The Manitoba Prostate Cancer Support Group NEWSLETTER

Prostate Cancer Canada Network Winnipeg

Vol. 247 – JANUARY 2012

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Family Practitioner

Thanks!

NEXT MEETING: Thursday, January 19, 2012
Dr. Harvey Quon, Radiation Oncologist
"The Changing Scene in Radiotherapy Delivery"
Location: Seven Oaks General Hospital
Main Floor Auditorium - Leila & McPhillips
Time: 7:00 p.m. - 9:00 p.m.

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.

CANCER FACTS

- In Manitoba, an estimated 710 men will be diagnosed with prostate cancer this year and an estimated 160 men will die of prostate cancer.
- Prostate cancer is the most common type of cancer in men.
- In Canada, an estimated 25,500 men will be diagnosed with prostate cancer this year and an estimated 4,100 men will die of the disease.

Source: Canadian Cancer Society 2011

Board members, Len Bueckert and Jim Leddy, passing out PCa information at the Winnipeg Re-Fit Centre Health Fair. October 14, 2011.

Thought for the Day

Why do we sing "Take me out to the ball game" when we are already there?

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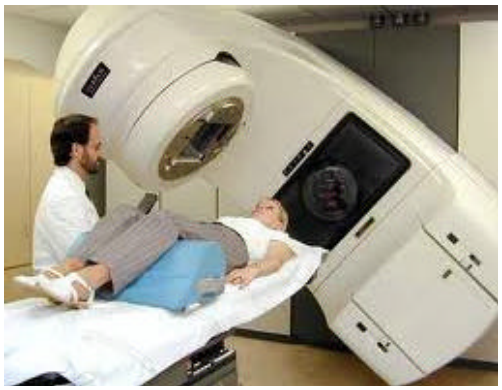
*A tax deductible receipt will be issued. Charity number: 88907 1882 RR001

What You Should Know About External Beam Radiation Therapy



External beam radiation therapy (EBRT) for prostate cancer involves aiming beams of radiation at the prostate from outside the body. External beam radiation therapy is a treatment option for men with localized prostate cancer (stage T1 and T2) or locally advanced disease (stage T3). Although no randomized trial has directly compared radical prostatectomy and external beam radiation therapy, available evidence suggests that for patients with cancer confined to the prostate, either approach offers a good chance of being cancer free five to 10 years after treatment.

Radiation oncologists have made a number of refinements in external beam radiation therapy in an attempt to increase cure rates and reduce the risk of complications. These refinements include three-dimensional conformal radiation therapy (3DCRT), intensity-modulated radiation therapy (IMRT) and proton-beam radiation.

· **3DCRT.** In 3DCRT, the radiation oncologist relies on dozens of CT scans to target the radiation precisely to the tumor. This allows higher doses of radiation to be delivered (potentially increasing the treatment's effectiveness) and causes less damage to healthy tissue (potentially reducing the severity of treatment side effects).

· **IMRT.** IMRT is a refinement of 3DCRT. Relying on computer software to determine the orientation, number and intensity of the radiation beams, IMRT is even more precise than 3DCRT.

· **Proton-beam radiation therapy.** Proton-beam radiation therapy is delivered in the same manner as 3DCRT but uses positively charged subatomic particles (protons) instead of X-rays to kill cancer cells. The potential advantage of the technique is that protons cause minimal damage to the tissues they pass through on their way to the cancer cells. The hope is that proton-beam radiation therapy will allow higher doses of radiation, with fewer side effects.

Complications. The complications of external beam radiation therapy are primarily adverse effects on the urinary tract and bowel. However, these effects usually disappear days to weeks after treatment is completed. The risk of long-term urinary complications, such as blood in the urine, bladder problems or narrowing of the urethra, is about 8 percent. The risk of long-term rectal complications, such as rectal inflammation (proctitis), bleeding, ulceration, narrowing and chronic diarrhea, is about 3 percent.

With external beam radiation therapy, the risk of erectile dysfunction becomes more likely with time. In an analysis from the Prostate Cancer Outcomes study, 63 percent of men treated with radiotherapy had erectile dysfunction five years after the procedure. Younger men and those with normal sexual function before external beam radiation therapy are the most likely to maintain potency, just as with surgery.

