THE MANITOBA PROSTATE CANCER SUPPORT GROUP NEWSLETTER

Prostate Cancer Canada Network Winnipeg

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Controversies in Prostate Cancer Treatments.

Canadian Urological Association conference - June 2013

Death from prostate cancer has plummeted dramatically in the U.S. since the introduction of prostatic specific antigen (PSA) testing, suggesting that early diagnosis and treatment does save lives. On the other hand, widespread PSA testing throughout the U.S. has led to overdiagnosis and overtreatment, Dr. Patrick Walsh, Professor of Urology, Johns Hopkins University, Baltimore, Maryland told delegates here. In an effort to correct this excess, the American Urological Association (AUA) recently released new guidelines curtailing the use of PSA testing. But as Dr. Walsh argued, the new AUA recommendations may, if anything, overcorrect excesses in diagnosis and treatment and leave individual groups of men not benefitting from being tested or treated, and subsequently dying from lethal disease.

"The strongest evidence supporting PSA testing is in men aged 55 to 69, which makes sense," Dr. Walsh said. However, as the guidelines indicate, screening should only occur after physicians and their patients weigh the benefit of preventing a single death from prostate cancer for every 1 000 men screened over 10 years against the known potential harm associated with screening and treatment. "This (recommendation) is based on mortality at 10 years," as Dr. Walsh emphasized.

(Continued on page 2)

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John Milner
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Jeff Sisler M.D.
Family Practitioner

Thanks!

Next Meeting: August 15, 2013

Gayle Nickol, C.R.N. Prostate Centre
Dr. Darrel Drachenberg,
Urologist & Director of Research

Topic: "Q and A – open forum on PCa"

Location: Main Floor Auditorium
Seven Oaks General Hospital
Leila and McPhillips
Time: 7 to 9 p.m.

SHARING IS CARING

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

Thought Of The Day

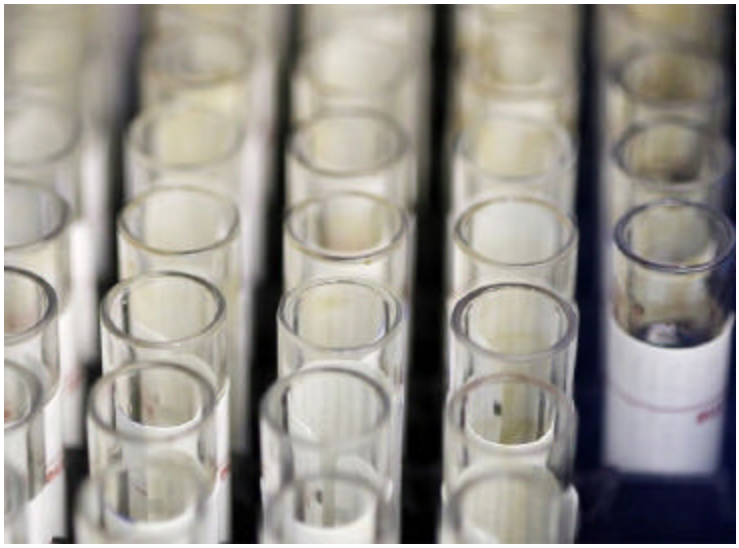
Why is it that doctors call what they do "practice"?

(Continued from page 1)

"But men who die from prostate cancer within 10 years of diagnosis did not have curable disease from the outset anyway so these men would not have been helped by PSA screening," he added. Conversely, most men with curable disease who are left untreated do not die of prostate cancer within 10 years of diagnosis. "So 10-year mortality rates are absolutely meaningless," Dr. Walsh said.

