Manitoba Prostate Cancer SUPPORT GROUP

Newsletter

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Thanks!

Next Meeting: August 20

Dr. Spencer Gibson
Manitoba Institute for Cell Biology

Topic: Genetic research approaches to improved therapy for prostate cancer

Location: Cindy Klassen Recreation Complex at 999 Sargent Avenue

Time: 7 – 9 pm.
Free Admission *Everyone Welcome*

SHARING IS CARING

The Manitoba Prostate Cancer Support Group offers support to prostate cancer patients but does not recommend any particular treatment modalities, medications or physicians ; such decisions should be made in consultation with your doctor.

MPCSG – active since 1992.

It's coming.

Our annual September Awareness Evening.

A time and place to learn more about prostate cancer and to have your questions and concerns dealt with by a team of cancer specialists.

Thursday, September 21, 2017 **7:00 to 9:00 pm**

Cabotto Centre, 1055 Wilkes Avenue, Winnipeg.

Free admission Everyone welcome

Thought of The Day

" Hospitality is the art of making guests feel like they're at home when you wish they were."

Not All Prostate Cancer Cases Need Treatment Right Away

The biopsy shows cancer, so you have to act fast, right? Not necessarily, if it's a prostate tumour.

Men increasingly have choices if their cancer is found at an early stage, as most cases in the U.S. are. They can treat it right away or monitor with periodic tests and treat later if it worsens or causes symptoms.

Now, long-term results are in from one of the few studies comparing these options in men with tumours confined to the prostate. After 20 years, death rates were roughly similar for those who had immediate surgery and those initially assigned to monitoring, and surgery had more side effects.

> "Many men, when they hear the word cancer, you want to do something about it," said one study leader, Dr. Gerald Andriole, urology chief at Washington University in St. Louis, Mo. "The reality is, if you have a low-risk cancer, like the study shows, you don't need treatment, certainly not urgently."

It's not all black and white, though. Early stage doesn't necessarily mean low risk. Some results in the study lean in favour of surgery, and it does have some advantages. It also may improve survival for certain groups. Here's what this and other studies tell us about who does and doesn't benefit from surgery.

Why not treat everyone?

Start with a fact many find hard to accept: Not all cancers are destined to kill. Some prostate tumours are deadly, but most grow so slowly that men will die of something else.

Treatments – surgery, radiation or hormone therapy – can cause impotence, incontinence, infections and other problems, and sometimes do more harm than the disease ever would.

Monitoring doesn't mean do nothing. Men can get frequent tests, and there are more and better ways to detect disease progression now than there used to be, so there's usually still a chance to treat and potentially cure it if it starts to worsen, Andriole said.

What the evidence says

Only a few studies have tested monitoring versus immediate treatment. One found no difference in death rates after more than 20 years; another found surgery improved survival odds, but only for men under 65.

Those were done before wide use of PSA blood tests, back when more tumours were found because they caused symptoms, which often means more advanced disease.

Researchers wondered: Would the results be the same with modern screening and treatments?

The new study, sponsored by the U.S. Department of Veterans Affairs, aimed to answer that. Doctors assigned 731 men to observation or surgery. After a decade, survival rates were similar, but doctors wanted longer follow-up.

Now, after 20 years, two-thirds of these men have died and the original conclusions still stand, though the numbers leaned in surgery's favour.

Fewer men died in the surgery group, but the difference was small enough that it could have been due to chance. Only about 9 per cent of men ultimately died from prostate cancer, showing how relatively seldom the disease proves fatal.

Results are in last week's New England Journal of Medicine.

Did surgery do any good?

Yes. Fewer men in the surgery group later had treatment because there were signs the disease might be worsening – 34 per cent, versus 60 per cent of the group assigned to monitoring. In many cases, it was prompted by rising PSA levels, but surgery also clearly prevented more cases from spreading throughout the body.

(Continued on page 3)

(Continued from page 2)

Half of the group assigned to monitoring wound up getting some sort of treatment within five years. In one quarter of those cases, men "just got fed up" with monitoring and thinking about cancer, Andriole said. The rest were prompted by signs of progression.

Surgery also may have improved survival for men in the middle range of risk, with PSA levels between 10 and 20, and a Gleason score (a measure of how aggressive cancer cells look under a microscope) of 7. Only about one-quarter to one-third of men in the U.S. fall in this category, though. Most men are early stage and low risk.

"Surgery is right for the right person, and it's somebody with intermediate-risk disease," Andriole said.

