

# The Manitoba Prostate Cancer Support Group NEWSLETTER



Vol. 243 – September 2011



## 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!*

NEXT MEETING:

**Thursday, September 15, 2011**

**Fran Rosenberg, Incontinence Specialist**

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

Knowledge is knowing a tomato is a fruit;  
Wisdom is not putting it in a fruit salad.

**SPECIAL NOTICE:  
SEPTEMBER AWARENESS EVENING  
CANCELLED**

### OUR NEW ADDRESS IS

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

### Special Thanks to



"Lilly makes medicines that help people live longer, healthier, more active lives."

PCCN Winnipeg appreciates the financial support. Together with our members we are able to continue our efforts providing "Awareness, Education and Support" to those in our community seeking answers about prostate cancer.

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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**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.*

### Johns Hopkins Health Alert

## Your Pharmacist: An Underutilized Resource

A survey commissioned by the American Pharmacists Association (APhA) found that people who know their pharmacists by name tend to keep them up to date on all the medications they take, read the labelling information on their prescriptions, know their medications' active ingredients and ask questions about their drugs more often. Pharmacists are trained experts on pharmaceuticals. They know about the chemical composition of drugs, how they function in the body, the diseases and conditions they are used to treat and how drugs are absorbed and metabolized by the body.

The medication issues that a pharmacist can help you with include:

=> the potential for harmful interactions between your prescription medications and over-the-counter drugs, dietary/herbal supplements, foods or alcohol

=> negative side effects you are most likely to encounter when taking medications and what you can do about them

=> activities that might be a problem while you take certain medications

=> what to do if you miss a dose

=> how to store your medications so that they retain their potency

=> ways you might be able to cut your medication costs

=> how to properly administer drugs not in pill form, such as inhalers, skin patches and nose- and eyedrops advice on over-the-counter medications

=> questions about Medicare Part D, the prescription drug benefit.

Help your pharmacist help you. If you can, use one pharmacy to fill all of your prescriptions. This allows the pharmacist to keep a complete record of all the drugs you are taking. Pharmacists' computer systems can identify potential interactions among your medications.



Tell your pharmacist if you start a new drug obtained from a different pharmacy, by mail order or on the Internet. Finally, when filling a new prescription, inform your pharmacist about what over-the-counter medications and dietary or herbal

supplements you are taking along with your prescription drugs.

*Posted in Prescription Drugs on August 9, 2011*

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## Safe To Skip Radiation For Prostate Cancer?

By Alison McCook

NEW YORK | Tue Jun 7, 2011 12:25pm EDT  
(Reuters Health) - A review of recent studies comparing different radiation treatments for prostate cancer reveals no clear picture of what works best for the majority of men with the disease.

Unlike many other cancers, prostate cancer often grows slowly and may never progress to the point where it threatens a man's life. This complicates treatment decisions, because therapies for prostate cancer carry risks - including long-term urinary incontinence and erectile dysfunction. So for many men, treating the disease could potentially do more harm than good.

As a result, experts are increasingly calling for expanded use of active surveillance, sometimes called watchful waiting, in managing prostate cancer. This can mean regular blood tests, visits to a urologist, and repeat biopsies, for example.

However, no large studies have done a sufficient job of comparing what happens to men who opt for active surveillance and those who receive radiation right away, making it difficult for doctors to give sound advice about the safety of holding off on radiation therapy, study author Dr. Raveendhara Bannuru at Tufts Medical Center told Reuters Health. "We had insufficient evidence to give any specific recommendations on that."

The lack of a conclusion was not a surprise to Dr. Peter Albertsen of the University of Connecticut Health Center in Farmington, who reviewed the findings for Reuters Health. In previous studies, prostate cancer patients who chose to forgo radiation were often "fundamentally different" from those who chose treatment - they were generally healthier or their cancer was less aggressive, for instance - which makes comparisons between the two difficult, he said.

As a result, for the majority of men who are faced with the choice, the main option is to speak with their doctors, radiation therapists, and surgeons, then "go back and try to decide what's right for you," Albertsen told Reuters Health.

