The Manitoba Prostate Cancer Support Group NEWSLETTER

Vol. 230 – August 2010

manpros@mts.net

Thought For Today

Why do psychics have to ask your name?

- Liz Feschuk

Medical Advisors to The Manitoba Prostate Cancer Support Group

=> Paul Daeninck M.D.
Pain Management

=> Darryl Drachenberg M.D. Urologist

=> Graham Glezerson M.D. Urologist

=> Ross MacMahon M.D. Urologist

=> John Milner M.D. Urologist

=> Jeff Sisler M.D.
Family Practitioner

=> Gary Schroeder M.D.
Radiation Oncologist

Thanks!

NEXT MEETING:

Thursday, August 19th, 2010 7 - 9 P.M.

Dr. Paul Daeninck,
Pain Management Specialist

"**Insights into Pain Management**"

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

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.

MOVING?

HELP US KEEP OUR RECORDS UP TO DATE

Phone: Darlene at (204) 837-6742
Email: manpros@mts.net

The Manitoba Prostate Cancer Support Group would like to acknowledge the recent donation from Pfizer Canada. Pfizer manufactures Viagra - a drug used to treat erectile dysfunction. We are grateful for their continued support. Their donation, along with those from individuals makes the running of our Support Group possible.

WE REALLY APPRECIATE YOUR SUPPORT

The Manitoba Prostate Cancer Support Group operates on your donations

Have you used any of our services?

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

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New Findings From University Of Toronto In The Area Of Prostate Cancer Described

Researchers detail in 'Prospective survey of sexual function among patients with clinically localized prostate cancer referred for definitive radiotherapy and the impact of radiotherapy on sexual function,' new data in prostate cancer. "The purpose of this study is to assess sexual function among patients with clinically localized prostate cancer referred for radiotherapy and to prospectively evaluate the effect of radiotherapy on sexual function, using the Brief Sexual Function Inventory (BSFI). A descriptive study, approved by the local research ethics committee, was prospectively conducted," researchers in Toronto, Canada report.

"At baseline, patients were asked to complete a self-administered BSFI, along with other questionnaires describing their clinical condition. Patients with normal erection at baseline were asked to complete a follow-up BSFI at 6, 12, and 24 months postradiotherapy. The collected data was analyzed using the SAS software. The study accrued a total of 117 eligible patients. The mean age was 66 years. Forty-two patients (35.9%) were considered to have erectile dysfunction (ED) at baseline. They were older and more likely on one or more medications affecting potency, compared with those with normal erectile function. They had a consistently lower mean score for all the five domains of BSFI and considered sexual activity less important. Of the 75 patients reporting normal erectile function at baseline, 61 completed a follow-up BSFI questionnaire. Among the 61 patients, 52 underwent radiotherapy with external beam radiotherapy or brachytherapy. Mean scores for all the BSFI domains declined after radiotherapy, suggesting that radiotherapy adversely affected not only erectile function but also other aspects of sexual function including sexual drive and ejaculation. Among the patients with clinically localized prostate cancer referred for radiotherapy, sexual dysfunction was prevalent with 35.9% reporting ED at presentation," wrote R. Choo and colleagues, University of Toronto, Cancer Center.

The researchers concluded: "Radiotherapy adversely affected all aspects of sexual function."

Choo and colleagues published their study in Supportive Care In Cancer (Prospective survey of sexual function among patients with clinically localized prostate cancer referred for definitive radiotherapy and the impact of radiotherapy on sexual function. Supportive Care In Cancer, 2010;18(6):715-22).

For additional information, contact R. Choo, University of Toronto, Dept. of Radiation Oncology, Odette Cancer Centre, Toronto, ON, Canada.

Publisher contact information for the journal Supportive Care In Cancer is: Springer, 233 Spring Street, New York, NY 10013, USA.

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Nanoparticle PSA Test Predicts If Prostate Cancer Will Return

Men who have just had their cancerous prostate gland removed have one pressing question for their doctors: Am I cured? But conventional tests haven't been sensitive enough to provide a concrete answer. Current tests that measure the level of protein called PSA (prostate-specific antigen), which signals the presence of cancer, often detect no PSA, only to have cancer return in up to 40 percent of the cases.

