Manitoba Prostate Cancer SUPPORT GROUP

Newsletter

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Thanks!

Thought of The Day

"Like everything in life, it is not what happens to you but how you respond to it that counts."

- Steve Backley

Public meetings cancelled until further notice

Covid-19 Update September 2021

The arrival of the fourth wave of covid, thanks to the delta variant, means the wait goes on for a while longer. Although vaccinations protect against this variant, at least to a considerable degree, the public health officials are being cautious and maintaining protective measures for the time being. No one knows for how long or how restrictive the measures will be. We continue to be guided by the advice from the public health professionals and will resume activities only once it is safe to do so.
In the meantime enjoy the autumn sunshine and stay safe.

The Board.

Study: Enlarged Prostate May Not Increase Risk for Cancer

New research suggests that having an enlarged prostate isn't a guarantee of cancer - and may actually protect some men from the disease.

Does having an enlarged prostate doom you to prostate cancer?

Far from it, a new study suggests.

Also called benign prostatic hyperplasia, or BPH, the condition may actually provide some protection for men from developing prostate cancer, researchers report.

"Men are often anxious about prostate cancer, as it is the second most common cancer in men, with some worrying BPH increases their risk of prostate cancer," said lead researcher Dr. Kiran Nandalur. He is vice chief of diagnostic radiology and molecular imaging at Beaumont Hospital in Royal Oak, Mich.

"Some previous studies have demonstrated BPH may increase the risk of cancer, given common driving forces such as genetics, hormones and inflammation. Our study should alleviate their concern, as BPH may decrease their odds of prostate cancer," Nandalur said.

BPH is common in aging men and can cause a frequent need to urinate, often at night, or a weak flow of urine. This is because the central part of the prostate enlarges and can block urine from leaving the bladder.

Surprisingly, as the prostate continues to enlarge, the

(Continued on page 2)

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.

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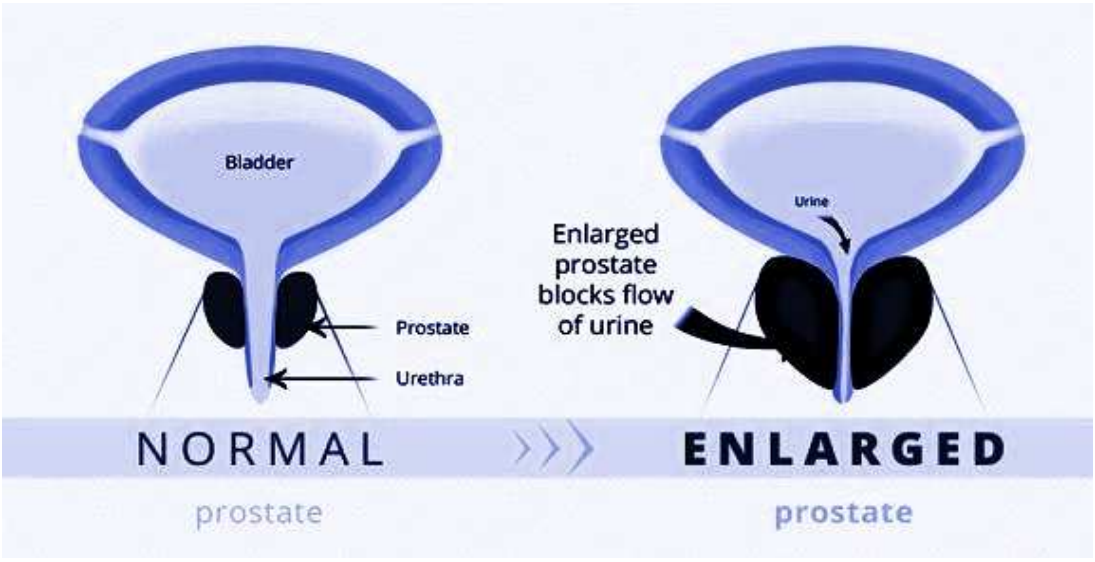
odds of prostate cancer goes down, Nandalur explained.

