

# CANADIAN PROSTATE CANCER SUPPORT GROUP

Newmarket, Ontario

Volume 14, Issue 2, October 15th, 2009

**A support group that provides understanding,  
hope and information to prostate cancer patients and their families**

Our Speaker for the October 15 meeting is Dr. D. Moseley, Assistant Professor in the Department of Radiation Oncology at PMH. His diversified educational background demonstrates to us how the medical profession is reaching out into other fields such as Applied Mathematics and Computer Science to improve their treatment techniques on prostate cancer. Dr. Moseley also brings to Princess Margaret and Southlake an Adjunct Professorship in the McMaster School of Computational Science and Engineering and the Faculty of Science at University of Western Ontario. His current research interests focus on the development of novel image processing techniques as well as the use of image-guidance with cone-beam CT for radiation therapy delivery at our hospitals. While he will be talking about the development of these techniques, I am sure he will also be bringing us up to date on the opening of Southlake's new Cancer Centre and the new technology in radiation therapy that will land on the ground there.

**Meeting Date**      **October 15th, 2009**

**Place**                      **Newmarket Seniors Meeting Place,  
474 Davis Drive, Newmarket**

**Time:**                      **7:00 pm to 9:00 pm**

**Speaker**                  **Dr. Doug Moseley, Southlake Health Centre**

**Subject:**                  **“New Technology in Radiation Therapy Treatment”**

**Canadian Prostate Cancer Support Group,  
Newmarket, Ontario. 905-830-0447  
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**a member of the**



Assisted by the Canadian Cancer Society  
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*The Newmarket Prostate Cancer Support Group does not recommend products, treatment modalities, medications, or physicians. All information is, however, freely shared.*

## September Notes . . . Dr. Thomas Morton, Urologist, Lakeridge Health Oshawa

### Subject: "Latest advances in Radical Prostatectomy Surgery"

*Dr. Thomas Morton is acting Chief of Surgery and Chief of Urology at Lakeridge Health Oshawa. a hospital he compared to our own Southlake in size and services. His talk focussed on the multiple variety of surgical treatments now available and the benefits they offered. He also talked about new studies that indicated more of us should adopt a watchful waiting approach to dealing with our cancers. Here is what he had to say.*

What I have learned in speaking to support groups, the greatest value and asset that you folks get out of it, is the interactive component. I can show you graphs and films of this and pictures of that and most of you are educated enough that you would be able to pick up on a lot of it and follow what we're talking about and get the gist of what I'm trying to get across to you. My feeling has always been that, when we meet like this, anything that I can give you that helps you on a personal basis with questions, without the use of any sort of video or other diagrams or pictures, is actually better than anything else.

I do have a couple of topics that I want to talk about that I think are important to people for two reasons: one is for people who have prostate cancer and want to go over a little bit about surgical options that have become available over the last little while and where some of the minimally surgical techniques are heading in this country, because I think that's important; the second thing which I think is probably even more exciting is some information and data that's come out about prostate cancer prevention and its impacts on men and where we see treatments for prostate cancer heading.

In terms of a little bit of background of our place. Lakeridge is probably a very similar hospital to Southlake. Southlake is a little bit bigger in the sense that they have cardiac surgery. We're a little bit bigger in the sense that we do a bit more oncology and cancer surgery. Both areas are probably two of the largest growing areas in the GTA. In Durham, we have now a very large cancer centre that has been built and established and we have a very strong medical oncology program, we have radiation bunkers, we do seed implantation. We now have a big GU oncology program. The same thing is starting to happen at Southlake. We have six and a half urologists in Lakeridge and we have a program in which we are providing dedicated across the board continuum of care concepts for prostate cancer care. We go from diagnosis and PSA screening to detection and diagnosis, to treatment options, to ultimately treatment for systemic disease and we have dedicated urologic oncologists and dedicated radiation oncologists and then surgeons, of which there are three of us who do the major bulk of the prostate cancer surgery.

