

### Can Red Wine Help Ward Off Prostate Cancer?



Drinking red wine may lower the risk of aggressive prostate cancer.

A study at Harvard University in the US found that moderate red wine drinkers had a 16 per cent lower risk of developing the disease, while men already diagnosed with prostate cancer who drank red wine

were 50 per cent less likely to see it progress into a deadlier form.

The study, reported in the journal Cancer Prevention And Control, was based on 47,568 cancer-free men and 5,182 men with localised prostate cancer.

Exactly why red wine appears to have a protective effect is unclear. One theory is that it is a

result of antioxidants such as resveratrol, the concentration of which in red wine is tenfold that in white.

18 July, 2019

<https://www.irishnews.com/lifestyle/2019/07/18/news/can-red-wine-help-ward-off-prostate-cancer--1658282/>

...

#### 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, August 21, 2019**

**Speaker:** Dr. Shantanu Banerji, MD, FRCPC

**Topic:** *“Genes and prostate cancer: promise and pitfalls of personalized treatments”*

**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 ☆*



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*

Life is 10% what happens to you and 90% how you react to it.

*Charles R. Swindoll*

## Stories Of Individual Cancer Journeys A Big Success At Manitoba Support Group Meeting

At the July 17, 2019 meeting of the MPCSG a packed house of prostate cancer patients along with their spouses or other support persons heard five panelists share their individual stories of their battles with their cancers. Each had a different story to tell, reflecting on their particular circumstances and

personal decisions for treatment. Two spoke about radical prostatectomies followed by secondary and further treatments; one spoke about HIFU; one about external beam radiation, and one about cryotherapy. All spoke passionately about the wonders of modern treatment for prostate cancer

and the life-saving benefits it bestowed on them. All were grateful for the gift of being able to continue living a life worth living despite their cancer, and shared their optimism with the audience. All in all, it was a truly great evening.



L to R: Kelly Cook (surgery), Erv Petkau (HIFU), Lorne Peters (surgery), Jack Evans (external beam radiation), Al Petkau (cryotherapy)

Audience members listen to the panelists weave their tales about their cancer journeys.

*Photo credits: Wally Jackson*

## Study: Prostate Cancer Therapy, Dementia Linked Together

Men face tough choices in treating prostate cancer. A Penn study strengthens the link between hormone therapy and dementia.

Men with prostate cancer and their doctors already have tough decisions to make. Do they go with watchful waiting? Surgery? Radiation?

Now a new, large study from Penn Medicine makes decisions about a level of treatment often added for men with aggressive or metastatic prostate cancer even harder. It adds to evidence that hormone therapy is associated with higher rates of Alzheimer's disease and dementia.

The lead author of the study, Ravishanka Jayadevappa, said the decision about whether to use androgen deprivation therapy will be most difficult for men with cancer that has not yet spread beyond the prostate but is known to be a more virulent type.

Previous work, including some done at Penn, has found a connection between

ADT and higher rates of dementia.

There also are studies that do not support the hypothesis. Jayadevappa said this study, which followed 154,000 men 65 and up with prostate cancer over an average of eight years, was larger than others and did a better job of adjusting for other illnesses. It also found that the association with dementia grew stronger the more ADT men had taken.

The study was published this month in the Journal of the American Medical Association.

Thirteen percent of men in the study who received hormone therapy were diagnosed with Alzheimer's disease compared with 9% who did not get ADT. The study also looked at dementia, an umbrella term for cognitive decline that includes Alzheimer's and several other forms of dementia. Twenty-two percent of the men who took ADT got that diagnosis, compared with 16% who didn't take it. No one was counted in both categories.

After controlling for disease severity and other medical and socioeconomic factors, the research team found that men who had taken ADT had a 14% higher risk of developing Alzheimer's and a 20% increased risk for dementia. The increases were consistent for patients who received surgery or radiation or decided on watchful waiting, although they were slightly higher in the radiation group, said Jayadevappa, who has Ph.D. in public policy and management and is a senior fellow at the Leonard Davis Institute of Health Economics.

