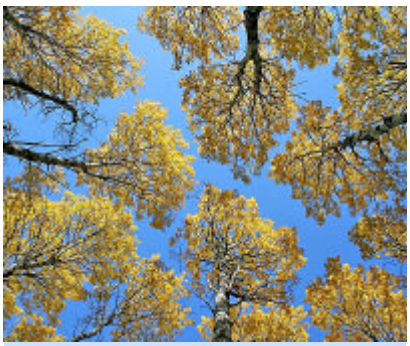
The Manitoba Prostate Cancer Support Group NEWSLETTER

Prostate Cancer Canada Network Winnipeg

Vol. 238 – April 2011



NEXT MEETING:

THURSDAY, APRIL 21, 2011 7 - 9 P.M.

Dr. Jason Bachewich, Naturopath

"Mistletoe injection therapies and intravenous Ascorbic Acid for the treatment of Prostate Cancer"

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

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

Thanks!

SHARING IS CARING

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.

THOUGHT FOR THE DAY

'If you don't like something, change it;
if you can't change it,
change the way you think about it."

- Maya Angelou

Special Thanks

The Manitoba Prostate Cancer Support Group would like to acknowledge a recent donation from Abbott Lab. Abbott produces Lupron, a drug used for prostate cancer hormone treatment. We are grateful that they have chosen to assist us with our work this year and their kindness is much appreciated. Their donation, along with those from individual members, makes the running of our Support Group possible.

Abbott
A Promise for Life

The Manitoba Prostate Cancer Support Group operates on your donations. Have you used any of Newsletter - General Meetings - Hospital visits -One-on-one visits – Speakers ?

WE REALLY APPRECIATE YOUR SUPPORT

Name: Mr. ✍✍✍✍✍Mr. & Mrs. ✍✍✍✍Mrs.✍✍✍✍Ms ✍✍✍✍Miss ✍✍✍

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The Canadian Association of Naturopathic Doctors

Naturopathic Medicine Today

Today, more people than ever before are seeking and benefiting from naturopathic medical care and the number of naturopathic doctors is growing at record rates to accommodate this increased demand. Currently there are naturopathic doctors practicing in every province and territory in Canada. The more than 1,675 naturopathic doctors across the country continue to be an emerging answer to Canada's health care concerns.

Naturopathic doctors are experiencing greater recognition as health care practitioners and as experts in the field of natural and preventive medicine. They provide leadership in natural medical research and enjoy increasing political influence. Positions for naturopathic doctors are opening up in hospitals, multi-disciplinary clinics and specialized health centres across Canada.

In Canada there are five provinces that have naturopathic regulations: British Columbia, Saskatchewan, Manitoba, Ontario and Nova Scotia. Regulation in Alberta is expected by 2011. Most of the other provinces are also in the process of seeking regulation.

In this new century, the naturopathic profession finds itself well positioned in health care. With more and more research supporting the therapies used by naturopathic doctors, the public demand for greater choice and increased access to more natural approaches to health care, naturopathic medicine is poised to make the transition from "alternative" medicine to "mainstream" medicine.

If you haven't experienced the benefits of naturopathic medicine yourself, take the time to regain control of your health by making an appointment with a naturopathic doctor in your area.

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Robotic Prostatectomy Expert Dr. David Samadi, MD Discusses Prostate Cancer Treatment Drug Abiraterone

NEW YORK, Oct. 13 /PRNewswire/ - Following recent FDA approvals for prostate cancer treatment medications from Dendreon and Sanofi-Aventis, a new study shows that the lives of men with advanced prostate cancer were prolonged almost four months on Abiraterone, a new medication from Johnson & Johnson. The drug, which could reach the market in 2011, is positive prostate cancer treatment news with the potential to change clinical practice by providing a new treatment option for aggressive prostate cancer. Dr. David Samadi, a robotic surgey expert who is the Vice Chairman, Department of Urology, and Chief of Robotics and Minimally Invasive Surgery at The Mount Sinai Medical Center in New York City, described the study, which was presented at the European Society for Medical Oncology (ESMO) congress, "As yet another in a series of successful scientific steps towards fighting prostate cancer, a common, and sometimes deadly enemy."

