Manitoba Prostate Cancer SUPPORT GROUP

Newsletter

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What Is Metastatic Prostate Cancer?

Metastatic prostate cancer is cancer that has spread from the prostate gland to other parts of your body.

For example, it may show up as a tumor on your spine or as cancer in your lung. Bone is the most common place for it to spread. But lungs and liver are also common sites. It could also occur, though rarely, in other organs such as the brain.

Having metastatic cancer doesn't mean you have a new kind of cancer. Metastatic prostate cancer in a bone in your hip is not bone cancer. The tumor will have the same type of cancerous prostate cells the original tumor had. The same is true if the metastatic cancer is in your lung or some other organ. It is still prostate cancer, and your treatment options are the same as when cancer was only in the prostate gland.

Metastatic prostate cancer is an advanced form of cancer. But the term "advanced" has different meanings depending on how it is used. "Advanced" usually refers to cancer that can't be cured. That doesn't mean it can't be treated and controlled. Most men with advanced prostate cancer live a normal life for many years.

Treatment can be effective to:

- Manage symptoms
- Slow the rate your cancer grows
- Shrink the tumor

Some cancers are called "locally advanced." That means the cancer has spread from the prostate to nearby

(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: November 21, 2013
Bernie Brandt and John Shinnimin
Topic: Just when you think you've heard it all ... along comes two exceptional stories.
Location: Main Floor Auditorium
Seven Oaks General Hospital
Leila and McPhillips
Time: 7 to 9 p.m.

SHARING IS CARING — SHARING IS CARING

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

Thought of The Day

Sign on a plumber's truck: ***Don't sleep with a drip - call your plumber!***

(Continued from page 1)
tissue. This is not metastatic cancer, which is cancer that has spread to other parts of the body. Many locally advanced prostate cancers are curable.

How Prostate Cancer Spreads

For cancer to become metastatic, individual cancer cells need to break away from the original tumor and move to a blood or lymph vessel. Once there, they circulate through the body. The cells finally stop in capillaries - tiny blood vessels - at some distant location.

The cells then break through the wall of the blood vessel and attach to whatever tissue they find. They then need to multiply and grow new blood vessels to supply nutrients to the new tumor. Prostate cancer prefers to grow in specific areas, such as lymph nodes or in the ribs, pelvic bones, and spine. Most cancer cells that break away form new tumors. Many don't survive in the bloodstream. Some die at the site of the new tissue. Others may lie inactive for years or never become active.

Chances of Developing Metastatic Prostate Cancer

About 50% of men diagnosed with local prostate cancer will develop metastatic cancer during their lifetime. Finding cancer early and treating it can help reduce that rate.

A small percentage of men aren't diagnosed with prostate cancer until it has become metastatic, either because they have no symptoms or the symptoms have been ignored. Doctors can tell it's metastatic cancer by doing a biopsy of the tissue and studying the cells.

If you've been diagnosed with prostate cancer, your doctor will order additional tests such as:

- X-rays
- CT scans
- MRI scans

These tests may focus on your skeleton and abdominal and pelvic areas. That way doctors can check for signs of the cancer's spread.

If you have symptoms such as bone pain and fractures for no reason, your doctor may order a bone scan. The bone scan can show if you have metastatic cancer in the bones.

Your doctor will also ask for blood tests, including a check of PSA levels, to look for other signs of the cancer's progression.

PSA is a protein normally made by the prostate gland. It can be measured with a simple blood test. A rise in PSA is one of the first signs of the progression of prostate cancer. PSA levels can be high without there being cancer, such as if you have an enlarged prostate or a prostate infection.

But if you've been treated, especially if your prostate has been surgically removed, PSA levels should become undetectable. The presence of any PSA after surgery is a concern. Any rise in PSA after radiation or hormone treatment suggests the possibility of the cancer spreading. In that case, the doctor will order the same tests used to diagnose the original cancer, including a CT scan, MRI, or bone scan.

