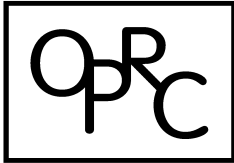


KELOWNA PROSTATE CANCER SUPPORT & AWARENESS GROUP NEWSLETTER



**OKANAGAN PROSTATE
RESOURCE CENTRE
SOCIETY**

Okanagan Prostate Resource Centre
Suite 210A – 3001 Tutt Street,
Kelowna, B.C., V1Y 2H4
Phone – (250) 712-2002
Fax – (250) 712-2004
E-mail – oprc@telus.net



**CANADIAN PROSTATE
CANCER NETWORK**

P.O. Box 1253
Lakefield, Ontario,
K0L 2H0
Phone – (705) 652-9200
Fax – (705) 652-0663
1-866-810-2726
<http://www.cpcn.org>

CCS Cancer Information Line – 1-888-939-3333

Publisher/Editor– Bren Witt

**Newsletter available on line at – www.cpcn.org
and at www.proicansupport.com**

VOLUME 12 – ISSUE 9 – (NUMBER 141) – APRIL 2009

We had a general discussion session at our March support group meeting. Several items were brought to the floor and discussed at this meeting including some of the side effects of Androgen Deprivation Therapy (hormone therapy) and some of the precautions one should take prior to having the Trans Rectal Ultra Sound (TRUS) biopsy. A couple of fellows spoke about some of the major side effects they suffered following the biopsy including some major infections that lasted quite a while.

We also had some discussion regarding the upcoming “Walking for Prostate Cancer Awareness” event we will be holding on Father’s Day June 21st in Kelowna. This event will act as fundraiser for the Okanagan Prostate Resource Centre Society. An update was given on some of the draw prizes we have received to date and asked those in attendance for suggestions or other companies that may donate. It was mentioned that this year we are not going to be having T-shirts but are going to be with Enviro-Bags for registered participants. We are looking of items that can be placed in these bags such as pens, scratch pads, etc. that can be placed in the bags.

Adjuvant Radiotherapy Following Surgery for T3 Prostate Cancer

The following is a short excerpt of an article that appeared in the *Vol. 181, 956-962, March 2009 issue of The Journal of Urology*. Dr. Ross Halperin Professional Practice Leader at the Cancer Centre for the Southern Interior in Kelowna forwarded this information to me.

Of the 186,320 U.S. patients estimated to be diagnosed in 2008, approximately a third will undergo radical prostatectomy, the only treatment which has been demonstrated to reduce the risk of death from the disease. A large community based series of men in the United States undergoing radical prostatectomy would suggest that about a third will have positive surgical margins. Another 9% in other surgical series would prove to have seminal vesicle invasion. Positive margins and seminal vesicle invasion are associated with a significantly increased risk of cancer recurrence measured at the earliest time with a detectable PSA, also known as a biochemical failure.

For decades the treatment of these high-risk patients and the use of adjuvant radiotherapy have been the subject of considerable debate. Literally hundreds of case series have been published on the subject with authors advocating for and against the treatment based on outcomes and side effects of highly selected series of patients.

A trial study involving a total of 431 men between August 1988 and January 1997, a total of 425 of these men were eligible for analysis and included in this trial study. The trial study was a randomized multi-institutional study of adjuvant

radiotherapy for pathologically advanced prostate cancer after radical prostatectomy.

Eligible patients with clinical T1-2 prostate cancer must have undergone radical prostatectomy within 16 weeks before randomization and must have had at least one criterion of pathological T3 disease such as extracapsular tumor extension, positive margins or seminal vesicle invasion. All patients had to have had a negative bone scan and were initially required to have had a negative pelvic lymphadenectomy. Starting in 1995 patients were not required to undergo lymphadenectomy if they met the low risk of 1) clinical stage T1a or T2a, Gleason 2-6 and a PSA of less than 10 ng/ml; 2) stage T1b-c, Gleason 2-5 and PSA less than 10 ng/ml; 3) stage T2b, Gleason 2-6 and PSA less than 6 ng/ml; or 4) stage T2c, Gleason 2-6 and PSA less than 4 ng/ml. An undetectable PSA after radical prostatectomy was not required. Additional eligibility requirements were adequate bone marrow and liver function, no evidence of total urinary incontinence, pelvic infection, and no history of intraoperative rectal injury. No prior radiotherapy or chemotherapy for prostate cancer was allowed.

