PCCN Markham

Prostate Cancer Canada Network

Newsletter

Volume 19 Issue 8 **April, 2018**

NEXT MEETING

Tuesday, April 10, 2018 - 7:30PM

St. Andrews Presbyterian Church – Main St Markham

Rose Room - Downstairs

(Free Parking off George St)

Peer to Peer Group

An interactive discussion group for Survivors/Partners to discuss issues, share concerns

Group is moderated by peers

Spouses Always Welcome

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THANK YOU !

DR. JOHN DiCOSTANZO. KIM HARTSBERG-LANG AND ASTELLAS FOR YOUR SUPPORT!

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'Screening Smarter' for Prostate Cancer

Roxanne Nelson Mar 23, 2018

Screening for prostate cancer with the prostate-specific antigen (PSA) test, once widely promoted for all men 50 years and older, has fallen out of favor as a population-based screening tool. But when it comes to PSA testing, the proverbial baby shouldn't be thrown out with the bathwater, experts caution.

"The right solution was not to 'screen none' but rather to screen smarter," said Peter R. Carroll, MD, MPH, from UCSF Helen Diller Family Comprehensive Cancer Center in San Francisco, during the National Comprehensive Cancer Network (NCCN) Annual Conference, held March 22–24 in Orlando, Florida.

Carroll explained that during the 1990s and 2000s, PSA screening was poorly implemented; older men were overscreened, younger men were underscreened, low-risk disease was overtreated, and high-risk disease was undertreated.

"[D]espite these problems, we drove down prostate cancer mortality rates by more than 50%, but at the cost of too much entirely avoidable treatment and its attendant side effects," he said.

Last year the United States Preventive Services Task Force (USPSTF) revised it recommendations on PSA screening and changed its "D" recommendation against PSA testing for men ages 55 to 69 and replaced it with a "C" recommendation. The task force now says that the men in that age group should decide individually with their doctors whether and when to undergo PSA testing.

The USPTF changed their recommendations for the early detection of prostate cancer based largely on two issues; randomized trials show a mortality benefit from screening, and overtreatment has been tempered by increased utilization of active surveillance.

So where does that leave PSA testing now?

Carroll pointed out that screening recommendations from the different professional organizations vary but NCCN believes in baseline screening, which is different from the guidelines of other groups. While some of the details vary, all of the groups recommend shared decision making and have moved away from broad population-based criteria.

One of the previous problems with PSA testing was that it was a low-value test. "We were testing outside of the target population and testing too frequently," he said, and the low specificity of the PSA test was also leading to frequent and unnecessary biopsies.

The detection/treat paradigm is now changing from a model of "detect all, treat all" to "detect some, treat some." The new approach is to have a target population (age, risk factors, etc), to stop screening after low PSA results/later age, and to increase screening intervals. Also important is knowing what to do if a patient has a high PSA level, he explained.

More stringent indications for biopsy are needed, Carroll said. The 2018 NCCN guidelines for early prostate cancer detection call for a repeat PSA and a digital rectal exam if one had not previously been performed during the initial assessment. The next step would be a work-up for benign disease.

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Before going to biopsy, clinicians should consider testing for biomarkers which will improve screening specificity for high-grade disease or using multiparametric MRI, he emphasized. New tests for specificity include the 4Kscore, which tests for PSA, free PSA (fPSA), intact PSA, and kallikrein-related peptidase 2; the ExoDx Prostate (IntelliScore), which tests for SPDEF, ERG, PCA3; the Michigan Prostate Score (MiPS), which tests for PSA and the two genes PCA3 and TMPRSS2:ERG; and the Prostate Health Index, which tests for PSA, fPSA, and [-2]proPSA.

Research has demonstrated that these tools can help men to avoid unnecessary biopsies; for example, the assessment with the 4Kscore Test avoided 36.2% of biopsies in one study and 51.3% in another.

"Prostate cancer early detection in well-informed healthy men saves lives," Carroll emphasized, while cautioning that the optimal screening regimen for men at greatest risk (those who are African American, have a strong family history of prostate cancer, and have high-risk germline mutations) is still not known.

Carroll added that that tests of specificity should be considered in men who wish to avoid a biopsy, and that "active surveillance is the preferred option for men with low-risk and very-low-risk disease."

http://www.cancernetwork.com/nccn/screening-smarter-prostate-cancer

Castration-Sensitive Prostate Cancer

Angelica Welch **Published:** Friday, Mar 23, 2018

James Luke Godwin, MD

The first-line treatment of patients with metastatic castration-sensitive prostate cancer has undergone a significant number of changes in the last few years. Most recently, the FDA approved abiraterone acetate (Zytiga) in combination with prednisone for patients with metastatic high-risk castration-sensitive disease. This approval of abiraterone was based on findings from the phase III LATITUDE trial. In the study, there was a 38% reduction in the risk of death with the addition of abiraterone and prednisone to androgen deprivation therapy (ADT) compared with ADT alone.[1]

Another pivotal trial of abiraterone in prostate cancer was STAMPEDE. This trial showed that the addition of abiraterone to standard initial therapy lowered the relative risk of death by 37% and improved progression-free survival by 71% in both nonmetastatic and metastatic patients with high-risk hormone-naïve disease.[2]

Although there is much excitement with androgen receptor (AR)-directed agents, docetaxel remains a staple of treatment. James Luke Godwin, MD, says that clinicians have now reached an interesting decision point on how to treat their patients in the frontline setting moving forward.

