

CANADIAN PROSTATE CANCER SUPPORT GROUP

Newmarket, Ontario

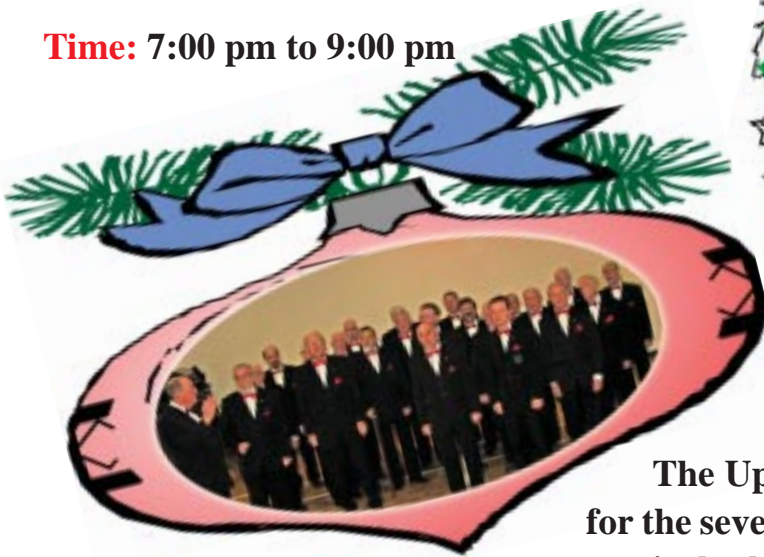
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**A support group that provides understanding,
hope and information to prostate cancer patients and their families**

**Make sure you come to our Christmas Meeting on
December 10th, 2009** (note date change, it's
the second Thursday this year).

At the Newmarket Seniors Meeting Place,
474 Davis Drive, Newmarket

Time: 7:00 pm to 9:00 pm



The Upper Canada Cordsmen will be back for the seventh straight year to add their special musical talents to our annual Christmas party,

Canadian Prostate Cancer Support Group,

Newmarket, Ontario. 905-830-0447

www.newmarketprostatecancer.com

a member of the



Assisted by the Canadian Cancer Society

Holland River Unit

Cancer Information Service

1 - 888 - 939 - 3333

Your Executive

Doug Armstrong, <i>Acting Chairman,</i>	905-778-0028
Ulli Baumhard, <i>Secretary,</i>	905-478-8843
Ron Stevenson, <i>Treasurer,</i>	905-836-1701
Doug Bowers, <i>Speakers,</i>	905-841-2759
Dennis Allibon <i>Publicity,</i>	905-722-6392
Jane & Frank Kennedy, <i>Newsletter,</i>	905-895-2263
Pat & Ron Stevenson, <i>Greeters,</i>	905-836-1701
Phil Harrison, <i>Member at large,</i>	905-895-1407
Dan Ho, <i>Member at large,</i>	416-953-8889
Doug Armstrong, <i>Member at large,</i>	905-778-0028
Murray Green, <i>Member at large,</i>	905-830-9753

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



Tanya Giaquinto's November Notes on Diet and Cancer will be in the January Newsletter

Side Effects of Hormone Therapy

Testosterone is the primary male hormone, and plays an important role in establishing and maintaining the typical male characteristics, such as body hair growth, muscle mass, sexual desire, and erectile function, and contributes to a host of other normal physiologic processes in the body.

The list of potential effects of testosterone loss is long: hot flashes, decreased sexual desire, erectile dysfunction, fatigue, osteoporosis, weight gain, decreased muscle mass, anemia, and memory loss. Most men who are on hormone therapy experience at least some of these effects, but the degree to which any man will be affected by any one drug regimen is impossible to predict.

Before beginning hormone therapy, every man should discuss the effects of testosterone loss with his doctors, so he can alter his lifestyle to accommodate or head off the changes.

