Manitoba Prostate Cancer SUPPORT GROUP

Newsletter

Vol. 322 1,300 copies printed/e-mailed **August 2018**

ITS COMING!

Our annual September Awareness Evening

A time and place to learn more about progress in the battle against this disease
and to have your questions and concerns dealt with by a leading prostate cancer specialist.

Wednesday, September 19, 2018 7:00 to 9:00 pm

Caboto Centre, 1055 Wilkes Avenue, Winnipeg

Free admission Door prizes Everyone Welcome

Medical Advisors

Paul Daeninck M.D.
Medical Oncologist

Darrel Drachenberg
M.D. Urologist

Arbind Dubey M.D.
Radiation Oncologist

Thanks!

Next Meeting:

Wednesday, August 15, 2018

Speaker: Dr. Piotr Czaykowski

Title: "Prostate cancer, you and CancerCare Manitoba"

Location: The First Unitarian Universalist Church of Winnipeg, 603 Wellington Crescent

Time: 7 – 9 pm.
(First hour for general discussion; second hour for expert guest speaker)

Free Admission Everyone Welcome
Plenty of free parking

SHARING IS CARING

The Manitoba Prostate Cancer Support Group offers support to prostate cancer patients but does not recommend any particular treatment modalities, medications or physicians ; such decisions should be made in consultation with your doctor.

MPCSG – active since 1992.

Thought of The Day

To be sure of hitting the target, shoot first and call whatever you hit the target.

Use Of Conservative Management For Low-Risk Prostate Cancer 'Increasing Rapidly'

Conservative management or deferred treatment is the preferred approach for men with low-risk prostate cancer, according to results of a large VA cohort study.

Stacy Loeb, MD, assistant professor of urology and population health at NYU Langone Health and the Manhattan VA, and colleagues assessed utilization of conservative management in a cohort of 125,083 veterans newly diagnosed with prostate cancer between 2005 and 2015. In 2005, 27% of men aged 65 years or younger chose to postpone immediate therapy and 4% elected to be managed with active surveillance. In 2015, 75% chose to forego immediate treatment and 39% chose active surveillance.

These trends persisted among men aged older than 65 years.

HemOnc Today spoke with Loeb about the distinctions between watchful waiting and active surveillance, the challenges of convincing both physicians and patients that conservative management is the preferred strategy for men with low-risk disease, and what future research should entail.

Question: C an you provide some context for the study?

Answer: There has been a lot of controversy over the years with regard to prostate cancer screening and treatment. One aspect of that is that patients with low-risk disease often have a good prognosis even without treatment. They do well even when they are just monitored over time. Guidelines recommend active surveillance as the preferred management strategy in this patient population, but it has been underutilized in many settings in the United States.

Q : Why is this approach underutilized?

A: There are many factors, both at the patient and the physician level. Patients are scared by the so-called "C" word, and they tend to think that treating upfront leads to a better outcome. We also see reluctance on the part of patients' family members. They want the patient to get treated rather than just being observed. On the physician level, the emphasis during training of physicians — particularly among surgeons and radiation oncologists — is to do something. There is much less emphasis on nonoperative or noninterventional management options. There also is incentive for some physicians for payment for different treatment options. Overall, it's likely a combination of these factors and not one single cause. Some patients also are not interested in the active surveillance option for legitimate reasons. For example, men who have complications from prostate biopsy may be less interested in active surveillance. Active surveillance still involves serial monitoring procedures that have potential complications. Biopsy doesn't have the level of risk of prostate cancer treatment in terms of expected side effects. Nevertheless, it's still an invasive procedure that may involve pain or lead to complications like infection or bleeding.

Q : How can members of the clinical community begin to overcome the barriers to uptake of watchful waiting or active surveillance ?

A : That is a very important question. The terms watchful waiting and active surveillance often are used interchangeably but they are actually very different. Watchful waiting is a conservative management approach without curative intent. Active surveillance entails continuing to do ongoing checks with the goal of starting curative treatment at the first sign of progression. Active surveillance is a continuum between less intense to more intense surveillance. It's not black and white. One thing that may increase uptake is tailoring the surveillance regimen to the patient. An older patient with a very low-risk tumor warrants less intensive surveillance than a younger patient with a higher-volume tumor. As use of these approaches continues to increase, there will be less reluctance among patients and their families because it will be clear that this is the prevailing approach. All of this will generate more data, which will lead more physicians to adopt the approach, and all of these factors will feed together. Everyone on both sides of the equation will be more comfortable with it and strategies will evolve.

