

Prostate Cancer That Remains or Recurs After Treatment.

If the prostate-specific antigen (PSA) blood level shows that the prostate cancer has not been cured or has come back (recurred) after an initial attempt to cure it, further treatment can often still be helpful. Follow-up therapy will depend on where the cancer is thought to be and what treatment(s) you have already had. Imaging tests such as CT, MRI, or bone scans may be done to get a better idea about where the cancer is located.

Cancer that is still thought to be in or around the prostate

If the cancer is still thought to be localized to the area of the prostate, a second attempt to try to cure the cancer may be possible.

If you've had a radical prostatectomy, radiation therapy might be an option, sometimes along with hormone therapy.

If your first treatment was radiation, treatment options might include

cryosurgery or radical prostatectomy, but when these treatments are done after radiation, they carry a higher risk for side effects such as incontinence. Repeating radiation therapy is usually not an option because of the increased potential for serious side effects, although in some cases brachytherapy maybe an option as a second treatment.

Sometimes it might not be clear exactly where the remaining cancer is in the body. If the only sign of cancer

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Medical Advisors

Paul Daeninck M.D.
Medical Oncologist

Darrel 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!

*Reminder:
There
will be
NO
MEETING
in July.*



Dr. Paul Daeninck addressing members at our Prostate Cancer Support Group meeting in May.
Photo courtesy of Board Member Joseph Borsa.



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

MPCSG – active since 1992.

Thought of The Day

Why do shops have signs, "Guide dogs only". The dogs can't read and their owners are blind!

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recurrence is a rising PSA level (as opposed to the cancer being seen on imaging tests), another option for some men might be careful observation instead of active treatment. Prostate cancer often grows slowly, so even if it does come back, it might not cause problems for many years, at which time further treatment could then be considered. In a Johns Hopkins University study of men whose PSA level began to rise after surgery for prostate cancer, there was an average of about 10 years before there were signs the cancer had spread to distant parts of the body. Of course, these signs appeared earlier in some men and later in others.

Factors such as how quickly the PSA is going up and the original Gleason score of the cancer can help predict how soon the cancer might show up in distant parts of the body and cause problems. If the PSA is going up very quickly, some doctors may recommend that you start treatment even before the cancer can be seen on tests or causes problems.

Observation might be a more appealing option to certain groups of men, such as those who are older and in whom the PSA level is rising slowly. Still, not all men might be comfortable with this approach.

Cancer that clearly has spread

If the cancer has spread outside the prostate gland, it will most likely go to nearby lymph nodes first, and then to the bones. Much less often the cancer will spread to the liver or other organs.

When prostate cancer has spread to other parts of the body (including the bones), hormone therapy is probably the most effective treatment. But it isn't likely to cure the cancer, and at some point it might stop working. Usually the first treatment is a luteinizing hormone-releasing hormone (LHRH) analog or antagonist

(or orchiectomy). If this stops working, an anti-androgen may be added. Other treatments aimed at bone metastases might be used as well.

Castrate-resistant and hormone-refractory prostate cancer

Hormone therapy is often very effective at shrinking or slowing the growth of prostate cancer that has spread, but it nearly always loses its effectiveness over time. Doctors use different terms to describe cancers that are no longer responding to hormones.

=> **Castrate-resistant prostate cancer (CRPC)** is cancer that is still growing despite the fact that hormone therapy (an orchiectomy, an LHRH agonist, or an LHRH antagonist) is keeping the testosterone in the body as low as what would be expected if the testicles were removed (called *castrate levels*). The cancer might still respond to other forms of hormone therapy, though.

=> **Hormone-refractory prostate cancer (HRPC)** is cancer that is no longer helped by any form of hormone therapy.

Men whose prostate cancer is still growing despite initial hormone therapy now have many more treatment options than they had even a few years ago.

