PCCN Markham

Newsletter

Volume 21 Issue 7 **March, 2020**

NEXT MEETING

Tuesday, March 10, 2020 - 7:30PM

St. Andrews Presbyterian Church – Main St Markham

Upstairs Hall

(Free Parking & Room access off George Street)

Guest Speaker

Dr. Rus Sethna, Chief of Psychiatry - MSH

Topic:

Prostate Cancer-Types of Depression and Coping Options

Coffee, Cookies and Conversation at 7:00pm

ALL WELCOME

IN THIS ISSUE …

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Volume 21 Issue 7 **March, 2020**

Study: Most men choosing surgery for prostate cancer do not regret their decisions

*Reviewed by Kate Anderton, B.Sc. (Editor)*Feb 10 2020

Men with localized prostate cancer are faced with deciding among a range of options for treatment - including a choice between robot-assisted versus conventional prostatectomy. A new follow-up study in The Journal of Urology® finds that most patients choosing surgery for prostate cancer don't regret their decisions. *The Journal of Urology®*, Official Journal of the American Urological Association (AUA), is published in the Lippincott portfolio by Wolters Kluwer.

Patients who play a more active role in making decisions about prostate cancer surgery are less likely to experience "decision regret" about their choices, according to the new research by Johannes Huber, MD, PhD, of Technische Universität Dresden, Germany, and colleagues. The study also finds no difference in decision regret in men opting for open versus robot-assisted surgery.

Study looks at decision regret after prostate cancer surgery

The study included data from a large-scale German healthcare research project, called HAROW, that analyzed outcomes for men choosing different treatments for localized prostate cancer - meaning that the cancer hasn't spread beyond the prostate gland.

The name HAROW refers to the major treatment options for patients with this diagnosis - namely hormone therapy, active surveillance, radiation, operation (surgery), or watchful waiting."

Dr. Lothar Weissbach, study co-author, founder of the HAROW project

In recent years, robot-assisted prostatectomy has become an increasingly popular alternative to conventional open surgery. While the robot-assisted procedure may enable faster recovery, studies have shown "no definite advantage" in terms of prostate cancer outcomes.

Few studies have looked at decision regret by men choosing among prostate cancer treatments. "Decision related regret is a negative emotion associated with thinking about a past choice and comparing the status quo with a hypothetical situation which might have taken place with having chosen a different treatment alternative," Dr. Huber and coauthors explain.

The authors analyzed decision regret in 936 men who underwent prostate cancer surgery, of whom 532 underwent open prostate surgery and 404 underwent robot-assisted surgery. At follow-up of about six years, patients rated their "distress or remorse" about their treatment choice using a 0 to 100 Decision Regret Scale (with 100 being the highest level of regret).

Men who underwent robot-assisted surgery showed a more "self-determined role" in treatment decision-making. They were more likely to use the internet to research their treatment options and were more active in selecting the hospital where the procedure would be performed. They also chose hospitals that performed a higher volume of prostate cancer surgeries, where robot-assisted surgery was more likely to be available. "Actively involved patients may choose another hospital if there is a strong desire for robotic surgery," the researchers write.

Overall, rates of decision regret about prostate cancer surgery were low: average score on the Decision Regret Scale was just 14 of 100. Decision regret scores were similar for men undergoing robot-assisted versus open surgery, with scores of 12 and 15, respectively.

Not surprisingly, patients with better treatment outcomes - which included no cancer recurrence, good erectile function and no incontinence - had fewer regrets. Men who played a more active role in treatment decision-making were about twice as likely to have a low decision regret score (less than 15). Shorter follow-up times were also associated with lower decision regret.

Decision regret could have a lasting impact on patient satisfaction with choices for prostate cancer treatment. The new results suggest generally low levels of decision regret several years after prostate cancer surgery, regardless of the choice of surgical approaches.

While good outcomes are obviously important, being more actively involved in treatment decision-making may also lead to fewer regrets. In a discussion accompanying their paper, Dr. Huber and coauthors write, "As our study shows, personal responsibility for one's own decisions has a significant influence on decision regret."

