Manitoba Prostate Cancer SUPPORT GROUP Newsletter

Vol. 280 1,300 copies printed/e-mailed October 2014

Don't Docetaxel And Drive!

The chemotherapeutic agent docetaxel (Taxotere), widely used as the foundation for chemotherapy in the treatment of advanced forms of prostate cancer, is actually dissolved in an alcohol solution in order to allow it to be appropriately infused at time of chemotherapy.

Now the percentage of men on docetaxel chemotherapy who actually drive themselves to and from the clinic to get their docetaxel infusions is probably small. However, it does appear that there is a sufficient amount of alcohol in a standard docetaxel infusion to cause the possibility of alcohol impairment … and trying to explain to a police officer that you haven't been drinking if your blood alcohol is over the limit sounds like a lost cause!

So, if you are a chemotherapy patient getting docetaxel infusions or a support group leader or educator responsible for helping patients to understand the risks and benefits of docetaxel infusions, you will probably want to read the brief safety announcement issued by the US Food & Drug Administration. Most particularly, those patients with a history of alcohol problems who need docetaxel chemotherapy should be making sure that their doctors are aware of their history of difficulties with alcohol.

Source: prostatecancerinfolink.net June 2014

(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: October 16, 2014
Greg Harochaw, Pharmacist
Topic: Testosterone levels
and Erectile Dysfunction Options
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

Why do we sing "take me out to the ball game" when we are already there?

(Continued from page 1)

Editor's note: I located the "safety announcement" (issued by the US Food & Drug Administration) and this is what it says:

Safety Announcement

[[6-20-2014] The U.S. Food and Drug Administration (FDA) is warning that the intravenous chemotherapy drug docetaxel contains ethanol, also known as alcohol, which may cause patients to experience intoxication or feel drunk during and after treatment. We are revising the labels of all docetaxel drug products to warn about this risk. Health care professionals should consider the alcohol content of docetaxel when prescribing or administering the drug to patients, particularly in those whom alcohol intake should be avoided or minimized and when using it in conjunction with other medications.

Patients should be aware that docetaxel may cause them to become intoxicated from the alcohol it contains. Patients should avoid driving, operating machinery, or performing other activities that are dangerous for one to two hours after the infusion of docetaxel. In addition, some medications, such as pain relievers and sleep aids, may interact with the alcohol in the docetaxel infusion and worsen the intoxicating effects.

Docetaxel is a prescription chemotherapy drug used to treat different kinds of cancer, including cancers of the breast, prostate, stomach, head and neck cancers, and non-small-cell lung cancer. Several forms of docetaxel are currently marketed, including generics and the brand-name products Taxotere, Docefrez, and Docetaxel Injection. The various products contain different amounts of alcohol, which is used to dissolve the active ingredients so docetaxel can be given intravenously (see Docetaxel Formulations and Alcohol Content). Health care professionals should be aware of the differences in formulations in order to monitor and counsel patients appropriately.

Source: www.Fda.gov/Drugs/DrugSafety/ ucm401752htm

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Support for the Caregiver

Taking care of someone you love with cancer can take its toll.

If you are the caregiver for a man with prostate cancer, you have probably felt the ups and downs of the journey right alongside him. No doubt, as his health has changed, your everyday life has too. With every medical appointment, every treatment, and every challenge you have faced together, it can have an emotional, mental, and physical toll.

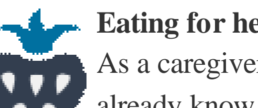
Being a caregiver can be a physically demanding experience. It may seem counter-intuitive, but in order for you to be the best caregiver you can be, you need to take care of your own health first.

That's why it's very important for caregivers to have support too.

Here are some things that you can do to help ensure you are at your caregiving best:

Get the sleep you need.
Sleep may come to you easier than it did before – or maybe not. But getting a good night's sleep is important, as a lack of it may affect your cognitive abilities, as well as your mood. Try sneaking in a power nap if you find yourself tired during the day.

Do something physical and fun.
Maybe it's exercise – or maybe it's just a walk in the park with your dog, or a bit of time gardening. Whatever you call it, let it be something you enjoy that engages your moving parts.



Eating for health.
As a caregiver, you may already know a thing or two about healthy eating. Canada's Food Guide provides a good snapshot of what a balanced diet should look like.

Breathe...
A deep breath. When things begin to stress us, our breathing can become quick and shallow, with less oxygen getting into our bodies. Take a few minutes to sit and breathe deeply.

