



# The Manitoba Prostate Cancer Support Group



Vol. 206 - August 2008

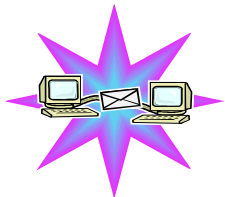


The Manitoba Prostate Cancer Support Group encourages wives, loved ones, and friends to attend all meetings.

Feel free to ask basic or personal questions without fear of embarrassment. You need not give out your name or other personal information.

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

Want to reach us by email ?



[manpros@mts.net](mailto:manpros@mts.net)

## Thought For Today

"WOULDN'T IT BE NICE IF WE'D KNOWN ALL THESE THINGS BEFORE WE WENT OUT INTO THE REAL WORLD?"

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PROSTATE CANCER AWARENESS EVENING

## Medical Advisors to The Manitoba Prostate Cancer Support Group

J. Butler M.D.  
Radiation Oncologist

Paul Daeninck M.D.  
Pain Management

Darryl Drachenberg M.D.  
Urologist

Graham Glezerson M.D.  
Urologist

Len Leboldus M.D.  
Urologist  
[Honorary]

Ross MacMahon M.D.  
Urologist

John Milner M.D.  
Urologist

Jeff Sisler M.D.  
Family Practitioner

Gary Schroeder M.D.  
Radiation Oncologist

**Thanks!**

## Cancer Information Service

Call toll free:  
1-888-939-3333 or  
1-905-387-1153

When you call the toll free number of the Cancer Information Service, your questions will be answered by someone who understands how confusing the subject of cancer can be. *All calls are kept confidential*

## NEXT MEETING:

Thursday, August 21, 2008 7 - 9 P.M.

*Dr. Darryl Drachenberg Urologist / Oncologist*

## **Update on Cancer Treatment**

*Location:* AUDITORIUM of the Seven Oaks General Hospital - Leila & McPhillips

## Urologists Identify Seven Biomarkers That May Help Pinpoint Prostate Cancer Recurrence

ScienceDaily (June 23, 2008) — A simple blood test may help doctors better predict whether prostate cancer will recur or spread in patients who have undergone surgery for the disease, UT Southwestern Medical Center researchers have found.

In a study published in the June 15 issue of *Clinical Cancer Research*, UT Southwestern scientists identified a panel of seven biomarkers that can predict with 86 percent accuracy which prostate cancer patients will experience a recurrence and progression of the disease. Biomarkers are proteins circulating in a patient's blood that are specific to a disease.

Current risk assessment methods, which include stage and grade of cancer and the level of prostate-specific antigen, can predict prostate cancer recurrence with about 70 percent accuracy.

"There are several unresolved issues in the clinical and surgical management of prostate cancer, one of them being the identification of men who have insignificant cancers and can be followed, and another being the identification of men most likely to have spread of disease and early or late recurrence," said Dr. Claus Roehrborn, chairman of urology at UT Southwestern and one of the study's authors. "In the future, once we can reliably identify those patients, we may be able to offer additional treatment to counteract that risk and give those men a better chance for a permanent cure. The panel of biomarkers is an important step in this direction."

For nine years, Dr. Shahrokh Shariat, who is now a resident in urology at UT Southwestern and the study's lead author, has been collaborating with basic-science researchers and clinicians to find a comprehensive group of biomarkers associated with prostate cancer that could more accurately predict the biological behavior of the disease.

Using commonly available blood testing methods, Dr. Shariat and his team measured the levels of seven biomarkers in 423 patients who were subsequently

surgically treated with a radical prostatectomy and bilateral lymphadenectomy.

Of the study participants, 75 had a recurrence of their cancer. All 75 had elevated levels of at least several of the seven biomarkers. Dr. Shariat's seven-biomarker model was able to accurately predict the risk for recurrence 86.6 percent of the time.

"We found that a combination of independent yet complementary markers may provide a more accurate prediction outcome compared to single markers," Dr. Shariat said. "This could help physicians provide individualized care and targeted therapy for patients. It will also allow us to design clinical trials to target these individual biomarkers."

Prostate cancer is the most commonly diagnosed cancer and the second leading cause of cancer death in men in the United States. Although prostate-removal surgery and radiation therapy have been successful in controlling the disease, up to 40 percent of patients experience a relapse.