In an interview during the 2018 *OncLive*® State of the Science Summit™ on Prostate Cancer, Godwin, assistant professor, Kimmel Cancer Center Network, Thomas Jefferson University Hospital, recapped recent

advancements in frontline metastatic castration-sensitive prostate cancer and highlighted emerging agents with potential in this space.

How has first-line treatment for patients with castration-sensitive prostate cancer evolved?

Godwin: This is a space that has been evolving over the past couple of years. Since 2014 or 2015, we have learned that adding docetaxel upfront provides a survival benefit when added to ADT as opposed to ADT alone. That became a standard of care in 2017, with data from 2 large studies—LATITUDE and STAMPEDE—showing impressive data with the addition of abiraterone to ADT upfront in this setting. Currently, we have good data for 2 separate agents that have different toxicity profiles.

For clinicians, when you meet a patient with metastatic castration-sensitive prostate cancer, it is an interesting decision point. What therapy should clinicians add to standard ADT in the first-line setting? That is an open question.

What are the differences in toxicity profiles between the 2 agents?

Docetaxel is a traditional chemotherapy; it is an old drug that has been used for a very long time. Common side effects include neutropenia, decreased cell counts, fatigue, and neuropathy. The benefit of docetaxel is that you give it for a set time period—only 6 cycles—and then that therapy is complete. You would then continue with ADT alone. Although there is a period where a patient may experience more toxicity, they are only on the therapy for a definitive amount of time. The majority of men in the CHAARTED study, which showed the survival benefit for docetaxel upfront, completed all 6 cycles as planned without dose reduction.

Abiraterone is generally well tolerated. The side effect profile does include some cardiovascular risk and hypertension, which can be managed. However, when considering first-line treatment with abiraterone, you are considering committing a patient to a longer treatment course than with docetaxel. When making that decision, the clinician should work with the patient and consider toxicity, length of treatment, and cost to figure out what works best for that particular patient.

Is there any rationale to look at other agents, such as enzalutamide?

Absolutely, there are trials ongoing looking at enzalutamide in the frontline space. There are the ENZAMET and ARCHES studies. There is also the PEACE1 study, which is looking at a variety of combinations. That trial will have some head-to-head data looking at docetaxel plus ADT versus abiraterone plus ADT, also with or without local radiation therapy dependent on the patient population. There are many subgroups in that study, so that will hopefully add some extra data for us to consider when choosing therapy.

There are also trials looking at combinations of all of the above, such as chemotherapy plus a next-generation AR-targeting agent. There is a trial looking at the combination of abiraterone and enzalutamide upfront. There are also multiple large phase III clinical studies that are ongoing, which will probably read out over the next few years and give us more data in which to decide the best possible therapies for our patients.

What is the potential for immunotherapy in this setting?

Immunotherapy in prostate cancer is a complex topic. Of the genitourinary malignancies that we treat, prostate cancer has been the most resistant to experience those responses to immunotherapy that we see in

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our patients with renal cell carcinoma or urothelial carcinoma. However, there are some strategies that have been looked at to sensitize the local tumor microenvironment in prostate cancer, to try to figure out how to infiltrate that space better or to make the prostate cancer cells seem more visible to the immune system. Combination therapies using vaccines plus immunotherapy are being looked at. There are multiple National Institutes of Health studies looking at that sort of approach, and there are large studies looking at the addition of immunotherapy to AR-targeted agents. For instance, the KEYNOTE-199 trial is looking at the addition of pembrolizumab (Keytruda) to enzalutamide in patients with metastatic castration-resistant prostate cancer. These are questions that we are continuing to ask, and we hope that we can find a way to select patients who may have prostate cancer and could respond to immunotherapy.

What are the remaining questions in this population?

It is pretty clear that men with high-volume metastatic disease significantly benefit from the addition of either docetaxel or abiraterone upfront. For even earlier disease states, or disease states where there is not as much disease burden, the question is a little more open. As we get longer follow-up from those trials such as STAMPEDE and LATITUDE, we will get more information about abiraterone in particular.

The other question is sequencing. Does it make sense to do AR-targeted therapy first and then chemotherapy, or vice versa? Where do combinations fit in? There is also the potential for immunotherapy. Those are all open questions asking how to best combine agents and sequence them. That is the purpose of a lot of these trials, and hopefully we will get some of these answers in the next few years.

