Manitoba Prostate Cancer SUPPORT GROUP

Newsletter

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New Test for Prostate Cancer Developed in Winnipeg

A new test for prognosis of prostate cancer is being hailed as a boon for men in the intermediate-risk category. The intermediate-risk group accounts for 30% of all newly diagnosed cases of prostate cancer.

This test was developed by Dr. Sabine Mai and her team of scientists at the Genomic Centre for Cancer Research and Diagnosis at the Manitoba Prostate Centre in Winnipeg. Dr. Mai, director of the Genomic Centre, presented her findings at a recent meeting in Boston. She co-founded 3D Signatures Inc. for commercialization of the test.

This test will be more accurate, cheaper and less invasive according to Vancouver neuroscientist, Dr. Oliver Prange, who has worked with Mai in the past. Dr. Prange has signed on with 3D Signatures as chief technology officer and said 3D is working to get certification for the test from Health Canada.

A diagnoses of "low risk" will get no treatment, while "high-risk" patients get aggressive treatment. The "intermediate-risk" group is split into patients that get active surveillance and those that get aggressive cancer therapy. The intermediate group would be subject to intrusive biopsies.

The new procedure involves a blood test that eliminates what is a bit of a guessing game. "We look at the structural arrangement of the chromosome component," said Dr.

(Continued on page 2)

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Thanks!

Next Meeting: April 16, 2015
Dr. Sabeer Rehsia
Topic: Biochemical Recurrence: What are your options?
Location: Main Floor Auditorium
Seven Oaks General Hospital
Leila and McPhillips
Time: 7 – 9 p.m.

SHARING IS CARING

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

MPCSG – active since 1992.

Thought of The Day

Ever wonder: Why is the time of day with the slowest traffic called "rush hour?"

(Continued from page 1)

Prange. "We can predict 100 per cent from that test which patients will advance and which will stay indolent (not progress in the disease)," he said. The treatment can then match a patient's condition.

"We hope that it will dramatically change the prognostic outlook of intermediate-risk prostate cancer patients," said Dr. Mai in a release.

Dr. Sabine Mai in her lab in Winnipeg.

"We need to have a better test to distinguish between the aggressive disease that a man will die of rather than the more indolent, or non-aggressive disease, that a man will die with".

Source: The Province (Vancouver)
February, 2015

Editor's Note: The Manitoba Chapter of Motorcycle Ride For Dad gives financial support to Dr. Mai's research. Many readers will recall that Dr. Mai spoke at our Support Group meeting in August 2014. We were thrilled to be able to hear, first hand, about her ground breaking research.

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Asking the Right Questions About Prostate Cancer Treatment

One in six American men will be diagnosed with prostate cancer during their lifetime, and many will go on to be treated with surgery, radiation or a hormone regimen known as androgen-deprivation therapy (ADT)

Each of these treatments comes with significant side effects and risks that can include sexual dysfunction, urinary incontinence, bowel dysfunction and bone loss. While the pros of these treatments may outweigh the cons for those with aggressive prostate cancers, older men (typically 65 and up) with prostate cancers that appear early or are considered low risk are often better suited to an active surveillance program that keeps a close eye on their prostate cancer as an alternative to immediate treatment.

According to H. Ballentine Carter, M. D., Professor of Urology and Oncology at Johns Hopkins Medicine, "Men who have early-stage prostate cancer should not ask their doctors, 'What treatment would be best?' but instead ask, 'Do I need treatment at all?'"

"A patient's personal preference and concerns are always critical when making a decision. Some men are OK with side effects if it means we can eradicate their cancer; others simply can't cope with having the lower quality of life that can come with surgery or radiation, and they opt for surveillance."

"Because prostate cancer tends to grow very slowly, patients have time to think through their decision. I encourage them to discuss the treatment experience, not only with their doctors but with other patients who have been through it, just to be sure they are comfortable with the realities of post treatment life."

Take-away message. If you've been diagnosed with prostate cancer, fully discuss your options with your oncologist or urologist. If he or she feels observation isn't appropriate, find out why -- and get a second opinion.

When discussing surgery as treatment, ask how it will be performed. For example, some doctors prefer to perform procedures robotically, which has been touted as an option that minimizes damage to normal, surrounding tissue and organs, and reduces complications. However, most studies have found little difference between traditional surgical techniques and robotic ones in terms of outcomes and complications, and many studies have found more complications with robotic surgery.

