

Questions About Chemotherapy Treatment

What is chemotherapy and how does it work?

Chemotherapy is the use of medicines or drugs to treat a disease, such as cancer. Many times this treatment is just called “chemo.” Surgery and radiation therapy remove, kill, or damage cancer cells in a certain area, but chemo can work throughout the whole body. Chemo can kill cancer cells that have metastasized or spread to parts of the body far away from the primary (original) tumor.

More than 100 chemo drugs are used in many combinations. A single chemo drug can be used to treat cancer, but often multiple drugs are used in a certain order or in certain combinations (called combination chemotherapy). Multiple drugs with different actions can work together to kill more cancer cells. This can also reduce the chance that the cancer may become resistant to any one chemo drug.

You and your doctor will decide what

drug or combination of drugs you will get. Your doctor will choose the doses, how the drugs will be given, and how often and how long you’ll get treatment. All of these decisions will depend on the type of cancer, where it is, how big it is, and how it affects your normal body functions and overall health.

What is the goal of chemo?

Depending on the type of cancer, its stage (how far it has spread), and where

(Continued on page 2)

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Thanks!

Next Meeting: August 14, 2014
Dr. Sabine Mai, PhD, Director, Genomic Center for Cancer Research & Diagnosis
Topic: Tracking tumour cells to individualize treatment.
Location: Main Floor Auditorium
Seven Oaks General Hospital
Leila and McPhillips
Time: 7 to 9 p.m.



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

Thought of The Day

Don't ever take a fence down until you know the reason it was put up.

(Continued from page 1)

you are in the treatment process, chemo can be used to:

- Cure the cancer.
- Keep the cancer from spreading.
- Slow the cancer's growth.
- Kill cancer cells that may have spread to other parts of the body.
- Relieve symptoms caused by cancer.

Your doctor will talk to you about the goal of your chemo before you start treatment.

Will chemo be my only treatment for cancer?

Sometimes chemo is the only treatment you need. More often, chemo is used along with surgery or radiation therapy or both. Here's why:

Chemo may be used to shrink a tumor before surgery or radiation therapy.

It may be used after surgery or radiation therapy to help kill any remaining cancer cells.

It may be used with other treatments if your cancer comes back.

When chemo is given after surgery to kill any cancer cells that may still be present, it's called adjuvant therapy. When chemo is used to shrink a tumor before surgery or radiation therapy, it's called neoadjuvant therapy.

How often will I need to get chemo and how long will it last?

How often you get chemo and how long your treatment lasts depend on the kind of cancer you have, the goals of the treatment, the drugs being used, and how your body responds to them. You may get treatments daily, weekly, or monthly, but they are usually given in on-and-off cycles. This means, for example, that you may get chemo the first 2 weeks and then have a week off, making it a 3-week cycle that will start over again after the week off. The break allows your body to build

healthy new cells and regain its strength.

Many people wonder how long the actual drugs stay in their body and how they are removed. Most chemo drugs are broken down by your kidneys and liver and then are removed from your body through your urine or stool. The time it takes your body to get rid of the drugs depends on many things, including the type of chemo you get, other medicines you take, your age, and your kidney and liver functions. Your doctor will tell you if you need to take any special precautions because of the drugs you are getting.



If your cancer comes back, chemo may be used again. This time, you may be given different drugs to relieve symptoms or to slow the cancer's growth or spread. Side effects may be different, depending on the drugs, the doses, and how they're given.

How will the chemo be given to me?

Most chemo drugs are put right into your bloodstream through a tiny, soft, plastic tube called a catheter. A needle is used to put the catheter into a vein in your forearm or hand; then the needle is taken out, leaving the catheter behind. This is called intravenous, or IV treatment. Intravenous drugs are given in these ways:

- The drugs can be given quickly through the catheter right from a syringe over a few minutes. This is called an IV push.
- An IV infusion can last from 30 minutes to a few hours. A mixed

drug solution flows from a plastic bag through tubing that's attached to the catheter. The flow is often controlled by machine called an IV pump.

- Continuous infusions are sometimes needed and can last from 1 to 7 days. These are always controlled by electronic IV pumps.

The needles and catheters can scar and damage veins with ongoing chemo. Another option is the central venous catheter (CVC). The CVC is a bigger catheter, which is put into a large vein in the chest or upper arm. It stays in as long as you're getting treatment so you won't need to be stuck with a needle each time. With a CVC, IV medicines can be given more easily. Blood can also be drawn from CVCs.

Many different kinds of CVCs are available. Some are soft tubes that stick out of the skin and require no needles. Another type is a port, which is like a small drum with a thin tube going into the vein. Ports are permanently placed under the skin of the chest or arm during surgery. Special needles are then stuck through the skin into the port to use it.

