

Montreal West Island

Prostate Cancer Support Group



**EVERYONE IS INVITED
TO ATTEND OUR
PUBLIC MEETINGS**
We meet every fourth
Thursday of each month except
July, August and December

NEXT MEETINGS

January 24 @ 7:30 PM

Dr. Yosh Taguchi
Senior Urologist

Royal Victoria Hospital

**What is Controversial in the
Management of Prostate Cancer**

February 28 @ 7:30 PM

Marie-Josée Lord
Physiotherapist

**Dealing With Urinary Incontinence.
How You Can Help Yourself**

March 27 @ 7:30 PM

Dr. Peter Chan
Urologist, MUHC

**Reclaiming Your Sex Life After
Prostate Cancer Treatment**

COME EARLY AT 7:00 PM TO CHAT

MEETING LOCATION
Sarto Desnoyers Community Centre
1335 Lakeshore Drive, DORVAL

Contributors

Marcel D'Aoust, Director 1996-2007

Marcel D'Aoust has taken the advice of his doctor and has ceased all of his volunteer activities including his role as a Director on the Steering Committee of our Support Group. The one exception will be his involvement as a volunteer with the Ste-Anne's Hospital and its Liaison Centre.

Marcel is a veteran of World War II having served with distinction overseas as a Major with the Fusiliers Mont-Royal regiment. He continued his association with the military through the Canadian Legion and the Ste-Anne's Hospital. One of his most rewarding activities was with the Lakeshore General Hospital where he was a director on the founding committee and later as a governor of the Foundation. Another was his involvement in the VON, (Victorian Order of Nurses), presently known as NOVA, where he served as a director for many years.

Marcel joined our group in 1996 after undergoing surgery for prostate cancer. He became a director shortly after that and served in that position until his recent resignation.

Governor General's Award

Marcel D'Aoust was presented with The Governor General's Caring Canadian Award in a ceremony at La Citadelle in Quebec City on March 2, 2005. The presentation was made by Governor General Adrienne Clarkson and the citation read in part: "...a World War II veteran (who) has

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*Marcel D'Aoust with Silvana Orrino, Executive Director,
Lakeshore General Hospital Foundation*

Marcel D'Aoust (continued from page 1)

worked at the Sainte-Anne-de Bellevue Hospital for some 15 years...". The citation also mentioned his other volunteer work including the Cancer Society and various support groups. We knew, of course, about his work with our Group and of his work with the VON and the LGH. News of the award was carried in two local newspapers - nice write-ups, one with a photograph of Marcel and the G-G

Marcel's Story

Our November 2005 issue of the newsletter contained Marcel's story in his own words, part of which is now superseded, as follows:

"Let me tell you about some of my volunteer work.

In 1940 I founded the Richelieu Club of Ste-Anne's, which still exists today; it is like the 'Kiwanis Club'.

I was asked to join a group of Lakeshore citizens to discuss, to plan, to achieve something - and to build a hospital for the West Island of Montreal population. I was proud to be the only French Director of the group for over 20 years and to serve under a prominent Chairman in the person of Clarence Campbell, ex-President of the National Hockey League.

During those same years, I was invited to join the board of the Lakeshore Association for the Retarded Children. At the time, these kids were not accepted in our schools. I was promoted to the Quebec Association, and to the Canadian Association - with meetings in Vancouver and Halifax.

Ten years ago, after surgery for prostate cancer, I was named a Director Founder of Montreal West Island Support Group for Prostate Cancer 'to help', 'to advise', and 'to assure' those who have this disease.

Since five years, I am a Director of the 'West Island Victorian Order of Nurses', known as the V.O.N. We have a restaurant called AU PETIT CAFE that serves only lunch, at noon. We also have two stores

that sell clothing, furniture, objects and books that are given to the V.O.N. We have 12 nurses that are helping old, sick people from Lachine to Vaudreuil.

When I returned from the last war, I was asked to join the Liaison Centre and the Ste-Anne's Hospital as a volunteer to help those who need some help in many ways. I am still doing it."

