Manitoba Prostate Cancer SUPPORT GROUP

Newsletter

Vol. 325 1,300 copies printed/e-mailed **November 2018**

Don't miss it!

MPCSG annual end-of-season windup

Food, Fellowship & Music

Live Entertainment by "Fire & Ice"

Wed Nov 21, 2018 7-9 pm

Unitarian Universalist Church,
603 Wellington Cres, Winnipeg

Everyone welcome Bring a friend
Free admission
Free parking Lots of exciting prizes

Bring your favorite dish for this potluck smorgasbord

(Note: Our 2019 program begins Wed Jan 16, 2019)

Medical Advisors

Paul Daeninck M.D.
Medical Oncologist

Darrel Drachenberg
M.D. Urologist

Arbind Dubey M.D.
Radiation Oncologist

Piotr Czaykowski M.D.
Medical Oncologist

Thanks!

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.

Thought of The Day

Hospitality: making your guests feel like they're at home, even if you wish they were.

Checkmate For Prostate Cancer

When prostate cancer is caught early, there are effective treatments that can provide a cure. If the cancer has spread, treatment becomes much tougher. Now a new trial is evaluating immunotherapy in patients with advanced cases of the disease.

Eighty-five-year old Ralph Stuart has been battling prostate cancer for the past nine years. At first, the cancer was slow-growing, but by 2011, his disease took a turn.

"At that time, it started to spread, spread to the bones," said Austine Stuart, Ralph's wife.

Ralph's doctors tried hormone treatment but his cancer kept spreading. That's when the Stuarts found Dr. Akash Patnaik. Dr. Patnaik was enrolling patients in a cutting-edge clinical trial known as Checkmate 650.

"With the PSA elevating so much and nothing else seemed to work we said this won't hurt," said Austine.

Patients in the trial receive an IV infusion of two drugs that boost the immune system: ipilimumab and nivolumab.

Akash Patnaik, MD, PhD, an Oncologist from the University of Chicago said, "We are trying to enhance the ability of the good immune cells, the T-cells are able to enter the tumor and overcome this fortress of immunosuppression."

Dr. Patnaik says when given separately, the drugs have little effect on patients with advanced prostate cancer, but together, certain patients, like Ralph Stuart do very well.

"He had a very dramatic response even after receiving the first cycle of treatment", said Dr. Patnaik.

At its highest, Ralph's PSA level, a measure of prostate cancer, was over 500. Right now, it's not detectable, the sign of a possible cure.

"There is a solution for a lot of people," Austine told Ivanhoe.

The two drugs have already gained FDA approval for advanced kidney cancer and metastatic lung cancer. The Checkmate 650 trial is ongoing at five centers across the U.S. including the University of Chicago.

By: Chelly Boutott Oct 14, 2018
CHICAGO, Ill. (Ivanhoe Newswire)
Contributors to this news report include: Cyndy McGrath, Field and Supervising Producer; Hayley Hudson, Assistant Producer; Roque Correa, Videographer and Editor.

MEDICAL BREAKTHROUGHS
RESEARCH SUMMARY

TOPIC: CHECKMATE FOR PROSTATE CANCER

REPORT: MB #4479

BACKGROUND: Prostate cancer is cancer that occurs in the prostate, a small walnut-shaped gland in men that produces the seminal fluid that nourishes and transports sperm. Prostate cancer is one of the most common types of cancer in men. Usually prostate cancer grows slowly and is initially confined to the prostate gland, where it may not cause serious harm. However, while some types of prostate cancer grow slowly and may need minimal or even no treatment, other types are aggressive and can spread quickly. Prostate cancer that's detected early, when it's still confined to the prostate gland, has a better chance of successful treatment.
(Source: https://www.mayoclinic.org/diseases-conditions/prostate-cancer/symptoms-causes/syc-20353087)

