

## Side Effects Of Hormone Therapy For Prostate Cancer

### What causes side the effects

Hormone therapies for prostate cancer cause side effects because they reduce the levels of male hormones in the body. Some side effects are common to all hormone therapies used for prostate cancer. Some effects vary from drug to drug.

### Erection problems (impotence)

Difficulty getting an erection (impotence) is a common side effect of hormone therapy for prostate cancer. You will not be able to get an erection

if you are taking luteinising hormone (LH) blockers, such as goserelin (Zoladex) or leuprorelin (Prostap) or buserelin (Suprefact). This is because the drugs stop you producing any testosterone. It may be possible for you to have erections again once the treatment stops. This can take 3 months to a year, or even longer. For some men, erection problems are permanent. It depends on the drug you are having and how long you have been taking it.

About half the men treated with anti androgens alone, such as bicalutamide (Casodex), keep their sex drive and can get erections. This is also true for high dose treatment with Casodex. But you may still become impotent with long term treatment. About 1 in 5 men (20%) keep their ability to get an erection, even with long term treatment.

### Hot flushes and sweating

Hot flushes and sweating can be

*(Continued on page 2)*

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*Thanks!*

**Next Meeting:** June 19, 2014

*Dr. Ainslie Mihalchuk, CMO &  
Director of Family Medicine,  
Concordia Hospital*

**Topic:** Your Prostate Cancer Journey:  
Finding the Light and Living Well

**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

*If it's true that we are here to help others, then what exactly are the others here for?*

(Continued from page 1)

troublesome. They are the same as the hot flushes that women friends and relatives may have had when going through menopause. The flushes are caused by your testosterone levels dropping. They may gradually get better as you get used to the treatment. Hot flushes are most likely with LHRH blockers because these drugs cut off testosterone production altogether. Unfortunately, in some men the flushes keep on happening as long as you take the drug.

Some men find that their flushes are relieved by a short course of hormones called progestogens, and you may want to discuss this with your doctor. Recently, there has been some evidence that a drug called venlafaxine (which is usually used to treat depression) may help with hot flushes.

Researchers in France recently compared venlafaxine, cyproterone and medroxyprogesterone as treatments for hot flushes. They found that they all improved the hot flushes but that cyproterone and medroxyprogesterone reduced the number of hot flushes more than the venlafaxine. However, they only followed the men for 12 weeks so we don't know of any long term effects. Cyproterone and medroxyprogesterone are hormone treatments and using them to treat hot flushes may affect how your cancer is treated. The researchers recommend medroxyprogesterone as the best treatment for hot flushes.

Getting overheated, drinking tea or coffee, and having nicotine can all make flushes worse.

### **Breast tenderness**

Breast tenderness is a particular

problem with high dose bicalutamide (Casodex). The breasts can become painful and enlarged. Taking the drug tamoxifen can help to reduce breast tenderness in about 6 out of 10 men taking Casodex. Or sometimes it can help to have a small dose of radiotherapy to the breasts before your hormone treatment starts.



### **Tumour flare pain**

Pain caused by the prostate cancer can worsen when you start hormone treatment and this is called tumour flare. Your doctor should always prescribe another hormone therapy when you start leuporelin or Zoladex injections to help prevent tumour flare causing bone pain. If the pain carries on, your doctor can prescribe drugs called bisphosphonates to treat it.

### **Side effects from long term treatment**

The side effects listed above can all occur as soon as you begin treatment. There are other side effects that will only happen if you take hormone treatment for a long time. These are

- Weight gain
- Memory problems
- Mood swings and depression
- Bone thinning (osteoporosis)
- Risk of earlier heart attack

### **Weight gain**

You may put on weight. You should be able to control this with diet and exercise, but it is often a struggle to keep weight down when you are having hormone treatment.

### **Memory problems**

Some men feel that their memory gets worse when they have been having hormone treatment for a while. This will not improve while you are taking the hormone treatment, but there are ways to make life easier, such as making lists so you don't forget things.

