Manitoba Prostate Cancer SUPPORT GROUP

Newsletter

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Thanks!

March Meeting:

Date: Wednesday, 18 March, 2020

CANCELLED

Thought of The Day

Adversity introduces a man to himself.

~Author Unknown

* Due to Covid-19 crisis all public meetings of MPCSG are suspended until further notice.

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.

Prostate Cancer Surgical Approach Not a Factor in Treatment Decision Regret

Type of surgical approach to radical prostatectomy—robot-assisted vs open procedure—is not associated with a patient's intermediate-term decision regret, according to a recent study.

Johannes Huber, MD, PhD, of Technische Universität Dresden in Germany, and colleagues conducted a follow-up of the HAROW (Hormonal Therapy, Active Surveillance, Radiation, Operation, Watchful Waiting) study involving 936 (of 1218) men who underwent surgery for localized prostate cancer in Germany during 2008 to 2013. A total of 404 patients had robot-assisted radical prostatectomy (RARP) and 532 underwent open radical prostatectomy (ORP) at 114 hospitals, representing a quarter of all hospitals in the country.

Overall, distress or remorse over their decision was low at a median 6.3 years, with a mean score of 14 on a range of 0 (no regret) to 100 (high regret). The investigators found no significant difference in decision regret between the 2 surgical approaches (mean RARP 12 vs ORP 15).

Nearly a third of patients preferred an active role, and 57% preferred shared decision-making for prostate cancer therapy. RARP patients appeared more self-determined than ORP patients.

A significantly higher proportion of patients undergoing robot-assisted vs open surgery actively participated in the decision to undergo surgery (39% vs 24%) and the choice of surgical approach (52% vs 18%), Dr Huber's team reported the Journal of Urology. More RARP patients also used the internet often as a source of health care information (87% vs 72%), selected the treating hospital (especially a high-volume hospital) based on an information search (25% vs 11%), and traveled a long distance (63 vs 42 km). In line with previous research, patients with good functional and oncological outcomes had low regret regardless of the surgical approach. In multivariate analyses, erectile function, urinary continence, freedom from recurrence, an active decision-making role, and shorter follow-up time, in descending order, predicted low decision regret (score less than 15).

In a study, a significantly higher proportion of patients undergoing robot-assisted vs open radical prostatectomy for prostate cancer actively participated in the decision to undergo surgery (39% vs 24%) and the choice of surgical approach (52% vs 18%).

"For future research it will be a worthwhile question whether an active role in treatment decision making is an individual trait or whether it can be influenced by decision aids or counseling."

References

Baunacke M, Schmidt M-L, Groeben C, et al. Decision regret after radical prostatectomy does not depend on surgical approach: 6-year followup of a large German cohort undergoing routine care [published online September 13, 2019]. J Urol. doi: 10.1097/JU.0000000000000541

Most men do not regret their choices for prostate cancer surgery [news release]. Wolters Kluwer Health; February 10, 2020.

Natasha Persaud February 21, 2020

source: www.renalandurologynews.com/home/news/urology/prostate-cancer/prostate-cancer-surgical-approach-not-a-factor-in-treatment-decision-regret/

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Stalling Need for ADT in Recurrent Prostate Cancer

— More evidence of benefits with metastasis-directed therapy but overall survival data remain elusive

SAN FRANCISCO -- Immediate treatment of limited metastatic recurrence of prostate cancer led to a fourfold improvement in the proportion of patients alive without androgen deprivation therapy (ADT) at 5 years, according to data reported here.

The estimated 5-year ADT-free survival rate was 34% for treated patients and 8% for those who were followed with active surveillance. Metastasis-directed treatment (MDT) led to better ADT-free survival regardless of prostate-specific antigen doubling time or lymph node involvement. Immediate treatment also delayed the time to development of castration-resistant prostate cancer (CRPC). Overall survival (OS) rate was 80-90% in both groups.

The results added to evidence that immediate treatment may delay progression and improve survival but cannot be considered definitive because predefined criteria for statistical significance were not met, Piet Ost, MD, of Ghent University in Belgium, said at the Genitourinary Cancers Symposium.