Source: Wolters Kluwer Health **Journal reference:**

Baunacke, M., *et al.* (2020) Decision Regret after Radical Prostatectomy does Not Depend on Surgical Approach: 6-Year Followup of a Large German Cohort Undergoing Routine Care. *The Journal of Urology*. doi.org/10.1097/JU.0000000000000541.

https://www.news-medical.net/news/20200210/Study-Most-men-choosing-surgery-for-prostate-cancer-do-not-regret-their-decisions.aspx

Brachytherapy for Intermediate-Risk Prostate Cancer

Allan S. Brett, MD reviewing Goy BW et al. Urology 2020 February 13, 2020

In a 10-year observational study, brachytherapy compared favorably to surgery and external beam radiation therapy.

Brachytherapy is the implantation of radioactive material into a tumor. No randomized trials have been performed to compare radical prostatectomy, external beam radiation therapy (EBRT), and brachytherapy in patients with intermediate-risk prostate cancer (defined according to Gleason score, prostate-specific antigen [PSA] level, clinical stage, and percentage of positive biopsy cores). In this observational study from the Kaiser Permanente healthcare system, researchers compared outcomes among 1500 patients with intermediate-risk prostate cancer who received one of these three options. To adjust for baseline differences among the three groups, multivariable analysis with propensity scoring was used.

During 10 years of follow-up, propensity-adjusted freedom from biochemical failure was more likely with brachytherapy than with EBRT or surgery (80% vs. 57% and 57%); in other words, brachytherapy patients were less likely to have rising PSA levels during follow-up. Correspondingly, patients in the EBRT and surgery groups were more likely to require “salvage therapy” during follow-up (e.g., radiation therapy for the surgical group, androgen-deprivation therapy for the EBRT group). Metastasis-free survival and prostate cancer-specific survival were not significantly different in the three groups.

Comment

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Various clinical factors — as well as patient preferences — play a role in choice of treatment for intermediate-risk prostate cancer. According to this observational study, brachytherapy compares favorably with the other options.

DITOR DISCLOSURES AT TIME OF PUBLICATIONDisclosures for Allan S. Brett, MD at time of publication*Nothing to disclose*

Citation(s):

Goy BW et al. Ten-year treatment outcomes of radical prostatectomy vs external beam radiation therapy vs brachytherapy for 1503 patients with intermediate-risk prostate cancer. *Urology* 2020 Feb; 136:180. (https://doi.org/10.1016/j.urology.2019.09.040)

Opening up about the mental toll of prostate cancer and how to cope with it

To mark World Mental Health Day, we're highlighting the often overlooked emotional impacts of prostate cancer. We spoke to men with the disease about their mental health challenges and ask what their, our Specialist Nurses' and your tips are for maintaining your emotional wellbeing.

10 Oct 2018

It sounds obvious but can so easily be ignored: the diagnosis and treatment of prostate cancer can take a huge mental toll. From the initial shock of hearing the 'C-word' to the helpless feelings during treatment that your life is no longer in your control, the range of emotions men go through can be vast. So what can you do to help manage these difficult feelings?

Get informed, feel empowered

Rod Coverley powerfully described his suicidal thoughts after he was first diagnosed. "I'd never thought about committing suicide. I was a confident, strong, successful person," he says. "But I felt like I couldn't do anything, like someone was taking my life away from me."

In the midst of it all, he found our publications and website a lifeline, helping him feel more reassured and less isolated.

"As I read through all the information, the thoughts of me taking my own life went away because I found I was not alone," he says. "Those negative thoughts stayed with me for a long time. But I still have my life and my wife. I'm active and I'm fine."

Talking therapy and medication

For Will Trubridge, the demands of balancing a physical job with hormone therapy left him tired and susceptible to mood swings.

"I just couldn't do as much as I was used to," he says. "People at work kept offering to help me lifting stuff or doing things for me, and I found myself shouting at them to leave me alone and let me do it myself. I just wanted to be normal. Things came to a head when I had a meeting with my Director and I just started crying."
He was subsequently diagnosed with depression by his GP and given anti-depressants as well as therapy, which helped him and his wife open up about their feelings and their relationship. He also found complementary therapies, like reflexology, beneficial.
"It won't do anything for my cancer, but it certainly helps with relaxation and emotional wellbeing," he says. "And when you're emotionally strong, it's easier to cope with hardships, isn't it?"