Androgen deprivation therapy suppresses the amount of androgens, or male hormones in a man's body, which fuel prostate cancer cell growth. Surgical castration is one form of hormone therapy, but there are multiple drugs that lower the amount of testosterone a man's body makes or that stop androgens from working.

Hormone therapy can cause reduced sexual desire, impotence, hot flashes, osteoporosis, loss of muscle mass and

*(Continued on page 3)*

*(Continued from page 2)*

several other negative side effects. Jayadevappa said there are times when ADT may be "life-saving," but doctors may want to limit doses in patients with intermediate disease. "After this study, I think they'll all be a bit more mindful or cautious of overexposure with ADP," he said. He thinks there should be more research on ADT and its biological mechanisms, not just against cancer but within the brain.



Ravi Parikh, an oncologist and prostate cancer specialist on the research team,

said hormone therapy clearly lengthens life for men with stage 4 or metastatic prostate cancer. While such cancer is often fatal, men with it can survive up to 10 years, although most live less than five years.

Among patients with localized, high-risk cancer, Parikh, who practices at the Corporal Michael J. Crescenz Medical Center in Philadelphia, said ADT is most beneficial for younger men who are healthy enough to live many years. About 80% of men with localized, aggressive cancer survive five years

when hormone therapy is part of their treatment, compared to 60% who do not get ADT, he said.

Some men with localized cancer currently get hormone therapy for as long as two years. "Those are the men that I worry about," he said.

Another group that could need extra consideration is older men who already have signs of cognitive dysfunction, Parikh said.

*Stacey Burling* *Tribune News Service*  
[https://cumberlink.com/live\\_well\\_in\\_the\\_cumberland\\_valley\\_study-prostate-cancer-therapy-dementia-linked-together/article\\_2c763d99-7684-59d4-816a-ea96eb60a0ba.html](https://cumberlink.com/live_well_in_the_cumberland_valley_study-prostate-cancer-therapy-dementia-linked-together/article_2c763d99-7684-59d4-816a-ea96eb60a0ba.html)

• • •

It's coming soon....

***Our highlight event of the year...***

**“Prostate cancer awareness evening”**

*Featuring two of Winnipeg's top doctors and researchers talk about the promise*

*of science-based advances*

*in treatment of prostate cancer*

**Wednesday Sept. 18, 2019**

**Watch for details**

***DON'T MISS IT !!!!***

## Should You Choose Treatment and Risk The Side Effects? Two Patients Explain Their Different Paths

Patients who are at low or medium risk are often left to make their own decisions between no treatment, prostate removal and radiotherapy. Bob Andrews and Kieran O'Connor made different choices over their treatment for prostate cancer.

### In brief

- *Treatment can cause urinary incontinence and erectile dysfunction*
- *New advice says low risk patients shouldn't be pushed into treatment*
- *Bob Andrews says op to remove prostate brought him 'peace of mind'*
- *Kieran O'Connor refused surgery and paid for proton beam therapy*

Prostate cancer is the leading cancer in males: nearly one in eight will get it at some point in their lives.

And with age a major risk factor, as our population continues to live longer, the number of men with the disease continues to grow too.

Localised cases (when the cancer is completely inside the prostate gland) often grow slowly – or not at all – and usually have a low risk of spreading, meaning for many having treatment is unnecessary.

Treatment – surgery and radiotherapy – can cause nasty side-effects, including urinary incontinence and erectile dysfunction, and with both there is a one in three chance the cancer will return, according to the NHS.

Yet watching and waiting can bring much anxiety for patients. The mortality statistics are frightening – one man dies every 45 minutes in the UK, according to Prostate Cancer UK.

Around half of those diagnosed are classed as low or intermediate risk.

They are left to decide if they should opt for an operation, called a prostatectomy, to remove the prostate gland and surrounding tissues, radiotherapy or just to be monitored.

