Manitoba Prostate Cancer SUPPORT GROUP

Newsletter

Vol. 279 | 1,160 copies printed/e-mailed | September 2014

Localized Prostate Cancer

Cancer is termed "localized" when bone and body scans are clear. Localized prostate cancer comes in three types or risk categories: "Low-Risk, Intermediate-Risk and High-Risk." High-Risk does not indicate a high risk of dying. "Risk" relates to the chance of the cancer relapsing after surgery or radiation, otherwise known as a "PSA relapse." Relapse from breast, colon and lung cancer is almost always fatal. Prostate cancer relapse, due to the typically slow growth rate of the cancer and due to the effectiveness of salvage therapy with testosterone inactivating pharmaceuticals (TIP), is usually not fatal. The majority of men with PSA relapse die of natural causes related to advancing age rather than from prostate cancer.

Low-Risk

In 2007, Peter Carroll, Chairman of Urology at University of California San Francisco, convened an international conference on Active Surveillance. He was concerned that too many men were receiving unnecessary radiation or surgery since men with Low-Risk prostate cancer rarely die or become ill from it, even if they never have treatment. The consensus from the 200 experts at the conference was that Active Surveillance was appropriate for men of any age who were in the Low-Risk category which means: PSA less than 10, Gleason score less than 7, no cancer felt on rectal examination, less than one third of core biopsies containing cancer and the absence of any single biopsy

(Continued on page 2)

Medical Advisors

Paul Daeninck M.D.
Pain Management

Darryl 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: September 16, 2014 (Tuesday)
Dr.Darrel Drachenberg, Urologist
Dr. Kevin Saunders, Family Physician
Topic: General overview of prostate cancer & treatments with time for Q & A.
Location: Caboto Centre – 1055 Wilkes Ave.
Time: 7 – 9 p.m.
Free parking, coffee, & info books available.
No registration necessary.

SHARING IS CARING

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

Thought of The Day

What do they plant to grow seedless grapes?

(Continued from page 1)
core more than 50% replaced by cancer.

Active Surveillance is defined as follows: PSA testing every three months, digital rectal examination twice a year and needle biopsy of the prostate after one year, and every two to three years thereafter. At Prostate Oncology Specialists we are actively monitoring over 400 men. In addition to the measures listed above, we also assess urinary PCA-3, imaging with Color Doppler Ultrasound and Endorectal MRI.

Active Surveillance is not a commitment to forgo treatment. It is a commitment to monitor closely and intervene at the first sign of growth or change in the cancer. Close observation over time is the best way to distinguish men who can be safely watched from the men who genuinely need treatment.

Intermediate-Risk
Intermediate-Risk patients have all the characteristics of Low-Risk patients except for one of the following: A PSA is between 10 and 20 or a Gleason of 7 or a small nodule can be felt on digital rectal examination or 33% to 50% of the biopsy cores with cancer.

Generally men with Intermediate-Risk disease require treatment. However, the following exceptions may suggest that Active Surveillance may be an option:

1. Over age 70
2. Favorable types of Intermediate-Risk disease
3. Men placing an extremely high priority on maintaining sexual function

Men in the Intermediate-Risk category face the most challenging decisions. Plausible arguments can be made for almost any one of more than a dozen approaches. To decide the best treatment, we recommend working backward from the known side effects associated with each of the different treatment options. Quality-of-life should be the primary determinate because in expert hands, survival is equally good with all the different treatment options. Our bias for younger men is brachytherapy at a center of excellence. Older men do well with intensity modulated radiation therapy (IMRT). Men with large prostates or excessive preexisting urinary problems can consider several options:

1. Nine months of testosterone inactivating pharmaceuticals (TIP)
2. Experimental focal treatment with cryotherapy (for men with unilateral disease)
3. Surgery (robotic or open) at a center of excellence

High-Risk
High-Risk is defined as any one of the following: PSA over 20 or Gleason of 8 or higher or a sizable nodule felt on digital rectal examination or more than 50% of biopsy cores involved with cancer. Also, men with two or more Intermediate-Risk factors are often considered High-Risk. Generally, the best cure rates are achieved with a combination of radiation and testosterone inactivating pharmaceuticals (TIP), not surgery. All too often with High-Risk patients, surgeons leave cancer behind—a positive margin. Cutting a clear margin around the prostate is difficult because the gland is within millimeters of the bladder and rectum.