For the mind and soul:
Just as the body needs rest and rejuvenation, your mind requires the same, so that you can continue to ask questions, do research, and be a sounding board for your partner. Here are some tried and true tips that can help you manage the emotional and mental stresses of caregiving:

Gather your network of support.
If you haven't already, now's the time, to ensure that you have a network of

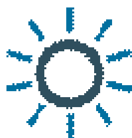
(Continued on page 3)

friends and family around you. Say YES to having coffee with a friend; say YES to letting someone bring over a casserole; say YES to letting a family member take over caring duties for a few hours. By saying YES, you allow others to become part of your support, and allow yourself some time to recover. In fact, why not set up a list of activities that your family or friends can sign up to do weekly or monthly? Make it a regular thing.

Laugh a lot.
Laughter may well be the best medicine: studies have shown that laughing can boost your immune system and give you a boost of energy. So make sure you leave room in your DVD player for lots of comedies.

Cry if you want.
You want to be brave in front of your loved one, but crying is not a sign of weakness. Allow yourself to feel the emotions that you're experiencing. If it's easier, talk to a social worker or counselor about your feelings.

Have ME time regularly.
Just as you would schedule a doctor's appointment or a treatment appointment for your partner, you need to ensure that there is a "ME" appointment regularly put in the calendar as well. It could be a few hours every week. Give yourself that time to do something important to you…or nothing at all.



Keep a routine, but mix it up too.
A routine may help things feel "normal" at home and give a sense of predictability in an unpredictable world. At the same time, plan some special events together – maybe a nice meal out, or a Sunday morning drive to the countryside. A break from the routine can be refreshing too.

Join a support group. Talking to others who "have been there" can be a relief. The Canadian Cancer Society and the Prostate Cancer Canada Network offer support groups for caregivers. In Quebec, Procure has links to services and support groups for families too.

In **Manitoba**, you can contact the **Manitoba Prostate Cancer Support Group** in Winnipeg by calling our answering machine (204) 989 - 3433. There is also a Prostate Cancer Support Group in Brandon and they can be reached at (204) 727 - 8128 or (204) 728 - 4202.

Source: www.prostatecancermatters.ca/

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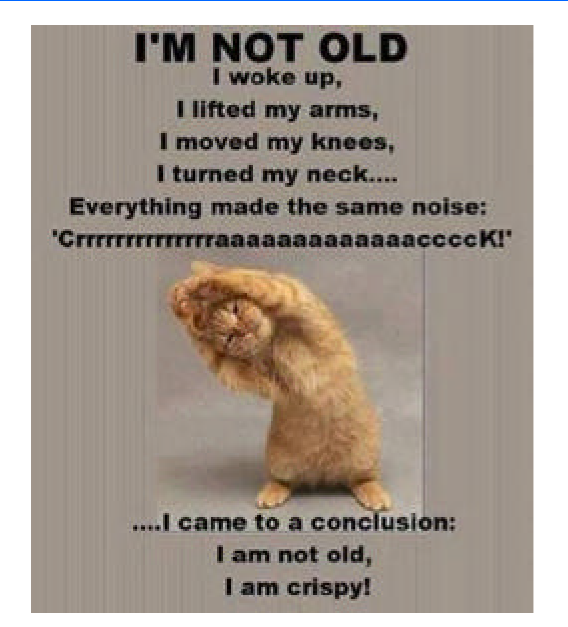
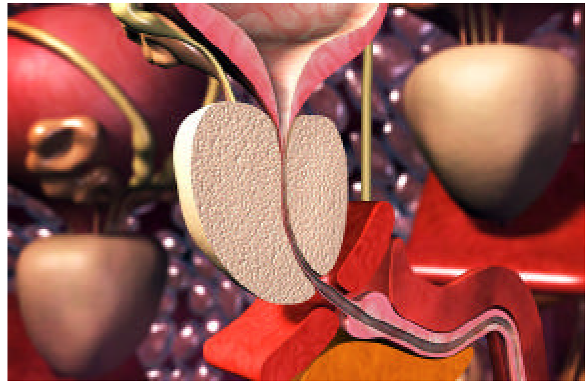
Moving???

HELP US KEEP OUR RECORDS UP TO DATE
(204) 989-3433
manpros@mts.net



Low-Risk Prostate Cancer : Just Say No to ADT

Should men with early-stage prostate cancer - meaning low grade and low stage with a PSA below 10 ng/mL - be treated with androgen deprivation therapy (ADT)? A new study published in JAMA Internal Medicine takes a close look at ADT for low-risk prostate cancer. It finds that while ADT plays a significant role in the treatment of advanced prostate cancer, it has no role in the treatment of older men with low-risk cancer.