Tell someone and don't feel guilty

Kurt Jewson also found medication and talking to a Macmillan counsellor helped – as well as learning not to feel guilty about his mental health.
"People said that I was 'fighting' cancer – I wasn't," he says. "The cancer treatment seemed pretty passive. The active fight was the depression, which I knew nothing about and had no way of coping with.
"If you feel like I did then it's OK. Don't panic and don't fight it. If you fight it, you end up depressed *and* guilty. Be brave and tell someone. A problem shared is a problem with a bit knocked off."

Talk to others and get support

It can be good to hear others' experiences of dealing with prostate cancer, and many men – like Kurt – say they find it cathartic to share their own. Our Online community is a great place to talk with others in the same situation as you, or you can talk to one of our trained volunteers who have experience of the disease through our One-to-one peer support service.
Of course, our Specialist Nurses are always available over the phone or online if you are feeling down or worried and are finding it hard to deal with things. And you can ring the Samaritans if you need help at any other time.

Our Specialist Nurses came up with these 10 tips for keeping the blues away, from getting outside to random acts of kindness. What tips do you have for maintaining your mental wellbeing, and what have been your experiences of depression or anxiety because of prostate cancer? Let us know below.

https://prostatecanceruk.org/about-us/news-and-views/2018/10/opening-up-about-the-mental-toll-of-prostate-cancer-and-how-to-cope-with-it

Overall Survival in mCRPC Cases Linked to Number of Radium-223 Doses

Publish Date February 18, 2020

Men with metastatic castration-resistant prostate cancer with predominantly bone metastases who receive more than 4 dose of radium-223 have significantly improved overall survival than those who receive 4 or fewer doses, a study found.

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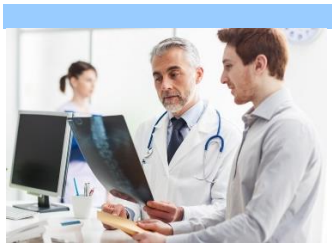

Radium-223 Plus Sipuleucel-T Found to Slow mCRPC Progression

Publish Date February 14, 2020

Combining sipuleucel-T and radium-223 improves progression-free survival among men with metastatic castration-resistant prostate cancer (mCRPC) who have bone predominant metastases, a randomized phase 2 study found.

Antitumour activity of abiraterone acetate against metastatic castration-resistant prostate cancer progressing after docetaxel and enzalutamide (MDV3100)

Androgen receptor (AR) signalling remains critically important in metastatic castration-resistant prostate cancer (mCRPC) as confirmed by recent phase III trials, showing a survival advantage for abiraterone acetate and enzalutamide (MDV3100). The antitumour activity of abiraterone and prednisolone in patients pre-treated with enzalutamide is as yet unknown.

We investigated the antitumour activity of abiraterone and prednisolone in patients with mCRPC who had progressed following treatment with docetaxel (Taxotere) and enzalutamide. Clinical data were retrospectively analysed for prostate-specific antigen (PSA) and RECIST responses, clinical benefit and survival.

Thirty-eight patients were included in the analysis. The median age was 71 years (range 52-84); metastatic sites included bone disease in 37 patients (97%), lymph nodes in 15 patients (39%) and visceral disease in 10 patients (26%). Abiraterone was well tolerated. Three patients (8%) attained a PSA response, defined as ≥50% decline in PSA confirmed after ≥4 weeks, while seven patients (18%) had a ≥30% PSA decline. The median progression-free survival (PFS) was 2.7 months (95% CI 2.3-4.1). Of the 12 patients assessable radiologically, only 1 (8%) attained a confirmed partial response.

Abiraterone and prednisolone have modest antitumour activities in patients with mCRPC pretreated with docetaxel and enzalutamide.

Annals of oncology : official journal of the European Society for Medical Oncology. 2019 Dec 04 [Epub]

Y Loriot, D Bianchini, E Ileana, S Sandhu, A Patrikidou, C Pezaro, L Albiges, G Attard, K Fizazi, J S De Bono, C Massard

Department of Cancer Medicine, Institut Gustave Roussy, University of Paris-Sud, INSERM 981, Villejuif, France. Electronic address: yohann.loriot@igr.fr., Section of Medicine, The Royal Marsden NHS Foundation Trust and The Institute of Cancer Research, Sutton, UK., Department of Cancer Medicine, Institut Gustave Roussy, University of Paris-Sud, INSERM 981, Villejuif, France.