Similarly, the AUA guidelines do not recommend routine screening in men between the ages of 40 and 54 at average risk. In contrast to men between 55 and 69 years of age, "there is absolutely no evidence for or against testing in men under the age of 55," Dr. Walsh noted. More importantly, a baseline PSA in men in their late 40s can be highly predictive of their risk of developing metastases over a lifetime, he added. If a man between 45 and 49 years of age has a PSA of = 0.7 ng/mL, his lifetime risk of developing metastatic disease from prostate cancer is extremely low. On the other hand, if a man in the same age bracket has a PSA = 1.6 mg/mL, his lifetime risk of developing metastatic disease is dramatically higher - suggesting that PSA testing in men under the age of 55 can be helpful in select patients, as Dr. Walsh indicated.

The AUA panel also do not recommend routine PSA screening in men over the age of 70, or in any man with less than a 10- to 15-year life expectancy. "This needs to be rethought," Dr. Walsh said. In the U.S., studies indicate that 50% of the men who die from prostate cancer are diagnosed after the age of 75. Furthermore, 9 years after stopping PSA testing, recent data indicate that the incidence of potentially lethal cancers equals that in an unscreened group of men. "We need to think more about healthy older men," Dr. Walsh observed.



In his own approach to PSA testing, Dr. Walsh feels that any man with a 10 to 15 year lifespan who doesn't want to die from prostate cancer should be screened.

Urologists should also avoid screening in men with a limited lifespan and avoid treatment in men who do not need it.

He also suggests urologists refer men who need treatment to high-volume centers so that the risk of treatment-related complications can be minimized.

"There is abundant evidence that early diagnosis and treatment of prostate cancer in the U.S. has resulted in a dramatic decline in deaths to the point where rather than having 60,000 people a year dying from the disease, it's now 30,000," Dr. Walsh said. "The bad news is that as a result of overdiagnosis and overtreatment, many patients have received treatments that they didn't benefit from, and actually were harmed by, because of side effects. I believe that the AUA guidelines will benefit from better clarification."

Presented by Laurence Klotz, MD, FRCSC and Patrick Walsh, MD at the 68th Canadian Urological Association (CUA) Annual Meeting - June 22 - 25, 2013 - Niagara Falls, Ontario Canada.

Written by Pam Harrison, medical writer for UroToday.com

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Erectile Dysfunction

Erectile dysfunction (ED) is when a man has trouble getting or keeping an erection. ED becomes more common as you get older. But male sexual dysfunction is not a natural part of aging.

Some people have trouble speaking with their doctors about sex. But if you have ED, you should tell your doctor. ED can be a sign of health problems. It may mean your blood vessels are clogged. It may mean you have nerve damage from diabetes. If you don't see your doctor, these problems will go untreated.

Your doctor can offer several new treatments for ED. For many men, the answer is as simple as taking a pill. Getting more exercise, losing weight or stopping smoking may also help.

Medline Plus Weekly Digest Bulletin - June 2013

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Final Intergroup Analysis Supports ADT plus RT as Standard of Care in Locally Advanced Prostate Cancer

Canadian Urological Association conference - June 2013

The combination of androgen deprivation therapy (ADT) plus radiation therapy (RT) improves both overall and disease-specific survival in patients with locally advanced prostate cancer, compared with ADT alone, and should be considered standard of care for this group of patients. Padraig Warde, MD, staff radiation oncologist. Princess Margaret Hospital, University of Toronto and multi-center colleagues found that 55% of patients who received ADT plus RT in the Intergroup randomized phase III study were still alive at 10 years compared with 49% of those who received ADT alone. At a median follow-up of 8 years, only 32% of patients in the combination arm (n=603) had died of their disease compared with 52% of those who received ADT alone (n=602)—a 54% disease -specific survival advantage in favor of the combination arm as Dr. Warde pointed out.

"We knew at the time that early introduction of hormonal therapy was actually valuable in patients with locally advanced disease, and what people wondered at the time was whether hormone therapy was actually sufficient in itself for these patients," Dr. Warde said. "So that was the thrust of the study—did the addition of RT improve survival and at what cost in terms of side effects"? The final analysis of the Intergroup study was presented here during the 68th annual meeting of the CUA.

