Manitoba Prostate Cancer SUPPORT GROUP

Newsletter

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Persistent Disease

Over 50,000 men relapse after surgery or radiation each year. With other types of cancer, colon or lung for example, relapse is detected when a scan shows metastases. Prostate cancer is different. Relapse can be detected by the PSA blood test when the cancer is still microscopic. With prostate cancer, scan-detected metastases may take ten or more years to appear after a PSA relapse occurs. In the context of the broader cancer world, therefore, a "PSA relapse," represents a "twilight zone" between two extreme situations— men who are still in remission and men with overt, scan-detected metastasis.

There are exceptions to the generally reliable rule that PSA is always detectable when cancer is present. These exceptions occur when, 1) There is a positive margin present after surgery and, 2) When there is a positive biopsy after radiation. In the former case, the amount of persistent disease after surgery is too tiny to be detected by PSA. In the latter case, PSA production originating from the residual prostate gland "overshadows" the PSA coming from cancer. Therefore, as a result, without biopsy, detection of relapse after radiation is generally delayed until the PSA rises above the 1 to 2 range.

Positive Margins

Positive margins occur after surgery in 10% to 50% of men (the percentage depends on patient variables and surgeon skill). Positive margins are

(Continued on page 2)

Medical Advisors

Paul Daeninck M.D.
Pain Management

Darrel 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:
November 20, 2014
Party time with Pot Luck food
Entertainment:
Campfire Junkies
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 doesn't glue stick to the inside of the bottle?

(Continued from page 1)
common because the prostate is only a few millimetres from the bladder and rectum. Therefore, even the finest surgeon will leave cancer behind if the cancer invades outside the gland. Cutting out a bigger area around the prostate, i.e. into the bladder or rectum in an attempt to achieve a clear surgical margin, is not an option.

Positive margins are reported a couple days after the operation by a pathologist, a type of doctor who specializes in examining the gland under the microscope. When a positive margin occurs, the risk of future PSA relapse is about 50%.

Minimal Extent
When surgical margins are positive several studies show that radiation to the prostate fossa, the area of the body where the prostate used to be, lowers PSA relapse rates and may slightly improve the ten-year survival rate. Some experts argue, however, that men with minimal positive margins have a 50% chance of being cured and therefore should only undergo radiation when and if the PSA starts to rise. These doctors recommend monitoring PSA closely, say every 3 months, and starting radiation when the PSA rises up to 0.1 or 0.2. This approach is attractive because we know that half of men with positive margins will never relapse and can be spared the potential side effects from radiation.

Multiple Areas
Multiple positive margins usually mean the cancer was large, high grade and that surgery was probably ill-advised in the first place. In any case, multiple positive margins should be handled like locally advanced disease, i. e. with radiation administered to both the fossa and to the lymph nodes in combination with testosterone inactivating pharmaceuticals and possibly with second generation hormonal agents like Zytiga and Xtandi. A short course of Taxotere might also be considered.

Local Relapse
Cancer recurring after surgery, radiation, cryotherapy or HIFU, in the area of the body where the prostate used to be, is termed a local relapse. Local relapses can be detected by a rise in PSA, a nodule felt on digital rectal examination, imaging (ultrasound or MRI) or by a biopsy. In this section about locally relapsed cancer, for the sake of discussion, it is assumed we are talking about isolated local relapse, i.e., that no metastases are detected by bone and body scans. If scans show metastases, systemic therapy is required. When systemic metastases are extensive, local treatment may be superfluous.

After Surgery
Radiation is the most common treatment for a local relapse after surgery. While radiation is often effective, the possibility of microscopic metastases outside the prostate fossa needs to be considered since radiation to the fossa alone will fail to be curative if cancer is also present in other parts of the body. The actual presence or absence of microscopic metastasis is never certain since there is no technology capable of detecting them. Microscopic metastases are more likely when the Gleason score is high and when PSA is rising quickly. In these situations, when the likelihood of microscopic metastases is higher, additional radiation to the lymph nodes in combination with testosterone inactivating pharmaceuticals (TIP) should be considered.

After Radiation
Biopsy-proven local relapse in the residual prostate after radiation is usually managed with cryotherapy rather than with surgery. Cryotherapy and surgery both potentially cause incontinence. However, the risk of incontinence from cryotherapy is substantially lower than it is with surgery. New experimental approaches are under investigation using genetically altered viruses, laser, and in some cases, a second round of radiation using radioactive seeds.