To help our readers understand this important issue, Jacek L. Mostwin, MD, professor of urology, Johns Hopkins Medicine and medical editor of The Johns Hopkins Prostate Disorders Bulletin, elaborates. Here are his insights.

Over the years, I have found that there's nothing like an elevated prostate specific antigen (PSA) test result to strike fear into even the most unflappable and courageous of men. That's because elevations in PSA in the blood can point to the presence of prostate cancer. On the other hand, elevated PSA can also indicate prostatic enlargement or inflammation of the prostate. However, an elevated PSA test result, combined with a digital rectal exam and a 12-core prostate biopsy to remove slivers of prostate tissue from the gland, will provide a very good idea as to whether a man has cancer or not.

About 40 to 50 percent of the 241,000 men expected to be diagnosed with prostate cancer this year will have a suspicious PSA score and a Gleason score of 6 out of 10, which is based on the prostate biopsy. A Gleason score of 6 is an indicator of a very favorable or low-risk disease, a disease that is treatable and curable - if, in fact, a man chooses to treat it.

Facing treatment decisions. Once a man has a prostate cancer diagnosis, he then has to choose what type of treatment he wants, which can include surgery or radiation therapy; men with low-risk cancer can also opt for active surveillance, or close monitoring without any immediate treatment.

The good news is that low-risk prostate cancer - meaning low grade and low stage with a PSA below 10 ng/mL - grows slowly, if at all. Therefore, a man should be sure to discuss with his doctor whether he really needs to undergo any therapy to treat his cancer. That's because in the majority of cases the answer will be "not now."

What we have learned over the years with low-grade cancer is that sometimes the best option is no treatment whatsoever. And that includes treatment with androgen deprivation therapy, or ADT.

Earlier this summer, I came across a study in JAMA Internal Medicine that reminded me that many men with low-risk prostate cancer are still being offered primary ADT to treat their cancer, something that we would not recommend at Johns Hopkins. The reason: ADT offers no survival benefit for men with low-risk cancer and it causes significant side effects, including osteoporosis, diabetes and decreased libido.

Androgen deprivation therapy-also called hormone deprivation, or hormonal or androgen ablation--is effective at turning off the body's supply of male hormones, which prostate cells need to grow and develop. When the supply is shut off by drugs or by removing the testes, a portion of the cancer dies, tumors generally shrink, and PSA levels drop.

It's androgens, or male hormones, that stimulate the growth of prostate tumors. The two most common androgens are testosterone and dihydrotestosterone (DHT). Since the Nobel Prize-winning discovery by Dr. Charles Huggins of the University of Chicago that prostate tumors depend on these hormones to grow, reducing androgen levels or blocking the action of androgen (androgen suppression) has become the standard of care for men with cancer that has spread beyond the prostate (metastisized) to the bones and other organs. There has also been increasing interest in using it in men whose PSA level has begun to rise after treatment with surgery or radiation ("biochemical recurrence," an early sign that the cancer has not been eradicated).

Most Johns Hopkins doctors typically wait until there is evidence of metastatic disease before starting with ADT. There is an exception, however, and that is when we see a rapid PSA doubling time (less than six months) -- because this provides indirect evidence of micrometastic disease that will develop in the next few years.

While ADT plays a significant role in the treatment of advanced prostate cancer, it has no role in the treatment of older men with low-risk cancer. Yet primary ADT is nevertheless

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being prescribed for one in eight men over age 65 diagnosed with localized prostate cancer.

The JAMA article. In the JAMA Internal Medicine study conducted by Grace L. Lu-Yao, Ph.D., a cancer epidemiologist at the Rutgers Cancer Institute of New Jersey and professor of medicine at Rutgers Robert Wood Johnson Medical School, more than 66,000 older men with low-risk prostate cancer were followed for up to 15 years. Dr. Lu-Yao reported that those men who received ADT lived no longer on average when compared with men who did not receive the therapy.

I called Channing Paller, M.D., an assistant professor of oncology at the Johns Hopkins University School of Medicine who treats men with advanced prostate cancer, and asked her why she thought that a doctor would recommend ADT as a sole treatment for a man with low-risk prostate cancer, since it really offered no benefit to the patient.

