



Canadian Prostate Cancer NETWORK

Dec. 2005

The Voice of Prostate Cancer in Canada™

NEWS

Order wristbands while supplies last

Have you heard about the new Canadian Prostate Cancer wristbands? CPCN now has a healthy supply of these wristbands which are emblazoned with the words, "Strength - Unity - Courage/Force - Unité - Courage." Wristbands are sent free of charge to any Canadian support group upon request. We suggest that support groups sell the wristbands for \$2.00 each. Groups keep the proceeds for their local awareness activities. Send your request to CPCN, P.O. Box 1253, Lakefield, ON K0L 2H0 or e-mail your order to cpcn@nexicom.net.

REPORTS FROM THE SUPPORT GROUPS

Dick Groot of the **Kings County NS PC Support Group** reports that group momentum is growing and meetings are held on the last Wednesday of the month (except in December, July and August) at the East Kings Public Health facility on Earncliffe Ave. in Wolfville from 7-9 pm.

Stephanie Ruckstuhl reports that the **free PSA clinic in Cornwall** saw enthusiastic participation. "The line ups were long to start. I would guess over 200 were in line by 10:00 am on Saturday. Four lab technicians worked straight through until 3 pm without a break. Most came because they were without a family doctor, but for those who had a family doctor their chief complaint and reason for attending had more to do with the cost and wanting more information to why not all doctors agree on the test as a screening tool. By the days end we had processed over 460 people and handed out over 100 colorectal screening kits."

Emmett Mulvaney from **New Brunswick** reports that their presence at the Moncton Woodworking Workshop generated about 400 contacts. They heard "lots of horror stories" including one from a "gentleman who said his father and brother have prostate cancer and all his doctor did was a rectal exam and told him not to worry."

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Conference 2005 – Review



Hats off to Aaron Bacher and all the support group members and spouses who did such a great job of hosting the Toronto event. (inset) Mac Butt from Newfoundland receiving the President's Award from CPCN president Bob Shiell.

The Second Annual Canadian Prostate Cancer Network Conference was, by all accounts, another big success.

Delegates from across Canada attended the conference, held on August 7th, 8th, and 9th at the Delta Chelsea Hotel in downtown Toronto. They enjoyed a variety of top-notch speakers, workshops, informal gatherings, and this year, for the first time, a trade fair where sponsors had displays offering information and spokespeople on hand to answer questions.

Floyd Mitchell, a member of the Vernon Prostate Support Group in BC's Okanagan Valley, was amazed at some of the new ideas and innovations that seemed to have been made in the one year that had passed since the Calgary conference. "I was quite astounded at how much more I could learn just a year later," he says. "I didn't realize laparoscopic robotic surgery was now becoming an option for some men who would have undergone a radical prostatectomy, and I had never heard of High Intensity Focused Ultrasound. The presentations really were first class, and I appreciated the time reserved for questions afterward."

Euclid Leblanc, of Fredericton, was

fascinated to learn about high dose brachytherapy. "That was something completely new to me," he says. "All we knew about was brachytherapy. I didn't know about this new technique."



Unlike brachytherapy, in which radiation therapy is delivered via radioactive seeds that are implanted in the prostate and remain there for an extended period of time (i.e. permanently), HDR brachytherapy enables doctors to deliver equivalent doses of radiation in just minutes by inserting and then removing the radioactive beads. HDR brachytherapy is usually performed as an outpatient procedure, and doctors are able to control the dose of radiation more precisely and minimize the potential for damage to surrounding tissues.

Dr. Edward Woods, a urologist from Scarborough General Hospital, headed the presentation about an exciting new treatment called HIFU - High Intensity Focused Ultrasound in which men are treated via an endorectal probe equipped with an ultrasound scanner and HIFU treatment applicator.