Source: Prostate Oncology Specialists - 2014

• • •

Treating Prostate Cancer

By Deborah Kotz
Boston Globe Staff June 09, 2014

While debate rages over how aggressively to treat early-stage prostate cancer, men with advanced metastatic disease could gain a year of life if they receive a chemotherapy drug soon after their diagnosis rather than receiving the drug after hormonal treatments have lost their effectiveness, a new Dana-Farber Cancer Institute study finds. Researchers from Dana-Farber and other cancer centers tested both methods in 790 men diagnosed with end-stage prostate cancer that had spread to other organs and was dependent on hormones to grow. The group that received hormone therapy along with the chemotherapy drug docetaxel (Taxotere) lived for nearly 58 months on average compared with 44 months for those who initially received only the hormone therapy.

The chemotherapy treatment also delayed disease progression, which was monitored by an increase in prostate-specific antigen (PSA), the appearance of new metastases, or a worsening of symptoms. The men who received docetaxel as a first-line therapy had an average of nearly 33 months before the cancer progressed, compared with nearly 20 months for those who did not get the drug initially, according to a study, which was presented at the annual meeting of the American Society of Clinical Oncology in Chicago.

"The benefit is substantial and warrants this being a new standard treatment for men who have high-extent disease and are fit for chemotherapy," said Christopher Sweeney of Dana-Farber's Lank Center for Genitourinary Oncology.

Source: www.bostonglobe.com

• • •

Genes and Prostate Cancer: Terms You Should Know

Our genes guide production of proteins that regulate every aspect of our physiology. Genes are made up of deoxyribonucleic acid, or DNA. The critical information found in DNA is contained in chemical "bases" known as adenine, guanine, cytosine and thymine (which are usually represented by their first initials, A, G, C and T). Genes form tightly wrapped pairs of threads called chromosomes. Every cell in your body contains two copies of each gene, one inherited from your father, the other from your mother.

Humans have approximately 23,000 genes arranged on their chromosomes. Differences in the sequences of DNA bases found in a relatively small number of genes give each of us our personal traits and characteristics, such as the color of our skin, hair and eyes. Genes can also develop changes in the sequence of DNA. These changes are known as mutations, many of which are harmless or even beneficial.

Other mutations are harmful; for example, many forms of cancer are caused by mutations that make cells grow out of control and form tumors. And still other mutations appear to make a person more susceptible to certain diseases, such as prostate cancer. A gene mutation may be inherited from a parent (as in hereditary prostate cancer) or acquired at some point during a lifetime (as in sporadic prostate cancer, responsible for most cases of the disease).

What's in a Name? When it comes to prostate cancer, doctors often use the following terms to describe the origins of prostate cancer.