The study followed over 1,000 men with aggressive prostate cancer and poor prognoses, who had only been given months left to live. In this group, 797 were prescribed abiraterone acetate as well as prednisone, a steroid, while the rest were given prednisone and a placebo treatment for prostate cancer. Abiraterone, discovered by Britain's Institute of Cancer Research, blocks the production of hormones that stimulate prostate cancer tumors. Abiraterone's side effects include fluid retention and hypokalemia (low levels of potassium in the blood).

The study showed that Johnson & Johnson's experimental drug not only delayed prostate cancer growth but also significantly increased the patients' life expectancy by 36%, from 10.9 to 14.8 months. The risk of death among patients on the drug also dropped by 35%. "Sure, 3.9 months does not sound like a lot of time, but in terms of the scientific history of prostate cancer, previously only four drugs had ever proven a survival potential," said Dr. Samadi, a robotic prostatectomy expert as well as a urologic oncologist with Mt. Sinai, "The discovery of this drug is even more significant because patients with the aggressive type of this disease have very limited prostate cancer treatment options and usually a terminal prognosis."

Analysts compared abiraterone to Dendreon's vaccine, Provenge, as "a nearly billion dollar opportunity" for Johnson & Johnson and "more compelling" than Sanofi-Aventis' chemotherapy, Jevtana. The latter had been approved this past June for advanced prostate cancer treatment after a study showed prolonged survival of 2.4 months. The FDA approved Provenge in April of this year for treating prostate cancer. However, sales have been impacted by limited production, which should be resolved by mid-2011. Critics says Provenge's hefty $93,000 price tag for three treatments is another sales hurdle though the company claims the price is comparable to other available treatments.

"It's been a landmark year for prostate cancer news, where we are hopefully moving towards making prostate cancer a treatable disease that the patient can survive with a specific drug treatment plan," said Dr. Samadi, "In fact, these drugs may not even be rivals, but viable prostate cancer treatment options that can be administered in a series to battle this disease."

SOURCE - RoboticOncology.com

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Robotic Surgery

http://www.rxlist.com/script/main/art.asp?articlekey=126022

In another study, researchers who examined the outcomes of nearly 3,800 robotic-assisted laparoscopic radical prostatectomy (RALP) operations performed by three skilled surgeons report that it took more than 1,600 procedures for the surgeons to become proficient.

Introduced in 2000, RALP provides surgeons with three-dimensional vision, improved magnification, hand tremor filtering, and a range of motion similar to the human wrist. The procedure has caught on quickly: Of the 90,000 surgeries to remove the prostate performed each year in the U.S., about 80% are done robotically.

"This study suggests robotic prostate surgery should be limited to a few centers of excellence, and not every community hospital or every surgeon should be doing the procedures," says researcher Prasanna Sooriakumaran, MD, PhD, a visiting fellow in urology at the Weill Cornell Medical College in New York.

More than 70% of RALPs in the U.S. are performed by surgeons who do fewer than 100 cases a year, he says.

These findings were presented at a medical conference. They should be considered preliminary as they have not yet undergone the "peer review" process, in which outside experts scrutinize the data prior to publication in a medical journal.

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Questions and Answers About Mistletoe

National Cancer Institute
U. S. National Institutes of Health 03/07/2011

1. What is mistletoe?

Mistletoe is a semiparasitic plant that grows on several types of trees, including apple, oak, maple, elm, pine, and birch. It has been used for centuries to treat medical conditions such as epilepsy, hypertension, headaches, menopausal symptoms, infertility, arthritis, and rheumatism.

Mistletoe is one of the most widely studied complementary and alternative medicine therapies for cancer. In certain European countries, extracts made from European mistletoe are among the most prescribed therapies for cancer patients. These products are made and sold under brand names including:

=> Iscador (also called Iscar).
=> Eurixor.
=> Helixor.
=> Isorel (also called Vysorel).
=> Iscucin.
=> Lektinol (also called Plenosol).
=> Abnoba-viscum.