Source: www.johnshopkinshealthalerts.com - October 2011

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If PSA Test Saves Lives, Averages Don't Matter

For men older than 50, a simple blood test to screen for prostate cancer is as much a part of annual physicals as weigh-ins and stethoscopes. The PSA test is painless, inexpensive and the only way to detect the disease — the most common male cancer — before symptoms turn up. Yet an influential commission charged with assessing medical treatments is recommending that routine screening be ended, to the furor of doctors, including the American Urological Assoc.

The commission, the U.S. Preventive Services Task Force, doesn't dispute that the test detects cancer. Instead, it argues, with a formidable arsenal of data, that the test leads to widespread over-treatment, which outweighs the benefits of early detection. Over the entire society, it says, there is no net gain and substantial damage to patients, ranging from needless worry, to impotence and incontinence, to death. And therein lies a dilemma for the older-than-50 male, for whom averages mean little.

If he isn't tested, he'll be spared the false positives the test commonly produces as well as treatment risk. On the other hand, if he has high-grade cancer, the disease might not be found until it has spread to other organs, which is fatal. The five-year survival rate for localized prostate cancer is 100%. Once the cancer reaches distant organs, the rate falls to 28.8%.

The panel's data make a compelling case that the overall societal benefit from widespread PSA screening is marginal, and it is not the first group to say so. In fact, the skeptics include the man who invented the PSA test. So in statistical terms, the diagnosis appears sound. But in tallying the damage, the commission makes some relatively small problems seem very big.

Yes, knowing you might have cancer is stressful, but it's better than not knowing. And yes, the biopsies that typically follow a rise in PSA can be painful, but for most patients they're not. As for the major complications — urinary incontinence and erectile dysfunction — they're usually temporary and highly treatable. They're also a lot better than being dead.

More troubling is the commission's solution.
It proposes eliminating the information that leads to over-treatment, rather than reforming the treatment itself. This is necessary, says the panel's chairman, Virginia Moyer, because once patients hear they have cancer, human nature drives them to demand aggressive action, necessary or not, and because engineering massive change in medical practices is a Herculean task.

She has a point, but ignorance is not bliss. It leaves the poor fellow with undetected high-grade cancer as collateral damage. The fact that his death might be statistically offset by the survival of someone who would have died from unneeded treatment is cold comfort.

It's important to note that the commission is not seeking to ban PSA testing. It just wants an end to routine screening. Doctors would still administer PSA tests when symptoms and risk factors warrant. Still, depriving people of information that empowers them to make choices is disturbing. Even more so because the panel's work has broader implications.

Meanwhile, at the risk of practicing medicine without a license, here's our suggestion for the 50-plus male: Get tested, then get smart. Information about prostate cancer and its treatment is readily available from the National Cancer Institute, major cancer centers and other sources.
Being left in the dark — whether by choice or medical fiat — is not a helpful option.

Source: USA Today editorial – Nov. 2011

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New oral drug for advanced PCa

Abiraterone (Zytiga)

What abiraterone is

Abiraterone is a new type of hormone therapy. It is used to treat advanced prostate cancer in men who have already had other types of hormone therapy and chemotherapy containing docetaxel that is no longer working. It is called abiraterone acetate, CB7630 or Zytiga.

Abiraterone works in a different way to other hormone treatments for prostate cancer. The male hormone testosterone stimulates prostate cancers to grow. Stopping the body making testosterone can slow the growth of the cancer, or even shrink it. Most testosterone is made by the testes. But a small amount of testosterone is made by other tissues in the body including the cancer itself. To make testosterone the body needs an enzyme called cytochrome P17 (CYP17). Abiraterone acetate blocks cytochrome P17, which stops the testes and other tissues in the body making testosterone.

How you have abiraterone

You have abiraterone as tablets. The normal dose is 4 tablets taken together once a day. You should swallow them whole with a glass of water on an empty stomach. The tablets should be taken at least one hour before food, or at least 2 hours afterwards. You take abiraterone with a steroid called prednisolone to help reduce some of the side effects.

It is very important that you take tablets according to the instructions your doctor or pharmacist gave you. For example, whether you have a full or empty stomach can affect how much of a drug gets into your bloodstream. You should take the right dose, not more or less. And never stop taking a cancer drug without talking to your specialist first.

