The Manitoba Prostate Cancer Support Group NEWSLETTER

Prostate Cancer Canada Network Winnipeg

Vol. 245 – November 2011

Medical Advisors to The Manitoba Prostate Cancer Support Group

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M.D. Urologist

John Milner
M.D. Urologist

Jeff Sisler M.D.
Family Practitioner

Thanks!

NEXT MEETING:

Thursday November 17, 2011

Dr. Ross MacMahon M.D. Urologist

"Understanding Hormone Therapy"

Location: Seven Oaks General Hospital
Main Floor Auditorium- Leila & McPhillips
Time: 7:00 pm to 9:00 pm

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

Be careful about reading health books. You may die of a misprint.
- Mark Twain

OUR NEW ADDRESS IS

Manitoba Prostate Cancer Support Group (MPCSG)
315 - 971 Corydon Ave
Winnipeg, Manitoba R3M 3S7

CHRISTMAS IS AROUND THE CORNER

WHICH SIGNALS THE END OF THE 2011 TAX YEAR.

We want to remind everyone planning to make a donation to the support group for a deduction on their 2011 income tax return, to do so soon. That way, Joseph, our Treasurer, will have time to issue your receipt **before December 31**.

Please act soon, because Joseph gets very busy Cooking his Christmas turkeys in December!

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 ✍✍✍

_____

Address: _____

Postal Code: _____Card to be signed from: _____

This gift is IN MEMORY of:_____

Please notify the following person of this gift:

Name:_____ _____

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✍**$25** ✍**$50** ✍**$100** ✍**$250** ✍**$500** ✍**$1000** ✍**$1000+** Make cheque or money order payable to:

Manitoba Prostate Cancer Support Group (MPCSG)

 # 315 - 971 Corydon Ave Winnipeg, Manitoba R3M 3S7

Charity number: 88907 1882 RR001 ***a tax deductible receipt will be issued.***

Services for Rural Patients in Manitoba

The Community Cancer Programs Network (CCPN) is a longstanding and innovative program of CancerCare Manitoba that works in partnership with the Regional Health Authorities to enable patients living outside of Winnipeg to receive their cancer care closer to home. The CCPN is comprised of 16 Community Cancer Programs (CCPs) and 1 Community Cancer Resource and Support Program (CCRSP).

CCP sites are outpatient units located in community hospitals and are staffed by a multi-disciplinary team of family physicians, nurses, pharmacists, social workers and other health professionals who have received specialized education in oncology. This group of specialists work with CancerCare Manitoba oncologists and staff to provide comprehensive cancer care, including chemotherapy, follow-up care and support closer to home, allowing patients to stay connected to their families and communities. The Oncologist maintains ongoing contact with the CCP team and retains overall responsibility for the patient's care. In 2009-10, over 19,000 outpatient visits occurred at Manitoba's CCP sites.. This means that more than 7.7 million kilometers of travel to and from Winnipeg were avoided by patients because they were able to have their cancer care closer to home.

The first CCRSP site opened in 2010 in Eriksdale. The focus of the CCRSP is supportive care services across the cancer care spectrum, from pre-diagnosis through survivorship or pallitive care. Unlike the CCps, the CCRSP does not provide chemotherapy treatment.

Collaboration between CancerCare Manitoba specialists and the staff of the CCPs and the CCSRP are supported through the use of the MBTelehealth Network which offers opportunities for consultation and education via videoconferencing.

There are sixteen CCPs throughout the province; Boundary Trails (Morden/Winkler), Brandon, Dauphin, Deloraine, Flin Flon, Gimli, Hamiota, Neepawa, Pinawa, Portage, Russell, Selkirk, Steinbach, Swan River, The Pas, Thompson and one CCRSP site in Eriksdale.

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Tasquinimod Promising For Refractory Prostate Cancer

OCTOBER 18, 2011

NEW YORK (Reuters Health) - The investigational drug tasquinimod slowed progression and improved survival in men with metastatic castration-resistant prostate cancer (CRPC), researchers report.

In 211 men evaluated at 6 months, progression-free survival was 69% with active treatment vs 37% with placebo ($p<0.001$). Median progression-free survival (PFS) was 7.6 and 3.3 months with tasquinimod and placebo, respectively. The new data, published online September 19th in the Journal of Clinical Oncology, are from a phase II study. The drug has since moved on to phase III testing in a similar, but larger, population.