Overall Survival –

Of the 425 men who were eligible for analysis in the trial study 211 were randomized for observation and 214 men had adjuvant radiotherapy. Of the 211 subjects in the observation only group 110 or 52% have died and of the 214 in the adjuvant radiotherapy group 88 or 41% have died. Median overall survival in the observation and adjuvant radiotherapy groups was 13.3 and 15.2 years.



Up Date on Expansion at BC Cancer Agency Centre for the Southern Interior in Kelowna

Dr. Halperin sent me an up date on the expansion of CSI in Kelowna.

The installation of the newest state of the art Varian Linear Accelerator is well underway at the Cancer Centre for the Southern Interior in Kelowna and It is expected that our Cancer Centre will have a fifth Linear Accelerator installed by Christmas of 2009. Then the decommissioning of the remaining three older machines and the installation of new machines will begin, this process will take a couple of years because the process has to be done one machine at a time. The decommissioning and replacement of the final three machines is slated to start in early 2010. By 2012 we should have five very modern up-to-date Linear Accelerators, up and operating at our local cancer centre. The BC Cancer Agency Centre for the Southern Interior is an extremely busy facility. At the moment they have five permanent Radiation Oncologists that as part of their sub specialties deal with prostate Cancer. The latest addition to their staff of Radiation Oncologists is *Dr. Juanita Crook* who recently joined the local

staff from her position at the Princess Margaret Hospital in Toronto.

Compound can Distinguish Between Benign Tissue and Localized and Metastatic Prostate Cancer –

The following information is an excerpt of information that was obtained from the Internet and originated with the *NIH News (The National Institutes of Health in the U.S.)*

At our support group meeting in February one of the fellows at the meeting mentioned some new research involving the discovery of this new molecule *Sarcosine*. For more information please see below.

Researchers have determined that a molecule produced by the body's metabolism could be used to differentiate between benign prostate tissue vs. localized and metastatic prostate cancer. They also found that this molecule, known as sarcosine, may be associated with prostate cancer invasiveness and aggressiveness. The findings were reported by researchers at the Michigan Centre for Translational Pathology, Ann Arbor and were supported by the National Cancer Institute's (NCI) Early Detection Research Network (EDRN). The research appeared in the February 12, 2009 issue of *Nature*. NCI is part of the National institutes of Health.

“Current biomarkers for detection or progression of prostate cancer are not as precise as we would like. Therefore, a more accurate indicator of cancer is of great interest,”

said *Sudhir Srivastava, Ph.D., Chief of NCI's Cancer Biomarkers Research Group*. "Sarcosine and some other select metabolites may be excellent indicators of progression."

Multiple complex molecular events characterize cancer development and progression. Determining which molecular networks dictate whether cancer will be confined to the prostate or spread to other parts of the body could lead to the identification of critical biomarkers associated with prostate cancer invasion and aggressiveness.

Although many genes and proteins related to cancer have been extensively characterized by genomic and proteomic studies, little is known about metabolomic changes that mark a tumor's progression. Metabolomics, upon which this current findings is based, is the study of the unique chemical fingerprints that cellular processes leave behind, which can help scientists understand the makeup of a cell. One of the challenges that scientists currently face is integrating genomic, proteomic, and metabolomic information to give a more complete picture of living organisms and the diseases that afflict them.

Using a long-established laboratory call mass spectrometry, which sorts chemical compounds by their molecular weight, the researchers profiled more than 1126 metabolites from 262 clinical samples related to prostate cancer (42 tissue samples, 110 urine samples and 110 samples of blood plasma). These metabolomic profiles enabled researchers to distinguish between benign prostate tissue, clinically localized prostate cancer, and metastatic

disease. Sixty metabolites were identified in localized and/or metastatic prostate tumors that were not present in benign prostate tissue. Ultimately, six metabolites, including sarcosine, were to be significantly elevated during progression from benign tissue to localized cancer to metastatic disease. Sarcosine was also detected in the urine of men with prostate cancer. Because this metabolite showed progressive elevation from benign to localized prostate cancer to metastatic disease, it was selected for further study.

