Manitoba Prostate Cancer SUPPORT GROUP

Newsletter

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PROSTATE Cancer AWARENESS MONTH September >>Support - Advocate - Cure

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Thanks!

Don't Miss It !

Our annual

September Awareness Evening about Prostate Cancer

Darrel E. Drachenberg
MD, FRCS(C)

Sabine Mai, Ph. D.

Two top specialists in cancer treatment and research address the theme:

"Science-based pathways towards improved treatments for prostate cancer"

Don't miss this opportunity to learn more about how scientific advances are opening new pathways leading to the next generation of therapies in the battle against this disease, and to have your questions and concerns addressed by these leading specialists.

Date and time: Wednesday, September 18, 2019 7-9 pm
Location: Caboto Centre, 1055 Wilkes Ave., Winnipeg
Everybody Welcome Free Admission 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

"Life shrinks or expands in proportion with one's courage."
Anaïs Nin

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.

Dear Dr. Roach: Will Prostate-Shrinking Meds Affect Low-Grade Prostate Cancer?

Dear Dr. Roach: I've had low-grade prostate cancer for several years and am presently on "active surveillance." My PSAs have been high but steady, running around 7.8 to 9.2. I have a greatly enlarged prostate, which I believe contributes to the high PSA numbers.

I would like your opinion regarding finasteride (Proscar), as I am considering taking it. I see one of its side effects is that it increases the risk of developing a very serious form of prostate cancer. Since I already have this cancer, am I at an increased risk of mine growing more aggressive?

A: A 2013 study showed that although finasteride reduced the overall risk of prostate cancer from 15% to 10% in men followed up to 18 years on finasteride, there was a small increase in high-grade, aggressive prostate cancer, from 3% to 3.5%. However, there was no increased risk of prostate cancer death among treated men.

Several follow-up studies have suggested that the apparent small increase in aggressive prostate cancers reflected an easier ability to find these cancers, since finasteride shrinks prostate tissue, making it easier to both biopsy and read the results. My view is that the apparent increase in aggressive prostate cancer is unlikely to represent a real danger in taking finasteride. There is no evidence to suggest that finasteride would change the behavior of an existing tumor.

Dr. Roach Writes: A recent column on easy bruising in older adults prompted several readers to recommend specialized makeup products to cover the discolored areas. That is not something I had considered, and I appreciate the recommendation. Another reader recommended dry skin brushing, but I could not find good evidence that this helps with skin discoloration.

DR. KEITH ROACH
For the Herald & Review

Dr. Keith Roach writes for North America Syndicate. Send letters to 628 Virginia Dr., Orlando, FL 32803 or email ToYourGoodHealth@med.cornell.edu.

Source: https://herald-review.com/lifestyles/health-med-fit/dear-dr-roach-will-prostate-shrinking-meds-affect-low-grade/article_c925ed06-329c-5aa2-a97c-a6afd719bd78.html

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Active Surveillance May Be Right For Prostate Cancer

Not pursuing treatment can seem unacceptable to some who are diagnosed, but it could be the best option to improve quality of life if your disease isn't progressing

Cancer is the most polluting word in the English language, there's no question. Immediately upon diagnosis, the word instills fear and a wide range of emotions.

For some men who have low-risk prostate cancer, the word cancer doesn't need to prescribe a dire situation. In fact, the treatment plan for these men is to, well, not to immediately treat the cancer. Called active surveillance, these individuals are monitored over time, having regular PSA tests and office visits.

While this may seem like a counter intuitive strategy, active surveillance actually allows the men to maintain their quality of life without treatment side effects.

What is active surveillance?
Just because you have a diagnosis doesn't mean you have to be treated. The knee-jerk reaction is to want a surgeon to cut the cancer out, radiate it, provide chemotherapy or do something. Anything. It's a common feeling.

Active surveillance is a more conservative approach for those with low- or favorable-risk disease. Instead of doing any treatment, active surveillance includes routine monitoring via rectal exams, prostate-specific antigen (PSA) testing and periodic biopsies.

Surveillance is the answer for a large population with prostate cancer. For example, about 30 percent of my new consults are candidates for active surveillance.

Think about that. Almost a third of patients can be managed without immediate treatment. And of those eligible for active surveillance, two thirds of them will never need treatment. The goal of a good active surveillance program is to stay on top of the patient and assess those that may need treatment early.