It is natural to feel cheated and upset if you have this particular side effect. Talk to your doctor or specialist nurse if you feel this is having a significant effect on your life.

### **Mood swings and depression**

Hormone therapy can affect your mood. Some men say they have mood swings and even depression while having treatment such as Zoladex. A patient with prostate cancer told us "I would go into real 'black dog' moods that could last for days. I would burst into tears at the slightest thing, or even for no reason at all. And I was moody and argumentative."

He found the greatest help was talking to his wife. "You need to share your darkest thoughts with someone you totally trust, who can pull you through these very difficult times. She forced me to think positively, to see light at the end of the tunnel." If you don't feel comfortable sharing your feelings with people you know, seeing a counsellor may help.

### **Bone thinning (osteoporosis)**

Men taking hormone therapy for prostate cancer are at risk of bone thinning (osteoporosis). There is evidence that the risk of problems, such as bone fractures, is slightly higher for men having long term treatment to block testosterone (for example, Zoladex).

Bisphosphonate treatment can sometimes reduce bone thinning.

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But the National Institute for Health and Clinical Excellence (NICE) recommend that bisphosphonates should not be used in men with prostate cancer to prevent or reduce bone damage from secondary cancers or osteoporosis. They only recommend bisphosphonates to control pain from bone secondaries if other treatments, such as painkillers or radiotherapy, are not working.

Your doctor may suggest taking vitamin D and calcium to help lower your risk of problems from

osteoporosis. Other advice is to stop smoking, reduce the amount of alcohol you drink, and take regular weight bearing exercise, such as walking.

Your specialist may ask you to have tests such as a DEXA scan to measure your bone mineral density. The scan can show if your bones have become weaker and may be at increased risk of fracture. If your bones are weaker your doctor may ask you to have bisphosphonate treatment.

#### **Risk of earlier heart attack**

There is some evidence that if you are

over 65 and having hormone treatment for 6 months or longer your risk of having heart problems may be higher than a man not having treatment. This includes having a heart attack. You may have regular checks for this.

If you have heart problems, your heart specialist may need to check your heart medicines before you start hormone therapy. And you may need to have check ups more often while you are having treatment.

Source: Cancer Research UK

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## **A Treatment Choice: Active Surveillance**

Active surveillance allows for delayed primary treatment.

Active surveillance is being evaluated as a management strategy in younger patients with low-volume, low- or intermediate-grade (up to Gleason score 3 + 4 = 7) tumors to avoid or to delay treatment that might not be immediately necessary.

- Monitoring of the patient for progression for either watchful waiting or active surveillance patients are usually observed with semiannual PSA determinations, DRE, and annual biopsies.
- Intervention is recommended if Gleason pattern 4 or 5 is present, more than two biopsy cores are involved, or more than 50% of a biopsy core is involved.
- Progression is more likely in patients who have cancer present on every biopsy procedure.
- The absence of cancer on repeated biopsy significantly decreases the likelihood of progression.
- Biopsy criteria used in active surveillance have been reported to be more accurate than PSA criteria in predicting progression.
- No study has found DRE or imaging studies to independently predict progression.



- In most studies of active surveillance, approximately 25% to 50% of patients, depending on their individual risk factors, develop objective evidence of tumor progression within 5 years.
- Presently, no tumor marker can identify indolent tumors with certainty.
- Additional clinical and laboratory research are needed to define the parameters for safe use of active surveillance in younger men, including the appropriate selection criteria, follow-up procedures, and trigger points for intervention.
- All prostate cancer patients are at risk for progression.
- If the PSA level is rising, the DRE suggests tumor growth, or surveillance biopsy specimens show evidence of increased involvement by cancer, treatment should be instituted.
- Patients may change their minds about remaining on an active surveillance

protocol; therefore the physician should review management options on follow-up visits.

