The Manitoba Prostate Cancer Support Group
NEWSLETTER
Prostate Cancer Canada Network Winnipeg

Vol. 253 July 2012

Ultrasound Used To Kill Prostate Cancer
Less Invasive Treatment Currently Being Tested

By: Kevin Rollason 09/20/2009

DIAGNOSED with prostate cancer, Martin Hiebert was facing surgery and a weeklong painful recovery in hospital.

Instead, Hiebert, 62, went in for treatment at 7 a.m. and was on his way home by 3 p.m.

"There was no pain," he said recently about his experience almost a year ago.
"I had a catheter on for eight days and I had some discomfort because of that, but then I was back to normal," he said.

"It was amazing."

Instead of using a scalpel and radiation to attack the prostate cancer, Hiebert took part in a test treatment using high-intensity focused ultrasound with the Sonablate 500.

The device is being used locally at the Maples Surgical Centre by Dr. Darrell Drachenberg, a surgeon and urologist at the St. Boniface General Hospital.
Almost a year after undergoing treatment, Hiebert's prostate cancer hasn't returned.

Drachenberg said the treatment is minimally invasive and has been used for several years in Asia while countries in Europe have used it for about five years.
Fifteen patients in Manitoba have already undergone treatment in the testing phase during the last 18 months.

(Continued on page 2)

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:
JULY 19, 2012

Members Forum – Enjoy a relaxing evening while 3 members describe their personal stories of PCa treatment.
Snacks and beverages will be served.
- **Martin Hiebert -** HIFU (high intensity focused ultrasound) Treatment 2008.
- **Al Petkau** – Cryotherapy Treatment 2011.
- **Garry Timm** – Self researched Alternate Treatment – on going

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

SHARING IS CARING

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

(Continued from page 1)

The doctor said a device is inserted into the patient through the rectum and the focused ultrasound heats the tissue, quickly allowing surgeons to destroy only the prostate and with it the cancer.

Drachenberg said the treatment isn't a miracle cure that will be used by everyone with prostate cancer, but it is another tool in the toolbox of cancer doctors.

"It will never overtake surgery or radiation," he said. "It's not the ultimate treatment for prostate cancer.

"If it is approved, probably about 20 to 40 per cent of patients will use it."

Because the treatment, while approved by Health Canada for the study, is not covered by Manitoba Health, Hiebert had to shell out $22,000 for it.

Hiebert said it was money well spent.

"I feel better than I did a year ago," he said.

"I have energy. Everything has come together. It's amazing what this machine can do. It's an amazing discovery.

"I'll tell anyone who will listen to me." <<

Early Detection Is Still The Key To Fighting Prostate Cancer

By Bryan Donnelly, Calgary Herald
June 17, 2012

Re: "Don't make yourself sick fretting over medical tests," Susan Martinuk, Opinion, June 15.

I would like to respond to Susan Martinuk's column on overuse of medical screening in the general population and whether it's worth the accompanying risks. As a urologist who has practised for over 30 years and chair of Calgary's Prostate Cancer Centre, my comments are restricted to PSA testing.

The Prostate Cancer Centre supports PSA (Prostate Specific Antigen) blood testing and recommends men age 40 and over discuss the benefits of screening for prostate cancer (PSA and digital rectal exam) with their family physician.

The debate on whether to screen misses the point. PSA testing is just one tool a urologist would use to determine whether to order further tests.

It is like checking the oil in your car to determine if you need a new engine.

You would look at a host of other information to make that determination.

The U.S. Preventative Services Task Force, which recently recommended against PSA screening, did not have a single physician who treats prostate cancer on the team, and they ignored the recent longer term analyses of the large European studies that showed that PSA screening decreased the relative risk of death.

The five-year survival rate for prostate cancer patients in Alberta has increased from 69 per cent in 1992 to 93 per cent in 2008, mainly due to PSA testing.