Though very rare, it's possible to have metastatic prostate cancer without an elevated PSA. And it's possible to have an elevated PSA without cancer. The average length of time from original diagnosis to the discovery of metastatic cancer is eight years. If you have had prostate cancer, work with your doctor to determine your risk and determine a schedule for routine PSA checks.

Source: webmd.com

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"What fits your busy schedule better, exercising one hour a day or being dead 24 hours a day?"

Urinary Incontinence: A Common Side Effect of Prostate Cancer Treatment

One of the side effects of prostate cancer treatment that concerns men the most is urinary incontinence. As treatments for prostate cancer improve, urinary incontinence will become less common. For now, however, men should be aware that there are effective ways to alleviate urinary incontinence.

Surgery or radiation therapy may irritate the urethra or bladder or damage the urinary sphincter (muscles that contract to prevent urine from flowing out of the bladder). As a result, some degree of urinary incontinence (inability to control bladder function) is common immediately after prostate cancer treatment.

For example, urge incontinence (the strong and sudden need to urinate, followed by a bladder contraction and involuntary loss of urine) is common for a few days after catheter removal in men who have undergone transurethral prostatectomy (TURP) for the treatment of benign prostatic hyperplasia (BPH). In the initial period after radical prostatectomy for prostate cancer, men typically experience stress incontinence, in which urine leakage occurs during moments of physical strain (such as sneezing, coughing or lifting heavy objects).

Recovering bladder control can be a slow process and may take up to six months. Fortunately, severe urinary incontinence occurs in fewer than 1 percent of men after surgery for BPH and in fewer than 3 percent of men following radical prostatectomy or radiation therapy for prostate cancer.

What to do about urinary incontinence

Several approaches can be taken to reduce urinary incontinence. In addition to lifestyle measures – such as losing weight, limiting alcohol and limiting caffeine – men with incontinence can consider:

=> Kegel exercises
=> collagen injections
=> implantation of an artificial
=> sphincter
=> absorbent products
=> penile clamps
=> external collection devices,
=> catheters
=> Medications

Source: John Hopkins Health Alerts.

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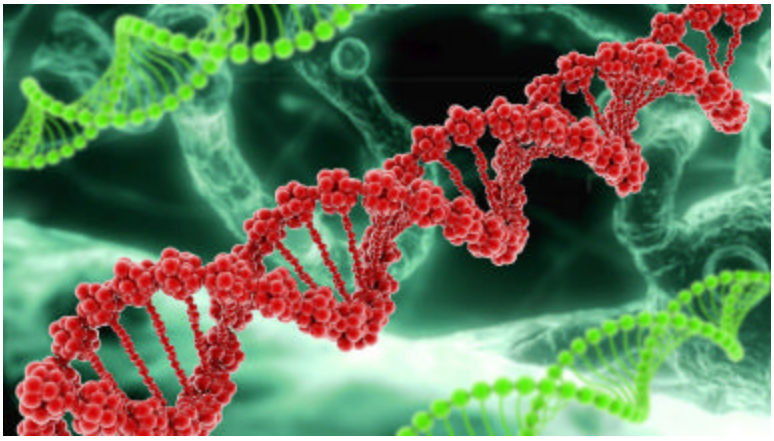
Scientists Unravel Genetic Causes Of Prostate Cancer.

A national screening program for prostate cancer could be introduced by the NHS following an international effort by more than 1,000 scientists to unravel the genetic causes of prostate cancer.

The study, the largest to look for the faulty DNA that drives the cancer, revealed scores of genetic markers that can identify people most likely to develop the disease.

Doctors said a simple saliva test based on the markers could give patients a personalized "risk profile" for the disease and pave the way for individually tailored screening, with those most at risk having more regular health checks.



The findings have major implications for the treatment of prostate cancer. A test based on markers for the disease could identify men whose lifetime risk was 50%, nearly five times the national average.

