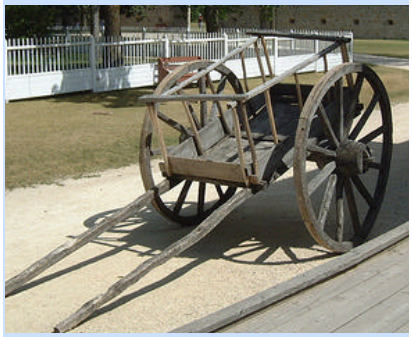
The Manitoba Prostate Cancer Support Group NEWSLETTER

Prostate Cancer Canada Network Winnipeg

Vol. 250 – April 2012



NEXT MEETING: **April 19, 2012**

Dr. Darrel Drachenberg, Urologist -

"New Prostate Cancer Therapeutics "

Location: Seven Oaks General Hospital Main Floor Auditorium - Leila & McPhillips

Time: 7:00 p.m. - 9:00 p.m.

Medical Advisors

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!

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.

Thanks to ABBOTT

The MPCSG would like to acknowledge a recent donation from Abbott Laboratories. Abbott produces Lupron, a drug used for PCa hormone therapy. 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 it possible for us to promote prostate cancer awareness

Abbott
A Promise for Life

Thought for the Day

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

The Manitoba Prostate Cancer Support Group has been providing services for 20 years:
Newsletter – Website - Monthly Meetings - Hospital visits - Presentations
Your **DONATIONS** make it all possible. **We Thank You.**

Donor's Name: _____
Address: _____ Postal code: _____
This gift is in memory/honour of_____ Please send notification to:
Name: _____
Address: _____ Postal code: _____
$25 $50 $75 $100 $250 other_____ Make payment to:
Manitoba Prostate Cancer Support Group 315 – 971 Corydon Ave. Winnipeg, MB R3M 3S7
*A tax deductible receipt will be issued. Charity number: 88907 1882 RR001

Special Thanks

PCCN Winnipeg would like to thank the Eastman ATV Association for making a very generous donation to our Prostate Cancer Support Group – from their 2011 **"Ride of Hope"**. We gratefully acknowledge this contribution as it helps us provide awareness, education and support locally. In addition, Eastman donated an equal amount for research to Prostate Cancer Canada. We salute their efforts and thank all those that contributed!

Pictured below are (L to R) Chris Fox-Decent, Donald Eidse, Dave Lee, President, Eastman ATV, and Brian Sprott, Chair, PCCN Winnipeg. (Picture taken by Sharon Jonas at Enns Bros. Power Sports)

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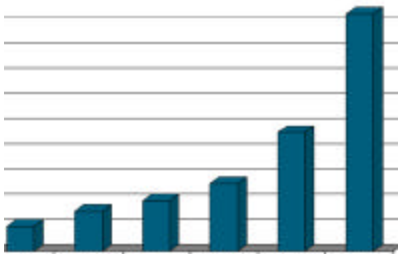
Myriad's Prolaris(R) Test Shown to Significantly Predict Prostate Cancer Outcome in Needle Biopsy Tissue

British Journal of Cancer Study Shows Prolaris Predicts Risk of Death From Prostate Cancer

SALT LAKE CITY, Feb. 24, 2012

(GLOBE NEWSWIRE) -- Myriad Genetics, Inc. (Nasdaq:MYGN) announced today that a study published in the *British Journal of Cancer* demonstrated the prognostic ability of the Company's Prolaris test in needle biopsy material. The study entitled, "Prognostic Value of a Cell Cycle Progression Signature for Prostate Cancer Death in a Conservatively Managed Needle Biopsy Cohort," highlighted the ability of the test to significantly and accurately predict prostate cancer aggressiveness and consequent death from the disease.



"The Prolaris test offers men and healthcare providers a tool to make better-informed treatment decisions based on the aggressiveness of prostate cancer," said Jerry Lanchbury Ph.D., Chief Scientific Officer of Myriad Genetics Inc. "We believe this test will provide critical information needed to avoid unnecessary and life altering morbidities associated with treating the disease in men who have a less aggressive form of prostate cancer."