References: Fizazi K, Tran N, Fein LE, et al; the LATITUDE investigators. LATITUDE: A phase 3 double-blind, randomized trial of androgen deprivation therapy (ADT) with abiraterone acetate (AA) plus prednisone (P) or placebos (PBOs) in newly diagnosed high-risk metastatic hormone-naïve prostate cancer (mHNPC) patients (pts). *J Clin Oncol.* 2017;35 (suppl; abstr LBA3). James ND, DeBono JS, Spears MR, et al. Adding abiraterone for men with high-risk prostate cancer (PCa) starting long-term androgen deprivation therapy (ADT): Survival results from STAMPEDE (NCT00268476). *J Clin Oncol.* 2017;35 (suppl; abstr LBA5003).

http://www.onclive.com/web-exclusives/frontline-advances-continue-in-castrationsensitive-prostate-cancer?p=2

Finasteride Cuts Prostate Cancer Risk Long Term

Jody A. Charnow, Editor March 21, 2018

New study shows that men are at lower risk of prostate cancer for years after they stop taking the medication. Finasteride use results in a significantly lower risk of prostate cancer (PCa) long after the medication is discontinued, researchers concluded.

The finding extends the results of the Prostate Cancer Prevention Trial (PCPT), which demonstrated that 7 years of finasteride treatment decreased the risk of PCa by 25% compared with placebo among men aged 55

years and older. Whether this risk-lowering effect of finasteride is maintained after discontinuing the drug has been unclear.

To examine PCa risk beyond the 7-year study period, Joseph M. Unger, PhD, MS, of the Fred Hutchinson Cancer Research Center in Seattle, and colleagues linked PCPT study records to subjects' Medicare claims data. The linkage enabled PCa to be identified by both clinical records and Medicare claims. The median follow-up was 16 years. Overall, finasteride recipients had a 21.1% decreased risk of PCa compared with placebo recipients, Dr Unger's team reported online in the *Journal of the National Cancer Institute*.

The beneficial effect was most pronounced in the first 7.5 years (29% reduction in PCa risk), consistent with original PCPT findings, Dr Unger's team reported. After 7.5 years, the investigators observed no increased risk of PCa among finasteride recipients.

In the PCPT, investigators randomly assigned 18,880 men to receive finasteride or placebo daily for 7 years. To be eligible for the study, men had to be aged 55 years or older with normal findings on digital rectal examinations and PSA levels of 3.0 ng/mL or less. In the current study, 14,176 participants (75.1%) had a linkage to Medicare claims (7069 in the finasteride arm and 7107 in the placebo arm), although all 18,880 men were included in the analysis.

"The use of Medicare claims data to augment follow-up for PCPT participants illustrates how the use of secondary data sources can enhance the ability to detect outcomes over the long term from prospective studies," the authors noted.

Reference: Unger JM, Hershman DL, Till C, et al. Using Medicare claims to examine long-term prostate cancer risk of finasteride in the Prostate Cancer Prevention Trial. *J Natl Cancer Inst*. 2018; DOI: 10.1093/jnci/djy035

https://www.renalandurologynews.com/prostate-cancer/finasteride-lowers-prostate-cancer-risk-long-term/article/752569

Patients who choose alternative medicine for cancer are richer, smarter, younger and healthier - but it makes their risk of dying MUCH higher

- **Those who skip proven cancer treatments for alternative ones are over five times more likely to die of their curable disease**
- **Alternative medicine has blown up into a $34 billion business in the US**
- **Doctors explain how advantages like money and more education can lead cancer patients down a deadly path**

By Natalie Rahhal For Dailymail.com Published: 18:03 EDT, 21 March 2018 | Updated: 19:00 EDT, 21 March 2018

People who choose to get alternative treatments for **cancer** tend to have everything else going for them - being happier, younger, wealthier, and more educated.

Yet those who try to treat curable cancers with alternative medicines - including crystals and homeopathy - are 5.68 times more likely to die than people who get traditional treatments.

The alternative medicine business is booming in the US, where it is worth $34 billion, even though only a third of its 'treatments' have been tested.

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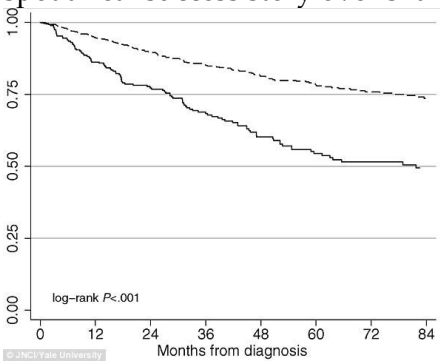
But more highly-educated people may be sabotaging themselves by believing that they are smart enough to spot a real success story over snake oil instead of trusting doctors.



Survival rates for patients with curable cancers were significantly worse for those who got alternative treatments (solid) than for those who had traditional ones (dashed)

Dr Skyler Johnson, lead author of a study on cancer survival times and alternative medicine, found out that his wife had been diagnosed with a late stage lymphoma while he was in medical school.

The first thing the couple did was to ignore all of the advice that Dr Johnson gives his patients: they went online.

