THE MANITOBA PROSTATE CANCER SUPPORT GROUP NEWSLETTER

Vol. 254 August 2012

What to Expect from a Prostate Biopsy

If you're facing a prostate biopsy, it's natural to be apprehensive. Here's a realistic guide to this commonly-performed procedure.

An abnormal prostate-specific antigen (PSA) test provides an important clue to your prostate health. But it cannot determine with certainty whether you have prostate cancer. Until more sophisticated tests are developed, a biopsy of the prostate -- though not perfect - is the best way to find out whether a high PSA level indicates cancer.

About 800,000 prostate biopsies are performed in the U.S. each year. Known formally as transrectal ultrasound-guided biopsy, prostate biopsy is an in-office procedure that takes about 15 minutes to perform. Despite its reputation as a very painful procedure, a prostate biopsy can be performed with minimal to moderate pain through the use of lidocaine, a local anesthetic. Lidocaine gel can be applied inside the rectum, or the anesthetic can be injected through the rectal wall to numb the nerves around the prostate. Some urologists also may give a mild sedative before the procedure. Good pain control not only keeps you comfortable during the prostate biopsy, but it also helps ensure that the proper number of samples can be taken.

You will be advised to discontinue blood-thinning medications like aspirin, Coumadin (warfarin), or Plavix (clopidogrel) seven-10 days before the prostate biopsy to help prevent excess bleeding after the procedure. If you take vitamin E, fish oil, ginkgo biloba or other dietary supplements with blood-thinning effects, be sure to let your doctor know. He or she may recommend that you stop taking those as well.

Because the prostate biopsy usually is taken through the wall of the rectum,

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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!

NEXT MEETING:
August 16, 2012

Ed Johner
"My Mayo Clinic Experience"

Location: Seven Oaks General Hospital
Leila & McPhillips
Past Main Floor Auditorium to the Wellness Centre
(Follow the signs)

Time: 7:00 PM to 9:00 PM

The Manitoba Prostate Cancer Support Group does not recommend treatment modalities, medications, or physicians.

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an enema is required the day of the procedure to clean out the intestines and reduce the risk of fecal contamination and infection. As an extra precaution against infection, most doctors also prescribe an antibiotic to be taken before and after the prostate biopsy.

During the prostate biopsy, you will be asked to lie on your side, with your knees pulled toward your chest. A thin ultrasound probe is inserted into the rectum. The probe emits sound waves that are converted into video images of the prostate. These images are used to guide the lidocaine injection (if one is used) and to position the biopsy device. The spring-loaded biopsy "gun," with its hollow, ultra-thin needle, is mounted on the ultrasound probe. The biopsy device is directed at varied areas of the prostate, removing a thin (1/16 of an inch) column of prostate tissue (called a core) with each split-second firing through the rectal wall. At least 10-12 cores should be taken and sent to the pathologist for evaluation.

You may experience minor rectal bleeding, or see blood in your stool or urine for a few days. Small amounts of blood in your semen may give it a pinkish tinge for several weeks.

Bear in mind that infection is rare but serious. Call your doctor if you experience any symptoms of infection: fever, painful urination or discharge from the penis. You also should call your doctor if you experience heavy or prolonged bleeding; significant pain, swelling or redness near the biopsied area; or difficulty in urinating.

Posted in Prostate Disorders on November 14, 2006

Reviewed June 2011
Johns Hopkins Health Alert

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Don't Rush Into A Prostate Operation... It Could Be The Worst Thing You Do.

By DR. CHRIS PARKER

PUBLISHED: 21:04 GMT, 23 June 2012 | **UPDATED:** 21:04 GMT, 23 June 2012

A diagnosis of prostate cancer is shocking and most often quite unexpected. The thought of a tumour growing inside you is sickening.

Almost immediately, men face a decision about treatment – and the first impulse is, for many, to want it cut out. As an oncologist with more than 15 years specialising in the condition, you might expect me to agree.

But I urge patients not to be so hasty. Mounting evidence shows that surgery is not always the best treatment.