New research from Northwestern University Feinberg School of Medicine and the University International Institute for Nanotechnology shows that an ultrasensitive PSA test using nanoparticle-based technology (VeriSens" PSA, Nanosphere, Inc., research-use-only) may be able to definitively predict after surgery if the cancer is cured long term or if it will recur.
The new test, which is based upon assays invented at Northwestern in the laboratories of co-principal investigator Chad A. Mirkin, is 300 times more sensitive than currently available commercial tests and can detect a very low level of PSA that indicates the cancer has spread beyond the prostate. The test also may pick up cancer recurrence at a much earlier stage, when secondary treatment is most effective for a patient's survival.
"This test may provide early and more accurate answers," said co-principal investigator C. Shad Thaxton, M.D., an assistant professor of urology at Feinberg and a member of the Robert H. Lurie Comprehensive Cancer Center of Northwestern University. "It detects PSA at levels in the blood that cannot be detected by conventional tests. It may allow physicians to act at the earliest and most sensitive time, which we know will provide the patient with the best chance of long- term survival."

This ability to quickly detect very low levels of PSA may enable doctors to diagnose men with prostate cancer recurrence years earlier than is currently possible. Prostate cancer is the second leading cause of cancer death for men in the United States.
Not only may the new test more accurately predict the course of the disease, it also gives an early indication of whether secondary treatments, such as radiation and hormone therapy, are working. If not, then doctors can quickly begin alternative treatment and refer patients to clinical trials.

The study results will be presented June 2 at the American Urological Association 2010 Annual Meeting. These and the results of other Northwestern PSA studies will be presented at the meeting by Lee Zhao, Dae Kim and Hannah Alphs, urology residents at Feinberg.
"These studies suggest that the nanotechnology PSA test might become the preferred postoperative PSA test for men who have been treated with radical prostatectomy," said William Catalona, M.D., professor of urology at Feinberg, a physician at Northwestern Memorial Hospital and director of the clinical prostate cancer program at the Lurie Cancer Center. "It should be especially useful in the early identification of men who would benefit from adjuvant postoperative radiation therapy and those who need postoperative salvage radiation therapy for recurrence." Catalona, a senior investigator on the study, was the first to demonstrate that the PSA test could be used as a screening test for prostate cancer.

The study confirms and builds on the previous findings of a 2009 pilot study Thaxton conducted with Mirkin, the George B. Rathmann Professor of Chemistry in the Weinberg College of Arts and Sciences, and other colleagues.

PSA is a protein normally secreted out of the prostate cells into the semen in high concentrations. Usually, very little diffuses into the blood stream, and the normal PSA value for men without prostate disease is less than 2 nanograms per milliliter. When the prostate gland has a disease process, such as inflammation, benign enlargement or cancer, the barriers to PSA diffusion into the blood stream are breached, and PSA levels rise. In a man who has his cancerous prostate removed, there should be no PSA in the blood except for a minute amount produced by the periurethral glands. However, any PSA produced by cancer recurrence ends up in the blood stream and can be detected earlier with the more sensitive nanotechnology PSA assay.

For the new study, researchers obtained blood serum retrospectively from men whose PSA serum samples had been frozen after surgery and whose assays (blood analysis) showed an undetectable PSA level based on the conventional test. Northwestern researchers then tested those serum samples using the more sensitive nanotechnology-based test. They wanted to see if they could detect PSA at levels below the limit of the conventional test, and if those results could predict the cancer outcome for those patients, who were followed for up to 10 years. Using the new test, Thaxton and colleagues found that the low and non-rising PSA levels (presumably produced by the normal periurethral glands) of patients meant that the prostate cancer was effectively cured and did not return over a period of at least 10 years. Scientists also found a PSA level higher than that expected from the periurethral glands based on the new test meant the patients would have their disease recur.

As result of the study, researchers were able to assign a PSA level number to a cure for the first time as well as a number that indicated the disease would recur and if it would recur aggressively. These newly identified levels were below what could have been detected with the conventional PSA test. The researchers were able to quantify PSA values at less than 0.1 nanograms per milliliter, the clinical limit of detection for commercial assays.