TREATMENT: If you have an advanced stage of prostate cancer (stage III and IV), it means the disease has spread outside the prostate gland. Doctors can treat this type of cancer, but they can't cure it. Still, there are good options that can ease symptoms and help patients live a long, active life. The main options for treating advanced prostate cancer include radiation, hormone therapy, surgery, or active surveillance.
(Source: https://www.webmd.com/prostate-cancer/advanced-prostate-cancer-treatments#1

NEW RESEARCH: Akash Patnaik, MD, PhD, an Oncologist at the University of Chicago recently launched a phase 2 clinical trial, known as CheckMate 650, for men with metastatic prostate cancer that is resistant to hormonal therapy. The study combined two immune system-boosting drugs: ipilimumab and nivolumab. The trial is currently open at five institutions in the United States and four in France. These drugs, both monoclonal antibodies, work in slightly different ways. Ipilimumab blocks a protein called cytotoxic T-lymphocyte antigen 4 (CTLA-4) that sits on the surface of T cells and prevents them from doing their job, attacking cancerous cells. When ipilimumab, the first known immune checkpoint inhibitor, attaches itself to CTLA-4 on T cells, it can help those cells get back in action, destroying cancer cells. It also inhibits activity of other cells, such as regulatory T cells, that further hinder an immune response. Nivolumab blocks a different pathway, known as PD-1. Tumors exploit the pathway to protect themselves from T cells. PD-1 is an immune checkpoint that shuts down T cell-mediated attack on tumors. PD-1 inhibitors, such as nivolumab, can restore the ability of T cells to penetrate and attack tumors.
(Source: https://www.uchicagomedicine.org/cancer-articles/an-unexpected-success-for-cancer-immunotherapy-treating-prostate-cancer)

source: https://www.wearegreenbay.com/health-watch/healthwatch-checkmate-for-prostate-cancer/1524351263

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Shortened Radiation Therapy Recommended in New Prostate Cancer Guideline

The American Society for Radiation Oncology (ASTRO), American Society of Clinical Oncology (ASCO), and American Urological Association (AUA) developed a new guideline that suggests hypofractionated radiation therapy as an alternative to conventional radiation for early-stage prostate cancer.

The guideline has been published in Journal of Clinical Oncology (Online October 11, 2018; doi:10.1200/JCO.18.01097) and also appears in Practical Radiation Oncology as well as The Journal of Urology.The target population for this new guideline are patients who choose treatment instead of surveillance and have opted for external beam radiation therapy (EBRT) instead of radical prostatectomy, brachytherapy, or other treatment options for localized prostate cancer. To develop the guideline, 16 expert clinicians, researchers, and a patient advocate reviewed studies published from December 2001 through March 2017. Key recommendations include:

- For men who have opted for EBRT, moderate hypofractionation (fraction size of 240-340 centigray (cGy)) should be offered as an alternative to conventional fractionation (180-200 cGy) regardless of cancer risk group, patient age, comorbidity, anatomy, or baseline urinary function.
- Ultrahypofractionation (≥500 cGy) guidance varies by prostate-cancer risk. For low-risk patients who have opted for EBRT, it may be offered as an alternative to conventional fractionation. For intermediate-risk disease, patients are strongly encouraged to enroll in a clinical trial or multi-institutional registry. For high-risk disease, ultrahypofractionation outside of a trial or registry should not be offered. Recommendations for ultrahypofractionation were graded by the panel as "conditional," reflecting the limited base of current evidence on this approach.
- Recommendations also address the technical aspects of planning and delivering hypofractionated prostate radiation, including target and normal tissue volumes, dose constraints, margin definitions and delivery techniques. The expert panel universally recommends the use of image-guided radiation therapy and avoidance of non-modulated conformal techniques.

Fraction sizes between 340 and 500 cGy were outside the scope of the guideline due to a lack of available literature. Also excluded from the guideline are treatment for locally advanced or metastatic disease, post-operative radiation, salvage therapy, and re-irradiation.