"Moreover, BPH decreases the odds of not just a single focus of cancer, but also more than one site. Based on these findings, BPH may be producing mechanical pressure throughout the gland, which inhibits cancer growth and decreases the odds of prostate cancer," he added.

For the study, Nandalur's team collected data on 405 men with BPH and looked for evidence of prostate cancer on MRIs of prostate tissue.

The researchers found that as the size of the prostate increased, the risk of prostate cancer decreased. For every one cubic centimeter increase in the volume of the prostate, the risk for prostate cancer dropped by about 3%, they noted.



"The size of the central gland from BPH may help to stratify risk for patients with prostate cancer," Nandalur said.

"Currently, prostate cancer patients are categorized into low, intermediate and high risk, with central gland contributions not taken into account. In the future, the degree of BPH as measured on prostate MRI may also be contributory to help determine prognosis and the course of therapy," Nandalur said.

Some commonly used BPH drugs called 5-alpha-reductase inhibitors -- including finasteride, which is marketed as Proscar -- decrease the size of the prostate, and have a U.S. Food and Drug Administration drug safety warning because they have been found to increase the risk of high-grade prostate cancer, Nandalur noted.

"Our study finds a potential explanation for the findings, as decreasing the prostate size with these drugs may lead to decreased pressure throughout the gland and possibly allow cancer to grow. These are very useful drugs to treat BPH, but care should be taken," Nandalur said.

Dr. Anthony D'Amico, a professor of radiation oncology at Harvard Medical School in Boston, said that he would take these study results with a grain of salt.

"I would approach this with extreme caution," D'Amico said.

These findings could result because BPH makes cancer harder to find with a biopsy, D'Amico said. "BPH could make it harder to find cancer because your needle is now going into a much smaller area. So I think it's interesting, there may be something there, but certainly not something that I would call conclusive at this time," he explained.

The findings may, however, have a biological explanation, he said. "If you have a lot of BPH, that's competing with prostate cancer for growth factor, maybe the prostate cancer gets a growth disadvantage," D'Amico said. "That's a biological premise, but it's not been proven."

D'Amico advises men with BPH to have an MRI and biopsy to be sure there isn't cancer.

"If you have a large prostate I would not assume that any prostate cancer you have is going to be clinically insignificant. You should still have an MRI and a fusion biopsy to rule out clinically significant disease," he said. "This study is interesting, but not conclusive."

The report was published this month in the journal *The Prostate.*

By Steven Reinberg, HealthDay News

AUG. 25, 2021

Source: https://www.upi.com/Health_News/2021/08/25/enlarged-prostate-may-not-mean-cancer/9761629902024/

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What is the Gleason Score and Grade?

Grading prostate cancer
The grade is a description of how the cancer cells look and act compared to normal cells. Knowing the grade gives your healthcare team an idea of how quickly the cancer may be growing and how likely it is to spread. This helps them plan your treatment. The grade can also help the healthcare team predict your prognosis (the outcome) and how the cancer might respond to treatment.

Gleason classification system
The Gleason classification system is most often used to grade prostate cancer. It is used for adenocarcinoma, which is the most common type of prostate cancer. The Gleason classification system looks at the differentiation of cancer cells and the pattern (arrangement) of the cancer cells in the prostate. Differentiation describes how different the cancer cells are.

Gleason patterns and grade
To find out the grade of prostate cancer, the pathologist looks at tissue samples from the prostate under a microscope.

There are 5 patterns of prostate cancer cells based on their differentiation. The lower the pattern number, the more cancer cells look, act and are arranged like normal cells. Gleason patterns 1 and 2 are not commonly used because these cells look a lot like normal cells. The pathologist will give a grade for each pattern of prostate cancer cells found in the biopsy. The grade of the cancer corresponds to the pattern number. Most prostate cancers have a Gleason pattern of 3, 4 or 5.

Calculating the Gleason score
If the pathologist sees only 2 patterns of cancer cells, they will add the grades for each pattern together to get the total Gleason score. For example, if the pathologist gives the cancer cells in the most common pattern a grade of 3 and the cancer cells in the 2nd most common pattern a grade of 4, the total Gleason score is 7. This is often written on the pathology report as 3+4=7/10.

