# The Manitoba Prostate Cancer Support Group

Vol. 196 - October 2007

The Manitoba Prostate Cancer Support Group encourages wives, loved ones, and friends to attend all meetings.

Feel free to ask basic or personal questions without fear of embarrassment. You need not give out your name or other personal information.

**The Manitoba Prostate Cancer Support Group does not recommend treatment modalities, medications, or physicians. All information is however freely shared.**

Want to reach us by email ?

**manpros@mts.net**

## Thought For Today

"If you're going to start cross - country skiing, start with a smaller country."

*- Norm Oman*

## In This Issue



## Medical Advisors to The Manitoba Prostate Cancer Support Group

J. Butler M.D.
Radiation Oncologist

Paul Daeninck M.D.
Pain Management

Darryl Drachenberg M.D.
Urologist

Graham Glezerson M.D.
Urologist

Len Leboldus M.D.
Urologist
[Honorary]

Ross MacMahon M.D.
Urologist

John Milner M.D.
Urologist

Jeff Sisler M.D.
Family Practitioner

Gary Schroeder M.D.
Radiation Oncologist

***Thanks!***

*Cancer Information Service*

Call toll free:
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When you call the toll free number of the Cancer Information Service, your questions will be answered by someone who understands how confusing the subject of cancer can be. *All calls are kept confidential*

## NEXT MEETING:

October 18, 2007 7 - 9 P.M.

***Speaker:*** **Darryl Drachenberg M.D. Urologist Oncologist**

***Topic:*** *Preventing Prostate Cancer : Chemo Prevention*

*Location:* AUDITORIUM of the Seven Oaks General Hospital - Leila & McPhillips

Publications Agreement #40037332 Return Undeliverable Canadian Addresses to: Manitoba Prostate Cancer Support Group #705 - 776 Corydon Ave Winnipeg, Manitoba R3M 0Y1

# A Velocity: Important New Tool in Fight Against Prostate Cancer

By William J. Catalona, MD

One of the big but unanswered questions about prostate cancers is: Which ones are aggressive and which ones are not?

In a recent study, my research partners and I have found some answers that very likely will change the way prostate cancer is diagnosed and then treated.

We have found that the rate of rise in the PSA level, which is called the PSA Velocity, prior to diagnosis of prostate cancer (CaP) is a more powerful indicator of eventual recovery or death from prostate cancer than the actual PSA level itself.

Our study, (Anthony V. D'Amico, M.D., Ph.D., Min-Hui Chen, Ph.D., Kimberly A. Roehl, M.P.H., and William J. Catalona, M.D.) was published in the July 2004 issue of the New England Journal of Medicine and has been reported in major media outlets across the United States.

The study results indicate that men with a high PSA velocity should not be managed by “watchful waiting”, which could be especially harmful if the cancer is fast-growing.

Our study suggests that a rapid rise in the PSA score is a sign the cancer is particularly aggressive, and some men with CaP and a high PSA Velocity will require more than a radical prostatectomy to prevent prostate cancer death.

*"PSA Velocity will likely change the way CaP is diagnosed and treated."*

The results also imply that PSA velocity measurements during the year before the diagnosis of prostate cancer can help identify the potential aggressiveness of the cancers. Those with a .75 PSA increase within a year show a worrisome risk for prostate cancer. Those with a 2.0 increase within a year are more likely to have an aggressive cancer with a higher potential risk for death.

We also found that if the PSA level had been increasing slowly before surgery, then treatments are most effective and patients have little chance of dying from the cancer.

Our study found that when PSA levels rose by at least 2 points during the year before surgery, about one in six of those patients had died from prostate cancer within seven years.

Although the relative risk of death from prostate cancer was nearly 10 times greater in the higher PSA velocity group, other variables were important as well. PSA can also rise because of BPH or prostatitis, so when the PSA does begin to rise, men should be treated with antibiotics to see if the PSA will return to normal before proceeding to biopsy.

