Informed Prostate Cancer Support Group Inc.
"A 501 C 3 CORPORATION ID # 54-2141691"

AUGUST 2015 NEWSLETTER

P.O. Box 420142 San Diego, CA 92142
Phone: 619-890-8447 Web: http://ipcsg.org

We Meet Every Third Saturday (except December)

Wednesday, August 12, 2015 Volume 8 Issue 7

Next Meeting
Aug 15, 2015
10:00AM to Noon

Meeting at

Sanford-Burnham Auditorium

10905 Road to the Cure, San Diego CA 92121

SEE MAP ON THE LAST PAGE

What We Are About

Our Group offers the complete spectrum of information on prevention and treatment. We provide a forum where you can get all your questions answered in one place by men that have lived through the experience. Prostate cancer is very personal. Our goal is to make you more aware of your options before you begin a treatment that has serious side effects that were not properly explained. Impotence, incontinence, and a high rate of recurrence are very common side effects and may be for life. Men who are newly diagnosed with PCa are often overwhelmed by the frightening magnitude of their condition. Networking with our members will help identify what options are best suited for your life style.

Table of Contents

Editor: Gene Van Vleet

PROSTATE CANCER IT'S ONLY 2 WORDS NOT A SENTENCE

Our speaker for the July meeting was Dr. Donna Hansel, Division Chief of Anatomic Pathology at UCSD. She is an expert in genitourinary pathology and talked about prostate cancer grading and staging. She indicated she has seen tens of thousands of prostate glands.

She queried the audience as to how many had seen their pathology report or talked with the pathologist. Very few had.

Whether through biopsy or surgery, the prostate material is put in a container which goes to

(Continued on page 2)

Video DVD's

DVD's of our meetings are available in our library for $10ea. Refer to the index available in the library. They can also be purchased through our website: http://ipcsg.org Click on the 'Purchase DVDs" button.

The DVD of each meeting is available by the next meeting date.

(Continued from page 1)

pathology. Pathology opens the container, looks at it, describes it, and puts it in paraffin blocks. It is then put in sections which come out on glass slides and the pathologist looks at those slides to make a diagnosis. Then a pathology report is sent back to the urologist who will use it to assist in coming up with a treatment plan.

Why prostate specimens are obtained: Screening for prostate cancer; Re-biopsy following atypical findings or disease monitoring; Relief of urinary obstruction (TUR); Inflammation causing elevated PSA; Definitive therapy of prostate cancer (radical prostatectomy); Increasing PSA following prostatectomy (prostate bed biopsy).

The general types of prostate specimens:

- Biopsy
  - – Often 6-12 cores; 18 cores may be used for some patients (fewer if image guided)
  - – Includes apex, mid and base of right and left side
  - – Suspicious areas may be additionally sampled
  - – No College of American Pathologists (CAP) template required for final report
- Transurethral resection (TUR)
  - – Most commonly performed to relieve outflow obstruction
  - – Often cancer is incidentally found in these specimens
- Radical prostatectomy
  - – Accompanied by lymph node dissection when Gleason score is >6.
  - – May have additional margins submitted
  - – May have preprostatic fat submitted as an individual specimen
  - – CAP template required for final report

Indications for prostate biopsy

- Elevated prostate specific antigen (PSA)
  - – Total PSA (≥4.0 ng/mL), PSA velocity, PSA density, etc.
  - – Elevated PSA can precede disease development by 5-10 years
- Abnormal finding on digital rectal exam (DRE)
  - – Nodule, asymmetry
- Repeat biopsy for suspicious findings
  - – "Atypical" glands
  - – Extensive high-grade prostatic intraepithelial neoplasia (PIN)
- Repeat biopsy during active surveillance
- Repeat biopsy for poor sampling (rare)

Reporting parameters for prostate biopsy

- Presence of cancer
  - – Grade and score
  - – Perineural invasion
  - – Extraprostatic extension
- Presence of atypical glands
  - – Incorporation of Immunohistochemistry (IHC) stains
- Presence of Prostatic intraepithelial neoplasia (PIN)
  - – Describe if extensive
  - – Discriminate from intraductal carcinoma and intraductal spread of carcinoma
- Presence of PIN