"Tasquinimod is a small molecule with antiangiogenic and immunomodulatory activity," lead author Dr. Roberto Pili told Reuters Health by email. "Its potential mechanism of action makes this agent quite interesting in the current therapeutic options for these patients."

Dr. Pili of Roswell Park Cancer Institute, Buffalo, New York and colleagues randomly assigned chemotherapy-naive men with MRPC and minimal symptoms to oral tasquinimod reaching a dose of 1.0 mg a day or to placebo.

Patients were assessed using the Response Evaluation Criteria in Solid Tumors Group, Prostate Cancer Working Group (PCWG2) standard.

When patients were stratified into prognostic groups based on site of metastasis, PFS duration (with treatment vs placebo, respectively) was 6.1 vs 3.1 months with nodal metastasis, 8.8 vs 3.4 months with bone metastases, and 6.0 vs 3.0 months with visceral metastases.

The rate of grade 3 to 4 adverse events was 40% with tasquinimod vs 10% with placebo. The rate of deep vein thrombosis was 4% in the active treatment group; the problem didn't arise in any placebo patients.

Dr. Pili and colleagues note that currently available options for these men include autologous cellular therapy with sipuleucel-T (Provenge), docetaxel (Taxotere), and cabazitaxel (Jevtana) and secondary hormonal manipulations such as abiraterone acetate (Zytiga).

"If (tasquinimod's) clinical benefit is confirmed in the ongoing phase III clinical trial, we will have an additional tool in our armamentarium to treat recurrent prostate cancer," Dr. Pili said.
Three of the paper's 10 authors are employed by Active Biotech (Lund, Sweden), sponsor of the phase II and phase III studies. Another five receive research support from the company.

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Authors and Disclosures

Journalist
Zosia Chustecka

Zosia Chustecka is the News Editor for Medscape Oncology. A pharmacology graduate based in London, UK, she has edited and written extensively for publications aimed at clinician audiences. Winner of a 2011 Award for Excellence in Urology Health Reporting for an article on prostate cancer, her work also has been recognized by the British Medical Journalists Association, and recently she was awarded a Harvard University Fellowship on Cancer Genetics (May 2011) as well as a US National Press Foundation Cancer Issues Fellowship (October 2010). She can be reached at zchustecka@medscape.net.

Disclosure: Zosia Chustecka has disclosed no relevant financial relationships.

From Medscape Medical News > Oncology

Recommendation Against Routine PSA Screening in US
Zosia Chustecka

October 7, 2011 — Routine screening for prostate cancer using the prostate-specific antigen (PSA) test will no longer be recommended in the United States, where it is currently used more than in any other country in the world. As a result, prostate cancer is the most commonly diagnosed cancer in American men.

The recommendation against routine screening with the PSA test comes from the US Preventive Services Task Force (USPSTF), and was to have been published October 11 in the *Annals of Internal Medicine*, but the entire draft paper was leaked and posted October 6 on the *Cancer Letter* Web site, in "an egregious breach of our embargo and media policies," according to the journal. The news has since been widely disseminated on the Internet; as a result, the journal published the paper early.

(Continued from page 3)

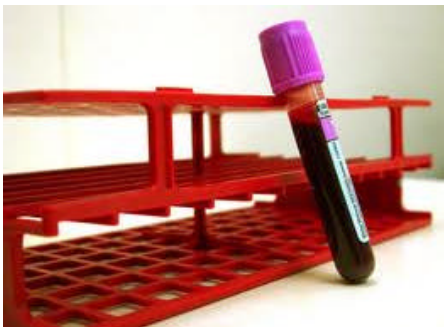
The USPSTF already recommends against routine PSA screening in men older than 75 years. In the new draft recommendation, it extends this to all men. It now recommends against routine screening in men younger than 75 years, giving this a "D" rating, which means "there is moderate or high certainty that the service has no benefit or that the harms outweigh the benefits."

The news is likely to spark a furor in medical circles, not unlike the outcry that followed the USPSTF's recommendation in 2009 against routine mammography screening for breast cancer in women younger than 50 years. This provoked outrage from some breast cancer experts, patient advocates, and professional societies, with accusations that this was a move toward the "rationing" of healthcare.

