PCCN Markham

PCa Newsletter

Volume 14 Issue 9 **May, 2013**

MEETING NOTICE

Small Group Discussion

Tuesday, May 14 @ 7:30 PM

St. Andrews Presbyterian Church

Main St. Markham

Rose Room – Downstairs

"Join us for an interactive evening"

Thank you again to Dr. Mateya Trinkaus, Medical Oncologist at Markham Stouffville Hospital, who spoke to the group at our April meeting. The Doctor provided a very informative presentation and answered lots of questions from the very large audience. The feedback has been excellent! Thanks, Dr. Trinkaus!

IN THIS ISSUE ...

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Nearly Half of All Deaths from Prostate Cancer Can Be Predicted Before Age 50

Apr. 16, 2013 —

Focusing prostate cancer testing on men at highest risk of developing the disease is likely to improve the ratio between benefits and the harms of screening, suggests a new paper.

Prostate specific antigen (PSA) screening is widely used for the early detection of prostate cancer, but remains highly controversial, as it became widespread long before evidence to prove its value. There is now evidence that PSA screening can reduce prostate cancer mortality in men who would not otherwise be screened. However, this can come at considerable harm.

As there is little evidence to support many aspects of screening guidelines, researchers from Sweden and the USA carried out a case-control study taking data from the Malmo Preventative Project (MPP) cohort, in an attempt to develop an evidence-based scheme for prostate cancer testing. A previous study from the MPP, published in the *BMJ* in 2010, demonstrated that PSA level at age 60 is strongly predictive of the risk of death from prostate cancer by age 85.

The Malmo cohort included 21,277 men aged 27 to 52 who participated in the MPP between 1974 and 1984. All these men gave a blood sample. A smaller group of these men were then invited to provide a second blood sample about six years later: 4922 (72%) of those re-invited complied.

The researchers focused their studies on men close to age 40, mid-to-late forties (45-49) and early-to-mid fifties (51-55).

Within 25 to 30 years, 44% of deaths from prostate cancer occurred in those with the top 10% of PSA levels at age 45-49, a PSA of about 1.5 ng / ml or more. The risk of prostate cancer death was more than 10 times greater in this group compared to men with the lowest 25% of PSA levels.

The researchers questioned whether PSA screening should start at age 40, mid-to-late 40s or early 50s: they found that even for men with PSA in the top decile at age 40, the risk of metastatic prostate cancer was very low at 0.6%, after 15 years of follow-up. The researchers say that due to this, it would be difficult to justify initiating PSA testing at age 40 for men with no other significant risk factor.

In contrast, the risk of developing metastatic prostate cancer within 15 years is close to three-fold higher for men in the top level PSA at age 45-49 (1.7%) and close to ten-fold higher at age 51-55 (5.2%). This suggests that initiating PSA screening after age 50 would leave a significant proportion of men at elevated risk of later being diagnosed with an incurable cancer.

The researchers also looked at screening intervals: results showed that the absolute risk of metastatic cancer remains very low within 15 years follow-up for men with PSA in the low deciles and as such, a screening interval less than five years for these men is unnecessary.

The researchers conclude that PSA levels are informative of the current risk of cancer as well as being "predictive of the future risk of prostate cancer" and any cancer-specific death. They say that screening programmes can be designed so as to "reduce the risk of over-diagnosis whilst still enabling early cancer

detection for men at highest risk of death from prostate cancer." As it turns out, the best way to determine risk is a single PSA before the age of 50.
http://www.sciencedaily.com

Clinical trial first for less invasive procedure to treat prostate cancer

DAVID ANDREATTA The Globe and Mail Published Wednesday, Apr. 24 2013,

When Brian Danter, a 61-year-old youth pastor from Windsor, Ont., learned he had early-stage prostate cancer five years ago, he chose to monitor it closely rather than risk the sometimes debilitating side effects that accompany conventional treatments for the disease.

Fatigue, erectile dysfunction and urinary and bowel complications are common for patients who undergo radiation therapy or surgery.

