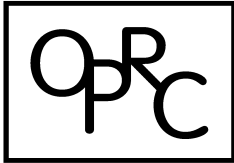


KELOWNA PROSTATE CANCER SUPPORT & AWARENESS GROUP NEWSLETTER



**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 2- (NUMBER 134) – SEPTEMBER 2008

Yvonne and I would like to welcome back all those involved with the Kelowna Prostate Cancer Support and Awareness Group, we hope you had a good summer.

The next several months may be a bit confusing for those involved with our support group. The Kelowna Health Centre will be undergoing some major renovations beginning September 22. These renovations are expected to take several months, and according to a letter received from Interior Health there is no guarantee that we will be able to use facility following the renovations.

Our October meeting will be held in the *First United Church Hall* located at the rear of the large Brick Church on the corner of Bernard Ave. and Richter Street. Hopefully, by that time we have more information on a location for future meetings. We are looking for something that will be a stable location and will not cost the support group a great deal of money. **Note: Email address at office changed NOW –oprca@telus.net**

PSA as an Effective Early Marker of Prostate Cancer –

The following information was published in 2007 by *Johns Hopkins Health Alerts*, and was written by *Dr. Jacek L. Mostwin, Medical Editor of the Johns Hopkins Prostate Bulletin*.

Editors Note: Last month I had an article in our newsletter about a new report that stated that men over the age of 75 should not continue with PSA testing. The following is another view regarding PSA testing.

Dr. Mostwin writes: As you probably know, PSA or prostate specific antigen, is a protein produced by cells within the prostate, and blood levels of PSA can be measured in the blood. While higher PSA blood levels are often noted in men with prostate cancer, PSA elevation is not specific to prostate cancer. That said, at present, an elevated PSA test value (4.0 ng/ml or higher) is the most common way that prostate cancer is detected in the United States. [Many physicians also use age and race adjusted PSA readings].

At a press briefing to describe this interesting study, **Hans Lilja, M.D., Ph.D.**, and attending research clinical chemist at Memorial Sloan-Kettering Cancer Centre in New York, detailed how a single PSA test given to more than 21,000 men in their early 40s was highly predictive of their developing advanced prostate cancer over 20 to 25 years later. More than 60% of advanced cancers (T3) that developed over a 25-year period were associated with

PSA values in the 80th percentile or greater among men between the ages of 44 and 50. “It’s fascinating to realize that 2 to 25 years away from baseline sample, this (PSA) biomarker is so informative,” Dr. Lilja told assembled reporters.

Data for Dr. Lilja’s study came from archived blood samples that had been collected and stored in Malmö, Sweden between 1974 and 1986. By 2000, 161 men had developed advanced prostate cancer. Their PSA values were then compared with those of 500 age-matched controls. Small elevations in PSA increased the risk of developing advanced prostate cancer. By age 75, men whose PSA was 0.5 ng/ml at the time of sampling, years earlier, had a 2% likelihood of developing T3 prostate cancer. However, if the original PSA level was 2 ng/ml or higher, the risk of advanced prostate cancer was 12%, a sixfold jump.

“PSA is highly controversial, said Dr. Lilja, “but obviously a PSA test taken early in life, before the age of 50, has undoubtedly high capacity to predict future risk of prostate cancer, and cancer of unquestionable significance.”

What this study suggests supports what my Hopkins colleague **H. Ballentine Carter, M.D.** has suggested previously, based on his own PSA studies. That is, that men should have a PSA test in their 40’s. Based on that PSA reading, a man could be placed in a low-or high-risk group, which would then determine

how frequently his PSA is monitored over the next two decades.

Bottom line advice: At present, men are urged to have their first PSA test at 50 – and age chosen randomly and based on no real science. “This study looked at the development of advanced disease that is threatening to a man’s life, and it could help predict this,” said **Christopher L. Amling, M.D., Director Division of Urology, UAB Hospital Birmingham, Alabama**, and moderator of the press conference. “There should be new guidelines on how we screen for prostate cancer. These guidelines may appear soon, and this study certainly supports that.”

Editors Note: Depending at what age someone has been diagnosed with prostate cancer I personally may recommend that a son start PSA testing in his mid 30s, and not wait until he is 40 or older.

One of Five Young Men Checked for Prostate Cancer

The following information was obtained from *Reuters Health* and the source was *Cancer*, online August 11, 2008 –

New research suggests that roughly one in five American men in their 40s has had a blood test to screen for prostate cancer within the last year. However, screening rates in black men are still considered suboptimal, the investigators say.

“Our findings for black men are discouraging,” senior investigator **Dr. Judd W. Moul from Duke University in**

Durham North Carolina, commented in a written statement. “We’ve been encouraging black men to get screened at age 40 or 45 for more than a decade, yet only one-third of these high-risk men reported being tested.”