"I am concerned that those physicians prescribing ADT for these low-risk patients are trying to decrease the high anxiety level that a patient may have due to his cancer diagnosis, rather than helping their patients understand that such treatment may carry more risk than benefit," says Dr. Paller. "ADT helps reduce anxiety by quickly dropping PSA levels into the undetectable range, so the doctors may feel that they are doing something positive for their patients. However, ADT may not really be in the patient's best interest due to complex side effects. The doctor should really be talking to patients with low-risk disease about pursuing active surveillance, not ADT."

"With the serious potential risks associated with ADT, including coronary heart disease, and the associated high costs of the medications, the use of primary ADT should be limited to patients in the high-risk cancer group who are not suitable for, or opt not to receive, primary therapy - surgery or radiation -- that has the potential to cure."

The side effects associated with ADT. In general, hormonal therapy will cause significant side effects after several months of treatment. Long-term side effects of ADT may include one, some or all of the following:

· Anemia
· Coronary heart disease
· Decreased energy
· Decrease in mental acuity
· Depression
· Diabetes
· Erectile dysfunction
· Hot flashes
· Loss of muscle mass
· Osteopenia
· Osteoporosis

Source: johnshopkinshealthalerts.com July 2014.

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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.

Needle Tracking of Prostate Cancer Cells During Prostate Biopsy: A Review

A new review article in BJU International has addressed the perennial question of whether prostate biopsy is associated with a risk for spreading of the cancer ("seeding") as a consequence of so-called "needle tracking" of prostate cancer cells. Volanis et al. conducted a thorough search for published papers that addressed such issues as incidence of seeding, clinical presentation, and associated risk factors (e.g., type of biopsy needle used, transrectal vs. transperineal approach, tumor grade and stage). Here is the quick summary of their findings:
A total of 26 published papers were identified that report needle tracking and "seeding" of prostate cancer post-biopsy.

=> These 26 papers reported that seeding occurred in just 42 patients.
=> 9 such cases occurred after transrectal biopsy.
=> 33 such cased occurred after transperineal biopsy.
=> The incidence of seeding after biopsy "appears [to be] much less than 1 percent".

In other words, while it is certainly possible for a biopsy to cause "seeding" of prostate cancer along the track of a biopsy needle under rare circumstances, there is almost no evidence at all to suggest that such seeding has ever led to the true "spread" of prostate cancer. Furthermore, as the authors also note, even though — over the past 20+ years — there has been a massive increase in the number of prostate biopsies carried out each year, and a similarly massive increase in the number of biopsy cores taken, there is no evidence whatsoever to suggest that this is associated with any increase in reports of "seeding".

Patients regularly express great concern about the risk that a prostate biopsy will increase the risk that their cancer will be spread as a consequence of needle tracking. And there is no doubt that such "seeding" can occur. However, it is also extremely clear that the clinical risk associated with such needle tracking and seeding is so small as to be trivial.

There were probably well in excess of 2 million prostate biopsies conducted in America last year. Even if as many as half of the 42 identified cases of seeding had occurred last year in America (which they most certainly did not), this means that the individual risk for seeding at the time of a specific biopsy is certainly no higher than $21 \times 100 \div 2{,}000{,}000$ or 0.001 percent (i.e., 1 in 1,000), and it may be a lot lower than that. Furthermore, even when such seeding does occur, there is no evidence to suggest that such seeding is associated with any increase in risk for clinically significant prostate cancer.

Source: prostatecancerinfolink.net August 2014

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Prostate Cancer in Younger Men: An Important New Review

An article in a recent issue of Nature Reviews: Urology looked closely at the question: Is prostate cancer in some way "different" in younger men? An article by Salinas et al, has carefully examined the available data on the incidence and the known long-term outcomes of prostate cancer diagnosed very specifically in men of age 55 years and younger, and makes a series of important points:

=> As of 2012, approximately 10 percent of all cases of prostate cancer in the USA are being diagnosed in men of = 55 years of age.
=> The median age of prostate cancer diagnosis decreased from 72 years in 1986 to 67 years in 2009 (primarily because of the increased role of PSA testing) — but "this shift does not account for the steep rise in the incidence of early onset prostate cancer."
=> The data about long-term survival of men with early onset prostate cancer lack clarity — but there are at least strong suggestions that younger men have slightly worse long-term prognoses (for 10-year survival) than those diagnosed between the ages of 55 and 75.
=> In one study,
=> Men of 35 to 44 years of age diagnosed with AJCC Stage IV prostate cancer had a prostate cancer-specific mortality rate 1.5 times higher than comparable men of 65 to 74 years of age.
=> Men of 35 to 44 years of age diagnosed with Gleason 8 – 10 disease had a prostate cancer-specific mortality rate 1.4 times higher than

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comparable men of 65 to 74 years of age.