The best evidence demonstrates screening will reduce mortality. In Canada in 2012, an estimated 26,500 men will be diagnosed with prostate cancer and 4,000 will die of it. <<

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Thanks to Janssen Pharmaceuticals

The Board of PCCN Winnipeg would like to extend its appreciation and thanks to Janssen for their recent generous donation. This funding will allow us to further our work with prostate cancer education and awareness in the community. Janssen Pharmaceuticals is involved with the research and production of drugs that are used in the treatment of prostate cancer.

Meet Philip Ng – A Toronto Prostate Cancer Survivor

(The following article appeared in the June issue of the PCCN – Toronto newsletter. Mr Ng has given us permission to reprint his story for the interest of our readers. We thank him for his kindness and wish him well.)

Transurethral Hyperthermia treatment in Germany

Hyperthermia treatment is one of the least invasive procedures to treat prostate cancer. This treatment does not remove one's prostate, hence there is no side effect of incontinence or ED.

My name is Philip Ng. I discovered I had prostate cancer in January 2010. My PSA was 15 and the biopsy revealed a Gleason score of 7 (4+3). I saw a number of doctors in Ontario. They all suggested to me that I should have surgery to remove my prostate. And so, I decided to give that option careful consideration.

I was fortunate to meet a gentleman named Phil at one of our Tuesday night Peer Support Group meetings and he told me about a procedure being used in Germany called HYPERTHERMIA. So I searched the Internet, did a lot of research, and after much thought, decided to go over to Germany to have the treatment. I figured if it doesn't work, there is always plan B and that is to have the prostate removed. I flew over to Munich on a Sunday evening, and I was back in Toronto the following Saturday. There were two sessions of hyperthermia treatment with a day off in between.

The science behind this hyperthermia treatment is that the cancerous cells die when exposed to a temperature of 43°C, while healthy cells will only die at higher temperatures. The concept is similar to a fever, our body's natural way of getting rid of "the bad stuff". To treat the prostate, a catheter is used to heat the prostate to around 47°C for about two hours. It was uncomfortable but not unbearable. Nevertheless, during the procedure, I was wishing it were over! On the upside, however, during my "day off" I was well enough to visit the BWM factory in Munich, and then, after completion of the second session, to tour Salzburg. This was in April, 2010.

The hospital I went to for my treatment is called Klinik St. Georg. It's located in the spa town of Bad Aibling just outside Munich. The procedure cost was 6000 Euro, including room and board for five days. Of course OHIP does not cover the treatment cost! Furthermore, after the hyperthermia procedure, one has to be on hormone blockage treatment for an additional six months.

In my opinion, the six months of hormone blockage treatment is tougher than the two sessions of hyperthermia. The hormone blockage treatment is necessary to starve any remnants of cancerous cells by choking off the supply of testosterone. This is done by taking prescription medications and injections. During those six months, I lost muscle mass and gained weight even though I had continued to go to the gym to do weight training. The worst of it had to be the hot flashes that were waking me every couple of hours during the night. Now I have a much better appreciation and understanding of what women suffer with those hot flashes!

In August 2011, approximately sixteen months after my initial hyperthermia treatment, I had another biopsy to confirm the successfulness of the procedure. The pathology report revealed benign prostatic tissue with atrophy. In other words, the hyperthermia treatment was successful in killing off all the cells that were malignant.