'There was so much misinformation there, and it was hard for me to sift through it, and I thought, "if I have some medical training, and good education, then how hard is it for someone who doesn't to tell what's real?"' he says.

The more 'worldly'the person, the better educated ones are trying to figure out what they can do for their cancer and start researching far a field. It kind of makes sense

Dr James Yu, study author and radiologist

'So I totally empathize with the patients who do that after getting a diagnosis from doctors who don't really speak their language as well as they should so [the patients] go to the internet,' says Dr Johnson, who is now a radiology resident at Yale University.

In fact, he and Dr James Yu, director of the school's prostate and genitourinary cancer radiotherapy program, both theorize that being more educated may make people like Dr Johnson more likely to go looking for alternative therapies because they fancy themselves competent to choose a good one.

There is a kind of 'mirror effect,' Dr Yu says.

'The more "worldly" the person, the better educated ones are trying to figure out what they can do for their cancer and start researching far a field,' he says. 'It kind of makes sense.'

But, Dr Yu warns, 'that's a trap.'

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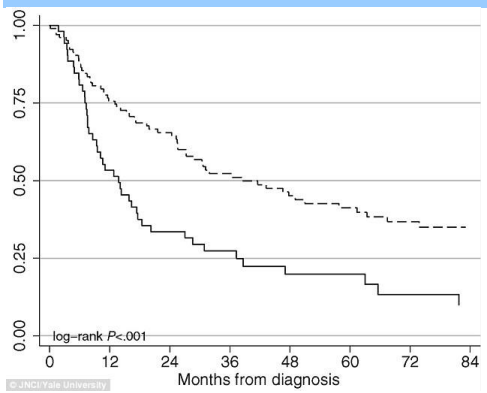
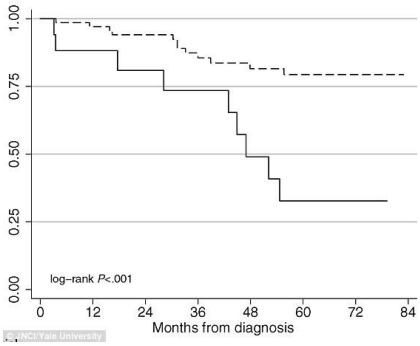


Lung cancer patients that only did alternative treatments have far worse five-year survival times than those who had traditional treatments



Survival for people who treated bowel cancer in non-traditional ways fell off steeply after about 40 months

He added: 'Steve Jobs is an example of somebody who initially pursued non-medical therapy [to treat his pancreatic cancer] and subsequently got traditional therapy.

'But at that stage, you are allowing your cancer to grow, which will make it worse than if you pursued appropriate therapy in the first place,' he says.

In spite of both his eventual traditional treatments and attempts at alternative - including rumored dietary measures - Jobs succumbed to cancer in 2011.

Though they never resorted to traditional medicine, alternative medicine patients whose data Dr Yu and Dr Johnson analyzed faced the same fate: they were more than twice as likely to die within five years of their diagnoses than those who got traditional treatments.

In their study, Dr Yu and Dr Johnson looked at survival rates for people who had been diagnosed with breast, prostate and bowel cancers.

The odds that someone with more than a high school level of education would get an alternative treatment for one of those cancer were higher for those who were less educated.

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'Maybe these people have just enough education to think that they may know better [than their doctors] but in reality they might not,' says Dr Johnson.

Higher degrees of education and higher incomes often go hand-in-hand, as was true in their study.

More disposable income also means that these patients can afford to pay out-of-pocket for alternative treatments not covered by their insurance.

Maybe these people have just enough education to think that they may know better [than their doctors] but in reality they might not

Dr Skyler Johnson, study author and radiology resident

'We know that complementary and alternative medicine is a growing, multi-billion-dollar industry, and one where patients pay more out of pocket [for treatment] than they pay doctors,' says Dr Johnson.

The industry has done nothing but grow in recent years, and Grand View Research even projected that it will be worth nearly $200 billion globally by 2025.

Its rise in popularity, Dr Johnson suggests, is driven in part by clever and ubiquitous online marketing campaigns, including tempting stories of seemingly miraculous recovery.

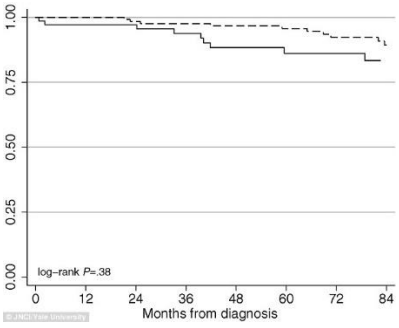
But, in reality, these alternative 'medicines' - which may include anything from special diets to cannabis oil and acupuncture - have not been properly studied as cancer treatments.

'In many cases, it would be unethical to randomize a patient [in a trial] between a proven therapy and quackery,' says Dr Yu.

'So it's difficult to disprove the quackery because you don't want to give it to someone fighting cancer because it won't work,' he adds.