"Decisions regarding treatment choice for localized prostate cancer should always be a shared decision between the patient and his physician," agreed Dr. Timothy Daskivich of the University of California, Los Angeles, who also reviewed the findings for Reuters Health.

Prostate cancer is the most common cancer among U.S. men. One in six will eventually develop it.

The advent of prostate cancer screening with blood tests for

PSA (prostate-specific antigen) has meant that a large number of men are now diagnosed with early stage cancer that's unlikely to ever become life-threatening. Indeed, most men are diagnosed with a localized form of the disease, meaning it has not spread throughout the body.

Recently, researchers have been finding that it may be okay for some men to skip treatment. Last year, researchers found that among 466 patients who chose active surveillance rather than immediate treatment, those with tumors at intermediate risk for progression fared as well as men with low-risk prostate cancer over four years. Earlier this year, Albertsen and his colleagues found that option may be safe even for some older men with riskier forms of the disease.

In the current study, published in the *Annals of Internal Medicine*, Bannuru and his colleagues reviewed 75 studies that looked at the benefits of different types of radiation therapy in prostate cancer, and the risks of skipping it altogether. Unfortunately, the studies didn't all evaluate the same results. Also, most allowed patients to select which treatment they received. That makes the comparisons unreliable, because the results could be influenced by differences between people who selected different types of treatment, said study author Dr. Mei Chung, who works with Bannuru at Tufts.

However, the authors found enough convincing evidence to suggest that higher doses of radiation beamed at the prostate - usually an extra 1500 rads, said Albertsen - are more effective at bringing down PSA to a healthy level, with no extra urinary or bowel side effects.

Extra treatment often brings extra risks, cautioned Bannuru, and the studies tracked men for no more than a few years, so it's not clear whether the additional radiation might cause more problems in the longer term.

Fortunately, researchers in the UK and Canada are comparing outcomes in similar men who were randomly selected to receive either no treatment or surgery and radiation, and these studies will hopefully help determine which men can safely skip treatment, said Bannuru. "We expect results from these trials will help clarify some concerns."

This type of study has been difficult to conduct in men with prostate cancer, Daskivich told Reuters Health in an email. "Patients generally don't want to be enrolled in a study where they're randomized to either surgery or radiation; they want to make the decision for themselves," he said. "And they certainly don't want to be randomized to a trial of therapy vs. no therapy."

According to the American Cancer Society, approximately 27,000 men died of prostate cancer in 2009.

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## Metastasis or "mets": How Cancer Spreads

**metastasis** (*meh-TAS-ta-sis*): The spread of cancer from one part of the body to another. Tumors formed from cells that have spread are called "secondary tumors" and contain cells that are like those in the original (primary) tumor. The plural is metastases.

*(further resources at the end of this article)*

Tumors are called "malignant" because they have the ability to invade normal tissues (replacing healthy cells with cancer cells) and to metastasize (spread) to other parts of the body. Death from cancer often comes not from the primary site (where the cancer first began) but from the metastases [also known as "mets"]. For example, a patient with stomach cancer may actually die from liver failure after the cancer has spread to that organ.

When a certain type of cancer spreads to another part of the body, it does not change its type. For example, if a person with a lymphoma develops a tumor in the lung which is a metastasis from this lymphoma, the tumor growing in the lung has the same characteristics as the lymphoma. It does not represent a new lung cancer of the type which would develop if the cancer was to start in, or to be "primary" in the lung. It is important to understand this as the treatment that will be effective against the metastasis will be the same treatment that will be used for the primary lymphoma. This is why it is most important for the doctors treating a patient to be able to establish the primary site at which any cancer originated.

Metastases takes place in many ways: through the lymphatic system, through the bloodstream, by spreading through body spaces such as the bronchi or abdominal cavity, or through implantation.

The most common way for cancer to spread is through the lymphatic system. This process is called "embolization". The lymph system has its own channels that circulate throughout the body, similar to the veins and arteries of the bloodstream. These channels are very small and carry a tissue fluid called lymph throughout the body.