The side effects associated with abiraterone are listed below. Because abiraterone is a relatively new drug we are still learning about the side effects, especially longer term ones.

Common side effects

Many people have one or more of the following side effects

· Tiredness (fatigue)
· Swelling of the legs due to fluid build up (known as peripheral oedema) affects about 3 in 10 men (30%)
· Low levels of potassium in the blood (hypokalaemia) occur in 17 out of 100 men (17%) and you will have blood tests to check your potassium levels – if you have muscle twitching or a fast heart beat contact your doctor immediately
· Aching joints and muscles occur in about 1 in 4 men (25%)
· High blood pressure during treatment happens in about 1 in 10 men (10%) – your nurse or GP will check your blood pressure regularly
· Bladder infections affect just over 1 in 10 men (10%) – let your doctor know if you are passing urine more often or have pain when passing it

Occasional side effects

Some people have one or more of the following effects

· A mild effect on the liver that is unlikely to cause symptoms and will almost certainly go back to normal when you finish treatment – you will have regular blood tests to check how well your liver is working
· Heart problems including a faster heart beat, a change to the heart rhythm and chest pain
· This drug may have a harmful effect on a developing baby so do talk to your doctor or nurse about contraception before having treatment if there is any chance that your partner could become pregnant
· Bone thinning (osteoporosis) can occur with advanced prostate cancer and abiraterone can increase this – it can make bones more likely to break

Important points to remember

You won't get all these side effects. A side effect may get worse through your course of treatment. Or you may have more side effects as the course goes on. This depends on

· How many times you've had a drug before
· Your general health
· How much of the drug you have (the dose)
· Other drugs you are having

Talk to your doctor, pharmacist or nurse about all your side effects so they can help you manage them.

Source: Cancer Research UK

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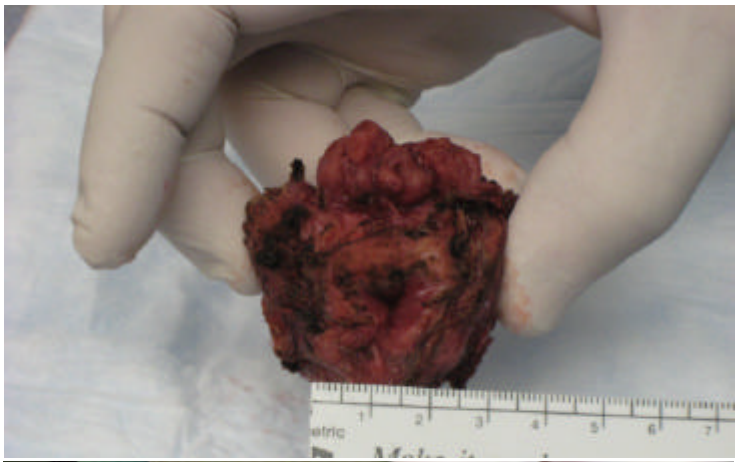
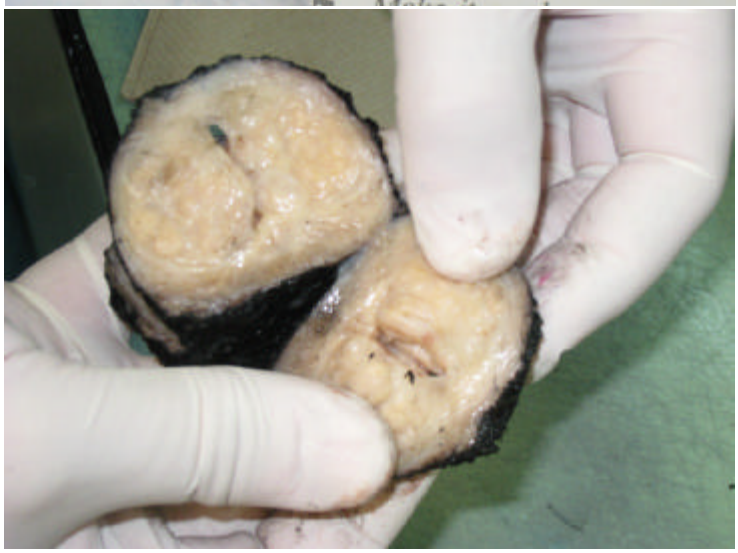
Pictures of a Prostate

Photos taken by Brian Sprott
during a recent tour of a pathology lab.





