PROSTATE CANCER CANADA - NEWMARKET

Volume 15, Issue 8, April 15th, 2011

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

We've invited Doctor Charles Catton of Princess Margaret Hospital to speak to us at our April 21st meeting. 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 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. Come and hear what he has to say.

Meeting Date: **April 21st, 2011**

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

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

Speaker **Dr. Charles Catton, Princess Margaret Hospital**

Subject: **The Latest Developments in Radiation Therapy**

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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.

March notes . . . Dr. Anthony Joshua - Princess Margaret Hospital

Subject: "Some new treatments for advanced Prostate Cancer"

At our March 17th meeting we invited Dr. Anthony Joshua from Princess Margaret Hospital back to bring us up to speed on the new treatments that are now in clinical trial stages and might change how we deal with a recurrence of our Cancer. . . . Here is what he had to say.

Tonight I would like to give you an idea of some of the clinical advances we are experiencing in Prostate Cancer treatment. There are different stages of Prostate Cancer which we will talk about. We may or may not progress through all these stages. You usually start off with a clinically localized disease, if you have prostate cancer identified through a biopsy. That may be taken out or radiated but sometimes it comes back and your PSA starts going up. Sometimes when the PSA starts going up, your doctor may recommend that you have a castration treatment, it could be injections or the operation. There may be some metastases that appear, where the cancer spreads to other parts of the body and requires other treatments, which may or may not respond to that. If it does progress, it generally takes ten years or more to develop into a serious problem. What's important to realize is that most men who have localized prostate cancer which has just been diagnosed, are cured. Then the cancer is gone and you never need to come back. There's a whole big debate about whether to treat some cancers and which cancers need to be treated and can you leave some of them there, depending how aggressive they look under a microscope, how old a man he is, whether you should start screening over 40. There's a lot to be said about that topic and that would take two hours to discuss, so I'll leave that aside.

What I'll be concentrating on tonight is what happens when the cancer recurs. That happens in about one third of the patients, when the PSA starts to go up after radiation or surgery. These men are known to have biochemical failure. There are some prostate cells lying around in the body somewhere, that initially you can't find, which start making the PSA go up. What we don't know is how to manage these men. What's important is how long does it take? Dr. Walsh of Johns Hopkins collected information on 1,500 patients, who he had treated over his career and had relapsed after surgery. These were younger men, who had low risk prostate cancer. He didn't give them any hormones. He said he didn't believe in giving them hormones just for PSA and he only believed in giving them hormones if the cancer had spread to the lymph nodes or the bones. He found, if the PSA did come up, nothing happened for 7 1/2 years, until we could find cancer in the bones through a scan. So rising PSA by itself is not a death sentence by any means. Once the bone scan became positive, it then took about 6 1/2 years more, with hormone or other treatments, for them to die. This is just an overview. All men are different, some may spread rapidly and some may take much longer. Prostate cancer, when you find it, is not a death sentence. It is generally a prolonged disease and, unlike other cancers such as brain cancer, once you find it you can still live a long and healthy life.

What predicts which men are going to die from prostate cancer? That's what's important because you can live with prostate cancer. Most men, in fact, do. Your chance of having cancer in your prostate is roughly your age minus five to ten percent. So someone who is 40 has a 35% chance of having prostate cancer but someone who is 80 has a 72% chance and at that age there's a pretty good chance that it's just going to sit in your prostate and do nothing. We don't understand exactly why in some men it takes off and starts to grow and we also don't understand why it's such a phenomena in Western populations, especially in African-American men and less so in Asians. What we have to do is learn how to differentiate the dangerous cancers from the non-dangerous cancers. One way of doing that is seeing how quickly the PSA doubles, which gives us a reflection of how aggressive the cancer is. There are other indications, as well. How aggressive it looks under the microscope when you have the prostate out. The actual PSA number is not important. What is important is how quickly it doubles. I have a lot of men who have been running around with PSAs in the thousands and other men who are disabled when their PSA is seven. The numbers are not important, it's how quickly it doubles which tells me how dangerous that cancer is.