After Cryotherapy
Local relapse after cryotherapy can be treated with an additional attempt at cryotherapy or with radiation.

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PSA Relapse

Even though PSA has been questioned as a tool for screening, it's the Gold Standard for confirming cancer recurrence. However, a PSA rise from a low-grade recurrence may not require treatment. Determining the difference between a low-grade recurrence and a high-grade recurrence is heavily influenced by the rate of PSA doubling.

For a PSA relapse, treatment usually consists of testosterone inactivating pharmaceuticals (TIP) given intermittently. For example, after TIP is started, PSA usually drops to less than 0.1. Treatment is continued for 6 to 12 months. After TIP is stopped and the effects wear off, testosterone recovers and PSA will begin to rise. A second cycle of TIP is restarted when the PSA reaches a certain threshold (usually between 3 and 6). Immunotherapy administered during the holiday period may slow the rise in PSA and delay the need for restarting TIP.

PSA Doubling Time

The seriousness of relapsed prostate cancer is determined by the PSA doubling rate, an indicator of the rate of cancer growth. When PSA doubling requires more than 12-15 months to occur, the disease is low grade and therapy can usually be withheld. PSA doubling that occurs in less than 12 months is usually a sign that treatment will be required. PSA doubling in less than three months signals aggressive disease requiring maximal therapy. Additional factors that are predictive of greater aggressiveness are high Gleason score, a rapid relapse that occurs soon after local therapy and the presence of a high PSA nadir while taking TIP.

PSA Nadir

The lowest PSA achieved after starting testosterone inactivating pharmaceuticals (TIP) is called the PSA nadir. A favourable drop in PSA (to less than 0.05) after starting TIP predicts survival far better than PSA doubling time or Gleason score. A high PSA nadir in the face of ongoing treatment with TIP is an early indication of castrate resistance. A high PSA nadir strongly indicates the need for additional treatment including radiation, stronger hormone blockade, chemotherapy or immunotherapy.

Source: Prostate Oncology Specialists

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September Prostate Cancer Awareness Evening

On September 16, 2014 we held our annual Awareness Evening at the Caboto Centre. We are happy to announce that 200 people attended this prostate cancer information event. **Dr. Kevin Saunders**, Family Physician, presented the audience with four case studies. This format kept the audience intent and immersed as he analyzed each cancer journey.

Dr. Darrel Drachenberg, Urologist, spoke about PCa diagnosis, various treatments and their side effects. He also elaborated on the variety of new drugs for treatment of advanced cancer over the last number of years. Following their presentations, there was an hour of questions from the audience. In deed there were more questions than time allowed for the doctors to answer. However, they kindly remained after the meeting to speak with many individuals.

When asked as to the final "take-away" message they would like to leave with the audience, both doctors agreed that when you receive a diagnosis of PCa, "one should not panic". In general, PCa is slow growing and you have time to consider your options in discussion with your doctor.

The Caboto Centre proved to be a perfect location with lots of free parking. Four video screens made it very easy for the audience to see the powerpoint presentations. There was plenty of room in the conference room for a coffee tables and display tables.

Our Support Group gave out 343 books of information. These books were courtesy of **Abbvie, Amgen, AstraZeneca and Sanofi pharmaceuticals**.

As well, 44 new people signed up for our free newsletter.

The Manitoba Prostate Cancer Support Group Board thanks our sponsors and all those who worked to make this event a success.

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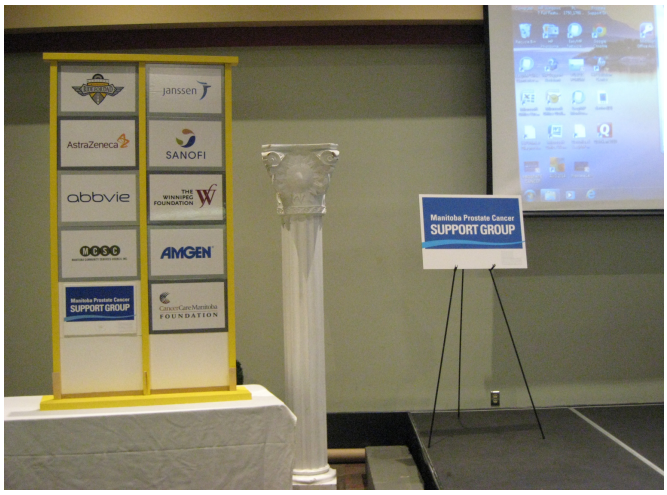

Brian Sprott, as presider at the September Awareness Evening, drew the attention of the audience to our list of sponsors. We thank them for making this event possible. Brian, who is a "wood-worker extraordinaire", made the sign and assembled it near the front stage.

