



# Montreal West Island

## Prostate Cancer Support Group

EVERYONE IS INVITED  
TO ATTEND OUR  
PUBLIC MEETINGS

### NEXT MEETINGS

February 23 @ 7:30 PM

Dr. Serge Carrier

Urologist

sexual dysfunction  
& prostate cancer

March 23, 2006 @ 7:30 PM

Dr. Irwin Kuzmarov

Urologist

Brings up-to-date news  
on current treatments for  
prostate cancer

COME EARLY AT 7:00 PM

To CHAT

### MEETING LOCATION

Sarto Desnoyers Community Centre  
1335 Lakeshore Drive, DORVAL

Contributors



sanofi aventis

Because health matters

NOVARTIS



Abbott Laboratories

## DO WE NEED A SUPPORT GROUP?

Your doctor tells you that you have PROSTATE CANCER!  
And that you have several treatment options.

He tells you about surgery. And then, if you are lucky, Radiation, Seed Implants, IMRT, EBRT, HDR and about Cryoablation and Hormonal Ablation Therapy, or even about doing nothing called Watchful Waiting. He might say something about Alternatives or Complementary Medicine.

Or combinations of the above! **(All in 15 minutes!)**  
He tells you that you have some decisions to make!

**And the only thing you know for sure when you leave the office  
IS that you have PROSTATE CANCER!**

Hearing that you have prostate cancer is so traumatic,  
for a while you can't process anything else.  
But when reality sets in,  
you need a place to go to learn and ask questions.

**THIS IS A PLACE TO LEARN  
THIS IS A PLACE TO JOIN AND ASK QUESTIONS**

Later, your doctor tells you that your  
TREATMENT IS FAILING!

**DO YOU NEED A SUPPORT GROUP???**

## HORMONAL THERAPY - DRUGS & AFTER

Have you tried to compare Hormonal treatments and were baffled by the various drug combinations? On page 5, we provide an extract from "**The Primer on Prostate Cancer**" by **Dr Strum & Donna Pogliano** which is in our Library. Look it up to find out how all these drugs work for you.

Starting on page 3, Bill Coreless wrote up a detailed report on **Dr Peter Gruner's** talk about what happens when hormonal therapy fails and the next stage is **Chemotherapy** or clinical trials, and how they are designed.

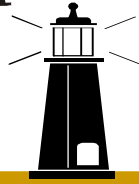
## RESOURCES IN OUR LIBRARY

Great collection of DVDs from the Prostate Conference in 2005 with some of the best Doctors in their specialty. These will play on your TV through the DVD player just like a movie. These 13 discs include 31 sessions on every pertinent topic.

For more information talk to one of the Group's librarians.

This Newsletter is available in colour via the Internet at :  
[www.procure.ca](http://www.procure.ca) & [www.cpcn.org](http://www.cpcn.org)

# RESEARCH



From the Crow's Nest

Report by Ludwick Papaurelis, Editor

## RADIATION THERAPY CAN FAIL - WHY?

Even high dose radiation fails to kill cancer cells, as I recently found out. My high dose radiation of 80 Gy, precisely targeted daily on the prostate appears not to have killed off my cancer cells in the prostate. Recent MRI indicates a large nodule suspicious of cancer in the same spot as the main tumour was indicated prior to radiation. I asked some questions - why? There appear to be several possibilities. One is genetic - some specialists believe that certain genes, or lack of them, may permit cancer cells to survive. They recommend checking the levels of bcl-2, P53, Ki67, and others before proceeding with RT. Another possible reason is "Hypoxia". Areas of hypoxia are common in solid tumors. Hypoxia and anemia (which contributes to tumor hypoxia) can lead to ionizing radiation and chemotherapy resistance by depriving tumor cells of the oxygen essential for the cytotoxic activities of these agents. This is because ionizing radiation damage to DNA depends (in large part) on its ability to cause free radicals from the oxygen surrounding the DNA. Enough DNA damage (single strand and double strand breaks) will overwhelm the normal cellular DNA repair mechanisms and trigger apoptosis leading to death of the tumor cell.

I was not told about these possibilities before undergoing radiation therapy and I wonder why this information is not more readily available.