One of the things that's come up out of this is surgery has become more confusing for people than it ever used to be. The reason is, you used to sort of say, "Yes, I have prostate cancer localized, what are my options?" Well you can have surgery in your lower abdomen, prostate comes out and off you go. You can have radiation, you can have seed implants. That was enough for people, right? That puts a bur-

den on you to decide what to do. Hopefully you'd have a relationship with your urologist and/or radiation oncologist. We provide you with information which will guide you in the right direction. Now if you decide to go to surgery, it's no longer just about an open prostatectomy. You could have a laparoscopic prostatectomy. You could actually have a robotic prostatectomy. Suddenly you're left with, "Well I know I want to have surgery but, what's this all about? What are laparoscopic prostatectomies all about, what are robotic surgeries about. Should I have what's new and newfangled, should I have what's tried and true over generations?" The reality is that there have now been 17 studies, as far as I know, looking at quality of life and surgical outcomes for prostate cancer surgery, comparing robotics and laparoscopies and open prostatectomies and the long and the short of it is, other than marginal variables, there is no difference in terms of long term outcome. I think the important thing for you to understand is, that whatever option you choose, your cancer survival chances are pretty much equivalent. Your chances of continence and maintenance of continence afterwards are almost identical. Your chances of potency after the surgery are almost identical with all three options. Recovery period is very similar, with a little less pain for the less invasive surgeries. A couple of little things that might be better for robotics are things like the catheter stays in for likely one week less, the amount of blood loss may be a little less but that doesn't extrapolate to transfusion rates. What it comes down to is it becomes a personal decision. Some people like newfangled things. People hear the word laser and they think they have to have laser, right. So, when it comes to robotics, everybody thinks well, it's new, it's got to be better. Right now, to date it has not been proven to be better. That doesn't mean that it won't prove to be better down the road. There are a couple of things that worry people about robotics and that is that there has been some evidence that the treatment, such as post operative radiotherapy rates in the United States is actually a little bit higher than it is for open prostatectomies, which would suggest, perhaps, the margin rates or the local recurrences are worse.

First laparoscopic prostatectomies came out. I do a ton of minimally invasive surgery for removing kidneys and reconstructing kidney problems and things like that however, when I start telling people that there's no improvement in their quality of life and they're not going to do better but I have to learn how to do this technique and you're going to be the person I'm going to be learning on, it's a difficult conversation to have with people. It's also a different thing for surgeons to take that step and do.

Then, robotics provides three degrees of motion, as opposed to two, which means, if you were to compare robotics to laparoscopic prostatectomy, I think most people would say robotics is a little bit better but the cost is enormous. Robotics is coming to Canada. It's clearly not worse than an open prostatectomy. Is it actually better? Well I think it remains to be seen. I think every technique that's available has to start somewhere and it improves over time. If it gets to a point where suddenly people are doing better with their continence and doing better with their erections and the learning isn't so steep because these techniques are very difficult to adopt. That's why there are only a very few people doing them because you have to have a lot of experience to be very good at them. That's true for all techniques and all surgeries. We are learning to figure out how it is going to fit into the Canadian system, because you can't have everybody doing them, it's too expensive. What's likely to happen is that robots are going to be available in teaching centres and major cancer centres and that may mean Southlake is included in that. It certainly means that we're a centre where robotics may come on line and be used and it's not for everybody. It's another way of doing the same operation and, I think at the end of the day, it's something that people need to look at discriminatively and decide whether they really want something that's new, not necessarily better, and only at certain centres. You're going to be caught with the "Yes, I can do your robotic prostatectomy but it's going to be five months down the road or you can have it at PMH or Dr. Lacornic can do it at Southlake and the waiting time is six weeks and it's open surgery". You have to decide and it's another burden that we're putting on patients. I think that, at the end of the day, I want you to understand that it is coming, that it is here, that it's evolving and I think it becomes a very personal decision but don't get caught up in "new is necessarily better." Just because you can do something doesn't mean you should do something. Don't feel that because you're having an open prostatectomy you're having a substandard operation because that is clearly not true.