Intergroup Trial

The intergroup trial was initiated in 1995. Patients were randomized to continuous ADT alone or to ADT plus RT. Approximately 90% of patients in both arms had T3 or T4 prostate cancer.

ADT was achieved either through bilateral orchiectomy or through the use of an LHRH agonist. Radiotherapy was administered at a dose of 45 Gy/25 F/5 weeks to the pelvis and at a dose of 20-24 Gy/10-12 F/2-2.5 weeks to the prostate. If the treating physician felt the patient was not a suitable candidate for whole pelvis RT, RT was given to the prostate alone.

As Dr. Warde pointed out, the overall and disease-specific survival advantage obtained with the addition of RT to ADT did not come at a significant cost in terms of an excess of side effects, with additional RT, at least with longer-term follow-up. At 6 months, the mean change in the quality of life assessment score was -8.90 in the combination arm vs -1.74 in the hormonal arm, which was significant. However, by 36 months, between-group differences in quality-of-life measures were no longer significant, he added.

In the bowel domain, the combination ADT plus HT showed a moderate worsening of bowel symptoms at 6 months, which was consistent with clinical expectations, Dr. Padraig noted. Again, however, scores improved in the ADT plus RT arm by 12 months and there were no between-group differences that persisted at 24 months or thereafter.

As Dr. Warde observed, when the study was initiated in the mid-90s, standard of care was to use life-long ADT. "We now know that lifelong hormones aren't necessary and that we probably only need 2 to 3 years of hormones, which is standard now-a-days." Similarly, the doses of RT used in the Intergroup trial reflected the doses generally used for prostate cancer at that time, suggesting that the benefit of RT as now used may be even greater with dose escalation.

"The key here is that local treatment improves survival," Dr. Warde said. "And we now know that local treatment with RT should be offered to patients with locally advanced disease, in addition to ADT, and that this should be the standard of care."

Presented by Padraig Warde, Wendy Parulekar, Michael Brundage, Peter Kirkbride, Mary Gospodarowicz, Gregory Swanson, Bingshu Chen, Matthew Sydes, and Malcolm Mason at the 68th CUA Annual Meeting - June 22 - 25, 2013 - Niagara Falls, Ontario Canada.

Written by Pam Harrison, medical writer for UroToday.com

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An interesting look at the PROS and CONS of Active Surveillance – Part 1

(This is a 2 part article on treating prostate cancer using active surveillance. Our August newsletter will feature Dr. Laurence Klotz talking about the PRO approach. Dr. Oliver Sartor will use the CON argument in the September issue.)

Active Surveillance Not Only Reduces Morbidity, It Saves Lives.

By Laurence Klotz, MD, FRCSC
June 11, 2013

Sunnybrook Health Sciences Centre, Toronto, Ontario, Canada

The concept of active surveillance is based on the observation that Gleason 6 prostate cancer is an indolent condition that poses little or no threat to the patient's life. This view is supported by the molecular characteristics and clinical behavior of the disease. Conservative management is thus appropriate for these patients. Close and ongoing monitoring is required for two reasons: (1) to identify those patients initially diagnosed with Gleason 6 disease who harbor higher-grade cancer, and (2) to find the small proportion of patients who have true biological progression over time. Despite these two concerns, the majority of patients will remain unaffected and untreated, thereby avoiding the significant quality-of-life effects of radical intervention for prostate cancer. Those patients who are eventually reclassified as higher risk and who are subsequently treated have an extremely small likelihood of dying of prostate cancer.

Interest in, and support for, the concept of active surveillance has increased substantially in recent years. This is due to a number of factors. The problem of overtreatment of prostate cancer has been widely recognized. In particular, the US Preventive Services Task Force (USPSTF) recommendation against prostate cancer screening was based to a large degree on evidence that rates of overdiagnosis and overtreatment were unacceptably high. For the USPSTF, the risks associated with overdiagnosis and overtreatment outweighed the evidence that screening was beneficial because of reduced prostate cancer mortality.