Breaking the news
Telling patients they are candidates for active surveillance is challenging for many reasons. First, let's get back to the beginning, where we said that the word cancer is "polluting." There are patients when they hear cancer just want… anything. They just don't want to hear that are recommending no immediate treatment.

How do patients come to terms with that? It's all in how it is presented. You have to engage the patients and say I don't think we need to treat it, at least for today. I am going to be by your side, managing you in real time. If anything happens with an MRI or your prostate-specific antigen (PSA) spikes, we got you covered.

Assuring them that they are going to be OK and that I will be with them throughout this experience has a comforting effect. Regardless of the acuity of their disease, I present them algorithms detailing the best course of action for a variety of situations and treatment options. The blueprint is visual evidence that a plan is in place, even if they choose active surveillance.

Oftentimes, men do research before their office visit and say they want radiation, but they don't need it, especially since they have low-risk disease, which has a 10-year survival rate of 98-99 percent. The message is to kick the can at having another MRI and PSA testing in four months. If your PSA is 6 and in four months its 7.5, we will treat you. If it comes back 6 or 5 or 4, let's kick the can for another four months. Once the patients are comfortable actually seeing their disease is stable, they become comfortable with active surveillance.

PSA increases
Above normal PSA numbers can be caused by prostate cancer and several other factors, including:

- Prostatitis: Inflammation of the prostate caused by bacterial and nonbacterial factors. There are more than 200,000 cases of prostatitis in the US each year.
- Aging: Generally, 2.5 is the PSA limit for men under 40. The limit increases to 4.5 by 60 and 6.5 by 70.
- Benign prostatic hyperplasia (BPH): Common among older men, BPH is an enlarged prostate. It is not cancer.
- Surgical procedures: Adding a catheter to the bladder, performing scopes or even a biopsy can unintentionally cause the PSA to increase.
- Exercise: Going too hard at the gym or even having a lot of sex can also cause your PSA to escalate.

Considering the numerous ways a PSA can spike, more testing may be necessary to determine if it is cancer. And active surveillance may be the right course of action.

Louis Potters, MD, is an internationally renowned expert in the treatment of prostate cancer and a leader in the field of radiation oncology. He is deputy physician-in-chief and director of radiation oncology for the Northwell Health Cancer Institute, and chair of radiation medicine at North Shore University Hospital, Long Island Jewish Medical Center and the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell.

https://www.northwell.edu/cancer-institute/news/insights/active-surveillance-may-be-right-for-prostate-cancer

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Mystery! The Vanishing Prostate Tumor

Do cancers really disappear spontaneously?
Or are they just eluding us?

Cancer specialists are comfortable with the terms partial remission and complete remission when patients undergo some sort of aggressive therapy such as radiation or chemo.

But the concept of spontaneous remission is more problematic, especially with low-risk prostate cancers in patients like me on active surveillance (AS) who have had no treatment at all.

Back in May, Michael Scott, a patient advocate and layman with loads of expertise with prostate cancer, went out on a limb to suggest in his blog that spontaneous remission was real and worthy of the attention of serious researchers.

Scott, founder of Prostate Cancer International and its Active Surveillance Virtual Support Group, mentioned my case and that of a man whose name he couldn't recall.

I asked other men in two virtual support groups for men on AS if they had experienced spontaneous remission. James Simms, 72, a retired banker from Tampa, was the only one to reply. As it happens, he had described his case at Scott's group.

Simms and Scott gave me a new perspective on what might have happened with my "lame" cancer, as my urologist calls it.

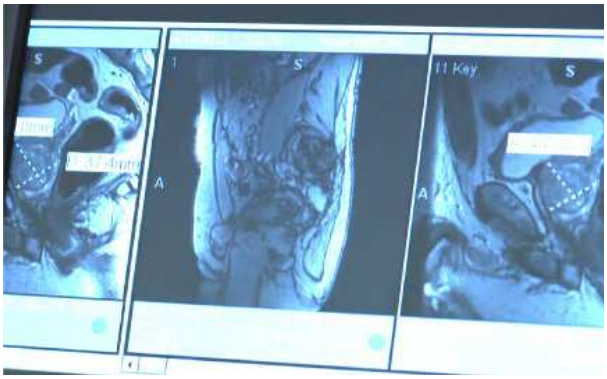
My case

I was diagnosed with a sliver of Gleason 6 in a single core in a blind biopsy in December 2010, and two tiny suspicious lesions were disclosed in a multiparametric magnetic resonance imaging scan a few weeks later. Follow-up biopsies in 2012-2016 showed no sign of cancer. Likewise, a follow-up MRI in 2016 revealed no lesions. I was cancer-free as far as the radiologists were concerned.

