

The Manitoba Prostate Cancer Support Group NEWSLETTER



Vol. 242 – August 2011



NEXT MEETING:

Thursday, August 18, 2011

Dr. Darrel Drachenberg & Paula Sitarik RN

Topic: *HIFU Trial for Recurrent Prostate Cancer*

Location: Seven Oaks General Hospital
Main Floor Auditorium- Leila & McPhillips

Time: 7:00 pm to 9:00 pm

Medical Advisors to The Manitoba Prostate Cancer Support Group

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!



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.

Thought for the Day

There is no danger of developing eye strain from looking on the bright side of things.

~ Unknown

OUR NEW ADDRESS IS

Manitoba Prostate Cancer Support Group (MPCSG)
315 - 971 Corydon Ave
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PCCN Winnipeg gratefully acknowledges the contribution of Sanofi Aventis. Together with our members PCCN Winnipeg is able to meet our goal to provide "Awareness, Education & Support".

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AUA: Robotics Blamed for Spike in Prostate Surgery

By Charles Bankhead, Staff Writer, MedPage Today

Published: May 15, 2011

WASHINGTON - Adoption of robotic technology fueled rapid growth in the use of prostatectomy at a time when the incidence of prostate cancer decreased, investigators reported here.

The annual prostatectomy volume in the United States increased by almost 50% from 2005 to 2008, after remaining stable during 1997 to 2004. The dramatic uptick in prostatectomy volume coincided with rapid adoption of robotic-assisted laparoscopic prostatectomy (RALP), which accounted for 15% of all prostatectomies in 2004 but more than 80% in 2008.

The growth in prostatectomy volume, particularly RALP, contrasted with a decline in prostate cancer incidence of 2.2 cases per 100,000 men from 1997 to 2008 (P=0.009), as

reported at the American Urological Association meeting. Robotic prostatectomy volume was based on publicly available data from Intuitive Surgical, a manufacturer of robotic surgical systems. Annual rates of robotic assisted laparoscopic prostatectomy were calculated for the periods 1997 to 2004 and 2005 to 2008, representing the "pre-robotic" and "robotic eras."

Overall, the volume of prostatectomy procedures increased by about 1,700 cases per year. However, closer inspection of the data showed that the prostatectomy rate remained stable at about 60,000 per year from 1997 to 2004. Beginning in 2005, the rate increased by an average of 11,243 cases per year (P=0.005), reaching a total prostatectomy volume of 87,675 in 2008.



The dramatic rise in the prostatectomy rate during the latter part of the study period coincided with the introduction and rapid adoption of RALP. In 2004, 9,000 robotic-assisted procedures were performed. By 2008, RALP accounted for 72,000 prostatectomy

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**Change In PSA Level
Does Not Predict Prostate Cancer
Screening for PSA Velocity
Leads to Many Unnecessary Biopsies and Should Be
Removed from Screening**

February 24, 2011

New York, NY - Researchers at Memorial Sloan-Kettering Cancer Center have found that change in PSA levels over time — known as PSA velocity — is a poor predictor of prostate cancer and may lead to many unnecessary biopsies. The new study of more than 5,000 men was published online February 24 in the Journal of the National Cancer Institute. Andrew Vickers, PhD, Associate Attending Research Methodologist in the Department of Epidemiology and Biostatistics and lead author said, "We have found no evidence to support the recommendation that men with a high PSA velocity should be biopsied in the absence of other indications. In other words, if a man's PSA has risen rapidly in recent years, there is no cause for concern if his total PSA level is still low and his clinical exam is normal."

"We have found no evidence to support the recommendation that men with a high PSA velocity should be biopsied in the absence of other indications. In other words, if a man's PSA has risen rapidly in recent years, there is no cause for concern if his total PSA level is still low and his clinical exam is normal." - Andrew Vickers, PhD, lead author of the study and Associate Attending Research Methodologist in the Department of Epidemiology and Biostatistics

Prostate cancer is the most common cancer among American men and the second leading cause of cancer deaths in men, according to the American Cancer Society. While PSA screening is widely used for the early detection of prostate cancer, it is also associated with a high rate of over diagnosis, which can lead to unnecessary treatment and anxiety. Currently, early detection guidelines of several organizations (the National Cancer Center Network and the American Urological Association) recommend that men with a rapid rise in PSA — or a high PSA velocity — have a surgical biopsy for prostate cancer, even if there are no other indicators that cancer may exist. Those indicators could be

an elevated baseline PSA or a positive digital rectal exam (DRE).