If there is a 3rd pattern in the biopsy samples, the grade of the most common pattern of cancer cells is added to the pattern with the highest grade. This may be the 2nd most common pattern or the least most common pattern. For example, if the pathologist gives the cancer cells in the most common pattern a grade of 3, and the cancer cells in the 2nd most common pattern a grade of 4 and another pattern of cancer cells has a grade of 5, the total Gleason score is 8.

Group grade
To make the Gleason score easier to understand, doctors have developed the Grade Group (GG) system. This gives a single score from 1 to 5 based on increasing Gleason scores. For example, GG 1 corresponds to a Gleason score 6 and GG 5 corresponds to Gleason score 9 or 10.

Gleason score descriptions The Gleason score and Grade Group are described in the following table.

Group grade	Gleason score	Grade	Description
1	3+3=6 or less than 6	Low	The cancer cells are well-differentiated, which means that they look, act and are arranged much like normal prostate cells. The glands in the prostate are seen. The cancer is growing very slowly and often doesn't need treatment.
2	3+4=7	low-intermediate	The cancer cells are moderately differentiated, which means they look different than normal cells but aren't as abnormal as poorly differentiated or undifferentiated cells. The cancer may grow very slowly and sometimes doesn't need treatment.
3	4+3=7	high-intermediate	The cancer cells are moderately differentiated, which means they look different than normal cells but aren't as abnormal as poorly differentiated or undifferentiated cells. The cancer is growing at a moderate pace and usually needs to be treated.
4	4+4=8	high	The cancer cells are poorly differentiated. They look, act and are arranged very differently than normal prostate cells. The glands in the prostate can't be seen or can't be seen well. The cancer is growing quickly and is more likely to spread.
5	9 or 10	very high	The cancer cells are undifferentiated. This means that they are very abnormal. They look, act and are arranged very differently than normal prostate cells. The glands in the prostate can't be seen or can't be seen well. The cancer is growing very quickly and is more likely to spread. It has a poor prognosis.

Source: www.cancer.ca/en/cancer-information/cancer-type/prostate/grading/

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Novel Blood-Based Test Could Bolster MRI-Based Prostate Cancer Screening

— Combination reduced overdetection, but still found clinically significant tumors in Swedish study

Addition of a novel blood test to MRI-targeted biopsy in prostate cancer screening decreased overdetection while maintaining the ability to detect clinically significant cancer, Swedish researchers reported.

They found that use of the test - called Stockholm3 - in a screening setting where MRI and targeted biopsies were used, performed at least as well as a traditional strategy of using prostate-specific antigen (PSA) measurements and systematic biopsies. The number of MRI procedures was reduced by 36% and the number of men referred for biopsy was reduced by 8%, reported Tobias Nordström, MD, PhD, of Karolinska Institutet in Stockholm, and colleagues.

"The ultimate aim of any screening program is to decrease mortality and harm among participants. Although our study does not include prostate cancer mortality endpoints, we argue that, based on previous evidence of a mortality benefit from prostate cancer screening using PSA and systematic biopsies, it is plausible that maintained detection of significant cancer will translate to future mortality benefits," the researchers wrote in the study online in Lancet Oncology.

They also found that when compared with a screening approach of PSA combined with standard transrectal ultrasound-guided biopsies, Stockholm3 testing followed by MRI-targeted biopsy improved the detection of clinically significant prostate cancers and reduced the detection of low-grade cancers.

While the availability of MRI will be a limiting factor, "we now show that a novel blood test as adjunct to MRI can reduce the number of MRIs performed by a third," said co-author Martin Eklund, PhD, also of the Karolinska Institute, in a statement.

"Compared with the traditional PSA-based diagnostic strategy, we show that the novel strategy of combining the Stockholm3 test and an MRI-targeted biopsy approach is associated with a 69% reduction in the rate of overdetection, while maintaining the sensitivity to detect clinically significant prostate cancer," the researchers wrote. "This finding provides a viable option for prostate cancer screening, in which the mortality benefit of prostate cancer screening is maintained and the overdetection decreased compared with a traditional screening strategy (using PSA and systematic biopsies)."