"Conclusive evidence from several large, well-designed randomized trials now confirms that dose escalation can almost universally benefit men with early-stage prostate cancer who choose to manage their disease with external radiation," said Howard Sandler, MD, FASTRO, FASCO, Cedars-Sinai Medical Center (Los Angeles, CA), and co-chair of the guideline panel, in a press release (October 11, 2018). "Significant advances in treatment planning and delivery have enabled oncologists to deliver more powerful, life-saving doses of radiation in fewer visits and without compromising quality of life."—Zachary Bessette

10/17/18

source: www.journalofclinicalpathways.com/news/shortened-radiation-therapy-recommended-new-prostate-cancer-guideline

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"Moving Forward After Cancer" program at Reh-Fit Centre in Winnipeg

Check out this complimentary program if you're interested…..

What it offers: Participants will learn ways to address common post treatment stressors and health concerns, as well as how to foster an exercise lifestyle to transition back to life beyond cancer.

Intructor(s): Jen McLaren, Reh-Fit Fitness Professional & CancerCare Manitoba Social Worker.

For more information and to register call CancerCare Patient & Family Service at 204-787-2109

The Reh-Fit Centre is offering the Moving Forward After Cancer program in partnership with CancerCare Manitoba with the support of CancerCare Manitoba Foundation.

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I Miss My Prostate. How About You? Why Don't We Get Together And Talk About It?

At the August monthly meeting, in the open discussion segment, the topic of attendance at the meetings became a point of speculation.

The average attendance at our monthly meetings ranges from 40-70 men. Usually there are 2-5 new attendees. We know that there are approximately 700 men diagnosed with Prostate Cancer every year in Manitoba. How are these men coping with their medical situations? Why are other men with prostate cancer not seeking support by coming to the monthly meetings of the Manitoba Prostate Support Group (MPCSG)? After all, we have space for more than 200 and generous parking.

I have been attending monthly meetings since 2014 when I was diagnosed with prostate cancer. My PSA numbers had jumped from around 4 to close to 8 in less than a year. My biopsy showed that the cancer was aggressive, with one of the 12 core samples having a count of "9" on the old Gleason scale. My initial response to my diagnosis was panic. A few days later, I had coffee with Brian Sprott, a MPCSG board member whose positive attitude and generosity in sharing his own experiences greatly diminished my fears. I had a radical prostatectomy in 2014, followed by Radiation treatments and a round of Androgen Deprivation Therapy. I now monitor my PSA every 6 months and my numbers are slowly rising. I will have to return to treatment in the future. I am convinced that my regular attendance at our monthly meetings has had a positive effect on my learning about the disease and my coming to terms with life after a traumatic diagnosis. So, I wonder why some men chose not to attend the MPCSG.

We all live busy lives with many responsibilities. But might there be other reasons that keep men away? For some men, family and friends may provide the support they need. However, I think the greatest barrier to men coming to the MPCSG might be an overwhelming sense of vulnerability in the face of a prostate cancer diagnosis. Prostate cancer impacts, often dramatically, a man's sense of his sexuality. So entering a room full of men in a similar situation may prove a difficult task for some. It is not often that men step willingly into such spaces. Our culture often encourages and even demands that men be "strong" and suppress uncomfortable feelings. Also, there is the question of feeling safe among strangers. In group settings, respect, decorum and the rules of confidentiality are necessary to enable men to voice their concerns and share their stories. So trust can be an issue. Also, because MPCSG welcomes everyone, the situations of the men attending our meetings are diverse. To be sure, there will be some men who express their relief that their treatment has been successful and they are considered "cured". Their accounts will impact those who are facing more challenging outcomes. The disease itself is complex and is still hard to diagnose accurately. It is no wonder that the issue of vulnerability and concern about the type of welcome that may be extended to them, can result in men being reluctant to attend MPCSG meetings. For me the risk has been well worth it. Let me tell you why.