This study's population came from the Prostate Cancer Prevention Trial. Five thousand five hundred and nineteen men aged 55 years and older with no previous prostate cancer diagnosis, normal DRE, and a baseline PSA of 3.0 ng/mL or less were randomly assigned to finasteride — a drug commonly used to treat enlargement of the prostate gland, more commonly referred to as BPH, or benign prostatic hypertrophy — or placebo for seven years. This particular study focused on the men in the placebo group. The men were followed with yearly PSA tests, with biopsy recommended for men with a PSA higher than 4.0 ng/mL. After seven years, all men who were not diagnosed with prostate cancer were asked to consent to an end-of-study biopsy.



Dr. Vickers and colleagues found no important association between PSA velocity and biopsy outcome after adjusting for risk factors such as age, race, and PSA levels. PSA alone was a much better predictor of biopsy outcome than PSA velocity.

According to Peter T. Scardino, MD, Chair of the Department of Surgery, "This study should change practice. We have previously published papers determining that PSA naturally

varies from month to month and have urged men whose PSA suddenly rises to wait six weeks and repeat the test before agreeing to a needle biopsy. This new study in a large population of men provides even stronger evidence that using changes in PSA as a basis for recommendation for biopsy leads to many more unnecessary biopsies and does not help to find the more aggressive cancers that we want to find and treat." Dr. Scardino added that "men should be cautious before rushing into a biopsy for minor variations in their PSA level."

The work was funded by the Prostate Cancer Foundation, the Sidney Kimmel Center for Prostate and Urologic Cancers, and a P50-CA92629 SPORE grant from the National Cancer Institute to Dr. Scardino. Additional support was obtained from the National Institutes of Health.

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'Groundbreaking' New Technology Eases Diagnosis Of Prostate Cancer Software That Combines Imaging Techniques Helps Doctors Locate Danger Spots

By Tiffany Crawford, Vancouver Sun October 1, 2010

Radiologists at Vancouver General Hospital have conducted the first successful biopsy using new digital-imaging technology that can clearly show whether a man has prostate cancer.

The software system, developed in Toronto by Sentinelle Medical, fuses MRI - magnetic resonance imaging - with ultrasound images to create a super image of the prostate that allows physicians to pinpoint where the danger spots are so they can eventually treat just that area.

It is just one of many new technologies and treatments being developed in Vancouver that provide hope for the future of patients living with the disease.

On Wednesday, radiologists gave The Vancouver Sun an exclusive look at how the new technology works on prostate cancer patients. Shortly after he performed the first biopsy done using the fusion technology, Dr. Lindsay Machan, an interventional radiologist at VGH, emerged from the MRI room exceptionally pleased.

He said it was the first successful biopsy in the world done with the new fusion software.

"I'm stunned. I'm very impressed," he said. "This is groundbreaking technology that is really going to advance the diagnosis of prostate cancer."

The disadvantage of conventional imaging is there are many small cancers in the prostate that physicians can only see on the MRI screen, not on the ultrasound.

The benefit of ultrasound imaging, which uses high-frequency sound waves to produce pictures of inside the body, is that the images are captured in real time, meaning they can show movement of an organ, as well as blood flowing through blood vessels.

A prostate ultrasound typically requires insertion of an ultrasound probe into the rectum of the patient. Dr. Silvia Chang, head of body MRI at VGH explained that

MRI is a non-invasive technique that uses coils, placed on top of the body, that emit a powerful magnetic field and radio frequency pulses to produce detailed pictures of organs, soft tissues and bone.

"There is no question that this improves our ability to diagnose prostate cancer and in particular, what we can tell those men who are not sure if they have prostate cancer," said Machan, adding that it means "we can more definitively say they do or they don't have prostate cancer, which is really important."

