The Manitoba Prostate Cancer Support Group NEWSLETTER

Vol. 223 – January 2010

manpros@mts.net

Thought For Today

On the other hand.....
You have different fingers.

- Joseph Courchaine

Thanks For Your Generosity

Recently our Prostate Cancer Support Group has received a generous donation from **The Manitoba Community Services Council Inc.** This donation, along with those from individual members, makes the running of our Support Group possible.

We are grateful to all contributors.

Ken Kirk

Executive member, Ken Kirks decision for treatment in 2000 was brachytherapy. It was not available in Manitoba at that time, so he was sent by Manitoba Health to Quebec City for treatment. We are pleased to report that Ken continues to have good health.

Ken, who has been our "New Member Coordinator" for the past 10 years, has decided to hand his job over to someone else and retire from the Executive. He has been involved with the Support Group since 1997 and on the Executive since 1999. The Executive will miss his valuable contributions during discussions at our meetings. It is our wish to recognize all the work he has done over the years. We thank Ken for keeping in touch with new members and for his commitment to help others with prostate cancer.

NEXT MEETING:

Thursday, January 21st, 2010 7 - 9 P.M.

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

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.

CHALLENGES

The Mark and Dorothy Danzker Perpetual Trust Fund at the Jewish Foundation of Manitoba has stepped up to the challenge of helping the Manitoba Prostate Cancer Support Group produce this newsletter. In turn, the Danzker Trust issues a challenge to: other Trust Funds, Corporate Donors and Individuals to assist this Support Group. They exist through your generosity.

Canadian Cancer Society

Call toll free:
1-888-939-3333

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

Thanks

Many thanks to the **Grey Owl Golf Committee** for considering us as a worthy recipient of their charity fund raising monies at the annual Clear Lake tournament this past summer.

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!

Routine Evaluation of Prostate Size Not as Effective in Cancer Screening, Study Finds

ScienceDaily (Nov. 14, 2009) — New Mayo Clinic research studied the association between prostate-specific antigen (PSA) levels and prostate size and found that routine annual evaluation of prostate growth is not necessarily a predictor for the development of prostate cancer. However the study suggests that if a man's PSA level is rising quickly, a prostate biopsy is reasonable to determine if he has prostate cancer.

These findings are being presented this week at the North Central Section of the American Urological Association in Scottsdale, Ariz.

These Mayo Clinic study findings were based on data in the Olmsted County Study of Urinary Health Status among Men, a large cohort study of men living in Olmsted County, Minn. Researchers randomly selected 616 men between the ages of 40 and 79 who did not have prostate disease. Patients participated in examinations every two years for 17 years, which included PSA and prostate volume measurements using ultrasound, to determine changes in prostate disease.

(Continued on page 3)

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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(Continued from page 2)

"One of the major advantages of this large cohort study is that the men have participated in this study for over 17 years," says Rodney Breau, M.D., a Mayo Clinic urologic oncology fellow who led the study. Because of this, we have the ability to look at long-term relationships between prostate growth, change in PSA and development of prostate cancer."

Of the 616 men, 58 (9.4 percent) developed prostate cancer. Men who were diagnosed with prostate cancer had a faster rise in PSA levels (6 percent/year) compared to men who were not diagnosed with cancer (3.3 percent/year). However, the increase in prostate size was similar between these two groups (median change of 2.2 percent/year).

PSA is a substance produced in the prostate gland. Normally, a small amount of PSA enters the bloodstream. A higher amount of PSA or an abrupt rise in PSA levels can indicate a problem, possibly cancer.

"The question we're trying to answer is, if we see a man with a rising PSA level, could this change in PSA be explained by a proportional increase in prostate size?" says Dr. Breau. "Our data indicate that men with or without prostate cancer have similar rates of prostate growth. If a man's PSA is quickly rising, he likely deserves a prostate biopsy to determine if he has prostate cancer. Assessment of change in prostate size should not influence the decision to biopsy."

Other Mayo Clinic researchers involved in this study include: R. Jeffrey Karnes, M.D.; Debra Jacobson; Michaela McGree; Steven Jacobsen, M.D., Ph.D.; Ajay Nehra, M.D.; Michael Lieber, M.D.; and Jennifer St. Sauver, Ph.D.