"This was a phase II screening trial,

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and these are initial, nondefinitive results," said Ost. "Any P-value below 0.20 is considered significant for this specific trial, but a significant result does not mean this type of trial will change practice. This trial was designed to show maybe what we should be doing in the next trial, a phase III trial."

The findings came from the Belgium-based, multicenter STOMP trial involving men with metachronous oligorecurrent prostate cancer. The trial began in 2012, when the European Association of Urology (EAU) clinical guidelines dichotomized treatment recommendations for metastatic prostate cancer into symptomatic and asymptomatic. All patients with symptomatic disease received ADT, whereas clinicians had the option to offer asymptomatic patients either ADT or observation with delayed ADT until disease progression.

STOMP limited enrollment to men with asymptomatic or minimally symptomatic metastatic recurrence (oligometastatic, one to three extracranial lesions identified by choline positron emission tomography/computed tomography). In keeping with EAU recommendations at the time, the investigators chose observation as the standard of care for the control arm. In the intervention arm, patients received immediate MDT. In both groups, treatment continued until development of symptomatic local or polymetastatic progression, when ADT was initiated.

The trial had a primary endpoint of time to initiation of ADT (ADT-free survival). The researchers defined statistical significance for the trial as P=0.20, but only results associated with a P-value of <0.005 were considered definitive.

The study included 62 patients, with a median follow-up of 5.3 years. Baseline characteristics and other details of the trial design have been reported previously.

The primary analysis showed that immediate treatment led to a 43% reduction in the hazard for ADT-free survival (80% CI 0.38-0.84, P=0.06). A per-protocol analysis yielded a hazard ratio of 0.53 (80% CI 0.35-0.79, P=0.04). Subgroup analyses yielded hazard ratios of 0.41 for patients with a PSA doubling time of less than 3 months, 0.65 for those with a PSA doubling time of 3 or more months, 0.42 for patients with lymph-node involvement, and 0.74 for those without nodal involvement.

CRPC-free survival (post-ADT) favored the intervention arm (HR 0.62, 80% CI 0.35-1.09), but the difference did not achieve the trial-defined level of statistical significance. A per-protocol analysis showed a 49% reduction in the hazard ratio (80% CI 0.29-0.90, P=0.12).

Five-year OS was high in both groups, as was prostate cancer-specific survival, as only six of 14 total deaths resulted from prostate cancer, said Ost.

Whether MDT will lead to improvement in "outcomes that matter" remains to be determined, Neha Vapiwala, MD, of the University of Pennsylvania in Philadelphia, said during a review that preceded Ost's presentation. Studies of stereotactic ablative radiotherapy (SABR) have yielded encouraging results, but trials to date had small numbers of patients and limited enrollment to patients with limited metastatic disease burden (generally one to three metastases).

The previously reported primary results of the STOMP trial showed a median ADT-free survival of 21 months with MDT versus 13 months with surveillance. Vapiwala noted that metastatic progression was the principal reason for starting ADT in both treatment groups. Summarizing five recent studies involving about 350 patients total, she said half the patients had a solitary metastasis and nodal lesions accounted for about two thirds of the lesions versus one third for osseous lesions. Collectively, the studies showed a 2-year rate of freedom from systemic therapy of about 50%, accompanied by "promising gains in progression-free survival and distant metastasis-free survival."

Multiple trials of MDT with SABR are ongoing, including several randomized trials and trials of combination therapy.

"The value of metastasis-directed therapy is really in the eyes of the beholder," Vapiwala said. "Whether the beholder is the patient, the provider, the insurer, or society is for us to answer as a group. We know that MDT is safe, feasible, and effective by a variety of important measures, but whether the outcomes -- such as ADT-free survival -- justify the intervention is an unanswered question."

"Regardless of your take on the value, MDT is happening," she added. "Let's hope we can do it in a way that is scientific and explore it in a responsible way."

by Charles Bankhead, Senior Editor, MedPage Today February 14, 2020

Disclosures
The study was sponsored by University Hospital Ghent.

Ost disclosed relationships with Bayer, Bristol-Myers Squibb, Ferring, Janssen-Cilag, Merck Sharp & Dohme, and Varian Medical Systems.