If an anti-androgen drug was not part of the initial hormone therapy, it is often added at this time. If a man is already getting an anti-androgen but the cancer is still growing, stopping the anti-androgen (while continuing other hormone treatments) actually seems to help in some cases.

Other forms of hormone therapy may also be helpful for a while, especially if the cancer is causing few or no symptoms. These include abiraterone (Zytiga), enzalutamide (Xtandi), ketoconazole, estrogens (female hormones), and corticosteroids.

Another option for men whose cancer is

causing few or no symptoms is the prostate cancer vaccine sipuleucel-T (Provenge). This may not lower PSA levels, but can help men live longer.

For cancers that are no longer responding to initial hormone therapy and are causing symptoms, several options might be available. Chemotherapy with the drug docetaxel (Taxotere) is often the first choice because it has been shown to help men live longer, as well as reduce pain. If docetaxel does not work or stops working, other chemo drugs, such as cabazitaxel (Jevtana), may help. Another option may be a different type of hormone therapy, such as abiraterone or enzalutamide (if they haven't been tried yet).

Bisphosphonates or denosumab appear to help many men whose cancer has spread to the bones. These drugs can reduce pain and even slow cancer growth in many men. Other medicines and methods can also help keep pain and other symptoms under control. External radiation therapy can help treat bone pain if it is only in a few spots. Radiopharmaceutical drugs can often reduce pain if it is more widespread, and may also slow the growth of the cancer.

If you are having pain from prostate cancer, make sure your doctor and entire care team know about it. There are many very effective drugs that can relieve pain. There are several promising new medicines now being tested against prostate cancer, including vaccines, monoclonal antibodies, and other new types of drugs. Because the ability to treat hormone-refractory prostate cancer is still not good enough, men are encouraged to explore new options by taking part in clinical trials.

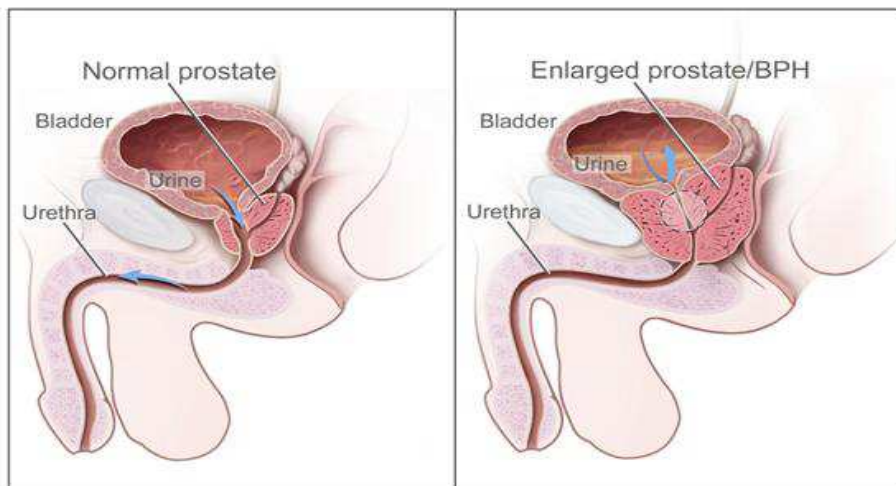
Source: American Cancer Society

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General Information About Prostate Cancer

Key Points for This Section

1. Prostate cancer is a disease in which malignant (cancer) cells form in the tissues of the prostate.
2. Signs of prostate cancer include a weak flow of urine or frequent urination.
3. Tests that examine the prostate and blood are used to detect (find) and diagnose prostate cancer.
4. Certain factors affect prognosis and treatment options.



Normal prostate and benign prostatic hyperplasia (BPH).

A normal prostate does not block the flow of urine from the bladder.
An enlarged prostate presses on the bladder and urethra and blocks the flow of urine.