A second factor has been an increased acceptance of surveillance as an antidote to overtreatment. Selective therapy confined to patients with potentially aggressive disease will reduce the number needed to screen and treat to the point where the risk-benefit ratio of screening is palatable.

A third factor is the mounting molecular and clinical evidence that Gleason 6 disease lacks the hallmarks of cancer. The aberrant genes and pathways that induce the features typical of cancer have been characterized. With remarkable consistency, where a specific gene or protein alteration is linked to one of these aberrant pathways, the alteration associated with malignancy is absent in Gleason 3 pattern disease and present in Gleason 4 and 5 patterns.

A confounder in determining the clinical outcome of Gleason 6 cancer has been the known rate of undergrading, which has been well documented as a feature of systematic biopsies. The rate of progression and metastases from pathologically confirmed Gleason 6 disease testifies to this. One would expect, if Gleason 6 cancer had even slight metastatic potential, that a few patients treated surgically would eventually fail—due to occult metastasis prior to surgery, or due to local failure from an incomplete resection with progression to metastasis—and that these patients would eventually die of the disease. In fact, patients with surgically confirmed Gleason 6 disease do not die of prostate cancer. This has been confirmed in several large series involving more than 10,000 patients.

Our understanding of the nature of occult high-grade disease in patients who had been classified as "low-grade" has improved since surveillance was introduced. 25% of patients initially diagnosed with low-risk PCa (Gleason 6, PSA < 10) harbor higher-grade disease. In 90% of cases, this higher-grade disease is Gleason 3+4—ie, at the low end of intermediate risk, it is often indolent as well. A few men with only Gleason 3+3 cancer will dedifferentiate over time to higher-grade disease (just as some patients without prostate cancer will develop high-grade disease over time). We estimate that this occurs at a rate of 1% per year, based on the relationship between the time since the diagnostic biopsy and the likelihood of upgrading in our cohort. Thus, patients require long-term follow-up.

Finally, the increasing use of multiparametric MRI is enhancing our ability to identify patients with large occult cancers early, and to reassure the remainder. Absence of an abnormality on multiparametric MRI has recently been reported to have a 96% to 100% negative predictive value for the presence of higher-grade

(Continued on page 5)

(Continued from page 4)
disease in a surveillance cohort. The urologist is the sole physician contact for many men on surveillance. This represents an opportunity to counsel these patients on other aspects of men's health, including smoking cessation, dietary modification, weight reduction, and exercise. These recommendations, if followed, may have as much of a beneficial health impact as prostate cancer monitoring, or perhaps more.

A compelling case can be made that active surveillance not only reduces morbidity, but saves lives. PSA screening reduces mortality from prostate cancer. However, screening has been rejected—because of concerns about overtreatment—by policy makers, primary care physicians, and patients. This rejection will result in an increase in prostate cancer mortality. Reducing overtreatment by active surveillance, which consequently reduces the number needed to screen and treat for each death avoided, will make screening more palatable, acceptable, and prevalent. This will result in the earlier diagnosis of life-threatening prostate cancer, and an improvement in prostate cancer mortality.

The real debate in 2013 is not active surveillance pro or con, but the nuances of how to optimize this approach. Which favorable-risk patients (high-volume disease at a young age, for example) should be treated; which intermediate-risk patients are candidates for surveillance; how to use MRI and biomarkers to better risk-stratify; how often to biopsy; targeted vs template strategies; and when to intervene—there are an abundance of challenging research questions to address in this field.

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Erectile Dysfunction Patient Information Fact Sheet

What is erectile dysfunction?