Q : Is it more important to spread this information to physicians or patients?

A: Both. We already are seeing results, as use of conservative management options has been increasing rapidly over time.

Q : Shifting gears, could you elaborate on the results of your study?

A: Our goal was to study conservative management — including watchful waiting and active surveillance — in a VA population from 2005 through 2015. The study included almost 125,000 veterans with low-grade prostate cancer. By 2015, 72% of veterans aged younger than 65 years were choosing conservative management, and 79% of those aged 65 years and older also chose conservative management. Thus, it had grown to the point that this was the primary management option.

Q : Is the uptake in a VA population greater than the uptake in non-VA populations?

A: Our paper only looked at VA data, so we didn't study that as an outcome. However, we have seen previous publications with SEER, MUSIC, and CaPSURE data that show lower use of conservative management strategies than what we observed in the VA.

Use of conservative management for low-risk prostate cancer 'increasing rapidly'

Q : Can you speculate why that might be the case?

A : It may have to do with the structure

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of the VA system. The VA is an integrated community, where all patients are on the same electronic record system. VA providers have regular email discussions about the best approaches and a listserv discussion of best practices. This is a very intertwined network of physicians. VA providers also do not have a financial incentive to do more treatment. It also may have to do with the veterans themselves, who may be more readily accepting of conservative management approaches.

Q : H ow do you build on this information?

A : We need to think about making surveillance protocols better to optimize these approaches. One way to think about this is individualizing intensity of follow-up for patients. We know that avoiding upfront treatment and the associated side effects can benefit many patients, but we don't know the optimal level of monitoring and how that can differ between patients. When you look at low-risk patient groups, even within that group, there is heterogeneity. Two patients with a PSA less than 10, a Gleason score of six and a tumor with a low clinical stage can still be very different with regard to extent of cancer. One of those patients can be on the low end of the spectrum and the other can be on the high end. We need to figure out how to tailor our protocols more effectively.

Q : This seems to dovetail into the era of individualized, personalized medicine.

A: The era of personalized medicine has arrived. The future of active surveillance, as in all of medicine, is tailoring things to individual patients. I do suspect that this paradigm will continue to evolve over the next decade.

Q : What is the next step in research?

A: We have designed a mathematical model showing the impacts of active surveillance, and we are working on more studies with the model. It is a Markov model that estimates likely results using a variety of testing protocols over the course of a man's lifetime if he has low-risk prostate cancer. The next step is to look at the model and observe how new testing options may influence the new paradigm. – by Rob Volansky

Loeb S, et al. JAMA. 2018; doi:10.1001/jama.2018.5616.

Disclosure: Loeb reports consultant fees or travel reimbursements from Astellas, Boehringer Ingelheim, Eli Lilly, General Electric, GenomeDx, MDxHealth, Minomic, Sanofi, and several other health care and pharmaceutical companies involved in cancer care or diagnostics.

Stacey Loeb July 16, 2018

https://www.healio.com/hematology-oncology/prostate-cancer/news/online/%7Bc9066626-d158-43bc-b9ec-36a44a7edb1e%7D/use-of-conservative-management-for-low-risk-prostate-cancer-increasing-rapidly

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Hardcopy or email? It matters.

It matters to you to receive it in the manner that is most convenient to you. Also how you prefer to read it.....in hardcopy form, or on your computer screen?

To us it matters because we want the newsletter to reach the maximum number of prostate cancer patients who want to receive it. This involves having both hardcopy (mailed to you via snail mail) and electronic forms (delivered via the internet) available. Hardcopy is the traditional form, and reaches all those members who do not have access to the internet or who prefer the traditional format for whatever reason. For those who do have internet access the electronic form can be delivered via email message to you or it can be directly accessed by going to our website (manpros. org) and clicking on the "newsletter" tab. We're happy to provide both forms, but we encourage the transition to the electronic form wherever possible because it is a more efficient and cost effective way to deliver this information to you. In the long run that provides better service and lowers our operating expenses.

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Thank you, we appreciate your feedback.

~ The Board.