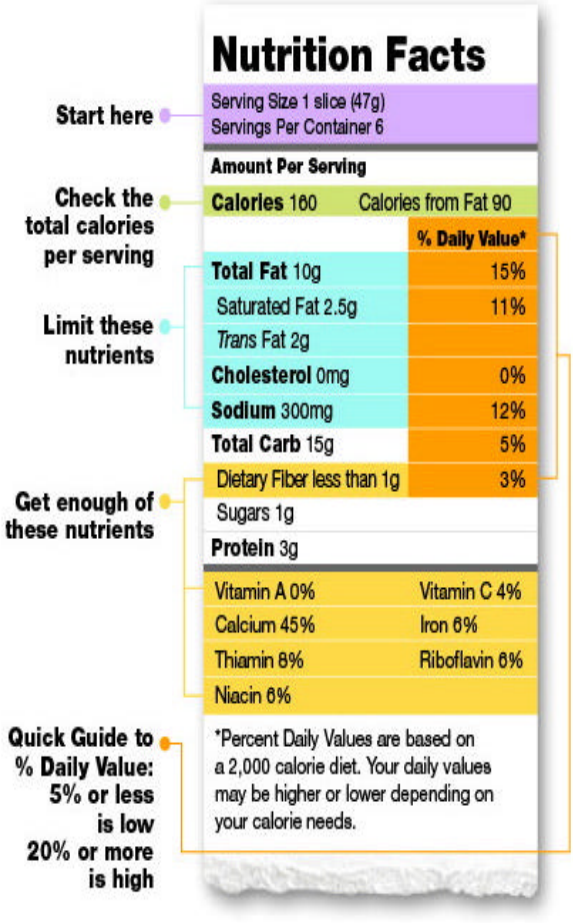
Based on the success of my treatment, Edward, Sam, and Peter who are members of our Tuesday night support group, and another gentleman named Delbert ,have received the same hyperthermia treatment at Klinik St. Georg. In fact, John is flying over to Munich this week as I'm writing this article. We also learned that a gentleman from Michigan named Ted had his prostate treated successfully twelve years ago at the same facility, and he was back for a second treatment recently because his PSA went up. Ted continued to praise the hyperthermia treatment versus other more invasive treatments his friends had received. For him, it was the right decision.

Now our small group pools our knowledge to support one another and we pass along and share our experiences with newcomers to the group. This is something we learned from the peer support group – to help each other. The support you will receive is invaluable.

Google "Transurethral Hyperthermia treatment in Germany" for more information. <<

Reading Food Nutrition Labels

Learning how to read and understand food labels can help you make healthier choices. Here are some tips for making the most of the information on the Nutrition Facts label:



Start here. Note the size of a single serving and how many servings are in the package.

Check total calories per serving. Look at the serving size and how many servings you're really consuming. If you double the servings you eat, you double the calories and nutrients, including the Percent Daily Value (% DV).

Limit these nutrients. Remember, you need to limit your total fat to no more than 56–78 grams a day — including no more than 16 grams of saturated fat, less than two grams of trans fat, and less than 300 mg cholesterol (for a 2,000 calorie diet).

Get enough of these nutrients. Make sure you get 100 percent of the fiber, vitamins and other nutrients you need every day.

Quick guide to % DV. The % DV section tells you the percent of each nutrient in a single serving, in terms of the daily recommended amount. As a guide, if you want to consume less of a nutrient (such as saturated fat, cholesterol or sodium), choose foods with a lower % DV — 5 percent or less is low. If you want to consume more of a nutrient (such as fiber), seek foods with a higher % DV — 20 percent or more is high.

Here are more tips for getting as much health information as possible from the Nutrition Facts label:

> Remember that the information shown in these panels is based on 2,000 calories a day. You may need to consume less or more than 2,000 calories depending upon your age, gender, activity level, and whether you're trying to lose, gain or maintain your weight.

Find out your personal daily limits at www.heart.org/HEARTORG/GettingHealthy/FatsAndOils/Fats101/My-Fats-Translator_UCM_428869_Article.jsp

> In general, as you think about the amount of calories in a food per serving, remember that for a 2,000-calorie diet:

- 40 calories per serving is considered low;
- 100 calories per serving is considered moderate; and
- 400 calories or more per serving is considered high.

> There is no % DV shown for *trans* fat on the panel because the U.S. Food and Drug Administration (FDA) does not have enough scientific information to set this value. We recommend eating less than 20 calories or (less than two grams of *trans* fat) a day – that's less than 1 percent of your total daily calories (for a 2,000-calorie-a-day diet).