Intermittent Therapy

Over the years, researchers have explored different ways to minimize the side effects of testosterone loss while maximizing the therapeutic effect of hormone therapy. The most commonly explored strategy is known as intermittent therapy.

This strategy takes advantage of the fact that it takes a while for testosterone to begin circulating again after LHRH agonists are removed. With intermittent hormone therapy, the LHRH agonist is used for six to twelve months, during which time a low PSA level is maintained. The drug is stopped until the PSA rises to a predetermined level, at which point the drug is restarted. The “drug holidays” in between cycles allow men to return to nearly normal levels of testosterone, potentially enabling sexual function and other important quality of life measures to return before the next cycle begins again.

At this time, however, the true benefits of this approach remain unclear, and large clinical trials are currently underway to evaluate its use in men with advanced prostate cancer. If the approach proves to be as effective as continuous therapy in suppressing tumor growth, intermittent therapy will likely become popular because of potential for an improved side effect profile.

Hormone Therapy

Prostate cancer cells are just like all other living organisms—they need fuel to grow and survive. Because the hormone testosterone serves as the main fuel for prostate cancer cell growth, it is a common target for therapeutic intervention in men with prostate cancer.

Hormone therapy, also known as androgen-deprivation therapy or ADT, is designed to stop testosterone from being released or to prevent the hormone from acting on the

prostate cells. Although hormone therapy plays an important role in men with advancing prostate cancer, it is increasingly being used before, during, or after local treatment as well.

The majority of cells in prostate cancer tumors respond to the removal of testosterone. But some cells grow independent of testosterone, and therefore remain unaffected by hormone therapy. As these hormone-independent cells continue to grow unchecked, over time, hormone therapies have less and less of an effect on the growth of the tumor.

Hormone therapy is therefore not a perfect strategy in the fight against prostate cancer, and does not cure the disease. But it remains an important step in the process of managing advancing disease, and will likely be a part of every man’s therapeutic regimen at some point during his fight against recurrent or advanced prostate cancer.

The most common types of hormone therapy are described below. Although each of these therapeutic options is effective at controlling prostate cancer growth, the loss of testosterone confers significant side effects in nearly all men.

Orchiectomy

Because about 90% of testosterone is produced by the testicles, surgical removal of the testicles, or **orchiectomy**, is an effective solution to blocking testosterone release. This approach has been used successfully since the 1940s, but because it’s a permanent and irreversible surgical solution, most men opt for drug therapy instead.

For men who choose this option, the procedure is typically done on an outpatient basis in the urologist’s office. Recovery tends to be rather quick and no further hormone therapy is needed, making orchiectomy a very attractive choice for someone who prefers a low-cost, one-time procedure.

LHRH Agonists

LHRH, or luteinizing-hormone releasing hormone, is one of the key hormones released by the body before testosterone is produced. (Note that LHRH is sometimes called GnRH, or gonadotropin-releasing hormone.) Blocking the release of LHRH through the use of LHRH agonists or LHRH analogues is one of the most common hormone therapies used in men with prostate cancer.

Drugs in this class, including leuprolide (Eligard, Lupron, and Viadur), goserelin (Zoladex), and triptorelin (Trelstar), are given in the form of regular shots: once a month, once every three months, once every four months, or once per year.

Antiandrogens

LHRH agonists cause what is known as a “flare” reaction because of an initial transient rise in testosterone. This can result in a variety of symptoms ranging from bone pain to urinary frequency or difficulty.

Antiandrogens such as bicalutamide (Casodex), flutamide (Eulexin), and nilutamide (Nilandron), help to block the action of testosterone in prostate cancer cells. They are therefore often added to the LHRH agonist for at least the first 4 weeks of therapy when the flare reaction typically occurs. In this setting, antiandrogens can be helpful in preventing the flare reaction.

Although the sexual side effects of the antiandrogens when given alone are typically far fewer compared with the LHRH agonists, antiandrogens might not be as effective as orchiectomy or LHRH agonists and are not the optimal choice for men with documented metastatic prostate cancer.