In an accompanying commentary, Caroline Moore, MD, of University College London, called the study "an important step towards smarter screening for prostate cancer."

The blood-based Stockholm3 test uses an algorithm to analyze clinical data (age and previous biopsy status), and a combination of genetic and protein markers (including PSA) to yield a percentage risk of clinically significant prostate cancer.

In a prior study, the test was shown to reduce benign biopsies by 44% and the detection of clinically insignificant cancers by 17%. At the same time, Nordström and colleagues pointed out, studies (such as PRECISION) have shown that using MRI before biopsy can reduce overdetection and increase detection of clinically significant prostate cancers.

The new study was a prospective, population-based, randomized, open-label non-inferiority trial that included 12,750 men ages 50 to 74. Of these, 2,293 were considered to have an elevated risk of prostate cancer (i.e., a PSA level ≥3 ng/mL or a Stockholm3 score ≥11) were randomized 2:3 to either the standard group (systematic prostate biopsies) or the experimental group (biparametric MRI followed by MRI-targeted and systematic biopsy in MRI-positive men).

The primary outcome was detection of clinically significant cancer (Gleason score of 3+4 or higher). Secondary outcomes included the proportion of men with clinically insignificant prostate cancer (defined as a Gleason score of 3+3), and the number of any prostate MRI and biopsy procedures performed.

In the intention-to-treat analysis, Stockholm3 score ≥11 detected more clinically significant prostate cancers

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than did PSA (227 vs 192; relative proportion [RP] 1.18, 95% CI 1.09-1.28). However, compared with a PSA of 3 ng/mL or higher, Stockholm3 ≥11 was also associated with detection of a similar number of low-grade prostate cancers (50 vs 41; RP 1.22, 95% CI 0.96-1.55) and a greater number of MRIs and biopsy procedures.

Use of Stockholm3 ≥15 resulted in fewer MRI procedures performed compared with PSA (545 vs 846; RP 0.64, 95% CI 0.55-0.82), the researchers reported, adding that the number of biopsy procedures performed was also lower, although not significantly different (311 vs 338, respectively).

The investigators also compared the performance of two diagnostic workflows for the entire cohort of 12,750 men, and found that Stockholm3 combined with MRI-targeted and systematic biopsy (7,609 men) detected clinically significant cancers in 3% of that group compared with 2.1% of the men tested with PSA plus standard biopsy (RP 1.44, 95% CI 1.15-1.81).

Stockholm3 ≥11 plus MRI also detected fewer low-grade cancers (0.7% vs 1.4%, RP 0.46, 95% CI 0.32-0.66), and led to fewer biopsy procedures than did the PSA plus standard biopsy workflow.

Study limitations, the researchers said, included that as with all prostate cancer research, there is no universal definition of clinically significant prostate cancer; that there were no subsequent screening rounds; that not all invited men participated in the trial and some participants did not undergo the assigned intervention; and that despite the use of prostate biopsy procedures, the true disease status of participants was unknown.

Moore pointed out in her commentary that in screening programs in general, getting high enough uptake of the invitation to participate can be problematic. Nordström and colleagues reported a 26% uptake of the screening invitation, compared with 32% in the European Randomized Study of Screening for Prostate Cancer in The Netherlands (which eventually increased to 42%).

She suggested that a combination of interventions may help increase participation, particularly if the need for digital rectal examination is eliminated.

Another challenge is implementing high-quality MRI during screening: "This diagnostic strategy is markedly more challenging than standard transrectal ultrasound-guided biopsy," Moore wrote. "Implementation requires a coordinated approach across multiple departments, including imaging, urology, and histopathology, and might include a formal quality assurance and quality control program, with accreditation by professional bodies."

by Mike Bassett, Staff Writer, MedPage Today August 13, 2021

Mike Bassett is a staff writer focusing on oncology and hematology. He is based in Massachusetts.