Many people talk about CVC options with the doctor even before starting treatment. Some find out during treatment that they need a CVC because their hand and arm veins are not good enough to complete the planned chemo. Your doctor can help you decide if you need a CVC and the right type of CVC for you.

Other routes

Depending on the drugs and where the cancer is, your chemo also may be given in one or more of these ways:

- Orally or PO – This means by mouth. You swallow the drug as a pill, capsule, or liquid – just as you do other medicines. This is

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usually more convenient because the drugs can often be taken at home. If you take chemo drugs by mouth, it's very important to take the exact dosage, at the right time, for as long as you're supposed to do so.

- Intrathecal or IT – The drug is put into the spinal canal and goes into the fluid that surrounds your brain and spinal cord. This fluid is called the cerebrospinal fluid (CSF). Chemo put into the CSF is carried throughout the brain and spinal cord. You may either have a needle put right into your spine to quickly give the drug, or a long-term catheter and port can be put under the skin on your head during surgery. This port is called an Ommaya reservoir. The Ommaya is a small drum-like device that has a small tube attached to it. The tube goes into the CSF in a cavity of your brain. The Ommaya stays in place under your skin until treatment is done.
- Intra-arterial – The chemo drug is put right into an artery to treat a single area (such as the liver, an arm, or leg). This method helps limit the effect the drug has on other parts of the body and is called regional chemo.
- Intracavitary – Chemo drugs may be given through a catheter into the abdominal cavity (the space around the bowels and other organs in the belly; this is called intraperitoneal chemo) or chest cavity (the space around the lungs and other organs in the chest).
- Intramuscular or IM – The drug is put in through a needle into a muscle (as an injection or shot).
- Intralesional – A needle is used to put the drug right into a tumor in the skin, under the skin, or in an internal organ.
- Topical – The drug is put right on an area of cancer on the skin as a cream, gel, or ointment.

Does chemo hurt?

You already know how it feels to take a pill or rub medicine on your skin. And you've probably felt the brief discomfort of a shot before. IV medicines should not hurt after the first needle stick to put in the catheter. If you feel pain, burning, coolness, or anything unusual while you are getting chemo, tell your doctor or nurse right away.

What causes side effects?

Cancer cells tend to grow fast, and chemo drugs kill fast-growing cells. But because these drugs travel throughout the body, they can affect normal, healthy cells that are fast-growing, too. Damage to healthy cells causes side effects. Side effects are not always as bad as you might expect, but many people worry about this part of cancer treatment.



The normal cells most likely to be damaged by chemo are blood-forming cells in the bone marrow; hair follicles; and cells in the mouth, digestive tract, and reproductive system. Some chemo drugs can damage cells in the heart, kidneys, bladder, lungs, and nervous system. In some cases, medicines can be given with the chemo to help protect the body's normal cells.

What should I know about side effects?

- Every person doesn't get every side effect, and some people get few, if any.
- The severity of side effects (how "bad" they are) varies greatly from person to person. Be sure to talk to your doctor and nurse about which side effects are most common with your chemo, how long they might last, how bad they might be, and when you should call the doctor's office about them.
- Your doctor may give you medicines to help prevent some side effects before they happen.
- Many people have no long-term problems from chemo. And while side

effects can be unpleasant, they must be measured against the need to kill the cancer cells.

How long do side effects last?

Most side effects slowly go away after treatment ends because the healthy cells recover over time. The time it takes to get over some side effects and regain energy varies from person to person. It depends on many factors, including your overall health and the drugs you were given.

Many side effects go away fairly quickly, but some may take months or even years to completely go away. Sometimes the side effects can last a lifetime, such as when chemo

causes long-term damage to the heart, lungs, kidneys, or reproductive organs. Certain types of chemo sometimes cause delayed effects, such as a second cancer that may show up many years later. Patients often become discouraged about how long their treatment lasts or the side effects they have. If you feel this way, talk to your doctor. You may be able to change your medicine or treatment schedule. Your doctor or nurse also may be able to suggest ways to reduce any pain and discomfort you have.

How will I know if the chemo is working?

Your cancer care team will measure how well your treatments are working by doing certain tests. This may include physical exams, blood tests, bone marrow biopsies, scans, and x-rays. Ask your doctor about the test results and what they show about your progress. You may have side effects, but these side effects do not tell you whether treatment is working.