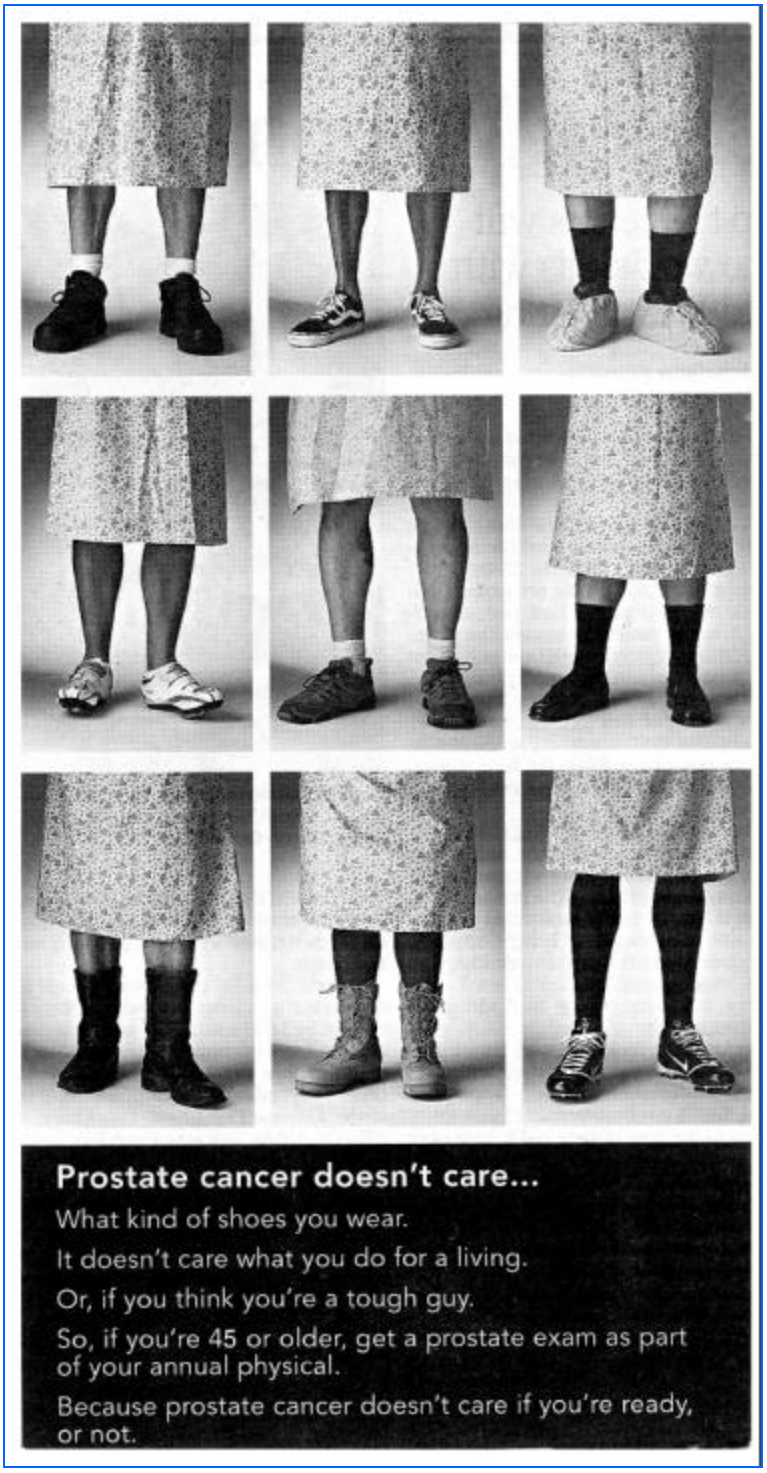
· Sporadic prostate cancer is the term for disease that occurs "out of the blue," that is, it strikes men who have no family history of prostate cancer. You might think of sporadic prostate cancer as a "nonhereditary" form of the disease.

· Hereditary prostate cancer is a form of prostate cancer that is linked to certain changes in genes that have been passed from parent to child. These changes, or mutations, can trigger the growth of malignant tumors. A mutation in the HOXB13 gene significantly increases the risk for hereditary prostate cancer.

· Familial prostate cancer is the term doctors use when prostate cancer strikes several times within one family - more often than one would expect to occur strictly by chance. Familial prostate cancer also tends to be diagnosed in younger males. This form of prostate cancer may be linked to gene mutations that increase the odds of developing the disease. However, shared environmental factors (such as diet) can't be ruled out as a cause of familial cancers. A man whose father or brother has or had prostate cancer has a twofold increased chance of developing prostate cancer.

Source: johnshopkinshealthalerts.com
July 24, 2014

• • •



Supportive Care for PCa

Supportive care helps people meet the physical, practical, emotional and spiritual challenges of prostate cancer. It is an important part of cancer care. There are many programs and services available to help meet the needs and improve the quality of life of people living with cancer and their loved ones, especially after treatment has ended.

Recovering from prostate cancer and adjusting to life after treatment is different for each man, depending on the extent of the disease, the type of treatment and many other factors. The end of cancer treatment may bring mixed emotions. Even though treatment has ended, there may be other issues to deal with, such as coping with long-term side effects. A man who has been treated for prostate cancer may have the following concerns.

Incontinence
Urinary incontinence is the involuntary loss of urine or the inability to control urination. Urinary incontinence can occur in men with prostate cancer:

- Enlargement of the prostate can obstruct the neck of the bladder neck. This can cause an overflow of urine when the bladder becomes too full (overflow incontinence).
- Prostate surgery or radiation therapy can damage the nerves or muscles that control bladder function or the release of urine.
- Pelvic radiation can cause irritation of the lining of the bladder, resulting in frequent urination and urgency.

Incontinence may be embarrassing and inconvenient, but it can be treated with medication, surgery or supportive measures to achieve better control.