"I looked at the short-term options and the long term," said Mr. Danter, 61, who described his cancer as the size of a pencil dot. "I'm enjoying pretty good health and enjoying life, but it's always in the back of your mind that you have cancer."

So three weeks ago, Mr. Danter participated in a clinical trial of a far less invasive treatment that doctors hope can eradicate the disease in cases like Mr. Danter's as effectively as more traditional options – without the side effects. This is the first clinical trial of the new treatment, which uses thermal ultrasound energy, guided by real-time magnetic resonance imagery, to target prostate tissue without exposing healthy tissue outside the prostate to harm.

It is too early to tell whether Mr. Danter's cancer has been eradicated – that will be determined by checkups and a biopsy throughout the course of a year.

But while it can take months or years to recover from radiation or surgery, Mr. Danter, a married father of seven, said he felt back to normal eight days after his procedure and has no enduring side effects. His doctors had projected a recovery time of two-to-three weeks.

"For me, it was a great option," Mr. Danter said.

Similar procedures have been done in an experimental setting where the prostate was removed immediately after the treatment to examine its condition. In the trial, the prostate is not removed.

"This represents a significant advance in the management of prostate cancer," said Joseph Chin, the chief of surgical oncology at London Health Science Centre, which is conducting the trial.

The trial will treat 30 patients with localized prostate cancer, with 10 people expected to undergo the procedure at each of London, a hospital in Europe and another in the United States.

"This is not about improving mortality rate – those are already very good. This is about improving morbidity," said Steven Plymale, the chief executive officer of Profound Medical Inc., the Toronto-based medical device company developing the treatment. "The objective of our trial is to demonstrate it's possible to safely and effectively eliminate the cancerous tissue with decreased risk of side effects such as long-term impairment to bladder or bowel control, or erectile function."

Dr. Chin said he expected the trial to run for about a year, and that candidates will be chosen based on their suitability for the procedure
www.globeandmail.com

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Zoledronic Acid Did Not Prevent Bone Metastases in High-Risk Prostate Cancer

By Leah Lawrence | April 18, 2013

The use of zoledronic acid(Drug information on zoledronic acid) (Zometa) had no effect on the prevention of bone metastases in patients with high-risk prostate cancer, according to the first results of the Zometa European Study, or ZEUS, presented at the European Association of Urology 28th Annual Congress in Milan, Italy.

"There were no differences in the incidence of bone metastasis," said Manfred Wirth, MD, professor of urology at the Dresden University of Technology, in Dresden, Germany.

Wirth declared the trial to be "negative" for failing to meet its primary endpoint of a percentage difference in patients who developed bone metastases based on local image evaluation.

The ZEUS trial included 1,433 men with high-risk prostate cancer defined as a PSA score at diagnosis of 20 ng/dL or higher, a Gleason score of 8 to 10, or lymph node positivity. Patients were randomly assigned to treatment with 4 mg of zoledronic acid every 3 months for 48 months (n = 716) or to the control arm (n = 717). Patients in the zoledronic acid arm were followed for a median of 4.7 years, and patients in the control arm for 4.8 years. No difference in the rate of bone metastases was found between the two groups at the end of follow-up (13.7% for zoledronic acid vs 13% for control).

More adverse events were reported among patients in the zoledronic acid arm compared with the control arm. In addition, more patients in the zoledronic acid arm withdrew due to adverse events, including fever and flu-like symptoms, joint pain, and osteonecrosis of the jaw.

The researchers also conducted a subgroup analysis that looked at the effect of prior local curative treatment. "Patients with no prior local curative treatment had a significantly higher metastases rate than those receiving prior curative treatment," said Wirth. "This is a very interesting result of the trial that seems to show that local curative treatment really is of benefit for those patients not to develop metastases."

Among patients in the zoledronic acid arm, 11.2% with prior treatment developed metastases vs 16.9% of patients with no prior treatment. In the control arm, 9.9% of patients developed bone metastases compared with 16.7% with no prior treatment.

The study showed no difference in overall survival between the two groups.