Extreme Apical Sampling and Prostate Cancer Diagnosis

A new article in the September issue of *Prostate* addresses the potential benefits of "extreme apical sampling" during the initial biopsies of men at risk for prostate cancer based on such standard parameters as PSA level, positive/negative DRE, and related factors.

Elshafei et al. carried out a retrospective analysis of historical biopsy data from 3,053 men in the Cleveland Clinic's database. This database includes:

=> 2,521 men (82.6 percent) who underwent a standard, systematic, 12-core biopsy

=> 532 men (17.4 percent) who underwent a standard, systematic, 12-core biopsy and had two extra cores taken from the extreme anterior of the apex

It is well understood that prostate cancer can often be identified in areas of the prostate apex than are not normally sampled during a standard, systematic, 12-core biopsy. This is one of the reasons why a repeat biopsy within 12 months after initial diagnosis is commonly recommended for men who are to be managed on active surveillance. The goal of the research team was to see whether this type of extreme apical sampling made any significant difference to the probability of diagnosis of prostate cancer for the majority of patients — and to the aggressiveness of the cancer identified.

The team stratified their 3,053 patients into two groups:

=> Group A: A "standard risk" group of patients with a normal DRE, an elevated PSA of < 10 ng/ml, and no evidence of abnormal lesions on transrectal ultrasound

=> Group B: A higher risk group of patients with one or more of an abnormal DRE and/or a PSA level of > 10 ng/ml and/or evidence of abnormal lesions on transrectal ultrasound

The authors conclude, taking two additional biopsy cores from the extreme apex of the prostate does increase the overall probability of a diagnosis of prostate cancer; it does increase the likelihood of finding slightly larger amounts of cancer in the positive cores among men at "standard" risk; and it does increase the potential to find higher Gleason grades among those patients at "standard" risk for prostate cancer.

What this study does not show, however, is that giving all men an initial 14-core biopsy (comprising a standard, systematic, 12-core biopsy and two additional cores from the anterior of the prostate) is necessarily a good idea. Appropriate biopsy strategies are now more complicated that this, and we have to find a way to ask ourselves how to make good judgments about appropriate biopsy strategies on a much more individualized basis in the future by thinking about which patients really need an MRI/TRUS fusion-guided biopsy; which patients need an extended 14-core biopsy to account for significant risk for apical cancer; and which patients can be satisfactorily assessed by use of a standard, systematic, 12-core biopsy.

In thinking about this question, it seems highly likely to The "New" Prostate Cancer InfoLink that, at some point in the not too distant future, all patients who are diagnosed with prostate cancer on initial biopsy and who are good candidates for active surveillance will receive an MRI/TRUS-guided repeat biopsy within 6 months of initial diagnosis. Thus, one of the key questions here is really what one does with a patient who is at standard or higher risk for prostate cancer but who has an initial, negative, standard, 12-core biopsy. Men who get an initial positive biopsy result aren't really the problem at all, because they will be re-biopsied or will have immediate therapeutic intervention of some type … but how do we minimize the risk for the man who really does have prostate cancer (particularly intermediate- or high-risk prostate cancer) which is not found on an initial, standard biopsy?

Source: prostatecancerinfolink.net 2014

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CHRISTMAS IS JUST AROUND THE CORNER ……. and this signals the end of the 2014 tax year.
If you are planning to make a donation to our Support Group, please do so soon.
That way, Al, our Treasurer, will have time to issue your tax receipt before December 31.
Please act soon, because Al gets very busy cooking his Christmas turkey in December!

Dr. K. Saunders and Dr. D. Drachenberg responding to questions from the audience at the September Awareness Evening on Sept. 16th, 2014.

What is Active Surveillance ?