Machan and Chang are working in collaboration with Dr. Larry Goldenberg, a urologist and associate director of the Vancouver Prostate Centre at VGH. They plan to conduct biopsies on more than 100 men during the pilot program over the next two years.



It will also allow a physician to determine the severity of cancer, and decide whether it is something that can be watched or one that needs more aggressive treatment. The implications are significant, given that overdiagnosis and overtreatment of prostate cancer continue to be a challenge.

The new US/MRI fusion system will allow physicians to get a much clearer picture of the prostate so they can use focal therapy, targeting the affected part of the prostate rather than removing the entire gland.

"This technology takes the MRI, which is all digital, and fuses it to your ultrasound image so now it becomes like one and you can direct your needle in to biopsy it or to treat it with heat or cold or inject a cancer-seeking drug," said Goldenberg.

A decade ago, MRI wasn't thought to be very useful in detecting prostate cancer because of the picture quality. Because the prostate is located in the pelvis, it has been difficult to scan.

"It's not like a breast where you can readily do a mammogram or ultrasound. It's tough to get at the prostate - it's in an awkward spot. It would be nice if it were stuck to your elbow but it's not, it's up your bum," he said. Goldenberg, who is also head of urologic sciences at UBC, expects to have data from the new system within a year. The goal is to minimize the side effects of treatment. Both surgery and radiation affect sexual and urinary function. In 2007, the Vancouver Prostate Centre began using a da Vinci robot after receiving a \$3-million donation from Jack

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Poole, former chairman of Vancouver's Olympic organizing committee who died of pancreatic cancer on Oct. 23, 2009, hours after the Olympic flame was lit in Greece.

The robot - named after artist and scientist Leonardo da Vinci, who is believed to have drawn and created the first robot - allows surgeons to see and work inside tight parts of the body, such as the pelvis and chest, with more accuracy. Nicknamed Jack, the robot uses small incisions making the surgery less invasive with less blood loss, and speeding up recovery time.

Surgeons sit at computer consoles to remotely operate the robotic arms. In a recent interview, Goldenberg said the robotics program is going great.

"I see the robot as a Model T Ford, the first car and we are going to get it better and better."

Goldenberg said he is becoming skilled at using the robot and believes his results will be an improvement over conventional surgery.

"I can't make those claims at this point. But I think that after a few hundred more cases - and add all these new technologies on top of it - the day will come where technology and the machinery and the digital world will actually make a better surgeon."

Less than five per cent of men suffer from urinary leakage after surgery with the robot, said Goldenberg, although the loss of sexual function continues to be a challenge.

Besides technological advances, Vancouver scientists have many new drugs that are showing promise.

One such drug is a cancer "seek and destroy" drug called Protox, which contains a toxin derived from bacteria attached to a molecule that recognizes prostate specific antigen (PSA).

The Vancouver company called Protox Therapeutics is in clinical trials for the treatment of enlarged prostate and prostate cancer.

"Only prostate cells have PSA. So imagine a drug that would be attracted to cancer cells that are making a lot of PSA. And it will only be activated by PSA. So if it lands in your eyeball it is not going to be activated. But when it finds a PSA cancer cell it explodes and kills the cell," said Goldenberg.

In about three to five years, scientists will be able to test a man's prostate cancer in a test tube. That means they will be able to determine how a cancer responds to drug combinations in the lab rather on the patient.

"Imagine a world where we say, 'Mr. Smith you have a cancer - and so we're going to run it in this lab, we are going to test a panel of ten different treatment options and we'll choose the best one for you based on how your cancer responds in the laboratory, rather than trying ten different things in you,'" said Goldenberg.

New treatments being tested for men living with advanced stages of prostate cancer are showing encouraging results. Over the last 60 years there has only been one form of treatment to prolong survival and that was called hormone therapy. Then about seven years ago a drug called Taxitere was approved to use along with chemotherapy to prolong lives.

But over the next five years, there will be five new drugs to further prolong survival.