- In discussing treatment for prostate cancer, it is important to consider patient factors such as age and general performance status as well as tumor factors such as Gleason score, initial serum PSA, and estimated clinical volumes/stage of the tumor.
- If a patient has less than a 50 percent chance of surviving 10 years, it is difficult to measure the positive effect of treatment.
- The side effects of different therapies also have to be considered. It is optimal when patients come to a treatment decision based on consultation and input from both surgical and radiation oncology services.

The current treatment paradigm

- Multiple guidelines endorse active surveillance for low-risk prostate cancer, but concerns regarding biopsy under-sampling and under-staging have limited its acceptance.

Source: urologyhealth.org  
June 2013

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## Radiation or Surgery ???

TORONTO - For men with prostate cancer, deciding whether to opt for radiation or surgical removal of the gland can be a daunting prospect, as both carry the risk of unpleasant side-effects such as urinary incontinence and erectile dysfunction.

But a large study suggests that radiation treatment may lead to a higher incidence of other adverse effects in the years following treatment for localized prostate cancer, depending on a man's age and other medical conditions. The study, published in the journal *Lancet Oncology*, found men treated with radiotherapy had fewer minimally invasive urological procedures, compared to those who chose surgery. But over time, the radiation group had a higher proportion of hospital admissions, rectal or anal procedures, related surgeries and secondary cancers.

Lead researcher Dr. Robert Nam, a urologic oncologist at Sunnybrook's Odette Cancer Centre in Toronto, says before patients make a choice, it's important they understand all the risks associated with each treatment, to maximize their quality of life.

"Some people may say, 'You know what? I can live with a little leakage. I don't need to have sex. That stuff is over for me, so I'm going to go ahead with (a particular) treatment,'" Nam said. "That's usually the logic of their thinking." But what this study now says is wait a minute. Do you want to be admitted to hospital all the time? Do you want to be bleeding from your bladder or bleeding from your rectum all the time? Do you want a second cancer?" These are new things that people need to think about."

To conduct the study, researchers analyzed hospital and physician administrative records for 32,465 Ontario men who were treated for localized prostate cancer between 2002 and 2009. Of those, 15,870 had surgery (median age 62), while 16,595 had radiotherapy (median age 70).

Nam said men who opted for



radiotherapy had rates of these complications two to 10 times higher than patients who had their prostate surgically removed. There are two types of radiotherapy: external beam radiation and brachytherapy, which involves inserting radioactive material inside the prostate, allowing more targeted treatment. "The rates of complications ... were quite significant," said Nam. "And this has never been described before. We knew about this happening. We knew patients would be admitted to hospital. We knew patients that had these procedures following the treatment. But we never knew the severity or the number. And what we found was that up to 30 per cent of patients ended up with one of these procedure-related complications." The study also found that five to nine years after treatment, a cumulative total of 4.5 per cent of men who had radiation had developed a second cancer, compared to 1.8 per cent in the surgery group, most often in the gastrointestinal tract.

Bob Maurice of Penetanguishene, Ont., was diagnosed with prostate cancer in March 2005 and opted for radiation, which was less invasive than surgery. At first he had difficulty passing urine, but over time he developed other side-effects that ended up "being quite severe." "It was pretty tough," said Maurice, now 78. "I went for quite a few years where I was bleeding and I was incontinent and then what happened was stones gathered because of the damage to my bladder." He had surgery three or four times to remove stones from his bladder and was put on antibiotics too many times to count. "I had four really bad years where I was in and out of hospitals. I had to be cathetered. I had to wear pads — there was at times quite a bit of blood," said Maurice, explaining he was often incapacitated and couldn't leave the house. "It just went on and on. It was four years of misery."

In August 2010, Maurice had his prostate and bladder removed. He now has an internal pouch and he self-catheters, allowing him to resume his favourite outdoor activities, among them hunting and fishing. "I feel great. I'm very thankful that I've reached this point in my life where I can function like a normal human being," said Maurice, who attributes his being cancer-free to the radiation treatment. Still, after going through so much difficulty, he said he would go with surgery if facing the choice today. "There's quite a great possibility that if I'd had surgery and had my prostate removed, that I may still have my bladder."