Genetic markers are like spelling mistakes in a person's DNA that raise the risk of disease. To find markers for prostate cancer, scientists compared the genetic makeup of 25,000 prostate cancer patients with a similar number of healthy men. They found 23 new faults in DNA that increase the risk of developing prostate cancer. Importantly, 16 of these drive the most aggressive and life-threatening forms of the disease.

While most men carry a small number of the genetic markers for prostate cancer, the 1% with the most genetic faults face nearly a five-fold increased risk of the disease.

The Guardian, UK. 2013

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Cancer: Sadness and Depression

Many people feel sad after a cancer diagnosis or while being treated for cancer. It's normal to feel sad when dealing with a stressful or upsetting situation. You may grieve the loss of good health or your ability to enjoy life as you used to. Many people with cancer even have passing thoughts of suicide, although they never act on them.

Sometimes people with cancer or their caregivers find that their mood never lifts or that it gets worse over time. Depression is much more than simple unhappiness. Clinical depression, sometimes called major depression, is much more than feeling unhappy or blue. It is not a sign of personal failure or not being able to cope.

About 1 in 4 people with cancer will be clinically depressed at some point during their cancer journey. These factors can add to the risk of depression:

- side effects of some chemotherapy drugs, biological therapies and hormonal therapies
- side effects of pain-relieving drugs like opioids
- having advanced cancer
- nutrition problems
- pain
- blood or hormone problems
- lack of family support
- previous history of depression or suicide attempts
- history of alcohol or drug abuse
- having other illnesses at the same time

If depression does occur, it can usually be treated successfully. The first step is recognizing it and getting the right help as soon as possible. The main symptom of depression is a sad, despairing mood that:

- lasts most of the day every day
- lasts for more than 2 weeks
- affects performance at work or at school or affects social relationships

Other symptoms of depression can include:

- feeling useless, hopeless, helpless or negative
- loss of interest or pleasure in work, hobbies, activities and relationships that you usually enjoy
- less energy or extreme tiredness (fatigue)
- trouble concentrating, remembering or making decisions
- feeling nervous, restless or irritable
- change in appetite and weight
- change in sleep habits such as trouble sleeping (insomnia), early-morning waking or oversleeping
- frequent thoughts of suicide (which should always be taken seriously)

These tips may help you feel less sad or depressed:

- Talk to family members or friends about these feelings. It may also help to talk to someone who has had a similar cancer experience. It may be hard to tell your family and friends how you really feel because you want to protect them. Finding the courage to talk to just one person can be the first step to feeling better.
- Seek out positive people and events to keep your spirits up. Many people find contact with pets soothing.
- Eat well and be as physically active as possible. Exercise releases endorphins, which are natural mood-boosters.
- Try to relieve tension with yoga or meditation.
- Look to your spiritual faith for comfort. Talk to a spiritual leader or clergy member for help in hard times.
- Talk to your healthcare team or your family doctor. They can refer you to a mental health expert who specializes in treating depression.
- Ask your doctor, psychiatrist or psychologist about medicine to treat depression. Do not take any over-the-counter or natural health products for sadness or depression without talking to the healthcare team. People with symptoms of depression should not try to treat themselves with natural health or herbal products. Some of these products may not be suitable for major depression or may interfere with cancer treatments.

Source: Canadian Cancer Society

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The Protective Role Of Vitamin D Against The Changes In Bone Mineral Density In Men Starting Androgen Deprivation Therapy.

Published on 08 October 2013

BERKELEY, CA (UroToday.com) - In an article recently published in the journal *Osteoporosis International* (April 2013), we explored the effects of starting continuous androgen deprivation therapy (ADT) on the changes in bone mineral density (BMD) in men with non-metastatic prostate cancer. The effects of supplementation with calcium and vitamin D on bone loss in these men were also evaluated.