So my cancer potentially disappeared sometime in 2011, though that was not acknowledged at that time.

My urologist, Brian Helfand, MD, PhD, of NorthShore University HealthSystem in Glenview, Illinois, joked last year that if my PHI (Prostate Health Index) were any lower, I wouldn't have cancer at all. Was he inadvertently on to something?

I have asked Helfand and my previous urologist what had happened to my cancer. Did it just go away -- albeit in a less dramatic fashion -- than the case of St. Peregrine, a 14th-century priest, patron saint of cancer patients, whose ulcerated cancerous leg healed the night before he was to undergo an amputation? Had I experienced a spontaneous remission or regression?



Such cases involving all sorts of cancers, confirmed in biopsies and advanced imaging, are sprinkled throughout the medical literature.

My urologists told me cancer still was lurking somewhere in my prostate, a dark passenger too small to find.

For the record, my PSA, which had reached a peak of nearly 9 ng/mL in 2013, has dropped and been stable for about six years, settling in at around the upper 4s and low 5s. The results produce a flat-line graph.

This phenomenon could not be explained. Otis Brawley, MD, former medical director of the American Cancer Society, suggested my slides had been switched. (Something like that happened in a study of pharmacogenomics for which I volunteered at the University of Chicago.) A radiologist theorized that the inflammation brought on by a biopsy in 2010 might have activated an immune response that gobbled up my mini-cancer.

Another theory was a biopsy scooped up my only trace of cancer. Who knows?

Simms' case

James Simms' urologist calls him an AS pioneer. In fact, he was among the first AS patients in the U.S. He was diagnosed with two cores with Gleason 6 at 10% or less. He went on AS in November 2006.

He had three blind biopsies from November 2006 to November 2010. Each showed the presence of Gleason 6 cancer. Multiparametric MRI scans he had in October 2017 and March 2019 suggested a growing presence of cancer based on his PI-RADS scores (Prostate Imaging Reporting and Data System) of 4 and 5, respectively, These are considered highly suspicious and a biopsy is indicated.

But then Simms experienced a sudden improvement, a St. Peregrine moment to some. This April, Simms underwent a follow-up, a 16-needle guided biopsy that showed no cancer. "NO CANCER! Regression in prostate cancer is seemingly rather rare," he said.

What might have caused his remission? Simms speculated, "Two UTIs (urinary tract infections), a swollen testicle and abscess from September through December 2018 kicked my immune system into action."

In August, Trushar Patel, MD, Simms' urologist at the University of South Florida, ordered a new biopsy with and without a gadolinium-based contrast agent. More good news. Simms got a PI-RADS 2. "This lesion has gotten smaller, and it may be prostatitis we're dealing with!" he said.

"In Jim's case, I think he had an infectious process that was mimicking cancer progression on MRI," said Patel. "This case highlights the limitations of MRI in distinguishing cancer from

(Continued on page 5)

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benign pathology. Unfortunately, we cannot prove that his immune response put his cancer into remission. We could have simply missed his cancer focus on the prior biopsy, as his cancer was small and can be difficult to localize."

Patel and Helfand told me the same thing: spontaneous remission is impossible to prove unless the prostate is removed and reexamined as a whole specimen pathology. For the record, no one on AS is volunteering for that.

Meanwhile, Scott checked the medical literature and found a single case of spontaneous remission in a man with advanced prostate cancer and none in men with low-risk disease. Still, he said he personally has encountered a number of such cases, including my "classic and very public case" described in this column in MedPage Today.

Scott theorizes there likely is nothing in the literature about such cases because AS is so new in the U.S., available only since the first decade of this century.