In my opinion, there are two aspects to our meetings; aspects that are also reflected in health care system. Medicine is a science and a practice. We do a good job focusing on the scientific aspects of prostate cancer at our meetings. Then there are the stories we share with each other. I value both, but it is the lived experience of other men that I want to focus on. Listening to others speak about the disease and how they are managing it is the biggest take away for me. Being diagnosed with cancer is traumatic. It takes time to integrate this event into the greater narratives of our lives.

Cancer changes you on all levels. There is the "me" before and the "me" after. Since my diagnosis I am able to be more compassionate towards myself and others and value talking with other men with similar experiences. This is a big change for me, one I have arrived at by learning to face my human vulnerability. MPCSG offers men the opportunity to become engaged in a very human process, an opportunity not usually found in a doctor's consultation room. For me, it is important that there are new attendees at our meetings. And I value the fact that new and old members can learn from each other. I understand that MPCSG may not be for everyone or that for some it may be a brief part of their recovery. Our meetings are a mixed bag: we share hard situations, we laugh, we challenge each other's assumptions, we share information and at our best, we offer each other a sense of community and acceptance.

Patrick Treacy

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"Reminder:
Please send your financial donation to our support group
before the end of the year
to qualify for a tax deduction for 2018.

To make a donation
simply follow the directions
as found on the back page of the newsletter.
Thank you. "The Board"

Long-Term Pfs Benefits Of Pelvic Irradiation Shown In Prostate Cancer

An updated analysis of the NRG/ RTOG 9413 trial shows that the benefits of whole pelvic radiotherapy (RT) plus neoadjuvant hormonal therapy (NHT) persist in the long term in patients with intermediate- or high-risk localised prostate cancer.

The initial phase III study findings, published in 2003, showed that whole pelvic RT plus NHT significantly improved progression-free survival (PFS) when compared with three other RT/hormone therapy combinations, namely prostate-only RT plus NHT, whole pelvic RT plus adjuvant hormonal therapy (AHT) and prostate-only RT plus AHT.

In the current analysis, with a median follow-up of 8.8 years for all patients (n=1270) and 14.8 years for living patients (n=346), the 10-year estimated PFS rate was still significantly higher with whole pelvic RT plus NHT compared with prostate-only RT plus NHT and whole pelvic RT plus AHT, at 28.4% versus 23.5% and 19.4%, respectively, but there was no difference when compared with prostate-only RT plus AHT, at 30.2%.

Whole pelvic RT plus NHT was also associated with a significantly lower risk of Phoenix biochemical failure than prostate only RT plus NHT. However, the researchers point out that the improvements in PFS and biochemical failure rates came at the cost of an increased risk of late grade 3 or worse gastrointestinal adverse events. These were experienced by 7% of patients in the whole pelvic RT plus NHT group, compared with 2–3% of those in the other treatment groups.

Writing in The Lancet Oncology, Mack Roach (University of California, San Francisco, USA) and co-authors say they "believe that this large phase 3 trial provides a proof of principle that, based on [prostate-specific antigen] findings, [whole pelvic] RT when given under the appropriate circumstances might render better long-term outcomes than [prostate-only] RT when short-term NHT is used."

But in a comment that accompanies the study, Guila Delouya and Daniel Taussky, both from the University of Montreal in Quebec, Canada, say they feel that "the decision on whether to treat the pelvis or not remains unanswered after this present study", particularly because the 2x2 study design caused interactions between RT and hormone therapy that make it difficult to make sense of the data.

Both the commentators and the study authors hope that the recently launched NRG/RTOG 0924 study in a similar patient population will address some of these questions.

Roach et al say the larger phase III trial "should provide a more definitive answer concerning the use and toxicity of [whole pelvic] RT in men with intermediate-risk and high-risk localised prostate cancer."