*"I recommend having a baseline PSA at 40."*

The lifetime risk of being diagnosed with prostate cancer – 1 in 6 – is higher than the 1 in 8 risk of breast cancer in women. It is a big problem and it kills a lot of men.

While some physicians counsel watchful waiting, the men I see in my office have the same attitude as women facing the possibility of breast cancer: they want it treated; they want it taken care of; and they want it to be over.

Previously, I had been recommending a biopsy with a PSA level of 2.6 or higher, and I will continue this recommendation. However, it will be tempered by the findings of our study that shows us no single value of PSA is as important as the PSA Velocity.

I recommend having a baseline PSA at 40. The nice thing about starting at age 40 is most men at that age have a PSA that is somewhere around 0.6. If the next annual PSA test shows a PSA of 1.4, those men should not wait until the next year to get checked again – even though it looks as if the PSA (less than 2.6) is not high enough to warrant a biopsy. Instead, they should get checked again within three months.

My new recommendation is to test early for a baseline PSA and test every year thereafter to recognize a rapidly rising PSA.

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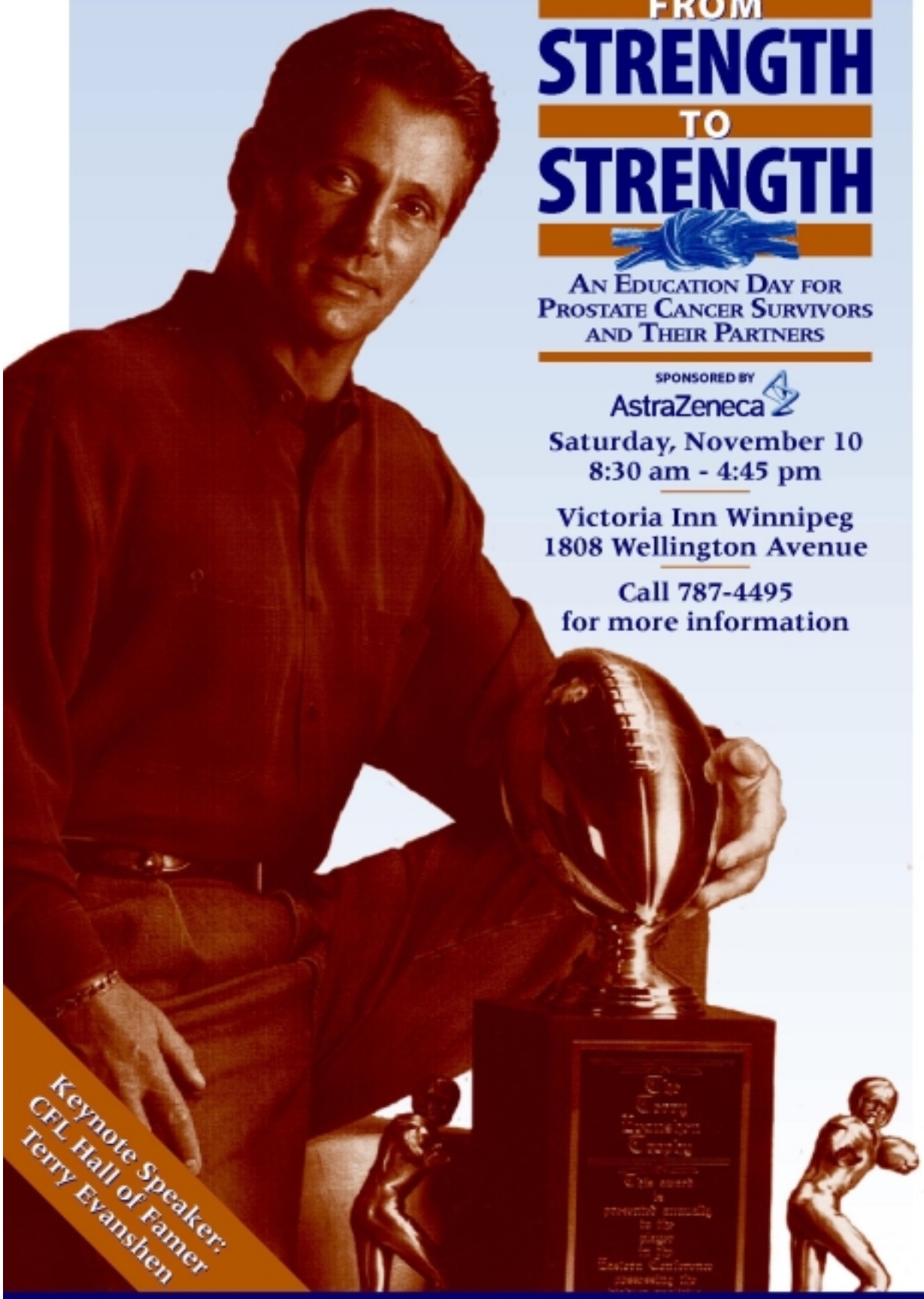

