The Manitoba Prostate Cancer Support Group NEWSLETTER

Vol. 228 – June 2010

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Thought For Today

What happens if you get scared half to death, twice?

- Darlene Hay

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, June 17th, 2010 7 - 9 P.M.

Nursing Staff from the Prostate Centre, Cancercare MB

"What Happens at the Manitoba Prostate Centre"

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.

Many thanks to Eli Lilly Canada Inc.
for their generous donation to our Prostate Cancer Support Group. Lilly manufactures Cialis - a drug used to treat erectile dysfunction. Their donation, along with those from individual members, makes the running of our Support Group possible. Their kindness is much appreciated.

Lilly

DID YOU KNOW ? ? ?

Several members of our Support Group Executive will come to your location to give a talk on prostate cancer. Awareness is one of our main goals and we are keen to pass on information.

If you have an interested group, please leave a message on our answering machine (989-3433) or call any Executive member listed on the back page of this newsletter.

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

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Many thanks to the Winnipeg Foundation for sponsoring this issue of our newsletter.

THE WINNIPEG FOUNDATION

The Foundation was formed in 1921 and has been supporting non-profit organizations in our city since that time.

We are grateful that they have chosen to assist us with our newsletter expenses.

What to Consider When Your PSA Is Rising After Initial Treatment

This section summarizes key points to consider when your PSA is rising after undergoing initial treatment. The list is by no means exhaustive, and there might be other points that you want to think about as well. The goal is to help you focus on what you need to know about each stage of disease so you can hold meaningful, regular dialogues with all members of your health care team as you find the treatment path that's right for you.

1) In the post-prostatectomy setting, the most widely accepted definition of a recurrence is a PSA > 0.3 ng/mL that has risen on at least two separate occasions at least two weeks apart and measured by the same lab. In the post-radiation therapy setting, the most widely accepted definition is a PSA that has risen from nadir in at least three consecutive tests conducted at least two weeks apart and measured by the same lab. It's important to always use the same lab for all of your PSA tests because PSA values can fluctuate somewhat from lab to lab.

(Continued on page 3)

WE REALLY APPRECIATE YOUR SUPPORT

The Manitoba Prostate Cancer Support Group operates on your donations

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2) PSA velocity or PSA doubling time, both of which measure the rate at which your PSA rises, can be a very significant factor in determining is the aggressiveness of your cancer. Men with a shorter PSA doubling time or a more rapid PSA velocity after initial therapy tend to have more aggressive disease, and are therefore more likely to need more aggressive therapies.

3) If your PSA starts to rise after you've undergone prostatectomy, "salvage" radiation therapy might be a good option to explore. With this approach, external beam radiation is delivered to the area immediately surrounding where the prostate was, in the hopes of eradicating any remaining prostate cells that have been left behind.

4) With 3D conformal radiotherapy, IMRT, and brachytherapy, local tissue damage is often kept at a minimum, and surgeons at some of the larger cancer centers have been seeing improved results with "salvage" prostatectomy. But even under the best of circumstances, post-radiation surgery is a very difficult operation to perform, and few surgeons across the country perform it regularly.

5) Regular monitoring of PSA levels after primary therapy is key, as is prompt initiation of treatment upon disease recurrence. The earlier the treatment is begun, the better the likelihood of improved results.

6) Androgen deprivation therapy ("hormone therapy") is a key treatment strategy for prostate cancer that has recurred following local treatment. The goal of all hormone therapies is to stop the production and/or interfere with the effects of testosterone which fuels the growth of prostate cancer cells. However, because not all prostate cancer cells are sensitive to increases or decreases in testosterone levels, hormone therapy is a treatment for prostate cancer but does not cure the disease.

7) There are several approaches to blocking the secretion of testosterone including the surgical removal of the testes, drugs known as LHRH agonists, and estrogens.

8) Antiandrogens block the action of testosterone by preventing the active form of testosterone known as DHT from entering the central part of the prostate cancer cell; without DHT, the growth of prostate cancer cells is halted.