Self-esteem and body image
How a person feels about or sees themselves is called self-esteem. Body image is a person's perception of their own body. Prostate cancer and its treatments can affect a man's self-esteem and body image. Often this is because cancer or cancer treatments may result in body changes, such as:

- changes in body weight and muscle mass due to hormonal therapy
- loss of the testicles (orchiectomy)
- loss of bladder control
- inability to get an erection

Some of these changes can be temporary, others will last for a long time and some will be permanent. For many people, body image and their perception of how others see them is closely linked to self-esteem.

Sexuality
Many men continue to have strong, supportive relationships and a satisfying sex life after prostate cancer. Sexual problems that can occur because of prostate cancer treatment include:

- Erectile dysfunction (ED) is the inability to get and keep an erection firm enough to have sex.
- Retrograde ejaculation can result from prostate cancer surgery (TURP). It occurs when semen flows backward into the bladder and mixes with urine, rather than out through the penis during orgasm.
- Dry orgasm can result from prostate cancer surgery (radical prostatectomy). A man who no longer produces semen may still have an orgasm. This is called a dry orgasm. A man who does not produce semen will not be able to father a child naturally.
- Decreased libido (loss of sex drive) may result from reduced testosterone levels due to hormonal treatments and other side effects of prostate cancer treatment.

It is common to have a decreased interest in sex around the time of diagnosis and treatment. When the man first starts having sex after treatment, he may be afraid that it will be painful or that he will not have an erection or orgasm. The first attempts at being intimate with a partner may be disappointing. Some men and their partners may need counselling to help them cope with these feelings and the effects of cancer treatments on their ability to have sex.

Fatigue
Fatigue causes a person to feel more tired than usual and can interfere with daily activities and sleep. It occurs for a variety of reasons. Fatigue may be caused by anemia, specific drugs, poor appetite, depression, or it may be related to toxic substances that are produced when cancer cells break down and die. Fatigue may get better as time goes by, or it can continue long after the person has finished their cancer treatment.

Osteoporosis
Some hormonal therapies that are used to block or decrease the body's production of testosterone can increase the risk of osteoporosis. The hormone testosterone causes prostate cancer to grow, but it also plays a role in maintaining strong bones. Hormonal therapies that lower the

(Continued from page 4)
levels of this hormone can increase bone loss. These therapies include luteinizing hormone–releasing hormone (LHRH) agonists and orchiectomy. Early detection and treatment of osteoporosis can decrease bone loss and reduce bone fractures.

Nutrition
Men diagnosed with prostate cancer may have questions about the kind of food that is good for them. Diets that promote healthy, well-balanced eating from a variety of food groups will contribute to better health while recovering from prostate cancer. There is no research that shows taking nutritional supplements of any kind can cure prostate cancer. Some studies suggest a link between prostate cancer and a high-fat diet. It is wise to minimize the amount of fat in the diet. Men with prostate cancer should consult their doctor or dietitian about the best nutrition for them.

Physical activity
The type and amount of physical activity a man can do after prostate cancer treatment often depends on:

- the type of prostate cancer treatment he received
- his overall health and physical condition

Heavy lifting and strenuous exercise should be avoided for a number of weeks after a radical prostatectomy, in order to allow the body to heal completely. Talk to the doctor or healthcare team before starting or resuming an exercise or physical activity program. Exercise can help a man return to the activities of daily living, reduce fatigue and improve energy levels.

Returning to work
Many men continue to work while being treated for prostate cancer, but it is quite possible that their way of working will change. They may have to take some time off or adjust their work schedule to allow for treatment and recovery. Returning to work is an important part of returning to a normal routine after treatment.

Men with desk jobs should be able to return to work after 3 to 4 weeks. Men with jobs that are more physical and require lifting and bending will have to wait longer before returning to work. When the doctor gives the go-ahead, normal work activities can be started again.

Source: Canadian Cancer Society

• • •

Sex Life and Prostate Cancer:

A Question for Dr. Mostwin

In a recent issue of the Prostate Bulletin, a reader asked, "I am 66 years old, recently remarried to a woman 20 years younger. I was diagnosed with Gleason 6 prostate cancer last week. My wife and I have enjoyed an active sex life and want to continue it. What other issues should I consider when choosing a treatment for my prostate cancer? Or might I not need any treatment at all?" Here is Dr. Mostwin's reply.

Fortunately, many men who are found to have Gleason 6 prostate cancer at your age may be excellent candidates for active surveillance. The criteria for active surveillance have recently been modified. The most recent recommendations can be found in a 2014 Journal of Urology article by Drs. Ballentine Carter, Bruce Trock and Jonathan Epstein, prostate cancer experts from Johns Hopkins.