The doctor's experience should be a major consideration. Generally, it's best to choose a doctor and center that regularly treat prostate cancer. Your doctor should also be able to answer questions about how he or she handles complications during treatment (should they arise), how effective the treatment is and provide information on your prognosis.

Source: Scientific American Health After 50 Alerts…..2015

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Tips for Reducing Your Risk for Cancer

Don't use tobacco. About one-fourth of all cancers are related to tobacco use. Smoking has been linked to several cancer types, including lung, oral, bladder, esophageal, throat, and laryngeal cancers. Heavy smokers and those who began smoking at a young age are at an increased risk of developing the disease. Second-hand smoke exposure puts non-smokers at risk as well.

Limit alcohol intake. If you drink alcohol, do so in moderation (if at all). Excessive alcohol consumption increases your risk for certain types of cancer, such as oral, throat, pharyngeal, laryngeal, esophageal, kidney, liver, colorectal, and breast cancers.

Protect your skin from the sun. Skin cancer is one of the most common types of cancer. Try to minimize your time in the sun. Use sunscreen with SPF 30 or higher, and wear a hat and protective clothing/eyewear. Do not use indoor tanning beds or sunlamps. Also, be aware of any changes to your skin, like moles or other marks, and discuss these changes with your doctor.

Maintain a healthy diet and weight. Eating well and maintaining a healthy weight for your body may help to reduce your risk of certain cancers, such as colon, esophageal, kidney and stomach cancers. Eat a well-balanced diet, including five or more servings of fruits and vegetables each day. Avoid foods high in saturated fat, sugar and salt. A dietitian can help you design a nutritious meal plan.

Stay active.Regular exercise may play a role in cancer prevention. Physical activity may lower your risk of cancers of the breast, colon, uterus, and prostate. It can also help you increase your energy and avoid obesity. A rehabilitation therapist can help you develop a safe exercise program to meet your individual needs.

Get regular screening tests. Your doctor may recommend routine self-examinations and screening tests to detect early signs of cancer, such as cervical, breast, skin, oral, colon and prostate cancers. Your doctor may also recommend immunizations to protect against viruses that may lead to certain cancers. Follow-up visits with your doctor can help identify any changes in your medical condition.

Avoid risky behaviors. It is important to avoid risky behaviors, such as having multiple sexual partners and sharing contaminated needles. Such behaviors can lead to infections (hepatitis B and C, HPV, HIV, etc.) that may increase your risk for certain cancers. Protect yourself from sexually transmitted infections by practicing safe sex and seek help for your addiction if you use drugs.

Be aware of environmental hazards. Excessive exposure to certain environmental substances (e.g., asbestos, benzene, radon, ionizing radiation) may increase your risk for cancer. Discuss your concerns about hazards in your workplace with your employer. Have your home tested for radon levels. Follow health and safety procedures, such as wearing protective clothing, to control your exposure to environmental hazards.

Reduce your stress. Ongoing stress can weaken your immune system and make you susceptible to infection. It's important to find ways to reduce stress, such as relaxation techniques, distraction, and meditation. A mind-body therapist, spiritual counselor, and/or support groups can help you manage stress as well.

Review your medical and family history. Knowledge also plays a role in cancer prevention. Understanding your family history can help you understand your hereditary risk for cancer so you can make informed healthcare decisions. You may decide to go for genetic counseling and testing. The decision to undergo genetic testing is a personal one, and you should consider the pros and cons of testing beforehand.

Source: Cancer Treatment Centers of America

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Treating Prostate Cancer: Surgery

About 186,320 American men will be diagnosed with prostate cancer this year. Most cases will be diagnosed by PSA (prostate-specific antigen) screening, with transrectal ultrasound-guided prostate biopsies. And most patients will have early disease that appears confined to the prostate itself.

Men with early prostate cancer face a choice of management options. The major choices are active surveillance, radiotherapy, and surgery. More often than not, men choose surgery. That means a *radical prostatectomy* to remove the entire gland. It's an obvious choice for men who want to "get it all out" and a reasonable option for any generally healthy man with a life expectancy greater than 10 years.

Most American urologists view the radical prostatectomy as the "gold standard" therapy for localized prostate cancer. But before a man submits to the knife, he should understand the advantages and disadvantages of surgery. And in the increasingly complex world of prostate cancer, he may be offered a choice of surgical techniques.