"A prediction tool based on the biomarkers we tested could improve the accuracy of standard models and help doctors counsel patients better about their risk for prostate cancer recurrence and help to determine the course of treatment," Dr. Shariat said. "There is no doubt that we are approaching a time when use of proper biomarkers will help detect, monitor and manage the progression of this disease, as well as assist with therapeutic decisions."

The next step is to explore the role of these biomarkers in patients treated with other therapies, such as radiation, and patients with a different range of disease severity.

Currently, the seven-biomarker panel is being externally validated in a clinical trial at two medical institutions, one in the United States and the other in Europe.

Dr. Jose Karam, a resident in urology at UT Southwestern, was also involved in the study.

An international team of researchers from the University of Montreal; Vita-Salute University in Milan, Italy; and Baylor College of Medicine contributed to the research.

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## Pathologic Stage T2a and T2b Prostate Cancer in the Recent Prostate-Specific Antigen Era: Implications for Unilateral Ablative Therapy

Wednesday, 25 June 2008

Duke Prostate Center and Division of Urologic Surgery, Department of Surgery, Duke University Medical Center, Durham, North Carolina.

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Early detection of small volume prostate cancer (PCa) has led to the concept of focal therapy to treat in an organ-sparing manner. We evaluated trends in pathologic staging among patients with localized PCa undergoing radical prostatectomy (RP), defining the frequency of unilateral cancers during 1988-1995, 1996-2000 and 2001-2006.

Data were abstracted from the Duke Prostate Cancer Outcome database selecting 3,676 men with available pathology treated with RP. Based on surgical pathology, trends in as pathological T (pT) stage, pathological Gleason Score (pGS), and percent tumor involvement (PTI) were evaluated.

pT2a increased from 2.8% of men undergoing RP in 1988-1995 to 13.0% during 2001-2006 ( $P < 0.0005$ ). PTI analysis shifted towards low volume disease, e.g. PTI  $\leq 5\%$  increased from 10% during 1988-1995, to 37% in 2001-2006 ( $P < 0.005$ ). Of all pT2a disease throughout 1988-2006, an increase in proportion of pT2a tumors from 10% during 1988-1995 to 69.4% during 2001-2006 was identified. Over three eras, pT2a had minimal (65% had PTI  $\leq 5\%$ ) or small volume (14% had PTI 5.01-10.00) disease, and 59% were low grade (pGS  $\leq 6$ ). Using a Cox Hazard model, pT2a versus pT2b disease, surgical margins, PTI, and PSA statistically contributed to PSA disease-free survival in the contemporary era 2001-2006.

The increasing prevalence of unilateral pT2a/T2b PCa characterizes a growing proportion of men recently electing RP. These tumors are associated with lower PTI, pGS  $\leq 7$ , and demonstrated better PSA-free survival in the 2001-2006 era. These low risk pathologic characteristics may allow for unilateral focal therapy in carefully selected patients.

Written by  
Polascik TJ, Mayes JM, Sun L, Madden JF, Moul JW, Mouraviev V.

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## Understanding Your Prostate Pathology Report

June 23, 2008 11:00 AM EDT

by Marc Garnick, M.D., Harvard Medical School

At least initially, the pathology report is one of the most important factors in the management of a man's prostate cancer. For example, it can provide valuable information about the location and extent of the cancer, thus helping your physician decide whether to recommend active surveillance, hormone treatment, radiation therapy, or surgery. The information is so important, that in my practice I use this to determine what kind of treatment I will recommend. While it would be ideal if the biopsy report were always unambiguous, it sometimes is not and may need to be repeated. In future blogs, we will discuss some additional uncertainties in the overall management of prostate cancer.