"It really shows that we are reaping the benefits of research done," said Dr. Martin Gleave, executive director of the Vancouver Prostate Centre, who earlier this summer announced that a new cancer-fighting drug the centre has been working on - called OGX-011 - will prolong the life of patients with advanced prostate cancer by seven months.

A report on the findings, written by a team of scientists led by Gleave, will be published in this month's edition of the Journal of Clinical Oncology.

The drug works by inhibiting the production of a gene protein called clusterin that protects cancer cells from cancer treatments, such as radiation and chemotherapy.

Gleave's team was the first in the world to develop an anticlustarin agent.



Clusterin can also be found in bladder, pancreas, colorectal, ovarian, breast and kidney cancers, meaning OGX-011 has the potential to prolong the lives of other terminal cancer patients as well.

OGX-011 will be available to patients in about two years. Phase 3 clinical trials with 800 patients begin this fall. The drug is licensed to Onco-Genex Technologies, a UBC spinoff company co-founded by Gleave.

"We here in Vancouver are world leaders in discovering

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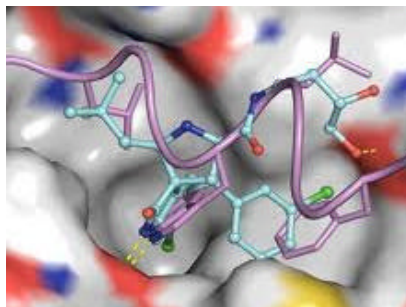
new genes and developing new inhibitors to better treat treatment resistance in cancer," he said.

Like OGX-011, which works by targeting a gene protein, Gleave's team has identified another gene protein called HSP-27, also known as a heat shock protein.

Research into a new drug that inhibits HSP-27 - called OGX-427- is led by Dr. Kim Chi, a radiation oncologist at the BC Cancer Agency. The drug is entering Phase 2 clinical trials and is also licensed to OncoGenex.

The researchers were awarded a \$1-million grant from the Terry Fox Foundation to do the study. About 80 patients will be involved in the trials.

The drug - EPI-001 - is designed to help men who suffer relapses when their cancer becomes resistant to androgen ablation therapy, which stops the production of testosterone, says lead researcher Dr. Marianne Sadar, a scientist with the BC Cancer Agency.



B.C. scientists are also working on an experimental drug to shrink prostate cancer tumours using material extracted from a marine sponge collected in New Guinea.

Several years ago, Sadar teamed up with Raymond Andersen, a natural compounds chemist and University of B.C. professor, who has spent much of his career combing the seas for natural compounds to be used as anti-cancer medicines.

"There's an entire new treatment that could buy a patient much more survival time. We have huge hopes that it might get rid of the tumour completely," Sadar said.

She said in the lab, scientists see the tumours shrinking and shrivelling up, but more tests need to be done.

Sadar hopes to get enough funding to continue the research and conduct trials in humans.

ticrawford@vancouver.sun.com

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Dietitians of Canada Sep 01 2010

How Much Calcium Do I Need? Should I Take Calcium Supplements And Other Bone Health Nutrients?

Calcium requirements

The calcium intake goal for healthy adults ages 19-50 is 1000 mg. daily. Adults age 51 and older should aim for an intake of 1200 mg of calcium every day. See the chart below for examples of food patterns containing approximately 1000 mg. of calcium each.

Team players in bone health

Calcium works together with vitamin D, magnesium, vitamin A, protein and fluoride to build and maintain strong bones and teeth.

Vitamin D is made in the skin when it is exposed to sunlight. However, research shows that Canadians do not make any vitamin D in their skin from October through March due to our northern latitude. The use of sunscreen in the summer further inhibits the ability of our skin to make vitamin D. Therefore it is necessary to get our vitamin D from food such as fatty fish (salmon and mackerel), milk, margarine and fortified soy beverages.

Eating Well with Canada's Food Guide recommends that adults over 50 take a vitamin D supplement of 400 IU per day.

Eating a variety of foods from the four food groups in Eating Well with Canada's Food Guide provide magnesium, phosphorus, vitamin A and protein. Supplements of these nutrients are not necessary providing that the recommended number of servings from each of the four food groups are consumed daily.