By Mark Scholz, MD

Active Surveillance is a revolutionary concept: The thought you can monitor prostate cancer rather than treat prostate cancer. This is a surprising development because anything called cancer, one would assume requires immediate and aggressive curative therapy. This anomaly now where there is a sub type of prostate cancer, we call low risk prostate cancer, that never spreads and never causes harm-has only come to medical attention over the last 5-8 years. It is causing quite a stir in the medical world now, because we have this huge industry that's been built over the last 20 years to try and aggressively cure all forms of prostate cancer.

So we've got different schools of thought now that are sort of at odds with each other. There is a wealth of scientific proof that low risk prostate cancer is safe to watch. But it's taking time for the doctors to learn about this and to accept and be willing to act on it. It is estimated somewhere between 30-40% of all men diagnosed with prostate cancer in the United States every year are eligible for Active Surveillance. That would be close to 100,000 men annually that could safely watch their prostate cancer rather than treat it.

It's important to know all this background about what's going on in the medical world, because people tend to get confusing messages from their physicians - different doctors will have different view points. It's important to realize this is here to stay, it is a medical fact that it is safe to watch prostate cancer. That's the starting point. Following that of course, there are different methods of monitoring - some centers use regular biopsies, frequent PSA testing, and different types of thresholds for deciding who has the type of cancer that does need treatment. I won't go into that at this point, because that is a complex area, but the first and most important take home message is that this idea - it's safe to watch certain types of prostate cancer - is an established medical fact.

Source: prostateoncology.com

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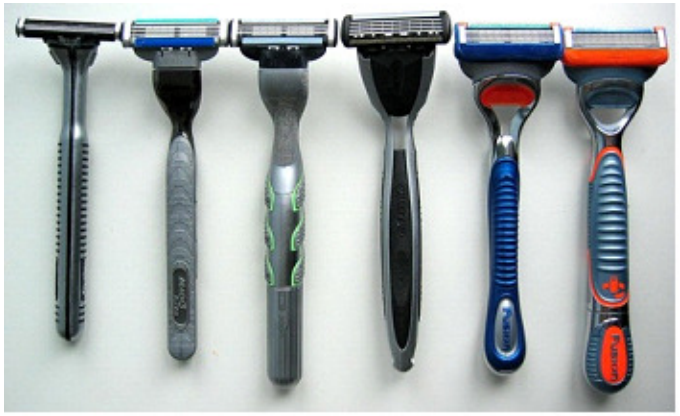
Support a Support Group



On your mark, get set .....

Put Your Razors Down

Typically November is the time of year when we see men of all ages sporting some "extra" facial hair. This scruffy ritual is a fun display for both men and women to support and raise awareness for prostate cancer. We appreciate and offer our thanks to all you men who have put down your razors to show your support. If you would like to support the **Manitoba Prostate Cancer Support Group**, you can make a secure online donation through our website at www.manpros.org or send us a cheque to: Box 315 – 971 Corydon Ave., Winnipeg, MB, R3M 3S7. A tax receipt will be issued. You can also support our services by letting others know that we are here to help. All our services (newsletters, meetings, information booklets, etc.) are free of charge.

Note: We receive no financial assistance from Movember or Prostate Cancer Canada.

Good Prostate Cancer (PCa) Outcomes Possible Despite Salvage Radiation Failure

Men who had PSA relapse after salvage therapy had a median overall survival of nearly 14 years.

Salvage radiation therapy (SRT) given after radical prostatectomy may improve outcomes in prostate cancer (PCa) patients, even in those who fail the treatment, according to study findings presented at the 56th annual meeting of the American Society for Radiation Oncology in San Francisco.

The study, led by radiation oncologist D. Nathan Kim, MD, PhD, Claus Roehrborn MD, and Yair Lotan MD, of the University of Texas Southwestern Medical Center in Dallas, included 61 PCa patients treated with SRT following radical prostatectomy (RP) from 1992 to 2000. The objective was to characterize the outcomes of those who failed SRT.

The median post-SRT follow-up was 126 months, during which 26 patients (42.6%) died, 10 (16.4%) from PCa. Of the 61 patients, 34 (56%) had PSA failure after SRT. These patients had a median follow-up of 157.5 months, during which 68% received androgen deprivation therapy (ADT). The median time from biochemical recurrence to initiating ADT was 48 months. The median overall survival was 13.6 years.