"Helping others is helping yourself" Marcel D'Aoust

Lakeshore General Hospital's Plaudit

The same newsletter issue referred to a full-page article in the West Island section of the October 20 Montreal Gazette telling of the conception and realization of the Lakeshore General Hospital and Marcel's role in this remarkable endeavour. The article includes a photograph showing Marcel standing before a plaque honouring the founding directors. Marcel, formally known as Jean-Marcel D'Aoust according to the inscription, was among a group of ten couples at a party in 1958 where it was decided that the West Island needed a hospital. From there it took five years of petitioning politicians and business people, raising money and finding the site before work began in 1963. The hospital opened in 1965 and the 40th Anniversary Celebration recognized the contributions of the wonderful people who started it all.

Gracious Greeter

The Support Group and the Steering Committee are going to really miss our great friend, colleague and collaborator. Marcel was the super-volunteer. He never said 'no', and very often took the lead in any project. Tall, ram-rod straight with a military bearing, and a grand smile with warm welcoming words and gestures, he was the perfect Greeter. His over-the-top Thank-you's to the guest speakers became part of his legend. He was and will remain a very important part of our existence.

By Tom Grant, George Larder and Joe Soul

MORE LIBRARY NEWS

The guest speaker for the January meeting is Dr. Yosh Taguchi, recognized by many as the dean of Montreal urologists. Dr. Taguchi is the author of several books on prostate cancer. In the Support Group library, there are three of his books: PRIVATE PARTS, A Doctor's Guide to the Male Anatomy; THE PROSTATE, Everything You Need to Know; and ZEN IN ACTION (new). The books will be on

display on the library desk before and after the meeting. These books are also available in local libraries, bookstores, and from Amazon.com

Also new to the library this month: FOODS THAT FIGHT CANCER and COOKING with FOODS that FIGHT CANCER. Both books are by Doctors Richard Beliveau and Denis Gingras and have been listed on best-selling lists in the Gazette.

By Tom Grant



From the desk
of Bill Corless

Lecture Notes

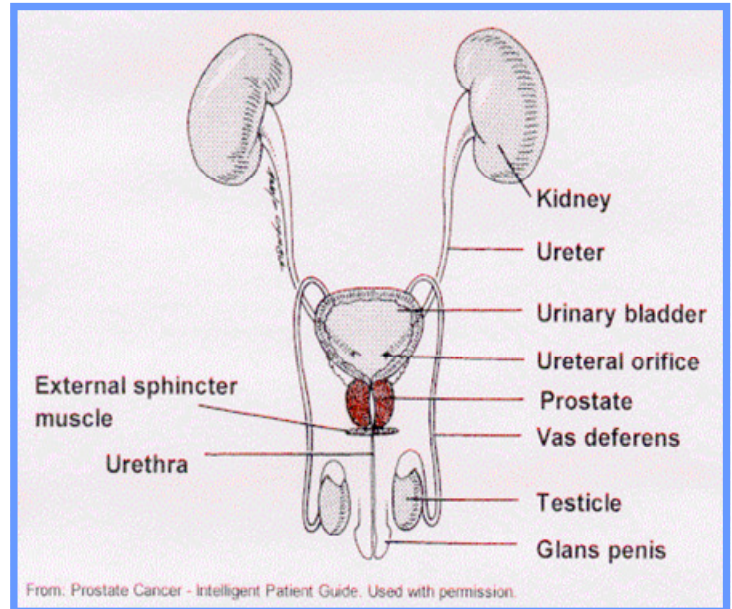
Dr. Wes Kassouf - Update on Diagnosis and Management of Prostate Cancer November 22, 2007

Dr. Wassim Kassouf, MD, CM, FRCSC, is an Assistant Professor in Urology at McGill University, and is an Attending Surgeon, Department of Surgery at the MUHC – Montreal General Hospital. He completed med school in Montreal with his graduation from McGill in 1998. He completed his residency training in Urology at McGill in 2003. He was able to participate first in the Physician Scientist Training Program, and then in the Fellowship in urologic oncology, at the UT M.D. Anderson Cancer Center in Houston. Dr Kassouf has been selected for many honours and awards including a very special prize, the Trainee Excellence Award from the M.D. Anderson Cancer Center. Many activities and contributions are listed under his name but one achievement stands out: the Founder, Canadian Bladder Cancer Research Network. In addition to these works, a great many published refereed articles, published abstracts, and published book chapters.