Often when a solid tumor is removed by surgery, the surgeon will remove not only the tumor but the neighboring lymph glands, even though there is no visible sign of cancer in those glands. This is done as a precautionary measure, because if even one cell has broken away from the tumor

and lodged in the lymphatic system, the cancer could continue growing and metastasizing.

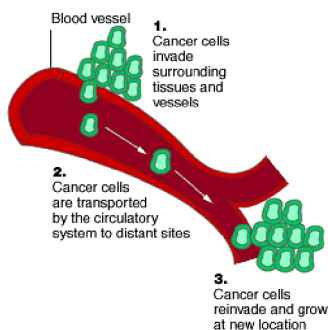
Cancer can also metastasize through the bloodstream. Cancer cells, like healthy cells, must have a blood supply in order to live, so all cancer cells have access to the bloodstream. Malignant cells can break off from the tumor and travel through the bloodstream until they find a suitable place to start forming a new tumor. (Tumors almost always metastasize through the veins rather than through the arteries.) Sarcomas spread through the bloodstream, as do certain types of carcinomas, like carcinoma of the kidneys, testicular carcinoma, and Wilms' tumor, a type of kidney cancer seen in young children. Cancers may spread by more than one route.

Cancers can also spread by local invasion - that is, by intruding on the healthy tissue that surrounds the tumor. Some cancers that spread this way do not venture very far from the original site. An example of this kind of cancer is basal cell carcinoma of the skin. When this kind of cancer is removed by surgeon, a wide area of healthy tissue surrounding it is also removed and it is usually "cured" immediately. Unless some cells have been left behind, it is very unlikely that it will recur. (However, it is possible that a second cancer of the same kind may start to grow at a later time at a completely different site - the new growth having nothing to do with the first.)

A very rare type of metastasis is caused by implantation or inoculation. This can happen accidentally when a biopsy is done or when cancer surgery is performed. In this case malignant cells may actually drip from a needle or an instrument (this is also called a "spill"). It is desirable, therefore, if possible and if the cancer is small to remove it completely at the initial surgery - that is at the time of the biopsy.

Cancers do not spread in a completely random fashion. Some parts of the body are more vulnerable to becoming metastatic sites than others. For example cancers rarely metastasize to the skin, but they often metastasize to the liver and lungs. Each type of cancer has its own pattern for metastases. See the individual site discussions for further information.

*[Text from the British Columbia Cancer Agency. Artwork originally created for the National Cancer Institute. Reprinted with permission of the artist, Jeanne Kelly. Copyright 2000.]*



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## Mechanism Of Bone Metastasis: The Role Of Osteoprotegerin And Of The Host-Tissue Microenvironment-Related Survival Factors

Prostate cancer, the most frequently occurring cancer in men, very often metastasizes to bone, as more than 84% of patients demonstrate skeletal lesions<sup>(1,2-3)</sup>. Although such metastases have been traditionally characterized to be osteoblastic, today it is well known that both bone formation and resorption are dysregulated and participate in the metastatic lesions<sup>(4)</sup>. Therefore, it is interesting to investigate the role of osteoprotegerin (OPG), a member of the tumor necrosis factor (TNF) receptor superfamily, in the context of prostate cancer, as its overexpression by tumor cells could partly explain the osteoblastic phenotype of metastasis.<sup>(1,2-3)</sup>

OPG has various biological functions including bone remodeling, as well as the protection of metastatic prostate cancer cells from apoptotic effects of TRAIL - and therefore provides tumor cells producing OPG with survival advantages. TRAIL (TNF- Related Apoptosis - Inducing Ligand) is secreted by monocytes and is responsible for their ability to induce the apoptotic mechanisms of tumor cells in vivo. OPG facilitates the survival of prostate cancer cells in vitro and this anti-apoptotic property seems to be due to its ability to bind to and inhibit the TRAIL death-activating receptors<sup>(2)</sup>.