A second subgroup analysis identified a regional variation of patients who developed bone metastases. Using Germany, which is where the majority of patients were enrolled, as a reference, data indicated that patients in Sweden, the Netherlands, and Norway had a significantly increased risk for metastasis. In contrast, patients in Italy had a reduced risk.

http://www.cancernetwork.com/

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Abiraterone and Prednisone Improve Prostate Cancer Survival

Kate Johnson Apr 05, 2013 MILAN, Italy —

First-line use of abiraterone acetate (*Zytiga*, Janssen Biotech) with prednisone for metastatic castration-resistant prostate cancer improves radiographic progression-free survival, compared with prednisone and placebo.

However, the difference is not statistically significant, according to results from the COU-AA-302 study. Overall survival "favored abiraterone but did not cross the prespecificed statistical boundary," the investigators report.

"This is the final preplanned analysis of this trial," said lead investigator Peter Mulders, MD, here at the European Association of Urology 28th Annual Congress.

"The progression-free survival is...consistent with previously reported results," he pointed out. "We have somewhat more data on overall survival. Although it's not statistically significant, you can see a consistent line in favor of abiraterone plus prednisone. You can also see that with the longer duration of abiraterone plus prednisone, toxicity did not increase, which is important to know," he added.

"These results have remained constant with no dramatic change over time," said session moderator Tomasz Borkowski, MD, from the Warsaw University of Medicine in Poland. He explained that he is happy with this finding, because, "as a urologist, I have more experience" with hormonal therapy than cytotoxic drugs.

Abiraterone was approved in the United States and Europe as first-line therapy for metastatic castration-resistant prostate cancer on the basis of a preplanned interim analysis of the COU-AA-302 data, which was performed after 43% of expected deaths had occurred. Those results were initially reported at the 2012 Annual Meeting of the American Society of Clinical Oncology.

For a long time, castration-resistant prostate cancer was a death sentence.

At that time, the data and safety monitoring committee unanimously recommended that the study be unblinded early (*N Engl J Med*. 2013;368:138-148).

The findings presented by Dr. Mulders extend those data to a preplanned analysis performed after 55% of expected deaths had occurred.

The phase 3, multinational, randomized, double-blind, placebo-controlled trial enrolled 1088 men with prostate cancer who had not previously received chemotherapy. All received prednisone 5 mg twice daily and were randomized to receive either abiraterone 1000 mg or placebo daily.

The coprimary end points were radiographic progression-free survival and overall survival.

At a median follow-up of 27.1 months, radiographic progression-free survival was significantly longer in the abiraterone group than in the placebo group (16.5 vs 8.3 months; hazard ratio [HR], 0.53; $P < .0001$).

Although median overall survival was longer in the abiraterone group than in the placebo group, the difference did not reach statistical significance (35.3 vs 30.1 months; HR, 0.79; $P = .015$). "One of the reasons it was not significant is because of the preplanned interim analysis — the *P* value goes down," Dr. Mulders told *Medscape Medical News*.

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Table. Secondary End Points

Time to End Point	Abiraterone (Months)	Placebo (Months)	Hazard Ratio	*P* Value
Initiation of cytotoxic chemotherapy	26.5	16.8	0.61	<.0001
Opiate use for cancer-related pain	not reached	23.7	0.71	<.0002
Prostate-specific antigen progression	11.1	5.6	0.50	<.0001
Decline in ECOG performance status of ≥1 point	12.3	10.9	0.83	.0052

"No new safety concerns were identified with abiraterone treatment," report the investigators.

The main finding from this analysis "is consistency in the radiographic progression-free survival data, which have matured," said Dr. Mulders. "There's also the indication that the overall survival lines look good, and even with longer duration, toxicity does not increase."

"For a long time, castration-resistant prostate cancer was a death sentence," Dr. Borkowski told *Medscape Medical News*. "Now we have at least 5 drugs that are prolonging survival. We're trying to find out the best timing, the best sequencing of the treatment, in which patients we should start with more cytotoxic drugs, and in which patients we can start with less aggressive treatment and prolong the hormonal therapy."