This summary discusses research done mainly with this mistletoe species.

The chemical makeup of mistletoe products varies, depending on many factors, including:

=> The type of host tree on which the mistletoe plant grows.
=> The time of year the plant is harvested.
=> The species of mistletoe.
=> Whether the extract is fermented or unfermented.
=> Whether the extract is prepared with homeopathic methods.
=> The company that makes the product.

Mistletoe extracts are prepared as water-based solutions or solutions of water and alcohol. Mistletoe products may be named according to the type of host tree on which the plant grows. For example, IscadorM is from apple trees, IscadorP comes from pine trees, IscadorQ is from oak trees, and IscadorU comes from elm trees. Some users believe that the type of mistletoe extract chosen should depend on the type of tumor and the sex of the patient.

2. What is the history of the discovery and use of mistletoe as a complementary or alternative treatment for cancer?

Mistletoe was used by the Druids and the ancient Greeks, and appears in legend and folklore as a panacea or "cure -all". Modern interest in mistletoe as a possible treatment for cancer began in the 1920s.

Extracts of mistletoe have been shown to kill cancer cells in the laboratory and to boost the immune system (the complex group of organs and cells that defends the body against infection or disease). For this reason, mistletoe has been classified as a type of biological response modifier (a substance that stimulates the body's response to infection and disease). Extracts of mistletoe have also been shown in the laboratory to prevent the growth of new blood vessels needed for tumors to grow.

Ingredients in mistletoe that have been studied for their usefulness in treating cancer include:

=> Alkaloids.
=> Viscotoxins.
=> Lectins.

3. What is the theory behind the claim that mistletoe is useful in treating cancer?

Mistletoe extract is studied as a possible anticancer agent because it has been shown to:

=> Have effects on the immune system.
=> Kill mouse, rat, and human cancer cells in the laboratory.
=> Protect the DNA in white blood cells in the laboratory, including cells that have been exposed to DNA-damaging chemotherapy drugs.

See the PDQ health professional summary on Mistletoe Extracts for more information on theory.

4. How is mistletoe administered?

Mistletoe extracts are usually given by injection under the skin (subcutaneous). Less common ways to give mistletoe include by mouth, into a vein (intravenous or IV), into the pleural cavity, or into the tumor. In most reported studies, injections under the skin were given 2 to 3 times a week for various lengths of time.

5. What preclinical (laboratory or animal) studies have been conducted using mistletoe?

Many laboratory and animal studies have been done with

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mistletoe, either alone or combined with other agents. Laboratory studies have suggested that mistletoe may support the immune system by increasing the number and activity of various types of white blood cells. One type of European mistletoe (IscadorQ) used in a 2004 laboratory study showed a strong anticancer effect on certain types of cancer cells but no anticancer effect on other types of cancer cells. While one laboratory study reported that mistletoe extract caused several types of human cancer cells to grow faster, this was not found in other recent lab studies.

Studies testing mistletoe's ability to stop cancer cell growth in animals have yielded mixed and inconsistent results, depending on the extract used, the dose tested, the way it was given, and the type of cancer studied. Results of a few animal studies have suggested that mistletoe may be useful in decreasing the side effects of standard anticancer therapy, such as chemotherapy and radiation therapy, and that it counteracts the effects of drugs used to suppress the immune system, such as cortisone.

6. Have any clinical trials (research studies with people) been conducted using mistletoe?

Most clinical trials using mistletoe to treat cancer have been done in Europe. Most study results have been published in German. Although many of these trials have reported mistletoe to be effective, there are major weaknesses in almost all that raise doubts about their findings. Weaknesses have included small numbers of patients, incomplete patient data, lack of information about mistletoe dose, and problems with study design.

Many studies involve using mistletoe as adjuvant therapy in patients with cancer. One retrospective cohort study done between 1993 and 2000 looked at the use of a mistletoe extract (Iscador) as long-term adjuvant therapy in 800 patients treated with chemotherapy and/or radiation therapy for colorectal cancer that had not spread. The study found that patients treated with Iscador had fewer adverse events, better symptom relief, and improved disease-free survival compared to patients who did not receive Iscador as adjuvant therapy.