Dr Kassouf introduced his objective for the evening as covering the A to Z of prostate health, management, treatment, and more. He noted that 'Prostate Cancer (PC) is one of the only human malignancies that is curable but which commonly does not need to be cured.' He defined the pros-



Dr. Wes Kassouf - Nov 22 2007 with Ron Sawatzky, President Montreal West Island Prostate Cancer Support Group



tate gland as an essential part of the male reproductive system. It produces and stores a component of semen and is located near the bladder and the rectum. The prostate surrounds part of the urethra, the tube that empties urine from the bladder, and is about the size of a walnut, 3cm wide, and 3-4 cm long.

BPH

He noted that as a man gets older, the prostate gland becomes larger, even if cancer is not present. This condition is known as BPH – Benign Prostatic Hypertrophy. One symptom is frequent urination, especially at night. A second symptom is the opposite - an inability to urinate. Some patients have trouble starting or holding back urination; the problem could be a weak or interrupted flow of urine. They may also suffer from painful or burning urination and/or blood in the urine or semen. In the limit the prostate becomes large enough to stop the flow of urine, and then a catheter may be installed to bypass the gland.

With age, BPH affects almost 50% of men. To underline this point Dr Kassouf noted that BPH is right up there in life's guarantees along with death and taxes. However all men with BPH do not require treatment. This depends on the severity of symptoms or bother. In his practice, he normally treats only 4 indications: an inability to void – Urinary Retention, or a recurrent urinary tract infection (UTI), or renal failure, or bladder stones which may result from urine staying in the bladder. Medical treatments are of two types, those which relax the prostate, alpha blockers like Flomax or Cardura, or those which shrink it such as Proscar and Avodart. Prostate shrinkage is achieved by stopping the formation of the chemical which converts the regular hormone, testosterone, to a much stronger version which acts as a growth hor-

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Dr. Wes Kassouf - Update on Diagnosis and Management of Prostate Cancer (continued from page 3)

There has been research to indicate that these medications may be capable of actually preventing prostate cancer (PC). This was discussed later in the lecture.

For a BTH problem, if medical treatments do not work, surgical processes such as TURP (transurethral resection of the prostate), laser, or microwave, can be used to open up the channel.

An international problem

Dr Kassouf spent some time on the statistics of PC. World wide, PC is highest in North America and Australia. It is lowest in South East Asia, especially in Japan. Diet appears to be the key to this distribution. The percentage of PC patients among Japanese immigrants to North America approaches the North American statistics within a relatively short time. It is very common especially in American and Canadian men where 1 man out of 6 will get PC; in 1994, this ratio was 1 man out of 8. Except for skin cancer, cancer of the prostate is the most common malignancy and the second leading cause of cancer death, in American/Canadian men. In Canada, on a weekly basis, an average of almost 400 will be diagnosed with PC and 81 will die of it.

PC has been called a disease of the elderly. This is based on data showing that only 0.1% are less than 50 years old. The mean age of the patients is 72 – 74, 85% are diagnosed after reaching 65 years old.

In most cases, when PC is detected early, there are no symptoms. Eventually, when there are symptoms, they are

the same as listed above for BPH. The only other means of detecting PC are the Digital Rectal Exam (DRE), Prostate Specific Antigen (PSA), a Transrectal Ultrasound (TRUS) and/or a Surgical Biopsy. Usually, these indicators are combined to confirm the conclusion.