Testing PSA 10 Years after Radical Prostatectomy

The question remains, for how long do men need to undergo prostate specific antigen (PSA) testing for the risk of prostate cancer after radical prostatectomy?

Of 10,609 men treated with radical prostatectomy Loeb et al from Baltimore, Maryland reported biochemical recurrence in 1,684. Predictors of late biochemical recurrence (more than 10 years after surgery) were examined.

Overall, 77% of biochemical recurrences were noted in less than 5 years, 16% at 5 and 10 years, 5% at 10 and 15 years, and 1.5% at greater than 15 years after surgery.

For men with undetectable PSA at 10 years, the probability of biochemical recurrence and metastasis at 20 years varied by stage and grade, with no metastases in patients with a Gleason score of 6 or less. In this study a single patient with undetectable PSA at 10 years died of prostate cancer within 20 years after radical prostatectomy. While the incidence of biochemical recurrence at 10 years is not 0, it is low and PSA testing can probably be discontinued at 10 years for men with a Gleason score of 6 or less.

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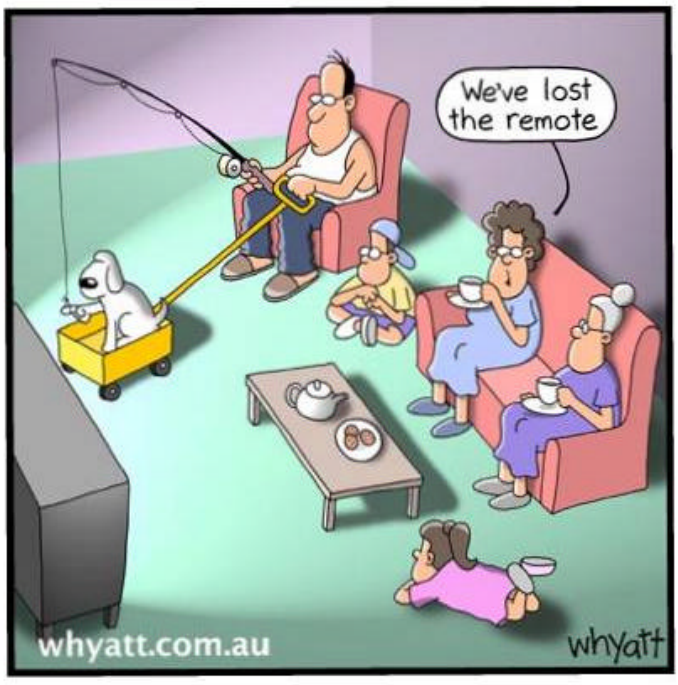

Radiation + Hormone Therapy Improves Survival For Men With High-Risk Prostate Cancer

Canadian Cancer Society - November 2011

Patients with high-risk or locally advanced prostate cancer live longer if they are treated with a combination of radiation and hormone therapy, according to findings from a Canadian-led clinical trial.

The results provide an important new treatment option and are expected to change clinical practice worldwide. Until now, most clinicians thought that patients with locally advanced or high-risk prostate cancer should be treated with hormone therapy only because radiation therapy was not an established treatment for these patients.

"Based on these results, we believe adding radiation to the treatment plan should become part of the standard therapy," says Dr. Padraig Warde, the study's principal investigator. Dr. Warde is a radiation oncologist at Toronto's Princess Margaret Hospital.

The international trial was coordinated by the NCIC Clinical Trials Group (CTG) and the Medical Research Council in the United Kingdom. The CTG is funded by the Canadian Cancer Society.

The clinical trial involved 1,205 patients whose disease, at the time of diagnosis, had spread to the area around the prostate gland or who had other high-risk factors, such as a high PSA level. About half the men were given the two therapies, while the other half received only hormone treatment. The study is one of the largest ever to test the effectiveness of this treatment method.

After seven years of follow-up, 74 per cent of men who had received the combination of radiation and hormone therapy were still alive, compared with 66 per cent of men who received hormone therapy alone. The researchers also found that the radiation therapy was tolerated well with no significant toxicity.