Blood levels of a protein called prostate-specific antigen, or PSA, typically rise when a man has prostate cancer, so PSA testing is often used to screen for the disease.

It is generally recommended that men discuss PSA screening for prostate cancer with their doctors starting at age 50. However, the American Cancer Society recommends screening at age 45 for African American men, or earlier if there is a strong family history.

The new study posted online today [August 11th] in the journal *Cancer* involved an analysis of data collected in 2002 on 58,511 men aged 40 and older.

The findings suggest that young black men are 2.4 times more likely than their white counterparts to undergo PSA screening. Still, the investigators comment that the rate in black men – 33.6 percent – is disappointingly low considering that they are at a higher risk for prostate cancer.

Overall, 22.5 percent of men aged 40 to 49 and 53.7 percent of older men reported having a PSA screen in the prior year. Predictors of PSA testing in young men included an annual household income of \$35,000.00 or greater, having an ongoing relationship with a physician, and health insurance coverage.

Obese Prostate Cancer Patients May Benefit More from Brachytherapy –

The following article was obtained from *DOTmed® News* and was written by *Barbara Kram, Editor*.

Brachytherapy, also called seed implants, may be a more beneficial treatment than surgery or external beam radiation therapy for overweight or obese prostate cancer patients, according to a study published in the August issue of the *International Journal of Radiation Oncology/Biology/Physics*, the official journal of the *American Society of Therapeutic Radiology and Oncology*. (ASTRO) – ASTRO is the largest radiation Society in the world, with more than 9,500 members who specialize in treating patients with radiation therapies. As the leading organization in radiation oncology, biology and physics, the Society is dedicated to improving patient care through education, clinical practice, advancement of science and advocacy.

“Brachytherapy may be the preferable treatment for obese men with early stage-prostate cancer,” *Anthony Zietman, M.D.*, one of the authors of the study and a radiation oncologist at Massachusetts General hospital in Boston, said. “Being overweight does not present any unique technical challenges for brachytherapy as it does for surgery or external beam.”

There has been some evidence published suggesting that men with a high body mass index

have a greater likelihood of PSA failure after some prostate cancer treatments than normal-weight men. This has been specifically shown for overweight or obese men who undergo surgery (radical prostatectomy) or external beam radiation therapy. The exact cause for this is unknown but it is suspected that higher BMI can be associated with more aggressive cancers and also with more technical difficulties during treatments.

Researchers at the Massachusetts General Hospital departments of radiation oncology and urology and the Boston Medical Center Department of Radiation Oncology, both in Boston, sought to determine if the same problems were seen in overweight and obese men treated with brachytherapy.

The study analyzed 374 prostate cancer patients who were treated with brachytherapy from 1996 to 2001, and researchers found that the six-year PSA failure rate for men who were overweight or obese was no higher than for those of normal weight.

WITT'S WIT (ON THE LIGHTER SIDE) -

Nudist Colony

A man moves into a nudist colony. He receives a letter from his mother asking him to send her a current photo of himself in his new location. Too embarrassed to let

her know that he lives in a nudist colony, he cuts a photo in half and sends her the top part. Later he receives another letter asking him to send a picture to his grandmother. The man cuts another picture in half, but accidentally sends the bottom half of the photo. He is worried when he realizes that he sent the wrong half, but then remembers how bad his grandmother's eyesight is, and hopes she won't notice. A few weeks later he receives a letter from his grandmother. It says,

'Thank you for the picture. Change your hair style, it makes your nose look too short!'

Understanding Your Prostate Pathology Report –

The following is an excerpt of an article that appeared in the August 2008 *Manitoba Prostate Cancer Support Group Newsletter*. This article was originally prepared by *Marc Garnick, M.D., Harvard Medical School*

At least initially, the pathology report is one of the most important factors in the management of a man's prostate cancer. For example, it can provide valuable information about the location and extent of the cancer, thus helping your physician decide whether to recommend active surveillance, hormone treatment, radiation therapy, or surgery. The information is so important, that in my practice I use this to determine what kind of treatment I will recommend.

While it would be ideal if the biopsy report were unambiguous, it sometimes is not and may need to be repeated.

Deconstructing the Report -

It is always a good idea to request a copy of your pathology report. A thorough reading will give you the information you need to have informed discussions with your urologist, surgeon, and oncologist, and better guide any decisions you need to make about what to do next.

If the findings on the pathology report lead to a diagnosis of prostate cancer, there are a few areas of the pathology report you'll want to scrutinize:

Gleason Score –

If your biopsy finds cancer, the first piece of information you'll want to note is the Gleason Score. This numerical value grades prostate tumor cells according to how they look compared to normal cells and how mutated they appear under a microscope, a quality known as differentiation. (Normal cells are well differentiated and cancer cell are not.) Because tumors often consist of multiple cell types, the pathologist assigns two values between 1 and 5: the first to the predominant cell type, and the second to the next-most-prevalent cell type. The sum, ranging from 2 to 10, is the Gleason Score, the higher the number, the more aggressive the cancer.