What are some of the advances in prostate cancer? One of them is the concept of doing the androgen treatment only intermittently. In the past, if your doctor told you that your PSA was going up, he would give you hormone treatments, which would be continuous every three months, for the rest of your life. A few doctors thought that didn't make sense. What we can do is give injections for three to six months, then don't give them for three to six months. The cancer will grow a little bit and then we can start the therapy again and the cancer will shrink a little bit. This is a great idea and it worked in mice but, does it work in humans? So there have been a number of trials, in many countries, which all showed the same thing, that this is a very effective way to maintain a man's quality of life and yet maintain control of the cancer. It doesn't differ in any material way from giving the injections

every three months for the rest of your life or stopping therapy at the point at which the cancer becomes resistant to the treatment. Until that point is reached, it is generally acknowledged now, that giving the hormones intermittently, allows a man to not have as many side effects as he otherwise would. Maintaining his bone strength and maintaining some libido, for example, leads to a better quality of life than giving the hormone treatment consistently. This is theory but, in practice, what happens? The first time you do it, the testosterone rebounds to its original level, the second time a little bit lower and by the time you do this the fourth time, the testosterone levels in the man are knocked down to about 25% as high as they used to be. You might not feel as energetic as you did the first time but you will feel better than you would if you had consistent treatment. This approach is being endorsed by the European Urology Assoc., the English Guidelines body and the Americans are slowly beginning to adopt it. In Canada, this concept of giving the hormone treatment intermittently is well accepted and it's also well accepted that it will be more beneficial to the man in terms of quality of life than the hormone treatment consistently at that early stage of the disease.

So what about extending a patient's life? Here we have some new drugs which are being used to battle prostate cancer: Abiraterone, MDV3100, Sipuleucel-T and Cabazitaxel. The way they develop a drug for prostate cancer, the first thing they do is test it on men in whom cancer is very advanced and then test it on men in whom cancer is less advanced and in the end you test it on a man in whom cancer has just been diagnosed, to see if it cures. Ultimately, we would like to know, if we give it to a man who is about to have an operation, a month or two before the operation, if it will make the chance of curing that man much brighter. As you can imagine, to know if a man has been cured of prostate cancer may require a few years of follow up for that man. To know that a man with very advanced prostate cancer's life expectancy has been increased by a few months, will give us information much quicker. So all the drug companies are concentrating on using the new drugs on men who have advanced cancer first, because then they can find out if it works before they try it on a newly diagnosed patient. So all the drugs I am mentioning today are working their way down that path. They are just being tested on men who have advanced prostate cancer. Three of them have been shown to increase the length of life and now they are going back and treating men who have earlier stages of cancer.

What we want to find out is what makes prostate cancer grow? What we thought we knew, which was that the castration is the be all and end all of hormone treatment, was incorrect. As it turns out, the cancer starts to make its own testosterone. So even if we're giving treatment to make the body stop producing the testosterone, the cancer makes its own testosterone and it's very difficult to interfere with that because the injections just take away the body's ability to make testosterone but we can't interfere with the testosterone being made by the cancer to stop the cancer from growing and that's what the new drugs are doing. Dr. Joshua, using his slide presentation, gave us a detailed, clinical look at how the drugs are tested on patients whose hormone and chemotherapy treatments are no longer effective. In a study for Abiraterone on 1150 men, about 750 got the new drug and the other were given a placebo. Patients on the new drug, on average, lived about four months longer, with a better quality of life. The drug company has forwarded their information to Health Canada. Although Health Canada has not yet been able to approve these drugs for general usage, as further studies are required, they are giving permission for me to give men in these extreme circumstances to be treated. The drug company then provides it free of charge, so while we are still testing, patients are being helped. Now I have about 10 men who are getting this drug. Canada is one of the few countries which has this process in place. Most of them do well, remain pain free and the PSA has fallen. The next process is on the men for whom the hormone treatment is not working but who are not sick enough to go on chemotherapy. Can they get this drug? I don't yet. The drug company has done a trial and we don't have the answer yet. We're hoping that in the next few months the drug company will make an announcement (and they usually tell the stock exchange before they tell the doctors) that this drug works even before chemo to help them live longer. Once I hear that, I can start giving the drug to men before chemo. After that they'll start giving it to men who haven't started to fail hormone treatment yet and after that they will give it to men before the operation or radiation to help those treatments work more effectively.