9) Testosterone is the primary male hormone, playing an important role in establishing and maintaining the typical male characteristics, such as body hair growth, muscle mass, sexual desire, and erectile function. Most men who are on hormone therapy experience at least some of the effects related to the loss of testosterone, but the degree to which you will be affected by any one drug regimen is impossible to predict.

10) LHRH agonists, the most commonly used drug class for hormone therapy, are given in the form of regular shots: once a month, once every three months, once every four months, or once per year. These long-acting drugs are injected under the skin and release the drug slowly over time.

11) Antiandrogens can be helpful in preventing the "flare" reaction associated with LHRH agonists resulting from an initial transient rise in testosterone. Their use for at least the first 4 weeks of LHRH therapy can relieve the symptoms often seen from the flare reaction, ranging from bone pain to urinary frequency or difficulty.

12) With intermittent hormone therapy, the LHRH agonist is used for six to twelve months, during which time a low PSA level is maintained. The drug is stopped until the PSA rises to a predetermined level, at which point the drug is restarted. During the "drug holidays" in between cycles, sexual function and other important quality of life measures might return. However, the clinical benefits of this approach remain unclear, and large clinical trials are currently underway to evaluate its use in this setting.

13) Deferring hormone therapy until metastatic disease can be detected might be an appropriate option for some men. In such cases, the goal would be to reserve an effective, albeit temporary, treatment option until it's clearly needed.

14) Hormone therapy typically is effective for only a few years. For many men who were using an antiandrogen in combination with an LHRH agonist, stopping the antiandrogen, or antiandrogen withdrawal, is the most common first step in secondary hormone therapy. Switching to a different antiandrogen might also be able to offer an extra few months of benefit, and drugs known as ketoconazole or aminoglutethimide can be used to block the small amounts of testosterone produced by the adrenal glands from being released.

15) Carefully review the side effect profile of the different hormone therapy regimens, and discuss with your health care team potential ways to minimize the effects. In the end, it's important that you not only understand the value of the therapy in the management of your prostate cancer, but also that you learn how to live your life as best as possible while fighting the disease.

www.prostatecancerfoundation.org

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Protect Your Erection: 11 Tips

How to avoid erectile dysfunction and protect your potency.

By David Freeman WebMD Feature

Reviewed by Laura J. Martin, MD

Erectile dysfunction (ED) is common in older men. But it's not a normal part of aging. How can you avoid ED? Here's what experts told WebMD.

1. Watch what you eat.

A diet that's bad for a man's heart is also bad for his ability to have erections.

Research has shown that the same eating pattern that can cause heart attacks by impeding blood flow in the coronary arteries— few fruits and vegetables and lots of fatty, fried, and processed foods— can impede blood flow to and within the penis. That blood flow is needed for the penis to become erect.

Anything that is bad for a man's heart is also bad for his penis, says Andrew McCullough, MD, associate professor of clinical urology and director of the male sexual health program at New York University Langone Medical Center.

Recent studies show that ED is relatively uncommon among men who eat a traditional Mediterranean diet, which includes fruits, vegetables, whole grains, heart-healthy fats including nuts and olive oil, fish, and wine.

"The link between the Mediterranean diet and improved sexual function has been scientifically established," says Irwin Goldstein, MD, director of sexual medicine at Alvarado Hospital in San Diego.

2. Maintain a healthy weight.

Being overweight can bring many health problems, including type 2 diabetes, which can cause nerve damage throughout the body. If that affects the nerves affecting the penis, ED can result.

3. Avoid high blood pressure and high cholesterol.

High cholesterol or high blood pressure can damage blood vessels, including those that bring blood to the penis. Eventually, this can lead to ED.

Make sure your doctor checks your cholesterol levels and blood pressure. You might also want to check your blood pressure between doctor visits. Some stores and fire stations offer free screening; blood pressure monitors are also sold for home use.

If your cholesterol or blood pressure is out of whack, get it treated.

Blood pressure drugs can make it hard to get an erection. But doctors say many cases of ED that get blamed on these drugs are actually caused by arterial damage resulting from high blood pressure (also called hypertension).