Thaxton said the next step for scientists is a prospective clinical trial to compare the nanoparticle-enhanced PSA assay to traditional PSA assays and determine if earlier detection and treatment can save lives.

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Treating Prostate Cancer Safely and Accurately with Radioactive Seed Implants

Michael J. Zelefsky, MD Chief, Brachytherapy Service

The use of radioactive seed implants to treat cancer, a process known as brachytherapy, stretches back to the 1950s, when some of the pioneering advances in the field were developed at Memorial Hospital. Today, Memorial Sloan-Kettering Cancer Center clinicians continue to lead the way in advancing the use of brachytherapy, including the development of a more refined approach for treating men with prostate cancer. Using real-time, computer-based treatment planning and intraoperative CT scanning, our doctors are able to optimize the radiation dose delivered to the prostate through seed implants while limiting radiation exposure to important nearby structures - thereby minimizing the likelihood of side effects. This approach allows our treatment team to use CT scanning to assess the accuracy of seed placement during the procedure, a significant improvement when compared to standard prostate brachytherapy assessment, which is typically done hours or even weeks later.

Michael J. Zelefsky, MD
Chief, Brachytherapy Service

Brachytherapy, which comes from the Greek word brachy, meaning "short distance," is a form of radiation therapy in which radioactive seeds are placed inside or next to a tumor. This distinguishes it from external beam radiation therapy, which uses a machine outside of the body to deliver high-energy x-rays directed at the cancer.

Brachytherapy for Prostate Cancer

In low-dose-rate brachytherapy, the most common type of brachytherapy used to treat prostate cancer, ultrasound images of the prostate and the surrounding structures - combined with the results of complex mathematical computerized computations run by medical physicists - are used to determine the most effective placement of the seeds. The radioactive seeds are then permanently inserted into the prostate during an outpatient procedure, which allows the man being treated to return home the same day.

The seeds, which are about the size of a grain of rice and are made of titanium, are implanted in the prostate through long, thin needles inserted in the perineum, the area between the anus and the testicles. Approximately 80 seeds are inserted during an average procedure, which usually takes less than two hours and is performed with the patient under either spinal or general anesthesia. Over several months, the seeds gradually lose their radioactivity. During that time, the patient is allowed to go about his normal routine.

In standard brachytherapy for prostate cancer, doctors use ultrasound images taken several weeks before the procedure as a map for seed placement. This has the potential to cause problems if swelling has occurred since the original ultrasound or if the prostate's shape or geometry has changed. Additionally, the position that the patient is placed in when undergoing the procedure can cause changes in the prostate's shape and relative position, which can result in less than optimal seed placement.

Continued Refinements for Improved Accuracy

Memorial Sloan-Kettering doctors and physicists have helped to develop a refined approach, known as intraoperative computer-based conformal optimization. Here, the treatment team - including radiation oncologists, medical physicists, and radiation therapists - visualize the prostate using CT scans to assess optimal seed placement while in the operating room.

Pioneered at Memorial Sloan-Kettering in 1998, the use of sophisticated computer programs in the operating room to help target where and how many seeds to place within the prostate gland allows the optimal radiation dose to be delivered to the prostate, sparing as much normal tissues as possible from radiation exposure. Planning is done in the operating room during the actual procedure instead of weeks before the procedure, as had been previously done.

"Using on-site computers and ultrasound images, our medical physicists employ a sophisticated computer program developed at Memorial Sloan-Kettering that can examine within minutes millions of configurations of seed-coordinate placement possibilities," says Marco Zaider, PhD, Head of Brachytherapy Physics at Memorial Sloan-Kettering. "The program selects the placement plan that will deliver the most effective dose to the prostate while keeping the dose delivered to the rectum and urethra as low as possible."

As an extra measure of safety, the calculations are checked by a separate program run by a second medical physicist, also present during the procedure. "This completes the

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quality assessment and planning stage of the implant," adds Dr. Zaider. "Next, we have to make sure that what we've planned is actually achieved, and this brings us to the newest tool in our arsenal, intraoperative CT scanning, which, for all intents and purposes, amounts to a shift in paradigm."