Another strategy to stop the cancer growing is to block out all the testosterone. That means while the cancer is making new testosterone, this drug, MDV3100, is blocking that testosterone from interacting in the cell. Many of you may be familiar with a drug called Casodex or Biflutamide, they are similar drugs to this one, but this one is ten to fifteen times more powerful. It looks like testosterone but it has a little kink in it, so when it sits in the cell, the cell tries to use it to activate the machinery but the cogs on the wheel get jammed by this molecule. That also works well to bring down the PSA in 70% of men, pre chemo treatment. If you look at how long it takes for the PSA to increase after it has fallen, it's about 186 days and men for whom there's been no chemotherapy given, they don't even know because it's working so well, it could be effective for a year and a half. The other good thing about MDV3100, is that it doesn't seem to have any side effects. It's very good news and it's definitely on the horizon, as well. In a preliminary trial of 1,000 men with advanced disease. Of every three men two got the new drug and the other got a placebo. They are seeing if it makes a difference in how long these men live. Again, we don't know the answer to this yet, unfortunately, but we expect that this will also help men live longer. This company has also said that they want to give it to men before chemo. They are doing a trial now with men before chemo. I have men in my clinic who have had hormone treatment and it's not working. I say

that I don't want to give them chemo therapy yet but that there's a new trial going on. I suggest that they participate in this trial. We haven't any answers yet on this.

The other advance I'd like to talk about, Sipuleucel-T, is a controversial treatment which has been in the press lately. It's a drug which helps your immune system attack the cancer. They take a man to a Apheresis centre, take out his immune cells on a machine, then they incubate them with a special protein, which they sprinkle on the cells and then sprinkle something else on to make them proliferate and get angry and give them back to the patient. They do that three times. The trouble with that is it is very expensive, $93,000 U.S. so it's unlikely to be approved by Canadian provinces. It's controversial because it doesn't show any improvement in PSA or any shrinkage of the cancer, as far as we know, but it does prolong life. At the moment this is the only treatment approved in the United State, given before chemotherapy that extends life expectancy. The drug company has not even applied in Canada because even if Health Canada approves the sale of it, nobody's going to buy it. The good news is there are other vaccines being evaluated, which are more like conventional vaccines, where they've taken a virus and they've altered it so that it looks like prostate cancer to the body and they are also very promising. The other advice I thought I would mention is a new type of chemotherapy. The old type of chemo is called Docetaxel (taxotere) and still works very effectively to prolong life. In a study, the new chemo, called Cabazitaxel, was given to patients who no longer responded to Docetaxel and it increased their survival by 30%. That chemotherapy is now available. Not surprisingly, the drug company has said that they should now try to use this chemotherapy earlier and give it to men instead of chemotherapy and change the dose so that it's not quite as toxic. So those things are happening.

Another aspect of prostate cancer, as many of you might know, is that, when it does spread, it often spreads to the bones. We don't understand why but in 80% of the men, when it does spread it goes to their bones. There are two ways to deal with cancer of the bones. Either you kill the cancer, which we try to do or we can make the bones stronger. You should try to maintain your bone strength, especially if you are on hormones. You should be taking Calcium and vitamin D. What we'd like to do, ideally, is make the bones stronger so we can eliminate the possibility that the cancer can cause fractures, pain or the need for radiation treatment. We have drugs now, that have been used for treating osteoporosis in women, which are now being used for men who have prostate cancer in their bones. What we're trying to do is buttress the bones so that they are as strong as possible so the cancer can't cause a fracture.

The first drug is called Zometa. What we know about Zometa is that it is used in men that have prostate cancer when the hormones aren't working and there's cancer in the bones. Giving this drug regularly reduces the chance that the cancer will cause a bone problem. By problem I mean pain, fracture, the need for emergency radiation, something like that.

Another drug company thought they could do better than that and they created a drug called Denosumab. They have an understanding of how bones work. Bone cells rely on constant growth factor to grow and differentiate to do their job. They compared Denosumab with Zometa and found that Donosumab was better. It reduced the chance of bone problems happening when given to men who have prostate cancer in their bones. This drug is available for sale in Canada but it's not yet being paid for by the province. What's interesting is that the drug company said, "What if we stop the cancer from getting to the bone in the first place?" What we want to do is take men that have a rising PSA and no cancer in their bones; take half of these men and give them the Denosumab and the other half with a placebo injection and see how long it takes for cancer to go into the bones, because we think that our drug makes the bones so strong that the cancer can't get in there in the first place. The company sent a press release out to the stock exchange some months ago stating that the trial was positive but I haven't heard anything more. It's going to be very interesting to see what happens in terms of Health Canada. The important thing, if you have cancer in the bones, is to prevent fractures.