The first results of these investigations have revealed that prostate cancer cells produce and secrete OPG<sup>(2)</sup>. Moreover, it has been shown that OPG can inhibit osteoclastogenesis<sup>(3,5)</sup>. More specifically, prostate cancer cells can produce sRANKL, which may be responsible for the CaP-mediated osteoclastogenesis. OPG was shown to bind to sRANKL and completely prevent the establishment of mixed osteoblastic- osteolytic tumor lesions in bone, although it did not prevent the tumor growth. All together, these data show that the ability of OPG to prevent tumor growth in bone is affected by factors in the bone microenvironment. Moreover, inhibition of osteoclastic activity can prevent the establishment of prostate cancer in the skeleton<sup>(3,5)</sup>.

Other in vitro studies<sup>(6)</sup> have revealed that OPG overexpression would decrease the growth of prostate metastatic tumors in the bone, without affecting the proliferation of cancer cells as a result of decreased bone lysis. Consequently, OPG influences the metastatic lesions in bone in an indirect manner.

Several studies have also been made to measure the levels of OPG in the serum of prostate cancer patients, in association

with the progression of the disease. OPG serum levels are increased in patients with advanced prostate cancer and bone metastasis, compared with patients with primary disease, or without osseous lesions<sup>(7)</sup>. These increased serum levels did not correlate well with serum PSA levels.

On the contrary, a more recent study<sup>(8)</sup> has revealed that human prostate cancer cells express RANK, RANKL and OPG in increased levels. In case of bone metastasis, the ratio OPG/RANKL was high. Interestingly, the overexpression of OPG/RANK/RANKL was observed in patients with other markers of advanced disease, such as Gleason score, TNM stage and serum PSA levels.

Several members of the TGF- $\beta$  superfamily are also candidate mediators of osteoblastic metastasis, as in vivo they stimulate new bone formation<sup>(9-10)</sup>. Prostate tumor cells express FGFs including FGF-1, -2 and -8 causing osteoblastic metastases.

Preventing a bone lesion from developing and limiting the progression of an established bone metastasis should be the primary goals of treating metastatic bone disease. However, the currently available therapies for bone metastasis such as bisphosphonates, radiotherapy, radiopharmaceuticals and surgery focus only on symptomatic management<sup>(11,12)</sup>.

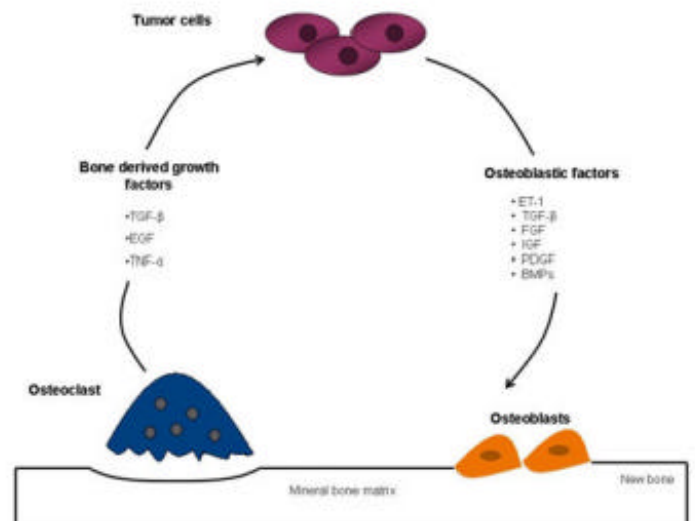


Figure: Mechanisms of osteoblastic lesions in cancer. Tumor cells directly contribute to osteoblastic lesions by producing ET-1 (endothelin-1), transforming growth factor  $\beta$  (TGF- $\beta$ ), fibroblast growth factor (FGF), insulin-like growth factors (IGFs), platelet-derived growth factor (PDGF) and bone morphogenetic proteins (BMPs).

Written by Sofia Fili, Maria Karalaxia, and Bernhard Schalle as part of Beyond the Abstract on UroToday.com

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## Life After Prostate Surgery Worse Than Men Expect

Thursday, June 30, 2011

By Kerry Grens

NEW YORK (Reuters Health) - Nearly half of men who undergo surgery to treat prostate cancer find themselves with greater incontinence problems and less sexual function than they had anticipated, according to a new poll.

Before the surgery, some men in the study had expected to get better urinary and sexual function a year after the procedure - a misbelief that the researchers say is out of step with the reality of prostate cancer surgery.