Primary Source
Genitourinary Cancers Symposium

Source Reference: Ost Piet, et al "Surveillance or metastasis-directed therapy for oligometastatic prostate cancer recurrence (STOMP): Five-year results of a randomized phase II trial" GuCS 2020; Abstract 10.

source:: www.medpagetoday.com/meetingcoverage/mgucs/84903

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How To "Live Well" With Prostate Cancer

Another Year Older, Another Year Better!
Achieve big results with simple changes

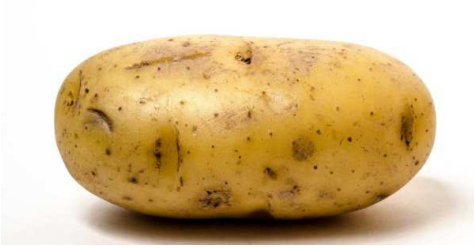
The good advice you are about to read comes from Elizabeth Platz, Sc.D., M. P.H., an epidemiologist at Johns Hopkins, who does a lot of research on factors that raise and lower the risk of prostate cancer. These tips aren't prostate cancer-specific, but they will help you to get and stay healthier – so you won't just be another year older, but another year better! It's easier than you might think. Ready? Let's get started!

Don't bother looking for a quick fix. There isn't a magic pill or miracle supplement or treatment, no matter what they may say on TV and the internet. Getting healthier can't be achieved by anything hawked in an infomercial. "For healthy living, for good well-being, for avoiding premature mortality," says Platz, "the right things to do are the things you have to work at," like eating right and getting exercise. But take heart: you can make big changes by doing lots of small things, if you do them steadily. You can also live it up sometimes – eat that slab of birthday cake, or have pizza night – if, in general, you practice moderation most of the time.

Be active: this doesn't mean that you must haunt the gym. One of the best things you can do for your health, says Platz, is easy: avoid sitting all day. "In the modern world, people tend to sit." We sit in the car. We sit when we're on our phones. We sit at the computer. "We have protracted periods of time where we're just stationary. Build intentional activity into your day." This doesn't mean you have to spend hours on the treadmill or elliptical; remember, we're talking about small changes here: Don't park right next to the building; park farther out and walk a little longer. Take the stairs instead of an elevator to go up one floor. Set a timer and walk around your house. Take the dog for an extra walk. Just move around.

Focus on the "big three macros," proteins, carbohydrates, and fats. "Macromolecules" is a trendy word, but it describes something very basic: "these major, fundamental components of our diets," says Platz.

Protein: "As we get older, we need more protein to help keep from losing muscle mass." How much? This varies a lot; one recommendation from an expert panel is 1.2 to 1.5 grams per kilogram of body weight; this could mean 123 grams for a 180-pound man; the minimum amount recommended by the U.S. government for the average 160-pound man is 56 grams. Bottom line: You need more protein than you think, and more than you're probably getting. Make a point of eating protein with every meal. Instead of just having a piece of toast or some cereal for breakfast, for example, add Greek yogurt (which is higher in protein) or an egg. Protein doesn't just come from meat; it's in fish, beans, dairy products, eggs, and soy products, too. It's also in meal replacement drinks like Ensure and Boost, and in protein bars.



Carbs: Again, moderation: "Don't overdo simple carbohydrates," the kinds of sugars found in sweets, white bread, and even plain old potatoes: yes, the humble potato, minding its own business and serving as a dietary staple to millions, now finds itself on the nutritional naughty list of "simple carbohydrates," because it takes less energy to digest a spud than, say, a sweet potato, which is a more complex carb. "Whole grains can be delicious," notes Platz. "They're more than just what's in whole-wheat bread" (which, admittedly, can taste like cardboard). "Many grains can be mixed into your diet without a lot of effort." In the rice and pasta aisle in the grocery store, check out farro – a nutty-tasting grain. There's also quinoa, barley, and bulgur, to name a few.

Fats: "Good fats are good for you. Try cooking with olive oil instead of butter," suggests Platz – who is quick to add: "You don't have to remove butter from your diet; olive oil just tastes good." And watch out for calorie-rich dressings, sauces, and gravy. Again, this doesn't mean don't eat them; "just make sure it's the right serving size – which is often more like a tablespoon, rather than a quarter-cup."

