Manitoba Prostate Cancer SUPPORT GROUP

Newsletter

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Side Effects of Hormone Therapy

The selection of treatment intensity has little meaning if the patient is not familiar with the advantages of the treatment and a good understanding of all the potential side effects of hormone therapy. Many of the side effects of TIP (testosterone inactivating pharmaceuticals) are reversible or preventable with simple measures. Side effects that are not completely reversible should receive much more attention than those that are reversible. Side effects of minor consequence (i.e. dry skin or loss of body hair) are not going to be addressed.

Loss of Libido

Libido, a passionate attraction to the opposite sex, needs to be contrasted with potency, which is the ability to get an erection. Libido can exist without potency and potency can exist without libido. This latter reality was studied at Prostate Oncology Specialists by using Viagra in 20 men who were potent prior to starting TIP. Nineteen of the 20 men on TIP who were administered Viagra were able to get an adequate erection.

However, Viagra may be underused in men taking TIP because TIP causes low levels of sexual desire. On average, libido is completely lost in 90% of men over age 70. Men between age 60 and 70 retain libido 15% of the time. Men less than age 50 retain libido as much as half the time. Generally libido returns to normal levels when testosterone recovers. However even after testosterone recovery about 25%

(Continued on page 2)

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Thanks!

Next Meeting: February 19, 2015
Bill Martin, Gimli Author
Topic: Ripped Out: One Man's Journey Surviving Prostate Cancer
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

Business conventions are important.....
because they demonstrate how many people the company can operate without!

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of men over age 65 describe their libido as diminished compared to before TIP.

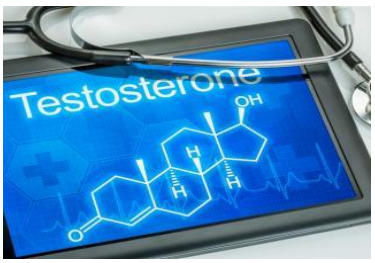
About 25% of men over age 70 who are treated with more than two years of TIP will not recover testosterone production. The risk of long term testosterone suppression after TIP is stopped is much less common in younger men and in men treated with TIP for shorter periods of time. A failure to recover testosterone is treatable. Testosterone replacement therapy can be administered with the daily application of testosterone gel to the skin.

The loss of libido and the subsequent temporary cessation of sexual activity have wide ranging ramifications far beyond the intended scope of this booklet. Briefly, healthy men have an average of three to five erections while sleeping every night. The cessation of this "exercise" can cause permanent penile atrophy. Therefore, while men are on TIP we counsel them to artificially induce erections two to three times a week with Viagra, a vacuum pump, or with injected prostaglandins to sustain normal functional status.

Loss of Muscle Mass

TIP causes tiredness and weakness. This side effect is much more common when the TIP is administered for more than 6 months. The degree of tiredness and weakness vary from nonexistent to incapacitating. Most commonly this side effect is described by patients as being noticeable, unpleasant, but tolerable. An example would be a loss of 20-30 yards on the distance of a golf drive or a less powerful serve in tennis. Some men start requiring a short nap in the afternoon.

The tiredness appears to be a direct result of muscle mass loss. The muscle loss problem can be counteracted with a strength training program. Unfortunately typical aerobic exercise programs are not sufficient to sustain muscle mass during the TIP treatment. Walking, aerobics, and stretching are healthy things to do, but they accomplish little toward building muscle mass.



The basis of strength training is lifting weights to the point of muscle failure. A professional trainer is highly desirable if you can afford it. Typically, strength training can be accomplished in a one-hour session two or three times a week. Strength training exercises are intense, so a day or two of rest is needed after each session. During each one-hour session all the major muscle groups are exercised: Pectorals, deltoids, biceps, triceps, latissimus dorsi, upper and lower back muscles, abdominals, gluteus, quadriceps, hamstrings, and calf muscles. Usually three sets of 10-12 repetitions are done with weights selected to result in muscle failure toward the end of the third set (once the break-in period is completed so no injury occurs).

Strength training is effective enough to enable men on TIP to increase their muscle mass. With strength training we find that the secondary side effect of tiredness and weakness from TIP is greatly minimized.