Source: American Cancer Society

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Incontinence Information

INCONTINENCE can sometimes occur as a result of treatment for prostate cancer. Now that you know your stats about the disease, and you've developed a solid game plan with your doctor, it's time to plan out your defense for any side effects of treatment. Many men experience incontinence as a result of prostate cancer treatment, but most men will ultimately recover urinary control.



WHAT IS INCONTINENCE?

Incontinence is the inability to control your urine. After prostate cancer treatment, you may experience leakage or dribbling of urine. Because incontinence may affect your physical and emotional recovery, it is important to understand what your options are.

WHAT ARE THE DIFFERENT TYPES OF INCONTINENCE?

There are several different types of incontinence:

=> **STRESS INCONTINENCE**, the most common, is urine leakage when coughing, laughing, sneezing or exercising.

=> **OVERFLOW INCONTINENCE** is the inability to empty the bladder completely, taking longer to urinate and when you do urinate, it is not a powerful stream.

=> **URGE INCONTINENCE** is the sudden need to go to the bathroom even when the bladder is not full because the bladder is overly sensitive.

=> **MIXED INCONTINENCE** is a combination of stress and urge incontinence with symptoms from both types.

=> **CONTINUOUS INCONTINENCE**, which is not common, is the inability to control urine at any time.

HOW LONG CAN INCONTINENCE LAST AFTER TREATMENT?

Improvement can take several weeks to several months. It varies from patient to patient; your particular recovery could be quick or slow.

HOW DO YOU TREAT INCONTINENCE?

Treatment is based on numerous factors including the type and severity of your incontinence. There are a variety of treatment options which can potentially help you regain complete control:

=> **KEGEL EXERCISES:** Strengthen your bladder control muscles.

=> **LIFESTYLE CHANGES:** Modifying your diet, losing weight and regular emptying of the bladder can decrease urination frequency.

=> **MEDICATIONS:** Affect the nerves and muscles around the bladder, helping to maintain better control.

=> **NEUROMUSCULAR ELECTRICAL STIMULATION:** Strengthens bladder muscles.

=> **SURGERY:** Consists of injecting collagen to tighten the bladder sphincter, implanting a urethral sling to tighten the bladder neck, or an artificial sphincter device used to control urination.

There are also many products available that do not treat incontinence but help maintain a high quality of life.

WHAT ARE THE SIDE EFFECTS FROM TREATMENT FOR INCONTINENCE?

It is important to know

what side effects you might experience with each of the available treatment options.

=> **MEDICATIONS** may cause dry mouth and, in rare cases, constipation, heartburn, blurry vision and rapid heartbeat.

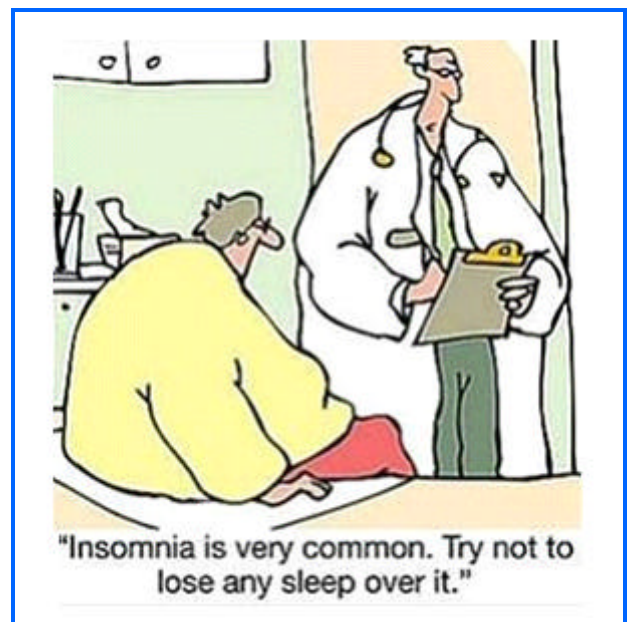
=> **NEUROMUSCULAR ELECTRICAL STIMULATION** may cause pain or infection and it is possible for the device to move.

=> **SURGERY** can cause various side effects depending on the type of surgery. The effectiveness of collagen injections can decrease over time, making future injections necessary; implantation of a urethral sling can cause infection and/or the sling could erode; and an artificial sphincter may cause pain and/or require replacement after several years.

It is always important to speak with your doctor if you are experiencing any urinary issues after your prostate cancer treatment. As a team, you can determine what will be best for you.

Source: www.KnowYourStats.org

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New Prostate Cancer Treatment Guidelines

New guidance for the NHS in England on how best to diagnose and treat prostate cancer has been published by the National Institute for Health and Care Excellence (NICE).

The guidance aims to ensure that men are given information about the treatment options available, even if they are not available locally, as well as help choosing the best option to suit them.

