoing treatment, Hiebert's prostate cancer hasn't returned.

Dr. Darrell Drachenberg, a Winnipeg surgeon and urologist, said the treatment is minimally invasive and has been used for several years in Asia while countries in Europe have used it for about five years. Fifteen patients in Manitoba during the last 18 months have already undergone treatment during the testing phase.

The doctor said a device is inserted into the patient through the rectum and the focused ultrasound heats the tissue quickly allowing surgeons to destroy only the entire prostate.

Drachenberg said the treatment isn't a miracle cure that will be used by everyone with prostate cancer, but it is another tool in the tool box of cancer doctors.

``It will never overtake surgery or radiation," he said. ``It's not the ultimate treatment for prostate cancer.

``If it is approved, probably about 20 to 40 per cent of patients will use it."

Because the treatment, while approved by Health Canada for the study, is not covered by Manitoba Health, Hiebert had to pay $22,000 for it.

Hiebert said it was money well spent.

kevin.rollason@freepress.mb.ca

• • •

High-Dose Radiotherapy for Prostate Cancer

Radiation therapy for prostate cancer has been a well-established option for men with early prostate cancer for many years, but advances make it more attractive than ever before. One major improvement is high-dose therapy.

All forms of radiation contain energy; it's what boils water in a microwave oven and what burns your skin after a too-long day at the beach. Radiotherapy delivers much more energy, enough to kill cells. Because cancer cells are growing faster than normal cells and are less able to repair radiation damage, radiotherapy can be used to treat many forms of cancer. The trick is to focus the radiation on the tumor as precisely as possible, thus minimizing damage to nearby healthy tissues. In the case of prostate cancer, doctors can focus the energy of radiation from outside the body (external beam radiation) or from the inside, by placing radioactive seeds inside the prostate (brachytherapy). Both techniques rely on high-tech methods of imaging the prostate to produce precise maps of the gland.

TARGETED THERAPY

In the case of external beam therapy, the goal is to deliver energy to the prostate while protecting the bladder and rectum. After a man chooses external beam therapy, his first step is to undergo a computed tomography (CT) scan. The CT image is relayed to a computer that constructs a precise, three-dimensional map of his prostate and seminal vesicles. The map allows the radiation oncologist to target precisely the cancerous tissues while shielding the healthy tissues nearby.

The next challenge is to deliver radiation to the target. Three techniques are available:

Three-dimensional (3-0) conformal radiation, which delivers energy in the form of photons (electromagnetic waves), is the most Widely available technique.

Intensity-modulated radiotherapy (IMRT) also delivers photons but uses a different system to boost radiation to the prostate while diminishing the intensity of the radiation that spills over to normal tissues. IMRT is more expensive than 3-D conformal therapy and is less Widely available.

Proton beam therapy, currently available at only a few centers in the United States, uses the same basic computer modeling to target the prostate as 3-D photon therapy, but it delivers energy in the form of protons (charged particles). The potential advantage of using protons is that it delivers a narrowly focused beam of energy with minimal scatter to surrounding tissues.

TESTING THE THERAPY

To find out if high-dose radiation produces better results than conventional treatment, doctors at Harvard Medical School and Loma Linda University studied 392 patients with early prostate cancer. The patients' average age was 67, and their average PSA was 6.3 ng/mL. Between 1996 and 1999, they were randomly assigned to receive conventional or high-dose therapy. All the patients received proton beam therapy initially, followed by photon therapy.

Researchers followed the men for an average of five and a half years. Survival was excellent in both groups; only two men in the conventional-dose group died from prostate cancer while none of the high-dose patients died from the disease. Because there were so few deaths from prostate cancer, these results were not significantly different. But there were significant differences in the risk of recurrent prostate cancer. Among patients with a low risk of recurrent cancer, the men who received high-dose therapy had a 51 % lower incidence of recurrence than the conventional-dose patients, while the men at moderate risk had a 44% advantage with high-dose radiation. And the improved results of high-dose therapy were achieved without an increase in major side effects.

PERSPECTIVE

The research shows that it is possible to deliver high doses of radiation safely and that high doses achieve better control of local disease. But longer follow-up is needed to see if high-dose treatment also produces better survival.

High-dose external beam radiotherapy is an important option for men with early prostate cancer. But there are other good radiotherapy choices, including brachytherapy, combined seed and external beam therapy, and combined androgen-deprivation and radiotherapy. And even with all these radiotherapy possibilities, many men chose surgical treatment and some select active surveillance without early treatment. Until randomized clinical trials tell us which patients benefit most from each method, each man should discuss the pros and cons of the various treatments with his doctors and his family, then decide for himself.

The treatment of prostate cancer is improving steadily - but the choices facing patients are also getting more complicated.

An article from Men's Health Series
Harvard Health Publications – Harvard Medical School

• • •

Early Detection is the Best Protection

Despite some controversy, the PSA test is necessary.

The usefulness of the PSA test has been debated in medical and political circles for some time; however, when deciding whether or not to take the test, all men should consider the pros and cons, and keep in mind, that early diagnosis is the key.

