Manitoba Prostate Cancer SUPPORT GROUP

Newsletter

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Please help us to serve you better……

We are working on improving our ability to reach all of you in a timely, cost-effective and convenient manner. To do this we need to update our contact information and go electronic as much as possible. Towards that end, if you are not yet connected to us via email, please provide us with your email address. It's easy… .. simply send us an email (addressed to manpros@mts.net) with "contact info" in the subject line. After that you'll receive your newsletter electronically, saving us the printing and mailing costs. If you don't have an email address you'll still be able to rely on a hardcopy of the newsletter delivered via surface mail for your updates on what's happening at MPCSG, but you will not be able to receive any rapid reminders or alerts. And of course the e-version is in full color, so switch today.

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!

Next Meeting:

Wednesday, April 17, 2019

Speaker: Jennifer McLaren (Fitness Professional; Reh-Fit)

Topic: "Moving Forward After Prostate Cancer"

Location: The First Unitarian Universalist Church of Winnipeg, 603 Wellington Crescent

Time: 7 – 9 pm.
(First hour for general discussion; second hour for expert guest speaker)

Free Admission Everyone Welcome
Plenty of free parking ✶Door prizes ✶

SHARING IS CARING 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.

Thought of The Day

Courage is the ladder on which all the other virtues mount. ~ Clare Boothe Luce

Unmet Need:' New Program For Men with Prostate Cancer Shows Promising Results

HALIFAX - Five men with prostate cancer sit in a tight circle, speaking of the sadness that overcame them when treatments led to impotency, a lack of bladder control and bouts of anxiety.

They're sharing their experiences at the end of an innovative 28-day program that has dealt with some very sensitive issues.

"I was depressed before ... and this program brought me out of it," Dane Berringer says during a recent gathering at Dalhousie University in Halifax.

The new Patient Empowerment Program (PEP) is part of a broader effort by the health system to help the roughly 23,000 men diagnosed annually with prostate cancer.

Developed by Dalhousie University researcher Gabriela Ilie and radiation oncologist Dr. Rob Rutledge, the program includes, among other things, pelvic exercises to reduce incontinence and counselling that teaches men how intimacy goes deeper than sex.

While surgery, radiation and hormone treatments can lead to a cure, those treatments can leave wounds.

For Berringer, the surgery caused nerve damage near his prostate, a walnut-sized gland above the genitals. The injury has limited the 60-year-old educator's ability to have erections - a common side effect that often leads to feelings of guilt, loss and inadequacy.

However, time spent with his wife in couples' therapy has helped him accept "there's more to life than penetrational sex."

When men lose sexual and urinary functions, many are left to cope on their own, according to Prostate Cancer Canada.

"There is currently an unmet need in our health care system to identify and understand sexuality issues related to prostate cancer ... both for heterosexual men and the LGBTQ community," Stuart Edmonds, director of research at the non-profit group, said an email.

Rutledge, who practises at the Nova Scotia Cancer Centre in Halifax, says it's a "silent epidemic."

He says too many men turn inward and develop mental illnesses related to their distress.

A recent survey of more that 400 prostate cancer patients in the Maritimes found 19 per cent suffered from depression and anxiety. Over 70 per cent reported challenges with sex and intimacy.

Ilie says many men associate intercourse with how they connect to their partners. When impotency sets in, they lose "a navigation system."

"Men aren't like women," says Ilie. "They don't go outward and seek advice. They go inward ... It becomes crucial therefore to find tools that ... bring their feelings to the surface."

Aside from couples counselling, the PEP program also teaches men how to find alternative forms of intimacy.

"There's 65 different ways they can connect (with their partners)," says Rutledge. "Go on a date with your partners, plan something. ... Ask for a hug sometimes."

As well, a buddy system encourages the men in the group to keep in touch on a weekly basis.

Mel Bartlett, 61, says daily exercises and better eating habits helped him lose ten pounds, and special pelvic exercises helped end urinary incontinence.

"My prostate cancer is gone, but I'm not cured of the consequences ... and the treatment of it," says the retired actuary.

"What this has done has treated the patient wholistically. It's tied all the pieces together."

Meditation is also part of the program.

When the men gathered at the beginning and end of the program, they were given small monitors to measure their progress in learning to quiet their minds.