**There's no question that historically that men with low risk cancers have been over-treated unnecessarily, and patients with a higher risk have been under-treated too**

*Professor Chris Eden*

For the first time, recent advice from the health watchdog says when it comes to 'low-risk' patients, evidence suggests there is no difference between the three approaches when it comes to 10-year survival rates. According to the National Institute for Health and Care Excellence (Nice), these cases should not be pushed into having treatment, and instead should be offered "equal choice" between the options.

Professor Chris Eden, a consultant urologist at Royal Surrey County Hospital in Guildford, told i: "There's no question that historically that men with low-risk cancers have been over-treated unnecessarily, and patients with a higher risk have been under-treated too, with fatal consequences.

"Radiotherapy causes damage to healthy cells and very few men who opt for radiotherapy first will be a candidate for a prostatectomy afterwards if it returns which is why some men choose surgery."

Here we speak to two men – one who chose to have a prostatectomy and one who didn't – about how they came to their decision.

Bob Andrews was diagnosed "accidentally" on his 55th birthday last year, after a scan for back pain revealed

a shadow on his prostate. The chief executive officer of Benenden Health is young to get the disease – the average age for diagnosis is between 65 and 69 years.

He had no symptoms – for most people the disease causes no issues until it's advanced – and his PSA levels were low (the test doesn't detect all cancers).

Bob's cancer was localised and his Gleason score (a grading system determining the aggressiveness) was seven (out of a maximum of 10). He was told he had a mixture of cells that were likely to grow at a slow rate, if at all, and at a moderate rate.

His NHS consultant offered him the choice of surgery, standard radiotherapy, or brachytherapy – where radioactive implants are put near or inside the tumour – or 'active surveillance' through tests and scans.

### The definition for low risk prostate cancer.

To work out your risk, your doctor will look at your PSA level (a protein produced by the prostate gland), your Gleason score (a grading system determining the aggressiveness of the cancer, which goes up to 10) and the T stage of your disease (the size and spread).

Low risk, according to Cancer Research UK, is defined as:

- A T stage of T1 to T2a is low
- A Gleason score no higher than 6
- A PSA level of less than 10 ng per ml

The CEO has suffered some of the typical side-effects of surgery but

*(Continued on page 5)*



(Continued from page 4)

says they are improving .

## **Sometimes a patient doesn't want too much choice**

*Bob Andrews*

“Sometimes a patient doesn't want too much choice,” he said. “You want a clear instruction on what works best.”

After weighing up the options, the father-of-three decided to have surgery. “For me waiting and seeing didn't sound good.

“I know they tell you worst case scenario, but I was worried about the risk of secondary cancers with radiotherapy. And I knew if I had the radiotherapy then the option to have a prostatectomy could be off the table.”

Since the operation last November, after which he needed two months recovery time off work, Bob has suffered some side-effects, but feels they are ones he can live with.

“Initially, I was leaking wee. It wasn't fun wearing incontinence knickers at age 55. But seven months on that's really improved.

“With my erectile function, it's not the same as it was. But they've given me a hand pump and Viagra so it's not that bad.

“You have dry orgasms afterwards which takes getting your head around and I've been left infertile but that's not an issue for me as I have three children.”

Bob recently achieved a 120-mile cycle and is set to take on a Tough Mudder soon. All in all, Bob says he doesn't regret his choice. “The operation means the cancer is gone and that brings me peace of mind.”

‘I wasn't prepared to risk being incontinent or impotent at 49 – I paid £35,000 for proton beam therapy’ Kieran O'Connor was also younger than average when he found out he had prostate cancer

Kieran O'Connor also had the same Gleason score at Bob. He too was diagnosed at a young age, 49, after getting his PSA levels tested because he had an increased risk due to his father having died from the disease.

Also like Bob, he had no symptoms. His cancer was localised, but with his test coming back high at 30ng/ml, and a biopsy confirming two malignant tumours, his specialist didn't think monitoring was sufficient.

“I've been fit as a butcher's dog all my life,” he said. “So, to get a diagnosis like that, a month away from turning 50, was devastating.”

## **Longevity isn't everything; I could end up living a life without quality. I wasn't taking that risk**

*Kieran O'Connor*

The former design engineer, from Falkirk, was urged to have a prostatectomy but he was dead set against it.