Prostate cancer is the most common visceral cancer and second leading cause of cancer death among men.

Approximately one in every two men with prostate cancer will receive ADT at some point after diagnosis, and the majority will take it for a minimum of 2-3 years. Although it has been shown that ADT can suppress tumour growth, delay progression of metastases, and prolong survival, the concurrent and marked reduction in androgen levels within the body are associated with numerous adverse effects including sexual dysfunction, metabolic side effects, and skeletal complications.

In the context of bone health, androgens such as testosterone and estrogen are vital for maintaining bone mass, extending the activity of bone-building cells (osteoblasts), and promoting the death of those involved in bone resorption (osteoclasts). Based on physiologic grounds, ADT should result in a reduction in BMD, a hypothesis corroborated by the results of our investigation.

Using a matched cohort study design, we measured BMD via dual x-ray absorptiometry (DXA) scans at baseline, and yearly over three years, comparing two groups of patients with prostate cancer, half of whom received ADT. Measurements were performed at the lumbar spine, total hip, and femoral neck. We showed that the loss in BMD was greatest in the first year following ADT initiation and at the lumbar spine. In addition, while calcium supplement use was not shown to significantly affect BMD, the use of vitamin D was associated with an increase in BMD at the lumbar spine in year one and at the hip in year 2.

In isolation, it can be argued that BMD levels and their associated decreases mean little to patients. However, the increased risk of low-trauma fractures, chiefly those at the hip and spine, are of great concern to patients and clinicians due to their excess morbidity and mortality. Given that low BMD levels have a high predictive value for subsequent fracture, clinicians prescribing or monitoring ADT should take heed of this increased risk and take steps to mitigate it.

A simple step available to clinicians is the measurement of baseline BMD (via DXA) before initiating ADT. Unfortunately, we and others have shown that clinicians do not commonly order BMD tests (or prescribe bisphosphonates for that matter) before starting ADT. A baseline BMD test enables clinicians to stratify the risk of future fracture as well as monitor BMD levels over time, allowing them to not only identify patients at high risk of future fracture, but also measure the effectiveness of prescribed treatments.

Historically, vitamin D and calcium have been prescribed to increase bone strength and reduce fracture risk, although their use in men on ADT has been variable. As shown in our study, significant increases in BMD were seen with vitamin D use, and therefore clinicians should implement this safe and simple intervention more widely. In addition, despite the lack of significant findings in regards to calcium use in our study, the effectiveness of calcium supplementation in slowing bone loss has been demonstrated in other patient populations and is recommended in major guidelines for men on ADT. At the same time, given the association of excess calcium with kidney stones and a possible link to cardiovascular disease, it is important to aim for no more than 1 000-1 200 mg of elemental calcium per day from all sources (i.e., both diet and supplements). To get a simple estimate of daily calcium intake, clinicians can recommend websites such as Osteoporosis Canada that feature dietary calcium calculators.

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Prostate Cancer: What You Should Know About Screening and Diagnosis

Cancer of the prostate gland is the most common cancer affecting men. Most of the time when prostate cancer is diagnosed, the tumor is still confined to the gland. Prostate cancer screening is important in the early detection of prostate cancer. This is because many men diagnosed with prostate cancer do not have symptoms. And the earlier cancer is found, the more treatable it is.

What screening tests are available?

The following tests are used to check for prostate cancer:

Prostate exam For this test, also called a digital rectal exam, the doctor inserts a lubricated, gloved finger into the rectum and feels the surface of the prostate for any lumps, swelling or other abnormalities.

PSA blood test PSA refers to "prostate-specific antigen,"a protein produced by the prostate gland. Older men generally have higher levels of PSA than younger men, as prostate gland size and PSA levels increase with age. Your doctor can tell you if your test results are normal for your age. High blood levels of PSA may indicate the presence of prostate cancer. Generally, levels under four nanograms per millimeter (4 ng/mL) of blood (a very tiny amount) are considered normal.