In 2002, the National Center for Complementary and Alternative Medicine (NCCAM), in cooperation with the National Cancer Institute (NCI), began enrolling patients for a phase I clinical trial of a mistletoe extract (Helixor A) and gemcitabine in patients with advanced solid tumors. This combination showed low toxicity and showed treatment benefits in almost half the patients. The trial is now closed and the data are being analyzed.[1]

Before researchers can conduct clinical drug research in the United States, they must file an Investigational New Drug (IND) application with the Food and Drug Administration (FDA). The FDA does not make information public about IND applications or approvals; this information can be made public only by the applicants. At present, at least two U.S. investigators have IND approval to study mistletoe as a treatment for cancer.

The National Cancer Institute's PDQ clinical trials database contains protocol abstracts for clinical studies of mistletoe as a treatment for cancer.

7. Have any side effects or risks been reported from mistletoe?

Very few serious side effects have been reported from the use of mistletoe extract products. Common side effects include soreness and inflammation at injection sites, headache, fever, and chills. A few cases of severe allergic reactions, including anaphylactic shock, have been reported.

8. Is mistletoe approved by the U. S. Food and Drug Administration (FDA) for use as a cancer treatment in the United States?

The United States Food and Drug Administration (FDA) has not approved the use of mistletoe as a treatment for cancer or any other medical condition. The FDA does not allow injectable mistletoe extracts to be imported or used except for clinical research.

At this time, there is not enough evidence to recommend the use of mistletoe as a treatment for cancer except in carefully designed clinical trials. These trials will give more information about whether mistletoe can be useful in treating certain types of cancer.

References

1. Mansky PJ, National Center for Complementary and Alternative Medicine: Phase I Study of Gemcitabine and Mistletoe in Patients With Advanced Solid Tumors, NCCAM-02-AT-260, Clinical trial, Closed. [PDQ Clinical Trial]

http://www.cancer.gov/cancertopics/pdq/cam/mistletoe/patient/page2

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Cancer Biomarkers: Adoption Is Driving Growth

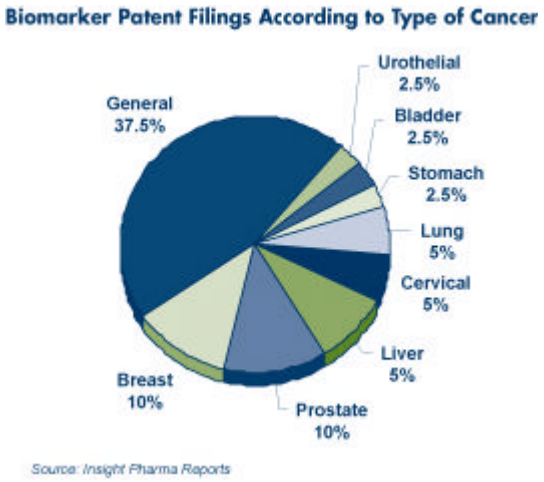
Author: John Bates, PhD

Aggressive adoption of cancer biomarkers will accelerate the growth of commercial markets for these products. This new report offers in-depth analysis of:

=> The current cancer biomarker products, applications, and markets
=> Key validation and assessment cancer biomarker programs integrating established "standards of care" for cancer diagnosis and treatment
=> Product opportunities for improved screening and early detection, to provide better guidance on therapy, for understanding cancer staging, response to treatment, and prognosis
=> Profile of business models behind cancer biomarker products and a SWOT analysis associated with specific strategies
=> Projections for market growth for cancer biomarker product categories

Cancer biomarkers are employed across the entire healthcare spectrum from the cancer biological research laboratory to patient monitoring in the clinic. Cancer biomarkers have contributed greatly to our current understanding of the heterogeneous nature of specific cancers and have led to improvements in treatment outcomes. Biomarker diagnostic and drug therapy combinations are the basis of established treatment protocols in the clinic.