He'd watched his father Gerry's health decline after the operation – he suffered incontinency – and despite the treatment, he later passed away aged 67 when the disease returned.

“My consultant said you're a young guy, we just want to get this out. But I said that option is not on the table. We even got into a full-blown argument.

“Longevity isn't everything; I could end up living a life without quality. I

wasn't taking that risk.

“They pushed my father down the surgery route very quickly. The cancer came back even after his prostatectomy and he was left facing further chemo, as well as all the terrible side effects from the surgery. He deteriorated so quickly once it spread. The last three months was especially bad.”

The 52-year-old says he was working out just two weeks after treatment.

Kieran, now 51, instead had pioneering proton beam therapy. A less invasive form of radiotherapy, it targets tumours more precisely than current treatments, with minimal impact to surrounding, healthy tissues and vital organs, such as the bladder and rectum.

However, NHS England will not routinely commission it for prostate cancer, and Kieran forked out £35,000 to have it privately at the Proton Therapy Center in Prague where toddler Ashya King was successfully treated in 2014.

After his treatment in November last year, Kieran was back in the gym and doing martial arts within two weeks. He has suffered no long-term effects, his PSA has now shrunk to below one and he is optimistic about the future.

“I wanted to protect my bladder, my rectum and my sexual function. These were the areas I was worried about the most. I didn't want incontinence and I want to enjoy relationships. Otherwise, why bother living?”

“Longevity is great, but it's only good if you can enjoy your life. To me, being fit and healthy is more important than living to an old age but not fully enjoying life.”

(Continued on page 6)

(Continued from page 5)

## Treatment options for prostate cancer

Treatment for prostate cancer will depend on your individual circumstances. For many men with prostate cancer, no treatment will be necessary. Sometimes, if the cancer has already spread, the aim is not to cure it but to prolong life and delay symptoms. The options are:

### Watchful waiting

This is often recommended for older men when it is unlikely the cancer will affect their natural lifespan.

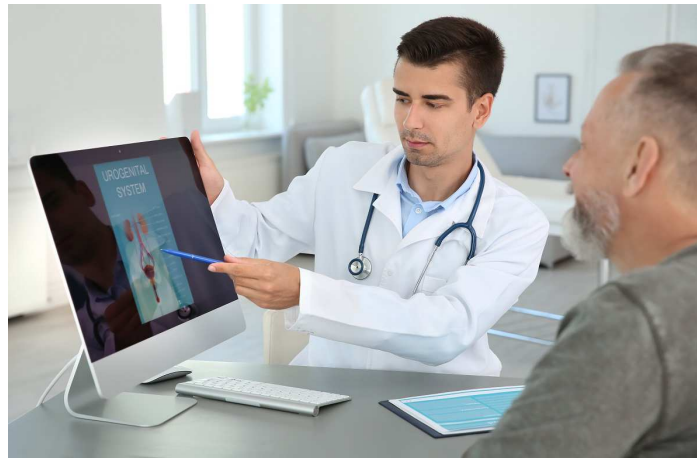
If the cancer is in its early stages and not causing symptoms, you may decide to delay treatment and wait to see if any symptoms of progressive cancer develop. If this happens, hormone medication to control prostate cancer is usually used.

### Active surveillance

This aims to avoid unnecessary treatment of harmless cancers, while still providing timely treatment for men who need it. It involves having regular PSA tests, MRI scans and sometimes biopsies to ensure any signs of progression are found as early as possible.

## A radical prostatectomy

This treatment is an option for curing prostate cancer that hasn't spread beyond the prostate or hasn't spread very far. Studies have shown that radiotherapy after prostate removal surgery may increase the chances of a cure, although research is still being carried out into when it should be used after surgery.



## Radiotherapy

This involves using radiation to kill cancerous cells and is an option for localised cancer or when the disease hasn't spread very far. It can also be used to slow the progression of prostate cancer that has spread, and relieve symptoms.

You may receive hormone therapy before undergoing radiotherapy to

increase the chance of successful treatment.