https://www.urotoday.com/recent-abstracts/urologic-oncology/prostate-cancer/119063-antitumour-activity-of-abiraterone-acetate-against-metastatic-castration-resistant-prostate-cancer-progressing-after-docetaxel-and-enzalutamide-mdv3100

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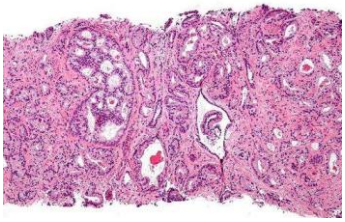
Statins may lower mortality in high-risk prostate cancer patients

by Thomas Jefferson University



Micrograph showing prostatic acinar adenocarcinoma (the most common form of prostate cancer) Credit: Wikipedia

Among high-risk prostate cancer patients—those with high PSA and Gleason scores of 8 or more—many will develop a difficult-to-treat disease. Preliminary research suggests that two commonly prescribed medications, cholesterol-lowering statins and the diabetes therapy metformin may have anticancer effects. However, it is unclear which of these two medications—commonly prescribed together—contributes the most and whether they can impact high-risk prostate cancer. New research shows that statins, alone or with metformin, increase survival in men with high-risk prostate cancer.

"Both metformin and statins have been associated with longer life in prostate cancer patients, yet because they are commonly prescribed together, no study we know of has looked at these two medications separately," says senior author Grace Lu-Yao, Ph.D., associate director of Population Science at the Sidney Kimmel Cancer Center—Jefferson Health, one of only eight NCI-designated cancer centers nationwide with a prostate cancer program of excellence.

The study, published in *Cancer Medicine* on Feb 8th, looked at a number of statin therapies, and metformin, an anti-diabetic medication, in high-risk prostate cancer populations.

Using data from the Surveillance, Epidemiology and End Results (SEER-18) database linked with Medicare files, Dr. Lu-Yao and colleagues looked at patients diagnosed with cancer from 2007 through to 2011. Based on 12,700 patients, the researchers observed that statins alone or in combination with metformin was significantly associated with reduced mortality from all causes.

Dr. Lu-Yao and colleagues saw the highest median survival of 3.9 months in men who took both metformin and statins, 3.6 with statins alone and 3.1 years with metformin alone. The median survival for those who did not use either drug was also 3.1 years.

"With respect to prostate mortality, metformin plus statin was associated with a 36% reduction in risk of death followed by statins alone," says Dr. Lu-Yao. "Those taking metformin alone were relatively rare, and there was no significant association with all-cause mortality."

Interestingly, the study revealed that men who took atorvastatin, pravastatin, or rosuvastatin—but not lovastatin—demonstrated a reduction in mortality compared with non-users, which is consistent with the findings from a recent population-based cohort study using Taiwan National Health Insurance Research Data. The Taiwanese research showed that these three statins are more effective at lowering triglycerides and low-

density lipoprotein cholesterol and raising high-density lipoprotein cholesterol than other statins in patients with hypercholesterolemia.

Of the three statins studied, men on atorvastatin did have a longer median time to progression on androgen deprivation therapy compared to those who weren't treated with statins. "Although the exact mechanisms remain unknown, it is worth noting that atorvastatin exhibits a potent lipid-lowering effect per dose of any statin, and has the greatest bioavailability and one of the longest half-lives," says to Dr. Lu-Yao.

The data presented in the current study provide crucial insight for the design of future randomized clinical trials of statin for high-risk patients with prostate cancer. Based on the existing evidence, a well-designed clinical trial is warranted to investigate the roles of statins and combination statins/metformin to reduce the mortality cancer of the prostate.

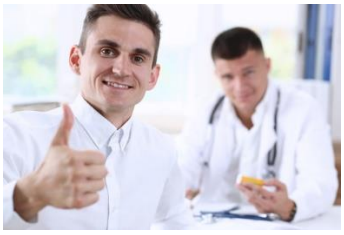
"Our study showed that the effects were more pronounced in patients taking statins after the diagnosis of prostate cancer, 54% reduction in PCA mortality among patients with high-risk prostate cancer," says Lu-Yao. "This magnitude of reduction is comparable to the results of men treated with androgen signaling inhibitors."