## CRYO THERAPY OR CRYOABLATION

Have you heard about this therapy? In our Library, there is DVD#104 with an interesting presentation on the results achieved with CRYO in a 7 year study by Dr Duke Bahn. His results compare favorably to external radiation and brachytherapy for disease progression and side-effects. The major drawback following this treatment is that impotency is nearly 100%. Most interesting for me, as it appears to be the least invasive treatment following radiation failure, CRYO claims a fairly good chance of success if the cancer cells are contained within the treatment field.

## WHY DO MORE MEN DIE FROM PROSTATE CANCER IN QUEBEC THAN ELSEWHERE?

In Quebec, the percentage of men dying compared to number diagnosed of prostate cancer is 26%. Compared this to Canada's 21% and the USA's only 13.6%.

**Nearly twice as many men die in Quebec as in the USA - WHY?**

*NB. The statistics are from the Canadian and American Cancer Societies.*



## Dr. Hassid El-Hakim

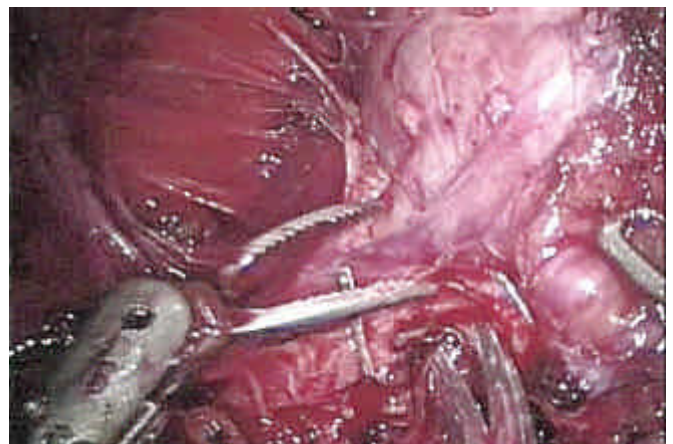
presentation Nov. 24, 2005

### Robotic prostatectomy in Montreal

Dr El-Hakim presented a very interesting lecture on the use of a Robotic system to carry out a radical prostatectomy. He supplemented his lecture with the presentation of an amazing video taken by the Robotic system of an actual prostatectomy. The video showed the images that were displayed for the surgeon as he carried out the operation.

Dr El-Hakim reported on the advantages of the robotic prostatectomy: in general, recovery times are less, with less blood loss and fewer complications. Post surgery results on continence and potency indicate a lower risk of problems. He was enthusiastic when he spoke of his own positive experience in performing surgeries with this new technology. Dr El-Hakim is a member of a committee that has been set up at the Montréal General Hospital to set in motion their plan to acquire a Robotic system. He hopes that the funding required, which is significant, will be approved this year.

Note that we have the DVD video # 104 of a robotic prostatectomy as presented by Dr. Tewari in our Group library. Dr. El-Hakim and Dr. Tewari have worked together on the robotic system and written several studies comparing the various techniques of surgery and their outcomes.



Robotic tool at work from the video.

It is note worthy that both Dr El-Hakim and Dr Tewari have stated that;

**"The experience of the surgeon is the most important factor", rather than the methods used.**

*Report by Bill Corless*

## From the PREZ

A great deal of thanks goes to Danny Peak of Sanofi Aventis, Isabelle Lanno of Abbott Laboratories, Eric Lefrancois and Manon Boisclair of Novartis, Alex Chaaban of AstraZeneca, Geoffrey Kelley, our local M.N.A. and Minister of Indian Affairs, and his always available Political Attaché Jennifer Ferguson.

Additional thanks to Marquis Nadeau, Director Health Policy Quebec for Novartis, Dennis Boucher of Pharma Com. Montreal, and Malvina Klag and Stephanie Lyttle of ProCure.

Your understanding and continuous support allows our group and myself the ability to function with assurance that our message concerning prostate cancer will be heard.

To see our Newsletter on the web be sure to check out ProCure's recently improved website, [www.procure.ca](http://www.procure.ca). Look for the following: "Click here for news and upcoming events". This will allow you to view information regarding our next general meeting etc.