Almost all men who have their prostate removed will suffer complications – whether that's just slight incontinence, or the permanent erectile dysfunction experienced by around one in two.
If this were a guaranteed lifesaving operation, the risk might be worth it, but for many men, we now know their cancer is so slow-growing that it will never spread and there are good alternative options.

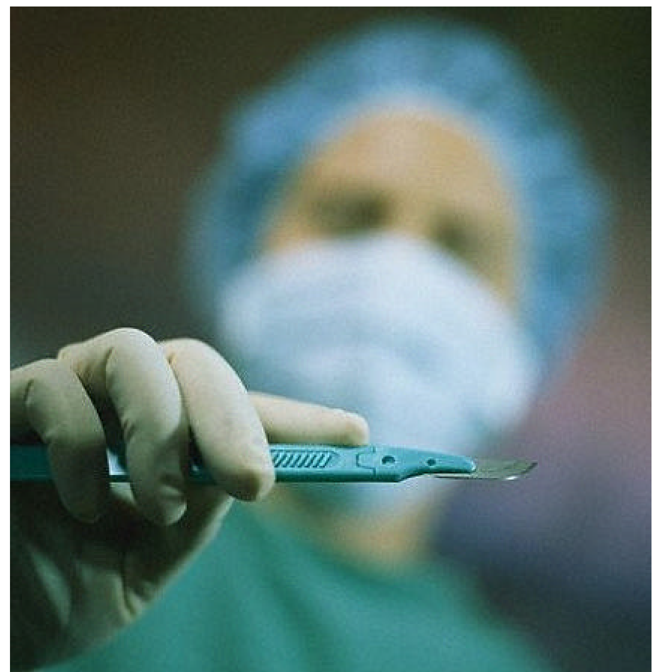
SURGERY DOES NOT IMPROVE SURVIVAL

The Prostate Intervention Versus Observation Trial (PIVOT) that began in 1994 included 731 men with an average age of 68 who had been diagnosed with the cancer.

Half of the men underwent surgery to remove the prostate – known as 'radical prostatectomy' – the others did 'watchful waiting', which means they had no immediate treatment.

Instead, they received hormone therapy if symptoms, including difficulty urinating, started to develop. The results showed that on average those who underwent surgery were no more likely to survive than the watchful waiting group.

Just seven per cent in the trial died of prostate cancer, compared with 41 per cent who died of unrelated conditions.



So, who should have surgery? Famous men who have faced this diagnosis – Hollywood actor Robert De Niro and

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South Africa's Nelson Mandela spring to mind – have opted for an operation.

But not all of the 37,000 British men diagnosed each year should do likewise.

BUT THERE ARE EXCEPTIONS

Men with prostate cancer frequently have no symptoms at all. The diagnosis is often made following prostate-specific antigen (PSA) testing. This checks for a protein that the prostate produces in larger quantities when a tumour is present.

Men will also undergo a digital rectal examination to feel if the surface of the prostate has become lumpy.

If the PSA levels are high or a change has occurred to the surface of the prostate, a biopsy is performed by taking tissue from the prostate with a needle.

The cancerous cells are examined under the microscope and a figure known as the Gleason score is calculated – the lower the score, the less likely the cancer will spread.

If results come back with a PSA score above 20 or a Gleason score between 8 and 10, it is usually advisable to have immediate treatment.

One thing PIVOT has highlighted is how much surgery appears to help those with high risk cancer.

ACTIVE SURVEILLANCE MAY BE THE BEST OPTION

In those diagnosed with a PSA score lower than 10 and a Gleason score of 6, I would not normally advise surgery. Instead, I would usually recommend active surveillance – which is a halfway house between watchful waiting and surgery.

The patient undergoes regular testing – MRI scans, blood tests and biopsies – to monitor the cancer. If there is evidence the cancer is growing, treatment options are discussed – this does not necessarily mean surgery.

Radiotherapy, brachytherapy (internal radiotherapy, where small radioactive metal seeds are placed within the tumour) and ultrasound treatment can be considered instead.