The authors note that there are many specific criteria by which a patient can be advised about whether or not to consider active surveillance. Generally, the lower your PSA and the smaller the amount of Gleason 6, and even sometimes Gleason 7 prostate cancer found on biopsy, the more likely you are to be a good candidate for active surveillance. Using active surveillance, you can avoid treatment at this time if you are willing to be followed closely and carefully.

In the Johns Hopkins program on which the article is based, we see patients every six months for PSA testing and digital rectal examination, and all patients who have volunteered for the study have agreed to undergo a transrectal ultrasound and biopsy every year. The good news is that for the majority of these patients, the cancer does not progress. And it is extremely rare that any patient who does progress finds himself in a category of high recurrence risk.

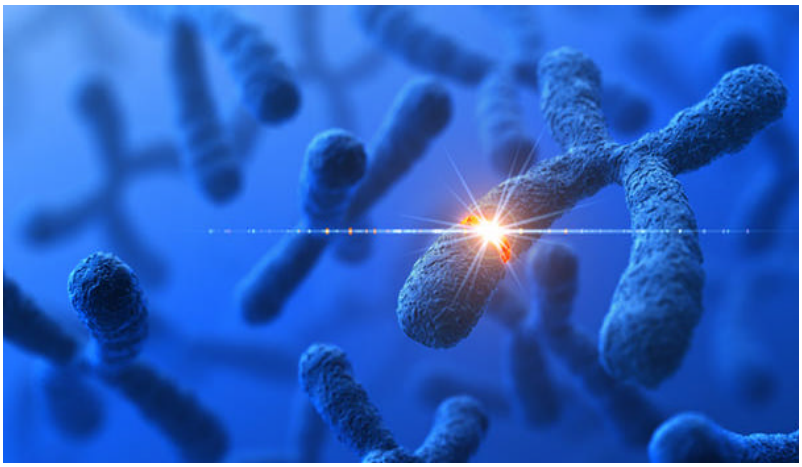
For patients who wish to avoid side effects of treatment, whether it be radical prostatectomy or radiotherapy, active surveillance offers an excellent alternative. However, if you have a higher volume of disease, or if your PSA shows signs of progression, you should certainly consider treatment. Many men in their later 60s can be excellent candidates for radical prostatectomy; sexual potency, however, is harder to recover as you get older.

Source: johnshopkinshealthalerts.com July 2014

• • •

Prognosis And Survival For Prostate Cancer

Men with prostate cancer may have questions about their prognosis and survival. Prognosis and survival depend on many factors. Only a doctor familiar with a person's medical history, type of cancer, stage, characteristics of the cancer, treatments chosen and response to treatment can put all of this information together with survival statistics to arrive at a prognosis.



A prognosis is the doctor's best estimate of how cancer will affect a person, and how it will respond to treatment. A prognostic factor is an aspect of the cancer or a characteristic of the person that the doctor will consider when making a prognosis. A predictive factor influences how a cancer will respond to a certain treatment. Prognostic and predictive factors are often discussed together, and they both play a part in deciding on a treatment plan and a prognosis.

More than 95% of prostate cancers are adenocarcinomas. The majority are slow growing and respond well to treatment. Rare types of prostate cancer include sarcomas, small cell carcinomas and transitional cell carcinomas. These make up less than 5% of all prostate cancers, and their prognosis is different.

The following are prognostic factors for adenocarcinoma of the prostate:

Stage

Stage is an important prognostic factor for prostate cancer. The less advanced a prostate cancer is at diagnosis, the more favourable the prognosis.

Tumours confined to the prostate (T1 and T2) have a better prognosis than tumours that have spread outside the prostate (T3 and T4).

Gleason score

The Gleason score indicates the aggressiveness of the prostate cancer:

- Scores less than 7 indicate a more favourable prognosis.
- A score of 7 indicates an intermediate prognosis.
- Scores greater than 7 indicate a less favourable prognosis.

Prostate-specific antigen (PSA) level

The prostate-specific antigen (PSA) level at the time of diagnosis may indicate how much prostate cancer is in the body (tumour burden). Higher PSA levels indicate that there is a higher tumour burden in the body. A PSA less than 10 is favourable, while a PSA greater than 20 is considered unfavourable. A PSA between 10 and 20 is intermediate.