Patients have reported that therapies like acupuncture and massage have helped to assuage the unpleasant side effects of proven cancer therapies, and doctors typically take no issue with this.

But desperation and fear - both of death and of these side effects - evidently drive some to try these therapies instead of traditional ones.



Prostate cancer survival rates were fairly high overall, but were still lower for alternative medicine patients

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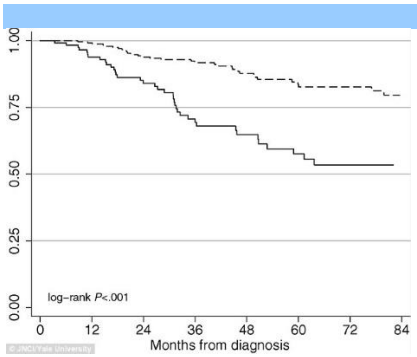

Breast cancer patients that forewent proven treatment deteriorated quickly

Dr Johnson and Dr Yu's study backs that notion up. They found that people in later stages of their cancers were more likely to forego traditional treatment.

'When faced with a treatment that can be difficult and you can be scared and try to think that there's a treatment out there that has the benefit and not the side effects,' says Dr Yu.

'It's human nature to deny reality,' he adds.

The reality is that there are countless unproven treatments being showcased online, and the differences between real science and 'quackery.'

So Dr Johnson decided to make the CRAP test for crap science.

His clever evaluation method uses scores for four factors to determine whether information about alternative 'medicines' can be trusted: conspiracies or claims too good to be true, requests for money, anecdotes, and publisher credentials.

It's human nature to deny reality

Dr Johnson knows, from his own experience with his wife, that after a cancer diagnosis, 'your first instinct is going to be to go home and look for things, and most can't be trusted.'

He advises his patients to use the CRAP factors during their own information gathering, 'but I don't say "don't go to that website," because if my doctor said that that's probably the first thing I'd do.'

The pair of doctors acknowledge that, even if they are placebo effects, many patients may simply feel better if they seek and use alternative treatments, and that's alright, so long as they do it in coordination with proven treatments.

'We as physicians need to do a better job of understanding that patients want to participate in their therapy,' says Dr Yu.

'We need to listen to them so we can help to persuade them to do traditional therapies with complementary alternative therapies,' and not forego proven, potentially life-saving treatments.

DR SKYLER JOHNSON'S TEST FOR SPOTTING 'CRAP' SCIENCE

When his wife was diagnosed with cancer while radiologist Dr Skyler Johnson was in medical school, even he struggled to wade through the wealth of misinformation he found online.

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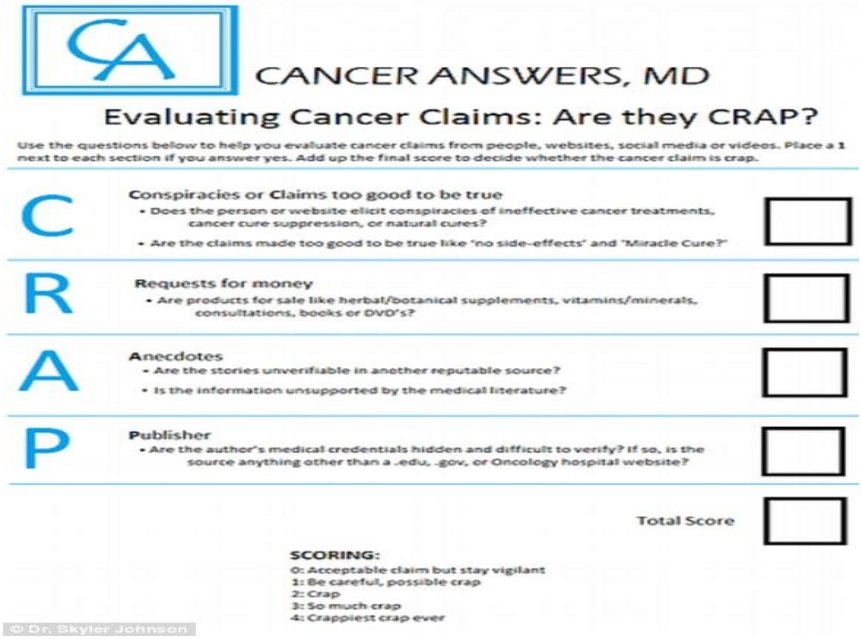

http://www.dailymail.co.uk/health/article-5528279/Richer-younger-smarter-cancer-patients-choose-alternative-medicine.html

Study reveals impact of prostate cancer on wives and partners of sufferers

March 19, 2018

Many wives of advanced prostate cancer sufferers feel that their lives are being undermined by their husband's illness, with nearly half reporting that their own health suffered. In addition a focus subgroup has revealed that many feel isolated and fearful, and worry about the role change in their lives as their husband's cancer advances. This study, developed with the wives of men with metastatic prostate cancer who were being treated with hormone therapy, is amongst the first carried out on how prostate cancer affects the partners of sufferers. It was presented yesterday at the EAU conference in Copenhagen.