> When the Nutrition Facts panel says the food contains "0 g" of *trans* fat, it means the food contains less than 0.5 grams of *trans* fat **per serving**.

When the Nutrition Facts label says a food contains "0 g" of *trans* fat, but includes "partially hydrogenated oil" in the ingredient list, it means the food contains *trans* fat, but less than 0.5 grams of *trans* fat per serving. So, if you eat more than one serving, you could quickly reach your daily limit of *trans* fat.

(Continued on page 5)

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In addition to the Nutrition Facts label, a lot of foods today also come with nutrient content claims provided by the manufacturer. These claims are typically featured in ads for the foods or in the promotional copy on the food packages themselves. They are strictly defined by the FDA. The chart below provides some of the most commonly used nutrient content claims, along with a detailed description of what the claim means.

If a food claims to be...	It means that one serving of the product contains...
Calorie free	Less than 5 calories
Sugar free	Less than 0.5 grams of sugar
Fat	
Fat free	Less than 0.5 grams of fat
Low fat	3 grams of fat or less
Reduced fat or less fat	At least 25 percent less fat than the regular product
Low in saturated fat	1 gram of saturated fat or less, with not more than 15 percent of the calories coming from saturated fat
Lean	Less than 10 grams of fat, 4.5 grams of saturated fat and 95 milligrams of cholesterol
Extra lean	Less than 5 grams of fat, 2 grams of saturated fat and 95 milligrams of cholesterol
Light (lite)	At least one-third fewer calories or no more than half the fat of the regular product, or no more than half the sodium of the regular product

Cholesterol	
Cholesterol free	Less than 2 milligrams of cholesterol and 2 grams (or less) of saturated fat
Low cholesterol	20 or fewer milligrams of cholesterol and 2 grams or less of saturated fat
Reduced cholesterol	At least 25 percent less cholesterol than the regular product and 2 grams or less of saturated fat

Sodium	
Sodium free or no sodium	Less than 5 milligrams of sodium and no sodium chloride in ingredients
Very low sodium	35 milligrams or less of sodium
Low sodium	140 milligrams or less of sodium
Reduced or less sodium	At least 25 percent less sodium than the regular product

Fiber	
High fiber	5 grams or more of fiber
Good source of fiber	2.5 to 4.9 grams of fiber

If you can't remember the definitions of all of the terms, don't worry. You can use these general guidelines instead:

=> "Free" means a food has the least possible amount of the specified nutrient.

=> "Very Low" and "Low" means the food has a little more than foods labeled "Free."

=> "Reduced" or "Less" mean the food has 25 percent less of a specific nutrient than the regular version of the food. . <<

Thought for the Day

Love who you are...
Love what you do...
Love every moment,
by being in the moment

John F. Barnes

Active Surveillance Of Prostate Cancer: Avoiding Unnecessary Treatment

Dr. Chris Parker Consultant Clinical Oncologist at The Royal Marsden.

Overview

We pioneered active surveillance of prostate cancer, which aims to individualise care by selecting only those men with significant cancers for curative treatment. Men on active surveillance are closely monitored using prostate specific antigen (PSA), blood tests and repeat prostate biopsies. The choice between continued observation and curative treatment is based on evidence of disease progression during this monitoring. A significant proportion of men who embark on surveillance will subsequently proceed to radical treatment. This does not mean that they made the wrong initial decision. Provided that delayed treatment is as effective as immediate treatment, they will not have come to any harm, will have delayed the onset of any treatment-related side-effects and will have some reassurance that their treatment was necessary.

Outcomes of active surveillance

Ten years ago, we began a prospective study of active surveillance of prostate cancer that has since recruited 500 men, making it the largest of its kind. Around 30% of these men have received treatment while the other 70% continue on observation. Just two of the 500 men have died from prostate cancer which is similar to what might have been expected if all 500 had been treated. For comparison, around 30 of them have died from unrelated causes. The results are encouraging and have helped to establish the feasibility of active surveillance for men with prostate cancer. In 2008, active surveillance was included in the National Institute for Health and Clinical Excellence (NICE) Prostate Cancer Guideline and has become a standard of care in routine clinical practice.