Cancer biomarker- based diagnostics have applications for establishing disease predisposition, early detection, cancer staging, therapy selection, identifying whether or not a cancer is metastatic, therapy monitoring, assessing prognosis, and advances in the adjuvant setting. As this report details, full adoption of cancer biomarkers in the clinic has to date been slow, and only a limited number of cancer biomarker products are currently in routine use. However, several major programs have been organized to facilitate the validation and assessment of cancer biomarkers alongside the established "standards of care" for cancer diagnosis and treatment. These programs are likely to be key to increasing the rate of cancer biomarker adoption in the clinic setting. Further, the regulatory environment is progressing as more cancer biomarker products gain approval.



Cancer Biomarkers: Adoption Is Driving Growth explores the various applications for cancer biomarkers across the healthcare spectrum by presenting the successful adoption of specific biomarkers. These applications include the identification of novel therapeutic targets in cancer drug discovery and uses of cancer biomarkers as surrogate markers for drug efficacy in clinical trials. This report describes a number of factors providing the driving forces behind cancer biomarker growth and commercialization. These factors include requirements to improve screening and early detection, to provide better guidance on therapy and the need to avoid therapy resistance attributes, for understanding cancer staging, response to treatment, and prognosis.

Cancer Biomarkers: Adoption Is Driving Growth reviews emerging cancer biomarker types and the increasing interest in circulating tumor cells, as well as data on potential DNA, RNA, and protein biomarkers under study, including:

=> Oncogenes
=> Germline inheritance
=> Mutations in drug targets
=> Epigenetic changes

The report presents the business models behind cancer biomarker products and a SWOT profile analysis associated with specific strategies. Also, the intellectual property issues around cancer biomarkers are presented, since clear ownership may be a problem in certain circumstances. Further, projections for growth areas within the cancer biomarker markets are provided.

Cancer Biomarkers: Adoption Is Driving Growth includes summaries of interviews with four experts from companies engaged in cancer biomarker product

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commercialization. Additionally, it provides an analysis of results from a recent Insight Pharma Reports survey, primarily aimed at the pharmaceutical industry, relating to the research, development, and commercialization of cancer biomarkers.

About the Author:

John Bates, PhD, is an experienced director and life science consultant. After receiving his PhD in cancer research, Dr. Bates joined Upjohn Ltd, managing a team of biopharmaceutical scientists, later taking a similar role with Glaxo. In 1989, he cofounded Melbourn Scientific Ltd, and Pharmaceutical Technology Ltd in 1994, where he invented and developed VectaSEP CLE, sold under exclusive license to Whatman plc in 1997. In 2000, Dr. Bates joined ANGLE Technology Ltd, providing management and due diligence on new life science company formation in the UK and US, later joining Acumen Bioscience Ltd (drug discovery instrumentation) as Technical Director. He formed VennBio in 2002 and has provided Board level management and consultancy to life science companies.

http://www.insightpharmareports.com/reports_report.aspx?r=559&id=78452

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From Medscape Medical News Oncology

HIFU for Prostate Cancer: Reasons for Caution

Janis C. Kelly

March 10, 2011 — High-intensity focused ultrasound (HIFU) has moved from salvage treatment for prostate cancer to being considered for front-line use, although both the US Food and Drug Administration and the European Association of Urology classify HIFU as experimental.

The first case series to report outcomes in men after failed whole-gland HIFU and salvage radical prostatectomy suggests that there is reason for caution.

The pathology results were "alarming," and morbidity was higher after salvage prostatectomy than after primary surgery, researchers report in the March issue of the Journal of Urology.

The findings come from 15 patients treated with HIFU by Nathan Lawrentschuk, MD, from the Department of Surgical Oncology at Princess Margaret Hospital in Toronto, Ontario, and colleagues in Melbourne and Sydney, Australia.

In this case series, pathologically extensive periprostatic fibrosis with persistent prostate cancer (pT3) was seen in 9 of 14 patients, and focally positive margins (pT3a) were seen in 3 of 11 patients. The authors note that early follow-up data suggest acceptable disease control after the salvage prostatectomies.