Side effects

Surgery had more side effects. Fifteen per cent of men in that group later sought treatment for trouble having sex, and 17 per cent sought treatment for incontinence. The numbers were 5 per cent and 4 per cent, respectively, of men assigned to observation.

"You can't divorce quality of life outcomes from cancer outcomes because they both count for patients," said Dr. David Penson, Vanderbilt University's urology chief, who had no role in the study.

"Some guys will look at this and say, 'I don't want to be impotent, I don't want to be incontinent,'" and will forgo surgery even if there's a chance it will help them live longer, he said.

"In the end, each man's going to make his own decision."

MARILYNN MARCHIONE

The Associated Press Jul. 16, 2017

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Long Term Survivors of Prostate Cancer Express Treatment Decision Regret for Up to 15 Years

Greater initial education and support could help mitigate later treatment decision regret in prostate cancer survivors.

Educating men more effectively about treatment options may help relieve treatment decision regret in long term survivors of localized prostate cancer, according to a study published in the Journal of Clinical Oncology.

Patients and clinicians are often uncertain which treatment options are ideal in prostate cancer as complications arising from therapy, such as urinary incontinence and sexual dysfunction, have negative implications for long term qualify of life.

The study identified 934 surviving participants who responded to an initial survey gathering data on socioeconomic, clinical, and demographic factors at 1, 2, 5, and 15 years. The 15-year follow up survey additionally addressed the impact treatment had on finances, relationships, physical function, as well as PSA concerns, outlook, perceptions of having made an informed decision, and regret.

Approximately 15% of patients surveyed — 16.6% of radiotherapy patients, 15.0% of surgery patients, and 8.2% of patients who received conservative treatment — expressed treatment decision regret.

Patients reported moderate or big sexual function bother (reported by 39.0%; OR, 2.77; 95% CI, 1.51-5.0), moderate or big bowel function bother (reported by 7.7%; OR, 2.32; 95% CI, 1.04-5.15), and PSA concern (mean score 52.8; OR, 1.01 per point change; 95% CI, 1.0-1.02), as factors most associated with regret.

Regret is not expressed by the majority of long term survivors of prostate cancer 15 years after initial diagnosis, but study authors conclude saying "[improved] supporting initial treatment decision making through informing patients about treatment options and potential outcomes, helping patients identify treatment preferences, and clarifying values might help mitigate regret over the long term."

July 10, 2017 *James Nam, PharmD*

Reference

Hoffman RM, Lo M, Clark JA, et al. Treatment decision regret among long-term survivors of localized prostate cancer: results from the prostate cancer outcomes study [published online May 11, 2017]. J Clin Oncol. doi: 10.1200/JOC.2016.70.6317

http://www.oncologynurseadvisor.com/prostate-cancer/prostate-cancer-survivors-express-concerns-about-sexual-function/article/673774/

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Does Prostate Cancer Screening Matter?

The latest guidelines suggest you should have an engaged conversation with your doctor about PSA testing.

An annual prostate-specific antigen (PSA) test to check for signs of possible prostate cancer sounds innocent enough, but new guidelines suggest the test offers few long-term benefits, and substantial possible harm.

The updated guidelines from the U.S. Preventive Services Task Force (USPSTF), published online April 11, 2017, by The Journal of the American Medical Association, reinforce the organization's 2012 conclusion that PSA screenings have only a small potential benefit for reducing the chance of dying of prostate cancer for men ages 55 to 69 — while exposing them to possible overtreatment and side effects from biopsies, radiation, and surgery.

"Today, as was the case in 2012, the ability to show an overall survival benefit from any screening recommendation still eludes us, and the cancer-specific survival benefit, if one exists at all, is at best very modest," says Dr. Marc Garnick of Harvard-affiliated Beth Israel Deaconess Medical Center.

A look at the numbers

In 2012, the USPSTF gave PSA-based screening for prostate cancer a grade of D and recommended against routine testing for all men. The poor grade was based on evidence that only about one man in 1,000 who underwent screening would avoid death from prostate cancer. In fact, if a 55-year-old man chooses not to get screened, his chance of dying from prostate cancer over the next 10 to 15 years is about 0.6%. If he does choose to be screened, he reduces his chance of dying from the cancer to only 0.5%.
The 2012 report also found that almost 90% of men with PSA-detected prostate cancer receive treatment, such as surgery, radiation, or androgen deprivation therapy, and 75% of this group experience harmful side effects like impotence and incontinence.

The new guidelines also repeated the 2012 recommendation that men ages 70 and older should skip PSA screenings altogether, as evidence shows that when they develop prostate cancer, it tends to be slow growing, and the 10-year survival rate is quite high. "Odds are these men will die from something other than prostate cancer," says Dr. Garnick.