**Q.** How do we judge the skill levels of a surgeon?

**A.** It's a difficult question to answer. I think what I would say about skill level is, there have been a number of studies that have shown that the experience of your surgeon absolutely plays a role in your long term outcome. If you see somebody who does two radical prostatectomies a year, you may wish to reconsider whether that's the right person to do your operation. It doesn't mean their not a quality individual, it doesn't mean they're not a quality surgeon. The reality is, experience is something that you cannot teach. You have to have volume to get good at something. You have to consider every potential permutation and computation when you get operated on. The number that people have looked at is somewhere between 20 and 25 radical prostatectomies a year. If somebody in Canada is doing that amount of prostate cancer surgery a year, at that point it becomes less of issue in terms of your blood loss and your margin rates and some of the

things that are in important to you in terms of long term outcomes. I would say that the experience is important, for robotics, for open prostates. Is it harder to do a robotic prostate surgery rather than an open one? I can't answer that. I think it depends what you're starting with. I've done easily 1,000 radical prostatectomies openly between my training and my career. I've been in practice for ten years, so what I would say is that operation has been around for so long, and I've done so many of them that I kind of know what I'm doing but I still can get fooled by people's anatomy, it still can be difficult as hell, there's no way around that. I also do a lot of laparoscopic surgeries but I don't know if I started doing robotics how hard I would find it. I think it depends.

I might say, "Wow, this is a lot easier, I can't believe I wouldn't switch over". Or it may be a very steep learning curve. It depends on what skill set you're arriving with. I think in terms of a person approaching surgery it's important for you to ask your surgeon, how many prostates do you do a year. Is the place that you do them comfortable looking after patients? As much as it's important that your surgeon is good, it's also important that the staff in the room have done that kind of operation before and the people in the recovery room know if something's not going right and the nurses on the floor are used to managing the issues that surround a major operation like this. Then you're getting the consummate full care from a place that is used to doing it. You also have to feel confident that you've made the right decision and that this surgeon and the staff are right for you as your personal feelings can impact the outcome.

**Q.** I had my surgery a few years ago and now I'm having leakage problems. When I go for my check up with my urologist, we just talk about my PSA. Is there anything I can take for this?

**A.** It's just a matter of figuring out what is causing this. I don't think I can figure it out in this room. You need to go back and talk to your urologist about your leakage problem and explain that it's now more of a problem that it ever used to be. You're not going back to get your prostate cancer checked, your actually going for a different reason. Set up an appointment with the receptionist saying that you're not going for your PSA test, it's been fine, you're good but you're peeing yourself all the time and it's driving you crazy and what can you do about it. You do have to stand up for yourself. It's not that people are ignoring you, it's just that they're busy and if you don't bring it up, sometimes we don't ask when we should.

I'm going to move on to the other topic that I think is exciting. What we have learned about prostate cancer, a lot of you already know. There's information that prostate cancer is a slow growing type of cancer. Not everybody needs to be treated. Well, who needs to be treated, who doesn't need to be treated, are we doing the right thing, have we been doing the right thing over the last 15 to 20 years in terms of treating prostate cancer? Most of the questions about treating prostate cancer come down to those people who have what we