Angry reactions to the latest news have already begun. The "decision of no confidence on the PSA test by the US government condemns tens of thousands of men to die," said Skip Lockwood, CEO of ZERO, the Project to End Prostate Cancer. ZERO is sponsored by many organizations with a stake in prostate cancer, such as Abbott, Beckman Coulter, Accuray, CyberKnife, Dendreon, and the American Urological Association (AUA).

Based on Reviews of Trials

The recommended change is based on a review of 5 randomized trials of screening and 3 trials and 23 cohort studies of treatments. Included in the review were the 2 largest trials of PSA screening, which reported conflicting results, the USPSTF notes. The European study found a reduction in mortality after 9 years of screening, but the American trial, which had high crossover and contamination rates, found no reduction in mortality after 10 years of screening, as previously reported by *Medscape Medical News.*



The review also noted that treatment for prostate cancer, such as prostatectomy and radiation, is associated with risks for problems such as erectile dysfunction, urinary incontinence, and bowel dysfunction.

The USPTSF concludes that "after about 10 years, PSA-based screening results in small or no reduction in prostate-cancer-specific mortality and is associated with harms related to subsequent evaluation and treatments, some of which may be unnecessary."

Delay in Announcement

This recommendation has been a long time coming, according to reports in the October 7 issue of the *Cancer Letter* and in the *New York Times* magazine. They assert that the timing of the release of this recommendation was influenced by political considerations. According to these reports, the task force first voted to recommend against routine PSA screening back in November 2009, but this "caused a violent political firestorm," and subsequent follow-up meetings were cancelled. The final vote was taken in March. After this, a paper summarizing the recommendation was submitted to the *Annals of Internal Medicine*, where is it expected to appear next week.

PSA Test is Not Specific

The main problems with the PSA test are that it is not specific for prostate cancer and it cannot differentiate between aggressive and indolent forms of the disease.

"It cannot distinguish cancer that will never make a difference in a man's lifetime from cancers that will make a difference," so might prompt men to undergo aggressive treatment unnecessarily, Virginia Moyer, MD, MPH, chair of the USPTSF panel that made the recommendation, stated in an interview yesterday with *Bloomberg News*. "So you go from being a guy who feels fine and who is potentially one of the majority who would never have known they had this disease, to being a guy who wears adult diapers," she said. Dr. Moyer is a professor of pediatrics at Baylor College of Medicine in Houston, Texas.

The PSA test is "hardly more effective than a coin toss," said Richard Ablin, PhD, research professor of pathology at the University of Arizona College of Medicine in Tucson. Dr. Ablin discovered PSA in 1970. Using this test to screen for prostate cancer in the general population has been a "hugely expensive public health disaster," he wrote in an opinion piece in the *New York Times* last year.

(Continued on page 5)

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"Drug companies continue peddling the tests, and advocacy groups push 'prostate cancer awareness' by encouraging men to get screened," he wrote. "The medical community must confront reality and stop the inappropriate use of PSA screening," he stated. "Doing so would save billions of dollars and rescue millions of men from unnecessary, debilitating treatment."

Although PSA testing is recognized as being imperfect, it is the only test for prostate cancer that is widely available, and it does provide information that can be useful, proponents point out. One of the professional bodies that has long supported the use of the test, the AUA, emphasizes that it should not be used on its own, but needs to be combined with other information (such as family history).

The AUA issued a statement in reaction to the new USPSTF recommendations: "We are concerned that the Task Force's recommendation will ultimately do more harm than good to the many men at risk for prostate cancer, both here in the United States and around the world."

"The AUA's current clinical recommendations support use of the PSA test, and it is our feeling that, when interpreted appropriately, the PSA test provides important information in the diagnosis, pretreatment staging or risk assessment, and posttreatment monitoring of prostate cancer patients," according to the statement.

"Not all prostate cancers require active treatment and not all prostate cancers are life-threatening," the statement points out, and the decision of whether to proceed to active treatment or whether surveillance is an option needs to be discussed in detail with the patient.