To our readers … **your views are important to us.**

"Please tell us via email (manpros@mts.net) or regular mail (Manitoba Prostate Cancer Support Group, Box 315-971 Corydon Ave., Winnipeg, MB R3M 3S7) your thoughts about the newsletter. We value your views on content, format, readability, length, and any other aspect on which you may want to comment. *Thanks in advance.*

Analysis of Prostate Tumors Reveals Clues to Cancer's Aggressiveness

Sequencing reveals genetic errors common in metastatic tumors

Using genetic sequencing, scientists have revealed the complete DNA makeup of more than 100 aggressive prostate tumors, pinpointing important genetic errors these deadly tumors have in common. The study lays the foundation for finding new ways to treat prostate cancer, particularly for the most aggressive forms of the disease.

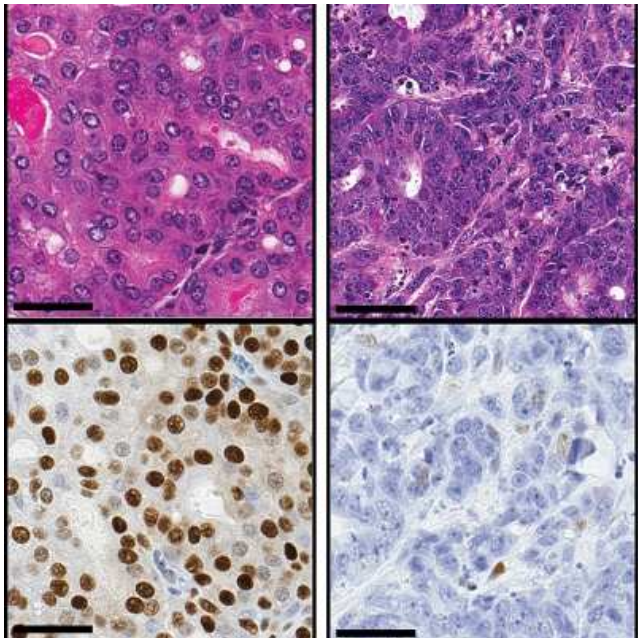
The multicenter study, which examined the genomes of tumors that grew and spread quickly, was led by Washington University School of Medicine in St. Louis and the University of California, San Francisco. The research appears July 19 in the journal Cell.

"This study could aid the search for better therapies to treat aggressive prostate cancer," said co-first author Christopher A. Maher, PhD, an associate professor of medicine and an assistant director at The McDonnell Genome Institute at Washington University School of Medicine. "More immediately, the new information could help doctors find ways to identify which patients may develop aggressive tumors, and help guide their treatment decisions."

More than 160,000 cases of prostate cancer are diagnosed each year in the U.S. While some 80 percent of prostate cancer patients have tumors that are slow-growing and have effective treatment options, about 20 percent of such patients develop the most aggressive forms of the disease — the focus of the new study.

Most genetic studies of prostate cancer have focused on parts of the genome that control what proteins a tumor manufactures. Proteins act like the machinery of cells. When they function properly, proteins perform cellular tasks required for good health. But when proteins don't work properly, disease, including cancer, can result.

Still, genes that make proteins represent only 1 to 2 percent of the entire genome. The new analysis is the first large-scale study of the whole genomes — all of the DNA, including all of each tumor's genes — of metastatic prostate tumors, and reveals that many of these tumors have problems in the sections of the genome that tell protein-coding genes what to do.



"Protein-coding genes are important, but when you focus only on them you can miss mutations in regions of the genome that regulate those genes," Maher said.

The researchers were surprised to find that about 80 percent of the aggressive tumors studied had the same genetic alterations in a region of the genome that controls the androgen receptor, Maher said. This genetic error dialed up levels of androgen receptor on prostate cancer cells. Such receptors bind to male hormones such as testosterone and drive tumor growth.

"This was one of the most surprising findings," said Maher, also a research member of Siteman Cancer Center at Barnes-Jewish Hospital and Washington University School of Medicine. "We saw too many repeated copies of DNA in this region of the genome. In some of these patients, the androgen receptor looks totally normal. But they have too much androgen receptor because the receptor's regulatory region is dialed up, which would be missed by the protein-coding focused sequencing studies."

A common treatment for prostate cancer, beyond the traditional options of surgery, chemotherapy and radiation, involves androgen deprivation therapy, in which drugs are used to block testosterone from binding to the androgen receptor. Since prostate tumors are often hormone-driven cancers, blocking testosterone from binding this receptor slows tumor growth.

All the men in this study had tumors that developed resistance to androgen deprivation therapy, meaning the androgen receptor is always switched on, fueling the tumor, whether testosterone is present or not. Patients in this situation have no effective treatment options. The researchers showed that more than 80 percent of these patients had mutations that help explain the aggressiveness of their cancers; these genetic errors activated the androgen receptor.