This study was funded by Janssen Research & Development. Dr. Mulders and Dr. Borkowski have disclosed no relevant financial relationships.

European Association of Urology (EAU) 28th Annual Congress: Abstract 97. Presented March 16, 2013.
www.medscape.com

What Is Metastatic Prostate Cancer?

Metastatic prostate cancer is cancer that has spread from the prostate gland to other parts of your body. For example, it may show up as a tumor on your spine or as cancer in your lung. Bone is the most common place for it to spread. But lungs and liver are also common sites. It could also occur, though rarely, in other organs such as the brain.

Having metastatic cancer doesn't mean you have a new kind of cancer. Metastatic prostate cancer in a bone in your hip is not bone cancer. The tumor will have the same type of cancerous prostate cells the original tumor had.

The same is true if the metastatic cancer is in your lung or some other organ. It is still prostate cancer, and your treatment options are the same as when cancer was only in the prostate gland.

Metastatic prostate cancer is an advanced form of cancer. But the term "advanced" has different meanings depending on how it is used.

"Advanced" usually refers to cancer that can't be cured. That doesn't mean it can't be treated and controlled. Most men with advanced prostate cancer live a normal life for many years.

Treatment can be effective to:

- Manage symptoms
- Slow the rate your cancer grows
- Shrink the tumor

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Some cancers are called "locally advanced." That means the cancer has spread from the prostate to nearby tissue. This is not metastatic cancer, which is cancer that has spread to other parts of the body. Many locally advanced prostate cancers are curable.

How Prostate Cancer Spreads

For cancer to become metastatic, individual cancer cells need to break away from the original tumor and move to a blood or lymph vessel. Once there, they circulate through the body. The cells finally stop in capillaries -- tiny blood vessels -- at some distant location.

The cells then break through the wall of the blood vessel and attach to whatever tissue they find. They then need to multiply and grow new blood vessels to supply nutrients to the new tumor. Prostate cancer prefers to grow in specific areas, such as lymph nodes or in the ribs, pelvic bones, and spine.

Most cancer cells that break away form new tumors. Many don't survive in the bloodstream. Some die at the site of the new tissue. Others may lie inactive for years or never become active.

Chances of Developing Metastatic Prostate Cancer

About 50% of men diagnosed with local prostate cancer will develop metastatic cancer during their lifetime. Finding cancer early and treating it can help reduce that rate.

A small percentage of men aren't diagnosed with prostate cancer until it has become metastatic, either because they have no symptoms or the symptoms have been ignored. Doctors can tell it's metastatic cancer by doing a biopsy of the tissue and studying the cells.

How Metastatic Prostate Cancer Is Found

If you've been diagnosed with prostate cancer, your doctor will order additional tests such as:

- X-rays
- CT scans
- MRI scans

These tests may focus on your skeleton and abdominal and pelvic areas. That way doctors can check for signs of the cancer's spread.

If you have symptoms such as bone pain and fractures for no reason, your doctor may order a bone scan. The bone scan can show if you have metastatic cancer in the bones.

Your doctor will also ask for blood tests, including a check of PSA levels, to look for other signs of the cancer's progression.

PSA is a protein normally made by the prostate gland. It can be measured with a simple blood test. A rise in PSA is one of the first signs of the progression of prostate cancer. PSA levels can be high without there being cancer, such as if you have an enlarged prostate or a prostate infection.

But if you've been treated, especially if your prostate has been surgically removed, PSA levels should become undetectable. The presence of any PSA after surgery is a concern. Any rise in PSA after radiation or hormone treatment suggests the possibility of the cancer spreading. In that case, the doctor will order the same tests used to diagnose the original cancer, including a CT scan, MRI, or bone scan.

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Though very rare, it's possible to have metastatic prostate cancer without an elevated PSA. And it's possible to have an elevated PSA without cancer.