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# Understanding a Cancer Diagnosis: Prostate Adenocarcinoma

Posted December 29, 2006

Prostate Adenocarcinoma can be characterized by changes to the size, shape or texture of the prostate.

**Definition of Terms**

Prostate: A walnut-sized gland located in the male reproductive system, just below the bladder and in front of the rectum.

Adenocarcinoma: A type of cancerous, or malignant, tumor that originates in a gland or glandular structure.

Invasive, Infiltrating: Capable of spreading to other parts of the body.

Malignant: Cancerous and capable of spreading.

Pathologist: A physician who examines tissues and fluids to diagnose disease in order to assist in making treatment decisions.

Lymphatic: Relating to lymph glands

**What is Prostate Adenocarcinoma?**
Prostate Adenocarcinoma accounts for 95 percent of all prostate cancers. It starts in the prostate gland and, if not treated successfully at an early stage, can spread to other parts of the body. Other than skin cancer, Prostate Adenocarcinoma is the most common cancer in American men, with 185,000 cases diagnosed each year.

**Who is most likely to have Prostate Adenocarcinoma?**
Prostate Adenocarcinoma becomes more common in men over age 50. Eighty percent of prostate cancer cases occur in men over age 65. African-American men have an above average risk. A family history of prostate cancer and a high-fat diet also increase risk.

**What characterizes Prostate Adenocarcinoma?**
Prostate Adenocarcinoma can be characterized by changes to the size, shape, or texture of the prostate. Physicians can sometimes detect these changes through a digital rectal exam (DRE). In addition, a Prostate Specific Antigen (PSA) exam detects the level of PSA, a protein produced by prostate cells, in the blood. Higher PSA levels indicate the possibility of cancer. While most prostate cancers do not present symptoms, urinary abnormalities (such as increased frequency/urgency, decreased stream, or impotence) can be associated with prostate cancer.

**How does the pathologist make a diagnosis?**
If the results of a DRE and/or PSA are not within the normal range, a biopsy will be preformed. In this procedure, the primary care physician will obtain multiple thin cores of tissue for the pathologist to examine under the microscope. Another way for the pathologist to make a diagnosis of prostate cancer, though less common, is by examining pieces (chips) of prostate tissue, which are removed from the prostate during a transurethral resection. This process is done for enlargement of the prostate gland (benign prostatic hypertrophy, or BPH). Pathologists can diagnose prostate cancer in whole prostate glands that are removed during a radical prostatectomy, a surgical treatment of prostate cancer. Finally, pathologists can diagnose prostate cancer that has spread by examining cells and tissue from other body sites.

