

CANADIAN PROSTATE CANCER SUPPORT GROUP

Newmarket, Ontario

Volume 12, Issue 3, November 15th, 2007

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

We've invited Doctor Cynthia Maynard of Princess Margaret Hospital to speak to us at our November 15th meeting. The subject of her talk is on the very latest in radiotherapy, "See the target to treat the target". I'm sure you'll want to hear it. A point that I have been stressing in past newsletters is that you have to come out to the meetings to get your questions answered. Dr. Catton the speaker at our October meeting was an excellent example of what you miss when you don't make the meeting. Firstly, much of his talk was illustrated by graphics which we can't put into the newsletter. He then stayed on for almost 40 minutes of questions. They kept on firing questions from the floor until we finally had to call for a break. Dr. Catton then answered questions privately as members lined up to talk to him. He was just an example of what happens most nights with the calibre of speakers we have been lucky to get. Come out to our meetings I'm sure you'll be glad that you did.

Meeting Date: November 15th, 2007

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

Time: 7:00 to 9:00 pm

Speaker: Dr. Cynthia Maynard, Princess Margaret Hospital

**Subject: New Progress in Radiotherapy for Prostate Cancer
"See the target to treat the target"**

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



Canadian Prostate Cancer Network

Assisted by the Canadian Cancer Society
Holland River Unit
Cancer Information Service
1 - 888 - 939 - 3333

Your Executive

Ron Stevenson, <i>Chairman,</i>	905-836-1701
Dennis Allibon <i>V/C and Publicity,</i>	905-722-6392
Phil Harrison, <i>Secretary,</i>	905-895-1407
Derek Lawrence, <i>Treasurer, Exec. Consultant</i>	905-853-2665
Doug Bowers, <i>Speakers,</i>	905-841-2759
Bill Tuplin, <i>Speakers,</i>	705-458-4881
Frank Kennedy, <i>Newsletter,</i>	905-895-2263
Thomas McCammon, <i>Greeter,</i>	905-478-4012
Ulli Baumhard, <i>Member at large,</i>	905-478-8843
Dan Ho, <i>Member at large,</i>	

The Newmarket Prostate Cancer Support Group does not recommend products, treatment modalities, medications, or physicians. All information is, however, freely shared.

October notes: Dr. Charles Catton, Princess Margaret Hospital

Subject: Post Opr. Radio. Therapy for P.C.

Dr. Catton has worked at the Department of Radiation Oncology at Princess Margaret Hospital since 1989. He has a particular interest in the development of new radio-therapy techniques for prostate cancer and is currently leading one national trial investigating post-operative radio-therapy for prostate cancer and one international trial investigating a new radio-therapy technique for prostate cancer. Dr. Catton is an associate professor of radiation oncology at the University of Toronto, he's a GU site group leader in the Department of Radiation Oncology at Princess Margaret and is also the radiation oncology representative of the executive committee of the National Cancer Institute of Cancer, GU Clinical Trials Group: He spoke to us at our October 18th meeting, backed up with a powerpoint presentation. Here's an excerpt of what he had to say.

I've spoken at a number of support groups around Southern Ontario and I've always enjoyed it very much. I've always found it a very useful way to talk to people about prostate cancer, to educate you and to allow you to educate me from time to time about the disease and about how we treat it.

I'd like to talk about something a little bit different from what you've heard before. Generally, when people talk about prostate cancer, they're either talking about surgery, or radiation

therapy or about drug treatments or hormone therapy. I'd like to talk about using radiation treatment in conjunction with another treatment, in this case surgery. This notion of combining treatments is something that's gaining a lot of interest and is becoming much more popular than it used to be. I think there's good reason to pay attention to this. If you want to be cured of prostate cancer generally you either need surgery or you need radio therapy and the choices have usually been one or the other. We're starting to realize now that there may be advantages in combining these different treatments. Each treatment, radiation and surgery, has its advantages and disadvantages and while I'm a big

proponent of radiation, there is one very big practical advantage to surgery. That is, once the prostate's removed and you get a chance to examine it, you get to learn a lot more about that particular prostate cancer than you did before the surgery. There may be ways of using that information to improve the treatment. When the pathologist examines the prostate after removal, he gets a good idea of the extent and location of the cancer. Sometimes he can see that the cancer has spread into the soft tissue outside the prostate but he can also see that all the cancer appears to have been removed. That's when we get to talk about margins. Margins are something which pathologists evaluate and it's fairly important to us in determining how effective an operation has been. What they do is take the whole prostate gland and dip it in India ink,