Hot Flashes

Hot flashes from TIP are irritating but are usually tolerable. They occur in about two-thirds of men treated with TIP. Ten to twenty percent of men on TIP are really bothered by them. The most effective measure is estrogen. Eighty percent of men treated with estrogen have a dramatic reduction in the incidence and intensity of the hot flashes. Patches are probably the best form of administration. However, there is some risk of breast enlargement and in some cases prophylactic breast radiation may be required (see below).

Effexor, a medication approved for the treatment of depression, seems to reduce hot flashes in about 50% of men treated. Neurontin, which is used in high doses to suppress seizures, seems to reduce hot flashes when used in low doses. Both of these drugs seem to have a fairly low incidence of side effects.

Weight Gain

With the loss of testosterone, as well as the loss of muscle mass, there is a slowing in the rate of body metabolism. Without careful discipline in regard to diet, TIP results in weight gain. The time to take note of this problem is before gaining weight. Following a diet to keep stable weight is much easier than initiating a diet to lose weight. It is wise to carefully evaluate your diet for evidence of excess fat and sugar intake at the time of starting TIP.

Breast Growth

Breast growth occurs in more that 50% of men on Casodex monotherapy. It occurs to a milder degree in about one-third of men treated with other forms of TIP. Men on Casodex monotherapy typically have to be treated with preventative radiation therapy to the breast area or with estrogen blocking pills such as Femara.

Osteoporosis

Accelerated calcium loss from the bones occurs in men deprived of testosterone just as with post-menopausal women deprived of estrogen. Untreated bone loss can result in hip and spine fractures. Men

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who fracture their hips have a 50% mortality rate. Fortunately osteoporosis is reversible or preventable with treatment. Common trade names for osteoporosis therapy are Prolia, Fosamax, Boniva, Actonel and Zometa. Some men already have osteoporosis before starting TIP. Therefore, men should obtain a baseline bone density test. We recommend starting treatment at the same time TIP is initiated as a preventative measure.

Memory Changes

Some men on TIP complain about problems with "word finding" and remembering names. Perhaps 10% of men treated with TIP will mention a problem remembering words. The problem reverses when the TIP is stopped. A good memory is directly related to one's overall strength and conditioning. Some of the difficulties with memory may occur because of "just feeling tired out." Complaints of memory problems occur less frequently with regular strength training.

Anemia

Blood is a mixture of red cells and "serum" (water). When the proportion of red cells in the blood is diminished this is called "anemia." Red cells carry oxygen so when anemia becomes severe the most common side effect is shortness of breath. A milder degree of anemia can contribute to a feeling of tiredness. As discussed above, tiredness can also result from loss of muscle mass. Therefore it is important to monitor for the development of anemia with a simple blood test called a CBC. Normally men have a blood hematocrit of about 42% (the hematocrit is part of the CBC blood test). Treatment with TIP on the average reduces the hematocrit to around 36% which is usually well tolerated.

About 10% of men develop a more severe degree of anemia with hematocrits less than 32%. This is significant for several reasons. First, if your doctor is unaware of this phenomenon he may conclude that you need evaluation with a bone marrow biopsy, a somewhat unpleasant and unnecessary procedure. Second, the anemia is easily correctable with low doses of hormone such as Procrit or Aranesp. This type of anemia does not respond to iron replacement.

Arthritis

Joint pains, particularly in the hands but sometimes in other joints, are fairly common with TIP. Actual joint swelling or visually arthritic changes are extremely uncommon if they occur at all. The pain may respond to Glucosamine, MSM, Motrin, Celebrex and Aleve. There is some soft evidence that Chondroiten, another popular over the counter preparation for treatment of the joint, is not a good idea for men with prostate cancer. It is possible (but not proven) that chondroiten may accelerate the growth of prostate cancer.

Liver Changes

Casodex, Flutamide, Nilutamide and Ketoconazole can occasionally cause irritation of the liver. This is easily detected at an early stage with simple blood tests. When the problem occurs, whichever agent is being used must be stopped because the irritation" can progress to severe liver damage if allowed to proceed unchecked. The problem is easily reversible if the process is detected and the offending agent stopped in a timely fashion. Once the liver tests revert to normal we have had good luck by switching from one type of anti-androgen to the other. In other words, if the liver problem was incited by Casodex we have found that Flutamide is usually safe and vice versa.