Statins are relatively inexpensive with good safety records. Further studies to understand the mechanisms of the observed association and its potential clinical utility are warranted.

https://medicalxpress.com/news/2020-02-statins-mortality-high-risk-prostate-cancer.html

Xtandi Significantly Improves Overall Survival in Men with High-risk CRPC, Phase 3 Final Data Show

 BY MARTA FIGUEIREDO FEBRUARY 11, 2020



Treatment with Xtandi (enzalutamide) significantly extends the lives of men with high-risk, non-metastatic castration-resistant prostate cancer (CRPC), according to final data from a Phase 3 clinical trial.

Developed by Pfizer and Astellas Pharma, Xtandi is an oral hormone therapy that works by blocking the interaction between male hormones and their receptors in cancer cells. Since this interaction can stimulate prostate cancer growth, Xtandi is expected to halt cancer progression in these patients. The therapy is currently approved in the U.S. and in Europe for the treatment of three types of advanced prostate cancer: high-risk non-metastatic CRPC, metastatic CRPC, and metastatic castration-sensitive prostate cancer (mCSPC). Xtandi's approval for treating men with high-risk non-metastatic CRPC was based on

positive data from the Phase 3 PROSPER clinical trial (NCT02003924). PROSPER was designed to assess whether adding Xtandi to standard

https://www.google.ca/search?q=,%22prostate+cancer%22,&client=safari&tbs=qdr:m&tbm=nws&ei=p-hKXtzjOeaOggf6t6y4Ag&start=60&sa=N&ved=0ahUKEwic07KkqNnnAhVmh-AKHfobCyc4MhDw0wMIbw&biw=509&bih=360&dpr=2

Cabozantinib Plus ADT Shows Promise in Hormone-Naive Metastatic Prostate Cancer

Darcy Lewis **Published Online:**2:30 PM, Mon February 17, 2020

Paul G. Corn, MD, PhD

Combining cabozantinib (Cabometyx) plus androgen-deprivation therapy (ADT) as first-line therapy in patients with hormone-naïve metastatic prostate cancer yields promising clinical activity, according to the new single-arm phase II study, which was published in *Clinical Cancer Research*.

"We observed promising anti-disease activity and identified blood and tissue-based markers to potentially identify patient subsets most likely to benefit," wrote the authors, led by Paul G. Corn, MD, PhD, of The University of Texas MD Anderson Cancer Center in Houston. "These data suggest that moving cabozantinib earlier in the disease course with more potent epithelial-targeting agents such as abiraterone or docetaxel could serve as a foundation to explore rational therapy combinations."

Median follow-up was 31.2 months. The median PFS for the entire cohort was 16.1 months (95% CI, 14.6–22.7 months). The high-volume group had a median PFS of 16.1 months (95% CI, 13.3–21.5 months), compared with 20.2 months for the low-volume group (95% CI, 15.1–NA months; Hazard Ratio [HR] 1.56; 95% CI, 0.66–3.66, $P = 0.31$). As of publication, 18 patients (29%) had died; the median OS had not been reached.

Additional findings of note include that 83% of patients experienced a reduction in PSA of at least 90%. Also, decreases in bone-specific alkaline phosphatase of at least 50% and urine N-telopeptides of at least 50% were observed in 87% and 86% of patients, respectively. A large majority of patients displayed responses in bone scans (81%) and measurable disease (90%).

There were no grade 4 adverse events (AEs) and no treatment-related deaths. The most common grade 3 AEs were hypertension in 12 patients (19%), diarrhea in 4 patients (6%), and thromboembolic events in 4 patients(6%). Of the 9 patients who discontinued treatment due to AEs, the most common reason was for stroke (n = 2, 3%). One patient each experienced transient-ischemic attack, pulmonary embolism, proteinuria, peripheral neuropathy, and several other conditions.

Corn et al contextualized their results by noting that previous MD Anderson data showed that the median time to castrate-resistant progression in patients with high-volume disease treated with ADT alone was 11.2 months. "Thus, the mPFS of 16.1 months we observed in high-volume patients in our study suggests

promising anti-disease activity … This clinical efficacy signal supports the hypothesis that therapeutic strategies that target the tumor stroma may improve patient outcomes," they wrote. "Our data further suggest that applying stromal targeting therapies earlier in the disease course may potentially enhance efficacy beyond what has been observed in heavily pretreated patients with castrate-resistant disease, the patient group most commonly studied in clinical trials with these agents."