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Intermittent Androgen Deprivation

Changing the Standard of Care for Men with Recurrent Prostate Cancer

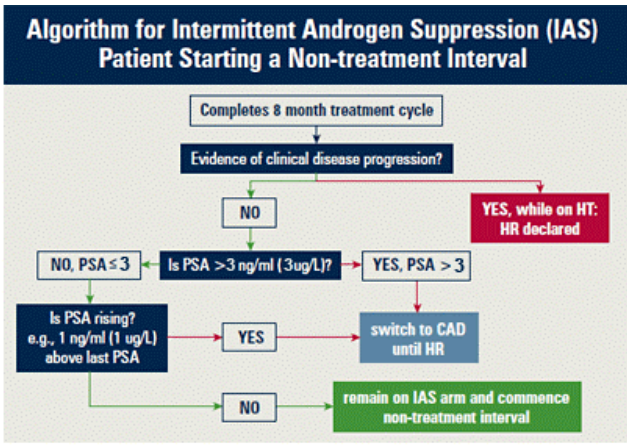
For men undergoing androgen deprivation therapy for metastatic prostate cancer, the side effects—including fatigue, hot flashes, mood swings and momentary memory loss—may be extremely taxing. Now, results of a large phase III randomized, controlled study conducted by the National Cancer Institute of Canada show that shorter, eight month cycles of intermittent androgen deprivation (IAD) therapy can deliver comparable clinical outcomes for some patients whose PSA levels rise following radical prostatectomy or radiation therapy.

Those who reviewed that study data at last month's ASCO meeting agreed that this study represents a "practice changing" milestone with ASCO endorsing the concept that IAD now be presented to patients at the time of biochemical PSA recurrence in the absence of metastatic disease on scans (detectable lesions in bone or soft tissue).

"We have known since the mid-1990's that androgen suppressive therapy could be used in an interrupted fashion, but we didn't know until now that men were not sacrificing length of life in the hopes of having a better quality of life," says Juanita M. Crook, MD, principal investigator and radiation oncologist with the British Columbia Cancer Agency. "The results of this trial will change the standard of care."

The Canadian study, supported by a team of cross-border North American scientists, administered intermittent androgen deprivation in patients for eight months then stopped and restarted only when their PSA levels reached >3 ng/ml when off the treatment, compared to men treated with continuous androgen deprivation (CAD). The data showed that intermittent antiandrogen treatment was equivalent to continuous antiandrogen treatment with similar overall survival and quality-of-life measures. Biostatiscally, intermittent therapy was called "a non-inferior" (in laymen's terms, "comparable") arm of the trial—disease specific death was 18% in the intermittent arm compared with 15% in the continuous arm.

Dr. Crook believes the IAD method will be widely accepted. "There is no detriment to survival, some men see quality-of-life benefit, and it also happens to be cheaper," says Crook.



Source: *ASCO Daily News*, June 7, 2011

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Summary

Intermittent androgen deprivation provides similar outcomes to continuous therapy with the potential for fewer side effects and less disruption to quality of life—good news for many men and their families. IAD patients complained of fewer hot flashes and 35% of them had full recovery of serum testosterone after completing IAD. Cardiac events and osteoporotic fracture events were equal in both arms. Further, intermittent androgen deprivation offers cost-savings to health systems as both patients and the systems pay only 27% of the cost of continuous treatment.

Patients about to start androgen deprivation therapy or currently undergoing continuous androgen deprivation treatment should ask their physician to see if they qualify for IAD.

Intermittent Androgen Deprivation Study Details

The patient group tested 1,386 men whose PSA recurred with no evidence of metastatic disease on scans—and after primary tumor treatment—either radiation therapy or radical prostatectomy. Eligible patients had a PSA of >3.0 ng/ml at more than 12 months following either surgery, radiation following surgery, or primary radiation therapy. The median follow up for all patients was 6.9 years and the intermittent androgen treated patients received between 1-9 cycles of treatment with the median number being 2 cycles of hormonal therapy between periods of discontinuation. Median survival was 8.8 years for the intermittent patients and 9.1 years for those patients who were treated continuously. The median age of the treated men was 74.2 years.

From: Prostate Cancer Foundation 2011

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Prostate Cancer Linked to High Triglyceride Levels

Jody A. Charnow September 28, 2011

Men aged 60 years or older who have elevated triglyceride levels are at increased risk of being diagnosed with prostate cancer (PCa), according to Japanese investigators. They also are more likely to be diagnosed with aggressive PCa.