4. Drink alcohol in moderation or not at all.

There is no evidence that mild or even moderate alcohol consumption is bad for erectile function," Sharlip says. But chronic heavy drinking can cause liver damage, nerve damage, and other conditions that can lead to ED.

5. Exercise regularly.

Strong evidence links a sedentary lifestyle to erectile dysfunction. Running, swimming, and other forms of aerobic exercise have been shown to help prevent ED. Watch out for any form of exercise that puts excessive pressure on the perineum, which is the area between the scrotum and anus. Goldstein says bicycle riding, in particular, can cause ED.

An occasional short ride is unlikely to cause trouble. But men who spend a lot of time biking should make sure their bike fits them properly, wear padded cycling pants, and stand up frequently while pedaling.

"No-nose" bike seats protect against genital numbness and sexual dysfunction, according to the National Institute for Occupational Safety and Health.

6. Don't rely on Kegels.

One form of exercise that doesn't seem helpful is Kegel exercises, which involve repeatedly contracting and relaxing the muscles in the pelvis. Kegels can be helpful for men and women suffering from incontinence. But there's no evidence that they prevent erectile dysfunction.

7. Keep tabs on testosterone.

Even in healthy men, testosterone levels often begin falling sharply around age 50. Every year after age 40, a man's testosterone level typically falls about 1.3%. Symptoms like a low sex drive, moodiness, lack of stamina, or trouble making decisions suggest a testosterone deficiency, as do spongy erections. Your doctor can check on that.

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8. Avoid anabolic steroids.

These drugs, which are often abused by athletes and bodybuilders, can shrink the testicles and sap their ability to make testosterone.

9. If you smoke, stop.

Smoking cigarettes can harm blood vessels and curb blood flow to the penis. And nicotine makes blood vessels contract, which can hamper blood flow to the penis.

10. Steer clear of risky sex.

Some cases of erectile dysfunction stem from penile injuries that occur during sex. To keep your penis from bending painfully, start thrusting only after making sure her vagina is well lubricated. And make sure your penis doesn't slip out of the vagina while thrusting (so you won't accidentally jam your penis against a hard part of her body). If she moves in such a way that hurts your penis - for instance, by bending it the wrong way - have her stop at once.

"If the woman is on top and comes down hard, and the penis does not enter the vagina, that is the equivalent of a big weight crashing down on the penis," Goldstein says. "No penis on earth can withstand that."

11. Curb stress.

Psychological stress boosts levels of the hormone adrenaline, which makes blood vessels contract. That can be bad news for an erection. Anything a man can do to ease tension and feel better emotionally is likely to give his sex life a big boost.

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Erectile Dysfunction: Test Your Knowledge

How much do you know about erectile dysfunction (ED)? Review these statements and learn which are true and which are not.

ED is a normal part of getting older.

FICTION: It is not normal for a man to lose erectile function completely as a result of aging. Generally, other factors may be involved. These may include vascular disease, diabetes, hypertension, low hormone levels (testosterone) and personal habits such as cigarette smoking.

Prescription drugs can contribute to ED.

FACT: There are more than 200 kinds of prescription drugs that may be associated with ED.

A man can get an erection whenever he wants.

FICTION: This may be true of teenage boys; however, erections do not occur as often as a man gets older. Hormones in a man's body and other life changes may affect a man's level of arousal. It may take longer for a man to achieve an erection and may require more direct stimulation and foreplay.

ED is sometimes a psychological issue.

FACT: Psychological factors are responsible for causing ED in about 10%-20% of people with the condition. However, the majority of men with ED have an underlying physical condition such as diabetes, heart disease, high blood pressure, have undergone prostate cancer surgery, chronic drug use, or alcoholism.

Tight underwear can cause ED.

FICTION: Causes of ED can be physical and/or psychological, but tight underwear is not among the causes of ED.

Tobacco, alcohol or illegal drug use may bring about ED.

FACT: These substances can damage blood vessels and/or restrict blood flow to the penis, causing ED.