The operations

The radical prostatectomy is not a single operation but a family of closely related procedures. Dr. Hugh Young began it all in 1904 when he introduced the *perineal* approach. The *retropubic* approach was developed in 1945 and quickly became the standard method of removing the gland. Then, in 1983, Dr. Patrick Walsh introduced the *anatomic radical prostatectomy*, which is better known as the "nerve-sparing" operation designed to preserve erectile function. Improvements in anesthesia and post-operative care followed in the late 1980s and early '90s, making the operation safer and hospital stays shorter. And since 1998, the less invasive *laparoscopic radical prostatectomy* and its variants have grown in popularity.

All these approaches have a common goal: to cure prostate cancer by removing all the disease. As a result, the operation removes the entire prostate gland along with the seminal vesicles and surrounding tissues. It's not an easy task. The prostate lies deep within the body, guarded by the narrow male pelvic bones, wedged between the rectum and bladder, wrapped around the urethra, and surrounded by important nerves that are vulnerable to injury (see figure).

Surgeons can perform an open prostatectomy from either of two directions. The older perineal prostatectomy uses an incision in the area between the anus and scrotum. But most doctors now favor the retropubic technique, which uses an incision in the lower abdomen. Its main advantage used to be that it allowed surgeons to inspect pelvic lymph nodes and remove suspicious ones to be sure they do not contain cancer before operating on the prostate itself; in the era of PSA screening and advanced imaging, however, lymph node removal is rarely necessary. Even without that advantage, most urologists believe the retropubic approach gives them a better view of the reclusive gland, reducing the risk of nerve injury and rectal complications.

If the lymph nodes appear normal, the surgeon carefully separates the prostate and seminal vesicles from the surrounding tissues. To actually remove the gland, the doctor has to cut through the urethra just above the bladder, but will sew the tube that carries urine out from the bladder back together once the prostate is removed. Once removed, the tissue is sent to the pathology laboratory for microscopic evaluation. If the cancer is confined to the prostate itself, the operation has the potential for cure, but if the tumor has already extended through the capsule surrounding the gland additional radiation or hormonal treatment may be recommended.

The nerve-sparing prostatectomy is an important variation on the theme. It is designed to protect and preserve the fine network of blood vessels and nerves that run along both sides of the prostate. If the nerves are not damaged, there is a greater chance that the patient will preserve his potency, but the operation requires special skill. Some doctors are concerned that a nerve-sparing operation may be more likely to leave some cancer cells behind, but 20 years of experience at major medical centers provides general reassurance that the nerve-sparing operation controls prostate cancer as well as standard surgery.

Nearly all radical prostatectomies are performed under general anesthesia, but spinal anesthesia is also an option. The operation is quite safe, with a mortality rate below 1% in most centers. After spending three to five hours in the operating room, the average patient will spend just one to four days in the hospital. Even so, he will need several weeks to recuperate at home and will have to urinate through a Foley catheter for one to three weeks while his urethra heals.

Like other minimally invasive operations, the laparoscopic prostatectomy aims to accomplish exactly the same goals as its traditional open counterpart. The difference is access. In the laparoscopic procedure, surgeons use small incisions, usually about a half-inch in length, to enter the body. Because they can't put their hands through such small openings, they use

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tiny instruments to repair damaged tissues or remove diseased organs. If all goes well, minimally invasive operations achieve the usual therapeutic goals with less postoperative pain, shorter hospitalizations, and faster recoveries.

The first laparoscopic radical prostatectomies were performed in 1991, using the retropubic approach. Like other abdominal laparoscopic operations, they required filling the abdomen with gas under general anesthesia. And they succeeded in removing the prostate gland and seminal vesicles, just like the open operation. Nevertheless, the operation did not take the urological world by storm. The early operations were very slow, taking an average of more than nine hours, and they did not offer any advantages over the standard approach.

Since 1998, however, laparoscopic prostatectomies have improved greatly. The reason is experience. The open operation is difficult and delicate in its own right, and it's important to have an experienced urologist. The laparoscopic prostatectomy requires even more training. The learning curve is steep, but urologists who have 40 to 60 operations under their belts are reporting results quite comparable to those of standard surgery. With an experienced team, the laparoscopic operation is nearly as fast as the ordinary operation and requires fewer blood transfusions, produces less pain, and allows a quicker recovery and return to activities. The complication rates are similar, and surgeons can perform nerve-sparing operations with either approach. Because the operation is relatively new, long-term results are not available, but early results are generally favorable.

