

PROSTATE CANCER CANADA - NEWMARKET

Volume 15, Issue 7,

March 15th, 2011

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



For our March 17th meeting, we are very fortunate to have Dr. Anthony Joshua of Princess Margaret Hospital Clinical Research as our guest speaker. Dr. Joshua was our speaker back in January 2008 when, by using a power point presentation, he took us behind the scenes in our own bodies in a search for answers to how our cells are converted into this disease. He talked about what PMH's clinical research has shown us are the causes of prostate cancer. He also presented us with a very positive picture of a future where, if not a cure, at least a very effective

low risk treatment for this chronic disease is on the horizon. Come and hear what he has to say.

Meeting Date: March 17th, 2011

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

Time: 7:00 pm to 9:00 pm

Speaker: Dr. Anthony Joshua - Princess Margaret Hospital

Subject: "Understanding and treating prostate cancer"

Prostate Cancer Canada - Newmarket
Newmarket, Ontario. 905-830-0447
www.newmarketprostatecancer.com

a member of the



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

Your Executive

Frank Kennedy, <i>March Host,</i>	905-895-2263
Ulli Baumhard, <i>Secretary,</i>	905-478-8843
Ron Stevenson, <i>Treasurer,</i>	905-836-1701
Jane & Frank Kennedy, <i>Newsletter,</i>	905-895-2263
Pat & Ron Stevenson, <i>Greeters,</i>	905-836-1701
Dan Ho, <i>Member at large,</i>	416-953-8889
Murray Green, <i>Member at large,</i>	905-830-9753
Doug Bowers, <i>Member at large,</i>	905-841-2759
Doug Armstrong, <i>Member at large,</i>	905-778-0028

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

February notes . . . Leah Jamnicky - Princess Margaret Hospital

Subject: Prostate Cancer through an RN's Eyes

For our February 17th meeting we invited Leah Jamnicky an RN and teacher of nurses from the Princess Margaret Hospital Department of Surgical Oncology to show us the role of the nurse in prostate cancer treatment. She said, "their role is looking after the physical and psychological well-being of patients. We, as care providers, can't take a back seat. We have to be pro-active". . . Here is what she had to say.

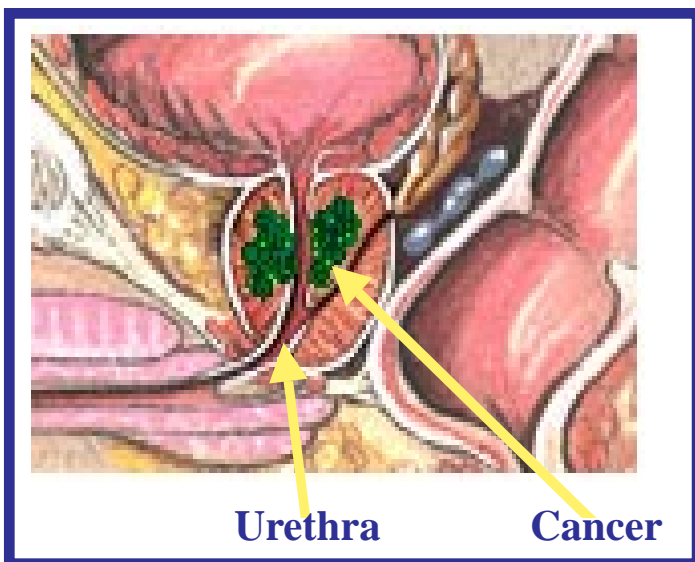
I understand some of you have had surgery and/or radiation and some have had nothing and are trying to make that all important decision. My presentation tonight is a little bit of everything. It starts off with the basic Urology 101 and then we will go through detection, lifestyle and the nurses role in all of this.

As most of you know, the prostate is part of the male genital system and usually weighs about 20 gm. It is about the size of a walnut. Like a walnut it has a capsule with soft tissue inside and that is where the cancer is formed. The role of the prostate is when semen is excreted, it nourishes the semen so that it can do its journey. It's not something that we call a primary organ, it's what we call an accessory sexual organ. The nerves for the erections are around the side of the prostate. It sits below the base of your bladder. It's a small organ which is usually right behind the pubic area. So, for any sort of treatment options, it's very difficult to get to, because it's behind the pubic bone. When I started nursing 25 years ago, they had just stopped where they split the pelvis to take the prostate out. Not only did you have prostate surgery, you had orthopedic surgery, too and you were in hospital for six weeks.