The Gleason Score is one of the most important factors in determining whether the cancer is likely confined to the prostate and how aggressive it is.

Number of Cores –

An ideal report also specifies how many samples, or cores, were removed during the biopsy. The standard number of cores used to be six: three from the right side of the prostate and three from the left. However, this limited sampling meant that cancerous portions of the prostate, if there were any, might be missed. As a result, as many as one in four patients eventually diagnosed with prostate cancer was told, on the basis of the initial biopsy, that he did not have cancer – meaning that the test provided a false-negative finding.

Today, most doctors agree that an initial biopsy should include at least 10 to 12 core samples. In certain situations, some doctors recommend doing a saturation biopsy, which typically removes 12 to 14 cores – and sometimes as many as 20 or more – but less agreement exists about this practice.

Anatomic Location –

Ideally, the pathologist who prepares your report will have separated and labeled the core samples according to what part of the prostate they came from. This labeling will tell you and your doctors whether the cells came from the right or left side and whether they were drawn from the apex (counter intuitively, at the bottom) mid zone (middle), or base (top) of the prostate. In a saturation biopsy you may see even more detailed labels, such as RMA and RMB to differentiate between the right and mid zone near the apex and the right mid zone closer to the base.

Extent of Cancer –

In addition to paying attention to the number of cores taken, you'll want to look at how much cancer found. This information may be provided as the number of positive cores, the length of cancer in millimeters among the cores, the percentage of cancer per core, the fraction of positive cores, or the total percentage of cancer in the total specimen. Regardless of the type of measurement, your doctor can use this information to determine the likelihood that the cancer is confined to the prostate or has spread.

Clinical Data –

In the clinical portion of the report, you may see notes from your physician to the pathologist offering any relevant information about why the biopsy was performed and what the physician is looking for. [Locally the urologist will request the biopsy, which is done by a radiologist, in many places in the U.S. an urologist performs the biopsy.]

Gross Description –

Your pathology report should also include a gross description with such important identifying information as the container in which the tissue was shipped to the department, length of various pieces of tissue, their colour, and how the tissue is labeled.

Don't be alarmed if you see mention of rectal or colonic tissue. Small fragments of bowel lining (colonic mucosa) are common in needle core biopsy specimens since the needle has to poke through this tissue to get to the prostate.

Comments –

Sometimes, you will find notes to your physician or urologist in a section labeled “comments.” This may be an important source of additional information such as whether the pathologist has found high-grade PIN or any atypical tissue. This section may also describe various features of the tissue and offer clues about the pathologist’s thinking, especially if the final diagnosis is not entirely clear.

Identifying Details –

Last the report should include identifying information such as your name, age and patient number, and the date, as well as the name and signature of the pathologist who prepared the report, the name of the person who performed the biopsy, and the name and address of the laboratory.

OncoGenex Wins Fast Track Designation for Prostate Cancer Drug –

The following information was obtained off the Internet and this article originated with *RedOrbit News-*

OncoGenex Pharmaceuticals has announced that **OGX-011**, also known as Clustirsen sodium, received fast track designation from the FDA in combination with docetaxal (Taxotere ®) for progressive metastatic prostate cancer.

OGX-011 is currently completing five Phase II clinical studies in prostate, lung and breast cancer, and is designed to inhibit the

production of a specific protein, clusterin, associated with treatment resistance.

The request for fast track designation was based on data from phase II studies in hormone-refractory prostate cancer as well as supporting data in non-small cell lung cancer indicating that OGX-011 treatment can significantly reduce serum clusterin levels and that achieving low serum clusterin levels during treatment is correlated with improved survival.

Scott Cormack, CEO of OncoGenex, said: “Obtaining fast track designation for custirsen sodium while developing our Phase III program for hormone-refractory prostate cancer and in advance of initiating our Phase III study is very important and should help us move forward expeditiously on our pathway toward commercialization.”

Editors Note:

OGX-011 is a drug that has been primarily developed in British Columbia by Drs. Martin Gleave, Larry Goldenberg and their team of doctors and researchers at the Prostate Centre Vancouver General Hospital. This drug has been in the development stages for many years. Some of the development funds for this drug actually came from the U.S. government though the military that funds cancer and other research.

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-

October 11th – November 8th – December 13th -

Our regular monthly meetings are held on the second Saturday of each month in the meeting rooms of the Kelowna Health Centre – 1340 Ellis Street. Our meetings begin at 9:00 A.M. and are generally over by 11:00 A.M.

I would like to thank Sanofi Aventis manufacturer of Eligard®, Taxotere® and Xatral® 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>