Indeed, watch your portions. One basic strategy to make sure you're not getting more than you need: use a measuring cup. "Even when you're eating something that's healthier, make sure you're not overdoing it from a calorie perspective." Those pesky calories add up, and this is how you gain weight: consuming more calories than you burn.

Weigh yourself. As we get older, sadly, the weight we gain "tends to be fat," says Platz, "at the same time as we are losing muscle mass. Loss of muscle mass is particularly worrisome, and is linked to premature death. It's not just how much you weigh, but the proportion of lean mass – muscle and bone." What's a good way to maintain and build muscle mass? "Weight-bearing or resistance exercise. Lifting weights."

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Weight-bearing exercise. Again, this isn't as hard as you may think. Nobody's suggesting that you need to bench press the weight of a Saint Bernard, or dead lift the equivalent of Dwayne "The Rock" Johnson. "I'm talking about hand weights. Light-weight weights. You can even use your body weight," by doing planks, push-ups, or yoga-type exercises. If you are new to exercise or are trying a new regimen, be sure to consult your health care provider before you start.

What about testosterone? If you are a man taking hormone therapy (androgen deprivation therapy, or ADT for short) for prostate cancer, your lower testosterone is intentional: the goal of treatment is to lower your testosterone level in order to deprive the cancer of its fuel. For these men, it's even more crucial to maintain lean body mass through proper nutrition and exercise, and incorporate weight-bearing exercise to maintain bone mass. But all men, as they get older, will experience some drop in testosterone level. "This naturally happens," says Platz, "but it drops in some men more than in others." Even if your testosterone is not low, it might be on the low side of normal, and it's still important to exercise and maintain a healthy weight.

An engaged brain functions better. Thus, get a hearing aid if you need one. "This is an emerging area," Platz says, "but there is solid, very sound research showing that people who have greater hearing loss tend to have greater cognitive decline." If you can't hear, "your engagement with others tends to wane. When your brain is no longer stimulated to the same extent, it's associated with cognitive decline." This is the "use it or lose it" idea; if your brain isn't actively engaged – if you're not hearing conversation, or the TV, or the sounds of nature, or a sermon in church, or your friends and family members talking to you – those un-engaged brain cells can shut down. Isolation is bad for the brain, and bad for your health in general.

So: **Stay active.** Volunteer, play poker, meet friends for coffee, take a class. Keep your brain working. Talk to people. That kind of engagement is good for your brain, and it prolongs life. We are hard-wired to talk to other people, and to listen to them, and hey! If we can help others while we're doing it, it's a win-win. "You've accumulated wisdom, experience, and expertise, and if you can share that with others, including the next generation, so much the better."

Take care of your liver. If you drink too much alcohol, or if you are overweight to the point where you are at risk of becoming pre-diabetic or diabetic, your liver can pay the price. "Fatty liver disease is emerging as an epidemic in the U.S.," says Platz. If the liver is overloaded, it accumulates fat, becomes inflamed, and several things can happen: the liver can develop fibrosis, or scar tissue, that may even lead to cirrhosis. "If you feel like you're starting to go down that path, now is the time to reassess your diet and lifestyle. The best analogy is foie gras, where we force-feed ducks to create fatty liver and make good pâté. When you accumulate fat in your liver, it's the same thing that happens with those ducks."

Make it your life's mission not to fall. The older you get, the harder it is to bounce back from a fall. A toddler can face-plant and spring back up. An older man can fall and break a bone, wind up in the hospital, and if he doesn't push the physical therapy and exercise afterward, not ever fully recover all his flexibility and strength. So, let's do our best to avoid this scenario! Here's where yoga and some very simple exercises can help you maintain balance and flexibility. "This needs to be a huge focus for men as they age," says Platz. It's not so much about strength – again, nobody's asking you to heft a giant barbell – as it is about stretching and working on your balance. And, keep your bones strong: make sure you get enough calcium. Calcium doesn't have to come from milk and cheese. You can get it from leafy green vegetables, and some foods you might not expect – like sardines, and even tofu. However: "The recommended dietary allowances for men aged 51-70 are 1,000 mg a day of calcium; and for men age 71 and older, 1,200 mg. A half-cup of raw broccoli has 21 mg. But if you're trying to get to 1,000 mg, you'd have to eat an awful lot of broccoli." In a perfect world, you would achieve dietary perfection by eating an exceptionally well-rounded diet. Most of us don't achieve that, and if you're not getting enough calcium, you may need a supplement. Don't go overboard! With dietary supplements, it's not a case of, "if a little is good, more must be better." Just getting enough is fine.