So men will have difficulties with urination, they will have incomplete emptying of the bladder, they can have some bleeding, they can have some pain; they can also have bone pain if the cancer has gone to the bone; and, for some men, it can actually paralyze, because usually with the bone metastasis, it goes to the spine which could put pressure and cause some paralysis.

When a physician does a digital rectal exam (DRE), people want to know what it feels like. I tell people the easiest way is if you put your hand into a fist and the flesh at the base of your thumb is what it feels like and if you have cancer it feels like a knuckle. While we are diagnosing more cases of prostate cancer per year, the number of deaths from it are remaining almost constant. When you look at prostate cancer there are some things you can't change, which we can't modify, such as age (the older you are, the more chances of being diagnosed with prostate cancer); your ethnic background (The Asian population is at the bottom, with the least prostate cancer, and the North American is at the top); and your genetic predisposition (there's a much higher familial incidence of prostate cancer than with breast cancer or colon cancer). There are some genes which are associated with breast cancer, which are also associated with the development of prostate cancer.

There are some things we can change, which are lifestyle factors which can also affect prostate cancer. We can't alter our age, we can't change who we are, we can't alter our genetic makeup but we can alter our lifestyle. The things that they've been doing a lot of research on are nutrition, exercise and stress reduction. The reason they look at nutrition is that the Asian population, if they live in Asia, has a very low incidence of prostate cancer. As soon as the Asian population moves to North America, within a generation their incidence is two to three times higher than it was in their own country. So, when you look at that, we find that diet is a very significant factor. Diet is also important when it comes to breast cancer, colon cancer and a few other cancers as well. So there is geographic evidence to support that finding and they are looking more in that field. We as North Americans eat a lot of fat. We eat a lot of red meat, so there are a lot of studies that actually reinforce the fat content as being a big problem. The easiest thing that we tell people in this regard is to follow the healthy heart diet because that information is everywhere. It's just the low fat, lots of vegetables, whole grains as opposed to highly processed foods. We've all heard of antioxidants. A lot of people take antioxidants. They have done research on Selenium and Lycopene. Selenium is found in soil, so there are areas in North America which have a higher Selenium



Most patients, when they come to the hospital, can't believe they have cancer because they have no symptoms. Most cancers give you symptoms, you have pain, you have bleeding. If you do have symptoms, it's usually associated with an enlargement of the prostate. What happens is that it might start cutting off your urine flow and that's usually why people come in to see why their urine flow is obstructed and when they do an investigation that's when they find cancer.

content, which means the food has higher Selenium. In those areas the incidence of prostate cancer tends to be lower. We've all heard a lot about Lycopene, which does have a significant protective quality. If you do have advanced prostate cancer, it does tend to have a protective property. Lycopene is found in red fruits or vegetables. The easiest way to get Lycopene is through tomatoes. Unlike other fruits and vegetables, this is one where it's better cooked than it is raw. It's more easily absorbed by the body when it is cooked, so tomato sauce is a good thing. Soy is also another factor that they are looking at because the Asian population has a very high soy element in their diet. So, as opposed to having red meat, they tend to have tofu, soy milk and that sort of thing. The other supplement they are looking at is Vitamin D. We've heard a lot about Vitamin D and it appears that about 1,000 mg a day is the more acceptable dosage. Other good things are cruciferous vegetables - broccoli, cauliflower, etc. They have really strong antioxidant properties. Garlic is another good one; Omega 3 fatty acids; and polyphenols like green tea and red grapes.

The other thing is exercise. Studies have shown that there could be up to 50% decrease in prostate cancer risk in men who have included exercise in their lifestyle. Exercise is also important for men who have metastatic disease if they're on hormone therapy. Men who have had surgery or radiation and have recurrence of the disease and are on hormones, a lot of times what happens is, they lose bone mass. We've actually got a program in the hospital, where we put a lot of these men on a light exercise program to try to build up their strength. The more exercise they do initially they end up being very tired because the hormones will take away their muscle mass. We can maintain it with light exercise, not a lot of weights and that sort of thing and break it up throughout the day, usually within four to six weeks their energy level is at the same level as it was before they started taking hormones.

The other one is stress management. I think we all have stress and it's a hard one to get rid of, no matter how much you try. However there is a strong connection between stress and your immune system. If your body's always stressed, stressed, stressed then your immune system takes a back seat. What happens is you will be more disposed to getting colds, getting sick or whatever. So that's why a lot of people who are in stressful situations, whether it be at work or in their personal life, tend to get sick much more easily.

