# THE WALNUT

**January 2015**

**Newsletter of the Prostate Cancer Support Group - ACT Region Inc.**

**Affiliated with the Prostate Cancer Foundation of Australia**

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## Monthly meetings

All men and women are welcome to attend our regular monthly meetings. No notice is required - simply come along and introduce yourself, or contact one of the people listed later in this newsletter.

### When

Meetings of our support group are held on every 3rd Wednesday of the month except in December.

### Usual Location

Room 22, Building 1, Pearce Community Centre, Collett Place, Pearce, ACT 2607. See our web site here for details and map showing the location: http://tinyurl.com/bjoyczu

### Time

6:30 for 7:00

### Next monthly meeting

Our next monthly meeting will be on Wednesday 21 January at our usual location and time (see details here: http://tinyurl.com/ley8grl ). There is no guest speaker. There will be lots of time available for current and new members to exchange information and to discuss things of interest or concern. All people are welcome: blokes, carers, partners, members, non-members, guys and gals.

## Contact us

### Postal address

Prostate Cancer Support Group - ACT Region Inc.
PO Box 717, Mawson, ACT 2607

### Personal support

If you would like immediate support, advice or assistance contact any of the following people:

**President**: Chris Hansen
Phone: 02 6161 4135
Email: **chriskayehansen@gmail.com**

**Treasurer**:
John Lucas
Phone: 02 6293 2532
Email: **jandklucas@bigpond.com**

## Web site

Our web site provides details about the activities of the group, meetings, meeting location map, contact persons and lots of other useful information:


**Link to our site:**
**prostate-cancer-support-act.net**

## From the editor

This edition provides information about our last meeting, some events of interest, and information about recent articles and reports that may be of interest.

If you are aware of news, products, publications, web sites, services or events that may be of interest to members of the group I'd be happy to be informed of them. If you have received this newsletter indirectly and would like to be emailed a copy directly please send me an email through the form here: http://tinyurl.com/2bdbbnk

I'm happy to add any of your friends and carers to the email list for the newsletter. Past issues of *The Walnut* can be downloaded from this page of our web site: http://tinyurl.com/42fyrxd

**Mike Boesen**
**Editor**

## President's report

The Murrumbateman Field Days event was held on 18 and 19 October and as in past years it attracted many people. Our marquee's position this year was facing into the oval, whereas the main thoroughfare was behind us on the road around the oval, so we had less passing trade. However, fortunately this was not reflected in the numbers of pamphlets distributed or people talked to - as in past events, we were able to chat with many folk. Following the creative lead of one of our members, next year we will look at opening both sides of the marquee and positioning it facing outward to the main traffic on the road.

Late last year I had a routine PSA test at a different laboratory to my normal one. The result came up as 0.04 ng/ml, which seemed a surprising jump from my normal of level <0.01 ng/ml. Following my queries to local labs, I received an invitation to Capital Pathology Laboratories where I met with the Director of Clinical Pathology, Dr Paul Whiting. He explained there are four different tests for PSA, each with differing levels of sensitivity, which could explain my result. He also gave me a guided tour of the lab, showing how the PSA test is undertaken. It is largely an automated process, although there were plenty of people in white coats. An interesting additional detail was a demonstration of how biopsy materials are evaluated; (and hence Gleason Scores generated) - thin sections are taken from the biopsy cores, stained and examined under the microscope. I also had the opportunity to see a recently excised prostate gland!

Dr Whiting has offered us the opportunity of visiting the labs one evening where members can see how the whole process operates. We will arrange for that to happen in 2015 if there is sufficient interest amongst members.

The Council on the Ageing (COTA) in the ACT is considering making a submission to the ACT Government seeking funding for a holmium laser. This would be used as an alternative to the current scalpel-based approach to treatment of prostate cancer and benign prostate enlargement. The holmium laser is currently only available to private patients in Canberra; acquisition by ACT Health would extend this option to public patients.

We have been asked to support this submission which seeks about $250,000 but which apparently would have offsetting benefits (mainly reduced hospital stay length) accounting for about $230,000 per annum.

I and the other members of our Ececutive Committee hope that you have had a happy time over the Xmas and New Year period, and wish you well for the 2015 year.

**Chris Hansen**
**President**

## Secretary's report

**Monthly meeting on 19 November 2014**

The monthly meeting on 19 November was the last for 2014. There were 25 people attending including two new members and their partners. Unfortunately, only 18 members bothered to sign the attendance book. I stress once again the importance of signing the attendance book. This is needed for insurance purposes (in case you trip over and break your ankle for example, the insurance company will want evidence of your attendance) and also for our own records of active membership. I have asked the President to point out at the beginning of each meeting that the attendance book must be signed and to ensure that it is either circulated or otherwise prominently available for signature.