Dr. Kim's group divided the patients who failed into 2 groups: those who failed within 1 year of SRT and those who failed more than 1 year after SRT. Compared with patients who failed SRT more than a year after treatment, those who failed within 1 year of treatment were 10.6 times more likely to die from PCa, 5.7 times more likely to die from any cause, 7.7 times more likely to develop distance metastases, and 8.9 times more likely to develop castration-resistant cancer at 10 years.

The authors concluded that their study supports previously published clinicopathologic parameters for predicting outcomes after SRT even after long-term follow up. It also supports a long lasting survival benefit of early SRT at a lower PSA level, and suggests that SRT is effective in preventing prostate cancer-specific mortality and a low rate of distant metastasis.

Patients with early PSA failure after SRT may represent a more aggressive subgroup that needs close follow-up and further improvement of therapy, the researchers noted.

Source: renalandurologynews.com
September 2014

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Aspirin Eases Genitourinary (GU) Toxicity from Prostate Cancer Radiotherapy

Low-dose aspirin use is independently associated with decreased acute genitourinary (GU) toxicity in patients undergoing radiotherapy for prostate cancer (PCa), researchers reported at the American Society for Radiation Oncology 56th annual meeting in San Francisco.

John L. Mikell, MD, and colleagues at Emory University in Atlanta studied 972 PCa patients treated with definitive radiotherapy.

Of these, 210 were on daily low-dose aspirin during treatment. In multivariate analysis, use of low-dose aspirin was associated with a statistically significant 27% decreased risk of acute GU toxicity and no statistically significant worsening of acute gastrointestinal or late GU toxicity, the investigators reported in a poster presentation.

"While these results require validation in a prospective study, aspirin use during radiotherapy for [PCa] should be considered, as low-dose aspirin is a safe, inexpensive medication already separately recommended for many patients planned for radiotherapy," the authors concluded.

Source: renalandurologynews.com

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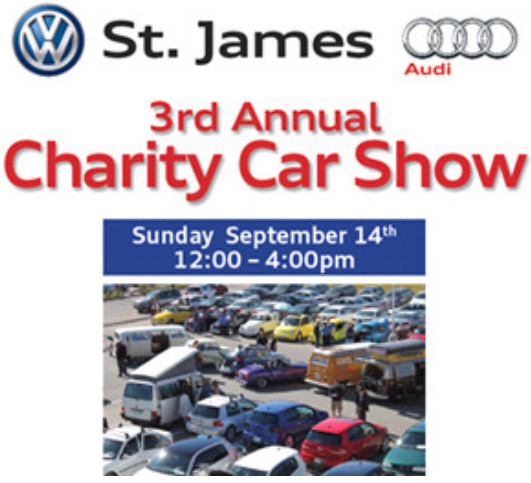

St. James Volkswagen held their 3rd annual Charity Car Show on Sept 14, 2014. This year the charity they chose to support was the "Manitoba Prostate Cancer Support Group". Three MPCSG members, John O'Grodnik, Jos Borsa and Len Bueckert were available to respond to prostate cancer queries from the public.

Approximately 50 to 60 classic cars were entered into the car show including campers, Beatles and a Mercedes Benz convertible. St. James Volkswagen made the event a family affair with face painting, kids car racing and a jumping balloon for the children to enjoy. A hot dog vendor was on site to ensure no one went hungry.

We wish to recognize the donation the St. James Volkswagen dealership has made to our Support Group and their desire to help us with our work in the community. Their kindness is much appreciated.

Caffeine Helps Cancer Survivors Reach Exercise Goals

Caffeine may improve exercise capacity and reduce fatigue in cancer survivors, a University of Queensland study has found.

The study is the first of its kind to investigate whether caffeine, the world's most commonly used stimulant, can help prostate cancer survivors exercise.

Dr. Tina Skinner from the Centre for Research on Exercise, Physical Activity and Health at UQ's School of Human Movement Studies said that caffeine might be an effective way to encourage exercise in prostate cancer survivors, improving their health.

"Cancer survivors face unique challenges relating to the risk of cancer recurrence and the development of other chronic diseases, as well as experiencing treatment and disease-related physical and psychological side-effects," she said.

"Common side-effects such as fatigue, pain, nausea and other symptoms make it difficult for cancer survivors to exercise at the optimal intensity for health benefits.

"Our study suggests that consuming caffeine one hour prior to exercise improves exercise capacity and muscular strength in prostate cancer survivors."

