Manitoba Prostate Cancer SUPPORT GROUP

Newsletter

Vol. 297 1,300 copies printed/e-mailed **May 2016**

Important Notice

Our Support Group meetings are moving
NEW LOCATION
Cindy Klassen Recreation Complex - 999 Sargent Ave.
Effective July 21, 2016. Meetings 7 – 9 p.m.
Phone: (204) 989-3433
Free admission – Free parking

Medical Advisors

Paul Daeninck M.D.
Medical Oncologist

Darrel Drachenberg
M.D. Urologist

Graham Glezerson
M.D. Urologist

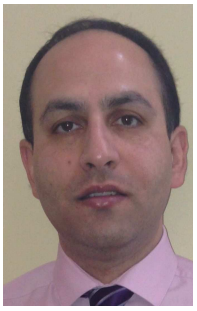
Ross MacMahon
M.D. Urologist

John Milner
M.D. Urologist

Jeff Sisler M.D.
Family Practitioner

Thanks!

Next meeting: May 19, 2016
Dr. Arbind Dubey, Radiation Oncologist
Topic: Modern Radiation Therapy
for Prostate Cancer
Location: Wellness Centre, Room 4
Seven Oaks General Hospital
Time: 7:00 General Discussion
8:00 Guest Speaker



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

Some days I just wish I had .... the wisdom of a 90 year old, the body of a 20 year old and the energy of a 3 year old!

Abiraterone Acetate (Zytiga) – Produced by Janssen Pharmaceuticals

The prostate is a gland that is a part of men's reproductive system. It is located below the bladder, near the rectum and around the urethra, and its main function is to produce a fluid that combines with sperm and makes semen more liquid. When a patient suffers from prostate cancer, the cells in the gland start to grow out of control, while healthy cells normally divide and die. Due to the location of the gland, prostate cancer affects both the reproductive and urinary systems.

Symptoms of prostate cancer include urinary problems like a slow or weak urinary stream or the need to urinate more often, especially at night, blood in the urine, erectile dysfunction, pain in the hips, back, chest, or other areas from cancer spread to bones, and weakness or numbness in the legs or feet, or even loss of bladder or bowel control from cancer pressing on the spinal cord. Prostate cancer kills about 27,540 people every year in the US, but there are treatment options to address the disease.

How Abiraterone Acetate Works

Abiraterone acetate is a drug from the family of steroidal antiandrogen that is used for the treatment of prostate cancer in combination with prednisone. "The male body naturally produces hormones called androgens. The most well known androgen in men is testosterone. For men with mCRPC, androgens play a role in fueling the tumor. While not the only source, androgen is produced primarily in the testes and some is also produced by the adrenal glands, which are located above the kidneys. We know now that the tumor itself is also a source of androgen production. While there are other key factors that contribute to the disease, androgen is one such factor. Reducing the production of androgen is key in managing your illness.

The compound abiraterone acetate is commercialized in the US under the brand name Zytiga by the company Janssen Biotech. The U.S. Food and Drug Administration (FDA) approved the use of abiraterone acetate in combination with prednisone in 2011 and expanded its use on December 2012. It is particularly indicated for patients with metastatic castration-resistant prostate cancer who have not previously undergone chemotherapy.

Over time, most prostate cancers become resistant to the treatment, being named castration-resistant prostate cancers. Abiraterone acetate works by blocking the production of androgen in the testes, adrenal glands, and prostate cancer tumors themselves. In a trial group of 797 patients, those receiving abiraterone acetate plus prednisone, reported a median overall survival of 4 months more than patients treated with prednisone plus placebo.

Source: Prostate Cancer News Today

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Pictured here is Support Group Chair, Jos Borsa, addressing the media at the Manitoba Motorcycle Ride For Dad kick-off. It was held at the McPhillips Station casino on Friday, April 8, 2016. Last year's ride raised $282,255 for Dr. Sabine Mai's prostate cancer research team at the Genomic Centre at CancerCare Manitoba.

What Every Man Should Know About Prostate Cancer Screening

Prostate-specific antigen (PSA) based screening for prostate cancer has long been controversial. With guidelines changing on a regular basis and experts disagreeing over its use, determining whether or not to get tested can be confusing. Arming yourself with a better understanding of the issues can guide your decision-making process.