**A delightful and prosperous New Year to all!**

**Many thanks, Joseph L. Applebaum**

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## Dr. Peter Gruner

*Notes on talk of Oct. 27, 2005*

Dr Peter Gruner is a true pioneer in the field of Medical Oncology – the use of medicine rather than surgery to treat cancerous tumours. After graduation from McGill's School of Medicine in 1959, Dr Gruner continued his studies in the Boston area where he witnessed the tremendous impact of chemotherapy on a patient with severe metastases of the liver. With that experience and convinced that this disease could be controlled, he became dedicated to the field of oncology. Although he was soon to learn How to Fall Gracefully (from the book by Phil Simmons who suffered from Lou Gering's disease,) he continued his work at St Mary's Hospital here in Montreal. He formed what eventually became a multi-disciplinary Oncology Clinic with oncology specialists in radiation, pathology, urology, surgery, and supportive care physicians and nurses. After being responsible for chemotherapy at St Mary's for 30 years, Dr Gruner retired to pursue his interest in the supportive aspect of cancer care. This has most recently resulted in his becoming involved with the West Island Palliative Care Residence as the resident pathologist.

Doctor Gruner reported on the many advances during his career, concentrating on the treatment of PC after hormonal treatment has lost its effectiveness. He noted that the medications in use today by patients where hormonal treatments are not helping, are more precise than in the past and secondary results are less widespread. Nausea, hair loss, problems within the bone structure, are still issues but, in general, not as severe as a few years ago. He admitted that chemotherapy is still a journey to find the right medication treatments for each specific patient but we are now at the level of studying the defence mechanisms of the cancer cells and the best possible approach to kill these cells.

Dr Gruner introduced us to a more detailed understanding of chemotherapy. In the normal progression of PC, the approach of using hormonal manipulation to eliminate the testosterone and thereby tumour growth is well known and widely used. Eventually this process loses its effectiveness and cancer cells normally attack the bones. Obviously it is important that the patient be aware of this in order to change the defence strategy. Today that change is often to chemotherapy.

Apart from PSA the only clinical manifestation of PC having reached a new stage is the pain caused by the bone metastases.

Dr Gruner described the process as affecting the normal balance in bone metabolism where there is a constant process of bone formation, as a result of the stimulation by cells that form bone (osteoblast), and bone destruction, as a result of stimulation by cells that break down bone (osteoclast). Once cancer cells are in the bone tissue they can alter the process of balance of bone tissue to build up and tear down the bone structure. However, as Medical Oncologists explore the ways to interfere with the cancer cells, new approaches are being developed to control the PC. The basic objective of chemotherapy is to kill the cancer cells by treating them with chemicals that interfere with the process of cell division. This is done either by damaging the proteins involved, or by damaging the DNA itself.

In the 1960's, only 3 or 4 chemotherapeutic agents were in use. One of these was Nitrogen mustard which modifies the DNA. "Descendants" of this agent are still in use but now there are many more from which to choose. Forty years ago, a cure was thought to have been found for childhood leukemia. Now we know that there are many different strains of leukemia and many different responses from the children affected. Today, researchers are looking into the effects of different combinations and different sequences of the drugs. Patients may be treated with eight or more drugs

Since the mid 1990's, drug manufacturers have produced monochrome antibodies to be used against PC cells. The theory was that a cell was either in an active state of growth or a state of rest. Resting cells were "hidden" from Chemotherapy unless very large doses were used which would have resulted in serious damage on regular cells. Today's drugs permit a more focused attack and therefore cells can be targeted with strong dosages during the state of rest.

Dr Gruner gave an excellent explanation of the cell cycle. He described the cycle as consisting of 4 stages: G1, a resting stage prior to DNA replication; S, the synthesis stages, in which the cell DNA is duplicated; G2, a 'gap' stage when the cell prepares for division; and M for Mitosis, in which cell division takes place and 2 daughter cells are created. Oncologists are looking at cell models, studying these different stages and learning more and more about the cancer we hope to control. From this knowledge, we can derive processes and schedules. The size of a patient's tumour can indicate the stage of the cancer development in that specific patient. This will establish the objective and thereby the treatment.

*(Continued on page 4)*

**Dr. Gruner** (Continued from page 3)

We learned more about the findings of these studies which show that the cancer cells adapt to their environment. For example, a protein, p53, normally acts as a tumour suppressor that causes non cancer cells to stop dividing. However in a cancer cell environment, mutations of the protein develop which do not stop the divisions. Thus cells divide uncontrollably and form tumours.