**What else does the pathologist look for?**
In all prostate tissue samples, a Gleason grade is assigned by the pathologist. This important number, which ranges from 2 (best) to 10 (worst), is a strong measure of how aggressive the prostate cancer is and can be used to help determine prognosis and type of therapy. Physicians often look at a combination of your Gleason grade, clinical stage, and serum PSA level (or how fast your PSA is rising) in deciding on the best treatment. For needle biopsies and prostate chips, the pathologist will also report the amount of tissue involved that is cancerous and this finding can influence treatment. For radical prostatectomy tissue, pathologists define the stage or extent of the cancer and whether the cancer is at the tissue edge (margins). These findings are very important for prognosis and will influence the decision as to whether additional treatment is needed after surgery. Stage in the radical prostatectomy can be 2 (better) or 3 (worse), with spread into seminal vesicles (structures attached to the back of the prostate) or lymph nodes removed before or during surgery indicating a worse prognosis. Physicians also perform clinical staging tests (radiology or x-ray studies), usually before surgery, to try to tell if the cancer has spread.

**How do doctors determine what surgery or treatment will be necessary?**
This decision depends on the state of your prostate cancer. For the majority of patients whose cancer looks like it is still in or near the prostate, the decision is based on the Gleason grade assigned by the pathologist, the serum PSA, the

*(Continued on page 5)*

*(Continued from page 4)*
clinical stage, your age, any other medical problems, and treatment or management preference.

**What kinds of treatments are available for Prostate Adenocarcinoma?**
Prostate Adenocarcinoma is treated through one or more of the following: watchful waiting, surgery, chemotherapy, hormonal therapy, and radiation therapy. It's important to learn as much as you can about your treatment options and to make the decision that's right for you.

Watchful waiting is most appropriate for older men with low-grade tumors and low PSA readings. With this approach, men hope to outlive the slow-growing cancer and avoid treatments and side effects including incontinence and impotency. Men choosing watchful waiting should receive DREs or PSAs every three to six months and may need periodic biopsies, as well.

The most common treatment for prostate cancer is surgery, which can remove the cancerous prostate from the body. Surgery is generally recommended for men with early stage or low-grade cancers but is sometimes used at advanced stages to relieve symptoms. The most common surgical procedure is radical prostatectomy – the removal of the entire prostate gland.

Radiation therapy can be used to treat men with small tumors confined to the prostate, as well as to relieve symptoms in advanced tumors. In one type of radiation therapy, brachytherapy, a surgeon implants radioactive pellets inside the prostate. Over time, the pellets radiate the prostate and surrounding tissue, killing the cancer cells. Another kind of radiation therapy is external beam radiation in which high-energy beams pinpoint and kill cancer cells. Radiation therapy generally creates fewer side effects than surgery; for this reason, it is often the preferred treatment for older men.

Physicians use hormonal therapy to reduce the amount of testosterone, which prostate cancers need to grow. Hormone therapy cannot cure cancer but can delay its growth and provide relief.

If the cancer has spread (usually to bones) and is no longer responsive to hormonal therapy, chemotherapy can be considered. This treatment delivers drugs throughout the body, slows the cancer's progression, and reduces pain.

Clinical trials of new treatments for Prostate Adenocarcinoma may be found at www.cancer.gov/clinical trials. These treatments are highly experimental in nature but may be a potential option for advanced cancers.

**What kinds of questions should I ask my doctors?**
Ask any question you want. There are no questions you should be reluctant to ask. Here are a few to consider:

• Please describe the type of cancer I have and what treatment options are available.

• What stage is the cancer in?

• What are the chances for full remission?

• What treatment options do you recommend? Why do you believe these are the best treatments?

• What are the pros and cons of these treatment options?

• What are the side effects?

• Should I receive a second opinion?

• Is your medical team experienced in treating the type of cancer I have?

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# What is PSA?

**Source: Prostate Cancer Research Foundation of Canada**

PSA (prostate-specific antigen) is a protein made by the prostate gland. Although PSA is mostly found in semen, a small amount is also found in the blood.

Men's prostate glands grow as they age and it is normal for a man's PSA to increase slightly with age as a result.

PSA levels can also increase if prostate cells "leak" more PSA into the bloodstream. Prostate cancer cells are more "leaky" than normal prostate cells so high levels of PSA can be a sign of prostate cancer.