The average length of time from original diagnosis to the discovery of metastatic cancer is 8 years. If you have prostate cancer, work with your doctor to determine your risk & determine a schedule for routine PSA checks.

www.webmd.com

Could carrots beat prostate cancer?

Vegetable and other foods rich in Vitamin A help make disease more treatable

Acid in Vitamin A can stop cancer spreading to surrounding tissue

By Daily Mail Reporter **PUBLISHED:** 22:25 GMT, 16 April 2013 | **UPDATED:** 22:25 GMT, 16 April 2013

Carrots could be used in the fight against prostate cancer

Carrots are the new weapon in the war against prostate cancer, scientists have claimed.

A study led by Professor Norman Maitland at the University of York says a diet rich in Vitamin A could be the key to beating the disease because it makes it more treatable.

The researchers have discovered that retenoic acid, a chemical made from Vitamin A, can reduce the ability of the cancer to invade surrounding tissue.

Vitamin A can be found in foods such as carrots, sweet potatoes and leafy green vegetables such as kale.

Prof Maitland said: 'If the cancer is confined to the prostate it's much more treatable with conventional medicine. This is about prevention rather than cure but it can stop the spread of cancer.

'We have found that specific twin genes are turned off in malignant prostate cancer stem cells. When we turn them back on using retenoic acid, the cancer becomes less aggressive.

'It has been known for many years that low vitamin A in samples of men's blood is associated with prostate cancer, but nobody knew the mechanisms involved.

'This is an exciting new development which links an element from our diet to prostate cancer stem cells.'

http://www.dailymail.co.uk/

Can Selenium Cut Risk of Advanced Prostate Cancer?

Study found men with higher levels of mineral were 60 percent less likely to develop disease

By Amanda Gardner *HealthDay Reporter*TUESDAY, April 9 (HealthDay News) –

Men who have higher levels of the mineral known as selenium may also face a lower risk of developing advanced prostate cancer, new research suggests.

The authors of the study said the mineral -- found in foods such as Brazil nuts, in supplements and in foods grown in selenium-rich soil -- might one day offer a way to reduce prostate cancer risk in men.

"There is very little evidence on modifiable prostate cancer risk factors," said study author Milan Geybels. "Any compound that would prevent the incidence of advanced prostate cancer would have a substantial impact on public health."

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Prostate Cancer Canada Network

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Geybels, who is a doctoral candidate in cancer epidemiology at Maastricht University in Maastricht, the Netherlands, was scheduled to present the findings Tuesday at the annual meeting of the American Association of Cancer Research, in Washington, D.C. Data and conclusions presented at medical meetings typically are considered preliminary until published in a peer-reviewed journal.

Still, the findings should not be construed as an endorsement of selenium supplements, experts warned.

"At this point, I wouldn't recommend that all men run out and buy a bottle of selenium to take," said Dr. Elise Cook, an associate professor of clinical cancer prevention at the M.D. Anderson Cancer Center in Houston.

Too much selenium can be toxic, resulting in skin problems, and may even be associated with an increased risk of diabetes, Cook said. Getting selenium from dietary sources, however, shouldn't be a problem.

Cancer researchers have been interested in the supposed benefits of selenium on prostate cancer for years, until results from a large trial several years ago showed that selenium, taken either alone or with vitamin E, did not prevent prostate cancer.

"Before that, selenium supplements had been flying off the shelves," said Dr. Alexander Kutikov, an associate professor of urologic oncology at Fox Chase Cancer Center in Philadelphia. "Enthusiasm [for selenium] was really dampened by that trial."

But that study looked at men with normal selenium levels when they entered the trial, and it did not focus on a specific type of prostate cancer. This latest study looked only at men who were deficient in selenium and tracked only cases of advanced prostate cancer, which is linked with a poor prognosis.

Among a group of almost 60,000 men aged 55 to 69 at the beginning of the study, the researchers found that men with the highest selenium levels, as measured in toenail clippings, had more than a 60 percent reduced risk for advanced prostate cancer.

Selenium levels in toenail clippings indicate long-term selenium intake, the researchers noted. The large trial from several years ago measured blood levels of the mineral, which reflects only recent exposure.