they stain the whole outside of the gland black so that when they slice it up into little margins, you've got this black line showing where the outside of the prostate is. This allows us to see if the cancer is well within the prostate gland and not reaching the outside edge. The pathologist can then say that the margin is negative. If the cancer cell is touching the black line, the pathologist would say that it's a focally positive margin – it doesn't mean that the cancer has extended outside

the black line and is still in the patient but one would be worried because the tumour was so close to the margin. Then you get situations where the margin is nothing but tumour and I think you can say, with a very high level of certainty, that if the pathologist sees this, then there's almost certainly cancer still inside the patient. The other important piece of information that we have after an operation, that tells us what the situation is, is the post-operative PSA level. It's also important after radiation but after radiation the prostate gland is still in place, so the PSA will not be zero because some normal prostate will still be producing PSA. It should come down

but it hardly ever goes to zero. In fact it can bounce around a bit without necessarily indicating anything bad. After surgery, however, the prostate gland should be gone. If it's gone, the PSA should be zero. If it's not zero then it means that there's a problem of some kind. Sometimes when the surgeon attempts to spare the nerves, he leaves a small part of the prostate behind, which could cause a very low PSA without indicating cancer. But the PSA should not be rising. That's very unusual. There's very good evidence that a rising PSA after surgery indicates that there is a problem of some kind.

One of my jobs, and all doctors that treat cancer, is we're asked to predict the future, in fact that's how we design treatments. We look at an individual and we say that we believe



that their cancer is going to behave in a certain fashion, based upon this information and therefore we should do this thing or that thing or the other thing. So the better we can predict the future then the more sensible the treatment is going to be. After surgery, we therefore have new information from the pathologist and from the PSA levels about the success of the treatment and the likely state of the prostate cancer at that time.

So, how can we use this information? Well, the traditional approach has been to file it away for future reference. This is what they did at John Hopkins University in Baltimore, Md. This is a study that they did 15 years ago. They did radical prostatectomies on a number of men and picked out men whose PSAs remained elevated and were rising following the surgery. The majority of these men, about 75% of them, went on to develop metastatic disease. It sometimes took ten or fifteen years to do it but sooner or later it happened. So there is very strong evidence that a rising PSA following a radical will eventually lead to trouble. We have this information which suggests that there could be a problem. What do we do about it? One, we wait and see what happens, which was the traditional approach. Or, we could give more treatment and get rid of the remaining cancer cells which we believe are still present and therefore turn a situation where there's residual cancer into a cure. The most practical treatment we have for doing this post-operatively is radiation treatment. This will only work if the cancer cells are localized in the area where the prostate used to be. This will not work if the cancer is floating around somewhere in the body, then radiation is not going to get rid of it. When we do try to radiate the localized cells, we have the problem of avoiding the bladder and the rectum. Once the prostate is removed, the bladder moves into the space vacated by the prostate and the rectum moves forward. So, the problem in this situation, of course, is that we want to treat where the prostate used to be and even with all our sophisticated planning and treatment techniques, we can't avoid the fact that the bladder and the rectum have shoved right in where the prostate used to be. So, it is much harder to protect the bladder and the rectum once the prostate is removed than if the prostate is still in place. It doesn't mean we can't protect them and we can still produce a radiation field which shapes itself to this volume but there will inevitably be more bladder and more rectum in the volume than if the prostate gland was still in place. On the plus side, however, when you're dealing with very small amounts of cancer in the post-operative situation, you don't have to give so much radiation. So what you lose in precision you gain in the ability to reduce the total dose of radiation.

So this notion of giving radiation after surgery is not that new, people have been doing it for about 15 years but it hasn't really caught on at all. It wasn't until the last couple of years, when two studies which had actually been going on since the 1990s were finally completed and published. Both of these

identified men with positive margins who were either treated immediately after surgery or they waited for a problem and treated them when the problem developed. The PSA test was not as sophisticated as it is right now and it couldn't read less than 0.3 so, while all these men had an undetectable PSA, we know that a lot of them had a reading of 0.3, we just didn't know it at the time. There were two studies, both of them showed that men who had immediate radiation did better than men who we waited until there was clearly a problem before we gave the radiation. In the study that has been going on for ten years, there was a 77% improvement for men who had radiation immediately compared to 53% and for the trial which had been going on for a shorter time, the advantage was 50% compared to 20%. The two studies have suggested that giving radiation immediately following surgery, improved outcome for individuals where we are concerned there is still cancer present. So, does that mean that all men who have positive margins should receive post-operative radiation? The answer is, probably not. First of all the studies also showed that not every man who had a positive margin, in other words some of the men, in fact 30% of them, never went on to develop any cancer, despite the fact they never got any radiation. So at least some of the men who got the radiation, got it unnecessarily. Furthermore, not everyone who received radiation after the surgery was cured. So, it didn't work for everybody. There was another group of men where radiation alone was not enough and thirdly, radiation did cause chronic bowel and bladder irritation in up to 17% of those treated (this was '80s radiation). So there was a cost associated with it as well.