Dr. Stuart Edmonds of Prostate Cancer Canada said the study "highlights the need for men and their families to

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consider treatment options very carefully, being aware that each treatment might increase the risk of certain complications. "It also highlights some of the potential deficiencies of current treatments and the need to continue to improve on them to reduce these complications," said Edmonds, the advocacy group's vice-president of research, health promotion and survivorship.

Dr. Tom Pickles, a radiation oncologist at the BC Cancer Agency, said he was not surprised at the findings, because it's known that any therapy for prostate cancer comes

with its own set of complications. "What I tell my patients is that all treatments have the potential to decrease quality of life," Pickles said from Vancouver, adding that erectile dysfunction rates are higher with surgery, while bowel problems are more common after radiation. "A lot of people have difficulty choosing because the cure rates are very similar and the side-effects, although it's apples and oranges, are similar."

And he doesn't think this study will make the process of choosing easier for men. "This just reinforces that all treatments come with side-effects and that a good discussion with the

urologist and the radiation oncologist about those side-effects, up front, is part of the decision-making process," Pickles said. Nam agreed, stressing the study isn't meant to say that surgery is better than radiation, but to identify and quantify their complications. "We're doing such a good job in curing the cancer, but then (men are) left with these types of problems surviving with cancer. And that needs to be part of the discussion with the patient."

By Sheryl Ubelacker, January, 2014

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## Link Found 'Between Cholesterol And Prostate Cancer Aggressiveness'

There is a possible link between the aggressiveness of prostate cancer and the accumulation of a compound created when cholesterol is metabolised in cells, according to research from Purdue University. This discovery could have a hand in the production of new diagnostic and treatment methods. In addition, the results suggest drugs developed to treat atherosclerosis may be repurposed to fight advanced prostate cancer.

Scientists found that a depletion of the compound cholesteryl ester dramatically reduced prostate cancer cell proliferation and suppressed tumour growth in mice.

Ji-Xin Cheng, a professor in Purdue University and lead author of the study, said: "Our study provides an avenue towards diagnosis of aggressive prostate cancer. Moreover, we showed that depleting cholesteryl ester significantly impairs prostate cancer aggressiveness."

The research team learned that

cholesteryl ester accumulation - which occurs in advanced forms in prostate cancer and its metastasis - is caused by the loss of a tumour-suppressing gene and the activation of an intracellular metabolic pathway promoting tumour growth.

Michael Koch, from the Indiana University School of Medicine, added that the findings improve current understanding of the role of cholesterol in cancer.

Source: spirehealthcare.com 6 March 2014

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**The Motorcycle Ride For Dad 2014 Kick-Off** took place on April 11<sup>th</sup> at the McPhillips Street Station Casino. The Kick-Off was the start to their annual fundraising event for prostate cancer research and awareness in Manitoba.



**Brian Sprott**, Support Group chair (checked shirt in the photo), thanked MRFD for their financial commitment to our Group. Other Support Group members attending included: **Mike Talgoy**, **Pat Feschuk**, **Betty** and **John O'Grodnik**.

## A New Approach to Prostate Cancer Screening

### Why Screen for Prostate Cancer?

Screening finds earlier stage cancers, allows for simpler treatments with fewer side effects, and saves lives. For example, in 1985, prior to PSA screening, the prostate cancer five-year survival rate was 69% compared to 99% in 2006. It's unclear whether this dramatic survival increase is entirely due to PSA screening. Other factors, such as improved therapy have also contributed.

### Why Is There A Controversy about Screening?

Prostate cancer can be very slow growing. If a man already has a short life expectancy, the cancer may never affect him. Therefore, the side effects of treatment may be worse than the disease. In addition, two studies evaluating the usefulness of PSA screening failed to show a benefit, perhaps because too many men in the comparative group who were supposed to forgo PSA screening ended up getting PSA testing outside the study. In a third study from Europe, in which the unscreened comparative group had a much lower exposure to outside PSA testing, the study showed an improvement in ten-year survival.