Still, the study is "hypothesis-generating at best," Kutikov said. Although the findings suggested an association between selenium levels and advanced prostate cancer risk, they did not prove a cause-and-effect link.

Geybels said the results could point the way to another trial assessing risk for advanced prostate cancer in men with low selenium levels.

http://www.webmd.com/

NOTABLE

Survival rates for prostate cancer

Survival rates are often used by doctors as a standard way of discussing a person's prognosis (outlook). Some patients with cancer may want to know the survival statistics for people in similar situations, while others may not find the numbers helpful, or may even not want to know them. If you would rather not read the survival rates, skip to the next section.

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The 5-year survival rate refers to the percentage of patients who live *at least 5 years* after their cancer is diagnosed. Of course, many of these people live much longer than 5 years (and many are cured).
Five-year *relative* survival rates, such as the numbers below, assume that some people will die of other causes and compare the observed survival with that expected for people without the cancer. This is a better way to see the impact of the cancer on survival.
According to the most recent data, when including *all* men with prostate cancer:

- The relative 5-year survival rate is nearly 100%
- The relative 10-year survival rate is 98%
- The 15-year relative survival rate is 93%

Keep in mind that 5-year survival rates are based on patients diagnosed and first treated more than 5 years ago, and 10-year survival rates are based on patients diagnosed more than 10 years ago. Modern methods of detection and treatment mean that many prostate cancers are now found earlier and can be treated more effectively. If you are diagnosed this year, your outlook may be better than the numbers reported above.

Survival rates by stage

The National Cancer Institute (NCI) maintains a large national database on survival statistics for different types of cancer. This database does not group cancers by AJCC stage, but instead groups cancers into local, regional, and distant stages.

- **Local stage** means that there is no sign that the cancer has spread outside of the prostate. This corresponds to AJCC stages I and II. About 4 out of 5 prostate cancers are found in this early stage.
- **Regional stage** means the cancer has spread from the prostate to nearby areas. This includes stage III cancers and the stage IV cancers that haven't spread to distant parts of the body, such as T4 tumors and cancers that have spread to nearby lymph nodes (N1).
- **Distant stage** includes the rest of the stage IV cancers – all cancers that have spread to distant lymph nodes, bones, or other organs (M1).

5-year relative survival by stage at the time of diagnosis

Stage	5-year relative survival rate
local	nearly 100%
regional	nearly 100%
distant	8%

These survival rates are based on previous outcomes of large numbers of men who had the disease, but they cannot predict what will happen in any particular man's case. Many other factors may affect a man's outlook, such as the Gleason score, the PSA, and the man's overall health. Your doctor can tell you how the numbers above may apply to you, as he or she is familiar with the aspects of your particular situation.

Last Medical Review: 02/27/2012
Last Revised: 01/17/2013
www.cancer.org

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QUOTABLE

"Worrying is like a rocking chair: it gives you something to do, but doesn't get you anywhere. " Van Wilder

"No matter how long the winter, spring is sure to follow" Proverb

“If you are caught on a golf course during a storm and are afraid of lightning, hold up a 1-iron. Not even God can hit a 1-iron.” Lee Trevino

PCCN Markham

Prostate Cancer Support Group

Meets the 2nd Tuesday
Every month
September – June
St. Andrew’s Presbyterian Church
143 Main St Markham

The Markham Prostate Support Group is generously supported by Dr John DiCostanzo, PCCN, St. Andrews Presbyterian Church, and the Canadian Cancer Society.
The group is open to all; survivors, wives, partners, relatives and those who are interested in knowing about prostate health.
Drop by St Andrews Presbyterian Church 143 Main Street Markham at 7:30PM, the 2nd Tuesday every month from September to June. No need to call.
The information and opinions expressed in this publication are not endorsements or recommendations for any medical treatment, product, service or course of action by PCCN Markham its officers, advisors or editors of this newsletter.
Treatment should not be done in the place of standard, accepted treatment without the knowledge of the treating physician.
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