Professor Mark Baker, Centre for Clinical Practice Director at NICE, says in a statement: "The last few years have seen significant improvements in the treatment of men with advanced prostate cancer. NICE has recommended new treatments such as abiraterone, and we have also recommended enzalutamide and degarelix in draft guidance.

"The updated guideline includes a number of new recommendations on the swift diagnosis and treatment of different stages of the disease and a new protocol for men who choose active surveillance, which involves regular check-ups to see if and how the cancer is developing, rather than radical treatment. The aim of this NICE guideline is to ensure that excellent treatment is provided for men who will benefit from it."

Common cancer

Prostate cancer is the most common

cancer in men in the UK. In 2010 around 41,000 men were diagnosed with the disease in the UK. Three-quarters of prostate cancer cases are diagnosed in men over the age of 65. The new NICE recommendations include:

- Doctors should discuss all relevant treatment and diagnostic options with men with prostate cancer and their partners or carers, irrespective of whether they are available through local services.
- Doctors should consider a specialised type of MRI scan called multiparametric prostate imaging. This allows better assessment of the prostate gland than standard MRI or ultrasound scans. A multiparametric MRI improves the detection of clinically significant tumours, reduces the detection of clinically insignificant tumours and can guide biopsies more accurately. The guidelines suggest use of this type of scan for men who have had negative biopsies to help reduce unnecessary repeat procedures.
- Doctors should offer active surveillance as an option to men with low-risk localised prostate cancer for whom radical prostatectomy or radical radiotherapy is suitable.
- Offer men with intermediate- and high-risk localised prostate cancer

a combination of radical radiotherapy and androgen deprivation therapy, rather than radical radiotherapy or androgen deprivation therapy alone. Androgen deprivation therapy is a hormone treatment that reduces levels of male hormones.

- Consider active surveillance for men with intermediate-risk localised prostate cancer who do not wish to have immediate radical prostatectomy or radical radiotherapy.

Dr. Sarah Cant, representing patients and carers on the Guideline Development Group, says in a statement: "We want to ensure that all men diagnosed with prostate cancer receive the same high level of care, no matter where they live.

"Men and their carers should be supported at all times by appropriately trained professionals who can explain all the treatment and support options that are available for them. By making sure information and support are important aspects of care, we hope that all men will be better able to make the treatment choices that are right for them."

WebMD UK Health News - January 2014

Medically Reviewed by Dr. Keith David Barnard

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What's Your QALE?

Men with low-risk prostate cancer who choose observation (active surveillance or watchful waiting) enjoy greater quality of life than those who elect to be treated right away, according to a new report published in *Annals of Internal Medicine* (Volume 158, page 853).

This study used a model known as Quality-Adjusted for Life Expectancy, or QALE, to estimate the quality of life that a man (age 65 to 75) with low-risk prostate cancer could expect based on his choice of the various prostate cancer

management options. QALE estimates the number of years a person can expect to live but accounts for factors that reduce quality of life, such as having invasive tests and experiencing complications from medical procedures.

In this study, choosing watchful waiting or active surveillance for prostate cancer produced more "good-quality" years than radiation or surgery. For instance, among 65-year-old men, watchful waiting offered an additional 11 months

of QALE compared with brachytherapy (which had the highest QALE of any treatment).

Our advice. If you are an appropriate candidate for observation, you may want to discuss these findings with your doctor. The results provide additional information to consider in your decision-making process.

Source: johnshopkinshealthalerts.com 2014

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Prostate Cancer & ED

So what exactly is ED and why is it so closely linked with prostate cancer?

Normal male sexual function is a constellation of processes, including desire, emotional and psychological considerations, and physical function. Erectile dysfunction - commonly known as impotence - is defined as the inability to achieve or maintain an erection that is sufficient for satisfactory sexual activity. However, almost all men who have ED/impotence can overcome it.

The link to prostate cancer: The prostate is a small gland located at the bottom of the bladder. Common treatments for prostate cancer include pelvic surgery to remove the prostate (called a radical prostatectomy) radiation and/or hormone therapy.

ED following major pelvic surgery is not uncommon. The nerves which allow for an erection lie within millimeters of the prostate. These nerves may be injured by being cut or separated from the prostate during surgery. This may cause temporary or permanent impotence, although sexual desire and the ability to achieve orgasm should remain. Radiation can also impact this group of nerves. Hormone therapy can also cause a reduction in libido and possible difficulties with erections. This is generally reversible when the therapy

is discontinued.