Watchful waiting is an option for those who are very elderly or who have other serious medical problems.

THE PSYCHOLOGICAL HURDLE

It is important that a man who has been diagnosed with low-risk prostate cancer overcomes the psychological hurdle that he has a cancer inside him.

Indeed, many specialists believe a Gleason 6 prostate tumour should not be termed as a 'cancer' at all because it differs enormously from the aggressive types – such as brain tumours – that spring to mind when the word 'cancer' is used.

Whether you suffer from low or high-risk cancer, there should be regular dialogue between your doctor, oncologist, urologist and yourself.

Don't be overwhelmed by the mass of literature you are handed about the condition.

Take time to think over the options available to you as removing the prostate is a life-changing course of action.

BE PROACTIVE BEFORE MAKING A DECISION

Ensure you check how experienced your surgeon is – they should be doing more than 50 prostate operations a year and you have every right to ask them if this is the case.

Something else that the study highlights is that too many men are being diagnosed with the cancer in the first place.

If low risk prostate cancer does not need any treatment then it does not need to be diagnosed either.

To my mind, when it comes to low risk prostate cancer ignorance really is bliss.

One Government-funded trial, the Prostate MRI Imaging Study (PROMIS), is currently looking into how we can better use MRI scans to improve the diagnosis of prostate cancer.

In years to come, men may have a prostate MRI scan in much the same way that women have mammograms.

But perhaps the most important fact to be taken away from this recent trial is that if you are diagnosed with prostate cancer, many options are available to you.

Radical prostatectomy is not the only avenue you must explore and your quality of life may not need to be dramatically reduced.

Thought for the Day

"Age is an issue of mind over matter. If you don't mind, it doesn't matter."

- Mark Twain

Safe to Skip Radiation for Prostate Cancer?

By Alison McCook

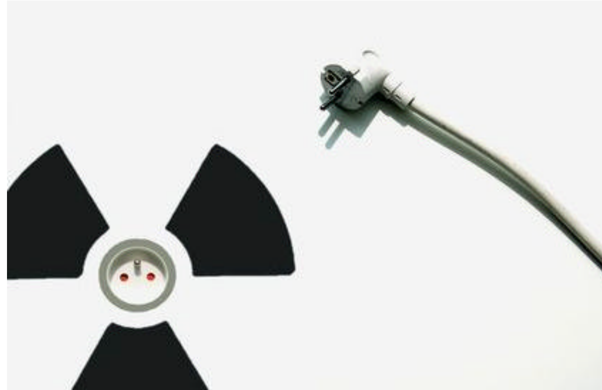
(Reuters Health) - A review of recent studies comparing different radiation treatments for prostate cancer reveals no clear picture of what works best for the majority of men with the disease.

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.

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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.

SOURCE: bit.ly/kFWu5C Annals of Internal Medicine, online June 6, 2011.

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Side Effects Persist After Prostate Cancer Treatment

By Amy Norton

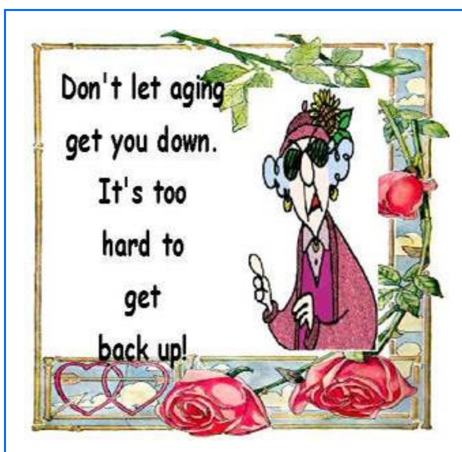
(Reuters Health) - Men who are treated for prostate cancer may still suffer side effects from treatment up to a decade later, a new study finds.

Researchers found that more than 500 men with cancer - including cancers caught through regular screening - ended up with poorer sexual function and more bladder control problems for up to 10 years afterward than men with no cancer diagnosis.