Researchers at the Queen Mary, University of London, and Myriad, analyzed the Prolaris Score of 349 prostate cancer patients who had been diagnosed by needle biopsy and managed conservatively. The authors concluded that the Prolaris test was the most significant predictor of disease aggressiveness and death, and may be a valuable tool in managing prostate cancer. Specifically, they found that the 81 percent of prostate cancer patients with lower Prolaris Scores when left untreated had an excellent five-year survival rate of 93 percent. Unfortunately, the probability of death from untreated prostate cancer increased significantly in men with high Prolaris Scores. In the 19 percent of prostate cancer patients with higher Prolaris Scores, the five-year survival rate was only 63 percent and the ten-year survival rate was 44 percent.

In discussing the results of the study, the authors highlighted the unmet clinical need in this field, namely, the inability of current clinical parameters to distinguish men with a fast-growing form of prostate cancer who are appropriate for aggressive treatment, such as radical prostatectomy or radiation, from those with an indolent or less aggressive form who are candidates for active surveillance. The Prolaris test was developed to provide a solution for this significant unmet clinical need in an effort to provide patients and physicians with the ability to better predict disease outcome, thereby optimizing treatment and decision making. With this fourth clinical study, the Prolaris test has been shown, in a total of over 1450 patients, to consistently be a highly prognostic tool to assess the aggressiveness of a man's prostate cancer.

Cancer Research UK was involved in funding this research.

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New Diagnostic Test to Diagnose Prostate Cancer

Prostate Cancer Foundation February 15, 2012

The US Food and Drug Administration (FDA) approved today a urine-based molecular diagnostic test that aids clinical decision-making for repeat prostate biopsies in men who have had a previous negative biopsy. This new test called the PROGENSA® PCA3 (Prostate Cancer Antigen 3) assay, tests for levels of PCA3 in the urine of men immediately after a Digital Rectal Examination. This test will potentially aid faster and more efficient diagnosis of prostate cancer. PCA3, the compound that this test checks for, is a gene that is normally expressed only in the human prostate tissue and is highly overexpressed in prostate cancer. The product of this gene, a noncoding RNA is excreted in the urine of patients with prostate abnormalities.

The current standard for prostate cancer screening employs the Prostate Specific Antigen (PSA) test which is prostate-specific but not highly cancer-specific. In contrast, PCA3 testing is highly cancer-specific, with better positive and negative predictive values compared to PSA testing.

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CancerCare Manitoba Foundation is delighted to announce A *Gold-Plated Evening*, the sixth bi-annual dinner in support of Prostate Cancer Research and Treatment, will be held on Monday, May 14th, 2012 at the Winnipeg Convention Centre.

This evening, filled with fine dining and good company, features special guest speaker, **John Furlong**. Mr. Furlong, the CEO of the Vancouver Olympic Committee, was the leader behind the team that organized and delivered the Vancouver 2010 Olympic and Paralympic Winter Games - hailed by the International Olympic Committee as the best ever in the world. He will share an extra-ordinary story of visionary leadership, deep integrity, love of country and the ability to dream boldly.

Funds raised will be invested in CancerCare Manitoba's Prostate Tumour Bank. Thanks to ongoing support through the Gold-Plated Evening, the bank has become a critical factor in the control, early detection, treatment and improving long-term outcomes for all Manitoba men living with prostate cancer.

For further information please contact our office at 204-787-1800 or special.events@cancercare.mb.ca

Member's Comment

Manitoba Prostate Cancer Support Group: just what the doctor ordered

By Jim Anderson

I've been a member of the Manitoba Prostate Cancer Support Group in Winnipeg for almost a year— long enough to know that for me, it's just what the doctor ordered (so to speak). Our support group's monthly meetings, attended usually by 40 to 50 patients and their wives and partners, seemed to work for me from the very beginning. The fellowship and support I felt from the first meeting was exactly what I needed at the time. I was still reeling from the news I indeed have cancer, and I felt one of the best ways to understand the disease was to get to know other patients who had been coping with it, and those who had been treated and cured.

The support group met my expectations and then some. I discovered it has two main functions— member discussion and formal talks by medical experts.

I found that the monthly open discussion among members, moderated by the group's affable and effective President, Brian Sprott, were remarkably frank, informal and informative. Some members of the group had more or less the same condition and prognosis as me, and if I needed to learn more about their treatment and their hopes for the future, I just had to speak to them during the break in the meeting, or give them a call afterward. This informal information exchange is supplemented by a monthly newsletter containing articles on some of the latest advances in prostate cancer care.