In an accompanying editorial comment, Declan G. Murphy, MD, from the Department of Urological Oncology at the Peter MacCallum Cancer Centre in Melbourne, Australia, writes: "Whether it is that standard prostate biopsy cannot be relied on to predict final pathological outcome, or that HIFU 'makes cancer angry,' patients should be fully counseled about what we know and, importantly, what we do not know about HIFU treatment for localized prostate cancer today."

"Our own initial experience with HIFU treatment for primary and recurrent prostate cancer unfortunately led us to conclude that the technology is not yet suitable for mainstream clinical practice, and led us to suspend our program," Dr. Murphy added.

Dr. Lawrentschuk told Medscape Medical News that the case series shows that radical prostatectomy as salvage is feasible after the failure of primary HIFU, but that the rate of extraprostatic extension is a concern.

Dr. Lawrentschuk said that "HIFU is experimental and should only be done in studies where patients are told of the risks of failure and the poor results of salvage. They need very careful monitoring, follow-up biopsies, etc. I do not advise patients to have HIFU. There may be a problem with HIFU selecting out more

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aggressive cells, but this warrants further study."
I think HIFU is inadequate in its current form. "Experimental treatments are fraught with danger. I was surprised at the aggressive nature of the disease and the recurrences in this supposedly low-risk group," Dr. Lawrentschuk said. "I think HIFU is inadequate in its current form, perhaps because of poor patient selection for HIFU and a lack of standardized ways of detecting post-HIFU recurrences in a timely fashion."

Howard Sandler, MD, chair of radiation oncology at Cedars-Sinai Medical Center's Samuel Oschin Comprehensive Cancer Institute in Los Angeles, California, reviewed the study for Medscape Medical News.

"I wouldn't conclude that the high number with extracapsular extension is a result of HIFU. It is more likely that patients who fail HIFU had worse cancers in any case from the start. Additionally, there may have been a bit of a delay after some suspicion of recurrence before salvage surgery was done, given the presurgery PSA [prostate-specific antigen] of 3.8, with the nadir PSA of 1.0. Thus, patients waited on average for their PSA to rise from 1.0 to 3.8 before something was done. During this interval, extracapsular extension may have occurred," Dr. Sandler said.

He noted that HIFU is being tested for whole-gland ablation, although that approach might be waning. However, that there is growing enthusiasm for HIFU (and other modalities) for focal therapy. "I think that HIFU is a poor choice for both approaches," he said. Dr. Lawrentschuk, Dr. Murphy, and Dr. Sandler have disclosed no relevant financial relationships.

J Urol. 2011;185:862-868. Abstract

Send comments and news tips to news@medscape.net.

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Email - manpros@mts.net

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2011 SPEAKERS:

April 21, 2011
Dr. Jason Bachewich, Naturopath
Topic: **"**Mistletoe injection therapies and intravenous Ascorbic Acid for the treatment of Prostate Cancer"

May 19, 2011
Greg Harochaw, Pharmacist
Topic: "Erection Misdirection: Penile Rehabilitation & Treatments for Erectile Dysfunction"

June 16, 2011
Dr. Chris Jensen
Topic: Non-Traditional Prostate Cancer Assessment & Treatment in Canada

July 21, 2011
TO BE ANNOUNCED

M.P.C.S.G. Executive

Brian Sprott - Chair	668-6160
Joseph Courchaine - Treasurer	257-2602
Len Bueckert - Newsletter	782-4086
Tom Boomer - Recording Sec./ New Member	663-1351
June Sprott - Corresponding Sec.	668-6160
Darlene Hay - Membership	837-6742
Kirby Hay - Information Kits	837-6742
Liz & Pat Feschuk - Special Projects	654-3898
Jim Leddy - Member at Large	326-1477
Laurie Courchaine - Member at Large	257-2602
Pam Boomer - Member at Large	663-1351

Prostate Cancer Canada Network Winnipeg