Disclosures

The study was funded by the Swedish Cancer Society (Cancerfonden), the Swedish Research Council (Vetenskapsrådet), the Swedish Research Council for Health Working Life and Welfare (FORTE), the Strategic Research Programme on Cancer (StratCan), Hagstrandska Minnesfonden, Region Stockholm, Svenska Druidorden, Åke Wibergs Stiftelse, the Swedish e-Science Research Center, the Karolinska Institutet, and Prostatacancerförbundet.

Eklund, Nordström, and another co-author, Henrik Grönberg, are partners in A3P Biomedical AB, which holds the development rights for the Stockholm3 test. Eklund and Grönberg have four pending prostate cancer diagnostic-related patents. The Karolinska Institutet collaborates with A3P Biomedical in developing the technology for the Stockholm3 test.

Moore reports grants from SpectraCure, the Medical Research Council, Movember, Prostate Cancer UK, the National Institute for Health Research, Cancer Research UK, and the EAU Research Foundation, and financial relationships with Sonablate, Astellas, and Janssen.

Primary Source

The Lancet Oncology

Source Reference: Grönberg T, et al "Prostate cancer screening using a combination of risk-prediction, MRI, and targeted prostate biopsies (STHLM3-MRI): a prospective, population-based, randomised, open-label, non-inferiority trial" Lancet Oncol 2021; DOI: 10.1016/ S1470-2045(21)00348-X.

Secondary Source

The Lancet Oncology

Source Reference: Moore CM "An important step towards smarter screening for prostate cancer" Lancet Oncol 2021; DOI: 10.1016/ S1470-2045(21)00449-6.

www.medpagetoday.com/urology/prostatecancer/94038

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Diagnosed With Cancer and Considering a Complementary Health Approach

- Gather information about the complementary health product or practice that interests you, and then discuss it with your health care providers. If you've been diagnosed with cancer, it's especially important to talk with your health care providers before you start using any new complementary health approach. If you're already using a complementary approach, tell your health care providers about it, even if your reason for using it has nothing to do with cancer. Some approaches may interfere with standard cancer treatment or may be harmful when used along with standard treatment.

Examples of questions to ask include:

◊ What is known about the benefits and risks of this product or practice? Do the benefits outweigh the risks?

◊ What are the potential side effects?

◊ Will this approach interfere with conventional treatment?

◊ Can you refer me to a practitioner?

- Do not use any health product or practice that has not been proven safe and effective to replace conventional cancer care or as a reason to postpone seeing your health care provider about any health problem.

- Tell all your health care providers about any complementary health approaches you use. Give them a full picture of what you do to manage your health. This will help ensure coordinated and safe care.

Source: www.nccih.nih.gov/health/cancer-in-depth

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The Challenges of Prostate Cancer Management

"The major shift for many urologists over the past 10 years has undoubtedly been the understanding of how to treat advanced prostate cancer," writes Raoul S. Concepcion, MD, FACS.

Historically, the urology community has been the "gatekeeper" for the diagnosis and management of prostate disorders, malignant or benign. Prior to the advent of medical therapy and minimally invasive procedures to treat benign prostatic hyperplasia (BPH), if one were finishing their training and in search of a job opportunity, the litmus test to determine how busy a urologist was in practice was to ask how many transurethral resections of the prostate (TURPs) were being performed annually? If the number was more than 125 cases per year, that was considered a robust clinical practice. My recollection from my case log as a resident in the late 1980s was maybe 100 cases over a 4-year residency span, and I cannot fathom what that might look like today in the modern era! The transition from open prostatectomy, TURP, medical therapy, and now minimally invasive procedures has required, to some degree, subspecialization to optimize outcomes rather than being the staple procedure for all urologists in practice.

The evolution in the diagnosis and management of prostate cancer has been equally complex. Akin to BPH, the various facets of the disease require the urologist in practice to stay abreast of the many advances and breakthroughs that are constantly being developed in order to stay current and provide state-of-the-art care. To that end—especially in larger independent practices, and certainly in academic centers—we have specialization in certain clinical areas within prostate cancer itself.