Eligible patients had pathologically confirmed adenocarcinoma without small cell elements and metastatic disease assessed by bone scan, CT scan and/or MRI, as well as an ECOG performance status of 0, 1, or 2. ADT consisted of LHRH agonist or antagonist therapy, and anti-androgens could be used up to 4 weeks at the beginning of ADT treatment.

The starting study dose of cabozantinib was 60 mg daily. The original trial protocol permitted dose reductions to 40 and 20 mg daily; this was later amended to permit dose interruptions up to 3 days per week and the use of 2 weeks on, 1 week off as an alternative schedule. Treatment continued until disease progression, excessive toxicity or radiation treatment to more than one site.

The primary endpoint was castrate-resistant PFS. Secondary endpoints included radiographic responses, OS, and biomarker modulation in blood and tumor tissues.

enrollment consisted of 62 patients. Of these, 46 patients (74%) had *de novo* metastatic disease and 54 patients (87%) had high-volume disease. At data cutoff, nearly all patients had discontinued the study regimen (n = 57, 92%) and a sizeable majority (n = 50, 81%) had developed castrate-resistant progression.

Corn et al found the median duration of cabozantinib treatment to be 13.8 months (95% CI, 10.5–15.7 months). Fifty-three patients (85%) required at least one dose reduction. Of these, 42 patients (68%) were reduced to 40 mg, while 11 patients (18%) were further reduced to 20 mg. The median time to the first dose reduction was 2.1 months (range, 0.7–11.3 months), and the median time to the second dose reduction was 5.7 months (range, 2.1–11.7). Nearly half the patients (n = 27, 44%) received an alternate dosing schedule, with the 5-day on, 2-day off schedule being most common (n = 17, 27%).

Corn et al also noted the limitation of their single-arm trial design, which "confounds the ability to distinguish whether baseline clinical features or potential biomarkers are predictive, prognostic, or both." They advocate for future randomized trials that make use of image-guided and liquid biopsies to explore whether therapeutic strategies that inhibit c-MET/VEGF2 signaling can be successful in patients with hormone-naïve metastatic prostate cancer.

Reference: Corn PG, Zhang M, Nogueras-Gonzalez GM, et al. A Phase II Study of Cabozantinib and Androgen Ablation in Patients with Hormone-Naïve Metastatic Prostate Cancer. Clin Cancer Res. Published online January 15, 2020.

https://www.targetedonc.com/news/cabozantinib-plus-adt-shows-promise-in-hormonenaive-metastatic-prostate-cancer

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Volume 21 Issue 7 **March, 2020**

Cholesterol Drugs Might Help Curb Prostate Cancers

By Robert Preidt *HealthDay Reporter*
FRIDAY, Feb. 14, 2020 (HealthDay News) –

Drugs that many men with prostate cancer might already be taking -- cholesterol-lowering statins -- may help extend their survival if they have a "high-risk" form of the disease, new research suggests.

High-risk patients include men with high blood levels of prostate specific antigen (PSA) and a "Gleason score" of 8 or more. Gleason scores are a calculation used to gauge prognosis in prostate cancer. Men with a high Gleason score may develop difficult-to-treat cancers.

Prior research had suggested that statins and the diabetes drug metformin (often prescribed together) have anticancer properties. However, it hasn't been clear which of the two drugs is the bigger cancer-fighter, or whether either might help against high-risk prostate cancer.

To help answer those questions, a team led by Grace Lu-Yao of the Sidney Kimmel Cancer Center--Jefferson Health, in Philadelphia, tracked data on nearly 13,000 high-risk prostate cancer patients. All were diagnosed between 2007 and 2011.

The study couldn't prove cause and effect, but it found that statins, taken alone or with metformin, did seem associated with an increase in survival.

Men who took both statins and metformin had higher median survival (3.9 years) than those who took statins alone (3.6 years), metformin alone (3.1 years), or those who did not take either drug (3.1 years).

The study was published Feb. 8 in the journal *Cancer Medicine*.

"Both metformin and statins have been associated with longer life in prostate cancer patients, yet because they are commonly prescribed together, no study we know of has looked at these two medications separately," Lu-Yao said in a center news release. She's associate director of population science at the center.

"With respect to prostate mortality, metformin plus statin was associated with a 36% reduction in risk of death followed by statins alone," Lu-Yao added.

