The Manitoba Prostate Cancer Support Group

Vol. 216 – June 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

Middle age is when you choose your cereal for the fiber, not the toy.

- Norm Oman

In This 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 confus ing the subject of cancer can be. *All calls are kept confidential*

NEXT MEETING:

Thursday, June 18th, 2009 7 - 9 P.M.

Tom Roche, Social Worker, Cancercare

So You've Been Referred to a Social Worker: Now What?

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

Gleason Score of 3+4 is not equal to 4+3 in Lethal Prostate Cancer

Published on 12 May 2009 by Insciences

Men with 4+3 score are at three fold greater risk.

Boston, MA - The Gleason scoring system is an important method of classifying prostate cancers based on the appearance of the prostate cancer cells under a microscope. Gleason patterns range from one to five, with higher Gleason patterns being associated with more aggressive disease. The Gleason score, which ranges from two to ten and is calculated by adding the primary (most prevalent) and secondary Gleason patterns, is an important prognostic tool for clinicians. Studies showing that short-term outcomes for prostate cancer differ according to Gleason scores have helped to guide clinical practice. Now, researchers at Brigham and Women's Hospital (BWH) have shown that Gleason score is a strong predictor of prostate cancer mortality and that mortality rates differ among patients with a Gleason score of seven depending on whether Gleason pattern four is primary or secondary. This research was published online in the Journal of Clinical Oncology.

Researchers collected tissue samples from prostatectomies and biopsies from men who were diagnosed with prostate cancer between 1984 and 2004 and were enrolled in the Physicians' Health Study and Health Professionals Follow-up Study. The samples were assigned primary and secondary Gleason patterns by study pathologists. Researchers found that within the group of men with Gleason scores of seven, men with primary and secondary patterns of 4 and 3 respectively had worse long-term outcomes compared to men with a primary pattern of 3 and secondary pattern of 4.

"Four plus three cancers were associated with a three-fold increase in lethal prostate cancer compared to three plus four cancers," said Jennifer Rider Stark, Post-doctoral research fellow at BWH and the Harvard School of Public Health. "If we are lumping these cancers into one category of Gleason score 7, then we are missing important prognostic information."

Lethal prostate cancer was defined by the development of bony metastases or prostate cancer death. Current clinical practice evaluates and treats men with three plus four cancer differently than a man with four plus three cancer, but until now there was no long-term mortality data to support this practice. Clinicians were making these decisions based primarily on surrogate outcomes such as prostate-specific antigen relapse.

"This study provides clinicians with further evidence that men who have Gleason scores of seven should be evaluated based on the predominant Gleason pattern," Stark said.

This research was funded by grants from the National Cancer Institute.

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Living And Loving With Prostate Cancer

(ARA) - A man is supposed to be physically healthy and emotionally strong. So where does he turn to when a disease such as prostate cancer comes along, which threatens this? An international call to action has been launched which draws attention to the impact that prostate cancer has on a man's love life, and calls for much better information to help couples through this difficult time.

More than 230,000 men are diagnosed with prostate cancer every year. "It is reaching epidemic proportions and is possibly one of the biggest challenges to men's health in the world today," says Tom Kirk of Us TOO International Prostate Cancer Education and Support Network.

The international call to action asks men and their families to confront the disease and assemble the best team of doctors and researchers around them for advice on treatment options, and draw strength from the loving support of their family to help them manage the impact the disease can have on how they feel emotionally.

Marriage and family therapists, Douglas and Sandy Jardine have firsthand experience living with prostate cancer, following Douglas' diagnosis in 2006. "We knew that after his surgery for prostate cancer, erectile dysfunction would be inevitable at least for a few months" says Sandy. "We planned a romantic weekend away just before surgery day. We joked about having sex all weekend, but it was bittersweet and somewhat sad."

"As a couple, we needed to know much earlier, and before the surgery, about the near certainty of some level of permanent sexual dysfunction after removal of the cancer. We needed clearer and more realistic predictions of how long it could take before things improved. Our hope is that health professionals will increasingly provide this education before surgery. This will empower the man and his partner, and could be of help in keeping the partners connected," she says.

Prostate cancer survivor Jim Kiefert was diagnosed with prostate cancer 20 years ago at age 50. Kiefert, who is chairman of the board of directors of Us TOO International, was told that he had between one and three years to live. "I was told that I had failed the treatments and there was no known cure," Kiefert says. "I felt very depressed. But my wife Maureen and I learned everything we could about prostate cancer and made changes in our diet and exercise, and practiced stress reduction. We've been real fighters."