That might sound like a good tradeoff for having your cancer found and treated.

But the issue is complicated. Prostate cancer is often slow-growing and may never get to the point that it threatens a man's life.

And a number of studies have found no proof that using PSA blood tests to screen men for prostate cancer actually saves lives.



Because of that the U.S. Preventive Services Task Force (USPSTF) - an expert panel with federal support - advises against routine prostate cancer screening.

With the benefits of screening in doubt, that makes the question of treatment side effects even more important.

"The reality is that right now, the screening decision and the treatment decision have to be made on an individual basis," said Kathryn L. Taylor, of the Lombardi Comprehensive Cancer Center at Georgetown University in Washington, D.C.

"This study doesn't answer those questions for individuals," said Taylor, who led the research.

But she said the findings do give men more information on the long-term side effects of prostate cancer treatment - whether it's surgery, radiation or hormone therapy.

Up to 10 years after treatment, more than 95 percent of men had some degree of sexual dysfunction, Taylor's team found. And about half had urinary symptoms.

Past studies have found such lingering side effects, too. But they have been shorter-term - following men for as far as five years. And they've left some question as to whether the sexual and urinary problems could just be a product of aging, rather than prostate cancer treatment, Taylor explained.

These latest findings, reported in the Journal of Clinical Oncology, suggest it's not simply the aging process that's to blame.

That's because Taylor's team had data on men who'd taken part in a large clinical trial on prostate cancer screening.

The researchers were able to compare 269 men who'd had prostate cancer detected and treated after screening with 260 men who'd also been screened but remained cancer-free.

And when they accounted for the men's age, overall health and other factors, the group treated for cancer had worse sexual and urinary function up to 10 years later.

The same pattern held up among men in the trial arms who weren't screened for prostate cancer and did or didn't get diagnosed and treated.

TREATMENT OPTIONS

That all suggests the blame lies with prostate cancer treatment, or possibly the cancer itself to some degree, according to Taylor.

"The bottom line is that the (prostate cancer) group was worse off," Taylor said. And that's something men should have in mind when deciding on prostate cancer screening, she and her colleagues say.

Once prostate cancer is detected, men

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have another big decision. If the cancer is early-stage, they can choose to put off treatment and instead have the cancer monitored to see if it's progressing - what doctors call "active surveillance."

Or they can go for treatment, with surgery being the usual option for earlier cancer.

"We like to tell men to think of it as one big question," Taylor said.

That is, don't think of the screening decision in isolation, she explained. Men should remember that if an early cancer is caught, they'll have to decide on treatment, Taylor said.

Active surveillance, by definition, is not treatment - but it does mean regular PSA blood tests and periodic biopsies.
The USPSTF recommendation against routine prostate cancer screening does not preclude men from asking for it, or doctors from offering.

And Taylor pointed out that studies look at population-wide effects. Even if PSA screening has not cut overall death rates from prostate cancer, some men may benefit.

She suggested men "get educated" about prostate cancer and make a screening decision based on a careful discussion with their doctors.

In the U.S., just over 28,000 men will die of prostate cancer this year, according to the American Cancer Society. But close to 242,000 new cases will be diagnosed, many of which will be early cancers.

According to the National Cancer Institute, about half of all U.S. men diagnosed with prostate cancer in 2009 fell into the "low-risk" category - meaning their cancer was unlikely to progress.

SOURCE: bit.ly/MU6YjL Journal of Clinical Oncology, online June 25, 2012.

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Tea Drinking 'Raises Cancer Risk'

MSN UK 19 June 2012 pa.press.net

Drinking large amounts of tea could increase the risk of prostate cancer, research has shown.

Scientists found that more than seven cups a day raised the chances of men developing the disease by 50%.

But whether the link is causal or due to coincidence is still unknown.

Study leader Dr Kashif Shafique, from the Institute of Health and Wellbeing at the University of Glasgow said: "Most previous research has shown either no relationship with prostate cancer for black tea or some preventive effect of green tea.

