Manitoba Prostate Cancer SUPPORT GROUP

Newsletter

Vol. 268 1,160 copies printed/e-mailed **October 2013**

Prostate Cancer Staging

Staging is a term that is used to describe if a cancer has spread from where it first began. Prostate cancer staging is commonly described as:

- Localized prostate cancer: the cancer is contained within the prostate gland and has not spread nearby tissues or elsewhere in the body.
- Locally advanced prostate cancer: the cancer has spread outside the prostate gland to surrounding tissue, most often the seminal vesicles.
- Advanced prostate cancer: the cancer has spread to nearby lymph nodes, bones, or elsewhere in the body.

How Is Staging Done?

Most of the time, tests such as an MRI scan or a CT scan are not very good at telling your doctor how much prostate cancer is present or whether it has spread.

Rarely, your doctor can feel a prostate cancer during a rectal exam. Sometimes a test called a bone scan will be done to see if the cancer has spread to your bones (a common place for the cancer to go).

However, your doctor will also use other information, to help guide treatment and follow-up and give you some idea of what to expect in the future. Other information includes:

- PSA levels (and related tests)
- Prostate biopsy results may be able to show how many areas of the prostate gland has cancer.
- The Gleason score or grade, which comes from the results of your prostate biopsy, tells how aggressive the prostate cancer might be. Two

(Continued on page 2)

Medical Advisors

Paul Daeninck M.D.
Pain Management

Darryl Drachenberg
M.D. Urologist

Graham Glezerson
M.D. Urologist

Ross MacMahon
M.D. Urologist

John Milner
M.D. Urologist

Jeff Sisler M.D.
Family Practitioner

Thanks!

Next Meeting: October 17, 2013
Pat Murphy, Clinical Ethicist
Topic: Health Care Directives -
Do they provide the relief they promise?
Location: Main Floor Auditorium
Seven Oaks General Hospital
Leila and McPhillips
Time: 7 to 9 p.m

The Manitoba Prostate Cancer Support Group does not recommend treatment modalities, medications, or physicians.

Thought of The Day
Sign on a restaurant window;
Don't stand there and be hungry, come on in and get fed up.

(Continued from page 1)

areas of the tumor are graded on a scale of 1 – 5. The sum of the two grades is the overall Gleason score. This tells your doctor information about how different the prostate cancer cells are from normal tissue. The higher the score, the more different the cancer cells are from normal, and therefore, the more aggressive the cancer is.

How Is Staging Used?

It is important to understand that only if and when you have surgery to remove the prostate gland can you and your doctor know for certain what the stage of your prostate cancer is.

However, using your symptoms, physical exam, and results of tests described just above, your doctors will often have a pretty good idea which stage of prostate cancer you have.

MedlinePlus Weekly Digest Bulletin - June 2013

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Prostate Brachytherapy

- Medline Plus Weekly Digest Bulletin 2013

Brachytherapy is a procedure to implant radioactive seeds (pellets) into the prostate gland to kill prostate cancer cells. They may give off high or low amounts of radiation.

Description

Brachytherapy takes 30 minutes or more, depending on the type of therapy you have. Before the procedure, you will be given medicine so that you do not feel pain. You may receive:

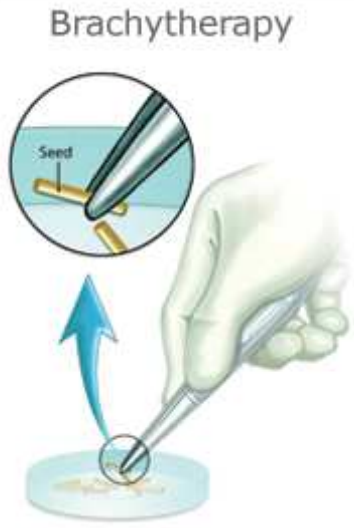
- A sedative to make you drowsy and numbing medicine on your perineum. This is the area between the anus and rectum.
- Anesthesia. With spinal anesthesia, you will be drowsy but awake, and numb below the waist. With general anesthesia, you will be asleep and pain-free.

<u>After you receive anesthesia:</u>

- The doctor places an ultrasound probe into your rectum to view the area. The probe is like a camera connected to a video monitor in the room. A catheter (tube) may be placed in your bladder to drain urine.
- The doctor uses ultrasound or a CT scan to plan and then place the seeds that deliver radiation into your prostate. The seeds are placed with needles or special applicators through your perineum.
- Placing the seeds may hurt a little (if you are awake).