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The researchers, including co-first author Ha X. Dang, PhD, a senior scientist at Washington University, also found important roles for other genes known to be involved in cancer, including those that help with DNA repair, such as TP53 and BRCA2.

This research was supported by a Stand Up To Cancer-Prostate Cancer Foundation Prostate Cancer Dream Team Award, grant number SU2C-AACR-DT0812 from the American Association for Cancer Research, the scientific partner of SU2C. This work also was supported by the Goldberg-Benioff Research Fund for Prostate Cancer Translational Biology; the Stand Up To Cancer-Prostate Cancer Foundation Prostate Cancer Dream Award, grant number SU2C-AACR-DT0712; several Prostate Cancer Foundation Challenge Grants; a V Foundation Scholar Grant; a BRCA Foundation Young Investigator Award; the Department of Defense (DOD), grant numbers W81XWH- 16-1-0747, W81XWH-15-1-0562, PC160429 and W81XWH-17-1-0192; an Early Detection Research Network Grant, grant number U01 CA214170; Prostate SPORE Grants P50 CA186786 and P50 CA097186; a National Cancer Institute (NCI) T32 training grant CA108462; and several Prostate Cancer Foundation Young Investigator Awards.

Quigley DA, et al. Genomic hallmarks and structural variation in metastatic prostate cancer. Cell. July 19, 2018

Newswise
Washington University in St. Louis

https://www.newswise.com/articles/analysis-of-prostate-tumors-reveals-clues-to-cancer%E2%80%99s-aggressiveness

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Surgical Skills Rather Than Tools Are The Key For Prostate Cancer Surgery

Men undergoing either robot-assisted or open surgery for prostate cancer experienced equally good outcomes, a study involving University of Queensland researchers has found.

The 24-month study was the first to compare the long-term functional outcomes of the procedure in a randomised controlled analysis.

UQ Centre for Clinical Research urologist Emeritus Professor Robert ('Frank') Gardiner said the study examined the urinary and sexual function and oncological outcomes of around 300 men.

"Twenty-four months post-surgery is still early days in terms of cancer control, but in terms of outcomes for urinary and sexual function, it is a widely accepted timeframe for recovery," Dr Gardiner said.

"Our study showed excellent results for both groups of patients, with no differences in terms of urinary or sexual function.

"On the basis of this research, we cannot support patients changing doctors to pursue one surgical option over the other.

"Patients should go to a surgeon who is good at what they are doing rather than choosing a surgeon based on the surgical option they are offering."

Robot-assisted surgery for prostate cancer has been rapidly adopted by health professionals and is now the most widely utilised surgical approach for prostatectomy.

Cancer Council Queensland CEO Chris McMillan said prostate cancer was the most common cancer diagnosed in men in Australia, excluding non-melanoma skin cancer.

"Around 18,300 men are diagnosed with prostate cancer every year in Australia, and about 3,200 die from the disease," Ms McMillan said.

"If men have questions about their individual risk of prostate cancer, we recommend they speak with their GP to discuss risk factors and pros and cons of prostate cancer testing."

The Cancer Council Queensland-funded study was undertaken by the Department of Urology at Royal Brisbane and Women's Hospital, UQCCR and Menzies Health Institute Queensland with support from the Urological Society of Australia and New Zealand.

The finding is published in The Lancet Oncology.

https://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(18)30357-7/fulltext

https://knowridge.com/2018/07/surgical-skills-rather-than-tools-are-the-key-for-prostate-cancer-surgery/

July 18, 2018

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Considering Prostate Cancer Treatment Options

For most men diagnosed with prostate cancer, the cancer is found while it's still at an early stage - it's small and has not spread beyond the prostate gland. These men often have several treatment options to consider.

Not every man with prostate cancer needs to be treated right away. If you have early-stage prostate cancer, there are many factors such as your age and general health, and the likelihood that the cancer will cause problems for you to consider before deciding what to do. You should also think about the possible side effects of treatment and how likely they are to bother you. Some men, for example, may want to avoid possible side effects such as incontinence or erection problems for as long as possible. Other men are less concerned about side effects and more concerned about removing or destroying the cancer.

If you're older or have other serious health problems and your cancer is slow growing (low-grade), you might find it helpful to think of prostate cancer as a chronic disease that will probably not lead to your death but may cause symptoms you want to avoid. You may be more inclined to consider watchful waiting or active surveillance, and less inclined to consider treatments that are likely to cause major side effects, such as radiation and surgery. Of course, age itself is not necessarily the best basis on which to make your choice. Many men are in good mental and physical shape at age 70, while some younger men may not be as healthy.