Surprisingly there are simple things you can do to avoid fractures. Those things include: stop smoking, don't drink too much coffee; don't drink too much alcohol; do exercise; take Calcium and vitamin D and make sure you're not going to trip over your rug at home - have a safe house. There's always a role for a physiotherapist or an occupational therapist to come to your house to see if they can improve the safety around your house, around the bath, stall handles, whatever makes it safe.

A little Irish humour

Muldoon lived alone in the Irish countryside with only a pet dog for company. One day the dog died, and Muldoon went to the parish priest and asked, ‘Father, my dog is dead. Could ya’ be saying’ a mass for the poor creature?’

Father Patrick replied, ‘I’m afraid not; we cannot have services for an animal in the church. But there are some Baptists down the lane, and there’s no tellin’ what they believe. Maybe they’ll do something for the creature.’

Muldoon said, ‘I’ll go right away Father. Do ya’ think $5,000 is enough to donate to them for the service?’

Father Patrick exclaimed, ‘Sweet Mary, Mother of Jesus! Why didn’t ya tell me the dog was Catholic?

Are you getting enough information to make an informed decision

The Canadian Press
Date: Monday Apr. 11, 2011 10:49 AM ET

HALIFAX —— When Richard Wassersug was diagnosed with prostate cancer more than a decade ago, he had little idea how profoundly it would change his life. The university professor got the grim news when he was 52 and set out on a treatment course that included a radical prostatectomy, radiation and a regimen of potent drugs to block the production of testosterone.

Wassersug, now 64, had a good grasp of what was involved in the surgical procedures, the recovery and the potential side-effects. But he says he received little information from the various health-care providers along the way about how the drugs, in particular, would affect a fundamental part of his life — his sexual health. "I was not prepared at all and I teach anatomy at a medical school," he said from his office at Dalhousie University in Halifax, where he is a professor of anatomy and neurobiology. "My physician didn't bring it up at all. It was remarkable how little interest he had. I went from a urologist to a radiation oncologist to a medical oncologist...This was not part of the discussion." It's an issue some in the medical community are trying to address through screening tests and education programs aimed at better informing men how cancer and its treatments affect sexual activity.

Deborah McLeod, a clinician-scientist who focuses on sexuality and cancer, says she doesn't think male patients are given enough information on the sex-related issues they might confront as a result of their treatment. She cited a 2007 study that found that 96 per cent of health professionals identify sexual concerns as being within the scope of their practice, but only two per cent of those address it. "There are all these different levels in the ways in which different cancers can affect sexuality," she said in Halifax, where she works for the Capital Health Cancer Care program. "Unfortunately as a health-care group, we don't attend to this at all. Even when we do, we only think about it when it involves sexual organs."

Peter Mallette, head of Prostate Cancer Canada's Atlantic office, was diagnosed with the disease in 2005 and said he felt the need to ask his surgeon how a radical prostatectomy would affect his sex life. "I was being given information from my doctor about prostate cancer and certainly contained in that information were some key points about some side-effects of surgery," he said. "But I felt the desire to have that conversation. The information, to me, just wasn't enough." Mallette said some of the most important information he received came from other men dealing with cancer, adding that discussions about sexual health come up regularly at his support group.

The effects of cancer and its treatments on sexual well-being can be as varied as the many forms of the disease, ranging from the physical to the psychological. For many men, including Wassersug, treating prostate cancer can result in some form of erectile dysfunction or castration. A prostatectomy, or removal of all or part of the prostate, can disrupt the nerve supply involved in erections. Chemotherapy can impact fertility, while any pelvic surgery for prostate, colon, colorectal or bladder cancers can cause scar tissue that can affect blood circulation to the sexual organs.

Radiation to the pelvic area damages blood vessels, which can impede erections.

Drugs can help restore sexual function, but the effects can carry a hefty psychological impact for those whose identities are strongly tied to their sexual ability.

McLeod said men facing sex-related challenges linked to their cancer generally tend to withdraw and not talk about their concerns, particularly if they are embarrassed by them. Prostate cancer treatment can lead to incontinence, physical disfigurement, diminished libido and hair loss, all things McLeod says take a toll on a man's psychological well-being. "These impact sexually on men — to a greater extent than women — cause them to hide and be silent," she said.

After surgery and radiation, Wassersug began taking anti-androgen drugs — chemicals that slow the growth of prostate cancer cells by depriving them of testosterone. Soon after, his mood soured, he lost hair on his arms and legs, muscle fell away, he gained weight and his memory suffered. Other men experience breast development, loss of erectile function and sexual desire, heightened emotions and hot flashes.