Laparoscopic prostatectomy is a work in progress, but even as the story is evolving, a new variant, the robotic laparoscopic prostatectomy, is on the horizon. This operation is still done by a person, but instead of holding the instruments in his hands, the surgeon sits at a control panel and manipulates a machine that performs the surgery using special instruments and techniques. Despite its name, the machine is not a true robot but an extension of the surgeon.

Technology makes the robotic procedure possible. In this case it's the da Vinci Surgical System, which allows three-dimensional video visualization, a wide range of motion, and 360-degree maneuverability of the instruments. These pencil-sized tools have tiny "wrists" that can imitate the movement of the surgeon's hand and wrist at the remote-control console. Special computer software translates large human movements into precise, tremor-free micromovements. Needless to say, all this gear is very expensive.

It's a new advance in laparoscopic surgery, and several centers in the U.S. and Europe have reported good results. But if laparoscopic prostatectomy is a work in progress, robotic surgery is a technique that's just beginning to make progress, and it's too early to say how it will fit into the spectrum of surgical options.

Surgical results

Even with advanced surgical techniques and improved postoperative care, a radical prostatectomy is a big deal. Knowing that, many men choose to have the operation because they believe it offers the best chance to cure prostate cancer. Indeed, men with low-grade cancers confined to their prostates can expect excellent results. The 10-year cancer survival rates for such men may exceed 90%.

With such excellent results, why doesn't every man choose a prostatectomy? For one thing, low-grade localized cancers also respond very well to less invasive management strategies, including radiotherapy and even active surveillance. In addition, the surgery carries a substantial risk of complications. As with any operation, pain is to be expected, but it usually responds well to treatment. Bleeding and infection are also possible, but they, too, can usually be corrected.

But a radical prostatectomy has other potential complications, including erectile dysfunction, urinary incontinence, and possibly fecal incontinence. The risk of these complications varies from surgeon to surgeon and hospital to hospital. This variability also makes it difficult to predict the risk of complications. In broad terms, the risk for erectile dysfunction ranges from 20% to 80% and for urinary incontinence, 2% to 15%. Fecal incontinence is much less common. A 2000 National Cancer Institute study of 1,156 prostatectomy patients found that 79.6% were impotent and 9.6% had urinary incontinence two years after surgery. And in 2004, the Prostate Cancer Outcomes Study reported similar results in 1,187 patients evaluated five years after surgery.

Erectile dysfunction is the most common long-term complication; it is nearly universal in the first months after surgery, but some men experience gradual improvement over months and years. Men under age 60 who had good sexual function before surgery and had the nerves on both sides of the prostate spared have the greatest chance of recovering sexual

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function. These men are also the most likely to respond to Viagra and other treatments for erectile dysfunction. Some men who do not recover erectile function can still experience orgasms, but others cannot.

The decision

Cure versus complications — it is a hard question to balance, particularly since the predicted percentages vary so widely. But there is even more to the equation, since a man with prostate cancer must also consider the stage of his disease, the grade of his tumor, and his age and general health.

Radical prostatectomy is potentially curative only when prostate cancer is confined to the gland. Even with the best available staging procedures, though, it is impossible to detect microscopic spread before surgery itself. Hence, 14% to 54% of patients undergo the operation only to learn that the pathologist detected unsuspected tissue invasion that may require additional treatment. For these men, unfortunately, the operation represents pain without gain. According to a study of 3,494 Medicare patients, 35% of radical prostatectomy patients receive additional treatment within five years of surgery.

A second issue is the grade of a man's tumor. Even with disease confined to the prostate, radical prostatectomies are most successful for low-grade cancers (Gleason scores 2 to 4); in a broad review of 59,876 cancer registry patients, for example, 94% of men with such tumors did not succumb to prostate cancer for at least 10 years after radical prostatectomy. But the corresponding figures for moderate (Gleason 5 to 7) and high-grade (Gleason 8 to 10) tumors were 87% and 67%, respectively. A study of 2,311 men produced similar results; the 10-year cancer-survival figures for surgical patients were 94% for low-grade, 88% for moderate-grade, and 64% for high-grade cancers.