Most men never experience ED.

FICTION: Most men experience ED at one time or another. Studies suggest that as many as 52% of men between the ages of 40 and 70 may experience erectile dysfunction.

It is advisable to seek treatment for recurring ED.

FACT: A man should seek medical advice and treatment if ED occurs more than 50% of the time or is otherwise a concern for him or his partner.

ED can result from the occasional riding of a bicycle.

FICTION: Bicycle-riding, in moderation, does not affect erectile function. However, men should take breaks when cycling long distances.

Impotence affects only the man with ED.

FICTION: Both partners can suffer if impotence goes untreated. Failure to acknowledge and treat the problem can lead to depression, anxiety and lack of self-esteem for both partners.

Reviewed by the doctors at the
Glickman Urological Institute at The Cleveland Clinic.

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Choosing— And Sticking With— Active Surveillance: A Patient's Story

****Please note that this is part two of a patient's prostate cancer journey – the rest to follow in a subsequent newsletter****

What other research did you do?

I read all the books on prostate cancer that were in print at that time, as well as books that came out later. I would read whatever books my doctor and I could find. I was always getting some new information from them.

But the biggest part of my due diligence was going through the raw data and reading scientific papers by the hundreds. I visited Web sites, attended meetings, and watched presentations that were posted online. I'd estimate that I spent three or four hours a day for about 18 months doing research.

That's an incredible amount of time! Did you not believe what you'd been hearing? Or was there a disparity between what your friends were saying and what you read in scientific papers?

What gradually became clear to me is that when you have early-stage prostate cancer, no one will tell you what to do because you have so many options. At the same time, none of the options are guaranteed to beat the cancer. And even if you do beat it, you may not really beat it.

With each option you face different probabilities of side effects. I realized that the good thing about early-stage prostate cancer is that I had a lot of options, but the difficult part is that no one can give you a definitive answer. It's not like having a late-stage cancer when your doctor says, "You need to have surgery tomorrow, because if you don't, you will be gone in six months."

I was playing around with the probabilities of different outcomes, trying to gain some perspective and make the best choice for my personal situation based on my values and my perceived life expectancy. So once I calmed down, I decided to invest an enormous amount of time in research. And being retired at that point, I had the time.

So how did you settle on active surveillance?

It was a very tough decision. I was trying to balance the risks with the potential rewards. I gradually became convinced that I was taking a reasonable risk with active surveillance. If my cancer had already metastasized, then neither surgery nor radiation would do me any good — the horse is already out of the stable, so to speak. I'd just be waiting for the symptoms to start and then trying to extend my life with hormones. You can hope that it hasn't spread, but you can't forget that it might have. It can spread microscopically, and microscopic spreading cannot be detected by current techniques.

Then I became aware that there are almost no hard data on differences in prostate cancer–specific survival among men undergoing the various treatments. There's one set of studies from Sweden that shows a very modest advantage for surgery over watchful waiting. But as I said, the advantage is very modest — about 5% after 10 years. And the number of patients in the study was relatively small, and they had more advanced cancers than I did. So I didn't think the data were definitive or directly applicable to my situation. A more recent study from the same group shows no statistically significant difference in overall survival between the two groups after 12 years.

Then the other factor that went into my decision is that in a lot of cases the cancer will come back after treatment. So obviously either the cancer had spread before treatment, or not all the cancer was removed or destroyed through surgery or radiation. In fact, you can go on the Internet, plug in your numbers, and find out the odds that your cancer will recur if you have surgery or radiation.
On the positive side, prostate cancer has a very long natural history. For many men, the diagnosis occurs at a time when it doesn't really matter because their life expectancy is such that something other than prostate cancer is going to kill them first.

With active surveillance, patients need regular biopsies. Was that a stumbling block in your decision to pursue active surveillance?

No. To be honest with you, without the anesthesia, it was quite unpleasant. But since my urologist started using local anesthesia, biopsies haven't been a big deal.

How did your family react to your active surveillance decision?