"Men are not well educated about these (drugs)," McLeod said. "The education tends...to be not really reflective of how profoundly difficult this is."

Wassersug, who has redirected his research and published extensively on cancer and sexual health, said the toll cancer and treatment took on him contributed to depression and, ultimately, the end of his marriage. He's concerned that it's an outcome many couples face as they grapple with the fear, heartache, confusion, anger and uncertainty surrounding the fallout of cancer treatments.

McLeod is involved in two national initiatives to improve the education of health-care workers on the effects of cancer on sexuality and to identify patients who might need help. The first is a screening of cancer patients to identify distress, whether it involves depression, fatigue, financial worries, relationship troubles, or intimacy and sexual concerns. The survey is being introduced in cancer centres across the country, with Halifax's being one of the first to use it. A

high score would trigger an intervention by staff or a referral to a counselling team, McLeod said. She is also the project leader of an education program for graduate students and practising health professionals that focuses on psycho-social oncology, with the latest course looking at sexual health counselling. “The interest in the course is just huge,” she said. “People need to be talking about this, but the degree to which they do varies tremendously.” An online chat site moderated by health professionals — http://cancerchatcanada.ca — gives patients and their spouses an anonymous forum to discuss certain issues, like sexual health.

For Wassersug, he says he has adjusted to the challenges of having a sex life while on hormonal therapies and encourages people to think creatively about their sexual activity. “I realized that as a long as I could see myself as different, I could adapt to it,” he said.

Prostate cancer screening doesn’t cut deaths: study

The Associated Press
Date: Friday Apr. 1, 2011 7:58 AM ET

LONDON — The longest study yet on prostate cancer testing provides more evidence that getting screened doesn’t cut the chances of dying from the disease. In a 20-year study of more than 9,000 Swedish men, researchers found no difference in the rate of prostate cancer deaths between the men who were periodically screened and those who weren’t.

Routine screening for prostate cancer is controversial and the new results aren’t likely to end the debate about the value of testing. Critics say screening leads to unnecessary biopsies and treatment with little proof that it saves lives. Testing is done with a physical exam and a PSA blood test. “There is no escaping the fact that we need a better tool ... to help detect prostate cancers that actually need treating, as opposed to innocent ones that do not,” said Malcolm Mason, a prostate cancer expert at Cancer Research U.K. in a statement. “In the meantime, men should be fully informed about the pros and cons of having their PSA measured.” The standard PSA blood test looks for high levels of prostate specific antigen. The test is controversial because the PSA level can be high for many reasons. A positive result must be confirmed by a biopsy. If prostate cancer is found, there’s no agreement on the best way to treat it: “watchful waiting,” surgery, hormone therapy, radiation, or some combination of those. Most tumours grow so slowly they are never life-threatening, and the treatments can have serious side effects.

The Swedish study was done in the eastern Sweden city of Norrkoping. From 9,026 men, about 1,500 were randomly selected to be screened every three years from 1987 to 1996. They only got digital exams on the first two visits; the PSA test was added for the next two. For the fourth and final screening, only men aged 69 or under were included. The remaining 7,532 men were not screened.

During the 20 years of follow-up, 85 men (about six per cent) in the screened group and 292 men (about four per cent) in the no-screening group were diagnosed with prostate cancer. The death rate from prostate cancer was similar in both groups, the researchers reported. The tumours found in the men who got tested were smaller and mostly hadn’t spread compared to the tumours found in the other group.

“Screening for prostate cancer did not seem to have a significant effect on mortality,” wrote Gabriel Sandblom of the Karolinska Institute in Sweden and colleagues. The study was paid for by the Swedish Cancer Foundation and other groups. It was published online Thursday in the journal, BMJ.

The American Cancer Society does not recommend routine screening for most men and there is no government screening program in Britain because officials say the PSA test is too unreliable. Two other big papers published in recent years have also failed to show much benefit for screening. That includes a large European study that found screening for prostate cancer could pick up cases a decade earlier, but to prevent one death from cancer, 1,410 men would have to be tested and 48 men treated.

False positive tests can cause significant harms, including psychological distress and treatments that can cause impotence and incontinence.

Add these dates to your Calendar

April 21, 2011, Charles Catton **- from Princess Margaret Hospital - topic to come**

May 19, 2011 Tanya Giaquinto **- from Sunnybrook Hospital - Diet and Cancer . . .**

June 16, 2011 Dr. Robert Bristow **- from Princess Margaret Hospital - topic to come**