What's the next step? We need to build upon this particular study. We've identified that radiation can be very useful for some men following surgery but we'd like to refine our predictive abilities. We'd like to identify those who are most likely to benefit from additional local treatment; sort out the 70% that benefitted from the 30% that didn't; identify those that might need a second treatment beyond radiation – that is the ones who had radiation and it didn't work and we should add another treatment on top (maybe hormone treatment); thirdly, we need to look at ways to make the treatment safer if we're going to use it at all.

There is a brand new study about to open in Canada in January, called PR13, run through the National Institute of Canada and it is post-operative radiation and hormones for those at risk of failure after surgery and we hope that this study is going to answer two questions. For men who have positive margins after surgery, should the radiation be given right away? Or can we wait a little bit to see if it actually goes up at all. Then, as soon as we're sure it's going up, give the radiation then. That way, we'd at least be able to avoid the men who have positive margins who are never going to have a problem and, if we catch it right away, the minute we're sure there's a problem, maybe it will work just as well. Secondly, does the addition of a short course – six months of hormones

– or a longer course of two years of hormones to the radiation reduce the risk of treatment failure compared to radiation alone? For men who have positive margins but their PSA is undetectable, if they agree to participate in this study, they will be chosen randomly to get radiation immediately or to wait to see what happens to the PSA and if it starts going up, get the radiation then. If their PSA is clearly elevated or rising after surgery, then they have to have radiation because they've still got a problem but would hormones help as well? Those indi-

viduals who get the radiation would either receive a short course or long course of hormones, chosen randomly again. In conclusion, there is good evidence that post-operative radiation improves the outcome for some men with prostate cancer but we still need to determine which ones are the most likely to benefit. Would adding a second treatment of hormones help even more and what is the best way of giving radiation? This particular study, we hope, in ten years time, is going to give us the answer.

A Lighter Moment

A woman accompanied her husband to the doctor's office.

After his checkup, the doctor called the wife into his office alone. He said, "Your husband is suffering from a very severe stress disorder. If you don't do the following, your husband will surely die."

"Each morning, fix him a healthy breakfast. Be pleasant at all times. For lunch make him a nutritious meal. For dinner prepare an especially nice meal for him. Don't burden him with chores. Don't discuss your problems with him, it will only make his stress worse. No nagging. And most importantly, make love with your husband several times a week. If you can do this for the next 10 months to a year, I think your husband will regain his health completely."

On the way home, the husband asked his wife. "What did the doctor say?"

"He said you're going to die," she replied.

A couple went on vacation to a resort up north. The husband liked to fish, and the wife liked to read. One morning the husband came back from fishing after getting up really early that morning and took a nap. While he slept, the wife decided to take the boat out.

She was not familiar with the lake, so she rowed out and anchored the boat, and started reading her book. Along comes the Game Warden in his boat, pulls up alongside the woman's boat and asks her what she's doing?

She says, "Reading my book." The Game Warden tells her she is in a restricted fishing area and she explains that she's not fishing.

To which he replied, "But you have all this equipment. I will have to take you in and write you up!"

Angry that the warden was being so unreasonable, the lady told the warden, "If you do that, I will charge you with rape."

The warden, shocked by her statement, replied, "But I didn't even touch you."

To which the lady replied, "Yeah, but you have all the equipment!"

Speakers for our 07/08 meetings. Mark these dates on your calendar

- November 15th, Dr. Cynthia Maynard, Princess Margaret Hospital
- December 20th, Special meeting
- January 17th, Dr. Anthony Joshua, PMH. Clinical Research
- February 21st Dr. Casey, Urologist,
- March 20th Dr. Juanita Crook, Princess Margaret Hospital
- April 17th Durhane Wong-Reiger, Pres. and CEO. Optimizing Health Org.
- May 15th Dr. Gary Rodin PMH. Depression
- June 19th to be confirmed