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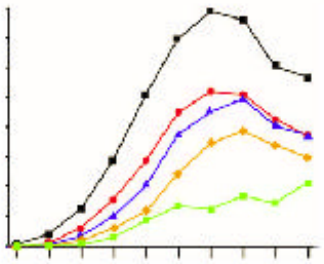
Men Older Than 70 Years Have Higher Risk Prostate Cancer and Poorer Survival in the Early and Late Prostate Specific Antigen Eras

Leon Sun, Arthur A. Caire, Cary N. Robertson, Daniel J. George, Thomas J. Polascik, Kelly E. Maloney, Philip J. Walther, Danielle A. Stackhouse, Benjamin D. Lack, David M. Albala, Judd W. Moul

Received 12 March 2009

Purpose

We clarified whether men older than 70 years have a higher risk of prostate cancer and poorer survival in the early and late prostate specific antigen eras.



Materials and Methods

A cohort of 4,561 men who underwent radical prostatectomy were stratified into 3 age groups (younger than 60, 60 to 70 and older than 70 years), and early and late prostate specific antigen eras based on the year of surgery (before 2000 and 2000 or later). Race, body mass index, prostate specific antigen, prostate weight, tumor volume, pathological Gleason sum, pathological tumor stage, extracapsular extension, seminal vesicle invasion and surgical margin status were submitted for univariate and multivariable analyses against the previously mentioned groups. Survivals (prostate specific antigen recurrence, distant metastasis and disease specific death) were compared among the 3 age groups using univariate and multivariable methods.

Results

Compared with younger age groups (younger than 60, 60 to 70 years) men older than 70 years had a higher proportion of pathological tumor stage 3/4 (33.0 vs 44.3 vs 52.1%, p <0.001), pathological Gleason sum greater than 7 (9.5% vs 13.4% vs 17.2%, p <0.001) and larger tumor volume (3.7 vs 4.7 vs 5.2 cc, p <0.001). Pathological Gleason sum in men older than 70 years did not differ between the early and late prostate specific antigen eras (p = 0.071). Men older than 70 years had a higher risk of prostate specific antigen recurrence, distant metastasis and disease specific death on univariate (p <0.05) but not multivariable analysis.

Conclusions

Men older than 70 years had higher risk disease and poorer survival in the early and late prostate specific antigen eras. Pathological Gleason sums did not change between the 2 eras. Patient age was an important variable in prostate specific antigen screening, biopsy, treatment and prognosis.

Written by:
Sun L, Caire AA, Robertson CN, George DJ, Polascik TJ, Maloney KE, Walther PJ, Stackhouse DA, Lack BD, Albala DM, Moul JW.
Reference:
J Urol. 2009 Nov;182(5):2242-9. doi:10.1016/j.juro.2009.07.034

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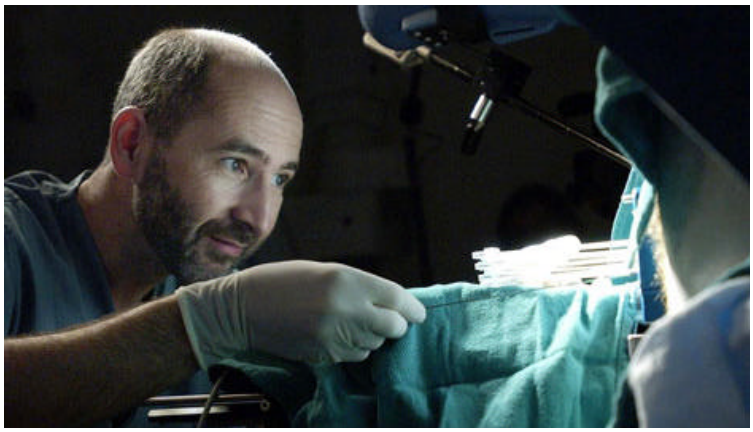
Watchful Waiting For Prostate Cancer Is Safe: Study

CTV.ca News Staff Mon. Nov. 16 2009

Taking a watch-and-wait approach to prostate cancer, rather than attempting to remove the cancer, is a safe approach and doesn't lead to more deaths, concludes a new analysis.