Diagnosis of prostate cancer

The early detection of prostate cancer remains critical and should always be in the hands of urology to educate the broader medical community. Mistakenly, we have applied the term screening to the various tests deployed. In its purest form, a screening test is used to aid in the detection of a certain disease in an asymptomatic population. A positive test suggests the high likelihood of that condition being present, and a negative test would indicate the absence of disease.[1] Prostate-specific antigen (PSA) is not a

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good test for screening, but if it is used judiciously, it is still the linchpin in early detection of prostate cancer. Despite the controversial and subsequent reversal of the US Preventive Services Task Force (USPSTF) recommendations,[2] most PSA testing is still carried out by primary care physicians in the United States.[3] It is our role, as the subject matter experts, to educate our primary care colleagues on the limitations of PSA testing, as well as the following:

- The goal of early detection is to identify those patients at risk for significant prostate cancer.
- Current adjuvant testing to PSA, whether that be imaging or liquid-based testing.
- Current advances in biopsy technique.

Localized prostate cancer

For decades, we have understood that if a man lives into his eighth or ninth decade of life, there is a strong likelihood that he will develop histologic prostate cancer, but not necessarily die of this disease. Most of these individuals will have a lower Gleason Score and Grade Group disease, vis à vis, pattern 3 microscopically. Semantically, as we discuss prostate cancer with newly diagnosed patients or colleagues, it is important for us to be more specific and base these conversations relative to risk stratification.[4] Due to the aforementioned USPSTF recommendation and the lay press, many of our patients—and referring primary care physicians—believe that prostate cancer does not need to be treated. We need to emphasize:

Active surveillance for low-risk disease is appropriate for initial therapy but does not mean that treatment will never be indicated.

The role of active treatment, either surgical or radiation, is still indicated in select risk groups.

Systemic therapies may also play a role in those with high-risk disease, especially in light of advanced molecular imaging.

Advanced prostate cancer

The major shift for many urologists over the past 10 years has undoubtedly been the understanding of how to treat advanced prostate cancer. Here, and in the countless number of publications currently available, the message has been the role of urologists to embrace the management of these patients. The complex nature of the disease, and the multiple agents and regimens now FDA approved for these patients, has led to specific providers within a practice being charged to oversee programs distinct from those managing localized prostate cancer. If we designate an arbitrary definition of "advanced" as any patient that requires androgen deprivation therapy (ADT) for suspected progression of disease, it is critical to acknowledge:

1. Not all patients with biochemical relapse who have been definitively treated for prostate cancer require ADT.
2. If ADT is required, urologists need to take inventory of preexisting cardiovascular risks, given the increasing data suggesting major adverse cardiovascular events associated with certain agents.
3. The standard of care for any patient with newly diagnosed metastatic prostate cancer is the initiation of ADT plus extended therapy, whether that be androgen receptor targeting agents or taxane-based chemotherapy.
4. The plethora of agents currently available for the patient with metastatic castration-resistant prostate cancer continues to expand, including many trials investigating unique combinations of drugs that are approved as monotherapy.

What's on the horizon?

Advanced molecular imaging. The current and forthcoming approvals of various prostate-specific membrane antigen (PSMA) scans will markedly change the therapeutic landscape of the disease, especially as the approval may allow use in staging for high-risk/high-grade prostate cancer.

Theranostics. Close on the heels of PSMA approval is radioligand therapy, which is already approved overseas, and is soon to be approved in the US. Yet another agent in our armamentarium.

Genomic testing. Probably the hottest and least understood area, the incorporation of germline and somatic testing to manage and define risk will be standard of care. However, incorporating this into our practice models remains a challenge, but not an excuse to ignore at the present.

Support clinical trials. The number of unique agents and regimens (bispecific T-cell engager, bipolar androgen therapy, androgen receptor transport disruptors/degraders, etc) continue to be investigated, with promising results early on. As our understanding of molecular drivers and resistance continues to increase through genomic testing, the promise of precision medicine may soon become reality.

August 25, 2021
Raoul S. Concepcion, MD, FACS

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Source: https://www.urologytimes.com/view/the-challenges-of-prostate-cancer-management

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FUTURE MEETINGS 2021

Our public meetings will not resume until the covid-19 restrictions are lifted.

Watch this space for information on the latest status.

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