The Manitoba Prostate Cancer Support Group

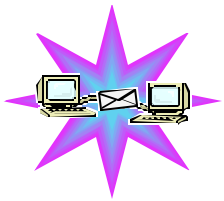
Vol. 213– March 2009

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

Thought For Today

SEE, THE PROBLEM IS THAT GOD GAVE MEN A BRAIN AND A PENIS, AND ONLY ENOUGH BLOOD TO RUN ONE AT A TIME.

- ROBIN WILLIAMS

In This Issue

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 confus ing the subject of cancer can be. *All calls are kept confidential*

NEXT MEETING:

Thursday, March 19th, 2009 7 - 9 P.M.

Dr. John Milner Urologist

Prostate Cancer: What Does Cure Mean For This Disease

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

November 25, 2008, 5:45 am

10 Lessons of Prostate Cancer

Every week, New York Times editor Dana Jennings shares his experiences coping with prostate cancer.

By Dana Jennings. (Lonnie Schlein/The New York Times)

Prostate cancer is a dark waltz, not the raging battle of popular imagination. From that first elevated PSA blood test, to the biopsy, to treatment, to those evil twins of impotence and incontinence and beyond, I'm still learning some very complicated steps more than seven months after my diagnosis.

Cancer is a hard teacher. No matter how much you glean from the Web, how many fellow travelers you talk to, how many questions you ask nurses and doctors, there are some lessons — physical, practical, emotional — that can only be learned firsthand.

I confess that I feel utterly vulnerable. But, as the poet Theodore Roethke wrote, "Those who are willing to be vulnerable move among the mysteries." So, as I continue to move among these mysteries, here are 10 nuggets of prostate cancer wisdom that I had to learn for myself.

1) Cancer takes you home. The hardest thing I've had to do since my diagnosis — and that includes having my radical open prostatectomy — was tell my parents that I had prostate cancer. My folks are working-class country people. They're both 68, and they were 17 when I was born in 1957 — eight days after they got married. The three of us, literally, grew up together, and I've always been their little hyper-verbal mystery. They never quite understood why I needed to get the hell out of Kingston, N.H. And when I called them last April to say that I had cancer — maybe, after all these years, confirming their worst fears about life in and around New York City — I could barely speak for my fierce tears. Tears more for them, I know, than for me.

2) Doctors forget to share the gory details. After my prostate was removed, my testicles swelled to the size of shot-puts — bright, red shot-puts — and stayed that way for days. Nobody told me to expect this condition, and only ice brought relief. (Conversely, now that I'm undergoing hormonal therapy, my testicles are shrinking.)

3) Insurance can cause more stress than cancer. The goal of your insurer — no matter how singular or complex your case is — is to try to turn you into a statistical cliché, a cipher, in the face of your very human flesh-and-blood disease. In the months after my diagnosis, as my wife and I struggled to find the right pair of highly-skilled hands to perform my potentially difficult surgery, wrestling with my insurer caused me more grief, stress and depression than my cancer did. In our modern health-care-industrial-complex — and I'm talking about the bureaucrats who try to herd you into the cheapest cattle car available, not the nurses and doctors who are on the front lines — the emphasis is neither on health nor care, but on the bottom line. It's our job, as patients, to resist with all our strength.

4) Humor is all around you. On Halloween morning my wife and I were driving to the Cancer Institute of New Jersey in New Brunswick for my treatment. Just a quarter-mile from the institute we were stuck in traffic behind a truck … a casket truck: "Batesville Casket Company," it read, "A Hillenbrand industry, helping families honor the lives of those they love." All I could do was laugh harder than I had in days. (On a different drive down, the Beatles' "Do You Want to Know a Secret" came on the radio, and I dissolved into tears. I still don't understand why.)

5) Not all blood techs are created equal. Some glide that needle into your vein as if they're figure-skating on your arm. Others jab and stab as if they got their only training from watching the "Saw" movies. (By the way, only blood is "blood red.")

6) Nurses know what you need. I groaned in absolute gratitude in the recovery room at the post-op ice chips the nurses spooned into my swollen, anesthesia-parched mouth.

7) Cancer can be a punch line. I learned pretty quickly, with my wife and sons, that the phrase, "I've got cancer," wasn't a bad punch line — as in: "You take out the dog. I've got cancer" or "You answer the phone. I've got cancer" or "I 'call' the TV to watch 'Monday Night Football.' I've got cancer." They'd all roll their eyes, laugh … then go do what I asked.