What are the screening recommendations for prostate cancer?

All men should talk with their doctor about the pros and cons of being screened for prostate cancer. *The following guidelines may help you in talking with your doctor about prostate cancer screening:*

Men at average risk of prostate cancer Start talking with your doctor about prostate screening at age 50.

Men who are at higher risk of prostate cancer Starting at age 45, talk with your doctor about what screening schedule is right for you.

Men at highest risk (for example, those who have had several relatives diagnosed with prostate cancer at an early age) Ask your doctor about screening starting at age 40.

What are the risk factors for prostate cancer?

All men are at risk of developing prostate cancer based on their having a prostate gland. The following are some of the other known risk factors. Talk to your doctor about your risk.

Age Prostate cancer is more common in men over 50. Most cases of prostate cancer (about 80%) are diagnosed in men age 65 or older.

Race African-American men are at a higher risk of developing prostate cancer. The reasons for this are not fully understood.

Family history Having a father, grandfather, uncle or brother with prostate cancer increases your risk. Having several close relatives diagnosed with prostate cancer at an early age puts you at a higher risk.

Diet A diet high in animal fat and red meat may increase the risk for prostate cancer.

Source: www.cancercare.org

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Free Book

Promoting Wellness (4th edition)
for Prostate Cancer Patients

by Mark A. Moyad, MD, MPH

This is a 216 page book divided into 4 parts:

1) promoting overall wellness,
2) from diagnosis to grading and staging,
3) treatment options, and
4) preventing and treating side effects.

I have 10 books to give away – 5 to rural Manitoba and 5 to Winnipeg. I will accept emails dated on, or after, November 15th (Everyone should have received their newsletter copies by this date).The first 10 people to send an email to me with your name, address, and telephone number will receive the book. Please put "To the Editor" in the subject line of your email and send it to: manpros@mts.net

This book is given courtesy of **Abbvie pharmaceuticals** and **The Manitoba Prostate Cancer Support Group.**

June Sprott - Newsletter Editor

P.S. *Watch for other "free books" in upcoming newsletters!*

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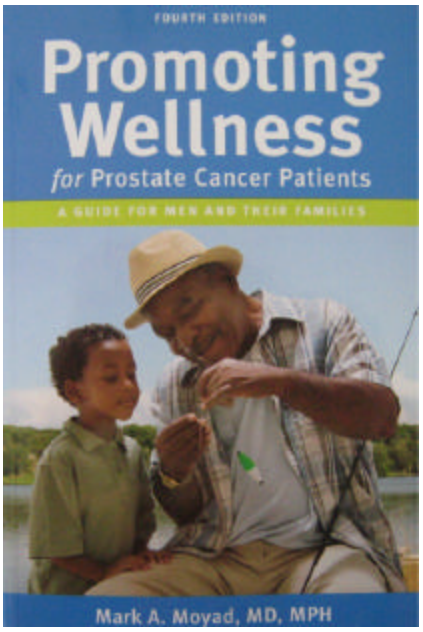

Current Issues In Hormone Therapy

There are many issues around hormone therapy that not all doctors agree on, such as the best time to start and stop it and the best way to give it. Studies are now looking at these issues. A few of them are discussed here.

Treating early stage cancer: Some doctors have used hormone therapy instead of watchful waiting or active surveillance in men with early (stage I or II) prostate cancer who do not want surgery or radiation. Studies have not found that these men live any longer than those who do not receive any treatment at first, but instead wait until the cancer progresses or symptoms develop. Because of this, hormone treatment is not usually advised for early stage prostate cancer.

Early versus delayed treatment: For men who need (or will eventually need) hormone therapy, such as men whose PSA level is rising after surgery or radiation or men with advanced prostate cancer who do not yet have symptoms, it is not always clear when it is best to start hormone treatment. Some doctors think that hormone therapy works better if it is started as soon as possible, even if a man feels well and is not having any symptoms. Some studies have shown that hormone treatment may slow down the disease and perhaps even lengthen survival.