The Risks of Prostate Cancer Screening

Prostate cancer screening involves a blood test to measure the level of PSA, a protein released by a man's prostate gland. An elevated PSA can indicate prostate cancer, but can also be a sign of several harmless conditions. Such false-positive results can create alarm and cause many men to undergo unnecessary biopsies, which put them at risk of bleeding, infection, or other complications.

Another risk with PSA screening, which helps identify prostate cancer early on, is over diagnosis. Often, prostate cancer grows so slowly that many men diagnosed with it are more likely to die of other causes before the cancer becomes fatal. But an elevated PSA test may lead them to undergo early, and probably unnecessary, treatment. Surgery and radiation, the mainstays of prostate cancer treatment, can have serious side effects, including erectile dysfunction and urinary incontinence (leakage).

Effects of a New Guideline

That's why, in 2012, the U.S. Preventive Services Task Force recommended against routine PSA-based screening for men of all ages, concluding that the benefits did not outweigh the harms. Two new studies published in The Journal of the American Medical Association show that this recommendation has had its intended effect: fewer men are indeed being screened and, therefore, fewer men are being diagnosed with early-stage prostate cancer. But is this good news?

The Task Force was on to something, but perhaps reacted too strongly. Addressing issues with PSA screening by rejecting it altogether has ended up minimizing the seriousness of prostate cancer. Prostate cancer still kills more than 27,500 American men every year. Reducing the number of biopsies and unnecessary treatments is a good clinical goal, but not looking for cancer at all is not the answer.

A Different Strategy

The question is how to find prostate cancer while it is curable, determine its severity, and treat it appropriately, while minimizing the harms of PSA screening. To do so, we don't need to test less--we need to test smarter. It is now possible to do this by augmenting PSA screening with new diagnostic tools that help prevent unnecessary biopsies and treatments, yet still catch aggressive cancers.

Prostate cancer is curable only when found very early. Evidence has shown that one man is prevented from dying of prostate cancer for every 1,000 men screened over a decade. It's true that not every patient needs to be treated, but if men are not routinely tested, we lose the opportunity to find prostate cancer early, and aggressive forms of cancer that do require treatment will be discovered too late to be cured.

New Tools Help Minimize Risk

When a basic PSA test reveals a high score, we can gather further evidence by combining more detailed variations of the PSA test with new types of blood and urine tests, sophisticated diagnostic imaging, and genomic analysis (study of a patient's genetic material obtained through blood or urine samples). The results help doctors determine if a biopsy is actually necessary and, when cancer is diagnosed, understand whether it needs treatment.

For example, magnetic resonance imaging (MRI) of the prostate can help pinpoint who needs a biopsy by showing whether the prostate tissue is normal or has potentially cancerous lesions. When a biopsy is required, MRI images can also help target the biopsy needles to the exact location, yielding precise diagnostic information. Combining imaging with genomic analysis of the biopsied tissue can tell doctors if a cancer is slow-growing or more aggressive.

The 'Active Surveillance' Option

The additional data provided by these advanced tools help doctors identify which patients are eligible for a wait-to-treat approach called "active surveillance." Rather than immediately undergoing surgery or radiation, patients on active surveillance are carefully monitored, typically through quarterly blood testing and digital rectal exams, annual imaging, and additional biopsies as needed. Men whose cancer never becomes a problem can avoid treatment and its side effects altogether. Those whose cancer is found to be getting worse and endangering their health can begin treatment while the cancer is still curable.

Talk with Your Doc

Choosing whether or not to be screened is a personal decision best made in consultation with your urologist, who can help you weigh the pros and cons and answer your questions. Discussing prostate cancer screening starting at age 45 is particularly important for men at higher risk - African Americans and those with a family history of prostate cancer. Men between the ages of 50 and 70 who are at average risk, are encouraged to do so as well. Be sure to ask your doctor to explain the newer approaches for minimizing biopsy and unnecessary treatments, while catching potentially lethal cancers while they are still curable.