(Continued on page 3)

(Continued from page 2)

- – Describe if extensive
- – Discriminate from intraductal carcinoma and intraductal spread of carcinoma
- – Variant/subtype

- Inflammation
  - – Subtype
  - – Special stains if granulomatous
- Other findings

Dr. Hansel went on to describe and show definitive slides of Gleason patterns 3, 4 and 5 which are more effectively viewed one the slides included on the DVD of the meeting.

She then discussed the pathological staging:

- No pathologic pT1 cancer
- pT2: Organ confined
  - –pT2a: Unilateral, one-half of one side or less
  - –pT2b: Unilateral, more than one-half of one side(but not bilateral)
  - –pT2c: Bilateral
- pT3: Tumor extends through prostate capsule–pT3a: Extraprostatic extension (EPE) or microscopic invasion of bladder neck
  - –pT3b: Seminal vesicle invasion
- EPE is considered tumor extension beyond the prostate limit
  - –No true capsule
  - –Includes fat involvement
  - –Challenge at apex and anterior part of the prostate
  - –Also includes tumor at low magnification beyond the limit of benign glands
  - –Can be subdivided into focal versus extensive
- pT4 disease
  - –pT4: Invasion of rectum, levator muscles and/or pelvic wall
  - –May not be treated with surgical resection – often identified on patient evaluation

Here is a sample surgical pathological report:

Specimen (s) received: Radical prostatectomy
Pre-operative Diagnosis: Prostate Cancer
Post operative Diagnosis: Prostate Cancer
Procedure: Radical prostatectomy
Gross Examination: Prostate is received weighting 46.0 grams, with attached seminal vesicles and vas deferentia. The specimen measures 4.6 cm x 4.5 cm x 4.0 cm. The right side is inked blue, the left side black. The apex is amputated and breadloafed. The bladder neck is shaved and breadloafed. The prostate is serially sectioned to reveal a firm, white-yellow region in the right posterior to posterolateral prostate in the mid portion…..
Final Diagnosis:
Prostate, radical prostatectomy:
-Adenocarcinoma of the prostate, Gleason score 3+3=6, involving the right posterolateral mid prostate.
-No extraprostatic extension is identified.

(Continued on page 4)

-No angiolymphatic invasion is identified.
-The surgical margins of resection are negative for tumor.
Stage: pT2a Nx MX

Take Home Points

Pathologists are medical professionals that provide a tissue, cytology or molecular diagnosis, as well as run the medical laboratory within the hospital

Pathologists work closely with clinical specialists to provide the correct diagnosis for patient care

Always ask if the pathology report is unclear or difficult to understand – **most pathologists are willing to talk to patients to explain their diagnosis**

Many pathologists perform tissue-based and/or molecular research to identify new cellular markers in disease diagnosis or treatment

As usual, this is a recap of the presentation and more thorough information can be derived from the DVD of the meeting which will be available by our next meeting on our website: www.ipcsg.org/shop and from our library at the next meeting.

FUTURE MEETINGS

Aug 15th - Round Table. A panel of members talk of their experiences followed by Q&A, then break-out sessions by treatment type for networking.

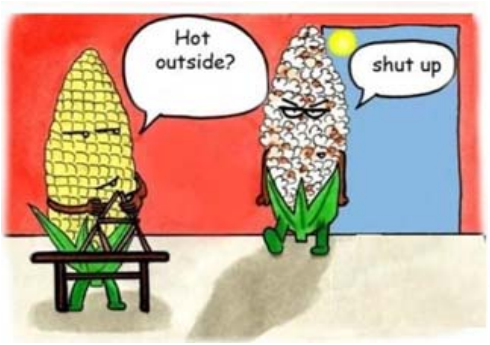
Sep 19th - Franklin Gaylis, MD, FACS, Chief Scientific Officer, Genesis Healthcare Partners. Perspective on Active Surveillance and

Oct 17th - Fabio Almeida, M.D. Medical Director, Phoenix Molecular Imaging - Southwest PET/CT Institute, Yuma. "Advances in Detecting Prostate Cancer in Bone and Soft Tissue." Dr. Almeida returns to speak about updates on Molecular Imaging and new clinical trials.