Types of brachytherapy

- Low-dose radiation brachytherapy is the most common type of treatment. The seeds stay inside your prostate and put out a small amount of radiation for several months. You go about your normal routine with the seeds in place.
- High-dose radiation brachytherapy lasts about 30 minutes. Your doctor inserts the radioactive material into the prostate. The doctor may use a computerized robot to do this. The radioactive material is removed right away after treatment.



<u>Why the Procedure is Performed</u>

Brachytherapy is often used for men with a small prostate cancer that is found early and is slow-growing. Brachytherapy has fewer complications and side effects than standard radiation therapy. You will also need fewer visits with the doctor.

Risks

<u>Risks of any anesthesia are:</u>

- Allergic reactions to medicines
- Breathing problems

<u>Risks of any surgery are:</u>

- Bleeding
- Infection

<u>Risks of this procedure are:</u>

- Impotence
- It may become harder to empty your bladder, and you may need to use a catheter
- Rectal urgency, or the feeling that you need to have a bowel movement right away
- Skin irritation in your rectum or bleeding from your rectum
- Other urinary problems
- Ulcers (sores) or fistula (abnormal passage) in the rectum, scarring and narrowing of the urethra (all of these are rare)

Before the Procedure

Tell your doctor or nurse what medicines you are taking. These include medicines, supplements, or herbs you bought without a prescription.

<u>Before this procedure:</u>

- You may need to have ultrasounds, x-rays, or CT scans to prepare for the procedure.
- Several days before the procedure, you may be told to stop taking

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medicines that make it hard for your blood to clot. These medicines include aspirin, ibuprofen (Advil), clopidogrel (Plavix), and warfarin (Coumadin).
- Ask your doctor which medicines you should still take on the day of the surgery.
- If you smoke, try to stop. Your doctor or nurse can help.

<u>On the day of the procedure:</u>

- You will likely be asked not to drink or eat anything for several hours before the procedure.
- Take the medicines your doctor told you to take with a small sip of water.
- Your doctor or nurse will tell you when to arrive at the hospital. Be sure to arrive on time.

<u>After the Procedure</u>

You may be sleepy and have mild pain and tenderness after the procedure. After an outpatient procedure, you can go home as soon as the anesthesia wears off. In rare cases, you will need to spend 1 - 2 days in the hospital. If you stay in the hospital, your visitors will need to follow special radiation safety precautions.

If you have a permanent implant, your doctor may tell you to limit the amount of time you spend around children and women who are pregnant. After a few weeks to months, the radiation is gone and will not cause any harm. Because of this, there is no need to take out the seeds.

Outlook (Prognosis)

Most people remain cancer-free or their cancer is in good control for many years after this treatment. Urinary and rectal symptoms may last for months.

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Cancer: Fear and Uncertainty

A cancer diagnosis raises many fears. It can make you feel as if your life is out of control and that you don't know what the future holds. It's normal to be afraid of the unknown. Uncertainty can make you feel angry, afraid, anxious or irritable.

The time between diagnosis and the start of treatment can be very hard. ***You may:***

- wonder if you will die or lose someone you love
- worry about pain
- be afraid of cancer treatment
- worry about how you will handle work, day-to-day tasks or finances
- wonder how family will react and cope
- be afraid that you can't do the things you enjoy or have to put your plans on hold
- feel helpless

These tips may help cope with your feelings of fear and uncertainty:

- Learn about cancer and its treatment. Some people find that looking for information and using that information to make decisions helps them feel more in control. Others prefer not to know too much. They are comfortable simply following the directions of their healthcare team. Tell your healthcare team how much you want to know.
- Ask questions. Tell the healthcare team if you don't understand what they're saying or when you want more information.
- Look beyond the cancer. Many people feel better when they stay busy. Some can still go to work but may need to adjust their work schedule. Hobbies such as music, crafts or reading can also help take your mind off cancer for a while.
- Try to think about what you can do, rather than what you can't do. Remind yourself that you are coping, no matter how bad you feel.
- Remember that the uncertainty that comes with a new cancer diagnosis often fades as you and your family come to understand more about the disease, the treatment and how you can better cope.
- Counselling and support programs may help. Talk to your doctor or another member of your healthcare team if fear or uncertainty is interfering with daily activities. You might like to talk to a social worker, a counsellor or someone who has been through a similar cancer experience.