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Prostate cancer is the most common male cancer. Prostate cancer which metastisises to other parts of the body is often difficult or impossible to cure, and so is often treated with androgen deprivation therapy (ADT), which slows down the tumour growth. ADT shuts down production of the hormone testosterone, but that leads to fatigue, frailty, and loss of sexual drive. The effects of prostate cancer and its treatment have been extensively studied in men, but there is almost no work on how this affects their partners.

A team of Danish researchers from Herlev and Gentofte University Hospital, led by registered nurse Jeanne Avlastenok and Dr. Peter Østergren, have been working with the wives and partners of men who had been undergoing exercise therapy to maintain body strength and resilience during prostate cancer treatment. They questioned 56 women on how the cancers were affecting the lives of their husbands. Nearly half of these women (26 women, i.e. 46%) reported that their partner's health problem had affected their own health.

The researchers randomly selected 8 women for in-depth, focus-group style interviews - aimed at encouraging the women to express how they are being affected by their partner's illness.

"We worked with the women as a group, encouraging them to be open about what they felt in a supportive group environment", said Jeanne Avlastenok.

"Three of the women - those with early stage disease - were less burdened than the others, but the remaining five expressed some significant concerns.

Many felt increasingly socially isolated. Their husbands were fatigued both by the illness and by the treatment, which meant that they couldn't socialize as a couple, which made the women feel cut off from social support".

Sample Comment: "Because he sleeps so much we do not visit the family or our friends and do not have many guests" said one.

RN Jeanne Avlastenok continued, "They also gradually developed a real fear of being alone, even within the relationship. They felt that they had to be strong, which meant that they couldn't share the burden of the illness.

The last theme which worried the women was over the role change in their relationship. As their men became less able to fulfil their usual roles, the women had to undertake tasks which had previously fallen to the men. Many of these are simple tasks but for the women they represented a sea change in the way their lives were structured".

Sample Comment: 'We have 22 windows and my husband thinks that he still can polish them and also do all the gardening. But nothing happens and he doesn't want me to arrange professional help"

All of the women were worried that their husbands would develop significant pain as the disease progressed.

The team stresses that the focus group findings is very much qualitative work on a small sample. "But in any study, you need to do the qualitative work before moving to any larger sample", said Dr. Peter Østergren, "We needed to let the women express their concerns first, so we can understand which questions to ask

Commenting, Professor Hein van Poppel (Leuven, Belgium), EAU Adjunct Secretary General for Education, said:

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"Many prostate cancer patients have a hard time, both physically and emotionally, and this work shows that this stress can spill over and affect wives and partners. This is good for neither of them. Good mental and emotional health needs to be part of how we judge a treatment, and we need to try to ensure that both patients and their partners get the support they both need".
https://www.news-medical.net/news/20180319/Study-reveals-impact-of-prostate-cancer-on-wives-and-partners-of-sufferers.aspx

The Mediterranean Diet for a long life

Mar 14, 2018 12:00 PM by: Dr. W. Gifford-Jones

Foods rich in polyphenols and lycopenes may extend both the quantity and quality of human life by preventing age-related diseases and conditions

Leonardo da Vinci once remarked, "Trifles make perfection and perfection is no trifle." Trifles can make a huge difference in surgery, when building rockets, in nutrition, or in life generally. For instance, a report in the publication LifeExtension shows that a Mediterranean Diet prolongs life. As we all age, this is no trifle.

For years doctors and nutritionists have known the Mediterranean Diet is a "Five Star" one. But no one knew why this diet had such remarkable benefits. Now, researchers have discovered its success is due to polyphenols (a plant based compound). They lower the risk of cardiovascular disease (CVD) by an amazing 60 per cent! This means fewer heart attacks, strokes, hypertension and less inflammation.

The author of the report, Michael Downey, says that most people fail to obtain sufficient polyphenols in their diet. Authorities agree that people should eat 10 servings of fruit and vegetables every day to reduce CVD risk. Unfortunately, for most people, it's impossible to consume this amount of fibre, nuts, artichokes, lentils, grapes, pomegranates, olives, fish and wine each day.

The Mediterranean Diet also affects the risk of dying. In 2016, at the European Society of Cardiology conference, a study showed that the number of those who followed the Mediterranean Diet were 37 per cent less likely to die than those who ate a non-Mediterranean diet.

One researcher made the sage remark that "the Mediterranean Diet provides more protection against heart disease than most of today's prescription drugs!" And this isn't a trifle!

Since so many North Americans suffer from hypertension, one study is of particular importance. After a year on two types of Mediterranean Diets, subjects showed that blood pressure had declined. Equally important, researchers discovered that increased amounts of polyphenols and nitric oxide were being excreted by the kidneys.

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Nitric oxide (NO) is nature's natural arterial relaxant. I've previously reported that, as we age, less NO is produced by our bodies, causing constriction of arteries, hypertension and erectile dysfunction. Neo40, a natural remedy, is a pill that produces NO and is available in health food stores (HFS).