If you are younger and otherwise healthy, you might be more willing to accept possible side effects of treatment if they offer you the best chance for cure. Most doctors believe that surgery, external radiation, and brachytherapy all have about the same cure rates for the earliest stage prostate cancers. However, there are pros and cons to each type of treatment that should be considered, and the benefits should be weighed against possible risks and side effects.

Choosing among treatment options is complicated even further by the development of newer types of surgery (such as robotic-assisted prostatectomy) and radiation therapy (such as proton beam radiation) in recent years. Many of these seem very promising, but there is very little long-term data on them, which means comparing their effectiveness and possible side effects is difficult, if not impossible.

Getting help with treatment decisions Making such a complex decision is often hard to do by yourself. You might find it helps to talk with your family and friends before making a decision. You might also find it helpful to speak with other men who have faced or are currently facing the same issues. It's important to know that each man's experience with prostate cancer is different. Just because someone you know had a good (or bad) experience with a certain type of treatment doesn't mean the same will be true for you.

You might also want to consider getting more than one medical opinion, perhaps even from different types of doctors. For early-stage cancers, it is natural for surgical specialists, such as urologists, to favor surgery and for radiation oncologists to lean more toward radiation therapy. Doctors specializing in newer types of treatment may be more likely to recommend their therapies. Talking to each of them might give you a better perspective on your options. Your primary care doctor may also be helpful in sorting out which treatment might be right for you.

Some things to consider when choosing among treatments

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Before deciding on treatment, here are some questions you may want to ask yourself:

- Are you the type of person who needs to do something about your cancer, even if it might result in serious side effects? Or would you be comfortable with watchful waiting/active surveillance, even if it means you might have more anxiety (and need more frequent follow-up) in the future?
- Do you need to know right away whether your doctor thinks he or she was able to get all of the cancer out (a reason some men choose surgery)? Or are you comfortable with not knowing the results of treatment for a while (as is the case in radiation therapy) if it means not having to have surgery?
- Do you prefer to go with the newest technology (such as robotic surgery or proton beam radiation therapy), which might have some theoretical advantages? Or do you prefer to go with treatment methods that are better proven and with which doctors might have more experience?
- Which potential treatment side effects (incontinence, impotence, bowel problems) might be most distressing to you? (Some treatments are more likely to cause certain side effects than others.)
- How important for you are issues like the amount of time spent in treatment or recovery?

If your initial treatment is not successful, what would your options be at that point?
Many men find it very stressful to have to choose between treatment options, and are very fearful they will choose the "wrong" one. In many cases, there is no single best option, so it's important to take your time and decide which option is right for you.

https://www.cancer.org/cancer/prostate-cancer/treating/considering-options.html

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"You Can Help Spread The Word About Prostate Cancer"

Prostate cancer is one of the most common cancers in men. Discovered early, it can be successfully treated in the majority of cases. Such early discovery is dependent on men being aware of the facts about this disease and getting checked.
Early discovery saves lives.

To help raise awareness and encourage "getting checked" the Manitoba Prostate Cancer Support Group is happy to provide speakers to make presentations to interested groups in the community. There is no charge for this service and the size of the group doesn't matter. If you are involved with a group that would like to learn more about prostate cancer, and perhaps save some lives in the process, please contact Pat Feschuk (tel: 204-654-3898; email: lizpat@shaw.ca).

Remember that if a man has prostate cancer the sooner he learns about it the better. Not knowing about it simply allows it to grow and spread.
So do something about it
….. help spread the word.

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FUTURE MEETINGS 2018

19 Sept. This is our highlight event of the year!
This year we will focus on the changes which have transformed prostate cancer treatment through the years and what the future may bring. Dr. Darrel Drachenberg will deliver the keynote address on this theme and will answer questions from the audience.
Mark your calendar and be there!
(Note that the September meeting location is at the Caboto Centre, 1055 Wilkes Ave, Wpg)

17 Oct. **Speaker:** Dr. Anne Katz
Title: "Sex, life and prostate cancer"

All meetings (except September) will be held at :
The First Unitarian Universalist Church of Winnipeg,
603 Wellington Crescent

All meetings are 7 – 9 pm.
(First hour for general discussion;
second hour for expert guest speaker)

Everyone Welcome Plenty of free parking

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