The Manitoba Prostate Cancer Support Group NEWSLETTER

Vol. 232 – October 2010

manpros@mts.net

Thought For Today

How long is a minute? Depends which side of the bathroom door you're on.

- Pam Boomer

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, October 21st, 2010 7 - 9 P.M.

Katherine Gottzmann, Psychosocial Oncology

"Keeping it Together: Coping with the Emotional and Psychological Impact of 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.

Please Note: Speaker Change

Due to unavoidable circumstances, our Sept. speaker, Dr. Wightman, Pathologist, was unable to attend on that date. Dr. Aziz Mhanni, Medical Geneticist, agreed to change his scheduled Nov. date to Sept.

Dr. Wightman will now speak on Nov. 18th. We apologize for any inconvenience this may have caused.

Special Thanks to AstraZeneca

The Manitoba Prostate Cancer Support Group would like to acknowledge a recent donation from AstraZeneca. AstraZeneca is a research-oriented company that produces Casodex and Zoladex - two drugs used for prostate cancer hormone treatment. We are grateful that they have chosen to assist us with our work this year.

AstraZeneca

WE REALLY APPRECIATE YOUR SUPPORT

The Manitoba Prostate Cancer Support Group operates on your donations

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Post Prostatectomy Urinary Incontinence Video

Urologist, Dr. Andrew Siegel has posted a very descriptive explanation of male incontinence on YouTube.

It also includes several other videos related to prostate cancer.

You can view them all at:
http://www.youtube.com/watch?v=sUza68Om18w

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Research News

Scientists at UCLA Identify for the First Time a Cell-of-Origin for Human Prostate Cancer

Discovery could result in better predictive and diagnostics tools and the development of new treatments

UCLA scientists have identified for the first time a cell-of-origin for human prostate cancer, a discovery that could result in better predictive and diagnostics tools and the development of new and more effective targeted treatments for the disease.

The researchers, from UCLA's Jonsson Comprehensive Cancer Center, proved that basal cells found in benign prostate tissue could become human prostate cancer in mice with suppressed immune systems, a finding that bucked conventional wisdom. It had been widely believed that luminal cells found in the prostate were the culprits behind prostate cancer because the resulting malignancies closely resembled luminal cells, said Dr. Owen Witte, a Jonsson Cancer Center member and director of the UCLA Broad Stem Cell Research Center.

"Certainly the dominant thought is that human prostate cancer arose from the luminal cells because the cancers had more features resembling luminal cells," said Witte, senior

(Continued on page 3)

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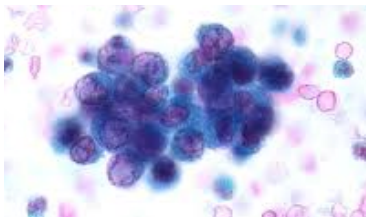
author of the study and a Howard Hughes Medical Institute Investigator. "But we were able to start with a basal cell and induce human prostate cancer and now, as we go forward, this gives a place to look in understanding the sequence of genetic events that initiates prostate cancer and defining the cell signaling pathways that may be at work fueling the malignancy, helping us to potentially uncover new targets for therapy."

The study appears July 30, 2010
in the peer-reviewed journal Science.

The researchers took healthy tissue from prostate biopsies and separated the cells based on their surface marker expression into groups of luminal cells and groups of basal cells. Using viral vectors as vehicles, they then expressed altered genes known to cause cancer into both cell populations and placed the cells in mice to see which developed cancer, said Andrew Goldstein, a UCLA graduate student and first author of the study.

"Because of the widespread belief that luminal cells were the root of human prostate cancer, it would have been those cells examined and targeted to treat the disease," said Goldstein. "This study tells us that basal cells play an important role in the prostate cancer development process and should be an additional focus of targeted therapies."

In normal prostate tissue, basal cells have a more stem cell-like function, Goldstein said, meaning they proliferate more to re-grow human prostate tissue. Luminal cells don't proliferate as much, but rather produce major proteins that are important for reproduction. Something is going askew in the basal cells that results in cancer and Witte and Goldstein plan to study those cells to uncover the mechanisms that result in malignancy.



Currently, there is a dearth of knowledge about how prostate cancer develops to treat it effectively in a targeted way, as Herceptin targets an out-of-control production of growth factor receptors in breast cancer cells. The major targeted therapy used for prostate cancer is directed at the androgen receptor and it is not always effective, Witte said.