Source: Mount Sinai Health System - January 2016

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Dr. Fred Saad's 2015 Prostate Cancer Year in Review

Fred Saad, MD, FRCSC, Professor and Chief of Urology and Director of G-U Oncology at the University of Montreal Hospital Centers, delivered the highlights of the past year's prostate cancer research at the ASCO GU symposium in San Francisco on January 7, 2016. Dr. Saad began by pointing out that "although there were no new drugs approved in 2015, we learned a lot about what we have available—some good and some not so good."

From a clinical perspective, and with a focus on topics that confirm or change current practice, Dr. Sadd summarize five key topics from prostate cancer research published in 2015: screening and active surveillance; local therapy; and androgen deprivation therapy, chemotherapy in men with hormone-sensitive disease, and new options in metastatic prostate cancer.

Screening and active surveillance
PSA screening for prostate cancer remains a controversial subject. In 2012, the United States Preventative Services Task Force (USPSTF) assigned a grade D recommendation to PSA screening, thus discouraging its use. However, a significant number of patients are still screened with the PSA test. One-third of men over 75 years old and one-third of men over 65 years with a high probability of death within 9 years continue to be screened, against the formal recommendations. This equates to approximately 1.4 million men who are inappropriately screened.

The question remains whether there is a better screening test to identify patients likely to have higher-risk prostate cancer. In other words, can we figure out a method of intelligent screening? This has been addressed well in a study published by Grönberg and the Swedish group in December. They developed a Stockholm 3 (STHLM3) model, incorporating plasma protein biomarkers, genetic polymorphisms, and clinical variables. This screening method was investigated in a prospective population-based study to determine whether it could increase sensitivity of diagnosing high-risk prostate cancer compared with the current PSA model. The authors demonstrated that the STHLM3 model was in indeed superior to PSA screening alone in its ability to detect prostate cancer with a Gleason score greater than 6. Use of this model could thus significantly reduce the number of biopsies done. Although not yet a standard of care, it suggests that the prostate cancer community is moving into an era of intelligent screening to minimize invasive procedures in patients unlikely to have higher-risk prostate cancer.

Once we have determined a more sensitive and specific screening method for prostate cancer, the next question is whether active surveillance for those patients diagnosed with lower-risk disease is safe. A recent study published by Tosoian and colleagues showed approximately one-third of patients were reclassified to higher-risk disease during active surveillance and were treated with curative intent, while the majority of the patients remained on active surveillance with lower-risk disease. Most reclassification went from Gleason score 3+3 to 3+4. The results from this study demonstrated a treatment-free survival of 8.5 years, with cancer-specific survival of 99% at 15 years, indicating a high degree of safety for patients with lower-risk prostate cancer on active surveillance.

These data confirmed a report from January 2015 by Dr.Klotz et al of almost 1000 patients with favorable-risk prostate cancer on an active surveillance program. After 15 years of follow-up, only 2.8% of patients developed metastatic disease and 1.5% died from prostate cancer. These numbers are similar to those found in the same patient population treated upfront with definitive therapy.

Importance of local therapy

A publication in July 2015 by Mason and colleagues demonstrated that local control with radiation in patients getting lifelong androgen deprivation therapy (ADT) delays onset to castration-resistant disease that translated to cancer-specific and overall survival.

The next question on this topic is whether there is a role for local control with radiation therapy for patients with advanced disease. This was answered with data published by James et al of the STAMPEDE trial. They looked at radiation therapy for patients with negative nodes and positive nodes. There was a failure-free survival benefit associated with using radiation therapy in patients with node-positive disease. The role of radiation is thus more clearly defined for high-risk prostate cancer and locally advanced disease, with mounting evidence for its role in

(Continued on page 5)