Mood Swings

Emotional changes as a result of hormonal treatment for cancer are not at all unexpected. How much of the emotional impact comes from medicines and how much is related to the overall situation (having cancer) is difficult to measure. Nevertheless men on TIP treatment do comment about being more closely in touch with their feelings and crying more easily. Some men find this effect of TIP unpleasant whereas others see it as a positive development. For men in the former situation low doses of common antidepressant medications (such as Zoloft, Celexa or Paxil) usually reverse the unpleasant feelings.

Blood Pressure and Cholesterol Changes

We have observed both upward and downward movement of blood pressure and cholesterol after the initiation of TIP. Standard management with the addition or removal of blood pressure or cholesterol medications is effective in a manner similar to people who are not on TIP.

Final Thoughts

TIP affects many aspects of a man's life. Our general impression after many years of experience delivering this form of treatment is that it is tolerable if the side effects are expertly managed. Preventative measures such as weight lifting and diet make a huge difference in how men feel while they are on the treatment. Careful monitoring of blood tests, bone density is essential. The management of side effects like joint pains, hot flashes, reduced libido and impotence is imperfect but expert medical care by knowledgeable physicians and care givers can go accomplish much toward reducing the impact of these problems.

Source: Prostate Oncology Specialists

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Understanding Your Pathology Report

When your prostate was biopsied, the samples taken were studied under the microscope by a specialized doctor with many years of training called a pathologist. The pathology report tells your treating doctor the diagnosis in each of the samples to help manage your care. The information below is designed to help you understand the medical language used in the pathology report.

1.What is "adenocarcinoma of the prostate"?

Adenocarcinoma of the prostate is a type of cancer (tumor) with a wide range of behavior from cases which are very slow growing with a low risk of causing men harm to cases which are more aggressive.

2. What is a "core"?

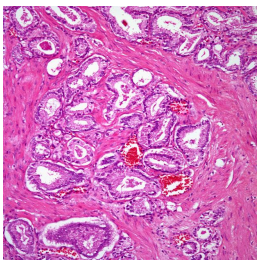
The urologist samples the prostate by removing thin threads of tissue with a hollow needle, each one referred to as a "core", from different areas of the prostate. The number of cores which contain cancer, as well as the amount of cancer present on each core, has a relationship to the tumors prognosis.

3. What is the "Gleason grade" or "Gleason score"?

The Gleason score is a measurement of how aggressive your tumor is likely to be. It is made by a pathologist looking at the cancer under the microscope.

4. What are the numbers in the Gleason score, for example 3+4=7 or 3+3=6?

Prostate cancer can have several patterns under the microscope, which are each assigned a different number. The first number in the score is the most common and the second number in the score is the next most common pattern seen under the microscope. The individual patterns typically range 3 to 5 on biopsy, with 3 being least aggressive and 5 the most aggressive. They are added together to get your total "Gleason grade" or "Gleason score", which typically ranges from 6 to 10. For example, in a Gleason score 3+4=7, most of the tumor is pattern 3 and less is pattern 4 and they are added together for a Gleason score of 7. In a tumor with a 3+3=6, the tumor is all pattern 3, and they are added together for a Gleason score of 6. Other ways that a Gleason score of 6 may be listed on your report are: "Gleason 6/10" or "Gleason 6 (3+3)" or "combined Gleason grade of 6".



5. What does it mean to have a Gleason score of 6 or 7 or 8-10?

The lowest Gleason score (least aggressive) tumor that is typically present on prostate biopsy is a 6 with higher grades (maximum Gleason score 10) corresponding to progressively more aggressive tumors.

6. What does it mean when there are different cores with different Gleason scores?

Different cores may sample different areas of the same tumor or different tumors in the prostate. Because the grade may vary within the same tumor or between different tumors, different samples taken from your prostate may have different Gleason scores. Typically the highest (largest number) Gleason score will be the one used by your doctor in predicting prognosis and deciding therapy.