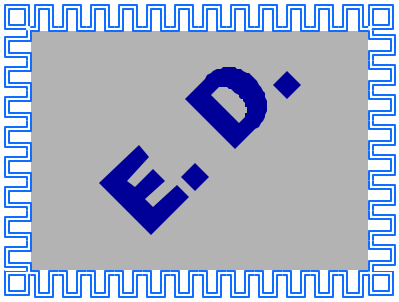
Erectile dysfunction, often referred to as impotence, is the inability to have or maintain an erection sufficient for sexual activity. It is a common problem affecting around one in every 10 men at some time in their lives and tends to affect men increasingly as they get older. Erectile dysfunction used to be regarded as an entirely psychological problem, but it is now known that in about 70% of sufferers there is a physical cause.

What causes erectile dysfunction?

Most men will suffer occasional episodes of erectile dysfunction at some time in their lives, which may be caused by factors such as excess alcohol or stress and anxiety. Previous erectile failure for one of these reasons may cause anxiety and so the problem can repeat itself. If you can achieve an erection on some occasions and not others, the cause is likely to be psychological. There are many possible psychological causes, including depression or sexual boredom or conflicts with a partner, which may lead to temporary sexual dysfunction with that partner. In addition, uncertainty about sexual orientation (i.e., whether heterosexual or homosexual), can cause problems. Excessive stress and anxiety at work may cause a temporary or long-term problem depending on whether the stress is short-term or permanent.

If erectile dysfunction is the result of a physical problem, the decline in sexual function is usually gradual. A number of physical conditions may result in erectile dysfunction. For example, if the arteries supplying the penis become blocked (atherosclerosis) the blood supply to the penis may not be sufficient to sustain an erection. The arteries can become blocked in the same way that arteries to the heart become blocked, as a result of smoking or high cholesterol levels.

Neurological diseases or disorders of the nerves that go to the penis, eg, in spinal cord injury, can also affect sexual function, as can a stroke. There are several other conditions that can cause erectile dysfunction, including diabetes, kidney failure, liver failure, hypogonadism (low levels of male hormone testosterone), high blood pressure and alcoholism.



Erectile dysfunction may also occur as a side effect of some drug treatments, for example, some treatments for high blood pressure. If you are taking medicine for high blood pressure and are experiencing erection difficulties, do not stop taking the tablets without consulting your GP. High blood pressure must be controlled and stopping the medication can put you at risk of other problems. Alternative treatments for high blood pressure are available and the problem may be resolved by a change in medication. Some drugs, particularly antidepressants, can cause lethargy or weight gain and may affect libido (sexual interest). Some medications given for serious mental illness may also affect the ability to achieve orgasm, while some medicines for anxiety or high blood pressure may delay or prevent orgasm. Use of certain illegal drugs may also cause sexual problems.

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Saskatchewan Improves Prostate Cancer Wait Times

Saskatchewan men now face a far shorter path to diagnosis and treatment for prostate cancer.

For 10 patients over the past month, that took just 35 days, compared to a previous high of 112 days. Those are the early results of the Saskatchewan Prostate Assessment Pathway, which the province rolled out last month.

"The biggest benefit I've seen is patient satisfaction," said Nicole Baba, one of three new, part-time nurse navigators.

She has been involved with trials over the past several months putting the pieces of the program in place.

"We have about a 70 per cent return rate of a mailed-out satisfaction survey with phenomenal results," she said.

Prostate cancer is the most common cancer in Canada, with 900 Saskatchewan men diagnosed annually. The new pathway streamlines and centralizes the workload that would normally be spread between a man's doctor and urologist to the nurse navigators.

Two navigators are stationed at St. Paul's Hospital in Saskatoon and the other is at Pasqua Hospital in Regina.

"We've taken over some of the duties the urologist was doing that a nurse could provide, which is a lot of the patient teaching," Baba said. "The pathway itself is what provided us with the infrastructure to determine who can safely have a biopsy through this pathway."

However, it's hard to determine the pathway's impact on patients' health outcomes, she said.

"Because prostate cancer isn't the kind of cancer we need to diagnose this absolute second. It is more about, first, the patient's experience, having that diagnosis quickly. It's also about the standard practice ... we provide the same, consistent message to patients so that decreased variation will improve the outcomes."