The results are very promising because they offer an important new treatment option," says Dr Michael Wosnick, Vice-President of Research, Canadian Cancer Society. "They show that a substantial portion of these patients with high-risk disease would benefit from the addition of radiation therapy. And the fact that radiation therapy techniques have themselves improved greatly since the start of this trial, makes this option even more compelling to consider".

About 15 to 25 per cent of all newly diagnosed prostate cancer is locally advanced and therefore high risk. Dr Warde expects that the findings will lead to a change in the standard of care for this group of patients.

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CancerCare Manitoba Doctor Receives Research Grant

Prostate Cancer Canada (PCC) awards numerous research grants to doctors across Canada each year. Our prostate cancer support group is pleased to announce that Dr. Harvey Quon, Radiation Oncologist at CancerCare Manitoba has received research grant monies from PCC. The research notice below is taken from the Prostate Cancer Canada website www.prostatecancer.ca

Name of Person or Group

Dr. Harvey Quon
CancerCare Manitoba

Name of Program or Research Project

Randomized Phase II Study of 2 Extreme Hypofractionated Radiotherapy Schedules for Low- and Intermediate-Risk Prostate Cancer

Investment and period of investment
$119,550 from 2011-2013

Outline of Program or Research Project

External beam radiation therapy is a standard treatment option for prostate cancer. Currently, men with prostate cancer that is confined to the prostate gland are treated with 39 doses ('fractions'), spread over 8 weeks. While this treatment schedule allows doctors to deliver very large total doses of radiation to the prostate (since the total dose is cumulative), it places a significant burden on both the patient (who needs to go to the clinic for daily treatments over 8 weeks) and on the health care system. In this research project, Dr. Quon's team is investigating whether it is possible to increase each individual dose of radiation, but decrease the total number of treatments, while maintaining the same ability to treat the prostate cancer with minimal side effects, but with far less burden on the patient. Dr. Quon's team will study two alternate treatment plans, each using the same total dose of radiation: one 29 days in length, and one 11 days in length. Dr. Quon's research will ultimately allow him to assess whether one of these treatment schedules is as effective and safe as the standard 8-week schedule, while potentially reducing the burden on the health care system, and being much more convenient for the patient.

Note: Dr. Quon will be addressing our January meeting with information on his research.

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Caregiver Burnout

Caregiver burnout is a state of physical, emotional, and mental exhaustion that may be accompanied by a change in attitude - from positive and caring to negative and unconcerned. Burnout can occur when caregivers don't get the help they need, or if they try to do more than they are able -- either physically or financially. Caregivers who are "burned out" may experience fatigue, stress, anxiety, and depression. Many caregivers also feel guilty if they spend time on themselves rather than on their ill or elderly loved ones.

Here are some steps you can take to help prevent caregiver burnout:

=> Find someone you trust -- such as a friend, co-worker, or neighbor -- to talk to about your feelings and frustrations.

=> Set realistic goals, accept that you may need help with caregiving, and turn to others for help with some tasks.

=> Be realistic about your loved one's disease, especially if it is a progressive disease such as Parkinson's or Alzheimer's.

=> Don't forget about yourself because you're too busy caring for someone else. Set aside time for yourself, even if it's just an hour or two. Remember, taking care of yourself is not a luxury. It is an absolute necessity for caregivers.

=> Talk to a professional. Most therapists, social workers, and clergy members are trained to counsel individuals dealing with a wide range of physical and emotional issues.

=> Take advantage of respite care services. Respite care provides a temporary break for caregivers. This can range from a few hours of in-home care to a short stay in a nursing home or assisted living facility.

=> Know your limits and do a reality check of your personal situation. Recognize and accept your potential for caregiver burnout.

=> Educate yourself. The more you know about the illness, the more effective you will be in caring for the person with the illness.

=> Develop new tools for coping. Remember to lighten up and accentuate the positive. Use humor to help deal with everyday stresses.

=> Stay healthy by eating right and getting plenty of exercise and sleep.

=> Accept your feelings. Having negative feelings -- such as frustration or anger - about your responsibilities or the person for whom you are caring is normal. It does not mean you are a bad person or a bad caregiver.