Over time other factors develop blood for the cells to grow - contribute to the growth of the cancer cell - the earlier you can attack the cancer the better it will be. The patient's health depends on finding agents that can neutralize the growth factor.

On another field, chemotherapy is to be used in concert with radiation therapy (Strontium 89). The expectation is to be able to deliver more therapy to affected tissue without affecting the normal cells.

Dr Gruner took us through the steps involved in proving the effectiveness and safety of newly developed drugs. Clinical trials are one of the most critical steps in the development, approval and application of new drugs and procedures. They are used to prove or disprove the capabilities of new chemotherapy agents and processes. These studies provide answers to the questions: at what stage in the cell cycle, and by what means, is it most effective to try to destroy a cancer cell. Forty years ago, chemotherapy treatments would be given on weekdays only. As Dr Gruner noted, cancer cells don't take the weekend off. These days, the treatments are more attuned to the schedule of the cancer cells and their environment.

It is essential that patients participate in these trials. National or even international trials are essential in the research, development and production of a new drug. A clinical trial usually consists of 3 phases.

A Phase 1 trial often involves 10- 25 people. The work may include these or other tasks: computer modeling, safety concerns, extrapolation of animal test results, tests for toxicity and the Maximum Tolerated Dose, and notes on any serious side effects.

A Phase 2 trial could involve over 100 subjects and is usually designed for clinical activity: safety, suitable applications within likely organ systems, responses of various types of tumour, patient tolerability.

Finally, a Phase 3 trial may be international or national in scope with a thousand participants or more, and will include certain institutions which have agreed as to the value of the trial, drug laboratories, manufacturers and others. During this final phase, studies will cover an ethical review of the testing and the applications, Quality of Life issues, effectiveness of the drug.

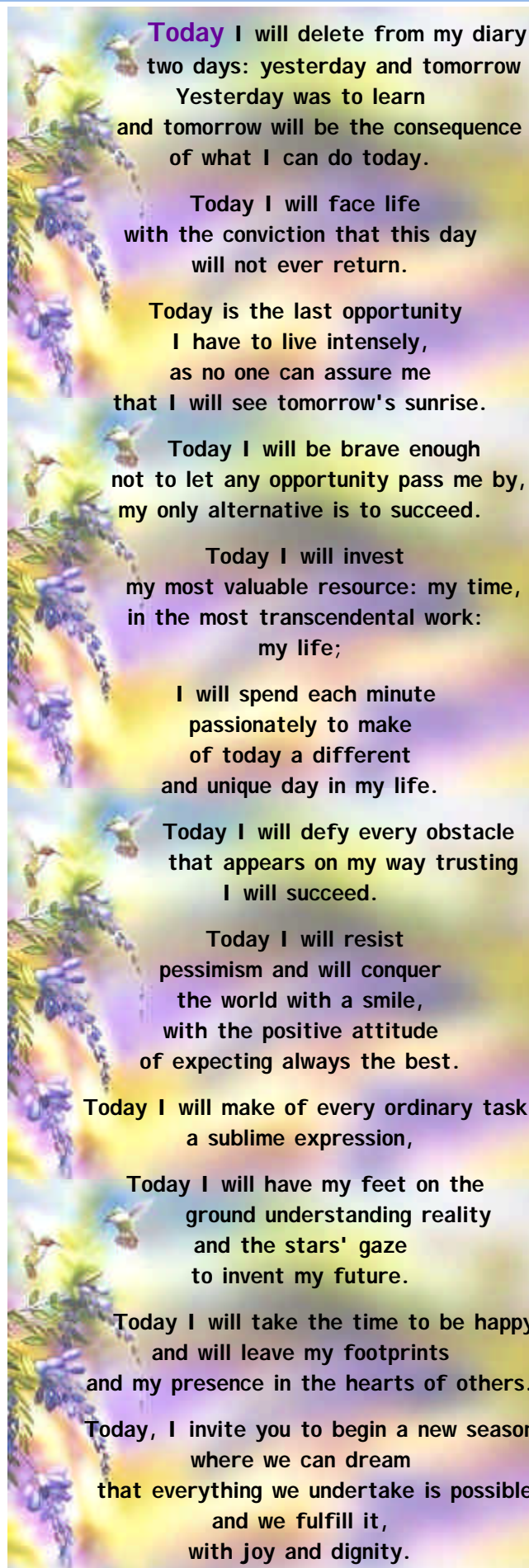
One recent example of this process was the clinical trial for Taxotere (docetaxel)