8) Home remedies are essential to cancer recovery. There is no better post-op therapy on a sweltering July day than a cold glass of lemonade, a transcendent oldie on the CD player — say, "Doggin' Around" by Jackie Wilson — a stack of comic books at hand ("The Incredible Hulk," "The Mighty Thor") and the grace of a funny and compassionate visitor.

9) Don't sneeze after surgery. My first post-op sneeze felt as if some beyond-feral wolverine had burrowed its way into my gut, possibly seeking a second prostate that the docs had somehow overlooked.

(Continued on page 3)

(Continued from page 2)

10) You can find hope in strange places. A few times a day, after my operation, I'd run my fingers up and down the 25 metal staples that the surgeon had used to close me up — the skin around them red-purple, proud, tender and feeling as if it belonged to someone else. Sometimes, in fingering those staples, I felt that they were the only things in this world, in their plain and utilitarian way, that were possibly holding me together.

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January 13, 2009 Vital Signs

Prognosis: Left Behind in Prostate Cancer Screening

By NICHOLAS BAKALAR

Prostate cancer screening has substantially increased early detection of the disease, but a new study suggests that too few low-income men are being screened.

The analysis, to be published in the February issue of The Journal of Urology, examined the medical records of 570 men who had received treatment for prostate cancer in a program for the poor and uninsured in California. It found that metastatic, or spreading, and other high-risk cancers were more common among them than in the general population.

Over a five-year period through June 2006, about 19 percent already had metastatic disease at the time of diagnosis, compared with just 4 percent nationally. By contrast, low-risk cancers were far more common among more affluent men, suggesting that they were being screened more often.

"In prostate cancer, there's a lot of talk about overdetection and overtreatment," said Dr. David C. Miller, the lead author and an assistant professor of urology at the University of Michigan. "But this study says that in these very disadvantaged men, there is underdetection and undertreatment, that the cancers are not being found early enough."

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Chemohormonal Therapy Did Not Improve Survival For Metastatic Prostate Cancer

The addition of ketoconazole and doxorubicin alternated with vinblastine and estramustine to standard androgen deprivation therapy increased treatment-related adverse events, according to data from a phase-3 trial.

Researchers examined the role of alternating chemotherapy plus sustained androgen ablation among 286 patients with metastatic prostate cancer. All patients were assigned to androgen ablation therapy, and 137 patients were assigned to three cycles of ketoconazole and doxorubicin alternated with vinblastine and estramustine (Emcyt, Pharmacia/Upjohn). Chemotherapy was repeated every eight weeks. The primary endpoint was time to castrate-resistant progression.

Eighty percent of patients in the experimental arm completed all three cycles of therapy. Those who discontinued therapy reported fatigue and thromboembolic events.

In the standard therapy arm, median time to progression was 24 months compared with 35 months in the experimental arm. Median follow-up was 6.4 years, at which time OS was 5.4 years for standard therapy and 6.1 years for experimental therapy.

According to the researchers, PSA kinetics at the time of androgen therapy and the nadir after hormone treatment were related to survival.

Chemotherapy increased treatment-related adverse events; 51% of patients exposed to chemotherapy had at least one grade-3 event, and most were considered related to treatment. Nine percent of patients in the standard therapy arm experienced at least one grade-3 event, of which most were considered unrelated to treatment.

"These data are consistent with at least 10 previous randomized trials of chemohormonal therapy in providing no support for adding cytotoxics to androgen ablation for androgen-driven prostate cancer," the researchers wrote.

J Clin Oncol. 2008;doi:10.1200/JCO.2007.15.9830.

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January 11, 2009

Donald F. Gleason, 88, Dies; Devised Prostate Test

By LAWRENCE K. ALTMAN

Dr. Donald F. Gleason, who devised the Gleason score, which has been used to help determine the aggressiveness of prostate cancer in millions of men, died on Dec. 28 in Edina, Minn. He was 88.

The cause was a heart attack, according to the University of Minnesota, where he taught. He was also former chief of pathology at the Minneapolis VA Medical Center, which was affiliated with the university and where he did most of the research that led to the score.

Dr. Gleason devised his scoring system in the 1960s through his observations of the cellular architecture of the prostate, the gland that produces seminal fluid. The score is considered the most reliable indicator of the potential for prostate cancer to grow and spread. It helps provide a prognosis and guide treatment, and it is a reference standard in clinical trials testing new therapies.

“Every prostate cancer patient knows his Gleason score,” said Dr. Bruce Roth, a professor of medicine and urological surgery at Vanderbilt University and an official of the American Society of Clinical Oncology. “It is remarkable that the Gleason score remains the standard test despite the millions of dollars spent on trying to develop molecular tests to displace it.”