Ross MacDonald, a pastor at Grace Chapel, says the program has helped him cope with the emotional pain that comes with erectile dysfunction and the "hot flashes" caused by hormone therapy.

"There's a grieving that comes in terms of losing that aspect of our relationship," he says.

"(However), the fact that I'm exercising, I'm eating well, I'm meditating and practising quiet ... It's all been very helpful for me, but I know the depression is there."

Preliminary results from PEP program have been encouraging.

After four weeks, the average weight and blood pressure readings for the men went down. Strength levels -- measured by hand grips -- "significantly improved," Ilie says.

"On average, our men reported fewer concerns about feeling a burden to others, feeling alone, having relationship difficulties, feeling sad (and) feeling angry."

Concerns about intimacy and bodily changes caused by medication were also reduced.

The key to the program, says Berringer, is the close contact of the group.

"If you just say, 'Here's an exercise system, go do it,' you won't recreate this," he says. "The human aspect is what they're seeing here."

Michael Tutton, The Canadian Press
Friday, March 8, 2019

https://www.ctvnews.ca/health/unmet-need-new-program-for-men-with-prostate-cancer-shows-promising-results-1.4328403

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New Risk Model Can Predict Survival of Non-metastatic Prostate Cancer Patients

A new risk model, easily accessible on a web interface, can predict the survival of non-metastatic prostate cancer patients, as well as the effect of different treatment approaches on survival. The modeling approach, developed by David Thurtle of the University of Cambridge, UK, and colleagues, is described this week in PLOS Medicine.

Among men with non-metastatic prostate cancer, a number of treatment options may be appropriate, ranging from "watchful waiting" to surgery and aggressive therapies. Prognosticating prostate cancer-specific mortality, all-cause mortality, and the impact of treatment are of crucial importance to inform decision making and avoid over-treatment of indolent disease and under-treatment of aggressive disease. In the new study, researchers developed the PREDICT Prostate model, using data from the UK National Cancer Registration and Analysis Service on 10,089 men diagnosed with non-metastatic prostate cancer between 2000 and 2010 in Eastern England as well as 2,546 men diagnosed in Singapore. The model—estimating 10- and 15-year survival outcomes—was constructed and validated using the men's age, level of PSA (prostate specific antigen), tumor histological grade, biopsy core involvement, disease stage and primary treatment.

The new PREDICT Prostate risk model predicted survival outcomes with concordance indices up to 0.84 (95% CI: 0.82–0.86). There were no significant differences between predicted and observed prostate-cancer-specific or overall deaths in the UK dataset. However, the study was limited by a relatively small external validation cohort and the inability to account for delayed changes to treatment beyond 12 months.

"The model does not require any additional tests beyond standard of care, and is freely available for use," the authors say, adding that it "has the potential to enable well-informed and standardized decision-making and reduce both over- and under-treatment."

Download PDF Copy at www.news-medical.net/news/20190313/New-risk-model-can-predict-survival-of-non-metastatic-prostate-cancer-patients.aspx#

Mar 13 2019

source: https://www.news-medical.net/news/20190313/New-risk-model-can-predict-survival-of-non-metastatic-prostate-cancer-patients.aspx

https://www.plos.org

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Did You Know?

• If you'd like an easy but comprehensive introduction and overview of the facts about prostate cancer you can now access our presentation "Simple Basics About Prostate Cancer" at our website (manpros.org). It's right on the main page and you can step through the talk at your own pace, one click at a time.

• Over the past three years MPCSG services and activities have included the following:

- distribution of some 43,000 newsletters (published in 33 volumes)
- some 1,500 attendees at our monthly public meetings
- some 450 attendees at our September Awareness Evenings
- some 150 information kits distributed through urologist's offices
- some 35 expert speakers arranged for our public meetings
- 33 regular board meetings convened - 3 special board meetings convened
- 7 public presentations at a variety of venues
- 6 Public Health Fairs attended with information stand

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Robot-Assisted Surgery Widely Embraced, But 'Newer Doesn't Always Mean Better,' Experts Warn

Robotic arms may offer smaller incisions and faster recovery, but uncertainty remains

Orthopedic surgeon Dr. Anthony Adili has performed hundreds of knee replacement surgeries in his career.