Other factors

Other factors may have an effect on a man's overall prognosis for prostate cancer:

- resistance to hormone treatment
- Castrate-resistant or hormone-refractory prostate cancer is cancer that has come back or has progressed after being treated with hormonal therapy.

Prostate cancer cells gradually develop a resistance to hormonal therapy.

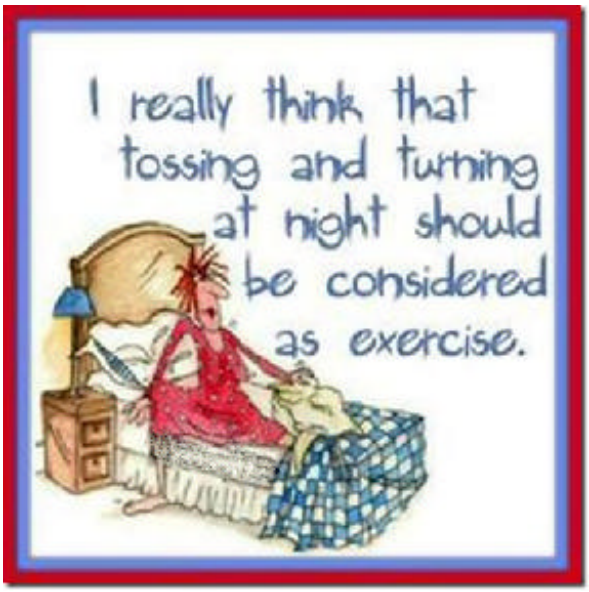
Age

- Younger men may have tumours that are more aggressive, with higher Gleason scores.
- Older men may have other illnesses that could affect the type of prostate cancer treatment they can tolerate.

Doctors also use nomograms to predict prognosis in different prostate cancer situations. Nomograms are statistical models that predict probable outcome. They take into account the stage, Gleason score, PSA level, biopsy pathology reports, use of hormone therapy, radiation dosage as well as other specific individual information such as age or treatment already received. This information helps in making treatment decisions as well as estimating prognosis.

Source: Canadian Cancer Society

• • •



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 Physican

Dr. Darrel Drachenberg
Urologist

Brian Sprott
Chair - MPCSG

Thanks to our sponsors:

janssen

THE WINNIPEG FOUNDATION

RIDE FOR DAD

CancerCare Manitoba FOUNDATION

abbvie

AstraZeneca

MCSC MANITOBA COMMUNITY SERVICES COUNCIL INC.

AMGEN

SANOFI

www.manpros.org Phone 204-989-3433

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:

Manitoba Prostate Cancer Support Group 315 – 971 Corydon Ave. Winnipeg, MB R3M 3S7
*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.*

Many thanks to the Gold Wing Riders and their Donors.

This is the 13th year the Gold Wing Riders have made the commitment to fundraise for our Prostate Cancer Support Group. This long standing relationship has indeed helped our Support Group provide awareness, education and support for those diagnosed with prostate cancer. It is with great admiration and appreciation that we recognize the work done by Grant Ubell, Bruce Zilkowski, Gary Ross and others. Their dedication and efforts have assisted us in raising awareness of prostate cancer in Manitoba.

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

September 16, 2014 (Tuesday)
Prostate Cancer Awareness Evening
Caboto Centre – 1055 Wilkes Ave.
Presenters: Dr.Kevin Saunders & Dr. Darrel Drachenberg
Time: 7 – 9 p.m.
Note: There will be no meeting at Seven Oaks Hospital on Sept. 18th.

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

November 20, 2014
Party Time
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!

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

MPCSG BOARD

Brian Sprott - Chair	(204) 668-6160
Betty O'Grodnik - Secretary	(204) 661-8549
Mike Talgoy - Speakers	(204) 515-1966
Al Petkau - Treasurer	(204) 736-4398
Len Bueckert - Presentations	(204) 782-4086
Darlene Hay - Membership	(204) 837-6742
Kirby Hay - Information Kits	(204) 837-6742
Liz & Pat Feschuk - Special Projects	(204) 654-3898
Jim Leddy - Outreach	(204) 326-1477
June Sprott - Newsletter	(204) 668-6160
John O'Grodnik - Member at Large	(204) 661-8549

This newsletter is a
Bottom Line Computer Services
publication
Bottom Line Computer Services is not responsible for content
www.misterpete.com