The new human-in-mouse model system developed in the study – created by taking healthy human prostate tissue that will induce cancer once it is placed in mice instead of taking malignant tissue that is already cancerous and implanting it – can now be used to evaluate the effectiveness of new types of therapeutics. By using defined genetic events to activate specific signaling pathways, researchers can more easily compare therapeutic efficacy. The new model, by deconstructing tissue and then reconstructing it, also will aid in analyzing how the cells change during cancer progression.

"There are very few examples of taking benign cells and turning them into cancer experimentally," Goldstein said. "We usually study cancer cell lines created from malignant tumors. This study resulted in the creation of a novel model system that is highly adaptable, such that we can test any cellular pathway and its interactions with other genes known to induce cancer, and we can start with any type of cell as long as it can be reproducibly purified." In this system, Witte and Goldstein know the "history" of the cells that became cancer, unlike the cancer cells lines used in other work.

"We know those cells are malignant, but we don't know how they got there," Goldstein said. "By starting with healthy cells and turning them into cancer, we can study the cancer development process. If we understand where the cancer comes from, we may be able to develop better predictive and diagnostic tools. If we had better predictive tools, we could look earlier in the process of cancer development and find markers that are better than the current PSA test at catching disease early, when it is more treatable."

Rising PSA levels can indicate the presence of cancer that is already developing in the prostate. However, now that it is known that basal cells are one root of human prostate cancers, they can study pre-malignant basal cells and uncover what they express that the healthy ones don't, perhaps revealing a new marker for early detection, Goldstein said. Also, a therapy directed at the pre-malignant basal cells about to become malignant could provide a way to prevent the cancer before it becomes dangerous.

This year alone, more than 217,000 men will be diagnosed with prostate cancer. Of those, more than 32,000 will die from their disease.

The study was funded by the Prostate Cancer Foundation Challenge Award, the Howard Hughes Medical Institute and the Department of Defense.

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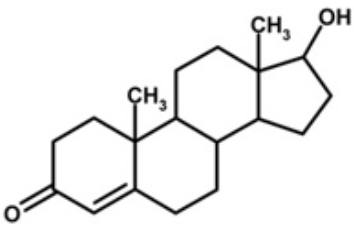
Recovery Time From ADT Treatment

By John Brennan, eHow Contributor

June 13, 2010



ADT suppresses production of hormones like testosterone in men with prostate cancer.

Androgen deprivation therapy (ADT), sometimes called hormone therapy, is a common treatment for prostate cancer. Androgens are male hormones like testosterone. Since these hormones stimulate cell growth in the prostate gland, temporarily or permanently reducing androgen levels can help shrink the tumor or slow its growth. The side effects and recovery time vary depending on the method used.

Prostate Cancer

Among men older than 50, prostate cancer is the most common cancer, affecting nearly as many as one in six U.S. men within their lifetime. Like other cancers, it's a disorder where mutant cells proliferate and grow out of control. Most men diagnosed with prostate cancer are over age 65. Symptoms often include difficulty in urination and impaired sexual function and are similar to benign prostatic hyperplasia (BPH), a disorder where an enlarged prostate presses against the urethra and the bladder. However, BPH--unlike prostate cancer--is benign, not cancerous. Chances of recovery for those diagnosed with prostate cancer depend on how far the disease has progressed and whether it has invaded other tissues.

ADT

Male sex hormones or androgens like testosterone can promote cell division in the prostate, so minimizing production of these hormones can help treat the disease. Sometimes doctors remove the patient's testicles, a procedure called orchiectomy, to stop production of testosterone. While surgical castration is a fairly simple surgical procedure, it's also irreversible. Many patients therefore prefer therapies that use drugs. LHRH hormone agonists are drugs intended to stop testosterone production in the testicles, while antiandrogens bind to androgen receptors on cells in your body, blocking the activity of androgens.

Uses and Side Effects

ADT is a very common treatment for advanced prostate cancer, especially if the tumor has already spread beyond the prostate gland. It can cause a number of side effects, including impotence, low libido, growth of breast tissue, osteoporosis and fatigue. It can also increase the risk of heart disease.