Due to my age I've been using this product daily for several years.

In view of the increasing prevalence of Alzheimer's disease another finding is significant. Those who were consistent in following the Mediterranean Diet had less age-related brain shrinkage.

Since it's a challenge for most people to consume sufficient polyphenols, extracts such as grapeseed, pomegranate, walnut, pecan and artichoke are also available in health food stores.

I love blueberries and was pleased to read that numerous studies show blueberries supply the brain with increased amounts of oxygenated blood. British researchers studied the effect of blueberry concentrate on brain function for 12 weeks on a group of people with an average age of 68.

What made this experiment unique was that researchers analyzed brain function with a powerful MRI scanner while subjects were being asked questions. This revealed that blueberries produced a significant increase in brain activity.

Later, the use of blueberry concentrate on a group of children 7 to 10 years of age showed another amazing finding. They were given a battery of tests over a period of several hours. Significant improvements in memory were seen as quickly as 1.25 hours after using blueberry concentrate.

Some authorities have labelled blueberries as the number one antioxidant. This means that blueberries destroy what's known as free radicals, the waste products of metabolism, which are associated with an aging brain, cancer, and heart
disease.

So the Mediterranean Diet is a prudent way to fight these major problems as it contains a variety of fruits, vegetables, fish, grapes, nuts, fiber, and tomatoes loaded with lycopenes which may help to prevent prostate cancer. A variety of healthy polyphenol extracts are all available in health food stores.

I'll add more blueberries to my diet. I'll also continue taking Neo40 and several thousand milligrams of vitamin C powder daily, which carries more oxygenated blood to the brain. Why? Because during the past year no reader has been able to inform me of anyone who has developed Alzheimer's disease while taking 4000 to 6,000 mg of vitamin C daily for several years. This is a very interesting finding.

https://www.timminstoday.com/columns/the-doctor-game/the-mediteranian-diet-for-a-long-life-861137

PCCN Markham

Newsletter

Volume 19 Issue 8 **April, 2018**

NOTABLE

I Have Prostate Cancer. But I Am Happy

George Monbiot March 13, 2018

The principles that define a good life protect me from despair, despite this diagnosis and the grisly operation I now face

It came, as these things often do, like a gunshot on a quiet street: shocking and disorienting. In early December, my urine turned brown. The following day I felt feverish and found it hard to pee. I soon realised I had a urinary tract infection. It was unpleasant, but seemed to be no big deal. Now I know that it might have saved my life.

The doctor told me this infection was unusual in a man of my age, and hinted at an underlying condition. So I had a blood test, which revealed that my prostate-specific antigen (PSA) levels were off the scale. An MRI scan and a mortifying biopsy confirmed my suspicions. Prostate cancer: all the smart young men have it this season.

On Monday, I go into surgery. The prostate gland is buried deep in the body, so removing it is a major operation: there are six entry points and it takes four hours. The procedure will hack at the roots of my manhood. Because of the damage that will be caused to the surrounding nerves, there's a high risk of permanent erectile dysfunction. Because the urethra needs to be cut and reattached to the bladder, I will almost certainly suffer urinary incontinence for a few months, and possibly permanently. Because the removal of part of the urethra retracts the penis, it appears to shrink, at least until it can be stretched back into shape.

I was offered a choice: radical surgery or brachytherapy. This means implanting radioactive seeds in the parts of the prostate affected by cancer. Brachytherapy has fewer side effects, and recovery is much faster. But there's a catch. If it fails to eliminate the cancer, there's nothing more that can be done. This treatment sticks the prostate gland to the bowel and bladder, making surgery extremely difficult. Once you've had one dose of radiation, they won't give you another. I was told that the chances of brachytherapy working in my case were between 70 and 80%. The odds were worse, in other words, than playing Russian roulette (which, with one bullet in a six-chambered revolver, gives you 83%). Though I have a tendency to embrace risk, this was not an attractive option.

It would be easy to curse my luck and start to ask, "Why me?" I have never smoked and hardly drink; I have a ridiculously healthy diet and follow a severe fitness regime. I'm 20 or 30 years younger than most of the men I see in the waiting rooms. In other words, I would have had a lower risk of prostate cancer only if I had been female. And yet … I am happy. In fact, I'm happier than I was before my diagnosis. How can this be? The reason is that I've sought to apply the three principles which, I believe, sit at the heart of a good life. The first is the most important: imagine how much worse it could be, rather than how much better.

When you are diagnosed with prostate cancer, your condition is ranked on the Gleason Score, which measures its level of aggression. Mine is graded at seven out of 10. But this doesn't tell me where I stand in

general. I needed another index to assess the severity of my condition, so I invented one: the Shitstorm Scale. How does my situation compare to those of people I know, who contend with other medical problems or family tragedies? How does it compare to what might have been, had the cancer not been caught while it was still – apparently – confined to the prostate gland? How does it compare to innumerable other disasters that could have befallen me?