In summary, we usually will tell people to reduce their fat intake. If they are going to take vitamins, take Selenium (200 ug/day), Lycopene (30-60 mg/day) Soy (40 g/day) and vitamin D (1000 mg/day) as well, just the dose that's suggested. The other thing is exercising regularly is very important. Try to reduce chronic stress.

Leah's presentation then guided us through a series of charts and graphs illustrating the results of research studies over the years on various treatment techniques. She then turned to her role . . .

The role of the nurse, my role is looking at the physical and psychological well-being of patients. An assessment is paramount. A needs assessment includes giving patients information and assuring that they've made the right decision. Sometimes it means clarification of that information. It's important for nurses to offer information because, as people come into the hospital, a lot of guys come in and say that they haven't been sick a day in their life. This is the first time they are walking into a hospital. So a lot of people don't know what to ask and it's important as health care providers to offer the information so that we can answer your questions. even the ones you haven't thought of. Then there's coordinating individualized care. What's good for one gentleman is not necessarily good for another gentleman. It's very important to look at the whole person and it's important to not just look at the disease but who that person is and what the surgery or radiation treatments means to them. The assessment is ongoing. Sometimes we start off on a certain pathway and then we deviate towards another way and that's all dependant on what we see in the individuals.

There's still a huge stigma when it comes to prostate cancer. Last week we had three guys saying that they were taking time off work but they didn't tell anybody that they were coming in to have surgery because they didn't want anyone to know they have prostate cancer. Three guys! That's huge. One didn't even tell his wife. It's still out there. Men don't share their emotions. They don't verbalize what they are feeling. They keep things in and there are significant side effects. There are significant urinary side effects, rectal side effects from radiation, erectile dysfunction. These are issues that are huge in the quality of life of men. Men still want to know how society will perceive them. A lot of men say that there's a loss of control. At least twice a week I have guys that start bawling once you start going through some of this stuff because, literally they've always been in control. All of this can be overwhelming and there can be feelings of despair and grief. There's a huge emotional component to it. Sometimes its important for men to talk to other men who have gone through the process because they can see that they are doing well. They've gone through it, they've survived it, they are who they were before. They are not their disease. They are still who they are. A lot of times men will come without their spouses, so we encourage them to bring their spouses or partners with them. We want to encourage open lines of communication with their spouse/partner. We want the wives to know what their husbands are going through. We want them to understand the process and what options are available to them. A pro-active approach is paramount when you're looking at people who are diagnosed with cancer and looking at treatment options. We, as care providers, can't take a back seat. We have to be pro-active.

Let's look at some of the side effects from the different treatment options. Regardless of the treatment, they all have the same side effects. Websites will say that you don't have the same side effects with brachytherapy. Yes you do. They'll

say that with radiation you don't get stress incontinence and you don't get erectile dysfunction. You do. You may not get it initially but you get it further down the road with the treatment, because the radiation is accumulative. Initially when you have surgery you get the side effects right away and you have to deal with them right away. If you get radiation you might be good for eight weeks but, as the radiation starts to take effect and starts destroying the tissues, you start to have side effects. The other thing that you go through with this is erectile dysfunction. That's huge for men. There's a lot of misconceptions. The one word I hate is impotent. Surgery never ever leaves anyone impotent. Impotence is psychological not physiological. What we're doing is physiological, we don't touch your brain. So it's erectile dysfunction, it's not impotence. Which means that the surgery, the radiation, the brachytherapy has absolutely nothing to do with sexual drive, desire, libido, orgasm, which are never affected by the treatment. Although the orgasm will be dry, because the prostate is either taken out or damaged, so there's no fluid to be released. Treatment options may impair the ability for men to maintain erections. Most men initially will require medication and usually, depending on the stage and grade, the results will be 50-50. 50% will always need to take medication, 50% probably don't. It varies according to where they're at in their stage. Healing for erections could be anywhere from a few days to two, three or more years. We see changes. It takes a long time for these things to heal. When you look at long term erection dysfunctions, about 40 to 50% will have difficulty with their erections over a period of time regardless of what treatments they are having.

In saying that, we know that, we need to take a proactive approach. Again, it comes down to communication. We know the issue and we need to share that with you. It takes planning and we do have a plan of care at PMH where we work on the sexual function. We always say it's not about the penis but it's about maintaining the intimacy. In saying that, couples also need to know that it's going to be a little bit different initially. There needs more planning, there needs

more preparation, there's a lot more foreplay than there was years ago. A lot of guys think, "it's like dating again, it's not like the way I like it now". Again, it's giving them information to know what the expectations are.