Prostate Cancer Canada and many doctors would agree that the PSA test is crucial in detecting prostate cancer. Yet, some medical professionals believe that, for several reasons, the PSA test is not always necessary.

Occasionally, PSA tests find prostate cancer which may never become life threating. Performing a biopsy in this case and treating their cancers may actually cause more harm than good, particularly for older men who have slow growing tumours which may never affect their health and never need treatment. The PSA test can be misleading as high PSA levels do not necessarily mean cancer is present, and low PSA levels does not always mean cancer is not present.

While these reasons can be worrying, men should be made aware that over 90% of prostate cancer cases are curable if detected and treated in their earliest stages, and although the test may not be fool proof, it is the best, and only, early detection tool men have at present. Since introducing the PSA test, North America has seen a 25% decline in prostate cancer-related deaths. It is likely that widespread testing has contributed to this trend.

Prostate Cancer Canada News - summer 2009 edition

• • •

Funding Innovative Research: 2009 - 2010 Grants

Each year Prostate Cancer Canada's Scientific & Medical Advisory Committee gather to review and assess grant applications submitted by researchers and scientists from across Canada. In June 2009, $1.6 million was awarded to fund 17 of the most promising and innovative research studies into the prevention, detection, treatment and cure of prostate cancer. Here are 3 examples of the types of investigations that will take place over the coming months:

1) Killing tumours with "micro-bubbles". Dr. Gregory Czarnota and his team at Sunnybrook Health Science Centre in Toronto will investigate and refine a technique that combines ultrasound with technology called "micro-bubbles". Under certain circumstances, this technique can be used to destroy the network of blood vessels that surround prostate tumours and in turn, kill the tumour by robbing it of its supply of blood and nutrients. If successful in the lab, this technique could be rapidly adapted for use in prostate cancer patients.

2) Preventing prostate cancer with a commonly prescribed drug for type 2 diabetes. Cancer cells require an abundant supply of energy to survive and grow. There is some evidence that a drug called metformin, which is usually prescribed to patients with type 2 (adult onset) diabetes and is known to lower blood sugar levels, may have the ability to prevent the onset of some cancers. Dr. Samy Suissa and his team in Montreal will conduct a study to look at men who have taken metformin for their type 2 diabetes and examine whether they have a lower risk of developing prostate cancer than men who did not take the drug for their diabetes. If this is the case, metformin might one day be prescribed for certain men to prevent prostate cancer.

3) Determining whether ER-Beta is a good target for new prostate cancer therapies. While a great deal of research has focused on the effects of male sex hormones (e.g. testosterone), less is known about the influence of other sex hormones, such as estrogen, on the prostate gland and the development of prostate cancer. Estrogen interacts with a protein called the estrogen receptor (ER), which comes in 2 varieties. One of these is called the "ER-beta" protein and is thought to be involved in the development of prostate cancer. Dr. Murphy and his research team in Winnipeg will examine how ER-beta may interact with other proteins known to promote the development of prostate cancer and how prostate cancer cells respond when ER-beta is turned on or off. This investigation will help determine whether ER-beta is a good target for prostate cancer therapies.

Prostate Cancer Canada News - summer 2009 edition

• • •

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.,
Winnipeg
R3M OY1

Publications Agreement
40037332

Depression, Insomnia Affect Many Prostate Cancer Patients

MONDAY, July 20 (HealthDay News) - Many men with prostate cancer suffer from insomnia, depression and distress, and younger men as well as those receiving radiation therapy are most at risk, according to a study published the August issue of Applied Nursing Research.

Shannon Ruff Dirksen, R.N., of Arizona State University in Phoenix, and colleagues conducted a study of 51 prostate cancer patients who attended a Veterans Affairs Medical Center outpatient clinic and who completed a questionnaire on insomnia, depression and distress.

Clinically significant insomnia was reported by 27 (53 percent) of the men, with 23 (45 percent) having difficulty initiating sleep and 28 (55 percent) having trouble maintaining sleep, the researchers note. As for depression, 26 (51 percent) of the men were depressed at a clinically significant level and of the 27 men with insomnia, 14 (52 percent) also had depression, the investigators found.

"This exploratory study suggests that clinically significant insomnia is experienced by many men, which is related to depressive symptoms and distress," the authors write. "Younger men and those receiving radiation therapy indicated higher levels of depression and distress, suggesting that nurses caring for these men may want to consider earlier recognition and intervention to decrease the severity of these symptoms."

• • •

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

***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 Coordinator	488-0804
Darlene Hay, Membership Coordinator	837-6742
Kirby Hay, Information Coordinator	837-6742
Ken Kirk, New Member Coordinator	261-7767
Jim Leddy, Executive Member	831-6119
Norm Oman, Events, Speaker Coordinator	487-4418
Brian Sprott, Chairman	668-6160
June Sprott, Secretary	668-6160
Lorne Strick, Videographer	667-9367
Arthur Wortzman, Executive Member	287-8621
Our Answering Machine	989-3433