Nov 21st - Richard Lam, M.D., Research Director, Prostate Oncology Specialists: : Updates and recent treatment developments

December - No Meeting

ON THE LIGHTER SIDE



Behind every successful man is a surprised woman - Marion Pearson

Authentic questions asked by attorneys during trials:

You were there until the time you left, is that true?
Were you present when your picture was taken?
How far apart were the vehicles at the time of the collision?
Were you alone or by yourself?

Cosmic Questions:

How do you draw a blank?
How do you throw away a garbage can?
Is half a large intestine a semi-colon?
Would the ocean be deeper without sponges?
What happened to the first 6 "Ups"?
Ever wonder what happened to preparations A through G?

A day without sunshine is like, you know, night. Steve Martin

INTERESTING ARTICLES

Alternatives to Immediate Prostate Biopsy
Posted Tuesday, August 4, 2015 From Prostate Snatchers Blog
BY MARK SCHOLZ, MD

Your PSA is elevated. Now your doctor recommends a needle biopsy, 12 cores through the rectum to check for cancer in the prostate. Sounds icky, but also logical; after all who wants to miss cancer? But come on, do you really have to do 12 stabs via the rectum?

Each year over a million men submit their prostates for a biopsy. At an average cost of around four thousand dollars, the prostate biopsy business is a 4-billion-dollar-a-year enterprise. But it's not merely the cost that gives pause. Three percent of men end up hospitalized with life-threatening infections. Around a 100,000 men every year get a confounding diagnosis of Grade 6 prostate cancer, a truly harmless entity, unless you get suckered into an unnecessary radical prostatectomy.

Obviously, prostate biopsy is an unpleasant proposition with notable risks. However, ignoring a high PSA incurs the risk of missing a diagnosis of a higher grade prostate cancer. As things stand now, of the

(Continued on page 6)

million biopsies being done annually, over a hundred thousand men with Grade 7 or higher cancers are being detected. For these men, their early diagnosis is beneficial, leading to early, curative treatment in a timely fashion.

How can we detect the 100,000 men with higher-grade cancers that need to be detected without doing 900,000 "unnecessary" biopsies? The answer to this question continues to evolve as technology marches forward. Our latest thinking at Prostate Oncology (assuming the PSA is not wildly elevated, say over 20) is a three step process:

1. Simply repeat the PSA to confirm it is indeed abnormally elevated. All sorts of things can cause temporary elevations of PSA ranging from nonspecific inflammation of the prostate, to recent sexual activity, to simple laboratory errors.
2. If the PSA remains elevated with repeat testing the next step to consider is an OPKO-4Kscore blood test. The OPKO test reports a percentage estimate of the likelihood of higher grade cancer being present. The test is not perfect, but it performs pretty well. For example, if a specific patient receives an OPKO report with an estimated risk of high grade disease of less than 15%, a standard random biopsy (if he elected to do one) will confirm the absence of high grade disease 92% of the time. Not bad.
3. Our next step at Prostate Oncology, in the cases where a patient has an OPKO test indicating that the risk of high grade disease is over 15%, is to obtain a prostate scan with high-resolution color Doppler ultrasound or with a 3-Tesla multiparametric MRI. With scanning, the location of the high-grade disease can be determined over 90% of the time so that a targeted biopsy with 2 or 3 cores can be substituted for the traditional 12-core biopsy.