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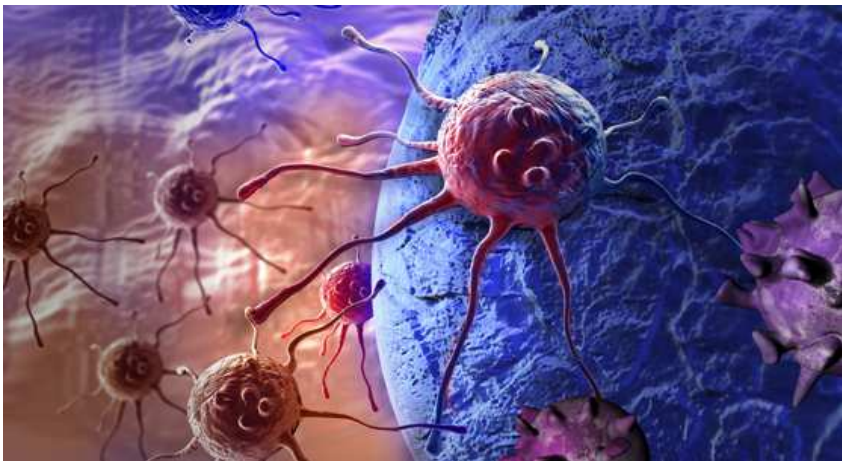
metastatic prostate cancer. However, the question of surgery in the metastatic setting lacks definitive data with randomized control trials.

The above data cover the role of radiation in locally advanced disease. What about hormonal therapy after salvage radiation therapy? To answer this question, Dr. Saad reviewed the results of a study by Dr. William Shipley. This study covered patients with an elevated PSA following radical prostatectomy. All patients had TNM stage T2–3 and NO (no tumour in the lymph nodes). Patients were randomized to receive salvage radiation therapy with placebo or salvage radiation therapy plus bicalutamide during and after radiation for a total of 24 months. With a median follow-up of over 12 years, the authors demonstrated a benefit in terms of overall survival, reduced metastatic prostate cancer, and reduced death from prostate cancer in patients in the bicalutamide arm.

The question remains, however, how much ADT is truly needed in this setting? Results as presented by Dr. Shipley indicate that 24 months of ADT during and after radiation results in superior outcomes. Another study published in 2015 by Zapatero et al, randomized patients to 4 months of ADT vs 24 months of ADT in the setting of high-risk prostate cancer in patients receiving radiation therapy. Patients receiving ADT for 24 months had improved 5-year biochemical-free survival, metastatic-free survival, and overall survival.

Taken together, these data demonstrate that patients with high-risk, locally advanced prostate cancer benefit from longer durations of ADT in addition to radiation therapy.



Androgen deprivation therapy and side effects

Despite the well-established data about the benefits of ADT, Dr. Saad cautioned that in 2015 a number of studies were published about the "dark side of ADT." Gonzalez et al reported that after 6 and 12 months on ADT, patients were more likely to demonstrate cognitive decline compared with matched controls not on ADT. This was confirmed by a similar study just recently published by Nead et al in which an increased risk for Alzheimer's disease was noted in patients on ADT within a general population cohort. So, although the use of ADT is integral to the treatment of prostate cancer, it is not without potential long-term adverse events, and these issues cannot simply be brushed aside.

Benefits of chemotherapy in hormone-sensitive prostate cancer

What are the benefits of adding chemotherapy to patients already on ADT for their metastatic prostate cancer? Two studies (CHAARTED in 2014 and STAMPEDE in 2015) showed the following results: patients receiving docetaxel in addition to ADT had an improved overall survival of 77 months compared with those patients receiving ADT alone of 67 months.

New options for metastatic prostate cancer

Highlighting the progress in metastatic castration-resistant prostate cancer (mCRPC), Dr Saad noted how the median overall survival for patients in this setting has most recently been reported as close to 3 years in the updated analysis from the PREVAIL trial, which compared enzalutamide with placebo in mCRPC.

Dr. Saad also noted that final overall survival analysis of comparing abiraterone with placebo in the pre-chemotherapy setting, also indicates that earlier treatment in this setting results in improved outcome.

The other important topic from 2015 in the setting of mCRPC is whether there is a role for bone-targeted therapy in the era of the oral agents enzalutamide and abiraterone, which have bone-protective elements as well. A study published by Saad et al in October 2015 demonstrated that, in patients receiving abiraterone, the combination with zoledronic acid improved overall survival, delayed time to opiate use, and delayed decline in performance status.