Limitations of active surveillance

Over the past ten years, we have learned how to do active surveillance better. We now know that monitoring the change in PSA level over time is not as useful as we thought it was. A stable PSA during the first two years after diagnosis does not preclude the possibility of a lethal prostate cancer. Furthermore, PSA levels fluctuate significantly over time and it is not easy to distinguish a spurious elevation from cancer progression.

"We pioneered active surveillance as a way of avoiding unnecessary treatment of prostate cancer."

Dr. Chris Parker

These observations highlight the importance of repeat prostate biopsy to detect disease progression. However, these repeat biopsies, while currently necessary, can be painful and cause bleeding or infection. Furthermore, because cancers within the prostate are not visualised, hitting them with a biopsy needle relies purely on chance. This sampling error means that significant cancers may be missed and disease progression go undetected. There is clearly an unmet need for a non-invasive method of monitoring disease progression during active surveillance in order to identify the appropriate trigger for treatment.

The role of imaging

In collaboration with Professor Nandita deSouza, we have shown that magnetic resonance imaging (MRI) of the prostate could meet that need. We observed several examples of men with apparently favourable prostate cancer, based on their PSA trends, who were found to have significant cancers on MRI (see Figure 1). We have since studied the value of MRI in around 150 men on surveillance and found that the MRI results appear to be an excellent indicator of subsequent disease progression. This finding requires validation in larger, multi-centre studies, but MRI offers the hope of a simple, non-invasive indicator of cancer progression. We hypothesise that men on active surveillance with favourable MRI results could safely avoid repeat biopsies and that for those with adverse MRI results, the repeat biopsies could be targeted to the site of the tumour seen on MRI. If further studies confirm the initial promise of MRI, active surveillance in the future will include regular MRI scans instead of repeat biopsies. This would be a major advance, avoiding the pain, bleeding and infections caused by biopsies while, at the same time, also improving the detection of disease progression.

Future direction

Active surveillance offers men with low-risk localized prostate cancer the hope of avoiding unnecessary treatment. It has been shown to be safe in the medium-term, but longer-term outcomes are awaited. There still remains a very real need for better markers of prostate cancer behaviour that could be used to identify who does, or does not, need treatment. We have stored blood and urine samples from the 500 men in the active surveillance program. In the future, this unique resource may enable us to identify new and better tissue markers of disease progression. <<

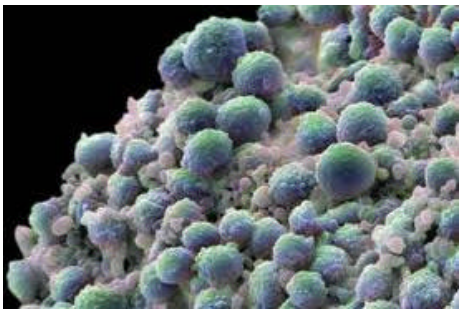
Radium-223 Prolongs Survival in CRPC

Emma Hitt, PhD

May 21, 2012 (Atlanta, Georgia) — In patients with bone metastases and castration-resistant prostate cancer (CRPC), radium-223 chloride (Ra-223) significantly prolonged overall survival and delayed time to first skeletal-related event (SRE), according to new findings from a phase 3 study.

Oliver Sartor, MD, from the Departments of Medicine and Urology at Tulane University School of Medicine in New Orleans, Louisiana, and colleagues presented the findings here in an oral podium session at the American Urological Association (AUA) 2012 Annual Scientific Meeting.

Dr. Sartor noted that Ra-223 is a first-in-class alpha-pharmaceutical that targets bone metastases. ALSYMPCA (ALpharadin in SYMptomatic Prostate CAncer), a phase 3, double-blind, randomized, multinational study, compared best standard of care plus Ra-223 or placebo in patients with bone metastases in CRPC.