The business of prostate biopsy has become so out of control the US Preventative Services Task Force advocates against PSA testing altogether. The Task Force's scientifically-based arguments that PSA testing is causing more harm than good are really quite convincing. However, back in 2011 when they published their recommendations, the OPKO test and 3-Tesla multiparametric prostate MRI were unavailable. With the advent of these new technologies, PSA screening to detect higher grade prostate cancers at an early stage when they are still curable makes perfect sense.

Two-drug combination boosts survival in metastatic prostate cancer

From Science Daily dated August 5, 2015

Newly diagnosed patients with metastatic, hormone-sensitive prostate cancer gained a dramatic survival benefit when started on two drugs simultaneously, rather than delaying the second drug until the cancer began to worsen, according to results of a clinical trial led by a Dana-Farber Cancer Institute scientist.

Patients who underwent six cycles of treatment with the chemotherapy drug docetaxel along with a hormone blocker survived for a median of 57.6 months, more than a year longer than the median 44-month survival for men who received only the hormone-blocker, according to a report in The New England Journal of Medicine. The immediate combination also prolonged the period before the cancer began to worsen -- a median of 20.2 months versus 11.7 months with the single agent.

The multi-center, phase III trial, involving 790 patients, "is the first to identify a strategy that prolongs survival in men newly diagnosed with metastatic, hormone-sensitive prostate cancer," said Christopher J. Sweeney, MBBS, of Dana-Farber's Lank Center for Genitourinary Oncology. He said the results of the multi-center phase III trial should change the way doctors have routinely treated such patients since the 1940s.

Sweeney had reported initial results of the trial in June 2014 at the annual meeting of the American

(Continued on page 7)

(Continued from page 6)

Society of Clinical Oncology (ASCO), and they were so favorable that the new regimen has been adopted by some physicians. Since then, confirmatory data from a trial called STAMPEDE were presented at the 2015 ASCO meeting, and those results, along with the new publication in the NEJM, are the final pieces "required for treatment guidelines to be updated around the globe," Sweeney said.

It has been standard practice for decades to treat this group of prostate cancer patients with hormone blockers, withholding chemotherapy until the hormone blockers become ineffective, which they do, on average, in about three years.

The new trial was designed and conducted by the ECOG-ACRIN Cancer Research Group to test Sweeney's hypothesis that adding chemotherapy to hormone treatment from the start would impair the tumor cells' ability to repair damage, delaying the development of resistance.

For prostate cancer patients, risk-specific therapies now more the norm

From Science Daly, July 24, 2015

Source: University of California, San Francisco (UCSF).

After decades of overtreatment for low-risk prostate cancer and inadequate management of its more aggressive forms, patients are now more likely to receive medical care matched to level of risk, according to a study by researchers at UC San Francisco.

In the first study to document updated treatment trends, researchers found that from 2010 to 2013, 40 percent of men with low-risk prostate cancer opted for active surveillance, in which the disease is monitored closely with blood tests, imaging studies and biopsies. Treatment is deferred unless these tests show evidence of progression.

In contrast, less than 10 percent overall of low-risk prostate cancer patients pursued active surveillance in the years from 1990 through 2009. Rates for radiation therapy for this low-risk group have also slipped since 1995, the authors noted in the study published in JAMA earlier this month.

Meanwhile men with higher-risk tumors are more likely to undergo surgical removal of the prostate and/or radiation, localized treatments that are more effective than androgen-deprivation therapy alone, in which drugs are taken to block the hormones that stimulate the growth of prostate cancer cells. In men with intermediate-risk disease, 9.7 percent were treated with this therapy in 1990 to 1994, versus 3.8 percent in the period of 2010 to 2013. Among those with high-risk disease, 30 percent and 24 percent of patients respectively underwent this treatment in these same periods.

"We expected to see a rise in surveillance rates, but were surprised by the steepness of the trajectory. It shows a major shift toward appropriate, risk-adapted management of the disease," said corresponding author Matthew Cooperberg, MD, MPH, associate professor in the departments of Urology and Epidemiology & Biostatistics at UCSF, and Helen Diller Family chair in Urology at the UCSF Helen Diller Family Comprehensive Cancer Center.