Recovery From Orchiectomy

Orchiectomy is an irreversible procedure; side effects generally include loss of libido and impotence. Recovery following the surgery, however, is typically quite rapid and complications are rare. For those patients who so choose, doctors can often replace the testicles with a testicular prosthesis, silicone sacs shaped like testicles, in order to restore normal appearance.

Recovery from ADT

According to a 2006 paper in BJUI, testosterone levels in most men return to normal some 18 to 24 weeks following the last LHRH injection in short-term ADT. Long-term androgen deprivation therapy (LTADT), however, is typically accompanied by more lasting side effects. Another study in BJUI in 2006 found that testosterone levels in many men did not return to normal levels for a year or more following LTADT. Moreover, even after testosterone levels have returned to normal, sexual function may not necessarily recover. The 2006 study found that only 10 percent of the men in the study recovered potency following treatment. The effect of ADT on sexual function may therefore be quite prolonged, although more so with long-term ADT.

Read more:
Recovery Time From ADT Treatment eHow.com
http://www.ehow.com/about_6623485_recovery-time-adt-treatment.html#ixzz0yI17nomX

References
* BJUI: Testosterone and Erectile Function Recovery After Radiotherapy and Long-term Androgen Deprivation; Wilke, Parker et al; 2006.
* Indian Journal of Urology: Adverse Effects of Androgen Deprivation Therapy; Bagrodia, DiBlasio et al; 2009.
* The Oncologist: Intermittent ADT for Prostate Cancer; Rashid and Chaudhary; 2004.
* Reviews in Urology: ADT in the Treatment of Advanced Prostate Cancer; Perlmutter and Lepor; 2007.
* BJUI: Recovery of Serum Testosterone After Neoadjuvant Androgen Deprivation Therapy; Murthy, Norman et al; 2006.

Resources
* National Cancer Institute: Prostate Cancer Treatment
* Prostate Cancer Research Institute: Newly Diagnosed Prostate Cancer: Evaluating the Options
* American Cancer Society: Hormone (Androgen Deprivation) Therapy

Photo Credit
testosterone image by Cornelia Pithart from Fotolia.com

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11 Ways To Comfort Someone Who's Grieving

If you have a friend or relative who is grieving, it can be hard to know how to console him or her. If it seems that nothing you can do or say helps, don't give up. You can't take the pain away, but your presence is more important than it seems. Accept that you can't fix the situation or make your friend or relative feel better. Instead just be present and offer hope and a positive outlook toward the future. Accept that the person's grieving will be a gradual process.

It is sometimes difficult to know what to say to a bereaved person. If you find yourself tongue-tied or uncertain of what to do in the face of someone's loss, here are some steps you might try.

1. **Name names**. Don't be afraid to mention the deceased. It won't make your friend any sadder, although it may prompt tears. It's terrible to feel that someone you love must forever be expunged from memory and conversation. (This suggestion does not apply in cultures in which mentioning the dead is taboo or bad luck, however.)

2. **Offer hope**. People who have gone through grieving often remember that it is the person who offered reassuring hope, the certainty that things will get better, who helped them make the gradual passage from pain to a renewed sense of life.

3. **Make phone calls**. Call to express your sympathy. Try to steer clear of such phrases as "It's God's will" or "It's for the best" unless the bereaved person says this first. Your friend or relative may need you even more after the first few weeks and months, when other people may stop calling.

4. **Write a note**. If you had a relationship with the deceased, try to include a warm, caring, or funny anecdote that shows how important to you he or she was. If you didn't know the deceased, offer your sympathy and assure the bereaved that he or she is in your thoughts or prayers.

5. **Help out**. Be specific when offering help. Volunteer to shop or do laundry, bring dinner, pass on information about funeral arrangements, or answer the phone. Pitch in to clean up the kitchen. A lawyer might volunteer to help with the estate. A handy person might button up the house as winter approaches.

6. **Be sensitive to differences**. People mourn and grieve in different ways. Religion plays a big role in how death is treated; so do ethnic, cultural, and family backgrounds. Avoid criticizing the funeral arrangements or memorial service. Also, try not to impose your beliefs about death on your friend.

7. **Make a date**. Ask your friend to join you for a walk or meal once a week. Be aware that weekends are often very difficult, and suggest an activity. Low-stress activities may be best: watch a video at home together versus going out to a movie. Sometimes just being there without saying much is enough — it may even be exactly what your friend wants.