- ♣1999 Ph 1 initial tests showed 23% improvement in life expectancy, an amazing result for a Phase 1 trial
- ♣2000 Ph 2 similar result over 70 patients
- ♣2004 Ph 3 FDA Approval, 15% longer life span

Trials are never predetermined. There is a risk, but the process must have participation during the trials in order to advance. As a result of the Taxotere trials a new standard has replaced the previous mainstays of chemotherapy. Any new offering will have to improve upon the Taxotere performance.

In conclusion, Dr Gruner simply pointed out the obvious, as he put it, there are lots of things happening in medical oncology. The mortality rate reflects the developments of this work. He expressed the hope that people would be motivated to continue this work.

*Report by Bill Corless*



**Today I will delete from my diary two days: yesterday and tomorrow  
Yesterday was to learn  
and tomorrow will be the consequence  
of what I can do today.**

**Today I will face life  
with the conviction that this day  
will not ever return.**

**Today is the last opportunity  
I have to live intensely,  
as no one can assure me  
that I will see tomorrow's sunrise.**

**Today I will be brave enough  
not to let any opportunity pass me by,  
my only alternative is to succeed.**

**Today I will invest  
my most valuable resource: my time,  
in the most transcendental work:  
my life;**

**I will spend each minute  
passionately to make  
of today a different  
and unique day in my life.**

**Today I will defy every obstacle  
that appears on my way trusting  
I will succeed.**

**Today I will resist  
pessimism and will conquer  
the world with a smile,  
with the positive attitude  
of expecting always the best.**

**Today I will make of every ordinary task  
a sublime expression,**

**Today I will have my feet on the  
ground understanding reality  
and the stars' gaze  
to invent my future.**

**Today I will take the time to be happy  
and will leave my footprints  
and my presence in the hearts of others.**

**Today, I invite you to begin a new season  
where we can dream  
that everything we undertake is possible  
and we fulfill it,  
with joy and dignity.**

## HORMONAL THERAPY - WHAT ARE THE DRUGS DOING?

**TABLE # 1 - Endocrine Therapies Used in the Treatment of PC**

The essential mechanism involved in ADT (androgen deprivation therapy) is the prevention of access of androgens to the prostate cancer cell. This may involve actual decrease in available androgen (orchiectomy, LHRH-A or LHRH antagonist), interference with the ability of androgen to interact or make contact with the prostate cell receptor (anti-androgen) or an alteration in the androgen receptor. This table includes the major forms of ADT which work exclusively on androgen-dependent PC (ADPC)

<b>Class of Therapy</b>	<b>Therapy Name</b>	<b>Mechanism(s)</b>	<b>Comments</b>
Surgical removal of testicles	Orchiectomy	Removes testicular source of testosterone (T)	Reflex Increases in LHRH, LH, FSH, and possibly ACTH leading to increase in adrenal androgens
LHRH agonists or LHRH-A	Lupron, Zoladex, Trelstar, Viadur, Eligard	Down-regulates LH to lower T; decreases FSH	Causes T surge lasting up 10-14 days; FSH rises after many months
LHRH antagonists	Abarelix, Cetrotide	Blocks LHRH to lower T; decreases FSH	No T surge; No FSH increase after months of use
Anti-androgens	Eulexin, Casodex, Nilandron, Androcur (CPA)	Blocks androgen receptor and prevents T and DHT from stimulating PC growth: CPA also lowers LH	Reflex increase in T with metabolism to estrogen can cause gynecomastia (breast enlargement and nipple sensitivity)

**TABLE # 2 - Endocrine Therapies Used in the Treatment of PC**

These approaches (estrogenic compounds and P450 enzyme inhibitors) are broader in activity because they have an anti-PC effect against both androgen-dependent PC (ADPC) and androgen-independent PC (AIPC). 5-AR inhibitors are gaining popularity in use and most often are combined with LHRH-A and anti-androgens or anti-androgens alone.