7. Does the Gleason score on my biopsy accurately indicate what the cancer grade is in the entire prostate?

The Gleason score on biopsy is usually an accurate record of your cancers true grade. However, in about 20% of cases the biopsy grade is lower than the true grade because the biopsy misses a higher grade (more aggressive) area of the tumor. In some cases, the biopsy grade can also overestimate the aggressiveness of the tumor, where the true grade of the tumor may be lower than what is seen on the biopsy.

8. How important is the Gleason score?

The Gleason score is one of the most powerful predictors of the behavior of prostate cancer but must be factored in with other information, such as the PSA blood test level, findings on rectal exam, number of cores involved by cancer, and in some cases radiology imaging studies to fully predict how the tumor will behave.

9. What does it mean if my biopsy mentions that there is "perineural invasion".

Perineural invasion on biopsy means that there is an increased chance that cancer could spread out of the prostate, but Gleason grade and amount of cancer in the cores are more important. Even with perineural invasion your cancer could still be very curable depending on other factors. In some cases, it may affect treatment and in other cases it has no significance. How this finding will affect your specific treatment is best discussed with your treating doctor.

10. What does it mean if in addition to cancer my biopsy report also says "high grade prostatic intraepithelial neoplasia" or "high grade PIN"?

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High grade prostatic intraepithelial neoplasia, also referred to as high grade PIN, is a precursor to prostate cancer (ie. a precancerous lesion) and has no importance in someone who already has cancer. The word "high grade" as it refers to prostatic intraepithelial neoplasia has no relation to the Gleason system and does not indicate a more aggressive tumor.

11. What does it mean if in addition to cancer my biopsy report also says "acute inflammation" (acute prostatitis) or "chronic inflammation" (chronic prostatitis)?

In some cases inflammation may increase the PSA blood test level but in most cases it is of no importance and has nothing to do with prostate cancer.

12. What does it mean if my biopsy report also says "atrophy" or "adenosis" or "atypical adenomatous hyperplasia" or "seminal vesicle"?

All of these terms are things that the pathologist sees under the microscope that in some cases can look like cancer but are of no importance when seen on the biopsy and has nothing to do with cancer.

13. What does it mean if in addition to cancer my biopsy report also says "atypical glands" or "atypical small acinar proliferation (ASAP)" or "glandular atypia" or "atypical glandular proliferation"?

All of these terms are things that the pathologist sees under the microscope that are of no importance when seen on the biopsy if there is cancer elsewhere on the sampling.

Source: *Johns Hopkins, Pathology*

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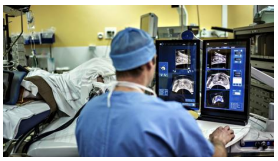
Being Overweight Raises Risk of Men Developing Aggressive Prostate Cancer

Men who are overweight or obese have a higher chance of developing an aggressive and potentially fatal prostate cancer, according to a new review of current research.

The World Cancer Research Fund says the cumulative evidence of the link between putting on too much weight and advanced prostate cancer is now strong. They estimate that 10% of advanced prostate cancers in the UK – those that can kill – could be prevented if men kept to a healthy weight.



A surgeon performs a robot-assisted prostatectomy.

Being overweight and obese have been linked to a variety of cancers. "This is the ninth one as a result of this global analysis of the world's literature," said Kate Allen, executive director for science and public affairs at WCRF. "Yet we have this huge overweight and obesity problem."

The findings come from the Fund's Continuous Update Project (CUP), a rolling programme of analysis of the global scientific research into lifestyle factors that contribute to cancer. The prostate cancer review, in partnership with Imperial College London, analysed 104 studies involving more than 9.8 million men and over 191,000 cases of prostate cancer.
Although the links with obesity were strong, the review found the evidence on the beneficial and harmful effects of certain foods was less than previously thought. It has downgraded the evidence linking diets high in calcium to an increased risk from "strong" to "limited". Evidence that foods containing lycopene, such as tomatoes, are protective, has been downgraded from "strong" to "no conclusion possible". There is still limited evidence that a diet higher in dairy products increases risk, says WCRF.