8. **Listen well instead of advising**. A sympathetic ear is a wonderful thing. A friend who listens even when the same story is told with little variation is even better. Often, people work through grief and trauma by telling their story over and over. Unless you are asked for your advice, don't be quick to offer it.

9. **Express your feelings**. If you share your friend's sorrow, say so. It's even all right to blurt out that you don't know what to say. Most likely, nothing you say will turn the tide, but your sympathetic presence may make your friend feel slightly less alone. (One caveat: try not to express your feelings so emphatically that your friend has to take care of you.)

10. **Handle anger gently**. People who are grieving sometimes direct angry feelings toward the closest target. If that happens to be you, try to be understanding. That is, wait until well after the person has cooled down before raising your concern in a non-threatening way.

11. **Keep your promises**. If you offer to do anything, follow through. This is especially important where promises to children are involved. Losing a loved one is abandonment enough.

http://www.health.harvard.edu/healthbeat/11-ways-to-comfort-someone-who%E2%80%99s-grieving

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Talking with Dr. Patrick Walsh About Radical Prostatectomy

In this article from an online issue of the Johns Hopkins Medicine Update newsletter, Dr. Patrick Walsh, creator of the nerve-sparing radical prostatectomy, talks about his recent refinements to the operation.

How do you make a good operation even better? Ask Dr. Patrick Walsh, Professor of Urology at the Johns Hopkins Brady Urological Institute, and he'll tell you the key is something professional athletes have used for years — a video camera. Twenty-eight years ago, Walsh developed the nerve-sparing radical prostatectomy. Ever since, he has worked to reduce its two major side effects, impotence and incontinence.

"I knew that minor differences in technique made a big difference," he says, "because I would operate on two people, doing what I thought was exactly the same operation on the same day, and one would have a perfect result immediately, and the other one's outcome might be delayed for months or years."

But it was impossible for Walsh to make satisfactory connections between what happened during surgery and the outcome; too much time had passed. Then, 14 years ago, he got a high-quality video camera and began taping his operations. He spent long hours scrutinizing the tapes, looking at men who had recovered quickly and at men who were still not potent after a year. Sometimes he stopped the film frame by frame.

Gradually, he identified some slight variations in his technique - in controlling bleeding from the dorsal vein and dividing the sphincter - that appeared to make the difference in the men who recovered sexual potency the soonest. He also learned that some men have a slight anatomical variation in the location of their neurovascular bundles, the very delicate nerves on either side of the prostate that are responsible for erection. The key to preserving potency, he discovered long ago, is to remove the prostate without injuring these nerves. But in these men, "if you didn't realize it, you could go where you thought everything was safe, and it really wasn't."

Walsh has continually refined his procedure. Inspired by laparoscopic prostatectomy and its close kin, the robotic laparoscopic procedure, he reduced his incision size to three inches several years ago. He also started using a technique called "high anterior release" of the neurovascular bundles, which has further eased traction on these fragile nerves. "At 18 months," he says, "we had around 90 percent potency, and using this technique, we moved it up to 12 months."

Recently, Walsh made another small change that has reaped big dividends. "From watching robotic prostatectomies," he says, "I saw that the prostate can be lifted anteriorly, and then you can dissect the prostate away from the nerves, rather than dissecting the nerves away from the prostate, which is the standard way we do it in open surgery." With the use of a Babcock clamp at the bladder neck, he can see further around the posterior side of the prostate, and with better access, he is able to release these nerves even more gently. "I've already had what appear to be some immediate responses that I have not seen up to this time," he says. "I haven't validated them yet, but I am very enthusiastic about this, because at least as a surgeon, I can see much better." Again, he's watching his videotapes to confirm these findings.

Written by Janet Farrar Worthington and published in the June 10, 2010 online edition of the Johns Hopkins Medicine Update

http://www.johnshopkinshealthalerts.com/alerts/prostate_disorders/JohnsHopkinsColonCancerHealthAlert_3629-1.html

Posted in *Prostate Disorders* on August 26, 2010

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Talking About CyberKnife

September 1, 2010

By Johns Hopkins Health Alerts;
www.johnshopkinshealthalerts.com

Recently a subscriber to the Johns Hopkins Prostate Bulletin asked: I am 63 years old and I was diagnosed last week with prostate cancer (4.7 ng/dL PSA; Gleason 7). I have begun my due diligence to find an appropriate therapy. My doctor recommends radical prostatectomy surgery, but I have now read a lot about a treatment called CyberKnife. What are your thoughts about this prostate cancer therapy? Since many of you are interested in learning about prostate cancer treatments, we thought we'd share our reply.