Joseph Johnston, a member of the Brockville Prostate Cancer Awareness and Support Group, was quite interested to learn of a cutting edge technology that uses viruses to combat cancer. "This technique is still down the turnpike somewhat, but it sounds like they will be able to inject specially developed viruses into the body which will go around

and look for cancer cells to destroy," he says. "It would be like being able to take a pill against the flu."

The conference's keynote speaker was Dr. Gerald Chodak, a urologist from Chicago, who founded the first North American support group back in 1989. Dr. Chodak gave a general overview of all the known treatment options and emphasized the importance of patients getting involved in their own care.

Euclid Leblanc was impressed with the workshops facilitated by Ron Benson and Jim Moran, both board members and volunteers with Toronto's Man To Man Prostate Cancer Support Group.

Leblanc also came away with the feeling that his participation in the conference would help him do an even better job of supporting and informing other men. "It was a nice feeling to learn about all these advances and feel that I was going home well-informed and able to



Dr. Gerald Chodak

provide new members of our support group with as much information as possible," he says.

Next year's conference will be held in Calgary July 30, 31 and Aug 1. The theme of the 2006 conference will be "Winning the War on Prostate Cancer", and our featured guest will be Dr. Stephen Strum world renowned prostate cancer specialist. In addition there will be extensive patient/support group related seminars as well as the opportunity to exchange best practices. Reserve the dates now.



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PCa Wives: the untold story

Would it surprise you to know that 85 percent of calls to CPCN come from women?

That statistic provides the first clue that significant others play a very important role when a man has prostate cancer.

Margaret Seeley, of Lakefield, knows this both from personal and volunteer experience. Margaret, wife of CPCN Executive Director Wally Seeley, fields some calls that come into CPCN and has had many conversations about prostate cancer with wives, partners and even daughters and daughters-in-law. "Some are concerned because their husband won't go for a PSA test," says Margaret. "In many cases the man has been diagnosed, but the partner feels she doesn't have enough information. I get the impression that often the men want the info, but they find it hard to go ahead and make the call."

Although information about prostate cancer diagnosis and treatment is readily available, some answers women need are hard to find in books and on websites. "The thing I wish someone had told me was how long it takes to recuperate from prostate surgery," says Catherine Wackett, of Orillia, Ontario. "It surprised me how long it took before my husband was up and around. Usually the man is only in the hospital for three or four days, but then he comes home and you've got a catheter to help him with and

drainage bags to look after."

Personal care was one of the issues that came up in the research of Lorna Butler, professor of nursing at Dalhousie University in Halifax. She has conducted surveys designed to shed light on the concerns of wives and partners of prostate cancer patients. "Many women expressed the concern that they were now having to provide care in a fairly intimate area that men were used to looking after themselves." Women identified helping men with drainage bags, catheter care and clearing around the penis as areas of awkwardness. In some cases, couples reported sleeping separately for reasons such as a fear of the woman getting her leg caught in the catheter and pulling it out accidentally.

Another challenge is that the patient, often a very independent man, finds it hard to be in the position of having to depend on his partner. "Colin felt bad that he had to ask me for assistance with things like his catheter and bags," says Catherine. "It wasn't easy for me either. I've always been a little weak when it comes to dealing with bodily fluids. It took me a while to get used to it."



Aki Arai, Linda Garshon and Roz Wagman at the 2005 CPCN Conference.

Margaret Seeley understands. "Sometimes it's the little embarrassing things that drive you crazy," she says. Wives may also find themselves struggling for just the right thing to say at certain times. For example, if hubby is doing more lifting than he should, how can she get him to stop without being a nag? Or let's say a man is reluctant to use a Depends, his wife might think, "If I can say just the right thing in the right way, it might help him." She may worry that if she says the wrong thing, he might become even more defensive. "Sometimes they don't say anything," says Butler. "And that doesn't help either."

"Such issues don't always come out in consultations with doctors and nurses, because the conversations tend to centre on concrete medical issues," says

Butler. "Sometimes the wife may be asking, 'How do I manage this catheter?' But her underlying question is, 'How does he feel about me doing this, and what does it do to our relationship?' That's the kind of thing couples need more help with."