"Those results were surprising," said Dr. Tracey Krupski, an assistant professor of urology at the University of Virginia, and who was not involved in this study.

"Any intervention that you do to a patient, whether it be surgical or radiation, is never going to make the person (function) better than they are at the present time," Krupski said.

According to the American Cancer Society, one out of every six men in the United States will be diagnosed with prostate cancer at some point.

While there is controversy over how to treat low-risk tumors, some of which may never cause any harm if left untreated, surgery and radiation are common options when the disease is more advanced. Every year, tens of thousands of men select surgery for their treatment.

As part of the new survey, 152 men who had part or all of their prostate removed for cancer treatment filled out a questionnaire before surgery. They first had counseling to educate them about the risks of the procedure, which include erectile dysfunction and incontinence.

The questions asked about their expectations of urinary, bowel and sexual function a year after the surgery.

About half of men expected that they would have the same function after surgery as before, and 17 percent of men anticipated better sexual function after the surgery.

One year later, the researchers followed up with the patients and found that just 36 percent of men's expectations for urinary function matched the true

outcomes, and 40 percent of the expectations for sexual function matched reality.

Daniela Wittmann, the sexual health coordinator in the urology department at the University of Michigan and a researcher on the study, said doctors are unable to tell patients specifically how well they are likely to recover their urinary and sexual functions.

"We can only (inform them) in terms of overall statistics, we can't predict for the individual man" how well he will recover, Wittmann said, "which means that, if in doubt, people tend toward being hopeful and optimistic."

One recent study showed that, one year after surgery, only one out of four men recovered his ability to have intercourse. (See Reuters Health report, April 21, 2011.)

In May, another research team found that some degree of incontinence was common, too, although men tended not to be significantly bothered by it. (See Reuters Health report, June 3, 2011.)

Krupski said men's unrealistic expectations can be a double-edged sword. On the one side, optimism is known to help people heal, but on the other side, "it may ultimately lead to disappointment when adjusting to a long term disability."

The inability to get an erection is one of the more common side effects from prostate cancer surgery, though some men are eligible for a "nerve sparing" procedure, which leaves intact the nerves that control erections.

A different study, published in the same issue of the Journal of Urology as Wittmann's, found that when patients were educated about the risks and benefits of nerve sparing, and then given the power to choose the type of procedure, they were likely to make choices similar to their surgeons'.

In this case, the men participated in both a routine, pre-operative counseling session as well as a separate appointment with a surgeon to discuss the risks and benefits of each procedure.

Krupski said additional pre-operative visits would be beneficial, but are generally not covered by insurance plans.

She said that a network of men who have been through the experience and can support new cancer patients might help them understand the realities of life after surgery.

*(Continued on page 7)*

(Continued from page 6)

Wittmann said that involving patients' partners is also vital to successfully regaining sexual relationships.

"Sex is a partnered activity for most people. The partner can be very effective as part of an intimate team recovering from the side effects of this surgery," she told Reuters Health.

The study did not examine whether men would make a different treatment decision given their hindsight after the surgery.

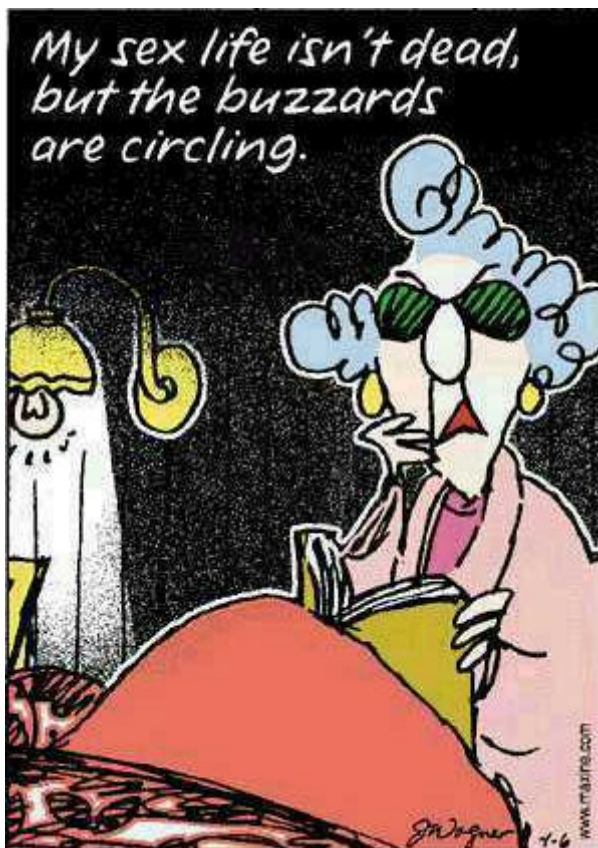
Wittmann said she thinks only a small proportion of men would choose not to have surgery if they fully understood the potential for erectile dysfunction, because there are other cancer-related reasons that drive their decision.