Source: Canadian Cancer Society

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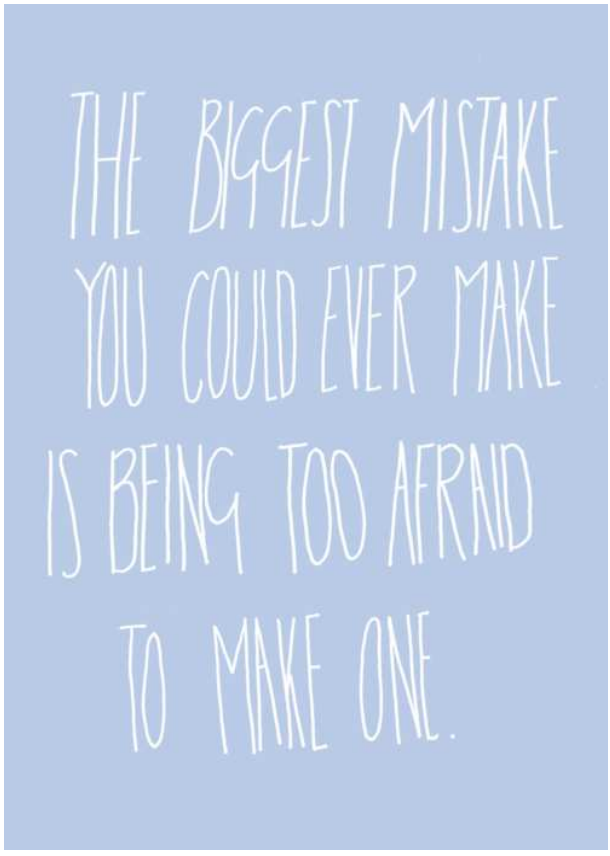
Overview of Current and Emerging Therapeutic Management Strategies for Patients with mCRPC.

The treatment of metastatic castrate resistant prostate cancer (mCRPC) has changed drastically over the past few years with the emergence of several new therapies. This review article summarizes the current data on the novel therapies that were recently approved by the FDA for the treatment of mCRPC and the ongoing trials with emergent therapies. Additionally, it also proposes a sequencing strategy.

Sipuleucel-T was approved by the FDA in April 2010 for treatment of asymptomatic or minimally symptomatic mCRPC, based on the landmark IMPACT trial which showed an overall survival (OS) benefit in the absence of significant PSA change. It became the first vaccine to be approved for any solid tumor.



Cabazitaxel was approved by the FDA in June 2010 as a second-line chemotherapy agent, in combination with prednisone, after failure of docetaxel, based on the pivotal TROPIC trial which demonstrated improvement in OS, progression free survival (PFS), and PSA response as compared to the mitoxantrone/prednisone combination.

Abiraterone acetate, a novel inhibitor of the cytochrome P450 17 (CYP 17), attained approval by the FDA in April 2011, in combination with prednisone, for mCRPC after docetaxel failure, based on the COU-AA-301 trial. That trial demonstrated OS, PFS, PSA response, and pain improvement compared to placebo post- docetaxel failure.

Denosumab is a fully human monoclonal anti-receptor activator of nuclear factor κ B ligand (RANKL) antibody that was approved by the FDA in November 2010 for the prevention of skeletal related events (SRE), in patients with mCRPC to the bones, based on a phase III trial that demonstrated decrease in the rate of SRE - albeit with no effect on OS, PFS or PSA progression.[5] Enzalutamide is a novel androgen receptor signaling inhibitor that demonstrated significant OS benefit compared to placebo in the landmark phase III AFFIRM trial and was granted FDA approval for mCRPC post-docetaxel failure.

Alpharadin is a first-in-class α pharmaceutical bone metastasis-targeting agent emitting high-energy α particles of short range, which demonstrated in the landmark phase III ALSYMPCA trial OS benefit, in addition to delay of SRE, in patients with bone metastases due to mCRPC. [7] Alpharadin was approved by the FDA on May 15, 2013 for symptomatic bone metastases due to mCRPC in the absence of visceral metastases. Several other agents appear to be promising and are currently part of clinical trials in mCRPC, and these include ipilumimab, PROSTVAC-VF, Custirsen, OGX-427 , OGX-011, orteronel, galeterone, tasquinimod, and cabozantinib.