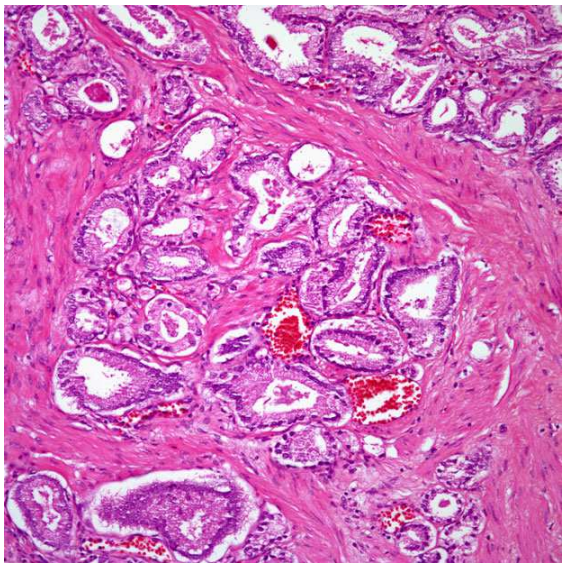
"It makes perfect sense that prior to the modern 'active surveillance era' reports of cases of spontaneous remission of low-risk prostate cancer would have been non-existent. Prior to the availability of the PSA test, most such patients would never have been diagnosed at all," he said.

"After the availability of the PSA test in the 1980s, and for the following 20 or so years, nearly every man who was diagnosed with low-risk prostate cancer was told he needed immediate treatment, and so there was no chance that he could have gone into spontaneous remission because his cancer had been eliminated (albeit, in many cases, unnecessarily)."

The idea of spontaneous remission for low- to intermediate-risk prostate cancer received mixed reactions in the medical communities involved with caring for men with prostate cancer, ranging from possible to impossible.

Pathologists weigh in

Jonathan Epstein, MD, director of surgical pathology at Johns Hopkins Hospital in Baltimore and a leading provider of second opinions on prostate exams, said in a terse email: "[Spontaneous remission] does not happen in prostate cancer. [Prostate cancer is] just a small cancer that on repeat biopsy can be easily missed." Lester Raff, MD, MBA, medical director of the laboratory at UroPartners in suburban Chicago: "I have not had much exposure to the concept of spontaneous remission. I am a little hesitant to accept it. It would mean 1) that the tumor stopped growing and 2) all malignant cells died. I have not seen evidence of that total tumor necrosis without some active intervention, such as radiation."



"The question I always have with such apparent cures is the accuracy of the initial diagnosis," Raff continued. "Lesions diagnosed as Gleason Grade 2 carcinoma on prostate biopsy 15 years ago might not be classified as cancer today. The usage of special stains has also made it possible to diagnose as benign some lesions that were once thought to be malignant."

Urologists too

Helfand: "While it is a good thought -- I do not know of anyone who has spontaneous remission. There are many examples where someone was diagnosed and treated historically and was not found to have disease in surgery pathology. But this was thought to be such a low-volume disease that the pathologist couldn't find it. I am not convinced that a tumor resolves -- especially a low-risk tumor that invoked little immune response. But who knows? Anything can be possible."

Laurence Klotz, MD, the University of Toronto urologist who pioneered active surveillance in 1997, commented in a 2018 lecture that spontaneous remission is well recognized in breast cancer and probably applies to prostate cancer as well.

And now radiologists

Speaking about all types of cancer, Joel Dunnington, MD, who recently retired as professor of diagnostic radiology at MD Anderson Cancer Center In Houston:

"There are some spontaneous remissions. But these are very rare without treatment. This probably just indicates a very good immune system that is actually doing what it is supposed to do."

Ari Goldberg, MD, PhD, medical director of MRI at Loyola University Medical Center in Maywood, Illinois, said he has seen a handful of men on active surveillance who would qualify as having experienced spontaneous remissions from an imaging standpoint. He added: "Playing the devil's advocate, the first thing you say is, 'Well, how do we know that the first diagnosis was correct?' We tend to think that the pathologist is always correct, but when the pathologist said, 'Okay, that's Gleason 6 or 7,' etc., was he or she correct? And now the MRI doesn't show the same thing and a targeted re-biopsy doesn't show the cancer. What else should we call it aside from remission?"