**What is the PSA test used for?**

PSA levels are used to help diagnose prostate cancer and they are also used after treatment to diagnose a recurrence of cancer. For example, after surgical removal of the prostate, men will be monitored through
PSA tests to ensure the cancer does not return. The higher the PSA level, the more likely the presence of prostate cancer. How is PSA measured?

PSA blood test results are reported in units of nanograms per millilitre (ng/mL). In the past, results under 4 ng/ml were considered normal and values between 4 and 10 were considered borderline. However, as a "normal" value for PSA is affected by age and race most doctors now take them into account when deciding if a patient's PSA is high.
The chart below shows the cut-offs for PSA values, based on a man's age and race. Anything above those numbers is considered a high PSA.

**Age and race-adjusted cut-off values for PSA**

| Age | Caucasians | Blacks | Asians |
|---|---|---|---|
| 40-49 | 2.5 | 2.0 | 2.0 |
| 50-59 | 3.5 | 4.0 | 3.0 |
| 60-69 | 4.5 | 4.5 | 4.0 |
| 70-80 | 6.5 | 5.5 | 5.0 |

Source: Prostate Cancer A Guide for Patients, by Dr. Laurence Klotz

**Does high PSA equal cancer?**

A high PSA does not necessarily mean a man has cancer though. High PSA levels can also be a result of: Benign prostatic hyperplasia (BPH) or Prostatitis.Both conditions are non-cancerous. PSA levels can also rise temporarily (for up to two days) after ejaculation.

PSA levels may also decrease in certain conditions, which can lead to falsely reassuring PSA measurements. It is important to tell your doctor if you are taking medications such as finasteride (proscar) or dutasteride (Avodart). Dietary supplements may also cause PSA to fall so it is also important to let your doctor know if you take supplements. How accurate is the PSA test?

The PSA blood test is not perfect. In some parts of North America, BPH is the most common cause of high PSA levels. As well, some research studies have found that as many as 25 per cent of men with prostate cancer have PSA levels less than 4 ng/ml.

However, the fact remains that more than 80 per cent of men diagnosed with prostate cancer have an elevated PSA. PSA measurement is also an invaluable tool after prostate cancer therapy.

Several methods are used to improve the reliability of PSA measurement including PSA Ratio, PSA velocity and PSA doubling time.

**PSA Ratio (Free to Total Ratio)**

Most PSA within the blood is bound to other proteins. But a small amount of PSA is unattached and is called free PSA. In prostate cancer the ratio of free PSA to total PSA is decreased. The lower the ratio the greater the risk of prostate cancer (especially if the free to total ratio is less than 25 per cent).

**Prostate specific antigen velocity (PSA-V)**

PSA velocity tracks how quickly PSA levels are rising over time. A rapid rise in PSA is more likely to signal an underlying tumor than a very slow increase. Therefore a biopsy is often recommended men whose PSA velocity is 0.75 ng/ml per year or greater.

Because PSA levels can change by as much as 30-40 per cent, three or more PSA values should be used to calculate PSA velocity.

**PSA doubling time (PSA-DT)**

PSA doubling time is the time it takes for the PSA to double in value. A short doubling time is a red flag for fast tumour growth. A longer doubling time suggests a more slow growing tumor or BPH. A physician is likely to recommend a biopsy if a PSA-DT is three years or less.

Research published by the Mayo Clinic in the USA in 2007 found that PSA doubling time can help diagnose a recurrence of prostate cancer after surgery.

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# A Closer Look At Prostate Cancer Treatment Options

## *Various Approaches Are Available, Each With Its Own Risks And Benefits*

Monday, August 27, 2007

STATEN ISLAND, N.Y. -- In my Aug. 13 article, I discussed the methods and procedures used in diagnosing and staging prostate cancer. Within this third part of our series on prostate cancer I will discuss treatments available, their results as well as side effects.

Various options are available for prostate cancer and each has its own risks and benefits. So-called "watchful waiting" (or expectant therapy) is a form of treatment in which the cancer is monitored until it shows signs of causing harmful effects. This approach may be considered for some patients such as those who have a very low, non-aggressive Gleason Score (2 to 4), are very debilitated, or the frail elderly.