What to Consider When Your PSA is Rising During Hormone Therapy

This section summarizes key points to consider when your PSA is rising while undergoing hormone therapy. The list is by no means exhaustive, and there might be other points that you want to think about as well. The goal is to help you focus on what you need to know about each stage of disease so you can hold meaningful, regular dialogues with all members of your health care team as you find the treatment path that's right for you.

1) A rising PSA during hormone therapy doesn't mean you're out of options—it means you need to consider the use of other systemic therapies such as chemotherapy or agents that target prostate cancer bone metastases.

2) The primary goal of chemotherapy is to stop the cancer cells from dividing and the cancer cells from growing. But when we look at whether a drug is working, there are generally two levels of effectiveness—whether a drug is palliative, meaning whether it can alleviate symptoms, and whether it can affect the cancer cell growth significantly enough to prolong life.

3) The benefits of chemotherapy in prostate cancer were only first realized recently: mitoxantrone (Novantrone) was approved by the FDA in 1996 when it was shown to provide palliative benefit to men with advanced prostate cancer; docetaxel (Taxotere) was approved in 2004 when it was shown to prolong the lives of the men who took it and relieved symptoms better than mitoxantrone.

4) Although all chemotherapy drugs are designed to slow or stop the growth of cancer cells, each one tends to work in a slightly different way, and using two or more together or one after another in a row can often be more effective than just using one drug alone.

5) Pay close attention to your reactions to the different chemotherapy drugs. You're the only one who really knows your own body, so you're the only one who can know whether you are able to tolerate a particular treatment regimen.

6) Don't be too tough or "macho." There are plenty of drugs available to help ward off or treat the different side effects of chemotherapy.

7) Focus on yourself. It doesn't matter what you do, as long as it can help you relieve stress and can help you with

the most important part of your cancer treatment—getting well.

8) Prostate cancer cells that have spread beyond the prostate seem to prefer bone tissue and tend to migrate there after escaping the pelvic region. Once the cells settle in, they're known as prostate cancer bone metastases. Unlike bone cancer, which originates in the bone, prostate cancer bone metastases are actually collections of prostate cancer cells that happen to be sitting within the bones.

9) When prostate cancer cells settle in the bones, they interact with the bone cells, causing new bone cells to grow and causing the bone tissue to break down. The dye-like material that's injected during a bone scan highlights areas of bone metabolism or activity—areas where bone tissue is changing more rapidly than it normally would in a healthy adult male.

10) Men who experience pain from a bone metastasis will often be treated with radiation targeted directly to the metastasis or with radiation-emitting drugs that settle in the metastasis after being injected through a vein. The radiation will kill the prostate cancer cells in the metastasis and thereby relieve the pain.

11) Bisphosphonates are drugs that are designed to help reset the balance in the bone between bone growth and bone destruction which is disrupted by the prostate cancer bone metastases. Zoledronic acid (Zometa) is a bisphosphonate given intravenously that can delay the onset of complications associated with prostate cancer bone metastases and relieve pain. It is typically given once every three weeks as a 15-minute infusion.

12) As the bones in the spine weaken, they can collapse one on top of the other, compressing the spinal cord and the nerves that run out from it. Cord compression associated with metastatic prostate cancer can cause serious problems if not managed immediately, so be sure to tell your doctors about any new pain, weakness, or changes in bowel habits, any of which can result from spinal cord compression.

13) Cancer can be painful, and there's no benefit in acting stoic and pretending it doesn't affect you. There are plenty of very effective pain medications available, and using them will allow you to feel better and stay stronger.

14) Don't assume that you can't get pain relief unless you're completely doped up. Some very simple and easy to take oral medications might be enough to ease your pain.

15) Don't worry about becoming addicted to pain medication. Taking pain medications so that you can spend your days feeling healthier and stronger is the opposite of addictive behavior. However, both physical dependence and tolerance are possible as your body starts to get used to the drugs, so you and your doctors should take them into consideration as you start and stop different pain medications.