### *Deconstructing the report*

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

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

#### Gleason score

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

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

#### *Number of cores*

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

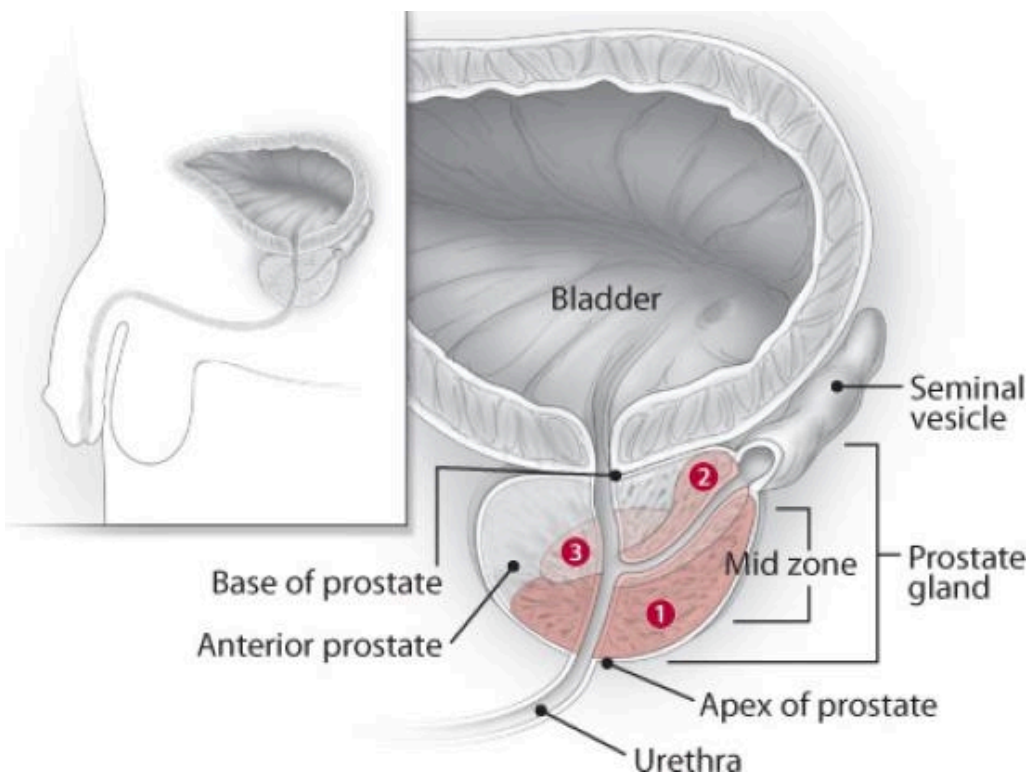
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Today, most doctors agree that an initial biopsy should include at least 10 to 12 core samples. In certain situations, some doctors recommend doing a saturation biopsy, which typically removes 12 to 14 cores — and sometimes as many as 20 or more —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

### Anatomic location

Ideally, the pathologist who prepares your report will have separated and labeled the core samples according to what part of the prostate they came from. This labeling will tell you and your doctors whether the cells came from the right or left side and whether they were drawn from the apex (counterintuitively, at the bottom), mid zone (middle), or base (top) of the prostate. In a saturation biopsy you may see even more detailed labels, such as RMA and RMB to differentiate between the right mid zone near the apex and the right mid zone closer to the base. Similarly, the report may refer to three zones: the peripheral, central, and transition zones (see Figure). All of this information can be invaluable in helping to determine the general location of the tumor, which helps guide treatment decisions.



To help your doctor more precisely determine the location of prostate cancer or another condition, such as high-grade PIN, your pathology report may name specific areas. For example, it may refer to the apex, located at the bottom of the prostate; the base, at the top; or the mid zone, the area between the apex and base. Alternatively, it may note three zones: the peripheral zone (1), the central zone (2), and the transition zone (3). Seventy percent of prostate cancers arise in the peripheral zone. Few arise in the anterior prostate.

### Extent of cancer

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

### Clinical data

In the clinical portion of the report, you may see notes from your physician to the pathologist offering any relevant information about why the biopsy was performed and what the physician is looking for.

### Gross description

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

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

### Comments

Sometimes, you will find notes to your physician or urologist in a section labeled "Comments." This

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may be an important source of additional information such as whether the pathologist has found high-grade PIN or any atypical tissue. This section may also describe various features of the tissue and offer clues about the pathologist's thinking, especially if the final diagnosis is not entirely clear.

### Identifying details

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

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## Yes, We Men Are Uneasy About Discussing Prostate Cancer, But It's Time To Walk It Off

MIKE BOONE The Gazette Friday, June 13, 2008

Men don't like to talk about prostate cancer, but on Father's Day some Montrealers will walk about it.

The second Procure Walk of Courage will have about 1,000 participants strolling around Jean Drapeau Park to heighten awareness of the disease and raise funds for research.

Organizers hope to raise \$1 million. This isn't a gargantuan amount by the standards of fundraisers such as breast cancer walks, but seven digits is impressive for a grassroots event two friends dreamed up over lunch about 18 months ago. John Walsh, parish priest at St. John Brébeuf in LaSalle, and Robin Burns, former NHLer and pioneer in the manufacture of hockey visors, patted their tummies and talked about collaborating on an altruistic project.