Introducing a CT scan unit into the operating room represents the next step in image guidance, enhancing the precision and safety of seed implants by allowing the treatment team to confirm the placement of the seeds during the procedure. This approach combines quality control and an attention to detail that is not available for patients receiving standard brachytherapy, in which routine assessments of seed placement are normally not done until hours or even a full month after the procedure."

Our goal going forward was to further minimize side effects and to try to improve accuracy in seed placement, which led to the use of intraoperative CT scans," says Michael Zelefsky, Chief of the Brachytherapy Service at Memorial Sloan-Kettering. "With this addition, we are working on ongoing enhancements and significant improvements in the actual delivery of the seeds."

"This image-guided approach that we are using is beginning to revolutionize the way that prostate cancer brachytherapy is being done," adds Dr. Zelefsky. "We are now able to assess the quality of the implant during the procedure, as the seeds are being implanted. This allows us the opportunity to make corrections, if necessary, and to optimize the quality of the implant."

As Dr. Zelefsky explains, sometimes there may be slight changes in the patient's anatomy during the procedure, which may cause some of the seeds to receive less than optimal placement. "This new refined approach to brachytherapy for prostate cancer has given us much greater confidence in knowing that we are able to deliver the radiation dose exactly where we intended to place it," he says.

Success Rates and Side Effects

Treatment success rates for prostate cancer brachytherapy have been excellent, especially for men diagnosed with an early stage of the disease, for which survival rates are generally comparable to those produced by prostate surgery. In addition, the new intraoperative computer-based conformal optimization approach, and the enhanced precision it allows, reduces the likelihood of both urinary and rectal side effects when compared to external beam radiation. Another benefit of treating prostate cancer with brachytherapy is that the time commitment required to perform it is dramatically less than that required for external beam radiation, which is usually delivered in about 50 sessions over the course of ten weeks."

We are one of a few institutions in the world using this particular intraoperative CT scanning device on a regular basis to help us to optimize the quality and accuracy of the seed implant procedure," Dr. Zelefsky notes. "We think it may be appropriate for many forms of brachytherapy, and we are exploring the use of these procedures to treat a variety of other cancers."

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Redneck Medical Dictionary

Artery	The study of paintings.
Bacteria	Back door to cafeteria.
Barium	What doctors do when patients die.
Benign	What you be after you be eight.
Catscan	Searching for Kitty.
Cauterize	Made eye contact with her.
Cesarean Section	A neighborhood in Rome.
Colic	A sheep dog.
Coma	A punctuation mark.
D&C	Where Washington is.
Dilate	To live long.
Enema	Not a friend.
Fester	Quicker than someone else.
Fibula	A small lie.
Genital	Non-Jewish person.
G.I.Series	World Series of military baseball.
Hangnail	What you hang your coat on.
Impotent	Distinguished, well known.

Labor Pain	Getting hurt at work.
Medical Staff	A Doctor's cane.
Morbid	A higher offer than I bid.
Nitrates	Cheaper than day rates.
Node	I knew it.
Outpatient	A person who has fainted.
Ovaries	You get to try again.
Pap Smear	A fatherhood test.
Pelvis	Second cousin to Elvis.
Post Operative	A letter carrier.
Recovery Room	Place to do upholstery.
Rectum	Pretty near killed him.
Secretion	Hiding something.
Seizure	Roman emperor.
Tablet	A small table.
Terminal Illness	Getting sick at the airport.
Tumor	More than one.
Urine	Opposite of you're out.
Varicose	Near by/close by.

New Targeted Therapy Effective in Treating Advanced Prostate Cancer

April 14, 2010

Charles Sawyers (left) and Howard Scher

NEW YORK, NY - An experimental drug is showing promise for the treatment of men with an aggressive form of advanced prostate cancer. A new multicenter study has concluded that the targeted therapy MDV3100 is safe and effective for patients with castration-resistant prostate cancer (CRPC), known for its poor prognosis and limited treatment options. The research, led by investigators at Memorial Sloan-Kettering Cancer Center, appears early online and in an upcoming edition of The Lancet.

"We were encouraged to see antitumor activity in men whose disease had spread to other parts of the body after either becoming resistant to previous hormone treatments or progressing following chemotherapy."