1. The prostate is a gland in the male reproductive system. It lies just below the bladder (the organ that collects and empties urine) and in front of the rectum (the lower part of the intestine). It is about the size of a walnut and surrounds part of the urethra (the tube that empties urine from the bladder). The prostate gland makes fluid that is part of the semen. In the Canada, about 1 out of 7 men will be diagnosed with prostate cancer.

2. Besides a weak flow of urine or frequent urination, other signs of prostate cancer may include;

=> Weak or interrupted ("stop-and-go") flow of urine.

=> Sudden urge to urinate.

=> Frequent urination (especially at night).

=> Trouble starting the flow of urine.

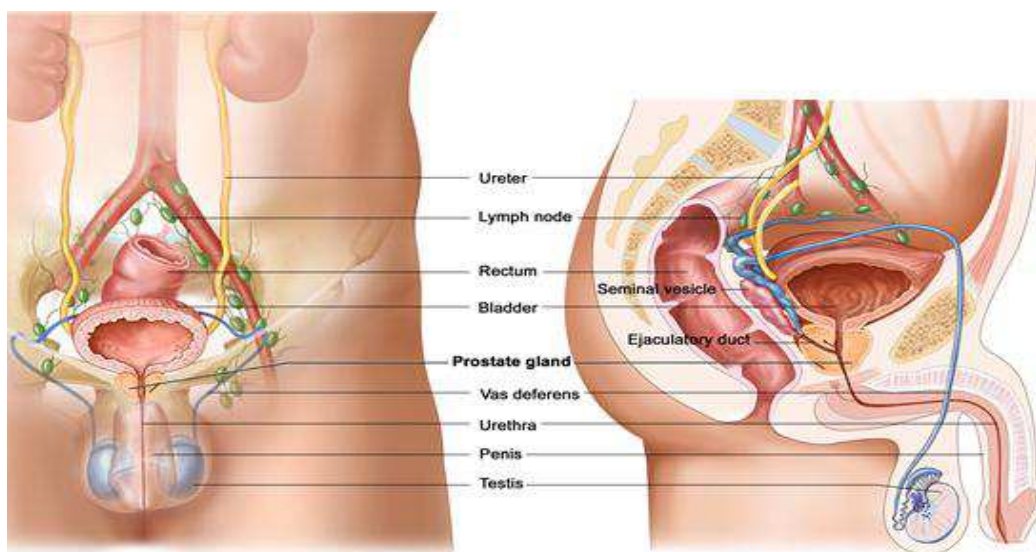
=> Trouble emptying the bladder completely.

=> Pain or burning while urinating.

=> Blood in the urine or semen.

=> A pain in the back, hips, or pelvis that doesn't go away.

=> Shortness of breath, feeling very tired, fast heartbeat, dizziness, or pale skin caused by anemia.



Anatomy of the male reproductive and urinary systems, showing the prostate, testicles, bladder, and other organs.

Other conditions may cause the same symptoms. As men age, the prostate may get bigger and block the urethra or bladder. This may cause trouble urinating or sexual problems. The condition is called benign prostatic hyperplasia (BPH), and although it is not cancer, surgery may be needed. The symptoms of benign prostatic hyperplasia or of other problems in the prostate may be like symptoms of prostate cancer.

3. The following tests and procedures may be used to detect and diagnose prostate cancer:

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Physical exam and history : An exam of the body to check general signs of health, including checking for signs of disease, such as lumps or anything else that seems unusual. A history of the patient's health habits and past illnesses and treatments will also be taken.

Digital rectal exam (DRE): An exam of the rectum. The doctor or nurse inserts a lubricated, gloved finger into the rectum and feels the prostate through the rectal wall for lumps or abnormal areas.

Prostate-specific antigen (PSA) test : A test that measures the level of PSA in the blood. PSA is a substance made by the prostate that may be found in an increased amount in the blood of men who have prostate cancer. PSA levels may also be high in men who have an infection or inflammation of the prostate or BPH (an enlarged, but noncancerous, prostate).