The other things to understand are patients perspectives. Have them verbalize what their understanding is and then expand on those areas of concern. We found this an issue with our gay population. A lot of time they don't ask questions because they are afraid to, because society still views the gay population in a different way. When I wrote my book on prostate cancer, I was doing research with the gay population. There were 48,000 studies looking at how men manage with prostate cancer and not one of them dealt with the gay population. Their concerns are actually very different, so we had to come up with a whole different plan of care for their needs. As health care providers, it's not enough to just deal with the disease, we need to look at the whole person and what is important to them. Such as: their body image concerns; feeling undesirable; fear of the cancer being transmitted during sex; their lack of desire; being too tired to participate in intimate or sexual activity; worry about the inability to perform sexually and not being able to satisfy their sexual partner; younger men are concerned about fertility.

In my role I travel to other hospitals to train other nurses about opening lines of communication and how to help these men and their partners dealing with these concerns. These topics are difficult for nurses to talk about because many of them feel this is a private issue and a sensitive topic. Cancer treatment is the focus of nursing care and now is a good time to discuss sexuality because it's a big part of who we are as individuals and it is important. If you don't bring it up now, when are you going to bring it up. As health care professionals we need to be prepared to assess and support patients who may experience difficulties with intimate relationships as a result of a cancer diagnosis and treatment.

Nurse Jamnicky then spent twenty minutes before our break answering a multitude of questions and another ten minutes during the break answering many more individually.

USE YOUR CANCER-FIGHTING POWERS

**volunteer as a driver on March 24th
delivering daffodils around our area
for the Holland River Unit**

**you can sign on at
(905) 830-0447
or at our meeting
on March 17th**

Another opinion when your PSA starts rising

Here is an email trace from communication between someone with recurring prostate cancer and Dr. Barken, Medical Director Prostate Cancer Research and Education Foundation in San Diego. Dr. Barken is a well-known and respected medical person in the States. In this email he acts as a "Coach" to help answer questions.

I was diagnosed and treated 10 years ago. With a PSA of 10 and a Gleason of 7, I received External Beam radiation followed by Seed Implant in 2001. With a NADIR of undetectable it rose to 0.1 in May 2007, 0.3 in Oct 2008, 0.4 in Jun 2009, 0.6 in Jan 2010, 0.8 in Oct 2010, and 0.9 in Jan 2011. I am scheduling an appointment with an Oncologist for next week. What steps and questions should I be asking?

Coach Barken: Below are the core questions in the decision making process. I believe the most important step you can take is to first investigate what further tests would be helpful. After getting all possible data and information about your biologically unique, one of a kind in this universe, prostate tumor, then you can focus on which treatment options best match your bid to control (or if possible, to eradicate) the tumor. Of course, you will also consider very carefully what price you will have to pay in quality of life and whether it's worth it to you.

The important questions to take into consideration:

1. What is your age?
2. What is your overall health status?
3. What other medical conditions do you have?
4. What was your risk assessment at the time you were diagnosed?

You will inevitably find yourself alternately deciding to treat and then deciding not to treat. You will examine treatment after treatment. You will ponder what treatment to consider doing first, and what treatments to hold in reserve should you need them later on. Remember, wars are rarely won with a single battle. Prostate cancer is most often a long-fought disease.

There is another important reason why you should do more tests. Whether you decide to treat or not to treat, you will need base line markers to be able to follow your situation smartly over time. Even Joshua sent out Scouts to gather intelligence before hitting Jericho, though he was certain that God was with him. You need bench marks for comparison to monitor changes, large or small, in your status with treatment or without treatment.

My overall approach would be as follows: "Minimum Intervention and Maximum Surveillance." Since all treatments end up being about the same in regards to their efficacy, I would recommend you use the less aggressive treatment in order to minimize side effects and preserve quality of life. Maximum surveillance means maximum testing in order to validate that you do not have more aggressive disease than was anticipated. The tests will provide bench marks for further follow up.

The standard approach is to leave the patient alone when you have such a slow rise of PSA. Nobody knows what the cut off level of PSA is that should trigger treatment. Regardless of that unknown number, if you are concerned about a certain level, think first and double check what else is going on before you jump to a treatment. You cannot rely only on the PSA level to determine that treatment is mandatory. I believe that the PSA should really be an immediate trigger to further testing, not treatment.