Many prostate cancers are not aggressive or grow so slowly that they cause no harm in a man's lifetime. But others are highly aggressive and can kill. Screening is controversial, because the blood test known as PSA can predict prostate cancer but not differentiate between those that need treatment and those that do not. Since treatment carries the risk of severe side-effects including impotence, men are faced with a difficult choice.

The link between men's weight and aggressive prostate cancers could help GPs advise patients on screening. "With so much controversy over the merits of screening for prostate cancer, it is vital in primary care for us to understand which patients are most at risk of developing this disease and are therefore most likely to benefit from PSA testing," said Dr. Jonathan Rees, a GP and chair of the Primary Care Urology Society.

"The findings of this review have significant implications: they add strength to the rationale for encouragement of a healthy lifestyle and control of weight, in terms of cancer prevention; they point us towards recognizing overweight or obesity as a risk factor to take into account when discussing screening with patients; and they point us towards avenues of research that may help us to reduce the impact of this disease which kills over 10,000 men a year in the UK alone," he added.

Source: The Guardian UK Nov. 2014

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Seven Critical Prostate Cancer Controversies

Long-time prostate cancer advocates (and of course all members of the clinical treatment community) are well aware of the controversies that complicate testing for, diagnosing, and managing prostate cancer. However, for men approaching their mid 40s and early 50s and newly diagnosed patients this can come as a major shock.

What we thought it would be useful to do would be to provide people with a list of seven really well-known and truly controversial issues that affect and complicate risk assessment for, diagnosis of, and treatment of prostate cancer. These are issues that affect very large numbers of men, and are truly divisive — not just for patients but also for many in the prostate cancer treatment community, which is why they are so problematic, and why, if you are a patient, who you choose as your doctor(s) can profoundly affect how your condition is assessed, managed, and treated.

Now let us be very clear. The seven controversial issues listed below are ***by no means*** the only controversial issues in the world of prostate cancer. However,

=> The first two affect every single male in the world.

=> The next three affect every single male in the world who is diagnosed with prostate cancer.

=> The last two are highly likely to affect every single male in the world who has progressive prostate cancer.

From that perspective, they were the seven most important controversies that we could identify.

So, here we go:

=> ***Who should receive regular tests ("screening") for risk of prostate cancer and how?***

This is a hugely controversial question that affects everything about the diagnosis and management of prostate cancer. The truth is that we really don't know the right answer to this question. We've been working on it for 40 years. We do know that many men who are diagnosed today with low-risk prostate cancer are being diagnosed with a biological condition that will never have clinical consequences if it is left untreated. We also know that if we stopped ***all*** PSA testing of asymptomatic men tomorrow, then the risk for diagnosis of clinically significant and metastatic disease would (slowly) return to the levels evident in the mid to late 1980s.

=> ***Does** ANY**thing actually prevent prostate cancer?***

People swear by all sorts of different things from vegan diets to patented nostrums. In fact, there is a host of things that we can do that ***may*** lower risk for a diagnosis of prostate cancer, but ***nothing*** (we repeat, ***NOthing***) has ever been proven to lower risk for the onset of prostate cancer by even 50 percent among undiagnosed men in a well-structured, randomized clinical trial. If you exercise regularly and eat well (i.e., eat healthier types of food and keep your body mass index within reasonable limits) this on its own will lower your risk for a multitude of chronic diseases … but it won't eliminate risk for any of them (prostate cancer included).

=> ***Who does** NOT **need immediate treatment for low-risk prostate cancer and how can we best identify them?***

We ***do*** know that many men with low-risk prostate cancer don't need immediate treatment. This group of men definitively includes the patients who have indolent disease and who will never have any significant clinical symptoms associated with their prostate cancer in their remaining lifetime. The problem is that we ***don't*** know how to identify these men with accuracy. We also ***do*** know that many men with low-risk disease can certainly delay having treatment for some or for many years and still be given effective (curative) treatment when it becomes apparent that they really need it.