<b>Class of Therapy</b>	<b>Therapy Name</b>	<b>Mechanism(s)</b>	<b>Comments</b>
Estrogenic compounds	DES, Stilphosterol, Honvan, Estradiol patches, Estradiol gel, Estradurin, (*PC SPES)	Lowers FSH, LH and lowers T; Direct cytotoxic effect on PC cell of androgen receptor	Increases sex binding hormone globulin which lowers free T; increases prolactin which increases sensitivity
P450 enzyme inhibitors	Nizoral (HDK or Ketoconazole)	Decreases testicular T, decreases adrenal androgens. direct cytotoxic effect on PC cell	Synergistic with many chemotherapy agents; decreases MDR gene; causes reflex increase of LH if pituitary-testicular axis not blocked by LHRH-A or estrogen
5-alpha reductase (5-AR) inhibitors	Proscar (finasteride) (Type 2 - 5-AR inhibitor) Avodart (dutasteride) (Type I & 2 - 5-AR inhibitor)	Blocks conversion of testosterone to DHT, DHT is 5 times more potent growth stimulator than T	Proscar: reduces DHT in blood by 70% and by 80-90% in prostate Avodart: reduces DHT in blood by 98%

\*PC SPES is no longer being manufactured as of June 2002 due to detection of DES, Coumadin and Indocin in various lots of PC SPES

**TABLE # 3 - Endocrine Therapies Used in the Treatment of PC**

These forms of ADT work by decreasing the sensitivity of the androgen receptor or by decreasing adrenal androgens.

<b>Class of Therapy</b>	<b>Therapy Name</b>	<b>Mechanism(s)</b>	<b>Comments</b>
Steroids	Decadron or Hexadrol Hydrocortisone, Prednisone	Decreases CRF and ACTH and diminishes adrenal androgens	Causes excessive bone loss unless bisphosphonates and bone supplements are used
Prolactin Inhibitors	Dostinex Bromocriptine	Reduces sensitivity of the androgen receptor	Requires careful dose titration; nausea common, hypotension possible
Selective blocker of adrenal androgens	Cytadren (Aminoglutethimide)	Decreases adrenal androgens	Requires use of hydrocortisone

## Survey Shows Many Men Falsely Believe They Are Cured Of Prostate Cancer Following Initial Treatment

**This** survey of prostate cancer patients diagnosed within the past two years shows that many men are unaware of the likelihood of recurrence of their cancer following initial treatment and believe they are cured. Of the men surveyed, 66 percent believed that as a result of their initial treatment their prostate cancer has been cured.

"**Unfortunately**, in many cases this is simply not true. Research shows that of all men treated for prostate cancer --including those treated by surgery or radiation --one-third or more will see their cancer return within ten years," said John Page, President and CEO of Us Too! International.

The 10-year clinical recurrence rates following radical prostatectomy (surgical removal of the prostate) and radiation therapy can exceed 30 percent. Of the men surveyed, about half either said they were not told (35 percent) or did not know (14 percent) what the chances of recurrence were. Of the other half who had at least some idea about the possibility of their cancer returning, most (37 percent) believed it is less than 25 percent. The survey also showed that 40% of patients were told by their doctor that they were cured.

**Four** out of five men surveyed (83 percent) said they have not discussed with their doctor any additional treatment to reduce the possibility of recurrence, and two-thirds (65 percent) said they are doing nothing to prevent a recurrence of the disease. Among the one-third of patients who are doing something, their activities include watching their diet, healthy eating and exercise, regular checkups, and a small percentage mentioned taking specific medications. Studies also show that a positive mental outlook and participation in outreach and support groups contribute to better outcomes.



"**This** survey underscores the critical need for better targeting and newer treatment options designed to ensure a longer, disease-free life. Men deserve the greatest choice of options possible so that they can better manage their disease, as well as balance the potential side effects of treatment to suit their lifestyle," said Page.

**In** the survey, more than two-thirds (69 percent) said they would be interested in a treatment that could reduce the chances of recurrence of their prostate cancer; including almost half (48 percent) saying they would be very interested.

*Note: While this survey was done in 2002 by Us TOO group in the USA, it appears equally relevant today.*

### Telephone Helpline (514) 694-6412

#### IMPORTANT NOTICES:

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

#### Mailing Address:

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### Your support is needed now!

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**VOLUNTEERS URGENTLY NEEDED!**