- Howard Scher, MD, study's lead author and Chief of the Genitourinary Oncology Service at Memorial Sloan-Kettering

According to the findings of the Phase 1-2 study, MDV3100 not only shrank patients' tumors, but also reduced serum levels of the tumor marker prostate-specific antigen (PSA), stabilized disease that had spread to soft tissues and the bone, and reduced the number of circulating tumor cells in the blood.

"We were encouraged to see antitumor activity in men whose disease had spread to other parts of the body after either becoming resistant to previous hormone treatments or progressing following chemotherapy," said the study's lead author Howard Scher, MD, Chief of the Genitourinary Oncology Service at Memorial Sloan-Kettering. "These findings strengthen the drug's potential to change the outlook for a group of patients who currently have limited effective treatment options from which to choose."

According to the research, MDV3100 slows tumor growth and induces tumor cells to die in men with CRPC, or hormone-refractory disease, which depends on male hormones to grow, but is unresponsive or becomes resistant to standard therapies used to lower or block those hormones. MDV3100 works by blocking testosterone from binding to the androgen (male hormone) receptor, stopping the movement of the androgen receptor to the nucleus of prostate cancer cells, preventing the receptor from binding to DNA, and inducing cancer cell death, even when the expression of the androgen receptor is elevated.

"This study validates what our preclinical studies have suggested: that sustained androgen receptor signaling drives CRPC and that a substantial number of CRPC tumors that progress despite multiple hormone and chemotherapy treatments remain dependent on androgen receptor signaling for growth," said study co-author, Charles Sawyers, MD, Chair of Memorial Sloan-Kettering's Human Oncology and Pathogenesis Program and a Howard Hughes Medical Institute investigator.

The drug was co-invented by Dr. Sawyers and Michael Jung, PhD, Professor of Chemistry at the University of California, Los Angeles. Their research originally demonstrated that CRPC cells have increased expression of the androgen receptor and that elevated expression of this receptor may contribute to disease progression due to a developed resistance to hormone treatment. Their collaboration led to the discovery of a number of nonsteroidal, small molecule antiandrogen compounds, including MDV3100.

In the current study, 140 patients were treated with doses of MDV3100 ranging from 30 to 600 mg daily. PET imaging, bones scans, and blood tests were used to assess the antitumor effects of the drug, which were observed at all dosages. Investigators reported declines in PSA of at least 50 percent in more than half of the patients and tumor regressions in 22 percent of the patients. Overall, two-thirds of patients had partial remissions or stable disease in tumors that had spread to soft tissue or bone.

The findings also showed that the number of circulating tumor cells fell in 49 percent of patients, and 91 percent of patients who initiated therapy with favorable counts retained favorable counts during treatment. This is important because previous research shows that changes in circulating tumor cell counts after treatment were more predictive of survival than were changes in PSA, with favorable post-treatment counts associated with a 21-month median survival.

The drug was generally well tolerated, with nausea, constipation, diarrhea, and anorexia being the most common mild side effects reported. The most frequently reported Grade 3 side effect at higher doses was fatigue.

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The researchers determined that the maximum tolerated dose for sustained treatment was 240 mg daily.

Based on the positive results of the current study, a multinational randomized Phase 3 clinical trial has begun to examine MDV3100 versus a placebo for the treatment of men with advanced prostate cancer who were previously treated with chemotherapy. Information about patient eligibility and enrollment can be obtained by visiting www.affirmtrial.com or by calling the AFFIRM study's toll free hotline at 888-782-3256.

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Quality of Life Issues After Prostate Cancer Treatment

Because prostate cancer progresses more slowly than other types of cancer, men can take some time to carefully consider the various prostate cancer treatment options. A man should talk with his doctor about the relative risks and benefits of each treatment and consider consulting physicians from different fields (urologists, radiation oncologists, and medical oncologists) to get a broader spectrum of opinions.

Doing your homework is especially important because the challenges after prostate cancer treatment are distinct and often vary by treatment. In a report published in *The New England Journal of Medicine* (Volume 358, page 1250), researchers explored quality-of-life issues among 1,201 men with prostate cancer who had radical prostatectomy, brachytherapy (implantation of radioactive seeds), or external beam radiation therapy and 625 of their partners. The couples reported treatment side effects and the impact they had on each partner.