Another challenge is that men and women have very different ways of processing information, Butler says. "We asked nurses to keep track of the questions that men and women asked during consultations. What they found was that men had very few questions and the women had lots of questions." Here's another striking finding. Almost all the women in Butler's survey said they were involved in treatment decisions. But when their husbands were asked the same question, only one in 20 said his partner was an active participant.

It seems like a cliché to say that communication is the answer, but it's true. However, since each man, his wife and their relationship are a little bit different, it is not easy to provide a communication blueprint. A good place to start is with the acknowledgement that, although the actual disease and recovery are happening to the man, his partner is experiencing both too. "You both have to learn to cope," Margaret Seeley says. "This is a team disease, and you have to work on it together."

Election opportunity...lobbying for CPCRI

On October 25, some prominent Canadians had the opportunity to get a free PSA test, just steps away from the House of Commons.

This event was put on by Canadian Prostate Cancer Research Initiative (CPCRI) as a way to reach out to some of our parliamentarians and drive home a message about the importance of prostate cancer awareness and research.

Last year, CPCN News reported that the federal government did not renew funding for the CPCRI when its five-year Health Canada funding ran out in 2004. The organization still gets some funding from the National Cancer Institute of Canada, but without the Health Canada dollars, which constituted two-thirds of the CPCRI budget, it has had to operate at reduced capacity and is urgently seeking new sources of funding.

Peter MacKay, Deputy Leader of the Progressive Conservative Party of Canada, hosted the free PSA test, which was attended by more than two dozen MPs, both male and female, two Senators and representatives of all political parties in the House of Commons.

In addition to a healthy breakfast and a free PSA test, the guests were addressed by Dr. Neil Fleshner, Chief of Urology at Princess Margaret Hospital in

Toronto; Dr. Lorna Butler, Professor of Nursing at Dalhousie University in Halifax; Ewan Clark, Chair of the CPCRI, and Wally Seeley, Executive Director of CPCN. Five members of the Ottawa Prostate Cancer Support Group were also in attendance. All speakers stressed the importance of research and the need for the federal government to support the CPCRI with renewed funding.

Despite the funding loss, the CPCRI is still very much in operation. Ongoing projects continue and some new ones have been funded.

With a federal election on January 23 **NOW** is the time to visit, write or email the candidates in your riding. Ask them to help in reinstating the research dollars Health Canada refused to continue for the Canadian Prostate Cancer

Research Initiative. Your current Member of Parliament may be easily identified by clicking on the appropriate link on the CPCN web page and inserting your postal code.

More information about the Canadian Prostate Cancer Research Initiative can be found at www.prostateresearch.ca

Full Steam Ahead for *Our Voice*

Many CPCN News readers will be familiar with *Our Voice*, a magazine for men with prostate cancer published by Parkhurst Publishing. Thanks to an unrestricted educational grant from AstraZeneca Canada Inc., *Our Voice* is now back to publishing four times yearly.

Along with updates on the latest medical and research information, *Our Voice* draws upon reader input for some of its editorial content. Readers may submit questions to be answered by specialists from the magazine's editorial board or personal stories. *Our Voice* publishes

personal stories, about 700 words in length, says managing editor, Mairi MacKinnon. "It may be a story written by the reader. Other times the story is based on an interview with one of our writers." Men and their partners are invited to submit questions or stories to the magazine. Mackinnon explains, however, that it is not possible to print all stories and questions, and it may

take several months for the answer or article to appear.

Our Voice also features regular listings of Canadian support groups. Therefore, support groups should contact Parkhurst Publishing with updated contact information for each group. Support groups will also be sent 10 copies of each new issue, upon request.

For a free one-year subscription, or to submit a question or a story, contact:

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Goodbye Watchful Waiting. Hello Active Surveillance.