The Journey To Solutions

Many couples who have successfully faced ED and prostate cancer stress the many facets of their journey:

=> Acknowledging the grief of the loss of their intimate life as they knew it before

=> Recognizing the fear that the level of intimacy they previously enjoyed would not return

=> Making a choice to remain open and discuss their feelings and concerns

=> Remaining willing to examine their intimate life and possibly redefine intimacy

=> Staying committed to exploring options and finding solutions.

Erectile dysfunction and sexual intimacy can be challenging to discuss under the best of circumstances. Add the stress of a prostate cancer diagnosis, and the challenge to remain open can be multiplied. When sexual challenges arise, many couples suffer far too long because the lines of communication shut down and fear takes over. Those who are successful at finding solutions are those who are willing to keep the lines of communication open, even when it is uncomfortable or difficult.

Most couples do not realize is that there are many possible solutions to restoring sexual intimacy, even after prostate

cancer treatment. From pills, to external devices, injections and surgical procedures, there are solutions for nearly everyone. With persistence, a little humor, open discussion, and medical support, couples can reclaim sexual intimacy once again.

Fortunately there are many medical professionals, generally urologists, who specialize in treating ED.

Don't let ED become a silent, unwelcome, over-bearing house guest. If you and your spouse are facing ED, whether is it the result of prostate cancer treatment or not, do not let fear, embarrassment, or discomfort destroy your love life. Become knowledgeable about ED. Seek help from medical professionals who specialize in sexual function and keep the lines of communication open. Some of the available treatments are listed below. Be sure to ask your urologist about them.

=> Oral Medication (Viagra, Levitra or Cialis)

=> Intra-Urethral Suppository (MUSE)

=> Penile Injection

=> Vacuum Device

=> Penile Prosthesis

Source: www.ustoo.org

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Bone Scans

A standard bone scan is performed by injecting radioactive technetium, a calcium analogue that accumulates in areas where the bone is "irritated." A sophisticated Geiger counter is passed over the body creating an image of the bones. Areas of accumulated radioactivity show up as "hot spots." These areas of abnormal accumulation are not always the result of cancer. Trauma or arthritis can also cause hot spots. Therefore, bone scan reports have to be interpreted by a clinician familiar

with the individual patient.

Bone scan technology has recently experience a serious upgrade. Fluoride 18 PET scans of the bone are decidedly more accurate than the older technetium technology. When F18 PET is available it should always be preferred over a technetium scan.

MRI of the bones with gadolinium contrast is also more accurate than a technetium bone scan. However, general use of MRI for scanning the bones is impractical. First, MRI of the ribs is

impossible due to respiratory motion. Second, MRI scanning of large areas of the body is very time consuming. MRI of the bones, therefore, is usually reserved for confirming suspicious but unconfirmed abnormalities detected with a bone scan. MRI of the spine and pelvis is sometime used as a screening tool to obtain the greatest assurance about the absence of bone metastasis.

Source: Prostate Oncology Specialists - 2014

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Manitoba Prostate Cancer
SUPPORT GROUP

presents
our annual

PROSTATE CANCER Awareness Evening

Tuesday, September 16, 2014 | 7-9pm
Caboto Centre - 1055 Wilkes Ave. Winnipeg

FREE ADMISSION



Dr. Kevin Saunders
Family Physician



Dr. Darrel Drachenberg
Urologist



Brian Sprott
Chair - MPCSG

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Special Thanks to Amgen

The Manitoba Prostate Cancer Support Group would like to acknowledge a recent donation from Amgen. Amgen produces Xgeva, a drug that is used in the treatment of bone health for prostate cancer patients.

Their continued support and generosity is sincerely appreciated. This donation, along with those from individual members, makes it possible for us to promote prostate cancer awareness. We appreciate their efforts in advancing the treatment of prostate cancer. *Many thanks!*



Email - manpros@mts.net

ALL MEMBER INFORMATION IS KEPT CONFIDENTIAL

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MEETINGS

August 14, 2014

Dr. Sabine Mai, PhD, Director, Genomic center for Cancer Research & Diagnosis.
 Topic: Tracking tumour cells to individualize treatment.

September 16, 2014 (Tuesday)

Prostate Cancer Awareness Evening
 Caboto Centre – 1055 Wilkes Ave. Time: 7 to 9 p.m.
 Presenters: Dr. Kevin Saunders, Family Physician
 Dr. Darrel Drachenberg, Urologist

This once a year program is a general overview of prostate cancer - includes time for Q & A. Come for coffee and info.
 No registration. Free parking.
 (Note: No meeting at Seven Oaks Hospital on Sept. 18th.)

October 16, 2015

Greg Harochaw, Pharmacist
 Topic: Testosterone Levels and Erectile Dysfunction Options

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

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