=> Join a caregiver support group. Sharing your feelings and experiences with others in the same situation can help you manage stress, locate helpful resources, and reduce feelings of frustration and isolation.

Source: WebMD 2011

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Research News

FDA Expands Approval For Denosumab

On Friday, September 16, 2011, the Food and Drug Administration (FDA) approved denosumab (Prolia) to increase bone mass in non-metastatic prostate cancer patients undergoing androgen deprivation therapy (ADT). Patients undergoing ADT tend to be at high-risk for fractures, including fractures of the spine. With denosumab injections, patients may reduce the risk of these fractures.

Matthew Smith, MD, PhD, director of the Genitourinary Malignancies Program at Massachusetts General Hospital Cancer Center, Boston has been a Prostate Cancer Foundation (PCF) funding recipient since 1997 for his work in improving prostate cancer survivorship. PCF has invested more than $1.8 million in Dr. Smith and his team's critical research projects on denosumab and treatment sciences on improving survivorship. The more than $1.8 million in funding support for Smith and denosumab from the Prostate Cancer Foundation came from peer-reviewed, non-corporate academic grants starting in 1997.

Dr. Smith was involved in the design of the registrational clinical investigations for Prolia. Denosumab is manufactured by Amgen pharmaceuticals.

Denosumab is also approved by the FDA for additional indications. Prolia was approved by the FDA on June 1, 2010 for the treatment of postmenopausal women with osteoporosis who are considered to be at high-risk for fractures. In November 2010, the FDA approved Prolia (Xgeva) to help prevent skeletal-related events (SREs) in prostate cancer patients treated with ADT whose cancer had metastasized to bone.

Source: Prostate Cancer Foundation

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

Publications Agreement
40037332

"Plan B": Cryotherapy as Salvage Therapy for Prostate Cancer

Every year, approximately a third of men with newly diagnosed prostate cancer will be treated with external beam radiation therapy or brachytherapy as their primary treatment choice. Unfortunately, many will experience a recurrence of cancer, with failure rates ranging up to 32 percent. This is when salvage cryotherapy becomes a possible option.

Think of salvage therapy for prostate cancer as "plan B," with the ultimate goal being to stop cancer growth and increase long-term survival. The time to consider it is when it's been confirmed that your initial form of cancer treatment -- external beam radiation or brachytherapy -- was not able to cure the cancer, and the disease has come back.

A rising PSA (prostate-specific antigen) level suggests recurrent prostate cancer, which must be confirmed by a prostate biopsy. The options available for salvage therapy of locally recurrent prostate cancer following radiation therapy include radical prostatectomy, brachytherapy, radiation therapy and cryotherapy.

The drawback to prostate surgery as a salvage procedure is that due to prostate scarring from the previous radiotherapy, the prostate will be very difficult to remove without significant damage to the bladder and rectum. When it comes to radiation therapy or brachytherapy as salvage possibilities, these procedures may actually cause increased rectal and urinary problems.

Cryotherapy is becoming an attractive option after radiation therapy failure because cryotherapy uses freezing temperatures rather than additional radiation to kill cancer cells that may somehow have become resistant to additional radiation and even to hormonal therapy.

How does cryotherapy work? Cryotherapy kills cancer cells by freezing them. In cryotherapy, thin needles (cryoprobes) are inserted through the perineum (the area between the scrotum and anus) and into the prostate. Needle placement is guided with an ultrasound probe placed in the rectum. Argon gas drops the temperature of the cryoprobes to a minimum of -40 degrees C (and often below -135 degrees C). The extremely low temperatures create iceballs that freeze the nearby tissue, killing the tissue and cancer cells with it. Helium is then introduced into the needles, which raises the temperature so the prostate can thaw.

Source: Johns Hopkins Health Alerts Nov. 2011

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Answering Machine - (204) 989-3433

2011 SPEAKERS:

January 19, 2012
Dr. Harvey Quon, Radiation Oncologist
"The changing Scene in Radiotherapy Delivery"

Feb 16, 2012
Dr. Darrel Drachenberg, Urologist
"New Prostate Cancer Therapeutics"

March 15, 2012
Dr. Dara Morden, Naturopathic Doctor
“The Impact of Adrenal Fatigue for both Patient and Caregiver”

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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