Watchful waiting has been part of the language of prostate cancer for many years. But if physicians like urologist/oncologist Dr. Stephen Strum and Toronto's Dr. Laurence Klotz have their way, the phrase will soon be history.

Watchful waiting became an accepted medical practice because prostate cancer is usually (but not exclusively) a slow-growing disease, which, in the past, was usually diagnosed in fairly elderly men. Some had other higher priority health problems, which sometimes made treatment risky. Others were not expected to live long enough for their prostate cancer to become clinically significant.

Klotz says that historically there are some unhelpful connotations around the term watchful waiting. "In parts of northern Europe, for example, watchful waiting has meant that men with prostate cancer were not treated until they progressed to the stage of metastatic disease [when the cancer has spread to other sites in the body]," he explains. At that point, they would get treatment designed to prolong their life, but which usually didn't offer the chance of a cure.

Strum agrees and would like to replace watchful waiting with a new term: active objectified surveillance (AOS). "I'd really like to see us put the term Watchful Waiting to bed since it connotes doing nothing whereas AOS involves diet, lifestyle and surveillance modes of operation."

Treatment standards began to evolve with the advent of PSA testing, which resulted in prostate tumors being detected in younger, healthier men, sometimes at a very early stage. This increased the chance of a cure but also raised the spectre of relatively young men having to live for a long time with the side effects of treatment.

Peterborough urologist/surgeon Dr. William Meade explains that prostate cancer specialists are trying to improve their selection of patients who need treatment.

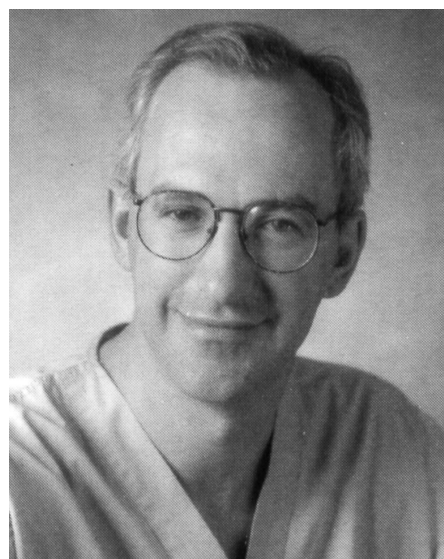
"Prostate cancer is unique in that it is very, very common [one in seven men will be diagnosed with prostate cancer at some point]," he says. "And though a lot of men still die from it, because prostate cancer progresses more slowly than other cancers there's a danger of treating men who probably didn't need to be treated."

Urologists use a tool called the Albertson Tables to assess a man's need for treatment. Meade explains. "Let's say a 55-year-old man has a Gleason [assessment of how cancer cells look under the microscope] score of seven, a PSA of seven and his biopsy showed that three of six cores have cancer cells. He would be estimated to have a 50% chance of dying in the next 10 to 15 years. Those odds point to treatment," says Meade, (Doctors also take into account criteria such the percentage

of each core that contains cancer cells, also the man's reasonable life expectancy given his age and general health.)

But if the same man had a Gleason score of six, with a cancer in only a portion of one or two cores, he would be thought to have only a 20% chance of dying in the next ten to 15 years. Meade would suggest monitoring his cancer with repeated PSA tests. It's men with Gleason scores (based on how the cancer cells look under the microscope) of six or less who historically have been the ones over treated, according to Meade. Five to ten years ago, a man with a Gleason score of six was in the need-to-treat category. That's not the case now. "Most Gleason six tumors are not fast growing," says Meade. That means that for most of these men there is a long window of curability. In other words, their cancer is not likely to progress to the incurable stage for a number of years.