I found the group's second principal function to be equally helpful. Each month a medical specialist is invited to make a power point presentation in his or her area of expertise. As a result, I've learned useful and practical information from a number of local urologists, oncologists, radiologists, pathologists and others medical professionals.

No need for an appointment, no rushed consultation, nearly an hour to absorb the expertise of a hand-picked physician or other medical practitioner and a question period to boot. And all this conducted in a no-stress atmosphere of a meeting called at the patient group's behest, and at the patient group's appointed time and place. Sometimes, the presentation I listen to is a power point presentation and is given by a member of my medical team whom I meet for consultation or treatment a week or a month down the road. Hard to beat that kind of access and information exchange.

Take our last meeting but one, back in February. The meeting began with a one-hour information session among members. Everyone who wanted to comment on his treatment was heard, members asked each other questions, spouses joined in, information was swapped, laughter, fellowship. I found myself feeling proud of this group, in which I was a newcomer just learning the ropes.

I'd been told by other members that our President, Brian, does not so much chair a meeting as orchestrate it. He is on his game this evening, encouraging this member to comment, asking that member a question, answering a question from another. He's clearly a charismatic and caring fellow who seems to know all members personally. He routinely calls up every newcomer and discusses that patient's journey through the medical maze. As a result, he has an encyclopedic knowledge of the membership. His wife, June, is equally engaged with the members.

Our speaker for the evening, Heather Wiens, is the Patient Representative in the area of Patient Navigation in Manitoba Cancer Care. Her talk focuses on the role she and her colleague play in assisting cancer patients to navigate the system, overcome problems and gather needed information. Her delivery is energetic and informed and I can tell it's well received. She had sat in on our open discussion period earlier, when I noticed her taking notes. I wonder if she's noted the unwritten code of cordiality and professionalism that prevails at our meetings— you could describe it like this:

> *We're all on the same team, whether we're a patient or a medical professional, and any differences we have can be overcome, for our common goal is to control, and if possible cure, the prostate cancer that concerns us all.*

Recently I learned that not all cities of the size of Winnipeg have such a healthy (I use the term advisedly) support group open to prostate cancer patients. I'm told we have an unusually high membership for the size of our city, and unlike some support groups that focus on fundraising, we emphasize patient participation and regular and detailed exchanges with doctors. Not to mention a monthly newsletter that some support groups in some other provinces send out to their members.

After almost a full year observing the Manitoba Prostate Cancer Support Group, I think I now understand just what how it functions for me and patients like me, and how fortunate I am that men and women in its ranks have worked so hard over the years to make it such an effective organization.

If you're a member or prospective member or a partner of either, I hope you come to our gatherings each month and contribute with your presence, your questions and your comments.

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New Prostate Cancer Treatment Drugs Could Pack Double Punch

Two new drugs, Ra-223 and MDV3100, deliver improved survival rates and bone health for men with metastatic castration-resistant prostate cancer.

NEW YORK, Feb. 17, 2012 /PRNewswire via COMTEX/ -- The arsenal of prostate cancer treatments for men with advanced prostate cancer may soon be strengthened as the FDA prioritizes the review of both Ra-223 and MDV3100 for treating metastatic castration-resistant prostate cancer (CRPC). Based on positive, independent research of each drug, better survival rates and improved bone health for patients with late-stage prostate cancer may be within reach.
Dr. David Samadi is Vice Chairman, Department of Urology, and Chief of Robotics and Minimally Invasive Surgery at The Mount Sinai Medical Center and a leading robotic surgery expert and PSA test advocate. He commended the efforts behind these advancements by saying, "I'm encouraged to see advanced prostate cancer treatment drugs that may not only extend life, but do so with improved patient health. That's the key - prolonging life with quality." Previous drug therapies, such as Provenge or Zytiga, have proven to extend survival rates, though do not offer additional benefits to the patient.

The drug Radium-223 chloride, also known as Ra-223 or Alpharadin, delivers radiation to the bone and the prostate cancer tumor. In trial, the drug improved patient survival by an average of three months. In addition, patients undergoing Ra-223 drug therapy experienced delayed bone damage or need for surgery or radiation by more than five months.
Medivation, or MDV3100, is an androgen inhibitor that prevents prostate cancer tumor growth by binding with cancer cell receptors. Patient trials with MDV3100 proved improved survival rates by nearly five months. Further, the drug caused tumor shrinkage in close to 30 percent of men, a 50 percent decline in PSA level, and an overall reduction in risk of death by 37 percent.