This rapid emergence of new therapies for mCRPC has led to the challenge of identifying the best sequence of their use. In the absence of direct level one evidence, we proposed dividing mCRPC into categories based on the clinical state on the disease. For asymptomatic mCRPC, current options include secondary hormonal manipulation, sipuleucel-T, and abiraterone. For rapidly progressive but asymptomatic mCRPC, options include abiraterone, docetaxel, or secondary hormone manipulations. For symptomatic mCRPC, docetaxel remains the standard first line treatment. In post-docetaxel failure, current options include abiraterone, cabazitaxel, enzalutamide, alpharadin, and mitoxantrone. With all these new therapies that are currently available, the challenge is to have guidelines to help determine the most effective therapy at the most appropriate time.

Published July 12, 2013 (UroToday.com)

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Omega 3 and Prostate Cancer

By: Mark A. Moyad, MD, MPH, University of Michigan Medical Center

Over the last 15 years I have tried to yell from the rooftops that when it comes to lifestyle, dietary supplements and many medications that "Heart Healthy=Prostate Healthy"! "Heart Healthy = Prostate Healthy!" Think about this for a second.

Everything and anything over the last several decades that has been effective in reducing the risk of the number 1 cause of death in men and women (cardiovascular disease) has also been shown to either reduce the risk of prostate cancer or the risk of dying from prostate cancer, and most of the major cancers for that matter. Reduced calorie diets, fruits and vegetables, fiber, weight loss, exercise, low cholesterol, low blood pressure, low risk of diabetes, not smoking … you name the heart healthy lifestyle change and it has been found to be prostate healthy. However, cholesterol lowering supplements and medications now have some evidence that they reduce the risk of aggressive prostate cancer or may slow the progression of this disease that we are actually just starting a clinical trial in Canada with Dr. Klotz (Sunnybrook Hospital Research Center, Toronto) to see if we can prevent the disease from advancing by using a cholesterol lowering supplement.

The majority of the studies on fish oil suggest that eating fish and potentially taking fish oil is not only heart healthy, but is FDA approved to reduce triglycerides (part of the cholesterol test). And, in the past few months and years have studies to suggest that omega-3 fatty acids from plants, fish, or supplements could:

- Improve most aspects of heart health
- Improve vision
- Improve dry eye syndrome
- Improve hearing
- Improves skin tone
- Maintain muscle mass
- Reduce kidney stone risk
- Improve results when combined with a cholesterol-lowering drug
- May improve pregnancy outcomes for mom and baby
- May reduce hot flashes
- May improve mental health
- May reduce the risk of Alzheimer's disease
- May reduce the risk of diabetes
- May improve erectile function
- May improve fertility
- May reduce risk and improve survival in prostate and other cancers

Dr. Moyad's Bottom Line:
Follow the American Heart Association's recommendation on eating fish. Eat fish, especially fatty fish with little to no mercury at least 2 times a week. Fish high in omega-3 and low in mercury include: Anchovies, Herring, Mackerel, Salmon, Sardines, Trout and Whitefish.

When it comes to fish oil supplements, the quality control of most products is excellent because fish oil supplements are mostly derived from tiny fish. Take a fish oil supplement for a medical reason and not just because you hear that it is good for you. For example, I take 1 pill several days a week for a little knee pain after running instead of traditional pain killers, and we recommend 1-2 fish oil pills for those on androgen deprivation treatment because of numerous benefits in reducing side effects. Do not take fish oil pills without discussing the reason you need it with the doctor you trust most.

Source: PCRI Weekly – Experts Weigh in

Editor's Note: Dr. Moyad spoke at the PCCN Canadian National conferences for Support Groups in 2009 (Newfoundland) and in 2012 (Regina). Some of the Manitoba Prostate Cancer Support Group Board attended these conferences.

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Risk Factors For Prostate Cancer

Any substance or condition that increases cancer risk is referred to as a risk factor. There isn't a known, single cause of prostate cancer. Most cancers are the result of many risk factors. However, some people with prostate cancer do not have any identifiable risk factors.