A radiation oncologist inserts needles into the prostate of a patient during high dose-rate brachytherapy for prostate cancer, in Toronto, on Tuesday, *Nov. 20, 2001. (Aaron Harris / THE CANADIAN PRESS)*

The study, in the Journal of Clinical Oncology, finds that patients with early-stage, slow-growing prostate cancers are not taking a risk if they choose to let their doctors simply "keep an eye" on their disease, rather than treat it right away.

For the study, researchers at the Odette Cancer Centre at Sunnybrook Health Sciences Centre in Toronto, reviewed the medical records of more than 450 prostate patients who were considered of "favourable risk" -- meaning their cancer was not considered aggressive or fast-growing. All were being managed with the watchful waiting approach called "active surveillance."

The men were followed for up to 13 years, with the median follow-up time being 6.8 years.

The researchers found that the rate of prostate cancer survival among the group was 97.2 per cent. Of the patients who did die during the study period, most died of causes other than prostate cancer.

In fact, at 10 years, the likelihood of death from something other than prostate cancer was 18.6 times greater than death from prostate cancer. In other words, patients in the study were more likely to die with prostate cancer than to die of prostate cancer.

"We hope this mature data will help quell resistance to the approach of active surveillance, which is aimed at reducing overtreatment and radical treatment side effects in men with low-grade prostate cancer," said Dr. Laurence Klotz, the lead author of the study and the head of the Genitourinary Cancer Care team at Odette.

When 66-year-old Gary Dailey discovered he had prostate cancer five years ago, he thought it would require surgery.

"The word cancer, to anyone, is terrifying," he told CTV News.

But he spoke with another prostate cancer patient who had been treated by Klotz. Now, Dailey is tested about every six months to make sure the cancer is not life-threatening.

"It's not growing. Hopefully I'll die from other causes," he said.

Many doctors prefer to take a "watchful waiting" approach to low-risk forms of prostate cancer because years of research has shown that the risks of many cancer treatments outweigh the benefits the treatments might provide. For example, surgery and radiation have high likelihoods of leaving patients incontinent, impotent, or both.

Active surveillance, meanwhile, means having patients go for regular PSA (prostate specific antigen) testing and watching the PSA doubling time, as well as periodically having the patient undergo biopsies. Doctors then treat only those patients whose cancer is reclassified over time as higher risk. In this study, 30 per cent of the patients were reclassified during the study period.

Klotz noted that earlier this year, a large, landmark study out of Europe found that there are benefits of using universal PSA screening to reduce death from prostate cancer. But the study also found a significant risk of overtreatment.

"This dilemma is the rationale for a more individualized approach through active surveillance with selectively delayed intervention based on predefined criteria of disease progression for favorable risk patients," says Klotz.

In 2009, an estimated 25,500 Canadian men will be diagnosed with prostate cancer and about 4,400 will die of the disease.

With a report by CTV's Scott Laurie in Toronto

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Aspirin May Prevent Prostate Cancer Recurrence

Anti-clotting Medications Lower Odds of Recurrence

By Charlene Laino
WebMD Health News

Reviewed By Louise Chang, MD

Nov. 6, 2009 (Chicago) -- The use of anti-clotting drugs, including aspirin, appears to lower the odds that cancer will recur in men undergoing radiation treatment for prostate cancer, researchers report.

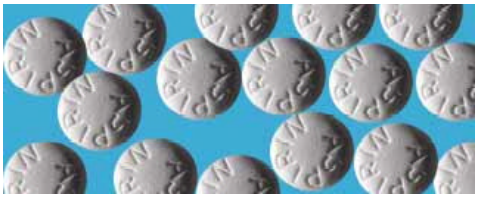
"We found that taking an anticoagulant lowers the risk [of recurrence] by almost half," says Kevin S. Choe, MD, PhD, a radiation oncologist at the University of Chicago.

The anti-clotting medications, or anticoagulants, studied were Coumadin, Plavix, and aspirin.