"The women do so much for breast cancer," Walsh said when I phoned him at the church. "Robin's line was: 'It's time for men to get off our butts.'"

"Maybe that's why we have problems with our prostate."

While there's been no verifiable link between sedentary non-activism and prostate cancer, another male trait inhibits knowledge of the disease.

"It's amazing," Walsh said, "how men don't want to talk about it."

Men of the cloth must be easily amazed, because taciturnity is a male trait. Four words that ruin Father's Day: "We have to talk."

Least of all do men wish to discuss their nether regions. Nicknames and euphemisms are fine, but no man could have written or performed the Penis Monologues.

And few of us are comfortable with south-of-the-border medical issues. Someone recently asked Walsh why men will "run into a burning building to save a dog, but are afraid to see a doctor."

Tony Soprano put it succinctly. When his psychotherapist asked if he'd ever had a prostate exam, Tony replied:

"Are you kidding? I don't let anyone wag their finger in my face."

It might take a while for Mafia bosses to come around. But Procure is raising awareness among the rest of us.

It's the brainchild of Walsh's friend Montreal businessman Marvyn Kussner, who was diagnosed with prostate cancer seven years ago.

"I wasn't aware of the type of disease that it is," Kussner said. "When I searched for some kind of information, it just wasn't available."

Years earlier, Kussner had survived lymphoma. He knew his way around the ominous world of cancer.

Kussner took his search for answers on the road to Johns Hopkins University in Baltimore and to the famed Memorial Sloan-Kettering Cancer Centre in New York.

After Kussner successfully underwent hormonal and radiation treatment in Montreal, doctors encouraged him to set up an organization that would demystify prostate cancer.

"This was a situation that existed with breast cancer maybe 20 years ago," Kussner said. "People were in the dark, and very little was discussed in public. I thought maybe I could make a difference."

Kussner launched Procure. The first step was creating a bilingual website three years ago.

"It's been very successful," Kussner said. "Information

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available on the Internet opened a whole new avenue to people who were frightened by the disease."

Procure.ca offers everything you always wanted to know about prostate cancer but were afraid to ask - including some chilling statistics, such as the likelihood that one in seven Canadian men will contract the disease.

The site also has news on another Procure initiative: four "bio banks" that collect tissue for research.

Walsh talked to Kussner about fundraising for Procure. The result was the debut Walk of Courage, which attracted about 350 participants last year.

It's a start.

"A lot of men are reluctant to discuss prostate cancer," said Kussner. "But talking about it very important. You have to know what the disease is all about. The more information you have, the better your decisions."

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## Salvage Radiotherapy Improves Prostate Cancer-specific Survival

CancerConsultants.com - News 6/20/2008

Radiation therapy following a recurrence of prostate cancer may reduce deaths specifically caused by the disease. These results were recently published in the Journal of the American Medical Association.

Prostate cancer is the most common cancer among American men. Often, men treated with initial therapy will experience a biochemical recurrence. This refers to an increase in prostate specific antigen (PSA) levels, which are small proteins shed into the blood by the prostate. Levels of PSA often indicate either the presence or recurrence of prostate cancer; therefore, follow-up after initial therapy includes PSA readings. PSA

doubling time refers to the duration of time it takes for PSA levels to double; this measurement is often even more important than the absolute levels of PSA.