What's new now?

The updated guidelines echoed the suggestions from the 2012 report, but screening was given a slightly higher overall grade of C for men 55 to 69. Why the change? This was in response to the greater use of active surveillance, in which men diagnosed with lower-risk prostate cancer delayed treatment and thus avoided side effects.

"In 2012, if you were diagnosed with prostate cancer, you were almost certain to receive treatment. Now, the cancer is more likely to be observed," says Dr. Garnick.

Other research confirms the new guidelines' assessment of risk versus reward. A study published online Dec. 1, 2016, by Cancer screened 76,685 men for various cancers, including prostate cancer, to see if yearly screening saved lives by finding the disease early.

The 15-year follow-up found little difference in death rates between men screened annually and those in the control group, who were screened occasionally. The researchers also noted that men with PSA lower than 1.0 have only about a 0.5% chance of being diagnosed with prostate cancer within 10 years.

Talk it out with your doctor

Does that mean you should always avoid PSA testing? Not necessarily, as prostate cancer is still responsible for 30,000 deaths per year. Dr. Garnick says that further research is needed to see if testing may benefit high-risk men, such as African Americans and those with a first-generation relative who's had the disease, like a father, uncle, or brother.

"For these men, while many would recommend screening, there is no solid evidence that there are any meaningful benefits as a result of screening," he says.

Still, the results of a PSA test can lead even high-risk men down a slippery slope, and they should proceed with caution, says Dr. Garnick. The emotional aspect of diagnosis can cause men to make poor decisions. In fact, a study in the February 2017 Journal of Urology found that the stress and anxiety of a prostate cancer diagnosis often pushes men to choose aggressive or unnecessary treatments like radiation or surgery.

The decision to have prostate cancer screening is never simple. It is a personal choice that depends on many factors, like age, degree of risk, and family history. "Have an in-depth talk with your doctor about all your options," says Dr. Garnick. "The more information you have, the better you can make an informed decision about PSA testing."

August, 2017

http://www.health.harvard.edu/mens-health/does-prostate-cancer-screening-matter

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Bone Scan Index Reliably Predicts Prostate Cancer Outcomes

CHICAGO — An automated bone scan index has been confirmed as a prognostic biomarker of OS, radiographic PFS and skeletal-related events among men with castration-resistant prostate cancer and bone metastases in a phase 3 trial presented at the ASCO Annual Meeting.

"Early bone scan progression is associated with reduced overall survival. The automated bone scan index permits a faster and more fully quantitative biomarker that can be used for clinical trials without limiting the clinical trial design to prevent both response and progression perturbations," Andrew J. Armstrong, MD, associate professor of medicine, pharmacology and cancer biology, and surgery at Duke University School of Medicine, said in a presentation. "The primary objective of this analysis was to clinically validate the baseline-motivated bone scan index as a prognostic biomarker for overall survival."

The automated bone scan index is a computational approach to bone scan imaging that uses artificial intelligence to determine the percentage of skeletal mass that is affected by cancer. The trial aimed to further validate the prognostic value of this tool.

Armstrong and colleagues enrolled 1,245 men with metastatic, castration-resistant prostate cancer and bone metastases who were treated with tasquinimod (Active Biotech) or placebo and conducted whole-body scans at screening on all participants. The researchers locked the prospective biomarker analysis of the automated bone scan index before unblinding treatment. They analyzed automated bone scan indexes for independent prognostic correlation with OS, radiographic PFS and symptomatic skeletal-related events.

The researchers evaluated scans from 241 trial locations in 37 countries. The patients who received automated bone scan indexes (n = 721) appeared characteristic of all participants involved in the study based on OS outcomes and patient characteristics at the time of screening.

The median automated bone scan index was 1.07 (standard error = 0.05). The researchers grouped the different indexes into quartiles (n = 180-181); levels ranged from Q1 to Q4 (Q1, 0-0.3; Q2, > 0.3-1.1; Q3, > 1.1-4; and Q4, > 4).

Median OS ranged from 35 months in Q1 to 13 months in Q4 ($P < .0001$). The researchers observed significant associations between baseline automated bone scan index and OS (HR, 1.2 per doubling of bone scan index; $P < .0001$); these correlations maintained independent associations with OS after the researchers adjusted for treatment, PSA, C-reactive protein, LDH and albumin. The baseline automated bone scan index also correlated with radiographic PFS ($P = .0005$), time to symptomatic progression ($P < .0001$) and time to symptomatic skeletal-related events ($P = .001$).