"Active surveillance has been a mainstay for years at UCSF and a few other academic centers, but is increasingly broadly endorsed in recent years. Our study follows on from numerous others that have documented consistent overtreatment of low-risk cancer that would never cause any symptoms or loss of life expectancy had it never been diagnosed. At the same time we're seeing more aggressive management of higher-risk disease, which will lead to better outcomes," he said.

Cooperberg, and senior author Peter Carroll, MD, MPH, analyzed data of close to 10,500 prostate cancer patients from 45 urology practices nationwide, collected in UCSF's CaPSURE registry. In patients aged 75 or older, they observed that the rate of active surveillance had soared from 22 percent in the

(Continued on page 8)

(Continued from page 7)

2000-to- 2004 period, up to 76 percent in the 2010-to-2013 timeframe. However, the incidence of surgery had stagnated in this high-risk group.

Low-risk patients seeking treatment may be younger and motivated by anxiety, perhaps related to a family history of cancer, or obstructive urinary symptoms, said Carroll, professor and chair of the Department of Urology at UCSF.

The authors say that they hope the results of the study will generate renewed discussion on the merits of PSA screening, a blood test that measures a protein produced by the prostate gland. PSA levels are frequently elevated in men with prostate cancer, but testing has invited controversy, because it has led to unnecessary treatment in men with low-risk disease.

"Because of concerns about overtreatment, many primary care physicians no longer support PSA testing. This means that low-risk tumors, which do not require treatment, go unnoticed," said Carroll. "But it also means that high-risk tumors that are potentially lethal without early identification and intervention may go unnoticed, too. We hope the results of this study will lead toward a smarter screening and treatment paradigm, which is what many men need and deserve."

NETWORKING

The original and most valuable activity of the INFORMED PROSTATE CANCER SUPPORT GROUP is "networking". We share our experiences and information about prevention and treatment. We offer our support to men recently diagnosed as well as survivors at any stage. Networking with others for the good of all. Many aspects of prostate cancer are complex and confusing. But by sharing our knowledge and experiences we learn the best means of prevention as well as the latest treatments for survival of this disease. So bring your concerns and join us.

Please help us in our outreach efforts. Our speakers bureau consisting of Lyle LaRosh, Gene Van Vleet and George Johnson are available to speak to organizations of which you might be a member. Contact Gene 619-890-8447 or gene@ipcsg.org to coordinate.

Member and Director, John Tassi is the webmaster of our website and welcomes any suggestions to make our website simple and easy to navigate. Check out the Personal Experiences page and send us your story. Go to: http://ipcsg.org

Our brochure provides the group philosophy and explains our goals. Copies may be obtained at our meetings. Please pass them along to friends and contacts.