There is a higher risk of complications from surgery in men who have previously had radiotherapy.

### New treatments

Some hospitals now offer new minimally invasive treatments if radiotherapy fails to work, sometimes as part of a clinical trial.

These include brachytherapy, high-intensity focused ultrasound (HIFU) and cryotherapy. These treatments have fewer side effects, but the long-term outcomes are not yet known.

### Proton beam therapy

This involves using a focused ray of proton particles to destroy cancerous tissues, bringing fewer side-effects than standard radiotherapy. It is not routinely commissioned by the NHS.

*Claudia Tanner July 19th 2019*

<https://inews.co.uk/news/real-life/the-prostate-cancer-conundrum-should-you-choose-treatment-and-risk-the-side-effects-two-patients-explain-their-different-paths/>

...

### 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.

...

## Aggressive Prostate Cancer Metastasis Mechanisms Uncovered

Scientists at the University of Texas MD Anderson Cancer Center say they have discovered how an aggressive form of prostate cancer called double-negative prostate cancer (DNPC) metastasizes by evading the immune system. The team also reported on the preclinical development of a new therapy which, when given in combination with existing immunotherapies, appears to stop and even reverse metastasis in mouse models. The study (“The Polycomb Repressor Complex 1 Drives Double-Negative Prostate Cancer Metastasis by Coordinating Stemness and Immune Suppression”) appears in *Cancer Cell*.

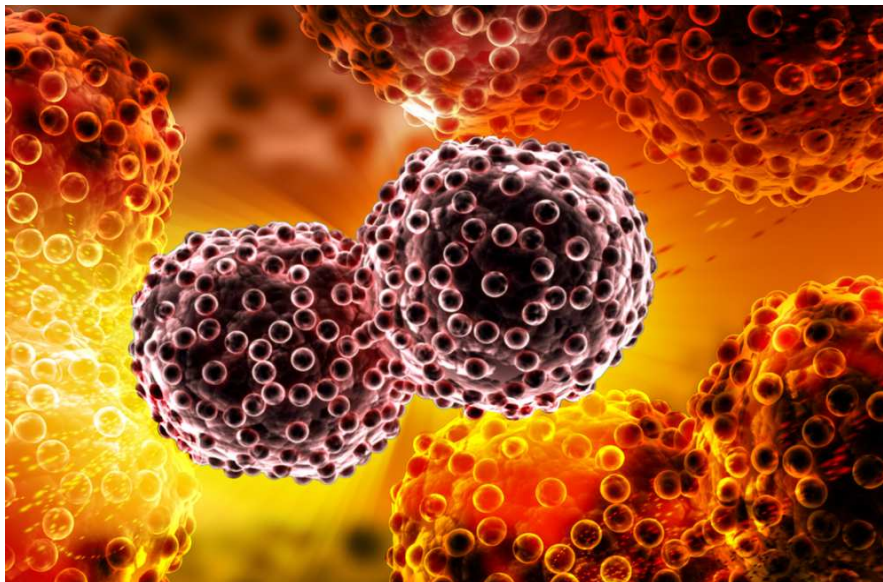
“The mechanisms that enable immune evasion at metastatic sites are poorly understood. We show that the Polycomb Repressor Complex 1 (PRC1) drives colonization of the bones and visceral organs in DNPC. In vivo genetic screening identifies CCL2 as the top prometastatic gene induced by PRC1. CCL2 governs self-renewal and induces the recruitment of M2-like tumor-associated macrophages and regulatory T cells, thus coordinating metastasis initiation with immune suppression and neoangiogenesis,” the investigators wrote.

“A catalytic inhibitor of PRC1 cooperates with immune checkpoint therapy to reverse these processes and suppress metastasis in genetically engineered mouse transplantation models of DNPC. These results reveal that PRC1 coordinates stemness with immune evasion and neoangiogenesis

and point to the potential clinical utility of targeting PRC1 in DNPC.”

DNPC is difficult to treat and frequently arises in patients previously treated with therapies that inhibit androgen receptors (AR), known to spur prostate cancer cells growth.