Although prostate cancer strikes only men, it can have a profound impact on the man, the couple and the family. "Keep talking to each other, reach out to family and friends, and learn all that you can about the disease. Join a prostate cancer support group, and put your relationship first. Listen to your partner's feelings, and be a safe haven for each other," says Sandy.

For additional information visit Us TOO International Prostate Cancer Education and Support Network at www.ustoo.org or ZERO - The Project to End Prostate Cancer at www.zerocancer.org.

Courtesy of ARAcontent

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Statins May Reduce Risk of Prostate Cancer

By CancerConsultants.com

Researchers from the Mayo Clinic have reported that use of statins may reduce the risk of developing prostate cancer. The details of this study were presented at the annual meeting of the American Urological Association. [1]

Other than skin cancer, prostate cancer is the most commonly diagnosed type of cancer among men in the United States. Each year, there are approximately 186,000 new diagnoses and more than 28,000 deaths from the disease.

Statins are a widely prescribed type of cholesterol-lowering drug. These drugs have been credited with reducing LDL cholesterol levels and improving cardiovascular health as well as possibly preventing strokes. Studies of effects of statins on the prevention of prostate cancer have been conflicting with some reporting no effect and some indicating a preventive effect. One effect that appears to be reproducible is that statins lower PSA levels in men without prostate cancer.

To explore the effects of statin use on risk of prostate cancer, researchers evaluated information from the Olmsted County Study of Urinary Health Status among Men. In this study, researchers followed 2,447 men—all residents of Olmsted County, Minnesota—for over 15 years.

* Compared with statin users, non-users of statins were three times more likely to develop prostate cancer.

Comments: These results are consistent with some studies showing that the incidence of prostate cancer is lower among statin users. This topic has been the subject of two recent reviews that suggest that statins probably decrease the risk of advanced prostate cancer. [2],[3] However, both studies stopped short of recommending statin use specifically for prostate cancer prevention.

References:

[1] Breau L et al. Statins may reduce risk of prostate cancer. Presented at the 2009 annual meeting of the American Urological Association.

[2] Hamilton RJ, Freedland ST. Review of recent evidence in support of a role for statins in the prevention of prostate cancer. Current Opinion in Urology. 2008;18:333-339.

[3] Platz EA, Does statin use affect the risk of developing prostate cancer? National Clinical Practice of Urology. 2009;6:70-71.

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Prostate Cancer

www.news10now.com 05/08/2009 04:00 AM
By: Marcie Fraser

“If they live long enough, almost all men will have some prostate cancer present. We are starting to see men in their late 30s and 40s we are starting to pick up because of screening,” said Dr. Mark White.

It affects men in their 60s and 70s.

“Prostate is pretty silent. Some men occasionally have changes in their urination patterns; they go more frequently. Some may have some blood in their urine,” said White.

Screening for cancer, at what age do you begin and how frequently. A blood test called a PSA varies greatly and not always a good marker for cancer.

“PSA is not a perfect test. It doesn't definitely tell you have prostate cancer, the PSA can be elevated for prostate enlargement, prostate infection or prostate cancer so the fact that you have an elevated PSA doesn't mean you have cancer,” said Dr. White.

According to some reports, early screening for prostate cancer is not having a significant effect on survival rates and may not be warranted. Right now, most testing at begins at age 50 and yearly year after that. The controversy surrounding when to begin testing and how frequently may have something to do with money.

"It's a blood test and it is an expensive blood test. It all come down to dollars and our health care and is it something everybody should have or should we be more selective about it,” said White.

Along with a PSA, a physical exam is also performed. The other screening is a digital rectal exam and our finger exam and our finger cannot feel the entire prostate so if we feel something that is abnormal, we tend to offer an ultra sound and biopsy.

Other related conditions like benign prostate disease or prostatitis does not necessarily indicate you have an increased risk of prostate cancer.

“We used to think infections in the prostate when men were younger may put them at higher risks for cancer later but most of those associations have never been proven,” White said.

If you do have risk factors, family history or symptoms, see your doctor.

"The jury is still out whether the prostate screening and whether PSA screening is right for everybody but there are certain populations that benefit from screening,” said White.