Transrectal ultrasound : A procedure in which a probe that is about the size of a finger is inserted into the rectum to check the prostate. The probe is used to bounce high-energy sound waves (ultrasound) off internal tissues or organs and make echoes. The echoes form a picture of body tissues called a sonogram. Transrectal ultrasound may be used during a biopsy procedure.

Transrectal magnetic resonance imaging (MRI): A procedure that uses a strong magnet, radio waves, and a computer to make a series of detailed pictures of areas inside the body. A probe that gives off radio waves is inserted into the rectum near the prostate. This helps the MRI machine make clearer pictures of the prostate and nearby tissue. A transrectal MRI is done to find out if the cancer has spread outside the prostate into nearby tissues.

Biopsy: The removal of cells or tissues so they can be viewed under a microscope by a pathologist. The pathologist will check the tissue sample to see if there are cancer cells and find out the Gleason score. The Gleason score ranges from 2-10 and describes how likely it is that a tumor will spread. The lower the number, the less likely the tumor is to spread. A transrectal biopsy is used to diagnose prostate cancer. A transrectal biopsy is the removal of tissue from the prostate by inserting a thin needle through the rectum and into the prostate. This procedure is usually done using transrectal ultrasound to help guide where samples of tissue are taken from the prostate.

4. The prognosis (chance of recovery) and treatment options depend on the following:

=> The stage of the cancer (level of PSA, Gleason score, grade of the tumor, how much of the prostate is

affected by the cancer, and whether the cancer has spread to other places in the body).

=> The patient's age.

=> Whether the cancer has just been diagnosed or has recurred (come back).

Treatment options also may depend on the following:

=> Whether the patient has other health problems.

=> The expected side effects of treatment.

=> Past treatment for prostate cancer.

=> The wishes of the patient.

Source: National Cancer Institute

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Adding ADT, Docetaxel to Radiation Improves Survival in Patients With High-Risk Prostate Cancer

Freedom from progression of prostate cancer in high-risk men was extended from historic numbers by adding androgen deprivation therapy and docetaxel to adjuvant radiation therapy, according to a study presented at the 56th Annual Meeting of the American Society for Radiation Oncology (ASTRO).

At 3 years follow-up, 73% of the men who underwent the 3-pronged treatment following prostatectomy had achieved freedom from progression, reported Mark Hurwitz, MD, Thomas Jefferson University, Philadelphia, Pennsylvania.

In his oral presentation on September 14, Dr. Hurwitz said that the aim of the single arm trial was to at least improve freedom from progression from its

historic 50/5 level in the high-risk population and improve that to at least 70% with freedom from progression of their disease at 3 years.

“The study endpoint was met,” said Dr. Hurwitz. “Addition of androgen deprivation therapy and docetaxel to adjuvant radiation therapy for men at high risk of failure despite adjuvant radiation therapy alone following prostatectomy results in greater than 20% improvement in 3-year freedom from progression as compared with historical controls.”

Dr. Hurwitz said the addition of chemotherapy increased adverse side

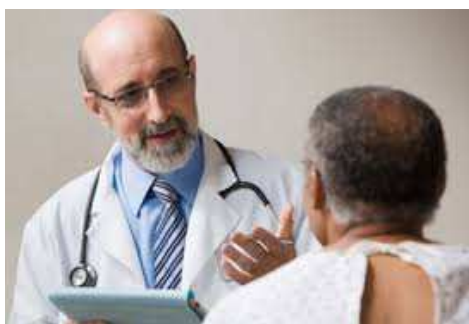


effects with more than 50 of the 74 patients in the trial experiencing grade 3 or Grade 4 neutropenia and leukopenia. However, “most of these adverse events was anticipated and was manageable,” he said.

Source: DocGuide.com

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Questions To Ask Your Doctor



If you or someone you love has just been diagnosed with prostate cancer, here are some basic questions to ask your Urologist:

1. What stage is my prostate cancer? Is it at an early stage, or is it more advanced and spread to other areas of my body (metastasized)? How did you make that conclusion?