Norihiro Hayashi, MD, and collaborators at Jikei University School of Medicine, Minato-ku, Tokyo, analyzed data from 905 men who underwent prostate biopsies. Of these, 528 (58.3%) had cancer on biopsy. Overall, men with triglyceride levels of 150 mg/dL or higher (hypertriglyceridemia) had a significant 66% increased risk of a PCa diagnosis, after adjusting for potential confounders, researchers reported in *BJU International* (published online ahead of print). Hypertriglyceridemia was associated with a significant twofold increased risk of a PCa diagnosis among men aged 60-69 years and those aged 70 years and older, but was not associated with an increased risk among men aged 59 years and younger.

The proportion of non-statin users aged 60 and older found to have aggressive PCa (Gleason score of 8 or higher) increased along with triglycleride levels, from 22.9% among men with levels below 100 mg/dL to 25.2%, 26.6%, and 39.7% among those with levels of 100-149, 150-199, and 200 mg/dL or higher, respectively.

Additionally, among men aged 60 years and older, statin users had a significant 44% decreased risk of high-risk PCa compared with nonusers, after adjusting for age and body mass index.

High triglyceride levels correlated significantly with high BMI. In addition, compared with subjects who had a BMI below 23 kg/m^2, those with a BMI of 25 or higher had a nonsignificant 41% increased risk of a prostate cancer diagnosis.

The researchers explained that potential mechanisms for the association between hypertriglyceridemia and cancer development include insulin resistance, infection, inflammation, and oxidative stress.

(Continued on page 7)

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The new study adds to mounting evidence linking PCa to metabolic and lipid abnormalities, said Stephen J. Freedland, MD, a researcher at the Duke Prostate Center and Associate Professor of Surgery (Urology) and Pathology at Duke University Medical Center in Durham, N.C. He and his colleagues recently reported on a study showing that obesity is associated with an increased risk of high-grade PCa.

Dr. Freedland explained that, unlike cholesterol, triglyceride levels are highest among those with insulin resistance, and many physicians consider high triglycerides as a sign of a problem with blood sugar levels. In the new study, individuals with high BMI had a nonsignificant elevated PCa risk, and high BMI is associated with high cholesterol and insulin resistance, both of which have been linked to PCa risk in previous studies, Dr. Freedland said. He said the new findings add to a growing consensus that metabolic disturbances and especially insulin are associated with promoting the growth of prostate tumors, especially aggressive PCa.

Clearly, men who are obese and have metabolic syndrome are at increased PCa risk, Dr. Freedland said, but whether losing weight and no longer meeting criteria for metabolic syndrome changes that risk is not known. “Intuitively, the answer should be ‘yes.' It makes sense, but we as a prostate cancer community have not shown that, yet.”

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Members Forum

Hormone injections as we know are costly. The injections are received by patients free of charge if their physician works at the Prostate Centre. If the patient’s physician does not practice at the Centre they cannot be referred to the Centre for the purpose of receiving the injection. Therefore, if hormone treatment is prescribed the cost of the injection is dealt with under the guidelines of Pharmacare or a private insurer. This is not equitable.

I expressed concern over the inequity to the Minister of Health, Theresa Oswald and received a response on her behalf from the Assistant Deputy Minister, Bernadette Preun. She responded,

“The Dr Ernest W. Ramsey Manitoba Prostate Centre located within CancerCare Manitoba (CCMB), is the provincial centre for prostate disease and functions as a centre of excellence for the diagnosis and treatment of prostate disease, including prostate cancer. CCMB has also established 16 Community Cancer Program (CCP) clinics, in community hospitals throughout the province, to enable patients living outside of Winnipeg to receive their cancer treatments closer to home. CCP clinics are staffed by multidisciplinary teams of health professionals, with specialized education in oncology, who work with CCMB oncologists and staff to provide comprehensive cancer care, including chemotherapy, follow-up care and support to patients.