To investigate the role of sarcosine in prostate cancer progression, the researchers performed analyses of laboratory-grown cells. They found that sarcosine levels were higher in invasive prostate cancer cells than in benign prostate cancer cells. Moreover, the addition of sarcosine to benign prostate cells caused them to become invasive. By manipulating levels of the enzymes that regulate sarcosine metabolism, the researchers found they were able to control the invasiveness of benign and malignant prostate cells.

"Components of the sarcosine pathway could serve as novel avenues for therapeutic intervention," said Arul M. Chinnaiyan, M.D., Ph.D., Michigan Center for Translational Pathology at the University of Michigan, Ann Arbor. "Our next step will be to confirm these findings in a greater number of specimens and to have our results validated by other laboratories."

Editors Note: As indicated in the above article this is very preliminary research and we will have to wait and see if other laboratories confirm the above findings.

WITT'S WIT (ON THE LIGHTER SIDE)

New Priest Dilemma

A new priest, born and raised in Texas, is nervous about hearing confessions, so he asks an older priest to sit in on his sessions.

The new priest hears a couple of confessions and then the old priest asks him to step out of the confessional for a few suggestions. The old priest suggests, "Cross your arms over your chest, and rub your chin with one hand and try saying things like 'yes, I see,' and 'yes, go on,' and 'I understand.'"

The new priest crosses his arms, rubs his chin with his hand and repeats all the suggested remarks to the old priest.

The old priest says, "Now, don't you think that's a little better than slapping your knee and saying, 'No shit...what happened next?'"

More Answers About Prostate Health –

The following originated with *The New York Times* by Tara Parker-Pope on Health and features questions to Dr. Paul Mulhall Director of the Male Health & Reproductive Medicine Program at Memorial Sloan-Kettering Cancer Center in New York.

We have had several questions raised at our support group meetings regarding PSA testing and the digital rectal exam. I came across the following and thought it would be of interest to those receiving this newsletter.

Q - I am 55. My father died of prostate cancer at 71. I am surprised that my doctor relies exclusively on my PSA and does not also perform a digital exam of the prostate. Is a PSA alone proper medical procedure?

A - We increase the ability of screening to diagnose prostate cancer by using both. Men with low PSA levels may have aggressive cancer. In fact, the more aggressive the cancer, the less likely that the PSA level will be elevated. The cells are so undifferentiated that they don't make a lot of PSA. The digital rectal exam helps us make a decision about whether men should be biopsied. The two tests together are better than either alone.

The Kelowna Prostate Cancer Support and Awareness Group does not recommend treatment modalities; however, all information is fully shared and confidential. The information contained in this newsletter is not intended to replace the services of your health care professionals. You are advised to consult with your health professional regarding matters of your personal health.

UP COMING MEETING DATES-

May 9th – June 13th – July 11th – NO MEETING IN AUGUST – Sept 12th

Please Note Change of Meeting Location:

Our regular monthly meetings are held on the second Saturday of each month in the meeting rooms of the Rutland Senior Citizens Centre – 765 Dodd Road. Our meetings begin at 9:00 A.M. and are generally over by 11:00 A.M.

I would like to thank both AstraZeneca manufacturer of Zoladex® and Casodex® and Sanofi Aventis manufacturer of Eligard® and Taxotere® for their support in producing this newsletter.

Thank you for helping us “Win the War Against Prostate Cancer.”

The Okanagan Prostate Resource Centre operates on donations. We would like to thank the Companies, Service Clubs, Organizations and Individuals that have made donations in order to help us operate this very valuable center. If you wish to make a donation please feel free to fill out the form below. Your support is gratefully appreciated. Our official Registered Charitable Number is - 89269 1718 RR0001

NAME - _____

ADDRESS - _____

CITY - _____ PROV. _____ POSTAL CODE _____

\$25. \$50. \$100. \$250. \$500. \$ Other amount _____

Please make your cheque payable to the –

Okanagan Prostate Resource Centre Society,
Ste. 210A – 3001 Tutt Street,
Kelowna, B.C.,
V1Y 2H4

An official charitable receipt will be issued and mailed out to you.

Canada Revenue Agency: <http://www.cra.gc.ca>