### Is Immediate Biopsy Appropriate?

As medicine is presently being practiced in the United States, an elevated PSA almost always leads to an immediate 12-core, random needle biopsy. Over a million men get biopsied every year. Unfortunately, few people realize that low-grade prostate cancer is so common in the general population that a biopsy will be positive 20% of the time, even in men with normal PSA! The majority of cancers found on random biopsy are small and do not require treatment. However, consider the emotional devastation of a cancer diagnosis. Men

can be literally frightened to death. Studies have shown that there is a sharp increase in suicides and heart attacks after a cancer diagnosis.

### Stop PSA Screening Altogether?

Due to concerns about over-diagnosis and serious side effects from unnecessary treatments, the U.S. Preventative Services Task Force has come out recommending against routine PSA testing. Unfortunately, the Task Force is missing the point. PSA is not the main concern. The problem is the prevailing medical policy in which doctors routinely refer men with high PSA for immediate random biopsy leading to over diagnosis of low grade cancers.

### Role of New Imaging Technology?

Rather than doing an immediate biopsy, doctors should consider prostate imaging with multiparametric MRI or Color Doppler Ultrasound. In experienced hands with state-of-the-art equipment, high-grade cancer can be ruled out with 95 to 98% accuracy. And when imaging detects a high-grade lesion, a targeted biopsy directed specifically at the area of abnormality can be performed. If the scans show that no high-grade disease is present, the patient can forgo biopsy and simply monitor the situation with further PSA testing and if necessary, consider additional imaging in six to twelve months.

### The Frequency of PSA Testing is Affected by Various Factors:

Annual PSA testing and a digital rectal examination are the foundation of screening. Men with increased risk due to

family history or because of African-American race should consider starting at age 40. Otherwise, men can begin PSA screening at age 50. It is reasonable however, for all men to get a baseline PSA between 40 and 50 years old, and then decide about further testing based on that initial reading.

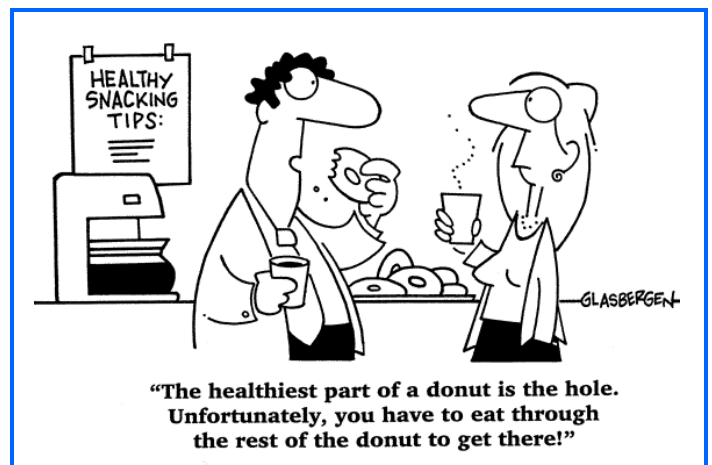
- Begin PSA testing age 40-45 if a relative had prostate cancer before the age of 60.
- Begin PSA testing age 45-50 if you have a father, brother, or uncle who had prostate cancer at any age or if you are an African American.
- Yearly PSA for men age 50-75 if your PSA 1-2ng/ml then every 2 years is okay.

After age 75 general health factors are the most important consideration. When overall health status is good it's reasonable to continue screening past age 75.

If the PSA is higher than 2.5ng/ml or if there is an abnormality detected on digital rectal examination, further evaluation with imaging is needed.

*By Peter Grimm, D.O. & Mark Scholz, M.D.  
February 2014*

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## Raw, Bitter Veggies For Prostate Cancer

AS if prostate cancer were not scary enough, hundreds of men with the disease are being subjected to a menu of raw, bitter vegetables for five years. That means lots of kale, turnips and radishes to go with their carrots and tomatoes.