Salinas et al. go on to argue that:
The unexpectedly poor prognosis of advanced-stage early-onset prostate cancer supports the idea that a new clinical subtype might exist in the subset of men with early-onset prostate cancer.

This is not a completely new idea by any means. However, the paper by Salinas has helped to give focus to this possibility.

The paper addresses in some detail the possibility that there is a key genetic component to the risk for prostate cancer among younger males. As the authors note, *A man with a positive family history for prostate cancer is two or three times more likely to be diagnosed with prostate cancer than a man with no family history.*
This risk is heightened among younger men with multiple affected relatives.
The effect of family history is not uniform across patient age groups.
Again, Salinas et al. go on to argue that *Despite the current limitations of genetic testing for prostate cancer, overall data suggest that genetic risk prediction is more useful in younger men than in older men.*

Their basic conclusion is that early-onset prostate cancer provides a series of important research opportunities that deserve further scrutiny, for several reasons:
Careful study of early onset prostate cancer "could also lead to further understanding and identification" of key genetic and phenotypic data relevant to the initial development of prostate cancer in younger men.

Because the majority of younger men diagnosed with prostate cancer tend to have low-grade, organ-confined disease, these are potential long-term survivors who can help us to find ways to optimize quality of life over time.

Inheritance of prostate cancer susceptibility genes is more important in the development of prostate cancer in younger as compared to older patients, but may also be important in helping us to appreciate the precise roles of such genes for all patients.

Source: prostatecancerinfolink.net June 2014

A Question About Kegel Exercises

Here's an important question from a recent issue of the Prostate Cancer Bulletin. "I am 68 years old and am scheduled for prostate cancer surgery next month. In a conversation with my urologist today, he told me that he wanted me to begin Kegel exercises daily to strengthen my pelvic floor muscles. He said that these special exercises would help speed up the return of urinary continence following the surgery. I had never heard of these exercises before and was even more surprised to hear that I may have problems with urination after the surgery. What are your thoughts on the value of Kegel exercises before and after prostate surgery?"

Dr. Mostwin replies. At age 68, you should definitely be concerned about urinary continence after prostate cancer surgery. Increased age is one of the risk factors in developing post-prostatectomy incontinence. Although men can be considered good candidates for surgery up to the age of 70 and even beyond, urinary continence is an important consideration in my practice.

The Kegel exercises were derived from the work of Dr. Arnold Kegel, a Los Angeles gynecologist who, in the 1940s, developed a method for rehabilitating the strength of the vaginal muscles after childbirth. Dr. Kegel created these exercises to strengthen the muscles that travel from the front of the pelvis around the rectum. Actively contracting these muscles shortens, tightens and rehabilitates the vaginal muscles. In men, they have the same effect on the muscles that control the urinary stream.

Kegel exercises have been adopted over the years as part of a rehabilitation program for urinary continence, initially in women, and later, when the era of radical prostatectomy began, for men. After radical prostatectomy, patients can exercise the pelvic floor muscles as a means of interrupting the urinary stream. Kegel exercise is commonly recommended, although the ability to interrupt the urinary stream doesn't guarantee that total urinary continence will be preserved.

Your urologist is correct in suggesting that doing Kegel exercises before surgery will familiarize you with the kind of muscle contractions necessary to interrupt the urinary stream. However, there's very little data to suggest that you will actually strengthen the sphincter muscle in any meaningful way. So start doing the Kegel exercises now in preparation for utilizing them after the operation, but understand that there are other factors in regaining continence post-surgery.

Source: Johns Hopkins Health Alerts August 2014

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315-971 Corydon Ave.,
Winnipeg R3M 3S7

Publications Agreement
40037332

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Advice !

One prostate cancer patient said, *"Don't dwell on what you've lost. Dwell on what you have left, and make the most of it. Don't waste your time."*

Another prostate cancer patient said, *"The most important thing is a positive attitude. I cannot emphasize this enough. Just because you're diagnosed with advanced stage prostate cancer, this does not mean it's a death sentence. And proof of that is myself...I've had advanced cancer for 18 years and I'm still here."*

Join a Support Group so that you can learn from others……. or ……you can pass on your advice and help others that are just beginning their cancer journey.

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Email - manpros@mts.net ALL MEMBER INFORMATION IS KEPT CONFIDENTIAL

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MEETINGS

October 16, 2014
Greg Harochaw, Pharmacist
Topic: Testosterone Levels
and Erectile Dysfunction Options

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
TBA

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

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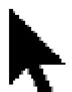

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