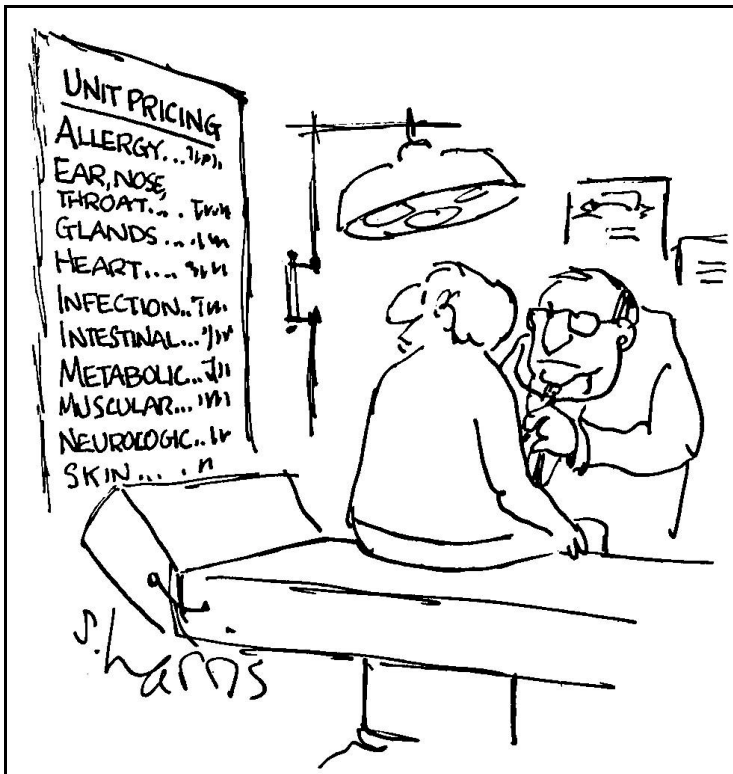
Researchers from Johns Hopkins University and Duke University recently reported that radiation therapy following a biochemical recurrence reduces deaths from prostate cancer among men with a PSA doubling time of less than six months. This study evaluated data from 635 patients who experienced a biochemical recurrence and/or a recurrence within the prostate following initial treatment with surgery. One group of patients had no subsequent therapy following a recurrence; one group received radiation therapy upon recurrence; and one group received radiation therapy and hormone therapy upon recurrence. Follow-up of the study was six years following a recurrence.

- => 22% of men who received no further therapy died from prostate cancer.
- => 11% of men who received radiation therapy died from prostate cancer.
- => 12% of men who received radiation therapy plus hormone therapy died from prostate cancer.
- => The increase in survival was limited to men with a PSA doubling-time of less than six months.

The researchers concluded that radiation therapy upon a biochemical recurrence among men with prostate cancer who have undergone initial surgery appears to improve survival, specifically among men with a PSA doubling time of six months or less. Men who experience prostate cancer recurrences should speak with their physician regarding all of their treatment options. In addition, since this was an evaluation of data, the researchers stated that a clinical trial that directly compares different treatment options is necessary to determine the true clinical benefit of each type of therapy.

Reference: Trock BJ, Han M, Freedland SJ, et al. Prostate cancer-specific survival following salvage radiotherapy vs observation in men with biochemical recurrence after radical prostatectomy. *Journal of the American Medical Association.* 2008;299:2760-2769.

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*Calling all men and the women who love them...*



DR. ANNE KATZ



DR. GRAHAM GLEZERSON



DR. JINKA SATHYA



DR. JEFF SISLER



NORM OMAN

# Prostate Cancer Awareness Evening

Tuesday, September 23, 2008 | 7pm to 9pm

Basic Medical Sciences Building | Theatre A | 730 William Avenue

**FREE ADMISSION**

***Guest Speakers:***

Dr. Anne Katz, Clinical Nurse Specialist

Dr. Graham Glezerson, Urologist

Dr. Jinka Sathya, Radiation Oncologist

Dr. Jeff Sisler, Family Practitioner

Norm Oman, Patient Advocate

**SPONSORS**



***September is Prostate Cancer Awareness Month***

For more information or to obtain a helpful brochure please call 989-3433

**FUTURE MEETINGS:**

M.P.C.S.G.		Manitoba		2008		
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

*August 21st, 2008*  
*September 18th, 2008*

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Awareness Evening:  
*September 23rd, 2008*

**Executive Committee:**

(204)

- Pam Boomer, Executive Member 663-1351
- Tom Boomer, Executive Member 663-1351
- Joseph Courchaine, Treasurer 257-2602
- Laurette Courchaine, Executive Member 257-2602
- Darlene Hay, Executive Member 837-6742
- Kirby Hay, Information Coordinator 837-6742
- Jim Leddy, Secretary 831-6119
- Ken Kirk, New Member Chairman 261-7767
- Norm Oman, Chairman, Events Coordinator 487-4418
- Brian Sprott, Executive Member 668-6160
- June Sprott, Executive Member 668-6160
- Lorne Strick, Videographer 667-9367
- Arthur Wortzman, Speaker Chairman 287-8621
- Our Answering Machine 989-3433

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**CAN YOU HELP?**

The Manitoba Prostate Cancer Support Group operates on your donations  
**We need your contributions**

Have you used any of our services?

**Newsletter - General Meetings - Hospital visits - One-on-one visits - Speakers**

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Make cheque or money order payable to:

**Manitoba Prostate Cancer Support Group (MPCSG)**  
 # 705 - 776 Corydon Ave., Winnipeg R3M OY1

*\*a tax deductible receipt will be issued.*