By Laura Cowen 18-10-2018

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https://www.medwirenews.com/oncology/prostate-cancer/long-term-pfs-benefits-of-pelvic-irradiation-shown-in-prostate-c/16205524

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Do Some Prostate Cancer Therapies Raise Patients' Risks for Bladder Cancer?

A retrospective study found that treatment for prostate cancer with external beam radiotherapy (EBRT) is associated with an increased risk for development of bladder cancer when compared with treatment with radical prostatectomy. The finding remains limited by potential biases in this type of analysis.

"Therapy of [a] first tumor might influence risk of harboring a second tumor, and identifying such a factor would improve selection of patients among those who are at an increased risk of developing a potentially deadly second primary tumor," wrote study authors led by Marco Moschini, MD, PhD, of the Luzerner Kantonsspital in Lucerne, Switzerland.

The new study used the SEER database

to investigate the influence of radical prostatectomy and EBRT on the risk of developing a secondary malignancy, specifically bladder cancer or rectal cancer. They included a total of 84,397 individuals, of whom 33,252 (39%) were treated with radical prostatectomy and 51,145 (61%) were treated with EBRT. The patients were followed for a median of 69 months, and the results were published in European Urology.

There were some important differences between the two groups of patients with regard to baseline characteristics. The radical prostatectomy patients had a median age of 69 years, compared with 74 years in those undergoing EBRT (P < .001). More radical

(Continued on page 6)

(Continued from page 5)

prostatectomy patients were white and more were married (82% vs 71%; P < .001), and more EBRT patients were smokers (32% vs 31%; P < .001). There were also differences with regard to Gleason scores and clinical disease stage.

The cumulative incidence of bladder cancer was 1.06% in the full cohort; for rectal cancer, this rate was 0.37%. The 5-year cumulative bladder cancer incidence in those undergoing radical prostatectomy was 0.75%, compared with 1.26% for those undergoing EBRT; at 10 years, those rates were 1.63% and 2.34% (P < .001). There were no differences in incidence between the treatment groups for rectal cancer.

A multivariate analysis found that patients treated with EBRT were more likely to develop bladder cancer, with a hazard ratio of 1.35 (95% CI, 1.18–1.55; P < .001). No such difference was seen with regard to rectal cancer.

The authors noted that a lack of information on the dose of radiotherapy is a limiting factor, and that improvements in EBRT technique in recent years may mean the risks have changed. Also, the retrospective nature of the study means that selection bias and other limitations cannot be ignored.

L. Michael Glodé, MD, a professor emeritus at the University of Colorado Cancer Center, who was not involved in the study, highlighted those limitations. "Although the concern regarding radiotherapy-induced pelvic cancers remains, the challenges of seeking comparable groups of patients in a retrospective study are significant," he told Cancer Network, noting that the patients with higher bladder cancer rates were also older, less healthy, and more likely to be smokers. "As with many surgery vs radiotherapy prostate cancer studies, the absence of prospectively randomized studies continues to plague our field."

Dave Levitan Oct 18, 2018

Bladder Cancer, Genitourinary Cancers, News, Prostate Cancer

http://www.cancernetwork.com/bladder-cancer/do-some-prostate-cancer-therapies-raise-patients-risks-bladder-cancer

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It matters to you to receive it in the manner that is most convenient to you. Also how you prefer to read it.....in hardcopy form, or on your computer screen?

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Thank you, we appreciate your feedback.

~ The Board.