2. How long do you suspect I've had prostate cancer and how quickly is the tumor growing?

3. Is my prostate cancer treatable?

=> What type of treatments should I

consider (pros & cons)?

=> What are the side effects of each treatment option?

=> What if any will affect my quality-of-life (erectile dysfunction, incontinence etc?)

4. What is your recommendation, assuming you were the same age and general health?

5. Do you have any suggestions regarding how I should prepare for the treatment? i.e. exercises, diet, recovery time, pain, etc?

6. How long will take for me to get back to my normal routines and social activities? How soon can I resume sexual intimacy and what will I need to make this happen?

7. Could you tell me which treatment (s) you are qualified to provide? Is there a local support group where I can speak with recent patients and understand treatment options from their point of view?

8. Where can I find more information to better understand my condition?

9. Do you mind if I get a second opinion from another urologist? Who would you suggest?

10. Will you continue to be my doctor after treatment and work with me about concerns that might arise?

Source: Courtesy of Markham, Ontario Support Group

Note: *If you have been diagnosed with prostate cancer and would like to talk to someone please contact us at manpros@mts.net or phone our answering service at (204) 989-3433. Our members have been where you are and we may be able to help. There is no obligation to join our Support Group.*

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Adjuvant Therapy: Treatment to Keep Cancer From Returning

*Understand your options before you decide whether adjuvant therapy is for you.
Balance the side effects with the benefits of treatment when making your decision.*

You've had surgery to take out your tumor, and your surgeon says all the cancer was removed. Yet, you've been referred to another doctor to consider more treatment — called adjuvant therapy. You may wonder why you need additional treatment when your cancer has already been removed.

Even if your surgery was successful in removing all visible cancer, there may be a chance that your cancer could return. Microscopic bits of cancer sometimes remain and are undetectable with current methods. Depending on your specific case, you may benefit from adjuvant therapy, since this additional treatment may reduce the risk of your cancer recurring.

Adjuvant therapy is often used after primary treatments, such as surgery or radiation. Adjuvant therapy given before the main treatment is called neoadjuvant therapy. This type of adjuvant therapy can also decrease the chance of the cancer coming back, and it's often used to make the primary treatment — such as an operation or radiation treatment — easier or more effective.

But the added benefit of adjuvant or neoadjuvant therapy doesn't come without a price — the side effects can be more than minor inconveniences.

Not everyone benefits from adjuvant therapy. Work with your doctor to determine if adjuvant therapy is right for you.

Types of cancer treatment that are used as adjuvant therapy include:

=> **Chemotherapy.** Chemotherapy uses drugs to kill cancer cells. Chemotherapy treats the entire body, killing cancer cells, no matter where they may be located. Adjuvant

chemotherapy isn't helpful in all situations, so talk to your doctor about whether this treatment is right for you and how much of a benefit it may provide.

=> **Hormone therapy.** Some cancers are sensitive to hormones. For these cancers, treatments to stop hormone production in your body or block the effect of hormones on your cancer may be helpful.

Your cancer will be analyzed to see if it's hormone sensitive. If it is, you might benefit from hormone therapy. Hormone therapy can be used in conjunction with surgery, radiation or chemotherapy.

=> **Radiation therapy.** Radiation therapy uses high-powered energy beams, such as X-rays, to kill cancer cells. Radiation therapy can be given internally or externally. Adjuvant radiation therapy focuses on the area around the original cancer site to reduce the risk of cancer recurring in that area.

=> **Immunotherapy.** Immunotherapy works with your body's immune system to fight off remaining cancer cells. Immunotherapy treatment can either stimulate your body's own defenses or supplement them.

=> **Targeted therapy.** Targeted therapy aims to alter specific abnormalities present within cancer cells. For example, women with a type of breast cancer that makes too much of a protein called human epidermal growth factor receptor 2 (HER2) may choose a targeted therapy drug that blocks the action of that specific protein. These medications target the specific protein within those cancer cells.