That's reassuring, but men with prostate cancer will have two key questions: "How do I know I'm not one of the exceptions" and, "How long is my window of curability?" The most widely used monitoring tool is PSA doubling time, which is considered a good indicator of the cancer's aggressiveness. With a low-grade cancer a man might be tested every three to six months. But when the cancer is higher-risk (more biopsy cores showing cancer and higher percentage of cancer in those cores) but still within the criteria for active surveillance, testing might be done every two months. The idea is to assess man's PSA doubling time



Dr. Laurence Klotz

(how quickly his PSA score doubles). Meade says "If the PSA score doubles within three years, we would treat more aggressively. In some cases that might involve another biopsy, but if the doubling time was very rapid, we might move straight to surgery."

Recent research suggests that careful implementation of this approach is safe. Dr. Klotz's data from the surveillance of 299 prostate cancer patients in the favourable risk category (Gleason six or less, PSA under ten, small volume of

tumor) showed that the average PSA doubling time for these men was about seven years. For close to half (42%) the doubling time was ten years. Only five percent saw their PSA double in less than a year. Klotz says that while there are ways to predict PSA doubling time using as few as three scores taken at least three months apart, the most accurate method is to get 8 or 9 scores over a two year period. Nine and a half years into this study 99.5 percent of men are still alive. Only two died, both within five years.

Now meet Rob, a man in his mid-fifties who requested that his surname not be published because, given his profession, he does not want to be seen as a health risk. His cancer was detected by biopsy at a very early stage, so he knows he doesn't have to rush into a treatment decision. Rob wants to gather information to help him assess and monitor his cancer, so he can make informed decisions as to whether or not or when treatment is needed. But he is very frustrated that he hasn't received more help with this.

Thus far he's been offered treatment options, but little else. "I saw a surgeon who, in a very brief consultation, essentially said, 'Yes your biopsy shows that you have cancer, there's not very much of it, I can take it out, and you'll be cured.'" However, Rob had looked at his biopsy report, done extensive internet research and figured out that with his profile (Gleason score of 6, two quadrants cancer-free, one with a trace and one with 5%, PSA under five) there was no need to rush into a treatment decision. "I said to the surgeon, 'It looks to me like I have a couple of years to gather more information and consider my options.'" The surgeon agreed. Rob was referred to a radiologist to discuss brachytherapy, but again came away with no concrete plan for monitoring his cancer. "The person who has given me the most information is a psychologist, and it's not even his job," he says. "Frankly, at this point, I'm not even sure who my doctor is."

In the meantime, based on his own research, Rob has made diet and lifestyle changes – less red meat, more vegan food and supplements like selenium, vitamin E and lycopene. He's also looking into non-mainstream treatments such as High Frequency Ultrasound (which costs \$13,000) and photo dynamic therapy, which kills cancer cells with combination of strong light and a drug that makes cells very sensitive to light. Like most people with cancer, he'd just as soon not have it lurking in his body, so if he can find a low-risk, non-invasive (and affordable) treatment, he might go for it. Currently, his outlook still is good, although he's confused by his PSA scores. "I had four PSA tests over 17 months. The



Dr. Stephen Strum

scores were 2.63, 4.55, 2.75, 4.85," he says. "The two lower scores were done at my local clinic, the higher ones at the hospital lab. Which do I believe?"

Unfortunately, discrepant scores from different labs is a well-known phenomenon, says Klotz. "It's best to get all your tests done by the same lab."

Now meet John, who is a little older, 62 (although like Rob, he was diagnosed at age 55). With a Gleason score of 8.3 (seven years ago), John is definitely considered in the need-to-treat category. However, he chose not to take treatment because of concerns about side effects. John had planned to wait, monitor his PSA tests, and seek conventional treatment when his PSA level was up to 15. He reached that threshold this past August. However, the rise had taken place over six years and his score had still not quite doubled. He decided to wait a little longer but, as his PSA has risen again, he has now made an appointment with a radiologist. "I've pretty much decided to go the radiation route," he says.