"We don't know whether tea itself is a risk factor or if tea drinkers are generally healthier and live to an older age when prostate cancer is more common anyway."

The Scottish researchers tracked the health of more than 6,000 men aged between 21 and 75, over a period of 37 years. Participants provided information about their tea, coffee and alcohol consumption, smoking habits and general health.

Just under a quarter of the men were heavy tea drinkers. Of these, 6.4% developed prostate cancer during the course of the study. Those drinking more than seven cups of tea a day were 50% more at risk than those who drank no tea or up to three cups.

The findings are reported in the journal Nutrition and Cancer.
Dr Shafique added: "We found that heavy tea drinkers were more likely not to be overweight, be non-alcohol drinkers and have healthy cholesterol levels. However, we did adjust for these differences in our analysis and still found that men who drank the most tea were at greater risk of prostate cancer."

The researchers concluded: "There has been much interest in the preventive effects of green tea on prostate cancer risk; however, we found a harmful effect of black tea on prostate cancer risk. The association between tea intake and prostate cancer should be investigated in prospective epidemiological studies in relation to different compositions of tea."

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IN MEMORY

JOSEPH COURCHAINE passed away suddenly July 11, 2012. Joseph has been our treasurer since October, 2001. His contributions to our Support Group will be missed. No longer will we be able to turn to the back of the room to ask Joseph for clarification.
No longer will his personal experience, knowledge or insight be "at the ready" for the benefit of the Support Group. Joseph met with our executive regularly providing direction, advice and maintained the financial records during all these years.
We mourn his passing and express our deepest sympathy to his wife, Laurette, and family.

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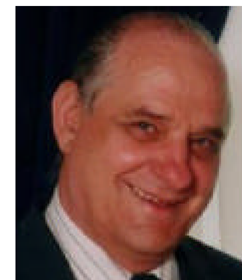
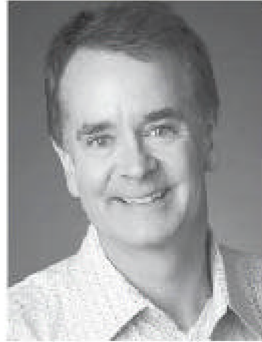


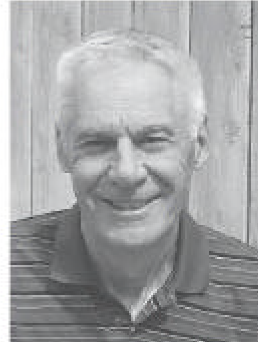
Manitoba Prostate Cancer Support Group

presents



Dr. Jeff Sisler
Family Physician

Dr. Graham Glezerson
Urologist



Brian Sprott
Chair

PROSTATE HEALTH Awareness Evening

Thursday, September 20, 2012 | 7:00pm to 9:00pm

Cohen Auditorium - St. Boniface Hospital Research Centre

351 Tache Avenue

FREE ADMISSION

Thanks to our sponsors:

Manitoba Prostate Cancer Support Group

www.manpros.org Phone 989-3433

Return undeliverable Canadian addresses to
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Special Thanks

PCCN Winnipeg would like to acknowledge a recent donation from AstraZeneca.
AstraZeneca produces Casodex and Zolodex – 2 drugs used in treatment for prostate cancer.
We are grateful they have chosen to assist us with our work this year.

Email - manpros@mts.net Answering Machine - (204) 989-3433

Help us lower our costs ~
Receive this newsletter by email. Please notify us and we'll make the changes ~ Thank-you.

SPEAKERS:

August 16, 2012
Ed Johner
My Mayo Clinic Experience

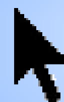
September 20, 2012
Prostate Health Awareness Evening
Cohen Auditorium
St. Boniface Hospital Research Center
351 Tache Avenue, 7 - 9 p.m.

No meeting at Seven Oaks Hospital on Sept. 20, 2012

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
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 - Outreach 326-1477
Laurie Courchaine - Member at Large.......... 257-2602
Jim Anderson - Member at Large 287-2397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