This trial is the largest to date to show "clinically important outcomes associated with the bone scan index at baseline," Armstrong said.

He also discussed the ways in which this study may inform practice.

"The automated bone scan index could be considered for clinical trial eligibility or for risk stratification based on these defined thresholds; they may be promising as endpoints. Ongoing work to define bone scan index criteria for bone progression will inform future work that may create a more quantifiable bone marker," Armstrong said. "This is not meant to replace the radiographic interpretation by nuclear medicine physicians who read a bone scan. It is intended to quantify what they're measuring so we can incorporate this into clinical trial practice and the designing of endpoints." – by Julia Ernst, MS

Reference:
Armstrong AJ, et al. Abstract 5006. Presented at: ASCO Annual Meeting; June 2-6, 2017; Chicago.

Disclosures: Armstrong reports he is a consultant or advisor for Bayer, Dendreon, Eisai, Janssen Biotech, Medivation, Novartis and Sanofi; receives honoraria from and serves on the speakers bureau for Dendreon and Sanofi; receives travel, accommodations and expenses from Dendreon, Janssen Biotech, Medivation and Sanofi; receives research funding through his institution from Astellas Pharma, Bayer, Bristol-Myers Squibb, Dendreon, Gilead Sciences, Janssen Oncology, Medivation, Novartis, Pfizer and Sanofi; and receives patents, royalties and other intellectual property through his institution for circulating tumor cell novel capture technology. Please see the full study for a list of all other researchers' relevant financial disclosures.

https://www.healio.com/hematology-oncology/prostate-cancer/news/online/%7B33eaa63d-599a-41be-98b7-e3fce08ed656%7D/bone-scan-index-reliably-predicts-prostate-cancer-outcomes

July 18, 2017

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The Board,
Manitoba Prostate Cancer Support Group

Early Use of Abiraterone in Hormone-Sensitive Advanced Prostate Cancer Recommended

Recent studies published in the New England Journal of Medicine and presented at the 2017 ASCO Annual Meeting in Chicago could pave the way for new guidelines regarding the use of abiraterone in the treatment of advanced prostate cancer.

Prostate cancer is common in older men. It can spread locally to lymph nodes, as well as to distant sites of the body like the bone, lung, liver and brain, with serious consequences.

'Abiraterone with prednisone may soon be used at an earlier stage of prostate cancer, when it is sensitive to androgen-deprivation therapy.'
Prostate cancer is treated with surgery, radiation, chemotherapy and hormonal therapy. Since hormones like testosterone and dihydrotestosterone, which are chemically androgens, promote the growth of prostate cancer, prostate cancer benefits from androgen-deprivation therapy. Androgen deprivation can be brought about either by surgical removal of the testes or medications like leuprolide and goserelin. In due course of the cancer, patients stop responding to androgen-deprivation treatment and require other therapeutic options.

Abiraterone acetate Abiraterone acetate is a drug that is emerging as a possible vital addition to the androgen-deprivation therapy for advanced prostate cancer. Abiraterone prevents the production of androgens in the body, and is currently approved along with the corticosteroid prednisone for patients with advanced prostate cancer, who do not respond to androgen-deprivation therapy. Thus, abiraterone is currently being used only when the standard hormonal treatment fails.

The Systemic Therapy in Advancing or Metastatic Prostate Cancer: Evaluation of Drug Efficacy (STAMPEDE) is a large trial which evaluated the addition of treatments for prostate cancer that has locally advanced or spread to distant sites in patients who did not receive prior hormonal treatment. It has come up with several important findings which, if introduced into clinical practice, could possibly improve the survival of patients with advanced prostate cancer.

The STAMPEDE study compared the use of ADT plus abiraterone and prednisolone, to the use of ADT alone for a period of two years or until disease progression. The study included patients who had localized disease as well as those in whom the cancer had spread, and who may have undergone surgery or radiotherapy. Fifty-two percent patients had metastatic cancer, that is, cancer that had spread to other sites of the body. Radiotherapy was administered along with hormonal treatment as and if necessary. The researchers found that, with respect to the group that received the standard treatment, the group taking abiraterone experienced:

- An improvement in overall survival by 37%
- An improvement in the failure-free survival by 71%
- A reduction in the symptomatic skeletal events by 55%
- More cardiovascular and liver related-side effects, with 47% patients in the abiraterone group and 33% patients in the standard treatment group suffering serious adverse effects with grades 3 to 5