A randomised controlled trial was carried out on 30 prostate cancer survivors who consumed either approximately six milligram per kilogram of their body weight of caffeine, or a placebo, one hour prior to completing a series of exercises.
The researchers examined immediate fatigue and perceived exertion pre and post exercise and measured changes in exercise capacity and functional performance.

"We found that caffeine appears to enhance exercise tolerance. Participants reported improved performance and muscular strength with no subsequent increase in fatigue or perception of exertion," Dr. Skinner said.

"This is good news for prostate cancer survivors as exercise can help counteract many of the side- effects of prostate cancer treatments such as decreased muscle mass, strength and bone density."

The next step in the research process involves conducting a dose-response study to provide a recommended optimal dose of caffeine for prostate cancer survivors.

The findings of this study were presented last month at the European College of Sports Science Congress in Amsterdam, The Netherlands.

Source: uq.edu.au September 2014

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2014 Year End Review

by Brian Sprott, Chair MPCSG

The purpose of this review is to highlight some of the activities of the MPCSG Board over the past year. Our motto, our goals and the focus of all our efforts relate to providing "Awareness, Education and Support" for those affected with prostate cancer.

This year we welcomed two new volunteer members to our Board to make a total of 4 women and 8 men. The Board meets monthly at the Caboto Centre, planning and organizing all the events throughout the year.

<u>Board activities during 2014 included:</u>

1) Contacting speakers for our monthly meetings at Seven Oaks Hospital Auditorium.

2) Meeting and corresponding with various sponsor representatives in order to maintain our funding.

3) Searching and preparing articles for the newsletter. We currently mail/email 1300 copies per month.

4) Setting up booths at health fairs and other venues to promote PCa awareness.

5) Making power point presentations on PCa to various organizations.

6) Phoning all new members. Meet one on one with them if requested.

7) Attending sponsor events and doing tv interviews that are involved with raising awareness of prostate cancer.

8) Preparing information kits and delivering them to some urologists who give them to newly diagnosed men.

9) Corresponding with some rural health care workers.

10) Planning our annual September Awareness Evening at the Caboto Centre.

11) Maintaining an informative website (www.manpros.org).

12) Organizing entertainment and food for our "pot luck" social event at year end.

Prostate cancer affects approximately 700 men in Manitoba every year. We trust that we have provided opportunities for individuals to gain knowledge and insight in order to understand their diagnosis. The Board hopes that our efforts have made some impact on the community by bringing attention to this disease.

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

Publications Agreement
40037332

The Manitoba Prostate Cancer Support Group has been providing services for 20 years:
Newsletter – Website - Monthly Meetings - Hospital visits - Presentations
Your **DONATIONS** make it all possible. **We Thank You.**

Donor's Name: _____
Address: _____ Postal code: _____
This gift is in memory/honour of_____ Please send notification to:
Name: _____
Address: _____ Postal code: _____
$25 $50 $75 $100 $250 other_____ Make payment to:
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*A tax deductible receipt will be issued. Charity number: 88907 1882 RR0001
Credit card donations can be made by going to our website at www.manpros.org *and clicking on the* donate *tab. Canada Helps will issue a tax receipt.*

Comments re: September Awareness Evening

"I was very impressed with the September public awareness meeting at Caboto Centre. From my seat in the crowd, the audience seemed to be spellbound. I learned some things that were important to me. The question and answer format worked smoothly, and speakers were kept within reasonable time limits so I never felt bored or taxed by anyone going on and on. The organization, format and guest speakers, the facilitators and the ushers/runners all did a tremendous job, I think".

Editors Note: These comments were received by email from attendee Jim Anderson.

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Email - manpros@mts.net ALL MEMBER INFORMATION IS KEPT CONFIDENTIAL
Answering Machine - (204) 989-3433 ***Help us lower our costs :***
Receive this newsletter by email ~ Please notify us and we'll make the changes. ***Thank-you***

MEETINGS

November 20, 2014
Party Time: Pot Luck with Entertainment by the Campfire Junkies

Note: There will be no December meeting and there will be no December newsletter.
The hard working Board Members will be out looking for Santa!

January 15, 2015
Dr. Rashmi Koul, Head of Radiation Oncology CancerCare MB
Topic: Prostate Cancer and Bone Health

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

MPCSG BOARD

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