Because none of these treatments is completely harmless, it's important to determine the risks of adjuvant therapy versus the benefits. The following factors can help you and your doctor determine whether adjuvant therapy is appropriate for you and, if so, which type:

=> **Type of cancer.** Treating certain types of cancer with adjuvant therapy can be very beneficial. Examples include breast cancer and colon cancer. For some other types of cancer, there might not be a benefit.

=> **Stage of cancer.** A cancer's stage refers to the extent of the cancer. If the cancer is at a very early stage — before it has had time to spread — then the chance of cancer recurring after surgery may be very small. Adjuvant therapy may offer little benefit in this case.

If cancer is at a later stage — if it is a larger tumor or if the cancer has spread to nearby lymph nodes — then the chance that cancer will reappear sometime in the future is much greater. Adjuvant therapy may be more beneficial in this case.

=> **Number of lymph nodes involved.** The more lymph nodes involved, the greater the chance that cancer cells will be left behind after local therapy, such as surgery.

=> **Hormone receptivity.** Hormone therapy won't be effective if your tumor is not hormonally sensitive.

=> **Other cancer-specific changes.** Certain cancers may have specific changes within their cells that indicate the likelihood that your cancer will return. If tests show your

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cancer is unlikely to recur, adjuvant therapy may offer little benefit.

But, if tests show your cancer has a greater chance of recurring, you're more likely to benefit from adjuvant therapy. Your doctor may request special testing of your cancer cells to determine if adjuvant therapy would be beneficial.

Receiving adjuvant therapy doesn't guarantee your cancer won't recur. It can, however, help reduce the risk that your cancer will come back.

As you're deciding whether adjuvant therapy is right for you, you might want to discuss the following issues with your doctor:

=> **What procedures are you considering?** Find out exactly what will be expected of you during adjuvant therapy. Will you have to

see your doctor for injections or will you take pills at home?

=> **What are the side effects?** What side effects are you willing to live with? Which ones will be too much for you to tolerate? Do you plan to work or stay active during treatment? Could side effects interfere with your plans?

=> **What are the chances you'll stay cancer-free?** Understand how likely it is that your cancer will return if you decide against further therapy and how much improvement you might experience if you do undergo additional therapy. Your doctor can estimate how well your treatment will work based on comparisons with data from studies of other people with your same type of cancer, at the same stage and given the same treatment.

=> **How is your overall health?** People who are otherwise healthy may experience fewer side effects during

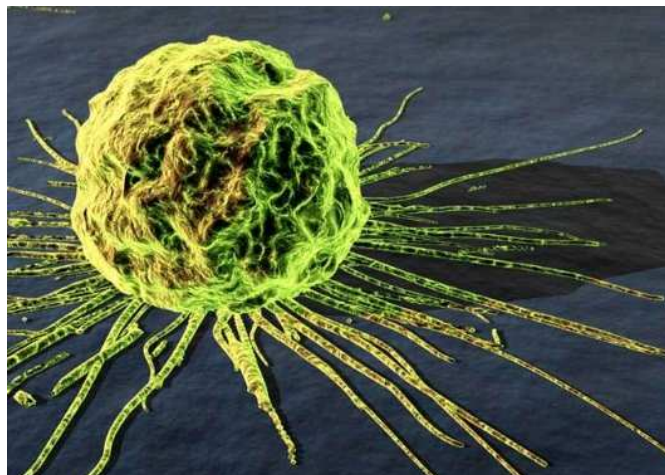
adjuvant therapy and are more likely to benefit from the therapy. People with severe health problems may be more likely to experience side effects during adjuvant therapy and may be less likely to benefit from the therapy.

=> **What is your preference?** Some people want to do everything possible to reduce the chance that their cancer will return, no matter the side effects. Others choose not to tolerate extra side effects if there is likely to be little benefit. Discuss your preferences with your doctor.