Scott said it's time to start carefully tracking the incidence of apparent spontaneous remission of prostate cancer in men on active surveillance. "Just how many of these men are there? Is it 1% of all the men with very low-risk disease, like Howard? Or might it be 5% of all the men with low- and favorable intermediate-risk prostate cancer? We don't currently have a clue."

Maybe there are lessons that can be learned from cases of suspected spontaneous remission that can help

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other men with prostate cancer.

Simms said: "Over the last several years I participated in the Blessing of the Sick at St. Mary's Catholic Church on the last Sunday of the month! Did I have a prostate cancer miracle? Was St. Peregrine operating in Tampa Bay? If nothing else, this experience calls into question those Facebook Fear Mongers who belong to a 'Prostate Cancer Surgery or Else' support group especially for low-grade cancer."

As for me, I retired from religion long ago. Whether my case is considered spontaneous remission or not, makes little difference. As I head into my tenth year on AS, I would be satisfied if my PSA remained stable and I had as few as possible MRIs and biopsies in the years ahead. That would rank as a miracle of sorts in my book.

by Howard Wolinsky, Contributing Writer, MedPage Today August 23, 2019

https://www.medpagetoday.com/special-reports/apatientsjourney/81775

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MRI Scans Improve Prostate Cancer Detection

Using MRI scans to target biopsies is more effective at detecting prostate cancers that are likely to need treatment than standard ultrasound guided biopsies alone, according to research published in JAMA Network Open.

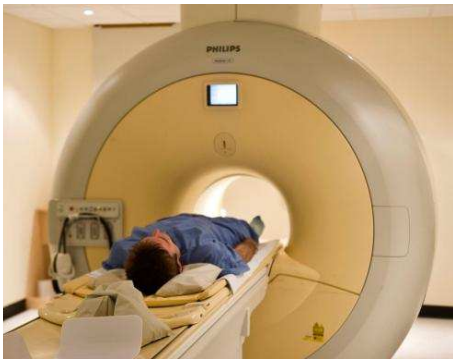
The research, led by the National Institute for Health Research (NIHR) and Universities of Bristol, Ottawa, Exeter and Oxford, combined the results from seven studies covering 2,582 patients.

The researchers found that the use of pre-biopsy MRI combined with targeted prostate biopsy was better than a biopsy alone in detecting prostate cancers that are likely to need treatment, despite the differences between the seven individual studies. Using pre-biopsy MRI led to fewer biopsy cores being taken per procedure, which in turn reduced side effects, and may potentially lead to avoiding biopsies for some men.

Taken together, this new evidence supports the use of pre-biopsy MRI in diagnostic pathways for suspected prostate cancer.

Prostate biopsies can cause side effects, and do not always identify the severity of a cancer when it is present. MRI scans are increasingly being used before undertaking a prostate biopsy as part of the clinical pathway to diagnose prostate cancer, but their use isn't yet widespread in many countries. In the UK, pre-biopsy MRI has recently been recommended by the National Institute for Health and Care Excellence (NICE).

The researchers looked at existing research in this area, focusing on men who had never had a prostate biopsy before.



Professor Richard Bryant, an Academic Consultant Urologist at the Nuffield Department of Surgical Sciences at Oxford University and one of the authors of the paper, said: 'This research adds to the growing body of evidence that targeting biopsies through pre-biopsy MRI, in men being checked for possible prostate cancer, leads to a more accurate sampling of the prostate gland. It could also potentially lead to fewer biopsies and less chance of a misleading biopsy result, through better initial sampling.

'Whilst there are obviously benefits for men to have a prostate biopsy if indicated, so that we can diagnose and then treat clinically significant prostate cancer, if we can reduce the potential side effects and increase the accuracy of the initial biopsy procedure, then that will be better for patients.'

Dr Martha Elwenspoek, Research Associate at the NIHR Collaboration for Leadership in Applied Health Research and Care West (NIHR CLAHRC West) and the University of Bristol, said: 'Our findings suggest that using an MRI to guide prostate biopsies is superior to performing a biopsy alone. This is increasingly used in the UK but isn't yet common practice in many other countries. However our work shows that this approach is better at detecting cancer that requires treatment, while also potentially avoiding some unnecessary biopsy procedures.

'This chimes with the findings of another recent paper looking at this issue.'