Prostatectomy for prostate cancer was associated with adverse effects on sexual function, but this was less likely when a nerve-sparing procedure had been performed. These men also experienced urinary incontinence but had improvements in urinary irritation and obstruction after the surgery.

Men who had had brachytherapy or external beam radiation for prostate cancer reported adverse effects on their sexual quality-of-life as well as issues related to bowel function. Men treated with external beam radiation plus hormone therapy were most bothered by long-lasting urinary irritation, bowel and sexual problems, and negative effects on energy level and mood.

Bottom line: A man's satisfaction with prostate cancer treatment was significantly influenced by his spouse's degree of distress over sexual and urinary symptoms. These findings reinforce the importance of considering quality of life issues and getting input from your partner when choosing a prostate cancer treatment.

www.johnshopkinshealthalerts.com

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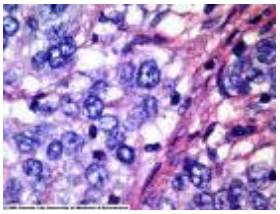
Understanding Prostate Cancer **Newly Diagnosed**

If you or someone you care about has recently been diagnosed with prostate cancer, this section will help guide you through the complexities of this diagnosis and other issues to consider



Understanding Your Diagnosis

A doctor typically diagnoses prostate cancer after closely examining biopsy cells through a microscope. There are several types of cells in the prostate, and each contributes in its own way to the prostate's development, architecture, and function.

But cancer cells look different than normal prostate cells. Pathologists look for these differences first to detect the presence of cancer and then to determine the cancer grade.

Gleason Grading

The Gleason grading system accounts for the five distinct patterns that prostate tumor cells tend to go through as they change from normal cells to tumor cells.

The cells are scored on a scale from 1 to 5: "Low-grade" tumor cells (those closest to 1) tend to look very similar to normal cells.

"High-grade" tumor cells (closest to 5) have mutated so

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much that they often barely resemble the normal cells.

The Gleason Score

The pathologist looking at the biopsy sample assigns one Gleason grade to the most similar pattern in your biopsy and a second Gleason grade to the second most similar pattern. The two grades added together determine your Gleason score (between 2 and 10).

Generally speaking, cancers with lower Gleason scores (2 - 4) tend to be less aggressive, while cancers with higher Gleason scores (7 – 10) tend to be more aggressive.

It's also important to know if any Gleason 5 is present, and most pathologists will report this. Having any Gleason 5 in your biopsy or prostate puts you at a higher risk of recurrence.

Prostate Cancer Foundation www.pcf.org

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DVD's Available

Did you know that Lorne Strick makes a DVD copy of all our guest speakers?
They can be purchased for individual or group use
Phone Lorne at 204-667-9367
Or email Brian Sprott at jbsprott@shaw.ca Cost is $5.00 plus shipping

2010 MEETINGS:

Jan. 21.....Dr. Anne Katz, Clinical Nurse Specialist
"Sexual Relationships Following Prostate Cancer"

Feb.18.....Dr. Aldrich Ong, Radiation Oncologist
" Radiation and Chemotherapy for Prostate Cancer"

Mar.18.....Dr. Piotr Czaykowski, Medical Oncologist
"New Developments in Drug Treatment"

April 15.....Dr. Graham Glezerson, Urologist
"Treating Erectile Dysfunction After Prostate Cancer - The Hard Facts"

May 20.....Dr. Spencer Gibson,
Provincial Director, Research, Cancercare MB.
"Research at Cancercare Tumour Bank"

June 17.....Nursing Staff from the Prostate Centre, Cancercare MB
"What Happens at the Manitoba Prostate Centre"

July 15.....TBA

Aug. 19.....Dr. Paul Daeninck,
Pain Management Specialist
"Insights into Pain Management"

Sept. 16.....Dr. Robert Wightman, Pathologist
"Understanding Your Biopsy Report"

Oct. 21.....Katherine Gottzmann, Psychosocial Oncology

Nov. 18.....Dr. Aziz Mhanni, Medical Geneticist.

Dec. 16.....Potluck Party Time

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