The LATITUDE Trial, conducted in 34 countries, evaluated the effects of abiraterone and prednisone along with ADT as opposed to ADT with placebos in the treatment of newly diagnosed metastatic, hormone-sensitive prostate cancer, that is, in cases where the patient did not receive any earlier treatment. The researchers found that as compared to the group administered only ADT, the group taking abiraterone and prednisone along with ADT:

- Had an overall survival of 66% at the end of 3 years while the comparison group registered an overall survival of 49%
- Had a median radiographic progression free-survival in patients of 33 months, as compared to 14.8 months in the control group
- Showed slower progression of other parameters assessed, like pain and next symptomatic skeletal event, and the need for chemotherapy and subsequent prostate cancer therapy
- More commonly caused side effects of high blood pressure, low blood potassium levels and increase in liver enzymes

Thus, the earlier use of abiraterone, along with androgen-deprivation therapy, instead of after it, if approved, could benefit hundreds of men with advanced prostate cancer.

References:
James ND et al. Abiraterone for Prostate Cancer Not Previously Treated with Hormone Therapy. NEJM; DOI: 10.1056/NEJMoa1702900
Fizazi K et al. Abiraterone plus Prednisone in Metastatic, Castration-Sensitive Prostate Cancer. NEJM; DOI: 10.1056/NEJMoa1704174

June 7, 2017 Source: Medindia

Written by Dr. Simi Paknikar

Article Reviewed by The Medindia Medical

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Gel Could Protect Prostate Cancer Patients From Side Effects Of Radiation

There was good news Monday, for the hundreds of thousands of men trying to decide which treatment to undergo after a diagnosis of prostate cancer.

As CBS2's Dr. Max Gomez reported, a simple gel could reduce the risk of side effects from radiation therapy.

John Schroeder is in many ways, a typical prostate cancer patient, he's 66, healthy, but with a PSA level that had been climbing for a few years.

"I did the biopsy just to prove that I did not have prostate cancer, and that came back positive," he said.

So like most men in his position he had to choose between surgery and radiation.

"I didn't want surgery. I woulda had the surgery as the last thing I would do. I wanted radiation," he said.

Trouble is, John has ulcerative colitis, and because of where the prostate sits in the pelvis, radiation was out of the question.

"There's certain side-effects to any form of radiation that have to do with the tissues that are right around the prostate, and that's the bladder and the rectum. So men can get the bladder or rectal irritation, sometimes they can get bleeding or ulceration," Dr. Edward Soffen said.

Then, John heard of a new material the FDA had approved to protect the rectum during prostate radiation. It's a kind of gel called Space-O-A-R.

The idea to simply to separate the prostate from surrounding tissues.

"It doesn't absorb or block the radiation. It just moves the rectum out of the way enough for the beam to come in and not hit the rectal tissues," Dr. Soffen said.

Dr. Soffen demonstrated how it's done on a training model for CBS2's cameras. Under ultrasound guidance, a long needle injects the gel in the space between the prostate and rectum. The soft cushion lasts at least three months after which it harmlessly dissolves.
John was able to safely have 44 radiation treatments.

"No problems with the ulcerative colitis. I had a colonoscopy last month, and I still have ulcerative colitis, but there was no damage done to the rectum, no damage done to the colon," he said.

The gel costs about $3,000 and so far is covered on a case by case basis, although medicare is considering approving it.

CBS New York
July 17, 2017 Dr. Max Gomez

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"Raising Awareness.....Spreading the Word"

The Manitoba Prostate Cancer Support Group works to increase education, awareness and support for the prostate cancer community. These services are provided through a variety of activities and are available without cost to the existing patient population as well as to the public at large.

Raising awareness is especially important to encourage more men, who may already have prostate cancer but don't yet know about it, to get checked.

Early detection makes all the difference in effecting a cure. As part of our efforts to raise awareness our group provides speakers to community groups, as well as attending "health fairs" in shopping malls and the like.

If your group would like to have a speaker talk about prostate cancer contact board member Pat Feschuk (Special Events organizer; telephone 204-654-3898; or email at lizpat@shaw.ca) to make arrangements.

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2017 MEETINGS

Sep-21 SAE- panel :
Dr. Jeff Saranchuk (surgical oncology),
Dr. Arbind Dubey (radiation oncology)
"Prostate Cancer…..treatment options and follow-up"

Oct-19 Dr. Mary Shariff
Faculty of Law, U of M
"Health care directive....what it is and why you need it"

Nov-16 Xmas pot luck

All meetings (except September)
will be held at :
Cindy Klassen Recreation Complex
at 999 Sargent Avenue

All meetings are 7 – 9 pm.
Everyone Welcome

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