Fasting? Intermittent fasting, in various forms, has been in the news lately, and "some studies suggest there is a biological benefit." However, there is an easy way for you to take a break from food every day: Cut out the late-night snacks. "If you get the munchies at 10 at night, you're basically having the calories of another meal. Just not having food after dinner can make a big difference. Sometimes, half the battle is simply recognizing what we're eating." Are you eating more than you think? An easy way to find out is to write it down, or use an app

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on your phone to record everything you eat. Keeping a record – just for a few days, even – might make you think twice before saying yes to that late-night piece of pie.

Try to get more sleep. Most of us don't get enough sleep, or don't sleep well. There are some simple things you can do for better "sleep hygiene," including not being on your phone or the computer right before going to bed; the blue light these devices produce messes up your body's clock. Drinking caffeine or alcohol too late in the day can affect your sleep, as well. Herbal tea, with lavender or chamomile, or other natural remedies can help; so can taking melatonin, a hormone your body naturally produces. We make less melatonin as we get older; ask your doctor about taking an over-the counter melatonin supplement. Also: "Many men tend to snore as they get older. If your partner tells you that you're snoring, maybe you should do something about it. Losing weight can help." If it's severe, talk to your doctor.

For more tips on cancer prevention and general wellness, download PCF's latest guide, **The Science of Living Well, Beyond Cancer** at https://www.pcf.org/guide/wellness-guide/

February 11, 2020

By JANET FARRAR WORTHINGTON

source: www.pcf.org/c/another-year-older-another-year-better/

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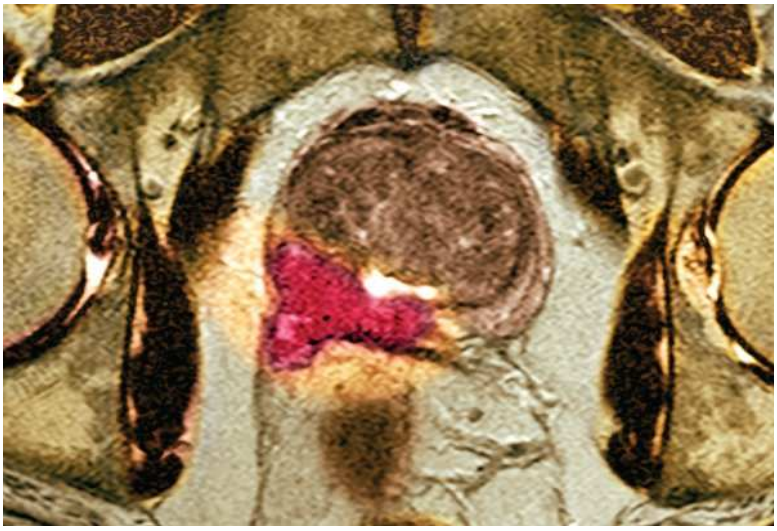
Functional Outcomes Similar Across Localized Prostate Cancer Treatments

(HealthDay News) — Most functional differences associated with contemporary management of localized prostate cancer attenuate by five years, according to a study published in the Jan. 14 issue of the Journal of the American Medical Association.



Most functional differences associated with contemporary management of localized prostate cancer attenuate by five years.

Karen E. Hoffman, M.D., from University of Texas MD Anderson Center in Houston, and colleagues compared functional outcomes associated with prostate cancer treatments over five years after treatment using data from five Surveillance, Epidemiology and End Results Program sites and a U.S. prostate cancer registry. The analysis included 1,386 men with favorable-risk and 619 men with unfavorable-risk prostate cancer.