Improved survival rates of three to five months may sound minimal, but these drugs each present a significant opportunity for men with a disease that, in its advanced stages, can progress very quickly. What's more, experts believe using these drug therapies in a layered approach could provide even greater impact on survival rates for men with metastatic castration-resistant prostate cancers over the next few years.

"In recent months, we've seen the launch of various drug therapies targeting metastatic prostate cancer," said Dr. Samadi, "but the combined survival benefits, tumor shrinkage, and bone improvements with these drugs could lead to a double punch approach. Unlocking the power of how they might work together could mean longer and better lives for these patients." Further research will be conducted to evaluate the extent to which combining or sequencing Ra-223 and MDV3100 would provide additional survival and health benefits.

Prostate cancer is believed to be a hormone-fed disease that thrives in the presence of testosterone. Castration-resistant prostate cancer is named for its resistance to testosterone-lowering treatment therapies.

As a robotic prostatectomy expert, Dr. Samadi addressed the limited benefits of late-stage advancements by saying, "The more we do on the front end of this disease - improving diagnostic tools, getting behind the PSA test for early diagnosis, strengthening treatment choices - the less need there would be for costly drugs that offer relatively short-term returns."

Based on both drugs' exemplary trial results and limited side effects, experts are hopeful that Ra-223 and MDV3100 will become available for FDA-approved patient use this year. "Men with late-stage prostate cancer deserve every opportunity to extend their time with loved ones. But we can do better; we have the resources to diagnose prostate cancer early. With robotic prostatectomy surgery and other treatments we can address the cancer in time for a full recovery and a long, healthy life," Dr. Samadi concluded.

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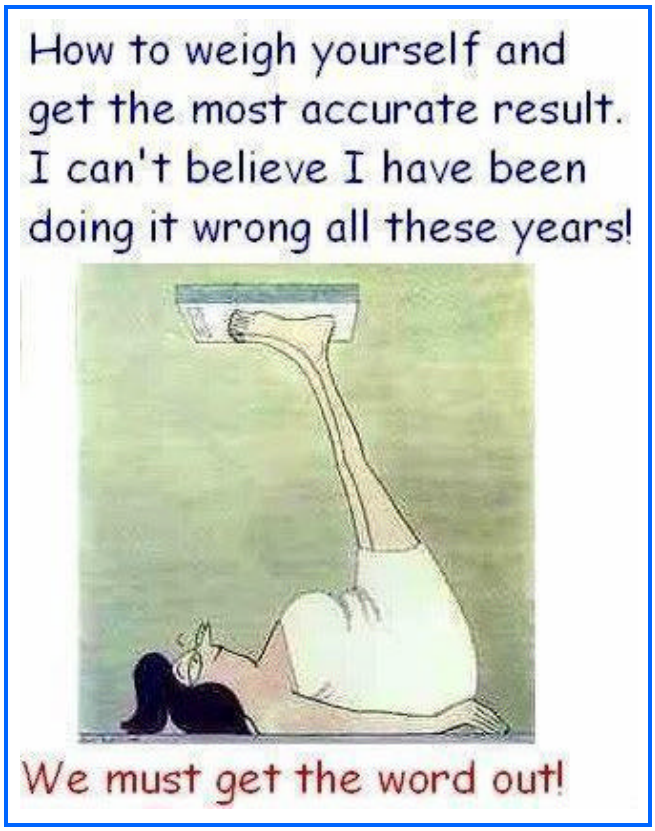

PCa: New Treatments

The Next Decade Should Do For Prostate Cancer What The Past One Has Done For Breast Cancer

Mar 10th 2012 PARIS
from the print edition of *The Economist*

MOST cancers are equal-opportunity killers. Some, though, are perforce sex-specific. Breast cancer is rare in men. And prostate cancer is obviously absent from women. Recent years have seen a plethora of new drugs—starting in 1998 with Herceptin—for treating breast tumours that are threatening to get out of control. No such breakthrough has happened with prostate cancer. Though easily treated if caught early, late-stage prostate cancer is serious and often fatal. But that may be about to change.

Better understanding of the biology of the disease, and particularly of the role of testosterone in promoting it, has stimulated a new era of drug development, reminiscent of the revolution that ushered in Herceptin. These novel treatments, which are now undergoing clinical trials, were one of the main topics of conversation at the Congress of the European Association of Urology, which took place in Paris on February 24th-28th.