SOURCE: <http://bit.ly/izjfw4>

The Journal of Urology, June 15, 2011.

Reuters Health

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## Diet Plays a Great Part in Prostate Cancer

Prostate cancer is affected by ageing, your ethnic origin and family history. Diet also plays a crucial part in prostate cancer .

In China there are 1.08 cases per 100,000 men, versus 92.39 cases per 100,000 men in North America. It is considered that the western diet accounts for this staggering difference.

In order to keep prostate cancer at bay, you can opt for a diet high in plant-based foods which includes various fruits and veg. They are sources of antioxidants and assist in the prevention of damage to cells which can trigger cancers. It is also advisable to include spices and fresh herbs in your diet.



Red veg like tomatoes and watermelon are good sources of lycopene, with beetroot, berries, grapes and pomegranates being great sources of the antioxidant, anthocyanins. Fruit and veg high in alpha and beta carotenes are excellent to prevent prostate cancer, such as, mangoes, carrots, sweet potato and pumpkin and sweet potatoes. Greens such as cabbage, broccoli, kale and pak choi are great disease fighters as are onions, chives and garlic.

In addition, dietary fibre is important to bolster our immune system and is to be found in whole grains, beans, peas as well as fruit and veg. It is better to lower the amount of animal protein in your diet and replace that with a considerable amount of plant based protein, such as, beans, peas and nuts. Soya is also considered to be a disease lowering food.

A healthy weight is vital to keep prostate cancer at bay as being overweight is related to aggressive prostate cancer and it is important to walk every day. A healthy lifestyle helps keep prostate cancer at bay as well as many other non-communicable diseases.

[diet.co.uk](http://diet.co.uk)

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## Members Forum

All of us experience prostate cancer in different ways. We are faced with decisions regarding various treatment options. Some of us are fortunate to experience the presentation of those options together with the opportunity of time to reflect on the specific treatment options available and to decide upon an approach that is amenable to our personal circumstances.

Hormone therapy is one of the treatment options available. It is a costly approach as each injection has a cost of approximately \$1800.00. We have at our monthly meetings made the members attending aware of the fact that the treatment is available to them at the Prostate Cancer Clinic, at Manitoba Cancer Care at no cost. Should you receive the injections elsewhere it is my understanding that your Doctor provides you with a prescription, you have the prescription filled at your cost, Manitoba Pharmacare regulations as they apply to your personal circumstances will apply and the end result is that you may or may not incur a personal cost for the injections. Your personal health care insurance plan

may cover the cost of the injections. You then return with the prescription and have the injection administered at the Doctor's office.

If you have further information about this approach, the allocation of the cost of the injections or 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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Email - manpros@mts.net

Answering Machine - (204) 989-3433

### 2011 SPEAKERS:

SEPTEMBER AWARENESS EVENING  
HAS BEEN CANCELLED

September 15, 2011 Fran Rosenberg,  
Incontinence Specialist

October 20, 2011 TBA

November 17, 2011 Dr. Ross MacMahon M.D.  
Urologist

December 15, 2011 Christmas Party

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

### M.P.C.S.G. Executive

Brian Sprott - Chair .....	668-6160
Joseph Courchaine - Treasurer.....	257-2602
Len Bueckert - Newsletter .....	782-4086
Tom Boomer - New Member Contact .....	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
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