The score is based on a pathologist’s microscopic examination of prostate tissue that has been chemically stained after a biopsy. Under a standard microscope, the cells can show in various patterns.

To determine a Gleason score, a pathologist assigns a separate numerical grade to the two most predominant architectural patterns of the cancer cells. The grade depends on how far the cells deviate from normal appearance. The numbers range from 1 (the cells look nearly normal) to 5 (the cells have the most cancerous appearance).

The sum of the two grades is the Gleason score. The lowest possible score is 2, which rarely occurs; the highest is 10. Scores of 2 to 4 are considered low grade; 5 through 7, intermediate grade; and 8 through 10, high grade.

High scores tend to suggest a worse prognosis than lower scores because the more deranged, high-scoring cells usually grow faster than the more normal-appearing ones.

Prognosis also depends on further refinements. In one example, a score of 7 can come in two ways: 4 plus 3 or 3 plus 4. With 4 plus 3, cancer cells in the most predominant category appear more aggressive than those in the second, suggesting a more serious threat than a 3-plus-4 score, in which cells in the most predominant group appear only moderately aggressive.

Donald Floyd Gleason was born on Nov. 20, 1920, in Spencer, Iowa, and grew up in Litchfield, Minn., where his father, Fred, ran a hardware store and his mother, Ethel, was a teacher.

Dr. Gleason earned his undergraduate, medical and Ph.D. degrees from the University of Minnesota. After an internship at the University of Maryland, Baltimore, as a lieutenant in the Army Medical Corps, he trained as a pathologist at the Minneapolis VA hospital. He became the hospital’s chief of anatomic pathology and laboratories and retired in 1986.

Dr. Gleason is survived by his wife, Nancy; three daughters, Donna O’Neill of Annandale, Va., Sue Anderson of Burnsville, Minn., and Ginger Venable of Eden Prairie, Minn.; a sister, Barbara Jarl of St. Paul; and nine grandchildren.

In 1962, Dr. George Mellinger, the hospital’s chief of urology, who also led a cooperative urological research project involving 14 hospitals, asked Dr. Gleason to develop a standardized pathological testing system for prostate cancer.

Dr. Gleason wrote in a personal narrative that he was well aware of the wide variation that existed in the speed with which prostate cancer spreads, as well as in the architectural patterns seen under a microscope. Many microscopic classifications existed at the time, but pathologists had difficulty applying them and often devised their own, thereby creating confusion in treatment and the evaluation of new therapies.

To sharpen comparisons, Dr. Gleason based his classification on a small number of changes seen in the architectural arrangement of cancer cells.

The patterns were strongly related to survival rates in the first 270 patients, he reported in 1966 in the journal Cancer Chemotherapy Reports. Extending the study to include 4,000 patients strengthened the findings.

Doctors adopted the Gleason score slowly until 1987, when seven leading experts in urology and pathology recommended that it be used uniformly in all scientific publications on prostate cancer.

The Gleason score became even more widely applied with the surge in the number of prostate cancers detected from a different test, the PSA (or prostate specific antigen) test, a blood test used for screening. As more cancers are detected, there is more reason to apply the score.

Last year, 186,320 people in the United States developed prostate cancer and 28,660 died from it, according to the American Cancer Society.

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Radiation Therapy plus Hormone Therapy Cuts Prostate Cancer Deaths in Half

Source: CancerConsultants.com

Researchers from Sweden have reported that combined radiation and hormonal therapy reduces deaths by 50% compared with hormonal therapy alone for treatment of locally advanced or high-risk prostate cancer. The details of this study appeared in an early online publication in Lancet on December 15, 2008.[1]

Patients with locally advanced high-risk prostate cancer are often treated with hormone therapy alone or with radiation plus hormonal therapy. Most recent studies have shown that patients with locally advanced prostate cancer have better outcomes when receiving combination therapy.

In 1996 researchers from the Scandinavian Prostate Cancer Group and the Swedish Association for Urological Oncology initiated a Phase III trial to evaluate the benefits of adding radiation to hormone therapy. The trial involved 875 patients who were randomized to receive either hormone therapy alone or combined hormone/radiation therapy. The median follow-up of this study was 7.6 years. The following table summarizes the main findings of this study:

Table 1: Hormone Therapy Alone Versus Combined Hormone/Radiation Therapy in Prostate Cancer

	Hormonal Therapy	Radiation & Hormonal Therapy
Number of Patients	439	436
Ten-year Cancer Mortality	23.9%	11.9%
Ten-year Mortality	39.4%	29.6%
Ten-year PSA Recurrence	74.7%	25.9%

After five years urinary, rectal, and sexual problems were slightly more frequent in the combination group. These researchers concluded that the combination of radiation therapy and hormone therapy was superior to hormone therapy alone and cut the rate of prostate cancer deaths in half. Furthermore, the side-effect profile for the combination therapy was acceptable.