The full publication, 'Comparison of multiparametric magnet resonance imaging and targeted biopsy with systematic biopsy alone for the diagnosis of prostate cancer: a systematic review and meta-analysis', is available to read in the journal JAMA Network Open.

https://www.ox.ac.uk/news/2019-08-21-mri-scans-improve-prostate-cancer-detection

https://www.miragenews.com/mri-scans-improve-prostate-cancer-detection/

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Could a 'Manogram' For Prostate Cancer Replace Invasive Test?

Painful Trus biopsy could be replaced by a simple ultrasound

The blood tests have come back. "Hmm, one of these is elevated", your doctor says. "I think it's best if you have some further investigations."

I suspect I'm not the only patient whose immediate thought at this point is to hope there is a non-invasive investigational option. The words "X-ray" or "ultrasound" have a sweet ring to them at times like this.

However, any recommendation containing the word biopsy may cause your heart to sink.

Take prostate cancer as an example. If a blood test for prostate specific antigen (PSA) is significantly elevated, referral to a urologist is likely to involve a discussion about Trus. Having a Trus (transrectal ultrasound guided) biopsy is the standard procedure following a raised PSA reading. It involves inserting an ultrasound probe into the rectum and then, guided by the ultrasound images, inserting a fine needle along the probe, through the rectum wall and into the prostate, to remove a tissue core. This is repeated about 12 times as the doctor takes samples from different prostate areas.

It can be a painful experience.

Just because you have an elevated PSA does not mean you have prostate cancer Brian Kavanagh, chairman of the patient advocacy group Men against Cancer, says he fainted as he left hospital after the Trus. He told Cancerworld, the journal of the European School of Oncology, the experience was "excruciating" and "medieval". A few days later, he was re-admitted with septicaemia, a bloodstream infection caused by the biopsy. It took him three months to shake it off.

The prostate is a walnut-sized gland that sits at the base of the bladder and surrounds the urethra – the tube that runs from the bladder to the penis. About 75 per cent of men in their 70s have urinary symptoms that are caused by a benignly enlarged prostate. Meanwhile, more than 3,000 men are diagnosed with prostate cancer in Ireland every year.

Just because you have an elevated PSA does not mean you have prostate cancer and so the test is not suitable as a screening test. And the decision to monitor or treat an early-stage cancer is not straightforward. One major study followed patients for 10 years and found no difference in death rates between men who were picked at random to have surgery or radiation, and those whose cancer was "active monitored". In addition, death rates from the cancer were low overall: only 1 per cent of patients were dead 10 years after diagnosis.

Evidence

With all this uncertainty, and the unpleasant nature of a Trus biopsy, an alternative, non-invasive test was badly needed. Thanks to a number of studies, including the PROMIS trial, it looks like we now have a viable alternative. There is compelling evidence that carrying out multiparametric MRI (mpMRI) scans before biopsy is an effective way of detecting the presence of prostate cancer. It also provides highly accurate guidance for a subsequent biopsy if the scan does identify suspicious lesions.

The PROMIS trial, involving 740 men with clinical suspicion of prostate cancer and no previous prostate biopsy, tested whether an mpMRI scan before biopsy could identify men who might safely avoid the invasive test. It found that using mpMRI to triage men might allow more than one in four men referred on suspicion of prostate cancer to avoid a primary biopsy. And if subsequent Trus biopsies were finely tuned by the mpMRI findings, up to 18 per cent more cases of clinically significant cancer might be detected.

In December 2018, the British National Institute for Health and Care Excellence (Nice), recommended mpMRI as the first-line investigation for people with suspected clinically localised prostate cancer. It seems the non-invasive test is set to become the gold standard.

Looking forward, could the MRI test replace PSA and ever become a "manogram", the male equivalent of a mammogram? It seems unlikely – let's just be happy an alternative to the sometimes barbaric Trus has been found.

Mon, Aug 19, 2019

Dr Muiris Houston

mhouston@irishtimes.com

https://www.irishtimes.com/life-and-style/health-family/could-a-manogram-for-prostate-cancer-replace-invasive-test-1.3980781

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FUTURE MEETINGS 2019 - 2020

16 Oct. Speaker: Jessica Wylychenko, Dietitian
Topic: *Nutritional considerations in prostate cancer*

20 Nov: Annual windup
Live music Potluck Prizes

18 Dec. *NO MEETING*

15 Jan. 2020 *Watch for it*

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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