Decreased Mortality

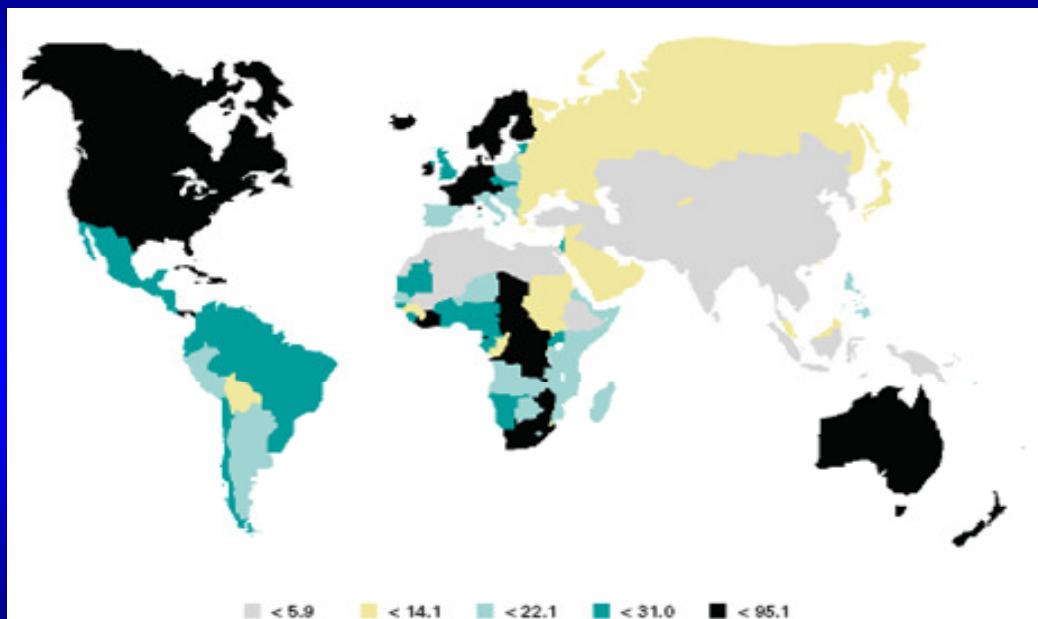
Dr Kassouf noted a 22-40% reduction in PC mortality in 1995-2000. It was suggested that the main reasons for a decreasing mortality rate was the use of PSA both in the monitoring and management of the changes in PSA when the PC is in a recurring phase and also in the initial detection of the PC. Other factors are better treatments and earlier detection of the advanced disease.

The Screening Debate

Dr Kassouf spent some time to explain the highly charged debate that accompanies any discussion regarding PC screening and especially the use of PSA. PSA is a protein manufactured in large quantities in the prostate and virtually no other organ. It is the enzyme responsible for liquification of semen a few minutes after it has clotted. However, PSA is not cancer specific, it is elevated in BPH, UTI, prostatitis. It is good, but not excellent, in the detection of cancer. However it does extremely well in detecting a change in recurring cancer cells. It is excellent for staging cancer, identifying cancer and monitoring cancer treatment. On the other hand, there are problems with the screening: the PSA weakness in detecting genuine PC, the morbidity of the TRUS biopsy, the cost efficacy, the inability to distinguish clinically aggressive

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Worldwide Map of the Incidence of PC



Dr. Wes Kassouf - Update on Diagnosis and Management of Prostate Cancer (continued from page 4)

and clinically indolent disease and finally, the morbidity of the treatment.

Recommendations for Screening

Dr Kassouf recommended men initiate their screening at age 50. This is for the average man, some men are at increased risk: black-skinned, family history of PC, high fat diet.

Screening for these men should be started at age 40.

To stratify patients that have been diagnosed with prostate cancer, their life expectancy should be reviewed with their overall health, and competing illnesses. The patient should take PSA and DRE tests and his biopsy results should be analyzed and reviewed with his Gleason score. If appropriate, the number of biopsies should be recorded and the length and percentage data for any tumor also should be part of the file. If the patient has a life expectancy of less than 10 years, the screening may not be judged as worthwhile.