Health Minister Dustin Duncan said the volume of diagnoses made prostate cancer treatment a natural place to implement a new pathway. However, the pathway team didn't set hard targets for reductions, he said

"We're obviously thrilled to see times have been reduced by that much and I think it really shows the benefits of the pathway," he said.

He also couldn't say how much money the streamlining might save the health-care system.

"At this point we're going to have to see over the next year what the savings will be. More important than any cost savings, though, we talk a lot about putting the patient first and this really looks at the process more clearly through the eyes of the patient.

"While there may be some savings down the road, where there will be benefits is just being able to provide services in a more timely fashion."

The province has already implemented pathways for hip and knee replacement surgery and for pelvic organ prolapse. Pathways for strokes and lower-extremity wounds are also in the works.

The Regina Leader-Post June 2013

Editor's note: In 2011 a Manitoba program called Cancer Patient Journey Initiative was launched. It aims to reduce to 60 days or less the time from suspicion of cancer to first treatment.

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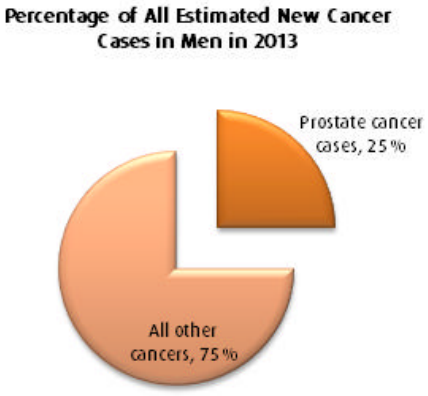
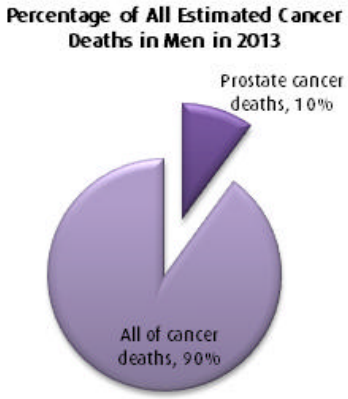
Prostate Cancer Statistics

Prostate cancer is the most common cancer among Canadian men (excluding non-melanoma skin cancers). It is the 3rd leading cause of death from cancer in men in Canada.





Trends in prostate cancer

Since 1980, the incidence rate for prostate cancer has generally increased. Part of the increase in incidence is likely due to the more widespread use of the prostate specific antigen (PSA) test for the early detection of prostate cancer.

The death rate rose much more slowly during the same period and started to decline in the mid-1990s.

Based on 2007 estimates, about 1 in 7 Canadian men is expected to develop prostate cancer during his lifetime and 1 in 28 will die from it.

***Source**: Canadian Cancer Society*

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Manitoba Prostate Cancer
SUPPORT GROUP

presents
our annual

PROSTATE HEALTH Awareness Evening

Tuesday, September 17, 2013 | 7:00pm to 9:00pm
Caboto Centre - 1055 Wilkes Ave. Winnipeg

FREE ADMISSION

Dr. Jeff Sisler
Family Physician
Director of Primary Care Oncology CCMB

Dr. Jeff Saranchuk
Urologist
Medical Director - Manitoba Prostate Centre

Brian Sprott
Chair,
MPCSG

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MEETINGS

September 17, 2013 (Tuesday)
Prostate Health Awareness Evening
Caboto Centre, 1055 Wilkes Ave.
Presenters: Dr. Jeff Sisler, FP & Medical Lead, Primary Care Oncology Program.
Dr. Jeff Saranchuk, Urologist & Medical Director – CancerCare Manitoba.

Note: No meeting at Seven Oaks Hospital on Sept. 19, 2013

October 17, 2013 ... TBA

November 21, 2013
Dr. Harvey Quon, Radiation Oncologist
Intimate Fire-side chat on Radiation Options and Fractionation in Winnipeg

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

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