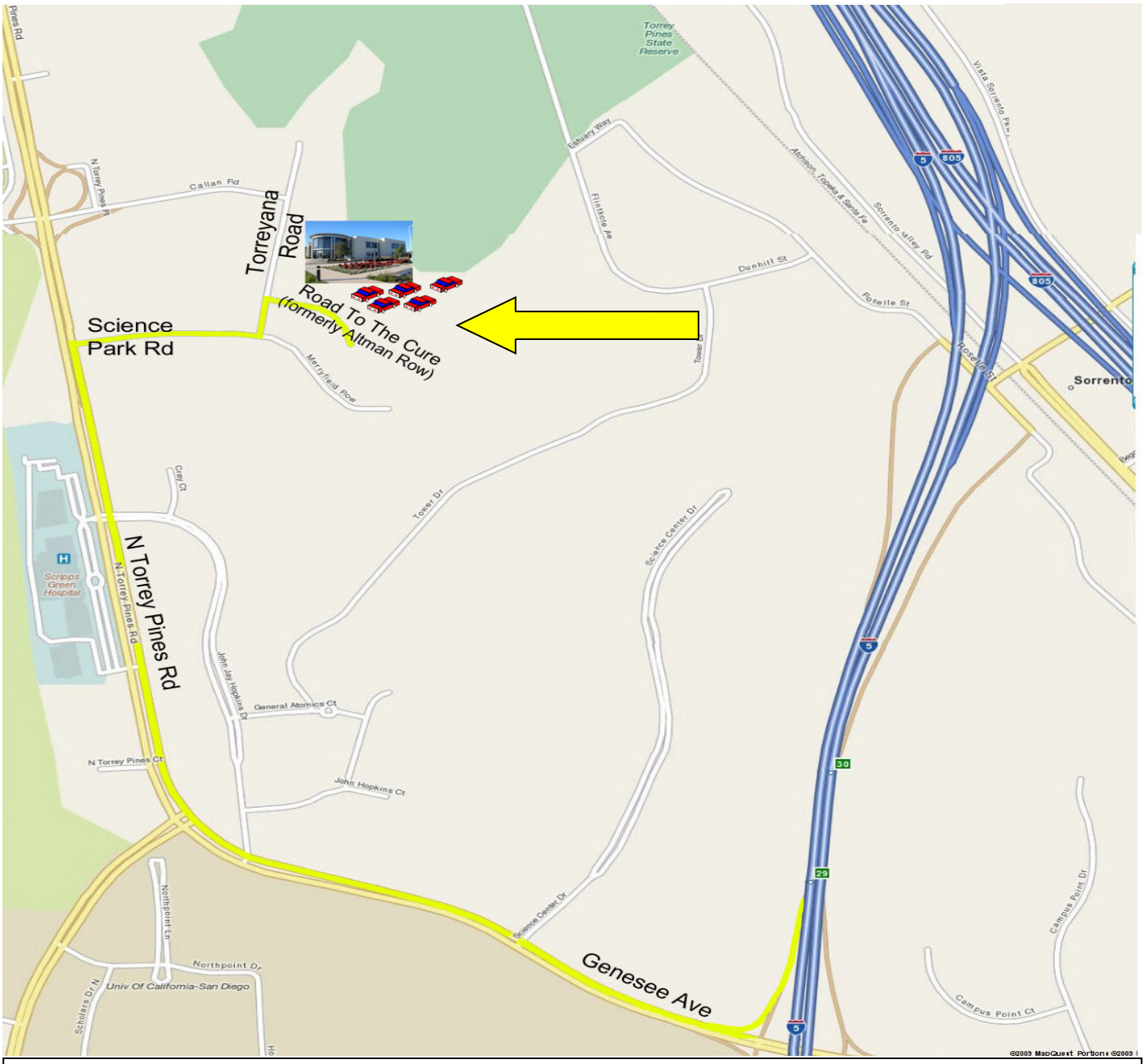
Ads about our Group are in the Union Tribune 2 times prior to a meeting. Watch for them

FINANCES

We want to thank those of you who have made special donations to IPCSG. Remember that your gifts are tax deductible because we are a 501(c)(3) non-profit organization.

We again are reminding our members and friends to consider giving a large financial contribution to the IPCSG. This can include estate giving as well as giving in memory of a loved one. You can also have a distribution from your IRA made to our account. We need your support. We will, in turn, make contributions from our group to Prostate Cancer researchers and other groups as appropriate for a non-profit organization. Our group ID number is 54-2141691. Corporate donors are welcome!

If you have the internet you can contribute easily by going to our website, http://ipcsg.org and clicking on "Donate" Follow the instructions on that page. OR just mail a check to: IPCSG, P. O. Box 4201042, San Diego CA 92142



Directions to Sanford-Burnham Auditorium
10905 Road to the Cure, San Diego, CA 92121

Take I-5 (north or south) to the Genesee exit (west).
Follow Genesee up the hill, staying right.
Genesee rounds right onto North Torrey Pines Road.
Do not turn into the Sanford-Burnham Medical Institute or Fishman Auditorium
Turn right on Science Park Road.
Turn Left on Torreyana Road.
Turn Right on Road to the Cure (formerly Altman Row).