This and exercise could help slow the disease, even in its advanced stages, says study leader Dr Kellogg Parsons, a speaker at the Urological Society of Australia and New Zealand. He is studying 464 US men with low-grade prostate cancer for five years to see how the disease progresses if they eat well and exercise regularly.

His previous population-based studies have shown people who regularly eat



vegetables significantly reduce their chance of dying from bladder, kidney or prostate cancer. "This is likely to be the case for all cancers," said Dr Parsons, an associate professor of urology at the University of California. Men in his study are encouraged to eat at least seven cups of vegetables a day. "It's a lot, so juicing some of the servings could make it

easier," Dr Parsons said. Our perspective is that raw vegetables are better than cooked."

Thirty minutes of moderate exercise a day can be beneficial for prostate cancer patients, but research suggests more rigorous exercise is especially beneficial.

Dr. Parsons continues, "People are likely to benefit from eating more vegetables, less fat, less meat, less processed carbohydrates and doing three or four exercise sessions a week."

Source: FYI From news.com.au



## Bone Metastases – Prevention (denosumab or zoledronic acid)

STOCKHOLM, SWEDEN - Patients who develop bone metastases from prostate cancer are at risk for skeletal complications that may seriously impact function and quality of life. Denosumab and zoledronic acid (ZA) are approved for the prevention of skeletal complications from bone metastases in solid tumors. Denosumab has demonstrated superiority over ZA for the prevention of skeletal-related events (SREs). An alternative study endpoint of symptomatic skeletal events (SSE), defined as symptomatic fracture, surgery or radiation to bone, or spinal cord compression) was introduced to describe these bone complications. Dr. K. Fizazi and colleagues compared the benefit of denosumab versus ZA in preventing SSEs in patients with advanced GU tumors and bone metastases.

Patients with advanced GU tumors, at

least one bone metastasis, and no prior IV bisphosphonate use were randomized to receive either denosumab or ZA every 4 weeks in a double-blind fashion. The risk of first SSE was reduced by 22% in patients treated with denosumab versus ZA. There were also fewer overall SSEs and a longer time to first-and-subsequent on-study SSEs in patients treated with denosumab versus ZA. Fewer SSEs of all types were observed in the denosumab treatment group. Denosumab reduced the risk of skeletal complications in patients with GU cancers and bone metastases regardless of whether the endpoint was defined as SRE or SSE. Because all skeletal complications from bone metastases have the potential to negatively affect patients' function and



quality of life, preventive treatment should be considered even when symptoms are not present.

Presented by K. Fizazi at the 29th Annual European Association of Urology (EAU) Congress

Published on 15 April 2014 - Stockholm, Sweden.

Source: Uro Today



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### Special Thanks to Sanofi



The Board of the Manitoba Prostate Cancer Support Group would like to thank Sanofi for their kind donation. Backed by decades of service to Canadian healthcare professionals and patients, Sanofi has partnered with their customers in the search for solutions to Canada's healthcare challenges. These include innovative initiatives to promote the appropriate use of medicines, make healthcare more efficient, cost-effective and help people better manage their health. Eligard, and Jevtana are 2 drugs produced by Sanofi. We appreciate their efforts in advancing the treatment of prostate cancer.

Email - [manpros@mts.net](mailto:manpros@mts.net)

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### MEETINGS

#### June 19, 2014

Dr. Ainslie Mihalchuk, Family Physician,  
CMO & Director of Family Medicine,  
Concordia Hospital.

Topic: Your Prostate Cancer Journey:  
Finding the Light and Living Well.

**July:** No Meeting

#### August 14, 2014

Dr. Sabine Mai, PhD,  
Director, Genomic center for  
Cancer Research & Diagnosis.

Topic: Tracking tumor cells to  
individualize treatment.

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

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