But if surgery is least likely to cure a patient with more aggressive tumors, these men may actually be the best candidates for surgery. It sounds like a paradox, but it is not. That's because the results of the competing therapeutic choices fall off even more sharply with advancing tumor grades. In the same two studies, the 10-year cancer survival rates for radiation were 90% and 83% for low-grade tumors, 76% and 72% for moderate-grade, and 53% and 43% for high-grade tumors. For watchful waiting, the drop-off was even sharper, falling from 93% and 94% for low-grade tumors to 77% and 75% for moderate grades, and to 45% (in both studies) for the most advanced tumor grades.

It is important to stress that these results are far from definitive. As pointed out by an American Urological Association Expert Panel, direct comparison between treatment modalities is not really valid unless they are generated by randomized clinical trials. Only one such trial has been completed . It showed that surgery is preferable to watchful waiting, at least for men younger than 65 with PSAs above 10 — but it did not provide data about radiotherapy or active surveillance, or about men with early PSA-detected disease. Still, most authorities interpret the available data as suggesting that radical prostatectomy is most likely to benefit men with localized but moderate- to high-grade prostate cancers.

The third factor is the patient's age and health. Because most prostate cancers grow slowly, aggressive therapy is most likely to help men with the longest life expectancies. Men with other serious diseases that could cause death or major disability within 10 years are not likely to benefit from radical prostatectomy. The same is true for men in their 70s and 80s, even if they are in fine general health. It is a tricky issue, since no man likes to contemplate his mortality. Many 80-year-olds feel great and are tempted to choose a surgical option that is best suited to younger men. In general, it is a mistake.

After surgery

Since a radical prostatectomy removes the entire gland, the PSA should fall to immeasurably low levels within a month of surgery. As long as your PSA remains undetectable, you can be sure that you are free of recurrent disease. If your PSA rises to measurable levels, however, it indicates the return of prostate cancer, a *biochemical relapse*. But in most cases, that is not as bad as it sounds. Since the PSA is so sensitive and since prostate cancer often grows slowly, it will take eight years for the average man whose postoperative PSA rises to at least 0.2 nanograms per milliliter (ng/mL) to progress to metastatic disease, even if no therapy is administered. Men whose original tumors were high-grade malignancies, men with early PSA relapses, and those with rapidly rising PSAs are the most likely to develop clinical problems. The time it takes for a man's PSA value to double (the *PSA doubling time*) is a particularly useful indicator. Men with doubling times of more than one year are at low risk of dying from prostate cancer within 10 years of diagnosis.

Doctors may perform ultrasounds, CT scans, bone scans, or biopsies to check for recurrent disease in men whose PSAs rise after surgery. Even if cancer is detected, radiation or hormonal treatment can be very helpful. It should be noted that radiotherapy is also an excellent option for the initial treatment of localized prostate cancer.

Source: healthyliving.msn.com

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Prostate Cancer Researchers Develop Personalized Genetic Test to Accurately Predict Recurrence Risk

TORONTO, ON - November, 2014 – Prostate cancer researchers have developed a genetic test to identify which men are at highest risk for their prostate cancer to come back after localized treatment with surgery or radiotherapy.

Study co-leads Dr. Robert Bristow, a clinician-scientist at Princess Margaret Cancer Centre, and Dr. Paul Boutros, an investigator at the Ontario Institute for Cancer Research, report that the gene test provides a much-needed quick and accurate tool to determine with greater precision the men who will do well with local treatment only (surgery or radiation), and those who will need extra treatment (chemotherapy and hormone therapy) to ensure the cancer is completely eradicated.

"Our findings set the stage to tackle the ongoing clinical problem of undertreating men with aggressive disease that will recur in 30% to 50% of patients due to hidden, microscopic disease that is already outside the prostate gland during initial treatment," says Dr. Bristow.

"This genetic test could increase cure rates in intermediate- to high-risk men by preventing progression to this metastatic spread of prostate cancer." The next step will be testing the gene signature on many more patients worldwide for three to five years to turn the test into one that is readily available in the clinic to guide personalized prostate cancer treatments.

The predictive test analyses biopsy tissue taken before treatment even starts to identify abnormal genetic characteristics (abnormal DNA) of the prostate cancer and its oxygen content. Low oxygen, or hypoxia, is an already known factor in the spread of prostate cancer. Together, this information can predict with almost 80% accuracy – and in about three days – those prostate cancer patients who are at greatest risk of their disease returning, the study shows.