BRACHYTHERAPY

Brachytherapy (aka, seed implantation) has become an incredibly popular form of therapy for prostate cancer in the past 10 years and with good reasons. For this treatment, radioactive seeds (palladium 103 or iodine 125) are inserted directly into the prostate using very specialized and sophisticated computer imaging in the ambulatory surgical suite.

According to Dr. Marc Adams, chief of radiation oncology and director of the radiation therapy and prostate seed implantation program at Richmond University Medical Center and Regional Radiology, "cesium 131 seeds are available for implantation. However, there are no long-term results available regarding cure or complication rates."

The seeds are implanted in the prostate by a urologist and a radiation oncologist in about 60-90 minutes, with no incisions needed.

The patient is then allowed to urinate after he recovers from the anesthesia and then discharged home on the same day. About 5 percent (1 out of 20) of patients -- especially those with larger prostates -- may have difficulty urinating immediately after seed implantation and may require reinsertion of the catheter and removal of it at a later time in the doctor's office for an additional voiding trial. With the aid of powerful medications for the prostate most of these men can also successfully urinate on their own.

The seeds are too small to be felt by the patient or to cause any discomfort. The seeds give off radiation for six to 24 weeks depending on the type of radioactive material used. However, as Dr. Adams explains, "they do not make the patient dangerously radioactive." As a precaution he suggests that patients not hold grandkids or other small children on their laps for six to 16 weeks.

CURE RATES

Results and cure rates with seed implantation are remarkable for patients with T1 to T2 tumors and PSA less than 10. In patients with PSAs higher than 10, Gleason scores more than 6 (7 to 10), as well as evidence of perineural invasion on biopsy reports, external beam radiation and hormonal therapy may be given prior to seed implantation. This is done to kill any potential cancer cells that may have escaped the prostate, or if it is believed these tumors have a higher tendency to metastasize.

After, the seed implantation procedure most patients are able to return to work or usual activities within a few days. Since they may need to urinate frequently until the radiation effect wears off, coffee, tea, spicy foods, acidic juices such as OJ and cranberry juice are not allowed for two to three weeks. Side effects, such as urinary incontinence are less than 1 percent (unless the patient has had prior prostate surgery, i.e. TURP, then it is about 30 percent and impotence from the seed implant is about 30 to 40 percent). Urinary retention is very uncommon and happens in some patients with larger prostates. Sexual dysfunction is reported in 30 to 40 percent of men.

According to Dr. Adams, who has treated over 1,000 patients with seed implantation, "our treatment results are excellent and have been presented at both national and international medical meetings."

Most patients choose seed implantation either alone or combined with radiation and hormonal therapy medications because of its superior results and much lower side effects, as well as the ability to resume their activities and lifestyle within a very short period of recovery.

Cryotherapy or freezing the prostate is sometimes used as "salvage" after some patients may have failed EBRT. It is also now used as a primary treatment.

Complications from the freezing and re-warming process may occur, such as urinary retention, impotence, recurrence of cancer or rarely fistula (in this case abnormal communication between rectum and urethra). As of yet, this is not a commonly used procedure since more data needs to reviewed.

This column is provided by the Richmond County Medical Society. Dr. Motta is immediate past-president of the society and director of Richmond University Medical Center's division of urology and urologic surgery. Questions may be sent to the column in care of the Advance.

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Manitoba Prostate Cancer Support Group
# 705 - 776 Corydon Ave.,
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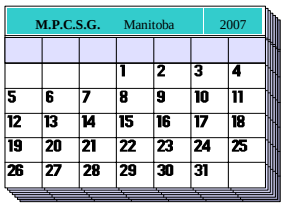
## FUTURE MEETINGS:




November 15, 2007

Janice Todd PhD
Professor and Head of Dept. of Physiology, U. of. Manitoba
*Update on Prostate Cancer : Research*

December 20, 2007

*Holiday Party*

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