call low risk prostate cancer. People who have Gleason score of six or less or their PSA was less than ten to begin with, or they didn't have a palpable lesion in their prostate to begin with that was big or abnormal. I think pretty much everybody has come to the conclusion and realized that not all of those people needed treatment. Some of them could have got away without treatment, with watchful waiting. People who have low risk disease have options in terms of their treatment. Certainly, in our society, people aren't comfortable with watchful waiting as they are in Europe, where it's a bit more laissez-faire. Active surveillance is something that's evolved in terms of following the PSA, getting periodic biopsies and keeping an eye on things for people who have small volume, low risk prostate cancer. Particularly in ages that are 65 and beyond. I think some people should be able to avoid treatment. We've taken it a step back. We're looking at how can we prevent cancer? Are there things that we know that we can do that are available to us that can decrease the risk of prostate cancer, because we believe it's environmental. There was some disappointing information that came out about vitamin E. There have been studies about dietary, nutritional things to decrease the risk of prostate cancer development. A very large study showed that there was no benefit in taking vitamin E, at least alone. We are taking all kinds of antioxidants, which are potentially beneficial but there hasn't been any scientific evidence that these are working. There's some good anecdotal science behind it but there isn't an Ah-ha factor. What we do know is that men who have big prostates can run into trouble. We have men who take alpha-blockers and things to improve their urinary symptoms. We are now recommending for men with bigger prostates medications to decrease its size. They're called Five-alpha reductase inhibitors and the two big ones are Proscar and Avodart. Studies have shown that, not only did these reduce the size of the prostate, they also reduced the risk of prostate cancer by 23%. What this is showing is that some of the cancers that were stressing people out, may not have required treatment. These guys would go on the medication, their PSA wouldn't go crazy, they wouldn't get the biopsy, they wouldn't find out they have low risk prostate cancer and then worry about the future, they wouldn't rewrite their will, have treatment for prostate cancer that may or may not have affected them. All of a sudden, all these men, who've been diagnosed with prostate cancer and the stress associated with it, weren't getting the diagnosis of prostate cancer.

Intermediate risk and high risk prostate cancers were still being diagnosed on a fairly equal level, so the Avodart was decreasing the risk of the types of cancers that we want to decrease the risk on, so that we lessen the impact of the diagnosis on people's lives. They're not getting diagnosed and they're not worrying about it. As you all know, half the battle of any diagnosis of cancer is the stress it puts on you and the worry it puts on you about the future. That's a wonderful thing.

The other issue that it may do is these medications may drop your PSA in half because they decrease the size of the

prostate. When you have a big prostate, your PSA's going to be up because the bigger the prostate, the higher the PSA. Not necessarily because of prostate cancer but just because of a big and enlarged prostate. By taking away the background noise of this big, benign prostate, by taking away that benign factor, it may make the PSA a more sensitive test. What that tells us is, Avodart is a great drug on many fronts and prostate cancer prevention is one of them. The problem is, we can't put everybody on it. It's like putting it in the water. What I call pharmacal prevention. To me that means we're taking a drug and trying to eliminate prostate cancer development. Well, that is a very, hard sell to our government and to patients, to say, take this pill and you may not get prostate cancer. Well you still might get it but you might get it in a lesser amount and there are side effects from these medications. They can affect your sex drive and libido in a very small percentage of men and on top of that they tend not to help people as much who have smaller prostates. It's not for everybody but maybe it's for men who have big prostates or strong family histories or who are of African-American descent who are at an increased risk for prostate cancer. There's a lot of information that still needs to be brought out of this but I think it gives a little bit of hope that says maybe we can figure out a way to lessen the impact of prostate cancer on people and decrease the development on people who are at greatest risk for it and maybe decrease the effect that the disease has on a lot of people. That's exciting. It's not there yet, we need to figure out who's going to benefit from it but I can tell you that I use it now in people who have had a couple of biopsies that are negative. We're not going to miss your cancer because people who have true cancers are going to be found but we're decreasing the anxiety and the process of going through the biopsies and the diagnosis and all those sorts of things. People who are at high risk for that with big prostates, those are the people who are going to benefit from these medications. I think it's moving forward. I think we're recognizing that it's important in this profession. If you don't look at yourself to see if you're doing the right thing or not, then you're not moving forward. I think our profession has realized that we're doing O.K., in fact we're doing well but we can do better and what are some of the things we're doing wrong and how can we make it better? We're a long way from being there but it's kind of exciting. I think it's also good because it shows people that we're paying attention to what we're doing and we're trying to get better. We were part of the study and my partner and I had about fifteen people involved. I think it's something to be excited and proud about. It doesn't affect you in the sense that you have a diagnosis of prostate cancer, you've got to figure out what to do but I think it bodes well for the future of how we manage the disease.

**November 19<sup>th</sup> Speaker**  
**Tanya Giaquinto, Sunnybrook**  
**Diet and Cancer; Continuing info on nutrition.**