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http://www.practiceupdate.com/explore/coe/advanced-prostate-cancer/11

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NHS Fast-Tracks Drug Docetaxel For Advanced Prostate Cancer Patients

National Health Service (UK)

Guidelines that said men must wait for chemotherapy drug until hormone-based treatments had stopped working, have been scrapped.

The NHS has fast-tracked a drug that can extend the lives of men with advanced prostate cancer by more than a year following clinical studies, and it can now be prescribed immediately.

The announcement scraps the previous guidelines that patients had to wait for the chemotherapy drug docetaxel until existing hormone-based treatments had stopped working.

Prostate is the most common cancer in men in the UK, affecting one in eight at some point. More than 38,000 men are diagnosed, and more than 9,000 men die from the condition each year. The drug could offer hope of extended life for about 4,560 men each year whose cases are already advanced, and incurable, when diagnosed.

Angela Culhane, the chief executive of Prostate Cancer UK, said the announcement was great news for men newly diagnosed with advanced prostate cancer.

"It is critical that specialists are made aware that this use of docetaxel treatment is available so that no man misses out. Culhane said: "This fast-track response to new evidence indicates what can be achieved when there is the will in the system. It must set a precedent for other treatments that demonstrate clear clinical benefit when used in different ways."

Jonathan Fielden, the director of specialised services at NHS England, said: "Rigorous new evidence shows that this drug brings significant benefits for patients with advanced prostate cancer. So working closely with patient groups and cancer specialists, NHS England is now pleased to be fast-tracking its wider availability."

Docetaxel chemotherapy is already a routine treatment for men with advanced cancer, but until now has only been prescribed after men have become resistant to androgen deprivation therapy (ADT) – now both treatments can be started at the same time.

Source: NHS England Jan. 2016

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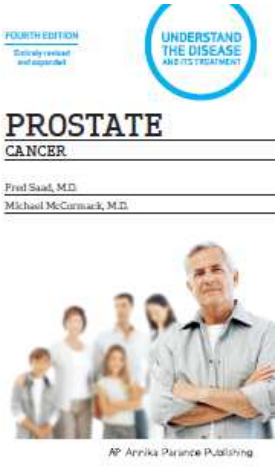

Recommended Reading

An electronic version of Dr. Fred Saad's book *Prostate Cancer – Understanding the Disease and its Treatment* is now available.

Go to the Resources page on our website (www.manpros.org) to read this book.

Dr. Saad is one of Canada's leading Urologists.
He practices at the University of Montreal Hospital Centre.

Our Support Group would like to thank ***Del Michie*** *and* ***Sanofi Pharmaceuticals*** *for making this available to our readers.*

New Advanced Prostate Cancer Treatment Approach

(combining radiotherapies - being tested in Belfast)

Queen's University Belfast researchers are leading a clinical trial evaluating a new combination of two radiotherapy treatments in men with prostate cancer where the cancer has spread to the bones.

The ADRRAD (Androgen Deprivation Therapy, Pelvic Radiotherapy and Radium-223) trial will treat patients with bone involvement (an estimated 10 percent of such cancers) over 18 months with two current forms of radiotherapy, Volumetric Modulated Arc Therapy (VMAT) to target PCa cells in the pelvis, and Radium 223 to target the disease in the bones.

VMAT is an externally delivered type of radiation therapy that manipulates beams to adapt to the shape of the tumor, delivering a more precise dose of radiation and limiting damage to surrounding tissue. Radium 223 is a recent 'bone-seeking' drug, a type of internal radiotherapy that is administered intravenously. Once inside the bones, the drug releases radiation that travels minimally – about 2 to 10 cells deep, or less than a millimeter – to deliver a high dose of cancer cell-killing radiation close to tumor deposits on bone.

Advanced PCa patients are commonly treated with hormone therapy that intends to diminish a tumor by limiting how much testosterone reaches cancer cells. If the new approach is successful, it has the potential to change how advanced prostate cancer is treated.