Together you and your doctor can weigh these factors and decide whether the benefits of adjuvant therapy outweigh the risks for you.

Source: Mayo Clinic

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When cancer comes back, doctors call it a **recurrence** (or **recurrent cancer**). Some things you should know are: A recurrent cancer starts with cancer cells that the first treatment didn't fully remove or destroy. Some may have been too small to be seen in follow-up. This doesn't mean that the treatment you received was wrong. And it doesn't mean that you did

anything wrong, either. It just means that a small number of cancer cells survived the treatment. These cells grew over time into **tumors** or cancer that your doctor can now detect. When cancer comes back, it doesn't always show up in the same part of the body. For example, if you had colon cancer, it may come back in your liver. But the cancer is still called colon cancer. When the original cancer spreads to a new place, it is called a **metastasis** (meh-TAS-tuh-sis). It is possible to develop a completely new cancer that has nothing to do with your original cancer. But this doesn't happen very often. Recurrences are more common.

Why and Where Cancer Returns

Where Cancer Can Return

Doctors define recurrent cancers by where they develop. The different types of recurrence are:

Local recurrence. This means that the cancer is in the same place as the original cancer or is very close to it.

Regional recurrence. This is when tumors grow in lymph nodes or tissues near the place of the original cancer.

Distant recurrence. In these cases, the cancer has spread (metastasized) to organs or tissues far from the place of the original cancer.

Local cancer may be easier to treat than **regional** or **distant cancer**. But this can be different for each patient. Talk with your doctor about your options.

Source: National Cancer Institute

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THIS GIFT IS IN MEMORY/HONOUR OF _____ PLEASE SEND NOTIFICATION TO: _____
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Credit Card donations can be made by going to our website at: www.manpros.org and clicking on the donate tab.
Canada Helps will issue a tax receipt. **Amount:** \$25 \$50 \$75 \$100 Other _____

Thanks to AstraZeneca

The Board of the Manitoba Prostate Cancer Support Group would like to acknowledge a recent donation from AstraZeneca.

They produce Casodex and Zoladex, 2 drugs used for prostate cancer hormone therapy treatment. AstraZeneca assists us in promoting prostate cancer awareness and education in the community.

We are indeed grateful for their financial contribution and support.

Many thanks!



Email - manpros@mts.net

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2015 MEETINGS

Jan. 15 Dr. Rashmi Koul, Radiation Oncologist
Topic: Prostate Cancer and Bone Health
Feb. 19 Bill Martin, Gimli Author
Topic: Ripped Out: One Man's Journey Surviving PCa
Mar. 19 Dr. Robert Wightman, Pathologist
Topic: Biopsy Report and its Role in Determining Therapy
Apr. 16 Dr. Sabeer Rehsia, Urologist
Topic: Biochemical Recurrence: What are Your Options?
May 21 Dr. Paul Daeninck, Medical Oncologist
Topic: Medical Marijuana: Is This "Bud" For You?
June 18 Edith Mulhall, Lymphedema Assoc. of Manitoba
Topic: Lymphedema Basics
July No Meeting
Aug. 20 Dr. Reece Malone, Sexuality Educator
Topic: Reclaiming Intimacy and Nurturing Connection
after Prostate Cancer.
Sept.17 Prostate Cancer Awareness Evening at
Caboto Centre - 1055 Wilkes Ave. 7 – 9 pm
Dr. Rashmi Koul, Radiation Oncologist
Dr. Piotr Czaykowski, Medical Oncologist
Oct. 15 Dr. Kelli Berzuk, Incontinence Physiotherapist
Topic: Living With Incontinence: Do I Have To?
Nov. 19 Christmas Pot Luck Party
Dec. No Meeting

All meetings 7 – 9 p.m. at
Seven Oaks General Hospital Auditorium
(except September)
Everyone Welcome

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