He's used to being hands-on. But now he can watch as Canada's first orthopedic surgical robot — the MAKO Rio Surgical Robotic System — does a lot of the work.
In January, the robot, guided by Adili and his team at St. Joseph's Healthcare in Hamilton, Ont., performed its first partial knee replacement on 66-year-old Peter Sporta.

Adili and his colleagues programmed the robot using 3D modelling, telling it exactly where the cut needed to be made. Then the robot took over.

"The robotic arm becomes the master," Adili said. "I am just pushing the arm and it will only cut ... where it needs to go to match what I created on my 3D model."

Before the surgery, Sporta said, he was in constant pain and relying on painkillers. Walking was also difficult.

When CBC News interviewed him weeks later, he said "everything seems fine.

"I'm walking straight. I'm so thrilled."

Robotic assistance is a good fit for this type of surgery, Adili said, because the mechanical arm can do a smaller, more precise incision. In this case, only part of Sporta's knee was damaged and, with the robot's help, the team was able to target the repairs and preserve the rest of the joint, rather than do a full knee replacement.

"The biggest difference is the ability to accurately get the alignment of the implant exactly where you want," Adili said.

Smaller incisions in surgery can also reduce pain and blood loss and lessen recovery time — all points proponents of robotic-assisted surgery have used to sell the equipment.

Not enough evidence, experts say
American hospitals first embraced the technology about 20 years ago, and robots now routinely assist in a variety of procedures in the U.S., including prostate, gynecologic and heart surgeries.

But some experts say robotic-assisted surgery still comes with many unanswered questions: Do robotic-assisted procedures achieve better results than traditional surgeries? Are they safer? What about cost?
The answers may depend on the specific type of surgery.

In February, the U.S. Food and Drug Administration (FDA) issued a caution about a "lack of evidence of safety and effectiveness" for robotic surgeries used in mastectomies and other cancer-related surgeries.

"We are warning patients and providers that the use of robotically-assisted surgical devices for any cancer-related surgery has not been granted marketing authorization by the [FDA], and therefore the survival benefits to patients when compared to traditional surgery have not been established," Dr. Terri Cornelison, assistant director for the health of women in the FDA's Center for Devices and Radiological Health, said in a news release.

The FDA said it had received a "small number of medical device reports of patient injury when these devices are used in cancer-related procedures," adding that it "urges health-care providers to complete the appropriate training for the specific robotically-assisted surgical procedures performed."

'Newer doesn't always mean better'
The technology has been widely

(Continued on page 5)

(Continued from page 4)
embraced too soon, said Dr. Jason Wright, chief of gynecologic oncology at Columbia University in New York.

"Newer doesn't always mean better," Wright said. "For many procedures and many diseases, there isn't long-term data that's available to either prove the safety of robotic surgery or demonstrate that it's superior to other alternatives."

"Unless we can demonstrate that the technology is superior to what's already out there ... I think we really need to look hard and re-evaluate what we are doing in practice," he said.

Dr. Irfan Dhalla of Health Quality Ontario agrees.

Two years ago, Dhalla led an expert committee that advised the province not to fund surgical robots for use in prostate removal surgery.

"We haven't found that cure rates are higher with the use of the robot," he said. "And then of course we look at things like complications. And with prostate surgery the big complications are urinary dysfunction and sexual dysfunction. And again there's no good evidence that using the robot reduces the rates of those complications."

Robotic surgery also typically costs more than traditional surgery, partly because the multi-million dollar technology itself is expensive and requires regular maintenance. In addition, the procedures tend to take longer to do, adding to the cost.

Hospitals that offer the robot-assisted procedures in Canada have funded the equipment primarily through donations. That's largely how St. Joseph's Healthcare got its orthopedic surgical robot, which the hospital says cost about $2 million.

Adili and his team are conducting randomized clinical trials to gather evidence on whether the costs of robot-assisted surgery are worth the benefits when it comes to orthopedic procedures, such as knee and hip replacements.

"That way we can definitively answer these questions, so we can say to the payer, 'There is advantage for this technology for this subgroup of people, and these are the outcomes you can expect,'" Adili said. "That's the discussion we need. We're not there yet."