"This trial represents a really exciting shift in how we think about prostate cancer — away from aiming to prolong life for men with advanced prostate cancer, towards taking the first steps to stopping the disease in its tracks once and for all. The scale of what we can achieve when we work together as funders, clinicians, scientists and men must not be underestimated. We are on the brink of remarkable breakthroughs in prostate cancer research, and this trial could be one of them," Dr. Iain Frame, director of Research at Prostate Cancer U.K., said in a press release. "That's why we mustn't falter now. If we continue investing in world class research like this, within ten years, the world of prostate cancer research and treatment will be a far more hopeful place for men with and at high risk of the disease."

Currently, an estimated 8,500 men in Ireland have been diagnosed with prostate cancer, and about 250 die of the disease each year.

"This is the first trial of its kind anywhere in the world. It is hoped that combining the two forms of radiotherapy will be more effective than existing hormone treatment in targeting prostate cancer cells at multiple sites and extend the life expectancy of men whose treatment options are otherwise limited. We expect results from the initial trial within two years, with the view to then embarking on a larger trial with a greater number of patients," said Professor Joe O'Sullivan of Queen's University, who is leading the trial.

Source: Prostate Cancer News Today – March 2016

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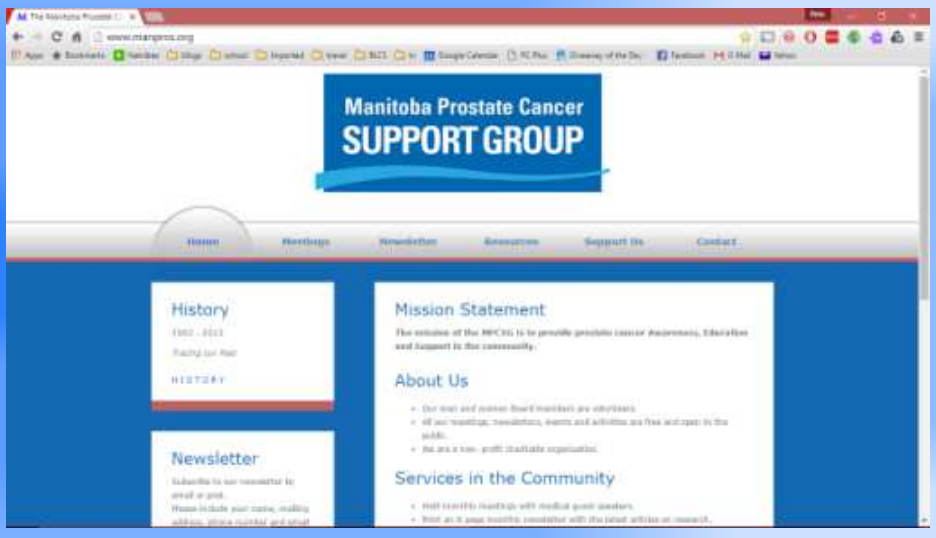
We have revised our website :-)

Take a look at
www.manpros.org



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THIS GIFT IS IN MEMORY/HONOUR OF_____ PLEASE SEND NOTIFICATION TO:_____

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Box 315 – 971 Corydon Ave., Winnipeg, Manitoba, 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.* ***Amount: *$25 $50 $75 $100 Other_____*

NOTE OF GRATITUDE

The Manitoba Prostate Cancer Support Group Board would like to thank Janssen Pharmaceuticals for a recent donation. Janssen's new drug, Zytiga (abiraterone), is used to treat men with metastatic prostate cancer. We gratefully acknowledge this contribution and Janssen's commitment to assist us. Their donation will be used to further our work of providing awareness, education and support for prostate cancer patients in our community. We appreciate their efforts in advancing the treatment of prostate cancer.

janssen | PHARMACEUTICAL COMPANIES OF Johnson & Johnson

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***

2016 MEETINGS

May 19 Dr. Arbind Dubey, Radiation Oncologist
Topic: Modern Radiation Therapy for Prostate Cancer

June 16 Kristen Bilenky, Social Worker
Topic: Cancer System Navigation

July 21 Member's Forum
Topic: Snacks/Juice and shared members stories

August 18 Dr. Eric Saltel, Urologist
Topic: Sub-urethral sling option for urinary incontinence

All meetings at
Seven Oaks Wellness Centre - Room 4
(except Sept.)
7 – 9 p.m.
Everyone Welcome

MPCSG BOARD

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