But the bottom line is that, through it all, John felt that he didn't have enough information to go on. "My gut feeling is that men like me who don't opt for treatment get set aside," says Winters. "There's a lot that I'd really like to know. I've made lifestyle changes, and I think they will make a difference, but has anyone monitored a group of patients for a long time and figured out how much of a difference lifestyle changes make and which ones are the most important?"

John would also like to connect* with other men in similar situations to see what they are doing and what they can learn from each other. He was looking for an Internet discussion group for men like him but hasn't found one yet.

Klotz understands the difficulty for men who are reluctant to undergo aggressive treatment such as radical prostatectomy. "Men want to survive but they also have

*Men interested in corresponding with John can e-mail him at johnpwinters@hotmail.com

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PSA monitoring after radical treatment

By Doug Scott – Eng-D

In August 1995, at the age of 62, I underwent a radical prostatectomy for prostate cancer. My pre-surgery PSA was 25 and Gleason score (index of disease aggressiveness) was 7, a quite aggressive disease level. Because of the high PSA level and Gleason score, I was aware that I was at significant risk for cancer outside the prostate gland not curable by surgery. Although the post-surgery pathology report showed no cancer into or near the prostate gland margins, I knew that close PSA monitoring and vigilance for residual disease were called for. I had ultra-sensitive PSA tests at 3 month intervals. PSA was very low and stable for several years, but in 1999, these tests showed several consecutive small rises, to about 0.1. I immediately sought advice from my urologic surgeon, who referred me to a radiation oncologist. Advice was, with low PSA and slow rise after several years, there was good chance that the very small amount of disease present was localized in the prostate bed, and that radiotherapy offered a good chance for cure.

I had radiation treatment in March/April 2000. After the usual brief spike, my PSA went down to a very low level and has been stable at "less than 0.002" on 6-month ultra-sensitive tests. There have been some significant side-effects. Erectile function, which within 2 years of surgery (one set of nerve bundles had been spared) had returned to almost pre-surgery level, deteriorated significantly after radiotherapy, but responds well to Viagra, Cialis, etc. Urinary continence which, within 2 years of surgery, was about 98% restored, deteriorated significantly following radiotherapy. However, I knew what these risks were, and I

completely accept these as a very favorable trade-off for the positive results of the radiotherapy treatment.

Men like myself with more aggressive prostate cancer (Gleason 7 or higher) treated with radical prostatectomy can be at significant risk for small amounts of cancer left behind, undetectable by post-surgery pathology analysis and below the detectable level of PSA tests for some time after surgery. These very small, even miniscule amounts of cancer, if unchecked and given enough time, can eventually progress to threaten quality of life, even life itself. But if detected early enough, while still small in volume and located in the prostate bed, not having spread outside this area, the disease can be treated with external beam radiation, successfully controlled and even eradicated.

The key to early enough detection is regular post-surgery PSA follow-up. Optimal time for radiation treatment, the only chance of cure, is when the PSA is very low, since PSA level is considered to be an index of cancer volume, and can be an indicator of the likelihood of still localized disease. Cure is possible in that situation. If steadily rising PSA (i.e., PSA relapse) is not detected early, the chance of curative radiation treatment can be reduced, even lost. If the cancer has progressed outside the confines of the prostate bed, this metastatic disease will not be subject to curative radiation treatment, and it would not be offered. The treatment has the best chance of success if the PSA is below 1.0, but the lower the better; therefore, the sooner persistent PSA rise is detected, the better.

PSA testing sensitive enough to discriminate at very low specific levels is essential to identifying earliest persistent PSA rise (usually defined as 3 consecutive rises). This

would suggest that the desirable intervals for PSA testing would be every three or four months (not six months, as is sometimes the practice) for the first four to five years following surgery, which is the period during which the large majority of PSA rises occur. Up until that time, men with more aggressive disease (Gleason 7 or higher) are at risk of residual disease. Also, the higher the pre-surgery PSA (e.g. 10 to 20+) the higher the risk of residual disease that may not have been detectable by post-surgery pathology analysis. PSA relapse is uncommon after 5 years from surgical treatment, and rare after 7 years. However, there are instances of PSA relapse/residual disease even 10 to 12 years after surgery. So continued PSA monitoring at least every 6 months is important.