Filippo Giancotti, MD, PhD, professor of cancer biology, noted that an epigenetic regulator known as the polycomb repressor complex 1 (PRC1) coordinates the initiation of metastasis by increasing the regenerative capacity of metastatic cells and by suppressing the immune system and spurring tumor blood vessel growth or angiogenesis.



“The findings open up potential new approaches to treating DNPC, which has been recognized recently as a new subtype that emerges at least in part in response to treatment with next-generation AR inhibitors,” said Giancotti, “We showed that PRC1 plays a role with immunosuppression at metastatic sites in DNPC, and we developed a novel in-class inhibitor of PRC1. This inhibitor exhibited efficacy as a single treatment and cooperated with double checkpoint immunotherapy to completely suppress metastasis in

preclinical DNPC models.”

Through in vivo genetic screening, the team identified a cytokine called CCL2 as the major pro-metastatic gene induced by PRC1. CCL2 binds to a tumor cell receptor called CCR4 to boost regenerative capacity and to CCR2 in immune cells, creating an immunosuppressive microenvironment and boosting tumor blood vessel growth.

“CCL2 also attracts tumor-associated macrophages (TAMS) and regulatory T cells (Tregs), which suppresses the immune system and stimulates angiogenesis,” continued Giancotti.

“Our study showed that targeting PRC1 inhibits recruitment of TAMS and Tregs, suppressing tumor metastasis.”

Giancotti’s team combined PRC1 with two types of immunotherapy agents, which attracted important immune cells called CD4 and CD8 T cells, resulting in “maximal induction” of tumor cell death in mice.

“This indicates that the inhibiting TAMS and Tregs with PRC1 inhibitors enables double checkpoint therapy to not only recruit but also to activate T cells, thus causing metastasis regression,” said Giancotti.

July 19, 2019

<https://www.genengnews.com/news/aggressive-prostate-cancer-metastasis-mechanisms-uncovered/>

...



**MANITOBA PROSTATE CANCER SUPPORT GROUP TAX DEDUCTIBLE DONATION**

NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ POSTAL CODE \_\_\_\_\_  
 THIS GIFT IS IN MEMORY/HONOUR OF \_\_\_\_\_ PLEASE SEND NOTIFICATION TO: \_\_\_\_\_  
 NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ POSTAL CODE \_\_\_\_\_

**Make payment to:** Manitoba Prostate Cancer Support Group;  
 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](http://www.manpros.org) and clicking on the donate tab.  
 Canada Helps will issue a tax receipt. **Amount:** \$25 \$50 \$75 \$100 Other \_\_\_\_\_



**Email - [manpros@mts.net](mailto: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**

**FUTURE MEETINGS 2019**

**18 Sep.** Our highlight event of the year, examining future therapies that are on the horizon. *Watch for details.*

**16 Oct.** Speaker: Jessica Wylychenko, Dietitian

**Topic:** *Nutritional considerations in prostate cancer*

**20 Nov:** Annual windup  
*Live music Potluck Prizes*

-----  
 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*

**MPCSG BOARD**

|  |                |
|--|----------------|
| Al Petkau - Treasurer .....            | (204) 261-5303 |
| Betty O'Grodnik – Secretary .....      | (204) 661-8549 |
| Jos Borsa - Chair .....                | (204) 219-7726 |
| Liz Feschuk - Special Projects .....   | (204) 654-3898 |
| Ernie Schade – Meeting Convener .....  | (204) 489-1648 |
| Pat Feschuk – Special Events .....     | (204) 654-3898 |
| John O'Grodnik - Vice Chair .....      | (204) 661-8549 |
| Wally Jackson - Member-at-large .....  | (204) 668-1222 |
| Deloris Ankrom - Member-at-large ..... | (204) 667-4156 |

**Volunteers On Committees**

Irek Iskat — membership

*For general information please contact Jos Borsa at number listed above*



This newsletter is a  
**Bottom Line Computer Services**  
 publication

Bottom Line Computer Services is not responsible for content  
[www.misterpete.com](http://www.misterpete.com)