With files from Adam Carter and CBC Hamilton

Melanie Glanz CBC News March 15

https://www.cbc.ca/news/health/robot-assisted-surgery-might-not-always-be-best-option-1.5054873

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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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Testosterone Slows Prostate Cancer Recurrence in Low-Risk Patients

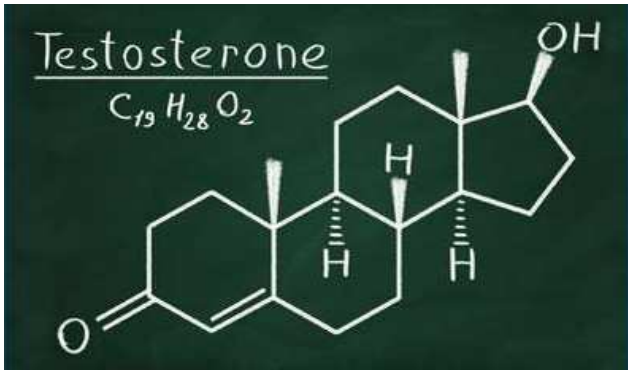
In the largest such study so far undertaken, US researchers have shown that testosterone replacement slows the recurrence of prostate cancer in low-risk patients. This may call into question the general applicability of Nobel-Prize winning hormonal prostate treatment. The work is presented at the European Association of Urology congress in Barcelona.

Doctors have long regarded testosterone as a hormone which promotes prostate cancer. The 1941 work of Huggins and Hodges won Huggins the 1966 Nobel Prize for Medicine, for reporting the dramatic impact of testosterone reduction on prostate cancer. Since then, medicines which reduce levels of the hormone testosterone have become a standard option for many patients.

However, in the late 1990s to 2000s, doctors discovered that although men on long term anti-testosterone treatments were not dying from prostate cancer, they were dying prematurely of cardiovascular disease. It seemed that although anti-testosterone therapies were treating the prostate cancer, the extremely low testosterone levels were significantly worsening metabolic complications such as elevated blood sugar, diabetes, elevated cholesterol, mid-abdomen visceral fat, etc. Low testosterone also caused a loss of sexual function in many men on anti-androgen treatment. This led some doctors to suggest testosterone treatment of some low risk men after radiation or surgical treatment.

What have they done?

Starting in 2008 a team of doctors from the University of California, Irvine, led by Professor Thomas Ahlering, began to carefully select patients for testosterone replacement after primary treatment of prostate cancer with robotic radical prostatectomy, in hopes of improving recovery of sexual function.



The team worked with 834 patients undergoing radical prostatectomy. They treated 152 low-risk patients with no evidence of disease with testosterone replacement therapy. After a median of 3.1 years following surgery, they tested the patients for biochemical recurrence of the cancer, as indicated by measurement of the Prostate Specific Antigen (PSA) levels. They found that the cancer had recurred in only approximately 5% of treated patients, whereas the cancer had recurred in 15% of the patients who did not receive testosterone. Overall, after accounting for differences between the groups, they found nearly a three-fold reduction by three years.

Importance

Thomas Ahlering commented: "This is not what we set out to prove, so it was a big surprise: not only did testosterone replacement not increase recurrence, but it actually lowered recurrence rates. While the testosterone is not curing the cancer per se, it is slowing the growth of the cancer, giving an average of an extra 1.5 years before traces of cancer can be found. We already know that testosterone can help with physiological markers such as muscle mass, better cholesterol and triglyceride levels and increased sexual activity, so this seems to be a win-win".

He continued, "There have been smaller studies which have hinted that testosterone may not be risky for certain patient groups, but this is the largest such study ever conducted. We're not suggesting that treatment methods be changed just yet, but this puts us at the stage where we need to question the taboo against testosterone use in prostate cancer therapy—especially for low-risk patients after radical prostatectomy. We need the oncology/urology community to begin to review testosterone use".

Commenting, Professor Francesco Montorsi (Milano), European Association of Urology's Adjunct Secretary General for Science said:

"The paper is indeed important, as it stresses the importance of checking testosterone levels as a part of the management of patients with sexual disorders following radical prostatectomy. Obviously selection of the right patients is vital, but if confirmed, this may have immediate benefits on quality of life; the possibility of reducing mortality would be an unexpected bonus. We now need bigger studies to support this work".