"This is the first presentation of ALSYMPCA to the urologic community," Dr. Sartor told *Medscape Medical News.* "The data are roughly comparable in overall survival benefit to the other newer agents, but the toxicity profile appears excellent, and I personally envision that combinations of these newer agents will eventually be used," he said.

In the current study, patients had progressive, symptomatic CRPC with 2 or more bone metastases on scintigraphy and no known visceral metastases. All were receiving best standard of care and had previously received docetaxel, were docetaxel ineligible, or declined to receive docetaxel. Patients were randomly assigned 2:1 to receive 6 injections of Ra-223 every 4 weeks or matching placebo.

Of 924 patients, 615 were randomly assigned to Ra-223 and 307 were assigned to placebo between June 2008 and February 2011. On the basis of data from a planned interim analysis including 809 patients, Ra-223 significantly improved overall survival vs placebo (median overall survival duration, 14.0 vs 11.2 months, respectively; 2-sided *P* = .00185; hazard ratio [HR], 0.695; 95% confidence interval [CI], 0.552 - 0.875).

Time to first SRE was significantly delayed in the Ra-223 vs the placebo group (median time to SRE, 13.6 vs 8.4 months, respectively; *P* = .00046; HR, 0.610; 95% CI, 0.461 - 0.807).

Safety and tolerability of Ra-223 were favorable, with 1.8% and 0.8% of patients reporting grade 3/4 neutropenia and 4% and 2% of patients reporting thrombocytopenia in the Ra-223 and placebo groups, respectively. The percentage of patients reporting adverse events was lower in the Ra-223 group than the placebo group (adverse events of any grade in 88% vs 94% and grade 3/4 adverse events in 51% vs 59%, respectively).

"I think two things were surprising," Dr. Sartor said after his presentation. "One is that you have overall survival-positive [attitudes] — everyone moves into these types of trials with a sense of optimism, but until the data is there, you don't know. The other thing that was very nice to see was the lack of toxicity. There was a lot of concern about bone myelosuppression, but the truth is, we just didn't see it."

According to Dr. Sartor, an updated survival analysis will be presented at the upcoming American Society of Clinical Oncology (ASCO) annual meeting.

Session moderator Sam Chang, MD, Vanderbilt-Ingram Cancer Center, Vanderbilt University Medical Center, Nashville, Tennessee, noted that as a bone-targeted agent, this product is "unique in improving overall survival, which would make it a very important option and perhaps game changing."

However, Dr. Chang told *Medscape Medical News* that these results are demonstrated in a very select population. "This product targets bone turnover, and so those lesions that are most active are the ones most likely to be targeted — the problem is that we don't know when that highest level of activity is," he said. "Also, the study was in a very select population of patients, and at a very late stage. Can it be used earlier on? We don't know."

The study was supported by Algeta. Dr. Sartor reports that he is a consultant and investigator for Algeta and Bayer. Dr. Chang has disclosed no relevant financial relationships.

American Urological Association (AUA) 2012 Annual Scientific Meeting: Abstract #684. Presented May 20, 2012. <<

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AMGEN

PCCN Winnipeg would like to acknowledge a recent donation from Amgen. Amgen produces Xgeva (denosumab) that is used in the treatment of prostate cancer bone metastases. We are grateful 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.
Thanks, Amgen

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

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SPEAKERS

July 19, 2012
- **Members Forum –** Enjoy a relaxing evening while 3 members describe their personal stories of PCa treatment. Snacks and beverages will be served.
- **Martin Hiebert -** HIFU (high intensity focused ultrasound). Treatment 2008.
=>**Al Petkau** – Cryotherapy. Treatment 2011.
=>**Garry Timm** – Self researched Alternate Treatment – on going.

August 16, 2012
- **Ed Johner** – My Mayo Clinic Experience

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

SEPTEMBER PCa AWARNESS MEETING
Sept. 20, 2012
Samuel N. Cohen Auditorium
St Boniface Hospital Research Centre
351 Tache Ave.

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