My wife participated in many of my meetings with physicians, and she's read all of the books I have and some of the scientific papers, too. Like me, she was concerned about the various side effects of treatment. She was very empathetic and helped me sort out the options, making it clear that she'd support whatever decision I made. If I had said, "I want surgery immediately," she would have supported it.

(Continued on page 7)

She played a major role in calming me down, too. We talked about beating the cancer, but we knew that it might not go away. She encouraged me to think about managing the situation toward an acceptable outcome — acceptable in terms of the trade-offs, what I could and couldn't live with.

Having been a businessman involved in the early stages of companies, I know that you have to make decisions even when you don't have all of the facts you'd like to have. You use the information you have to decide where to spend money, how to invest resources, and what projects to take on. As you gather more data, you either continue down the same path or change directions. I started to think of my medical situation the same way. There's a lot more information I'd like to have, but I manage as best as I can with what I know.

Under what circumstances would you stop active surveillance and turn to surgery, radiation, or another form of definitive treatment?

There are generally accepted criteria for who is a good candidate for active surveillance. [See "Suggested criteria for active surveillance," below.] For example, the PSA should be under 10 ng/dl. Mine is 5 ng/dl. The PSA doubling time should be slow. Mine is incredibly slow — it's taken nine years to go from 4 to 5 ng/dl, and that isn't anywhere near double. The Gleason score should be less than 7. Mine is 6, so that fits. My tumor is an early-stage tumor, and I had cancer in fewer than three biopsy cores. As long as you have cancer in only one or two cores, and it's in less than 50% of the core sample, you fit the criteria. I am completely under this umbrella. [See Figure 2.]

Suggested criteria for active surveillance

Researchers at the University of Toronto developed a treatment algorithm to better differentiate men with prostate cancer who can pursue active surveillance from those who need more immediate treatment. Those considered eligible for active surveillance have

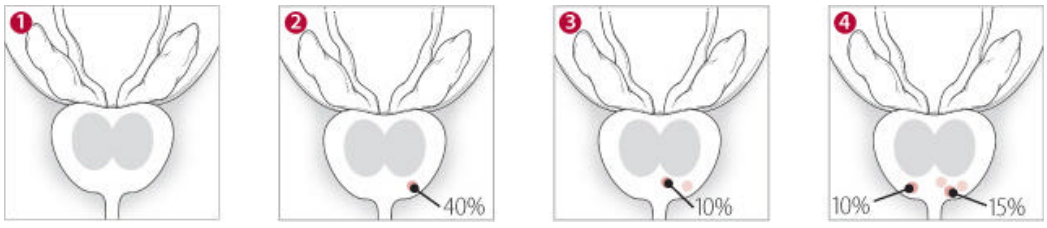
- a PSA of 10 ng/dl or less
- a Gleason score of 6 or less
- T1c to T2a prostate cancer.

T1c tumors cannot be felt during DRE; they're usually discovered after a rising PSA prompts a biopsy. T2a tumors can be felt, but they are confined to the prostate and less than half of one of the gland's lobes.

For men with a life expectancy greater than 15 years, the cancer should be in only one or two cores and constitute less than half of those cores.

Patients who meet these criteria can still opt for treatment. For example, some find the psychological burden of living with cancer too great. One's age, family history, and other medical conditions can also sway decision-making.

Figure 2: Caruso's biopsy results



To date, patient Jeffrey Caruso has had four prostate biopsies (above, rear view). The first (**1**), done in 1999, found no cancer. Six years later, the second biopsy (**2**) detected cancer in 40% of one core, or tissue sample, taken from the right apex. In 2006, a third biopsy (**3**) detected cancer in 10% of one core taken from the right mid-apex. (The lighter dots indicate where cancer was found on previous biopsies.) The most recent biopsy (**4**) found cancer in both the right apex (15% of one core) and the left apex (10% of one core). All of the cancers were scored a Gleason 6, meaning that Caruso meets the criteria for active surveillance.

Continued in our next newsletter

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Want to reach us by email ?

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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. 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

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

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