The researchers found that for men with favorable-risk prostate cancer, nerve-sparing prostatectomy was associated with worse urinary incontinence at five years and sexual function at three years versus active surveillance. Low dose-rate brachytherapy was associated with worse urinary irritative, sexual, and bowel function at one year versus active surveillance. While external beam radiation therapy (EBRT) was associated with urinary, sexual, and bowel function changes, they were not clinically different from active surveillance at any time point through five years. For men with unfavorable-risk disease, EBRT with androgen deprivation therapy was associated with lower hormonal function at six months and bowel function at one year but better sexual function at five years and better incontinence function at each time point through follow-up versus prostatectomy.

"These estimates of the long-term bowel, bladder and sexual function after localized prostate cancer treatment may clarify expectations and enable men to make informed choices about care," the authors write.

One author disclosed financial ties to the pharmaceutical industry.

February 20, 2020

Full abstract : https://jamanetwork.com/journals/jama/article-abstract/2758599

source: www.cancertherapyadvisor.com/home/cancer-topics/prostate-cancer/prostate-cancer-treatments-functional-outcomes-similar/

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More Time Between Prostate Cancer Screenings Could Improve Outcomes

A new study in JNCI: Journal of the National Cancer Institute, published by Oxford University Press, finds significant benefits to lengthening the amount of time between prostate cancer screenings for men.

Prostate cancer is one of the most common cancers in men, affecting one in seven men over the course of his lifetime. A blood test called a prostate specific antigen (PSA) test, which measures the levels of PSA in the blood, has been used to screen for prostate cancer for decades, because levels of PSA in the blood can be higher in men who have prostate cancer. But PSA levels are higher in other conditions that affect the prostate, such as certain medical procedures and medications, as well as an enlarged prostate or a prostate infection. Research regarding the effectiveness of such screenings in identifying and treating men with prostate cancer has so far been inconclusive.

Previous studies have shown that men with low PSA levels (<1.0 ng/mL) at ages 44 to 60 have very low risk of future prostate cancer. A study published this week in JNCI: Journal of the National Cancer Institute by Heijnsdijk and colleagues investigated benefits and harms of screening strategies associated with lengthening the screening interval when PSA is below 1.0 ng/mL at ages 45 or 50 or discontinuing screening when PSA is below 1.0 ng/mL at age 60.

Using statistical modeling techniques, they predicted the harms (measured in tests and overdiagnoses) and benefits (measured in lives saved and life-years gained) of PSA-stratified screening strategies versus the traditionally recommended screening for men between 45 and 69 every other year.

The models projected that screening 10,000 men ages 45 to 69 every other year would require more than 110,000 screens and result in up to 348 overdiagnoses. They found that lengthening the screening interval from two to eight years would result in a decrease of overdiagnosis by 5-24%, and only 3.1 to 3.8% fewer lives saved.

Additionally the models predicted that discontinuing screening at age 60 for everyone would greatly reduce overdiagnoses (by 79-82%) but would save substantially fewer lives compared to screening until age 69.

"This study shows the power of comparative modeling: by using two models with different underlying assumptions, we can identify uncertainty around the outcomes," said lead author Eveline Heijnsdijk, Ph.D.

by Oxford University Press
FEBRUARY 19, 2020

source: https://medicalxpress.com/news/2020-02-prostate-cancer-screenings-outcomes.html

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Notice to recipients of the printed version of this newsletter:

We are exploring ways to reduce costs while continuing to meet the information needs of our readership. To do this we are testing the effectiveness of providing meeting information for two months in one printed issue. That's why there are two meetings listed on the front page of this issue. <u>There will not be a printed version of our newsletter in the months of April , June.and August</u> .

Information about our speakers for these months will be published in the previous month's issue .

We welcome feedback from our readers and anticipate getting back to our regular monthly print schedule beginning in July. The electronic version will still be available each month and can easily be accessed on our website (manpros.org). We urge you to convert to email receipt of our newsletter if at all possible.

Thank you.

The Board

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FUTURE MEETINGS 2020

15-Apr Dr. Shelley Turner
Founder and Chief Medical Officer, EKOSI Health
"Medical cannabis as a complimentary treatment for dealing with prostate cancer" *

20-May Nathan Zassman
President, Aviva Natural Health Solutions
"Natural remedies for enhancing quality-of-life for prostate cancer patients" *

17-Jun Dr. J. Nayak
Urologic Oncologist, Rady Faculty of Health Sciences, UofM
"Early detection, diagnosis and management of prostate cancer" *

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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