"The clinical potential is enormous for thousands of patients," says Dr. Bristow. "This is personalized cancer medicine to the hilt – the ability to provide more targeted treatment to patients based on their unique cancer genetic fingerprint plus what's going on in the cancer cell's surrounding environment. We hope to improve cure rates by reducing the chances of the cancer recurring and prevent the cells from spreading."

The researchers developed the genetic test with two groups of patients. In the first group, the team analyzed DNA from initial diagnostic biopsies of 126 men who were treated with image-guided radiotherapy (IGRT) and followed for an average 7.8 years. In the second group, the team used the test on 150 men whose tumours were removed surgically (radical prostatectomy). The genetic test produced similar results in both groups and therefore can be used in patients who choose radiotherapy or surgery as their initial treatment.

The researchers further found that when testing tumours for hypoxia in the men treated with IGRT and the gene test, this combined information made the test even more accurate, says Dr. Bristow.

The study showed that the men with the best outcomes – lower than 7% recurrence of prostate cancer at five years – had low levels of genetic changes and low hypoxia. For men with high levels of genetic changes and high hypoxia, outcomes were worse – more than 50% of patients had recurrence and these are men who, in the future, could be offered intensified treatment as part of a personalized treatment plan.

The findings are published online in *Lancet Oncology*.

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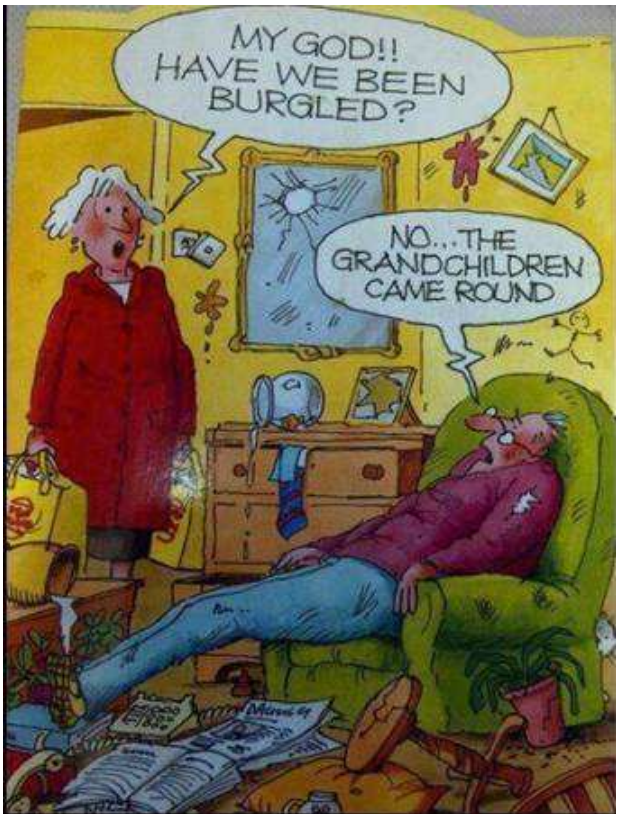

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2015 MEETINGS

2015 MEETINGS
Jan. 15 Dr. Rashmi Koul, Radiation Oncologist
Topic: Prostate Cancer and Bone Health
Feb. 19 Bill Martin, Gimli Author
Topic: Ripped Out: One Man's Journey Surviving PCa
Mar. 19 Dr. Robert Wightman, Pathologist
Topic: Biopsy Report and its Role in Determining Therapy
Apr. 16 Dr. Sabeer Rehsia, Urologist
Topic: Biochemical Recurrence: What are Your Options?
May 21 Dr. Paul Daeninck, Medical Oncologist
Topic: TBA
June 18 Edith Mulhall, Lymphedema Assoc. of Manitoba
Topic: TBA
July No Meeting
Aug. 20 Dr. Reece Malone, Sexuality Educator
Topic: Reclaiming Intimacy and Nurturing Connection after Prostate Cancer.
Sept.17 Prostate Cancer Awareness Evening at Caboto Centre - 1055 Wilkes Ave. 7 – 9 pm
Dr. Rashmi Koul, Radiation Oncologist
Dr. Piotr Czaykowski, Medical Oncologist
Oct. 15 Dr. Kelli Berzuk, Incontinence Physiotherapist
Topic: Living With incontinence: Do I Have To?
Nov. 19 Christmas Pot Luck Party
Dec. No Meeting

All meetings 7 – 9 p.m. at
Seven Oaks General Hospital Auditorium
(*except September*)
Everyone Welcome

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