PCHT is a unique chemotherapy in that patients and their physicians have a choice to have it administered either through CCMB and CCP clinics or in the community at family physicians’ offices. In Manitoba, cancer drugs and supportive therapies administered in an inpatient setting, such as hospitals or CCMB clinics, are provided to the patient at no cost. Medications accessed in the community are funded through public drug pans such as Pharmacare, private insurance and/or by the individual.”

The question now becomes one of how the patient and the physician have the choice to have the injection administered at the Prostate Centre or at one of the 16 Community Cancer Program (CCP) clinics.

The patient cannot be referred there specifically for that purpose so what must be done?

If you are able to shed some light on the issue please do so. The goal is to provide information to those having to deal with the cost of the injections. If you would like to express an opinion about this matter or any other matter pertaining to prostate cancer please send your response to:

manpros@mts.net

The Manitoba Prostate Cancer Support Group Newsletter Member’s Forum

Our intention of introducing a “Members Forum” is to provide an opportunity for exchange of information among our readers. Submissions for printing will be at the discretion of the editor and subject to edit.

Len Bueckert

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Return undeliverable Canadian addresses to
Manitoba Prostate Cancer Support Group
315-971 Corydon Ave.,
Winnipeg R3M 3S7

Publications Agreement
40037332

PCC Mantra: Take Charge Of Your Health

Alexandra Lopez-Pacheco, National Post · Jun. 30, 2011

If there's one overriding message Prostate Cancer Canada and many prostate cancer survivors have for Canadian men, it is to take charge of their health.

"It's your body, your health. We believe men need to educate themselves on prostate cancer, have the discussion about their risk with their doctor and request a PSA blood test if, after those discussions, they believe the tests are necessary," says Steve Jones, president and CEO of Prostate Cancer Canada (PCC).

This is especially important when it comes to prostate cancer -the most common cancer to afflict Canadian men -for a number of reasons.

First of all, there are still many public misconceptions about the disease. These include the belief that it only affects older men, so younger men with a family history of prostate cancer or of African or Caribbean descent often skip the tests necessary for early detection even though they are at higher risk of getting the disease.

"There are few, if any, symptoms in the early stages, so it is important that men initiate the prostate cancer discussion with their doctor. The good news is that more than 90% of prostate cancer cases are curable if detected and treated in their earliest stages," Mr. Jones says.

Men who wait for their physician to initiate a discussion on prostate cancer testing, however, might be waiting too long.

The reality is that while awareness of the disease has been growing in recent years, not all doctors are equally informed with up-to-date information.

PCC advises men to consider the merits of early detection through prostate specific antigen (PSA) screening. And take note: "A lot of men don't understand that PSA is just a simple blood test," says Mr. Jones.

PCC POSITION ON PSA TEST

Age 40 Establish a baseline PSA score. While the threat of prostate cancer is minimal at this age, it also precedes the onset of benign prostatic hyperplasia (BPH), the natural enlargement of the prostate that commonly occurs with age. The onset of BPH often results in rising PSA over time and it can be confused with the onset of prostate cancer.

Unless your resulting baseline PSA score is of concern to your doctor, the PSA need only be repeated each five years until age 50.

Men at higher risk of prostate cancer (those with a family history and/ or those of African or Caribbean descent) should begin annual PSA testing at age 40.

Age 50 All men should begin annual or semi-annual PSA testing if they have not yet done so. Results that show a minimal increase in PSA against your baseline score (at the discretion of your physician) requires no further action until your next annual test.

Those with significant increases should prompt a consultation with your doctor about follow up PSA tests and possibly a biopsy to test for cancer.

For more information, visit prostatecancer.ca

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Email - manpros@mts.net

Answering Machine - (204) 989-3433

2011 SPEAKERS:

November 17, 2011
Dr. Ross MacMahon M.D. Urologist
Understanding Hormone Therapy

December 15, 2011
Christmas Party,
Pot Luck
Entertainment by " Fire and Ice"

January 19 , 2012
Dr. Darrel Drachenberg, Urologist.
Zytiga: Benefits for advanced PCa

All meetings are held at
Seven Oaks General Hospital Auditorium
7-9 p.m.
Everyone welcome

M.P.C.S.G. Board

Brian Sprott - Chair	668-6160
Joseph Courchaine - Treasurer	257-2602
Len Bueckert - Newsletter	782-4086
June Sprott - Secretary	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