Possible risk factors
Diets high in fatDiets high in red or processed meatsDiets high in milk and dairy productsInherited gene mutationsInflammation of the prostate (prostatitis)Circulating (endogenous) testosteroneExposure to pesticidesOccupational exposures

The risk of prostate cancer increases as men grow older. Prostate cancer is not very common in men under 50 years of age. The chance of having prostate cancer increases after 50 and is diagnosed most often in men over the age of 65.

Men of African ancestry have a higher risk of developing prostate cancer. They have about a 60% higher rate of prostate cancer than Caucasian men. Men of African ancestry are more likely to be diagnosed at a younger age and with more aggressive and advanced tumours.

Men of Asian ancestry have lower rates of prostate cancer. The reason for these ethnic differences is not clear.

Family history is known to increase the risk of developing prostate cancer.
The risk of developing prostate cancer is higher if a first-degree relative (such as a father or brother) has been diagnosed with the disease. Men are at the highest risk if more than 1 relative has been diagnosed. The more first-degree relatives with prostate cancer a man has, the greater his risk of developing prostate cancer.

Risk is also influenced by the relative's age at diagnosis. If a man's relative was diagnosed with prostate cancer before the age of 65, his chance of developing prostate cancer is higher than if his relative was diagnosed at an older age.

Source: Canadian Cancer Society.

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Certain Foods Linked to Reduced PCa Risk

Latest Thinking on Diet and Prostate Cancer

The underlying cause of prostate cancer is unknown. As with other cancers, however, multiple events over a period of many years are probably necessary to produce a cancerous change in a prostate cell. The study of factors that initiate and promote prostate cancer is an active area of investigation.

We know that age, race and family history are all important risk factors for prostate cancer. In addition, diet and lifestyle factors may influence whether a man will develop the disease.

Focus on vegetables and fruits. Studies suggest that a high intake of vegetables may lower the risk of prostate cancer. In a study in the Journal of the National Cancer Institute, men who ate 28 or more servings of vegetables a week (four a day) were 35 percent less likely to develop prostate cancer than those who ate 14 or fewer servings per week (two a day).

Men who ate cruciferous vegetables, such as cabbage and broccoli, appeared to be at even lower risk of prostate cancer: Those who ate three or more servings of cruciferous vegetables a week (in addition to other vegetables) had a 41 percent lower risk of prostate cancer than those who ate less than one serving a week. Cruciferous vegetables are rich in substances that help detoxify cancer-causing substances. In addition, regular consumption of soy foods (such as tofu, soy protein and soy milk) has been linked to a reduced risk of developing prostate cancer.

Lycopene-rich cooked tomato products (for example, tomato paste, spaghetti sauce and ketchup) also may be protective of prostate cancer, although this is controversial. (Lycopene is an antioxidant, a substance that detoxifies damaging molecules called free radicals.)

For example, in the Physicians' Health Study, men who consumed the most tomato products had a lower risk of prostate cancer than those who consumed the least. In addition, pomegranates and pomegranate juice (which have strong anti-inflammatory and antioxidant effects) are under investigation for their potential to slow the progression of prostate cancer.

Source: Johns Hopkins Health Alerts August 2013

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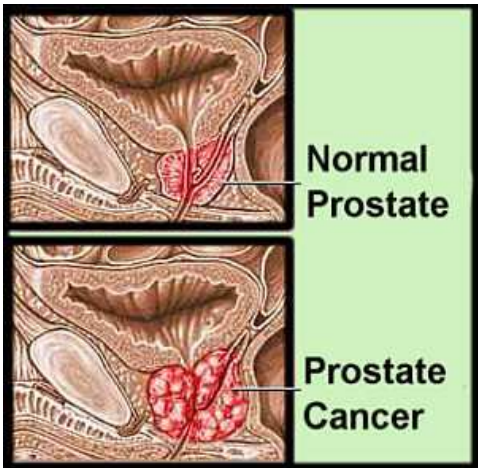
Aggressiveness of Prostate Tumors May Not Change as Cancer Evolves

From cancernetwork.com

By Anna Azvolinsky, PhD

August 30, 2013

Prostate tumors may not readily evolve from low to high grade, according to a research study published in Cancer Research. Kathryn Penney, ScD, epidemiologist at the Harvard School of Public Health and the Channing Division of Network Medicine at Brigham and Women's Hospital in Boston, and colleagues show that the aggressiveness of a prostate tumor could be established at the time of tumor formation.