Fluoride is mainly supplied through fortification of our local drinking water. Supplements of fluoride may be necessary in areas where the water is not fortified.

What about supplements?

If you are eating the recommended number of servings from each food group in Canada's food guide you should not require a calcium supplement. Foods from the Milk and Alternatives Food Group and orange and dark green vegetables from the Vegetables and Fruit Food Group contribute to our total calcium intake. If you think you need a calcium supplement check with a registered dietitian or physician about the amount and type of supplement that is best for you. It is important even when you are taking a calcium supplement to continue to eat foods containing calcium as research indicates that calcium from foods may be more effective in building healthy bones than calcium from supplements.

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Two examples of food patterns containing approximately 1000 mg of calcium:

Food Pattern	Approximately 1000 mg of calcium
1	2 cups of milk ½ cup broccoli, cooked ¼ cup almonds ½ cup canned salmon with bones
2	½ cup orange juice fortified with calcium 1 cup (250 mL) fortified soy beverage 6 dried figs ½ cup (125mL) white beans ¾ cups (175 g) plain yogurt

Dietitians of Canada Food Choices for Increasing the Calcium in Your Diet

Food Group	Best Choice [Choose Lower Fat Options More Often]	Serving Size	Calcium (mg)
Milk and Alternatives (2-3 servings each day)	Cheese [i.e. cheddar, mozzarella]	50 g (1 ½ oz)	390
	Cottage Cheese	113 g (4 oz)	70
	Yogurt: plain, low fat	175 mL (¾ cup)	320
	Or fruit flavoured	175 mL (¾ cup)	250
	Fluid Milk	250 mL (1 cup)	300
	Skim Milk Powder	45 mL (3 Tbsp)	280
	Calcium fortified soy beverage*	250 mL (1 cup)	320-370
Grain Products (6-8 servings each day)	Macaroni and cheese, baked	250 mL (1 cup)	165
	Cheese pizza	1/8 or 30 cm (12") pizza	115
Meat and Alternatives (2-3 servings each day)	Sardines, canned, with bones	6 medium	275
	White (navy) beans, canned	250 mL (1 cup)	190
	Salmon, canned including edible bones	125 mL (½ cup)	180
	Calcium-Set Tofu [Firm]		
	Cooked Soy Beans	80 g (1/3 cup)	545
	Baked beans	125 mL (½ cup)	150
	Almonds, dried	250 mL (1 cup)	155
	Brazil Nuts	60 mL (¼ cup) 60 mL (¼ cup)	150 100
Vegetables and Fruit (7-10 servings each day)	Calcium fortified orange juice	250 mL (1 cup)	310 -345
	Dried figs	3	80
	Bok choy, boiled	125 mL (½ cup)	80
	Orange	1 medium	50
	Broccoli	250 mL (1 cup)	50
	Kale	250 mL (1 cup) cooked	95
Desserts and Sweets	Frozen yogurt	175 mL (¾ cup)	250
	Puddings made with milk	125 mL (½ cup)	155
	Milk chocolate bar	50 g	95
Other Foods	Blackstrap molasses	15 mL (1 Tbsp)	180

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* The absorption of calcium from soy-fortified beverages varies by commercial product and may be less than that of cow's milk.

Daily Calcium Needs

Age	Calcium mg/d
1-3 years	500
4-8 years	800
9-18 years	1300
19-50 years	1000
51-70+ years	1200
Individuals at risk for or with osteoporosis	1500
Pregnancy & Lactation <18 yr	1300
Pregnancy & Lactation 19-50 yr	1000

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2011 SPEAKERS:

August 18, 2011 Dr. Darrel Drachenberg & Paula Sitarik RN
 Topic: HIFU Trial for Recurrent Prostate Cancer

September 15, 2011 Fran Rosenberg, Incontinence Specialist

SEPTEMBER 20, 2011
 WATCH FOR ANNOUNCEMENT RE:
SEPTEMBER AWARENESS EVENING

October 20, 2011 TBA

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

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