Some of the therapies discussed remain conceptual almost to the point of fantasy: a genetically engineered virus that could destroy prostate-cancer cells from within, for example. Several, though, are already available, or are just about to be.

Cabazitaxel, made by Sanofi, a French firm, is one. It is a relative of taxol, a drug used to treat breast and ovarian cancer. It works by preventing the formation of structures called microtubules, which pull the chromosomes apart in dividing cells (such as cancer cells). It was approved for use in 2010 after trials showed that it could prolong the lives of men with late-stage disease. A second drug, abiraterone, made by Johnson & Johnson, an American company, was approved in 2011 after a trial was stopped because it had been so successful that the organisers deemed it unfair on those in the control group that they were not receiving the medicine too.

Abiraterone works by interfering with an enzyme involved in the production of testosterone. Crucially, it does so in all testosterone-producing tissues, particularly including the adrenal glands, not just the testes. A common change that occurs when prostate cells turn cancerous is that they become extremely sensitive to testosterone—so much so that late-stage prostate cancer is often referred to as being "castration-resistant", because even that drastic testosterone-reducing treatment cannot halt it. But abiraterone can.

Testosterone poisoning

Cutting off the testosterone supply is not, however, the only approach possible. MDV3100, made by Astellas, a Japanese firm, and Medivation, an American one, reduces the cancer's sensitivity to what testosterone is already there. This drug, not yet approved for prescription, works by gumming up testosterone receptors on the cancer cells' surfaces, so they cannot react to the hormone. It also cuts the lines of communication between any receptors which are still activated and the cell nucleus, so that the nucleus cannot take instructions from the hormone.

A fourth drug, alpharadin, developed by Algeta, a Norwegian firm, has a completely different mechanism of action. It works not on the primary cancer but on one of its most dangerous consequences, secondary bone tumours. Ironically, its active ingredient is radium, a substance more usually thought of as a cause of cancer than as a treatment. But one reason radium is dangerous is that, as a glance at the periodic table will show, it is chemically similar to calcium, a principal ingredient of bone. It therefore gets absorbed by bones if ingested, rather than being excreted.

(Continued on page 8)

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Winnipeg R3M 3S7

Publications Agreement
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(Continued from page 7)

Algeta's researchers have exploited this to produce a drug that is taken up by bones. In someone who already has cancer that is a good thing, because the radiation produced kills the cancer cells, and the drug gets concentrated where it is needed most.

It sounds desperate, and it is. But it seems to work. A trial at the Royal Marsden Hospital, in London, was stopped last year for the same reasons that the abiraterone trial was stopped: the treatment was too successful to deny it to the control group. Alpharadin is now, therefore, awaiting approval by the authorities.

The final proven approach to castration-resistant prostate cancer is a vaccine. This is not a prevention, in the way that most vaccines are, but a treatment for existing disease. Sipuleucel-T, as the vaccine in question is known, is made by Dendreon, an American firm. The starting point is a culture of human dendritic cells. These are part of the immune system and, if suitably treated with a substance called a fusion protein, can be used to make prostate-cancer cells vulnerable to immune attack.

Sipuleucel-T's main drawback is that each treatment has to be handcrafted to the individual receiving it, using dendritic cells from his own body. This is hugely expensive—almost $100,000 a course. That is a sum which insurance companies and government health services might understandably be reluctant to fork out.

Cost, indeed, is a consideration for others among the new anti-prostate-cancer treatments. Britain's National Institute for Health and Clinical Excellence, which assesses the cost-effectiveness of new medicines that might be paid for by the country's National Health Service, reckons, for example, that abiraterone is too expensive to justify the extra months of life it brings. But Herceptin, too, was subject to scrutiny about its cost at the beginning. Now Herceptin treatment is routine, and many women's lives are the better (and longer) for it. With luck, in a few years' time, men will be able to say the same.

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Email - manpros@mts.net

Answering Machine - (204) 989-3433

SPEAKERS:

April 19, 2012
Dr. Darrel Drachenberg, Urologist -
"New Prostate Cancer Therapeutics "

May 17, 2012
Pat Trozzo, Pharmacist
CancerCare Manitoba

June 21, 2012
Jim Slater, CEO
Diagnostic Services of Manitoba

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
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