The results have important clinical implications for prostate cancer patients and clinicians when deciding on whether to choose active surveillance or treatment. If the aggressiveness of a tumor does not change drastically in the course of the disease, patients diagnosed with early-stage and low-grade prostate tumors may be more likely to avoid overtreatment and choose surveillance.

Men diagnosed with prostate cancer receive a Gleason score that indicates the potential aggressiveness of their disease. Together with the stage of disease at diagnosis, these factors indicate the likelihood of the progression of the prostate cancer. But whether the aggressiveness of a tumor remains static throughout the course of the disease or whether it changes, as reflected by the Gleason score, has not been clear.

The researchers show that the shift in Gleason score proportions over time is not likely due to changes in the age at diagnosis. "We were surprised by just how constant the incidence of high-grade disease has been over time," said Penney in a statement.

"Although we cannot rule out the possibility that Gleason grade progresses within an individual, we conclude that it is not a major feature of prostate cancer," state the authors in their discussion of the results.

Further studies to confirm these results are needed. The authors of the current study acknowledge that the biopsy data used for this analysis may have missed additional tumors in patients with a higher Gleason score. This highlights the problem of biopsy sampling from heterogeneous tumors, as the biopsy sample may not always capture representative cells of a tumor, which can result in an underestimation of the Gleason score.

The results also have implications for the biology of prostate cancer—both environmental and genetic risk factors may influence the development of either more or less aggressive disease, according to the study authors.

If these results are indeed supported, "the knowledge that Gleason score largely does not progress may make the choice of active surveillance more appealing for patients with low-grade disease," stated the authors.

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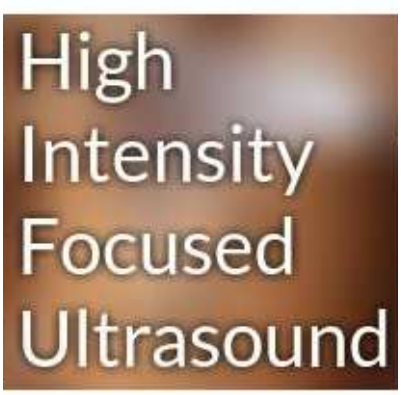
A Treatment Choice: High-Intensity Focused Ultrasound (HIFU)

- Transrectally applied high-intensity focused ultrasound (HIFU) can elevate the tissue temperature of the prostate up to 100° C.
- Treatment is performed under general or spinal anesthesia and takes 1 to 4 hours, depending on the prostate volume, which should not exceed 40 cc.
- Most patients require a urethral or suprapubic catheter for several days.
- The procedure is usually well tolerated; the most common side effect is acute urinary retention, occurring in about 20% of patients.
- Other potential complications are urinary fistula, incontinence, urethral stricture, and perineal pain.
- Erectile dysfunction has been reported in 27% to 61%.
- Clinical trials are continuing in the USA and other countries.

From urologyhealth.org - June 2013



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315-971 Corydon Ave.,
Winnipeg R3M 3S7

Publications Agreement
40037332

The Manitoba Prostate Cancer Support Group has been providing services for 20 years:
Newsletter – Website - Monthly Meetings - Hospital visits - Presentations
Your **DONATIONS** make it all possible. **We Thank You.**

Donor's Name: _____
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*A tax deductible receipt will be issued. Charity number: 88907 1882 RR001

Many thanks to the Gold Wing Riders and their donors.

This is the 12th year the Gold Wing Riders have made the commitment to fundraise for our Prostate Cancer Support Group. This long standing relationship has indeed helped our cause over the years. It is with great admiration and appreciation that we recognize the work done by Grant Ubell, Bruce Zilkowski, Gary Ross and others. Their dedication and efforts have assisted us in raising awareness of prostate cancer in Manitoba.

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MEETINGS

October 17, 2013
Pat Murphy, Clinical Ethicist
Health Care Directives –
Do they provide the relief they promise?

November 21, 2013
Dr. Harvey Quon, Radiation Oncologist
Intimate Fire-side chat on Radiation Options
and Fractionation in Winnipeg

December 12, 2013
Christmas Potluck Party
Entertainment by the Campfire Junkies

All meetings are held at
Seven Oaks General Hospital Auditorium
7-9 p.m.
Everyone welcome

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