The study also found that those who took one of three types of statin -- atorvastatin, pravastatin or rosuvastatin -- had longer survival than those who did not take any statins. A similar benefit was not seen with a fourth statin, lovastatin.

Because prostate cancer thrives on testosterone, patients often receive treatments that reduce levels of male hormones (androgens). The new study found that among patients who received such therapies, those who took atorvastatin had a longer median time to prostate cancer progression than those who didn't take statins.

It's not clear why such effects were limited to atorvastatin, Lu-Yao said, but it appears to have the best "bioavailability" of the statin drugs and lingers longest in the body.

The research team believes that, based on the existing evidence, a clinical trial should be conducted to assess the effectiveness of statins and the combination of statins/metformin in extending survival of prostate cancer patients.

Two prostate cancer specialists unconnected to the new study agreed that the findings show promise.

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"It appears that there may be a place in the treatment of prostate cancer for statins," said Dr. Elizabeth Kavaler, a urology specialist at Lenox Hill Hospital in New York City. "However, we are not yet at a point where we can use the data to direct patient care."

She believes testosterone may be key here. According to Kavaler, higher cholesterol levels promote higher levels of androgens, which in turn help encourage the growth of prostate cancer. Statins may help slow that process, Kavaler explained.

Dr. Manish Vira is vice chair for urologic research at The Arthur Smith Institute for Urology in New Hyde Park, N.Y. He agreed that the findings are encouraging, and noted that "a dozen actively recruiting clinical trials using either metformin or a statin in prostate cancer treatment" are already underway.

WebMD News from HealthDay

https://www.webmd.com/cholesterol-management/news/20200214/cholesterol-drugs-might-help-curb-prostate-cancers#2

The Connection Between Diet and Prostate Cancer Risk

Changes in what a man eats – and doesn't eat – could impact his risk for prostate cancer.

By S. Adam Ramin, M.D., Contributor Feb. 14, 2020

Prostate cancer is one of the most common types of cancer to occur in men. It's the second most common cause of cancer in males, just behind skin cancer. As frightening as a diagnosis of prostate cancer can be, the treatment options available today make it one cancer type that many men are able to successfully beat. But the goal, as always, is to prevent cancer before one must think about being diagnosed with or treating it. And there are plenty of helpful ways a man can reduce his prostate cancer risk, including what he eats. Here's what to know about the connection between diet and prostate cancer.

(Getty Images)

In general, what we eat affects every part of our bodies, and the prostate is no exception. Numerous studies indicate that some foods, consumed frequently, that can be detrimental to or may increase a man's prostate cancer risk. These foods include:

- Red meat.
- Alcohol.
- Dairy products.
- Foods that have a high amount of saturated fats.

Red meat, specifically hot dogs, beef, pork and sausage, contains a chemical compound known as heterocyclic amines, or HCAs. These chemicals develop during the red meat cooking process. Researchers suggest that

these HCAs are responsible for an increased risk of prostate cancer. Though these types of meat are often a primary source of protein, which is a necessary fuel for the body, there are alternatives. Consider fish, white meats like turkey, chicken,and other poultry, as well as non-meat sources such as tofu and beans.

Although many of today's dairy products are the go-to source of calcium for lots of people, large amounts of dairy should not be consumed regularly. The reason is that many dairy products have very high-fat content – which studies have shown to be associated with the progression of prostate cancer cells and lethality from the disease. A good goal is to keep daily intake of whole milk products, fatty cheeses, yogurt, butter and ice cream to a minimum and eat them in small portions. As an alternative, switch to non-dairy products such as soy, oat or almond milk, fat-free yogurts and low-fat ice creams. There are a variety of non-dairy options at most grocery chains today.

Now that we've outlined which foods may increase the risk of prostate cancer, let's explore those that may reduce the risk. By incorporating more fruits and vegetables into our diets, the risk of developing prostate cancer may be significantly reduced. And there are certain foods to consume that may accomplish this better than others. These include tomatoes, various berries, nuts, coffee (in moderation), and carrots. But truthfully, diets that are rich in whole foods (foods that have not been overly processed or altered beyond their natural state with manufactured ingredients or preservatives), like fruits, vegetables, and whole grains, may help to slow the progression or even possibly prevent prostate and other types of cancer.