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Distinguishing Fatal Prostate Cancer From 'Manageable' Cancer Now Possible

Scientists at the University of York have found a way of distinguishing between fatal prostate cancer and manageable cancer, which could reduce unnecessary surgeries and radiotherapy.
A recent study showed that more than 25 men were being unnecessarily treated with surgery or radiotherapy, for every single life saved. It is believed that success rates could be hindered as a result of treating all prostate cancers in the same way.
A team at the University of York and the University of British Columbia, Canada, however, have designed a test that can pick out life-threatening prostate cancers, with up to 92% accuracy.
Professor Norman Maitland, from the University of York's Department of Biology, said: "Unnecessary prostate treatment has both physical consequences for patients and their families, but is also a substantial financial burden on the NHS, where each operation will cost around £10,000.
"Cancers that are contained in the prostate, however, have the potential to be 'actively monitored' which is not only cheaper, but has far fewer negative side-effects in patients with non-life threatening cancer."
It is now understood that to find the different levels of cancer, scientists have to identify genes that have been altered in different cancer types. The team analysed more than 500 cancer tissue samples and compared them with non-cancer tissue to search for patterns of a chemical group that is added to part of the DNA molecule, altering gene expression.
A person's age, what they eat and how they sleep, for example, impacts on chemical alterations to genes and which ones are turned on and off. This is part of the normal functioning of the human body and can tell individuals apart, but the process can sometimes go wrong, resulting in various diseases.
Professor Maitland said: "In some diseases, such as cancer, genes can be switched to an opposite state, causing major health issues and threat to life.
"The challenge in prostate cancer is how to look at all of these patterns within a cell, but hone in on the gene activity that suggests cancer, and not only this, what type of cancer - dangerous or manageable?
"To put it another way: how to do we distinguish the tiger cancer cells from the pussycat cancer cells, when there are millions of patterns of chemical alterations going on, many of which will be perfectly healthy?"
The team needed to eliminate the 'noise' of the genetic patterns that make individuals unique, to leave them with the patterns that indicate cancer. They were able to do this using a computer algorithm, which left the team with 17 possible genetic markers for prostate cancer.
Dr Davide Pellacani, who began these studies in York, before moving to the University of British Columbia, said: "Using this computer analysis, not only could we see which tissue samples had cancer and which didn't, but also which cancers were dangerous and which ones less so.
"Out of almost a million markers studied, we were able to use our new tools to single out differences in cancer potency."
To take this method out of the laboratory, the team are now investigating a further trial with new cancer samples, and hope to involve a commercial partner to allow this to be used for patients being treated in the NHS.

The research, published in the British Journal of Cancer, was funded by The Freemasons of the Province of Yorkshire (North and East Ridings) and The Masonic Samaritan Fund. Yorkshire Cancer Research; Prostate Cancer UK; The British Columbia Cancer Agency Strategic Priorities Fund.

University of York 18-Oct-2018

https://www.eurekalert.org/pub_releases/2018-10/uoy-dfp101718.php

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"You Can Help Spread The Word About Prostate Cancer"

Prostate cancer is one of the most common cancers in men. Discovered early, it can be successfully treated in the majority of cases. Such early discovery is dependent on men being aware of the facts about this disease and getting checked. *Early discovery saves lives.*

To help raise awareness and encourage "getting checked" the Manitoba Prostate Cancer Support Group is happy to provide speakers to make presentations to interested groups in the community. There is no charge for this service and the size of the group doesn't matter. If you are involved with a group that would like to learn more about prostate cancer, and perhaps save some lives in the process, please contact Pat Feschuk (tel: 204-654-3898; email: lizpat@shaw.ca). *Remember that if a man has prostate cancer the sooner he learns about it the better. Not knowing about it simply allows it to grow and spread.* **So do something about it** ….. help spread the word.

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Future Meetings 2018-2019

December 2018 No meeting

16 January 2019 Speaker and title to be announced.
Watch for it.

Please note: *We still have some space for speakers in our 2019 program. If you have any topics you'd like addressed, or speakers you'd like to hear, please contact one of the board members and we'll consider your suggestions for our program schedule.*

All meetings (except September) will be held at :
The First Unitarian Universalist Church of Winnipeg,
603 Wellington Crescent

All meetings are 7 – 9 pm.
(First hour for general discussion;
second hour for expert guest speaker)

Everyone Welcome Plenty of free parking

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For general information please contact Jos Borsa at number listed above

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