With this data, patient stratification can be set up:

<u>Low Risk</u>	<u>Intermediate Risk</u>	<u>High Risk</u>
Low PSA		High PSA
Negative DRE		Advanced DRE
'Favourable cancer'		Aggressive cancer

How to choose the treatment(s)

Basic treatment options:

Dr Kassouf stressed that an open doctor-patient relationship is critical to any successful treatment. Once the patient has provided the information required by the doctors, the treatment options will be discussed. This starts with the most common technologies: Surgery (Radical Retropubic Prostatectomy, Laparoscopic Prostatectomy, Robotic Prostatectomy) and Radiotherapy (External Beam, Brachytherapy, Combination).

Side Effects of Treatment

<u>Treatment</u>	<u>Side Effect</u>	<u>Frequency</u>
Radical prostatectomy	• Erectile dysfunction • Urinary incontinence	20-70% 5-35 %
External beam radiation therapy	• Erectile dysfunction • Urinary incontinence	20-45% 2-16%
Androgen deprivation therapy	• Sexual dysfunction • Hot flashes	20-70% 50-60%
Watchful waiting	• Erectile dysfunction	30%

Other treatment options:

Cryotherapy - the use of liquid nitrogen probes to freeze a particular organ to extremely low temperatures to kill the tissue, including any cancerous tissue. This treatment is still quite new.

High Intensity Focused Ultrasound - (HIFU): a procedure which utilizes transrectal ultrasound that is highly focused into a small area, creating intense heat which is lethal to prostate cancer tissue. Now in an experimental phase.

Hormonal Therapy - (HT): the use of hormones, to treat disease. Since prostate cancer is usually dependent on male hormones (ex: testosterone) to grow, hormone blockade or deprivation (also called androgen deprivation therapy) can be an effective means of alleviating symptoms and retarding the development of the disease

Chemotherapy - the use of pharmaceuticals or other chemicals to kill cancer cells; in many cases chemotherapeutic agents kill not only cancer cells but also other cells in the body, which makes such agents potentially very dangerous

Biological therapy, (sometimes called immunotherapy, biotherapy), is a relatively new addition to the family of cancer treatments. Biological therapies use the body's immune system, either directly or indirectly, to fight cancer or to lessen the side effects that may be caused by some cancer treatments

Dr Kassouf described a treatment called Active Surveillance which has been found to appeal to elderly PC patients and others. These would include low risk cases where the cancer is not aggressive. There would be frequent monitoring of these treatments which involve PSA, DRE, and biopsy testing on a regular and pre-scheduled basis. Records of past testing would be examined to look for progression with go, no go, limits. More sensitive "trigger" points could be based on PSA D/T (PSA Doubling Time) or PSA F/T (PSA Free/Total). If the data from these tests showed any indication of cancer growth, appropriate treatment would be

HOW IS PROSTATE CANCER FOUND?

- Digital Rectal Exam (DRE)
- Prostate Specific Antigen (PSA)
- Transrectal Ultrasound
- Surgical Biopsy



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Dr. Wes Kassouf - Update on Diagnosis and Management of Prostate Cancer (continued from page 5)

started. Active Surveillance is a feasible option for properly selected individuals.

Perhaps the next treatment will be for the prevention of Prostate Cancer - Is it possible?

Three important trials are being discussed

The Prostate Cancer Prevention Trial (PCPT) started in October 1993 and was stopped in 2003, a year early, because the objective had been proven. Almost 19,000 men, age 55 and over, took part. Men were randomly assigned to take either 5 milligrams of finasteride (ProscarTM) or a placebo once daily for 7 years. By June, 2003, 25 percent fewer men taking this drug developed prostate cancer than men not taking the drug. However, men who developed prostate cancer while taking finasteride were more likely to have high-grade cancers, which can spread quickly even if the tumors are small. New explanations for these higher grade tumors are emerging and need to be resolved. More data on finasteride side effects will be available soon. NSAIDS medication appear to reduce risk of PC

Very large Randomized and Controlled Prostate Cancer Screening Trials in Europe and the USA are taking place now and the results will be available in 2006-2008