16) Consider enrolling in a clinical trial of an experimental new treatment or regimen. Clinical trials are the only way that new and better treatments will be developed and tested appropriately.

The importance of healthy bones as we grow older

We all think that our skeletal system is pretty stable, supporting our body but not changing much over the years. Not so. The skeleton is always changing and that's important, too. The skeleton is the body's source of calcium; without it the brain couldn't function. Bone health should be a concern for everyone, especially cancer patients. Your cancer, treatment may lead to increased bone loss.

These include:

- Breast cancer treatment
- Targeted therapy treatment
- Prostate cancer treatment
- Immunosuppressive agent treatment

Certain cancers, such as multiple myeloma, stimulate bone loss and inhibit formation of new bone.

Early menopause robs bones

Chemotherapy for breast cancer often induces early menopause (the end of a woman's menstrual cycles). Menopause leads to a deficiency in estrogen, which may cause bone loss. Many breast-cancer patients develop bone loss at a younger-than-normal age, which increases their risk of osteoporosis. If we don't do something to prevent bone loss at the beginning of treatment, a 45-year-old woman might begin to have bone fractures in 20 years.

Men are affected also

Testosterone in men helps protect bone, much like estrogen does for women. Although several therapies are available to treat prostate cancer, they all lower testosterone levels. In most cases, men begin with higher bone density than women, so it takes longer for them to reach levels of bone loss that might lead to fractures. However, the problem should be addressed.

Drugs deliver double punch

Patients who have bone marrow transplants and take immunosuppressive drugs, such as glucocorticoids, face two problems. High doses of these drugs, meant to decrease the risk of the body rejecting the transplant, may increase the rate of bone breakdown and decrease the rate of bone formation

Cancer patients often have decreased appetites, and if they receive chemotherapy they may be nauseated as well. As a result, they may not eat well, which may cause a calcium deficiency. If we don't take in enough calcium in our diet, our body will withdraw it from the skeleton. If unchecked, this will lead to osteoporosis.

Vitamin D is crucial

Many patients also have vitamin D deficiencies, either because they do not get enough in their diet, or they have liver or kidney failure so their body does not make it. Vitamin D enables the body to absorb calcium from foods and supplements. While the minimum daily requirement is set at 400 to 600 IUs (international units), many researchers suggest it should be much higher. Over fifty percent of the population in the United States and Canada are vitamin D deficient. This means that, even if they are getting the daily recommended amount of calcium, they are absorbing only about half of it.

Bone up on health

Take your bone health seriously. You may be able to prevent serious problems down the road if you add calcium-rich foods to your diet and Exercise regularly. You should speak to your doctor about any bone health concerns. Ask if you should take calcium supplements, have your vitamin D level checked and have a bone density test.

A Lighter Moment . . .

NEW MEDICINE FOR MEN

With Viagra such a great medical success for increasing men's sexual prowess, Pfizer is bringing forth a whole line of drugs oriented towards improving the performance of men in today's society.. Here are a few of the new ones:

DIRECTRA - a dose of this drug given to men before leaving on car trips caused 72 percent of them to stop and ask directions when they got lost, compared to a control group of 0.2 percent.

PROJECTRA - Men given this experimental new drug were far more likely to actually finish a household repair project before starting a new one.

COMPLIMENTRA - In clinical trials, 82 percent of middle-aged men administered this drug noticed that their wives had a new hairstyle. Currently being tested to see if its effects extend to noticing new clothing.

NEGA-VIAGRA - Has the exact opposite effect of Viagra. Currently undergoing clinical trials on sitting U.S. presidents.

NEGA-SPORTAGRA - This drug had the strange effect of making men want to turn off televised sports and actually converse with other family members.

LIAGRA - This drug causes men to be less than truthful when being asked about their sexual affairs. Will be available in Regular, Grand Jury and Presidential Strength versions