Proper nutrition can also help ward off the recurrence of disease while boosting the immune system. The key is knowing the right food ratios to consume, which foods to avoid and which are suitable in moderation. Following a heart-healthy diet is one of the best ways to prevent a variety of health issues, including cancer. If you're looking at this from a meal-by-meal perspective, it means that any given plate of food is going to contain mostly veggies and fruits, and a small helping of lean protein (avoiding red meat when possible). Dessert should be an on-occasion treat (preferably not daily) and tend toward a less sugary and fatty option, like sugar-free almond yogurt topped with fruit and a small drizzle of honey.

As beneficial as a healthy diet is, it cannot replace routine health checkups or screenings for prostate cancer. If you've been putting off that annual physical, make the appointment. You'll be glad you did.

S. Adam Ramin, M.D., Contributor

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PCCN Markham

Newsletter

Volume 21 Issue 7 **March, 2020**

NOTABLE

Canadian Cancer Society and Prostate Cancer Canada celebrate their amalgamation

Transformational partnership showcases leadership in the non-profit sector

February 3, 2020 (Toronto, ON) –

On the eve of World Cancer Day, the Canadian Cancer Society (CCS) and Prostate Cancer Canada (PCC) have finalized their amalgamation. This transformational partnership is a bold and critically needed step forward within the cancer charity sector in Canada. The newly amalgamated organization will be led by Andrea Seale, CEO of CCS.

"With more than 300 cancer charities in Canada, donors expect us to reduce duplication and work together so that donations go further in helping people facing cancer," explains Seale. "Through this amalgamation, we are bringing together the strengths of two organizations that share many common goals: preventing cancer, funding life saving cancer research, and ensuring no one faces cancer alone. By partnering, we will be more efficient while also amplifying impact for people facing prostate cancer, expanding awareness and activity around important issues like early detection and survivor support."

The amalgamation between PCC and CCS builds upon the momentum created by CCS's unprecedented 2017 merger with the Canadian Breast Cancer Foundation. That remarkable consolidation resulted in a 28% year-over-year reduction in fundraising expenses and increased funding for research, programs and services.

As a ewly amalgamated organization, CCS remains committed to improving the cancer experience for people facing all types of cancer, including prostate cancer – the most commonly diagnosed cancer in Canadian men.

"The reality is 1 in 9 Canadian men is expected to develop prostate cancer in his lifetime," says Peter Coleridge, former President and CEO of PCC. CCS's national reach, extensive community presence and deep history of public engagement allows us to invest in research and programs that will ultimately make an even bigger difference for Canadians affected by prostate cancer. I am committed to helping with a smooth transition to unify two reputable charities and am confident we can accomplish much more together than we ever could separately."

"CCS is proud to be entrusted with the opportunity to continue the mission of Prostate Cancer Canada. This amalgamation is an example of two great organizations combining for efficiency and increased impact. Together we will do more than we could have separately. More of our donors' dollars will go for mission and less for administration," says Robert Lawrie, Chair of CCS' Board of Directors. "Both PCC and CCS have sector leading governance, which will also become even stronger as Christopher Wein, the former PCC Chair and David Woollcombe, one of its former Vice Chairs, join the CCS Board."

"While PCC has contributed to cutting the prostate cancer mortality rate in half over the last 25 years, we still lose 11 men every day. This amalgamation bolsters our ability to continue our critically important work for

Canadian families," says Stephen Pike, former PCC Board of Directors Chair.

About the Canadian Cancer Society

The Canadian Cancer Society (CCS) is the only national charity that supports Canadians with all cancers in communities across the country. No other organization does what we do; we are the voice for Canadians who care about cancer. We fund groundbreaking research, provide a support system for all those affected by cancer and shape health policies to prevent cancer and support those living with the disease.

Help us make a difference. Call 1-888-939-3333 or visit cancer.ca today.

For further information:

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QUOTABLE

"Don't ever become a pessimist... a pessimist is correct oftener than an optimist, but an optimist has more fun, and neither can stop the march of events". Robert A. Heinlein

"March is the month God created to show people who don't drink what a hangover is like" *Garrison Keillor*

"Giving is not just about making a donation. It is about making a difference." Kathy Calvi

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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, St. Andrews Presbyterian Church, PCCN, 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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We look forward to your feedback and thoughts. Please email suggestions to markhampccn@gmail.com

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