So what needs to be done now is to define the current status of the disease by trying to find out how aggressive the prostate cancer is right now and where the location of the cancer is right now.

The list of tests to be considered when you sit down with your treating physician is:

1. The aggressiveness of the disease:
 - a. Tumor markers in the blood
 - b. Tumor markers from biopsy materials if available.
 - c. Considering past information about the aggressiveness of the disease if available.
 - d. Please see the Coaching Check list from PCREF (write to info@pcref.org for a copy or go to www.pcref.org)
 - e. Consider PCA3
2. Imaging tests:
 - a. Color Doppler Ultrasound and possible more advanced techniques using Contrast Material or Elastography.
 - b. S MRI or better yet, Multiparametric MRI
 - c. Consider Body scans by MRI if there is evidence from the marker tests that the low PSA is misleading.

The treatment options are:

1. Active surveillance with continuous, daily-practiced, life style changes. (Please read Take Your Daily M.E.D.S. at www.pcref.org)
2. Vitamin D3: Check the level in the blood and take vitamin D3 accordingly.
3. Minimal Androgen blockade: Minute amounts of Casodex and Proscar.
See the video lecture on Nerve Sparing, Body-System Sparing Hormonal Blockade.
 - a. Oral presentation on Casodex and Proscar http://www.pcref.org/call_past.php
 - b. Video lecture on Casodex and proscar <http://www.pcref.org/vdo.php>
4. Cryotherapy : Focal cryotherapy procedure preferred
It should be done by an expert after imaging and

- biopsy information if available to be used as target.
5. HIFU if available. You can join a clinical study in the US or travel abroad.
 6. Radical Prostatectomy after Radiation not recommended due to high rate of complications. It might be considered rarely. An example for that is a proven, very local, aggressive tumor and you are willing to accept the risks of side effects. You also need to understand that you may need more systemic treatment and surgery in this situation may not eliminate all the cancer.
 7. Combining local treatment and systemic treatment is the best approach in my opinion. This subject is controversial and needs further examination of the particular situation.

I think that a crucial point is who is going to be the doctor who will take care of you. You noticed I did not say: Who is going to treat your disease? There is more than the science of treating the disease. There is the art of taking care of a person who happens to have prostate cancer and probably due to age has other physical and emotional challenges.

The pitfalls in selecting a doctor:

1. He may be a medical oncologist or a urologic oncologist but he should be someone with expertise and a clinical focus on prostate cancer.
2. The physician may be biased and be inclined to offer only the gadgets he has in his tool box.
3. The physician may be very limited in the amount of time he has to dedicate to you to really listen to you.
4. In the words of one of my patients who taught me early on what a good doctor is: "I don't care how much the doctor knows. I want to know how much he cares."

The last 4 points bring me to the another out-of-the box suggestion. Beyond finding a physician, you may also want a Coach. Coaching is a service I offer through the Prostate Cancer Research and Education Foundation. If you are an individual who has a potentially life-altering decision to make, it makes sense to get a experienced guide before you set out on a route that is unfamiliar to you and has many hazards. What inexperienced climber would go up Mt. Everest without a Sherpa who knows the terrain?

Because I am part of a non-profit organization, not a medical practice that needs an influx of patients, I can offer an unbiased review of your medical situation and also an unbiased look at which treatment you are leaning toward choosing. And since I did devote my clinical career to dealing with all stages of prostate cancer and only that one disease, I can humbly say I have the experience to be an expert guide and Coach. I care a lot about putting the patient in the driver's seat. I care about getting you to your destination, not just safely, but also with peach of mind.

Best Wishes

Coach Barken

Israel Barken M.D.
 Medical Director
 Prostate Cancer Research and Education Foundation.

Coaching with Dr Barken — <http://www.pcref.org/per.coaching.php>

To listen to previous recording of Ask Dr Barken Show go to—
http://www.pcref.org/call_past.php

To open your own Medical Smart Chart go to —
www.pcref.org/MedSmartChart

Material posted here is for general education purposes only and does not take the place of medical advice from your treating physician. No patient-doctor relationship is created or implied.

Israel Barken, M.D.
 Medical Director
 Prostate Cancer Research and Education Foundation (PC-REF)
 501(c)3 non profit organization
 6823 Deer Hollow Pl
 San Diego, CA 92120
www.pcref.org
info@pcref.org
 619-906-4700

Add these dates to your Calendar

- March 17, 2011 Dr. Anthony Joshua - Princess Margaret Hospital**
- April 21, 2011, Dr. Pdraig Warde - 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**