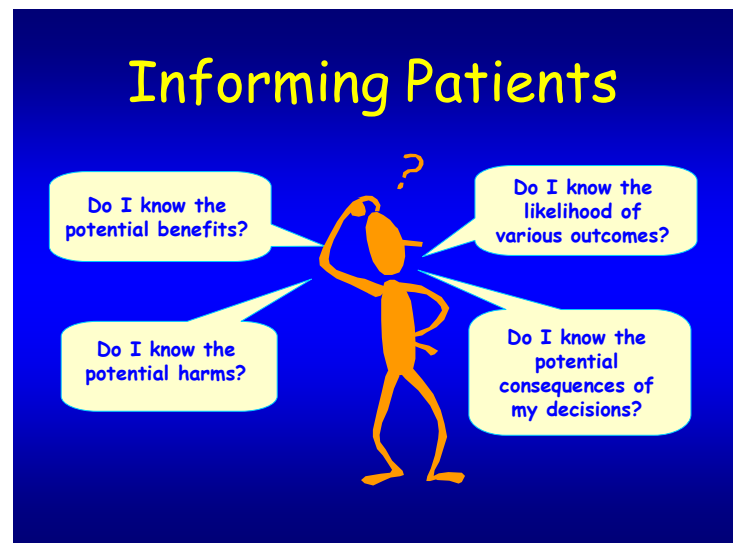
SELECT is now underway and is the first study to focus on whether or not selenium and/or vitamin E can help pre-

vent prostate cancer. SELECT is different than many trials because it seeks to prevent prostate cancer instead of treating prostate cancer that already exists. Trial planners hope to have 32,000 participants within 5 years in the United States, Puerto Rico, and Canada Patients will be followed for 7 – 12 years.

Dr Kassouf completed his lecture with his comments on the cancer prevention trials.

His ability to bring together all the details of the various processes and activities supported his interest in answering all of the questions that were put to him by the audience. We learned a lot. Thank you Dr Kassouf.

Report by Bill Corless



Telephone Helpline (514) 694-6412

IMPORTANT NOTICES:

- ❖ The Montreal West Island Prostate Cancer Support Group Inc encourages wives, loved ones and friends to attend all meetings. Please ask basic or personal questions without fear or embarrassment. You need not give your name or other personal information.
- ❖ The Montreal West Island Prostate Cancer Support Group Inc does not recommend treatment procedures, medications or physicians. All information is, however, freely shared. Any errors and omissions in this newsletter are the responsibility of the authors.
- ❖ The Montreal West Island Prostate Cancer Support Group Inc. is a recognized charitable Organization. All donations are acknowledged with receipts suitable for income tax deductions. Your donations as well as our annual membership fees (also voluntary) are the sole source of our funds, which are vital to our operation. These funds pay the cost of printing and mailing our newsletter, hall rental, speaker costs, research, library, stationery, etc.

Mailing Address:

Your support is needed now!

**Montreal West Island Prostate Cancer Support Group Inc.
P.O. Box 722, Pointe-Claire, QC
Canada H9R 4S8**

Steering Committee:

- | | |
|---|--------------|
| Joe Applebaum , Past President | 514-694-5667 |
| joerita@sympatico.ca | |
| Fred Crombie , Treasurer | 514-694-8149 |
| fred.crombie@videotron.ca | |
| Charles Curtis , Outreach | 514-697-4517 |
| Tom Grant , Hospitality & Writer | 514-631-9293 |
| tomgrant@total.net | |
| Edward Komulainen , Greeter | 514-453-4409 |
| George Larder , Secretary | 514-630-9632 |
| gflarder@sympatico.ca | |
| Allen Lehrer , Vice President | 514-626-1100 |
| allen.lehrer@videotron.ca | |
| Allan Moore , Library | 514-630-1865 |
| nmoore@total.net | |
| Les Poloncsak , Library & Hall Setup | 514-695-0411 |
| imppol@videotron.ca | |
| Ron Sawatzky , President | 514-626-1730 |
| ronsaw@hotmail.com | |

Senior Advisors:

- Lorna Curtis, Marcel D'Aoust, Ron McCune, Ludwick Papaurelis, Doug Potvin, Ron Schurman, Joe Soul

VOLUNTEERS URGENTLY NEEDED!