"Prostate cancer is very common among older men, the same people who have cardiovascular risk factors and often require anticoagulants to prevent a heart attack," Choe tells WebMD. "So we wanted to see if there was an interaction between the two."

Research in animals and in the lab suggests that anti-clotting medications can interfere with tumor growth and cancer spread, Choe says.

Also, research suggests that the drugs may cause molecular changes that make cancer cells more sensitive to radiation, says the University of Miami's Alan Pollack, MD, PhD, who was not involved with the work.



The findings were presented at the annual meeting of the American Society for Radiation Oncology.

Anti-clotting Medications Cut Risk of Prostate Cancer Recurrence

The study involved 662 men with prostate cancer undergoing radiation treatment at the University of Chicago from 1988 to 2005.

Of the total, 196 were taking aspirin, 58 were taking Coumadin, and 24 were on Plavix. The other men weren't taking any anti-clotting medication.

About four years after they were treated, cancer recurred in only 9% of men taking an anti-clotting medication, compared with 22% of those who weren't taking the drugs. After taking into account other risk factors for recurrence, taking an anti-clotting medication was associated with a 46% lower risk of recurrence, Choe says.

The benefit was most pronounced in men with high-risk aggressive cancers that had not yet spread (metastasized) at the time of radiation treatment. In this group, cancer recurred in 18% of men on anticoagulants vs. 42% of men not taking the drugs.

Cancer recurrence was defined as a rise in levels of prostate-specific antigen, or PSA. After radiation therapy, PSA levels usually drop to a stable and low level. Rising PSA levels are usually a sign of recurrence, Choe says.

The anticoagulant drugs benefited men regardless of whether they received traditional external beam radiation therapy or radioactive seeds. The study did not include men who received newer forms of radiation therapy, such as proton therapy.

The researchers did not analyze the three drugs separately.

Choe cautions that men with prostate cancer should not start taking blood-thinning drugs for purposes of cancer control.

The drugs have risks of their own, including internal bleeding, he notes. Choe's previous research showed that Coumadin and Plavix increase the risk of rectal bleeding in men undergoing radiation treatment.

"We need more data from a larger study before we can say with confidence that the benefits outweigh the risk of toxicity," he says.

But if your doctor has prescribed the drugs for reasons of heart health, "this may be an added benefit," Choe says.

SOURCES:

51st Annual Meeting of the American Society for Radiation Oncology, Chicago, Nov. 1-5, 2009.

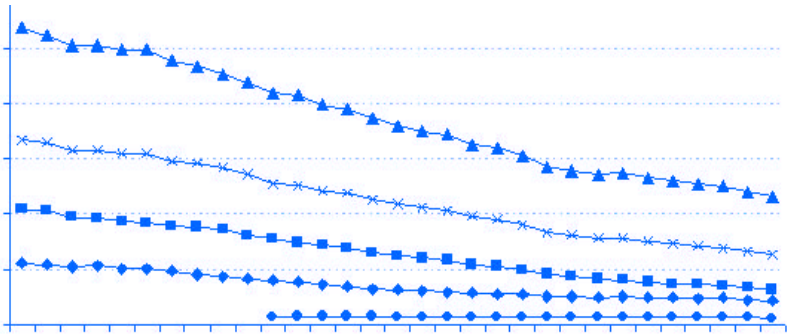
Kevin S. Choe, MD, PhD, resident physician, department of radiation and cellular oncology, University of Chicago.

Alan Pollack, MD, PhD, chair, department of radiation oncology, University of Miami.

Cancer Death Rate Steadily Declining Annual Cancer Statistics Report Shows Progress in Cancer Fight

Article date: 2009/05/27 By Rebecca Viksnins Snowden

Cancer death rates are falling steadily, according to the American Cancer Society's annual cancer statistics report, Cancer Facts & Figures 2009, and its companion article "Cancer Statistics, 2009," published in the Society's CA: A Cancer Journal for Clinicians. The drop is driven in large part by better prevention, increased use of early detection practices, and improved treatments for cancer.