Post-surgery PSA vigilance is essential, with PSA tests giving specific readings from at least 0.05 up, which now are available at major hospital and private laboratories. Lower specific readings (e.g., 0.03 or 0.04 vs. "less than 0.05"), available from some private and hospital laboratories, are even more helpful in providing baseline PSA levels to assist in early indications of rises. Ultra-sensitive PSA tests sensitive to even lower levels (e.g., 0.002) have been developed, but are not yet in widespread general use.

Post-surgery residual prostate cancer can be treated with hormone therapy, which may appeal to older men (70+) on grounds that it will likely keep the cancer in check for the rest of their lives and in the belief that radiotherapy carries greater risk of severe side effects such as incontinence and erectile problems. This may not be the case and is something to discuss with a radiation oncologist. Hormone therapy – which would become a

life-long treatment – over time, carries its own side effects, which can be considerable since it blocks supply of testosterone, the principal male hormone. Side-effects can include reduction in energy level, muscle bulk and strength; hot flashes; erectile dysfunction and loss of libido; loss of bone density; weight gain; increased breast and fatty tissue; emotional changes. These remain significant quality of life considerations for men into their 70s and 80s.

Early-enough radiotherapy (which offers the possibility of cure, and life free of prostate cancer, the complications of progressive disease and the life-long side-effects of hormone therapy) may be a desirable option for some men. Ongoing PSA monitoring, vigilance, and readiness to take timely action, are essential.

Two directors elected

CPCN is proud to welcome Claude Forget of Val-David, Quebec and Murray Gardner from New Glasgow, Nova Scotia to its board of Directors.

Watchful Waiting

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to weigh that against quality of life issues," he says. On the other hand he knows of men at the other end of the spectrum from Rob, men considered to be at low risk but who are very uncomfortable about living with cancer in their body. "Part of the problem is that, for some men who are detected at an early stage, the word cancer is almost a misnomer," says Klotz. "Cancer implies rampaging disease, but in most cases of early stage prostate cancer, that's not the case."

Dr. Klotz and various colleagues are working on a randomized trial called START (Standard Treatment Against Restricted Treatment) in which men with good risk prostate cancer are asked to agree to be randomly assigned to either receive standard treatment (surgery, brachytherapy or radiation) or active surveillance with selective intervention. Men in the active surveillance category will be monitored very closely (PSA tests and, in some cases, repeat biopsies),

and, if their cancer progresses quickly, they will be treated.

You might think it would be hard to find subjects. Consenting to join the study means that, in the short term, a man forgoes his right to choose treatment or not. But surprisingly, one in three men consented to become subjects.

"When the risks and monitoring procedures are explained, most men can understand when their cancer is low-risk and that they don't need treatment right away," says Klotz. "The challenge is to move both patients and professionals away from the seek and destroy mentality to one that is more about target and control."

The START Trial should provide knowledge that will help both physicians and patients accept this approach to treatment and understand how to use it effectively. Upon completion, this study will have followed men for a full 20 years – the amount of time it will take to get good data on survival rates and the effectiveness of monitoring.

Klotz says, "The crux of what we're trying to do is improve our ability to predict which men in the good risk category are most at risk of a bad outcome, because the current thinking is that we want to be more conservative about who we treat in the low risk category, but be very aggressive in treatment for the men with higher risk."

Questions to ask when your doctor suggests watchful waiting/active surveillance.

- What tools will we use to monitor the tumor's progress?
- How often should I get PSA tests and DREs?
- Should I get a repeat biopsy at some point?
- How can you help me understand the information coming from those tests?
- Is there anything I can do to help myself in the meantime?



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Visit the CPCN website
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