CyberKnife is a type of conformal beam radiotherapy that uses implanted "seeds" in the prostate to guide and adjust the accuracy of the beam in real time during surgery. The expectation is that this will improve precision in beam delivery due to small adjustments and changes in position during treatment, and can allow for a greater, more accurate concentration of the beam to the prostate than might be available by other methods.

Like many new forms of treatment, this therapy raises expectations that prostate cancer outcomes will be improved and complications will be reduced, but this has yet to be determined. The CyberKnife hasn't been around long enough for its effectiveness in prostate cancer treatment to be confirmed.

Like brachytherapy (seed radiation implants), CyberKnife relies in part for its accuracy of radiation delivery on target seeds that are placed by hand into the prostate, using needles and guidance systems. Conventional external beam radiotherapy relies only on CT-guided images for accuracy. The need to place seeds by hand into the prostate introduces a potential for error that is dependent on the experience and skill of the person placing the seeds.

In general, it takes a long time to prove the value of any new technology in medical care, but the public - and many members of the medical profession - are often quick to embrace new technology and make bold claims for its effectiveness.

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Soy and Prostate Cancer

Written by Gloria Tsang, RD of HealthCastle.com October 2005

Soy prostate cancerDiet has long been thought to be associated with the development of prostate cancer that is common in Western countries and rare in Japan and Asia. In a study published in October 2004 by the Urological Sciences Research Foundation found that when Japanese men migrate to the United States and adopt a Western lifestyle, the protection begins to disappear within one generation. The researchers suggested that the western diet containing high animal saturated fats and low soy content may be the contributors to the higher incidences of prostate cancer.

Soy and Prostate Cancer: decades of promising data

Many people often associate the benefits of soy with breast cancer. Indeed, data on soy and prostate cancer has been most promising; many studies support the role of soy in the prevention and possible treatment of prostate cancer. During the late 80s, researchers found that Japanese men in Hawaii who ate tofu at least 5 times per week had 65% less chance of developing prostate cancer than those who ate tofu only once a week or less. In 1998, researchers found that men who drank soy milk at least once a day had a 70% less chance of developing prostate cancer than those who never drank soy milk at all.

Soy has also been found to be potentially beneficial in treating prostate cancer and slowing its progression in many animal and in vitro studies. Lately, more human studies point to similar results. In a small study published in Urology in September 2004, Australian researchers found that men consuming a soy-enriched diet had a statistically significant drop of 12.7% in prostate-specific antigen (PSA) levels, compared to the control group whose PSA levels rose 40%.

Soy prostate cancerSoy and Prostate Cancer - the bottom line

Study after study seems to show that diet is one of the major factors in relation with incidences of prostate cancer. Prostate cancer incidence and mortality rates in Asian countries are much lower than in the United States. Research suggests that one of the reasons for this difference in incident rates may be the high soy content in the Asian diet. In Asian countries, the estimated isoflavone mean daily intake is between 10-50 mg per day. The Louis Warschaw Prostate Cancer Center in California recommends an intake of 35 to 40 g of soy protein daily. However, it is still not clear whether the benefits are due to its soy protein, or its isoflavones daidzein and genistein, or the combination of them. The best approach is to include soy foods such as tofu, tempeh, soy milk, edamame etc in your diet instead of taking soy isolate supplements.

With increasing public concerns regarding genetically modified foods, look for soy products which use non-genetically modified soy crops in their production.

www.healthcastle.com/soy-prostatecancer.shtml

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Canadian Cancer Society

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All calls are kept confidential

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.....Snacks and Sharing

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

Sept. 16.....Dr. Aziz Mhanni, Medical Geneticist.

Oct. 21.....Katherine Gottzmann, Psychosocial Oncology
"Keeping it Together: Coping with the Emotional and Psychological Impact of Prostate Cancer"

Nov. 18.....Dr. Robert Wightman, Pathologist
"Understanding Your Biopsy Report"

Dec. 16.....Potluck Party Time

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