Cancer death rates dropped 19.2% among men during 1990-2005 and 11.4% among women during 1991-2005. Cancer incidence rates are also on the decline – they decreased 1.8% per year among men from 2001-2005 and 0.6% per year from 1998-2005 among women.

"A drop of 1 or 2% per year may sound small, but as this report shows, that adds up to 650,000 cancer deaths avoided over 15 years," said John R. Seffrin, PhD, American Cancer Society chief executive officer. "And because the rate continues to drop, it means that in recent years, about 100,000 people each year who would have died had cancer rates not declined are living to celebrate another birthday. That is undeniable evidence of the lifesaving progress that we as a country must dedicate ourselves to continuing."

ACS researchers estimate that there will be about 1,479,350 million new cancer cases and about 562,340 cancer deaths in 2009. For all cancers diagnosed from 1996-2004, the 5-year relative survival rate is 66%, up from 50% in 1975-1977. That increase reflects improvements in both early detection and treatment.

Decreases in deaths from lung, prostate, and colorectal cancer accounted for nearly 80% of the decline in death rates among men, while decreases in breast and colorectal cancer made up 60% of the decrease among women. Those numbers suggest early detection practices – using colonoscopy to catch colon cancer early, for example - are working, and also reflect improvements in treatment. The decline in the lung cancer death rate among men is due to drops in tobacco use; the lung cancer death rate among women has stabilized after increasing for many decades. According to the report, prostate, lung, and colorectal cancers account for about half of all cancer diagnoses among men; in women, breast, lung, and colorectal cancer account for about half of new cancer cases. Together, these cancers account for almost half of the cancer deaths among men and women.

African-American men have an 18% higher incidence rate and 36% higher cancer death rate compared to white men, according to the report. African-American women are less likely than white women to get cancer, but when they do get it, they're more likely to die from it.

ACS researchers also noted that lung cancer rates vary greatly regionally, reflecting differences in tobacco use among states. In contrast, rates for other cancers – breast and prostate, for example – tended to be similar across the country.

Each year, ACS researchers include a special section in Cancer Facts & Figures highlighting an issue of cancer research or care. This year, researchers offer the latest information about cancer survivors' risk for developing a second cancer.

American Cancer Society *www.cancer.org*

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'Active Surveillance' Of Some Prostate Cancers Safe Approach: Study

Provided by: Canadian Press Nov. 16, 2009

Written by: Sheryl Ubelacker, Health Reporter, THE CANADIAN PRESS

TORONTO - A significant proportion of men newly diagnosed with prostate cancer can be safely managed with "active surveillance" instead of undergoing radical treatment that can cause a variety of unpleasant side-effects, a Canadian study suggests.

Active surveillance means frequent monitoring of a patient's PSA (prostate-specific antigen) levels and periodic biopsies to make sure the cancer hasn't become more aggressive and spread.

(Continued on page 7)

(Continued from page 6)

The long-term study found that men with low-grade, slow-growing prostate cancer who were managed with active surveillance had a 10-year cancer-related actuarial survival rate of more than 97 per cent, and an overall survival rate of almost 80 per cent.

Furthermore, researchers determined that patients in the study had an almost 19 times greater likelihood of dying at 10 years from a cause other than prostate cancer.

About 40 per cent of men newly diagnosed have a prostate cancer profile that makes them candidates for active surveillance, said principal researcher Dr. Laurence Klotz of Sunnybrook Health Sciences Centre in Toronto.

"We recognized about 15 years ago that PSA screening resulted in a diagnosis of a lot of men who had indolent, slow-growing prostate cancer that really was not a threat to their life," Klotz said Monday.

"And we tried to come up with a way to reduce the overtreatment, which is now widely acknowledged as being a major problem," he said, noting that prostate removal or radiation treatment can lead to erectile dysfunction, urinary incontinence and rectal problems.

In 2009, an estimated 25,500 Canadian men will be diagnosed with prostate cancer and about 4,400 will die of the disease.

The study, published Tuesday in the Journal of Clinical Oncology, enrolled 452 men with a median age of 70, whose prostate cancer was picked up through screening. The researchers followed their progress for up to 14 years, giving the men PSA testing every three months and periodic biopsies up to age 80.