=> ***Can we actually cure prostate cancer in** MOST **men diagnosed with high-risk disease?***

We know that we can cure (i.e., eliminate prostate cancer in) ***some*** men with high-risk, apparently localized disease. We also know that ***many*** men initially diagnosed with high-risk, apparently localized disease are not cured and will progress (over time, which may be many years) to have metastatic prostate cancer which can lead to their deaths. However, we really don't know why we can cure some of these men but not all of them … however early their disease is identified. Why? Because we don't have simple ways to tell whether their disease really is localized at the time of diagnosis, so treatment is a "hit or miss" affair based largely on guesswork.

=> ***What is the "best" type of treatment for localized prostate cancer?***

(Continued on page 7)

(Continued from page 6)

We don't know. There are many options, and some physicians definitely have ***very*** strong opinions about this. Almost none of the different options have been compared to each other in well-designed clinical trials in well-identified groups of patients. All that any truly honest clinician can tell a patient is that he (the patient) ***appears to be*** a good or a less good candidate for a particular type of treatment. Most newly diagnosed patients with localized prostate cancer are at least decent candidates for several different types of management.

=> ***When should androgen deprivation therapy (ADT, also known as "hormone" therapy) be started in men with progressive prostate cancer?***

Again, we really don't know. Some physicians like to start ADT early; others like to avoid using ADT for as long as they can. There is no right answer to this question.

=> ***Is intermittent ADT as good as continuous ADT for men with progressive prostate cancer?***

The truth is that the studies done to date are flawed in a variety of ways and so we don't have a definitive answer to this question either.

In our view, many of these "controversial" issues are absolutely not about black/white or right/wrong dichotomies at all. Rather they are about a whole host of factors that have to be considered in coming to ***optimal*** decisions, and about how the physiological, medical, and psychological profile of an individual man or patient and his family history affect risk and decision making for all concerned.

Source: *the "new" prostate cancer infolink September, 2014*

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Facts to know about PCa

Here is a simple list of the most important facts everyone should know about prostate cancer:

1. Around the world, hundreds of thousands of men will be diagnosed with prostate cancer this year — but (at least in the developed world) most of them will ***not*** die of this disease!

2. Men whose fathers or grandfathers, uncles or brothers have been diagnosed with prostate cancer are at higher risk than men with no family history of this disease.

3. At least in North America and the Caribbean, men of Black African ethnicity are at higher risk for prostate cancer than Caucasians, Hispanics, Native Americans, and Asians (but we don't really know why).

4. In its early and most curable stages, prostate cancer causes no symptoms at all.

5. Every man should know and understand his risk for prostate cancer; the keys to risk management are regular physical exams and appropriate blood tests.

6. Many men, particularly older men, with early stage prostate cancer may never need to be treated at all.

7. There are many different ways to manage early stage prostate cancer, but there is no absolute proof that any one form of treatment for early stage disease is better than any other.

8. Every form of treatment for prostate cancer has serious risks and serious possible side effects (from inability to control the need to urinate to loss of erections to deterioration of bone health).

9. For any specific type of treatment, doctors with extensive experience using that treatment technique can reduce the patient's risk for complications.

Source: *prostatecancerinfolink.net*

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Recognizing our Membership

The Manitoba Prostate Cancer Support Group Board would like to say a special "Thank-you" to the many individual members that have given donations to us in 2014. We are grateful that you have chosen to assist us with our work in helping those with prostate cancer. We specifically want to recognize your very generous donations and let you know they are sincerely appreciated.

Thank-you so very much.

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Email - manpros@mts.net ALL MEMBER INFORMATION IS KEPT CONFIDENTIAL
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2015 MEETINGS

Jan. 15 Dr. Rashmi Koul, Head of Radiation Oncology, CCMB
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: TBA
May 21 Dr. Paul Daeninck, Medical Oncologist
Topic: TBA
June 18 TBA
Topic: TBA
July No Meeting
Aug. 20 TBA
Topic: TBA
Sept. Prostate Cancer Awareness Evening at
Caboto Centre - 1055 Wilkes Ave. Date: TBA
Oct. 15 Dr. Kelli Berzuk, Incontinence Physiotherapist
Nov. 19 Christmas Pot Luck Party
Dec. No Meeting

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

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