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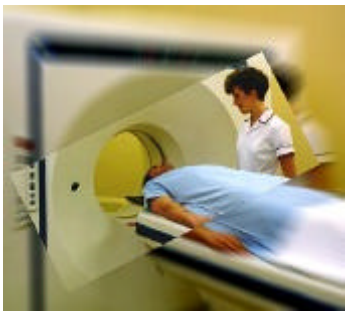
More Cancer Tests Mean More False-Positive Results

Risk for incorrect but worrying findings rises 50 percent by the 14th test, study finds

HealthDay news MONDAY, May 11 (HealthDay News) - The more cancer screening tests you undergo, the higher your risk of having at least one false-positive result, researchers say.

While that conclusion may seem like common sense, it's not something that patients or doctors often consider, suggest the authors of a study in the May/June issue of the Annals of Family Medic ine.



False-positive results from routine cancer screening can cause undue worry and in some cases lead to unnecessary biopsies or treatments, experts note.

In the new study, "after 14 tests total, over half of the people in our study had a false-positive result. No test is perfect, and you would expect to see it go up over time, but how rapidly the risk went up was surprising," said the study's lead author, Dr. Jennifer Croswell, acting director of the office of medical applications of research at the U.S. National Institutes of Health in Bethesda, Md.

"It's important to know ahead of time the risk of false-positives," she said. "Screenings have to be thought of like any other medical intervention and it's important to have the discussion about the risks and the benefits."

Croswell and her colleagues reviewed data from the Prostate, Lung, Colorectal and Ovarian (PLCO) Cancer Screening Trial, which included nearly 70,000 participants. The study volunteers were between the ages of 55 and 74, and were randomly selected to receive either normal care or more intensive screening.

Those in the normal-care group were offered screening through their own private physicians as usual. Those in the intervention group were offered a baseline chest X-ray along with a yearly follow-up for two years for non-smokers and three years for smokers to check for lung cancer; a baseline flexible sigmoidoscopy to check for colorectal cancer, along with a three- or five-year follow-up; annual tests for cancer antigen 125 (CA-125) and a transvaginal ultrasound yearly to check for ovarian cancer in women; and an annual digital rectal exam to check for prostate cancer in men, as well as a prostate-specific antigen test.

No information was included on mammography for women in either the intervention group or the usual care group.

For those who had 14 screening tests during the study period, the cumulative risk of having at least one false-positive was 60.4 percent for men and about 49 percent for women. The cumulative risk of having to undergo an invasive diagnostic procedure due to a false-positive test result was almost 29 percent for men and just over 22 percent for women.

Croswell said the researchers weren't sure why the false-positive rate was higher for men, but it likely had something to do with the tests that were studied.

"The fact is that screening tests aren't diagnostic," said Robert Smith, director of cancer screening for the American Cancer Society. "A certain risk of false positives and false negatives are to be expected. You can try to very aggressively reduce the false-positive rate, but then you also cut into cancer detection rates," he explained.

"Most people place a higher priority on finding cancer early than preventing false-positives. I think the public often understands that false-positives happen," said Smith. But, he added, "We really need to do a better job of explaining to adults that there is a plus side and a down side to screening. We need to do a better job of letting people know what to expect, and that screening tests aren't perfect."

In another study in the same issue of the journal, researchers at the University of Auckland, New Zealand, take a different look at medical errors, and focus on the types of errors that patients make. While the study didn't attempt to rank which medical errors patients are most likely to make, the researchers did try to identify the types of errors patients might make.

They found that patient errors could be classified into two broad categories: action or mental errors. Action errors are related to patient behavior and may include coming late to an appointment or not following directions when taking medications. Mental errors are when a patient has compromised thought processes, memory problems or knowledge deficits. Examples of mental errors include forgetting to take medications or a failure to understand the doctor's instructions. The authors suggest that future research should try to account for these errors and find ways for clinicians and patients to work together to reduce errors.

SOURCES: Jennifer M. Croswell, M.D., acting director, office of medical applications of research, U.S. National Institutes of Health, Bethesda, Md.; Robert Smith, Ph.D., director of cancer screening, American Cancer Society; May/June 2009 Annals of Family Medicine

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MANITOBA PROSTATE CANCER SUPPORT GROUP

SAFEWAY™

providing information and support for prostate patients and their families

next meeting
June 18, 2009
at 7:00 pm

Seven Oaks Hospital - Auditorium
2300 McPhillips Street at Leila

Everyone Welcome

Call us at 989-3433

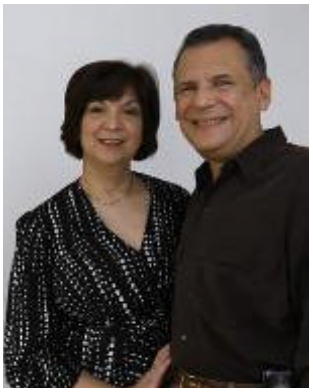
Prostate Cancer: Survivor

Posted to phily.com on Thu, Apr. 23, 2009

DURING a lucky bout with kidney stones in summer 2007, Carlos Perez underwent a scan in the emergency room that detected signs of prostate cancer. A biopsy confirmed it, and Perez had robotic surgery that October at Fox Chase Cancer Center to remove his prostate.