But not all doctors agree with this approach. Some are waiting for more evidence of benefit. They feel that because of the likely side effects of hormone therapy and the chance that the cancer could become resistant to therapy sooner, treatment should not be started until a man has symptoms from the cancer. Studies looking at this issue are now under way.

Intermittent versus continuous hormone therapy: Nearly all prostate cancers treated with hormone therapy become resistant to this treatment over a period of months or years. Some doctors believe that constant androgen suppression may not be needed, so they advise intermittent (on-again, off-again) treatment.

In one form of intermittent therapy, hormone treatment is stopped once the PSA drops to a very low level. If the PSA level begins to rise, the drugs are started again. Another form of intermittent therapy uses hormone therapy for fixed periods of time – for example, 6 months on followed by 6 months off.

Clinical trials of intermittent hormonal therapy are still in progress. It is too early to say whether this new approach is better or worse than continuous hormonal therapy. However, one advantage of intermittent treatment is that for a while some men can avoid the side effects of hormonal therapy such as decreased energy, impotence, hot flashes, and loss of sex drive.

Combined androgen blockade (CAB): Some doctors treat patients with both androgen deprivation (orchiectomy or an LHRH agonist or antagonist) plus an anti-androgen. Some studies have suggested this may be more helpful than androgen deprivation alone, but others have not. Most doctors are not convinced there's enough evidence that this combined therapy is better than one drug alone when treating metastatic prostate cancer.

Triple androgen blockade (TAB): Some doctors have suggested taking combined therapy one step further, by adding a drug called a 5-alpha reductase inhibitor – either finasteride (Proscar) or dutasteride (Avodart) – to the combined androgen blockade. There is very little evidence to support the use of this "triple androgen blockade" at this time.

"Castrate resistant" vs. "hormone refractory" prostate cancer: These terms are sometimes used to describe prostate cancers that are no longer responding to hormones, although there is a slight difference between the two.

"Castrate resistant" means the cancer is still growing despite the fact that hormone therapy (either an orchiectomy or an LHRH agonist or antagonist) is keeping the testosterone in the body at very low, "castrate" levels. Some men may be uncomfortable with this term, but it is specifically meant to refer to these cancers, some of which may still be helped by other forms of hormone therapy (and are therefore not completely "hormone refractory").

"Hormone refractory" refers to prostate cancer that is no longer helped by any type of hormone therapy, including the newer medicines.

Source: American Cancer Society, 2012

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Return undeliverable Canadian addresses to
Manitoba Prostate Cancer Support Group
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: _____
Address: _____ Postal code: _____
This gift is in memory/honour of_____ Please send notification to:
Name: _____
Address: _____ Postal code: _____
$25 $50 $75 $100 $250 other_____ Make payment to:
Manitoba Prostate Cancer Support Group 315 – 971 Corydon Ave. Winnipeg, MB R3M 3S7
*A tax deductible receipt will be issued. Charity number: 88907 1882 RR001

Board members Pat Feschuk, Len Bueckert and Jim Leddy attended the Winnipeg Re-Fit Center Health Fair on October 11, 2013. Pat and Len are shown discussing prostate cancer with two of the attendees. The photo is courtesy of Jim.

Email - manpros@mts.net ALL MEMBER INFORMATION IS KEPT CONFIDENTIAL
Answering Machine - (204) 989-3433 ***Help us lower our costs :***
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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
Bernie Brandt and John Shinnimin
"Just when you thought you'd heard it all .....
along comes 2 more exceptional stories".
(Note: Dr. Quon, Radiation Oncologist, had to make an unexpected change and will now speak at our February meeting).

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

January 16, 2014
Jodi Hyman RN, BScN,CON(C)
"Wake up: Cancer Related Fatigue"

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

MPCSG BOARD

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