Over the course of the study, 30 per cent of the patients' cancers were reclassified as higher risk and the men were offered treatment.

"Seventy per cent did not require treatment," said Klotz.

In all, 97 (22 per cent) of the men died during the study period, but only five from prostate cancer.

Gary Dailey, 66, of Whitby, Ont., was diagnosed with prostate cancer in 2005. Despite a rising PSA level, biopsies showed the cancer appeared to be restricted to a small area.

After being told he could undergo surgery or radiation where he lives northeast of Toronto, Dailey decided to see what other options were available and was enrolled in Sunnybrook's active surveillance study.

"I thought I like that idea far better, because you can always go for radical treatment any time later on," said Daily, explaining that unlike some people, he is able to live comfortably with the knowledge he has cancer.

"It gives me an opportunity to wait and see. It wasn't that I was all that afraid of the operation, it's that I couldn't convince myself that there was enough risk to do it."

Dr. Gilbert Welch, an expert in cancer screening at Dartmouth College in Hanover, N.H., said opting for active surveillance for men with low-grade, low-PSA prostate cancer "makes a hell of a lot of sense."

"This is exactly the kind of thing we need to be thinking about, is how can we separate people into meaningful groups and determine those groups where treatment is worse than the disease," Welch said from Hanover.

Klotz said the implications of the study's findings could be "huge" because 40 per cent of North American men each year - about 150,000 - would be candidates for this approach - even though the latest statistics show about 90 per cent receive radical treatment.

"One of the key facts that patients need to understand is that small amounts of prostate cancer develop normally with age," he said. "So your likelihood of harbouring prostate cancer is roughly equivalent to your age. In 60-year-olds, it's about 60 per cent of men."

Klotz stressed, however, that active surveillance isn't advisable for every man with prostate cancer.

"The patients who have higher-grade or more extensive prostate cancer need radical therapy."

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Even Small Prostate Cancers Relapse Following Radical Prostatectomy

Researchers from the Netherlands have reported that one in 10 men with small volume, or "insignificant", prostate cancers have a biochemical recurrence (BCR) following radical prostatectomy. The details of this retrospective study were published in the September, 2009 issue of Urologic Oncology. [1]

There has been much discussion about "overdiagnosis" of patients through prostate specific antigen testing (PSA). It has been suggested that many men will be diagnosed with prostate cancer that is not destined to result in death. However, attempts to identify men with indolent prostate cancer that does not require treatment have not been successful. One logical hypothesis would be that small prostate cancers with a low Gleason score could be "benign" or "insignificant".

In this study small-volume prostate cancers are defined as being less than 0.5 cc and insignificant tumors, which are defined as being less than 0.5 cc in volume with a Gleason score of less than 7. These researchers evaluated outcomes of 502 men with prostate cancer treated between 1992 and 2005. The median follow-up after surgery was 40 months.

In this cohort of patients, 16% (n=82) were categorized as small volume or insignificant. Sixty-four (13%) were categorized as insignificant. Positive margins were found in 16% of small-volume and 13% of insignificant prostate cancers. The five-year risk of BCR was 10% in men with small-volume or insignificant prostate cancers versus 35% for the other men in this cohort with more-advanced disease. These authors concluded that men with small volume or insignificant prostate cancers had a lower risk of BCR than men with more-advanced disease, but the BCR rate was not negligible.

Comments: These data suggest that even small-volume and insignificant prostate cancers are associated with a significant BCR rate, which could increase with further observation. Thus, size alone does not help in determining which prostate cancers are benign enough to warrant no treatment.

Reference:

[1] Van Oort IM, Kok DEG, Kiemeny LA, et al. A single institution experience with biochemical recurrence after radical prostatectomy for tumors that on pathology are of small volume or "insignificant". Urologic Oncology. 27:509-513.

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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. Darrel Drachenberg, Urological Oncologist, Director of Research
"Panel Discussion on Treatments:
Radical , Laparoscopic, HIFU, Cryotherapy"

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.....TBA

Nov. 18.....TBA

Dec. 16.....Potluck Party Time