Clear of cancer ever since, the 64-year-old retired SEPTA facilities manager now volunteers at the hospital, "taking paperwork back and forth, help the nurses out so they don't have to move around so much."

Perez, who lives in Rhawnhurst, also teaches Spanish pre-Cana classes about marriage and family life for the Archdiocese of Philadelphia. His wife, Serafina, teaches alongside him and was with him all the way through the turbulence of his diagnosis and treatment. He spoke with reporter Becky Batcha about his cancer treatment and recovery.



Carlos Perez, a prostate-cancer survivor, and his wife Serafina, went through his cancer together. (David Maialetti / Staff Photographer)

Kidney stones — his lucky day. "My father had prostate cancer. He died from stomach cancer. I started getting PSA tests annually at age 40. They were all coming out negative.

"Then one day I got up with a really bad back pain. My wife said I looked like I was going to have a heart attack. I went to go to work, but I had to turn back. It turned out I had kidney stones.

"The emergency-room doctors saw on the scan that my prostate was calcified, and they suggested I go see a urologist. That was a lucky shot. He did a digital rectal examination and felt that the prostate was hard, and he recommended I get a biopsy. When I went back to see him, he told me that the prostate showed I had cancer.

The shock of the diagnosis. "He just told me point-blank: 'You have prostate cancer.' I almost fell off the chair.

"When you hear that news, the first thing you think about your family. What's going to happen to them if you're gone? That's the initial shock. A lot of things go through your mind.

"Of course you're going to get angry. Why me? You have to have strong faith.

"My daughter's baby twins were in the hospital. They were born premature. My wife's mother had passed away. All this was happening at the same time.

"I didn't have a lot of time to think about it. It think that helped in a way.

Instant expert. "I went online and looked up the different treatments, then I made an appointment with Dr. David Chen at Fox Chase and he told me all the options that were available. I had my mind set on surgery with the da Vinci robotic system, and he said I qualified for it so we decided on that.

"They performed the surgery in October, and the next day I was up and walking around: no symptoms, no side effects. They said there could be a certain amount of incontinence, but that was limited, almost insignificant. In a couple months, it was over.

"The fortunate part about it was, it was caught by accident and it was caught early. It was contained within the prostate, and they removed the prostate. Everything came back clear. The kidney stones were a blessing in disguise.

Go ahead, ask him about the digital rectal exam. "That's something that a lot of men don't like. It's just the idea that Hispanic men — any man — doesn't like any part of his body touched by anyone else. It's uncomfortable, but it's only two minutes.

"My doctors had been doing them, but they weren't doing them every year because my PSA was low. That's why the prostate cancer took me my surprise.

"Every opportunity I get, I talk to people about it. I tell the men I know over a certain age — or even under a certain age — go get tested. Don't wait until it's too late.

Further community service. "My concern is that the information isn't getting out to the Hispanic community. If you know English and you read up on things, you know enough about it. The problem is, there's not enough information in Spanish. I hear about breast cancer in women, but nothing for the men on prostate cancer. People should know there's a national health line in Spanish called Su Familia. The number is 866-783-2645. They'll answer in Spanish.

Marriage, the master class. "In Spanish pre-Cana, we give a series of talks: Spirituality in marriage, communication in marriage, even sexuality in marriage. We have a team of couples teaching. Combined, we have over 100 years experience.

"My wife and I have been married 40 years. I don't know if we're an example, but we tell them what the truth is: It's not an easy thing. Romance comes first, but after that all the trials come along.

"I'm grateful to my wife. She's kind-hearted. She really takes care of me. It's been difficult for her, but she's been there for everybody. It was a blessing the day I met her."

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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

***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
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Jim Leddy, Secretary	831-6119
Ken Kirk, New Member Chairman	261-7767
Norm Oman, Chairman, Events Coordinator	487-4418
Brian Sprott, Media Coordinator, Editor	668-6160
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 # 705 - 776 Corydon Ave., Winnipeg R3M OY1

a tax deductible receipt will be issued.