When I completed the exercise, I realised that this bad luck, far from being a cause of woe, is a reminder of how lucky I am. I have the love of my family and friends. I have the support of those with whom I work. I have the NHS. My Shitstorm Score is a mere two out of 10.

The tragedy of our times is that, rather than apply the most useful of English proverbs – "cheer up, it could be worse" – we are constantly induced to imagine how much better things could be. The rich lists and power lists with which the newspapers are filled, our wall-to-wall celebrity culture, the invidious billions spent on marketing and advertising, create an infrastructure of comparison that ensures we see ourselves as deprived of what others possess. It is a formula for misery.

The second principle is this: change what you can change, accept what you can't. This is not a formula for passivity – I've spent my working life trying to alter outcomes that might have seemed immovable to other people. The theme of my latest book is that political failure is, at heart, a failure of imagination. But sometimes we simply have to accept an obstacle as insuperable. Fatalism in these circumstances is protective. I accept that my lap is in the lap of the gods.

There are, I believe, three steps to overcoming fear: name it, normalise it, socialise it

So I will not rage against the morbidity this surgery might cause. I won't find myself following Groucho Marx who, at the age of 81, magnificently lamented: "I'm going to Iowa to collect an award. Then I'm appearing at Carnegie Hall, it's sold out. Then I'm sailing to France to pick up an honour from the French government. I'd give it all up for one erection." And today there's Viagra.

The third principle is this: do not let fear rule your life. Fear hems us in, stops us from thinking clearly, and prevents us from either challenging oppression or engaging calmly with the impersonal fates. When I was told that this operation had an 80% chance of success, my first thought was "that's roughly the same as one of my kayaking trips. And about twice as good as the chance of emerging from those investigations in West Papua and the Amazon".

There are, I believe, three steps to overcoming fear: name it, normalise it, socialise it. For too long, cancer has been locked in the drawer labelled Things We Don't Talk About. When we call it the Big C, it becomes, as the term suggests, not smaller, but larger in our minds. He Who Must Not Be Named is diminished by being identified, and diminished further when he becomes a topic of daily conversation.

The super-volunteer Jeanne Chattoe, whom I interviewed recently for another column, reminded me that, just 25 years ago, breast cancer was a taboo subject. Thanks to the amazing advocacy of its victims, this is almost impossible to imagine today. Now we need to do the same for other cancers. Let there be no more terrible secrets.

PCCN Markham

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So I have sought to discuss my prostate cancer as I would discuss any other issue. I make no apologies for subjecting you to the grisly details: the more familiar they become, the less horrifying. In doing so, I socialise my condition. Last month, I discussed the remarkable evidence suggesting that a caring community enhances recovery and reduces mortality. In talking about my cancer with family and friends, I feel the love that I know will get me through this. The old strategy of suffering in silence could not have been more misguided.

I had intended to use this column to urge men to get themselves tested. But since my diagnosis, we've discovered two things. The first is that prostate cancer has overtaken breast cancer to become the third biggest cancer killer in the UK. The second is that the standard assessment (the PSA blood test) is of limited use. As prostate cancer in its early stages is likely to produce no symptoms, it's hard to see what men can do to protect themselves. That urinary tract infection was a remarkably lucky break.

Instead, I urge you to support the efforts led by Prostate Cancer UK to develop a better test. Breast cancer has attracted twice as much money and research as prostate cancer, not because (as the Daily Mail suggests) men are the victims of injustice, but because women's advocacy has been so effective. Campaigns such as Men United and the Movember Foundation have sought to bridge this gap, but there's a long way to go. Prostate cancer is discriminatory: for reasons unknown, black men are twice as likely to suffer it as white men. Finding better tests and treatments is a matter of both urgency and equity.

I will ride this out. I will own this disease, but I won't be defined by it: I will not be prostrated by my prostate. I will be gone for a few weeks but when I return, I do solemnly swear I will still be the argumentative old git with whom you are familiar.

https://www.theguardian.com/commentisfree/2018/mar/13/prostate-cancer-happy-diagnosis-operation?CMP=share_btn_link

QUOTABLE

"It's so important to realize that every time you get upset, it drains your emotional energy. Losing your cool makes you tired. Getting angry a lot messes with your health." Joyce Meyer

"I think everyone in their life goes through challenges, whether it's love or money, kids or illness... You have to really not run away from that stuff." Chris Martin

"Be careful about reading health books. You may die of a misprint." Mark Twain

"The only time my prayers are never answered is on the golf course." Billy Graham

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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 PCCN Prostate Support Group is generously supported by Dr. John DiCostanzo, Astellas Pharma, PCCN, St. Andrews Presbyterian Church, and the Canadian Cancer Society.

The group is open to all; survivors, wives, partners, relatives and those in our community 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. 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.

The majority of information in this newsletter was taken from various web sites with minimum editing. We have recognized the web sites and authors where possible.

PCCN Markham does not recommend treatment, modalities, medications or physicians. All information is, however, freely shared.

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