Comments: These data are consistent with the data reported in previous studies.

Reference:

[1] Widmark A, Klepp O, Solberg A, et al. Endocrine treatment, with or without radiotherapy, in locally advanced prostate cancer (SPCG-7/SFUO-3): An open randomized phase III trial. The Lancet [early online publication]. December 16, 2008.

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January 13, 2009 Gannett News Service

Vitamins Get 'F' In Cancer Prevention

Individual Supplements Offer No Benefit

A flotilla of recent studies - including two papers published Wednesday - has sunk the notion that individual vitamin supplements prevent cancer.

With so many earlier studies suggesting that people can eat their way to longer lives, experts acknowledge that their latest findings may leave people confused and even frustrated.

"A lot of people are looking at this and asking, 'What happened?' " says Lori Minasian, whose study in Wednesday's Journal of the American Medical Association found that taking vitamin E or selenium does not ward off cancer.

But researchers also say that diet is one of the most difficult areas to study.

Unlike lab rats, after all, no one eats one thing all the time.

"Cancer is complex and the interaction of nutrients is complex, so put the two together and you've got a lot of really tough scientific questions to answer," says the American Cancer Society's Colleen Doyle.

Researchers have noted for years that populations with healthy diets - lots of vegetables, little junk food - are less likely than others to get cancer, says Peter Gann of the University of Illinois-Chicago, who wrote an editorial accompanying the new papers.

It's been much more challenging to tease out the specific foods - or even compounds - that keep cells from turning malignant, Gann says. Is it the fish oil? The soy? The lack of red meat?

Experts also note that the specific dose of a vitamin may be critical.

People who get too little of a nutrient may be at greater risk of cancer, but so may those who get too much, Minasian says. Given the popularity of vitamins and other supplements, she says it's important for researchers to find the right combination.

Other experts, such as Gann, say it may be time for researchers to abandon the idea of using individual vitamins to prevent cancer.

Instead, he says, health-conscious consumers should focus on getting their vitamins from plant foods, such as vegetables and whole grains, which contain precise mixtures of hundreds or even thousands of compounds. Many of these compounds may work better in the combinations selected by nature.

Doyle says there are still lots of proven ways, in addition to a plant-based diet, to reduce the risk of cancer: Exercise, maintain a healthy weight and avoid tobacco. Screenings for colon cancer, cervical cancer and breast cancer also have been shown to save lives.

Yet in spite of several decades of nutrition research, Gann says, doctors haven't yet found an exact prescription for the perfect anti-cancer diet.

"I wouldn't want to give anyone the impression that you just need to eat five servings a day and limit meat," Gann says. "It may turn out that you need to do much more. It's not clear how much dietary modification people have to make to see any benefit."

WHAT THE STUDIES HAVE FOUND

Recent studies have found that vitamin pills failed to prevent cancer or heart disease.

Supplement Findings and the source

Vitamins C, E: Did not prevent prostate cancer or cancer in general. Journal of the American Medical Association, January

Vitamin E, selenium: Did not prevent prostate cancer; vitamin E actually increased prostate cancer risk, and selenium raised risk of diabetes, though the findings could be a result of chance. Journal of the American Medical Association, January

Beta carotene, vitamins C, E: Did not prevent cancer. Journal of the National Cancer Institute, December

Folic acid, B vitamins: Did not prevent breast cancer or other cancers. Journal of the American Medical Association, November

Vitamin D, calcium: Did not prevent breast cancer. Journal of the National Cancer Institute, November

Vitamins C, E: Did not prevent heart disease in men; vitamin E increased stroke risk. American Heart Association meeting, November

Vitamin B-12, folic acid: Did not prevent heart disease. American Heart Association meeting, November

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CancerCare MANITOBA

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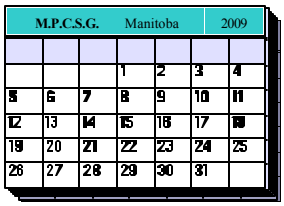
FUTURE MEETINGS:



March 19th, 2009
April 16th, 2009
May 21st, 2009

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