Professor Montorsi was not involved in this work.

by European Association of Urology
March 17, 2019

https://medicalxpress.com/news/2019-03-testosterone-prostate-cancer-recurrence-low-risk.html

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Study Finds Upsurge In 'Active Surveillance' For Low-Risk Prostate Cancer

Many men with low-risk prostate cancer who most likely previously would have undergone immediate surgery or radiation are now adopting a more conservative "active surveillance" strategy, according to an analysis of a new federal database by scientists from Dana-Farber Cancer Institute.

The use of active surveillance increased from 14.5 percent to 42.1 percent of men with low-risk prostate cancer between 2010 and 2015, said the researchers, led by Brandon Mahal, MD, from the department of radiation oncology at Dana-Farber/ Brigham and Women's Cancer Center who led the study published by JAMA.

During that same period, the percentage of men undergoing radical prostatectomy (removal of the prostate gland) declined from 47.4 percent to 31.3 percent. The use of radiotherapy for low-risk disease dropped from 38.0 percent to 26.6 percent.

"What we know from high level evidence is that conservative management of low-risk prostate cancer is associated with a very favorable prognosis," said Mahal. "Many men with low-risk disease are able to be spared the toxicity of treatment so it's an important discussion to have between clinicians and patients."

National guidelines advocating conservative management rather than immediate "definitive treatment" with surgery or radiotherapy were established in 2010 for men with low-risk prostate cancer. Low-risk disease is defined as a small tumor confined to the prostate gland that is assigned a grade of 6 on the Gleason scale following a biopsy; an early pathological stage, and a low PSA (prostate-specific antigen) blood level.

"This encouraging finding suggests that clinicians are better adhering to current recommendations and guidelines for men with low-risk prostate cancer, as the use of active surveillance in appropriately selected men will reduce rates of overtreatment," said Howard Soule, PhD, executive vice president and chief science officer of the Prostate Cancer Foundation.

Mahal said men with low-risk tumors have a "very, very low risk of dying" from prostate cancer, and that invasive treatments don't necessarily improve survival odds. In the current study, Mahal and his colleagues, including senior author Paul Nguyen, MD, a Dana-Farber/Brigham and Women's Cancer Center radiation oncologist, made use of a federal database that for the first time specified whether patients made use of watchful waiting or active surveillance. (Patients adopting a watchful waiting approach are told to report symptoms such as changes in urinary habits, pain, or irritation, or bone pain that could reflect metastatic progression. Active surveillance involves periodic follow-up tests for PSA levels, repeat biopsies, and exams by a doctor every six to 12 months).

The study also revealed changes in treatment for high-risk prostate cancer from 2010 to 2015 – though the researchers were somewhat surprised by the findings. The use of radical prostatectomy increased from 38 percent to 42.8 percent during that period, while radiotherapy decreased from 60.1 percent to 55 percent.

"This shift in management patterns away from radiation therapy and toward more radical prostatectomy is not supported by any recent high-level studies," said Mahal. "This finding is provocative and may be a focal point of debate."

Funding for the research was provided by Prostate Cancer Foundation-American Society for Radiation Oncology award to Mahal; Prostate Cancer Foundation funding to Nguyen; and support from the Wood Family Foundation, Baker family, Freedman family, Fitz's Cancer Warriors, David and Cynthia Chapin, Frashure family, and other donors.

FEBRUARY 11, 2019

https://www.dana-farber.org/newsroom/news-releases/2019/study-finds-upsurge-in--active-surveillance--for-low-risk-prostate-cancer/

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FUTURE MEETINGS 2019

15 May Speaker: **Dr. Sean Ceaser**, ND
Topic: "*Naturopathic medicine and prostate cancer*"

19 Jun. Speaker: **Sue Ostapowich**, RN, Psychiatric Nurse, Mindfulness practitioner
Topic: *"Stressed out about your prostate cancer diagnosis? De-stress via the mindfulness approach"*

17 Jul. Panel discussion with **patients** who have chosen different treatment modalities. Comparison of their experiences.

21 Aug. Speaker: **Dr. Shantanu Banerji**, MD, FRCPC
Topic: *"Genomics: what it is and the promise it offers for better prostate cancer treatment"*

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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