There was no guest speaker. However, one of our members related his journey of testing and biopsies, which ultimately led - thankfully - to the conclusion that he did not have prostate cancer. He is 58 years of age. In summary, his journey started with a worrying PSA test result of 65. This led to a number of diagnostic procedures, with none indicating the existence of prostate cancer: DRE, bone scan, MRI scan, retropubic biopsy and transperineal biopsy (in Sydney). Fortunately, neither of the two biopsies led to any consequential infection. The good news is that his PSA is now 2.1 and in view of the two negative biopsy results, he is confident that he does not have cause for concern. The cause of the elevated PSA was never identified. Unfortunately and surprisingly, it appeared that the possibility that he had a non-cancerous infection or other transient condition leading to the high PSA reading was not discussed. If testing and treatment for such transient conditions had been undertaken early on, the expensive series of tests and invasive biopsies may not have been necessary. He will continue to have PSA tests every 6 months.

We welcomed two new members and their carers. They told us about their situations. One has been

diagnosed with prostate cancer, but the doctors are hesitant to recommend a prostatectomy because of previous hernia operations which might pose problems for such an operation. Radiation therapy may be an appropriate option. The other new member has had a prostatectomy some time ago (around 18 months) despite prior hernia repair surgery. Unfortunately he is still incontinent. He also experienced some problems due to adverse reactions to Viagra and Cialis (headaches etc). The new members' circumstances led to much discussion and exchange of very useful information and lots of suggestions about options for management of their problems.

The President stressed the importance of physical fitness in preparing for any procedure and in recovery after any procedure. He displayed a ***Certificate of Appreciation*** that is to be given to the Club Group Pty Limited. That organisation provides concessionary rates to members of our group for full Platinum level membership of the fitness club LIME. If you have an interest in this concessionary membership, please contact the President - Chris Hansen.

There was a brief debate on whether we should make a donation to the John Curtin School of Medical Research. John Hayhoe and U N Bhati will address this in more detail at a future meeting.

The formal meeting was closed at 19:40 and afterwards the customary end of year pizza with wine and sweets were served with the best wishes for Xmas and the New Year from the management.


***Discussion continues over supper***

Our next monthly meeting will be on Wednesday 21 January 2015 - see details on page 1 of this newsletter.

**George Kayaba**
**Secretary**

## Launch of the Australian Cancer Consumer Network (ACCN)

The On 26 November 2014, I attended the launch of the ACCN at Parliament House, representing both the Prostate Cancer Support Group – ACT Region and Cancer Voices ACT. The Network brings together all cancer "consumer groups" for a more effective advocacy on all aspects of cancer: prevention, detection, treatment, care, research and policy.

The Parliamentarians Supporting Cancer Causes invited Cancer Voices Australia (CVA) to co-host the launch. Senator Deborah O'Neill, Mr Dan Tehan MP and Ms Sally Crossing AM, Convenor of CVA, performed the launch ceremony. Members of many cancer consumer organisations from around Australia, some members of the Senate and the House of Representatives and their staff were in attendance at the launch.

***Senator Deborah O'Neill and myself***

One member of Parliament told me that about a month ago he had a PSA test and that no problem was indicated. He also stated that all of his fellow members were aware of the importance of regular PSA testing.

**U.N. Bhati**
**Librarian**

## Recent articles and reports that might be of interest

The following articles that have appeared recently on web sites or other sources may be of interest to some members. The group's Executive has not attempted to evaluate the articles' findings and conclusions or the credentials of the authors. The articles are simply being drawn to your attention so that you can make your own evaluations. If you cannot access any of the articles, contact me and I'll help.

**Mike Boesen**
**Editor**

### Lower death rates related to exercise amongst men diagnosed with prostate cancer

In a 23 December 2014 online article in *Medscape Urology,* Pam Harrison states that "*Yet another study is confirming the benefits of physical activity following*

*the diagnosis of cancer, this time of prostate cancer, on all-cause and prostate-specific survival, Swedish researchers report."*

Her article is available here or here: http://tinyurl.com/m8l7eyt The study referred to is by S E Bonn et al and an abstract is published in OnlineFirst on 19 December 2014 (see here: http://tinyurl.com/p2qndb2 )

Some other extracts from Harrison's article:

*"Being physically active has many positive effects on health, and now we can see that it has specific effects on survival among prostate cancer patients as well," Stephanie Bonn, MSc, Karolinska Institute, Stockholm, Sweden, told Medscape Medical News.*

*"Since a man's physical activity level is something he himself can change, there is great potential for men to improve their own survival by being physically active and we believe that physical activity after a prostate cancer diagnosis is beneficial for survival regardless of the patient's activity level before the diagnosis," Bonn said.*

*Men who walked or cycled for 20 minutes a day or more had a 30% lower risk for all-cause mortality and a 39% decreased risk for prostate cancer–specific mortality compared with men who walked or cycled less than 20 minutes a day, the investigators report.*

*For those exercising 1 or more hours a week, all-cause mortality was reduced by 26% and prostate cancer–specific mortality by 32% compared with men who reported exercising less than 1 hour a week.*

*After considering all time spent walking, cycling, exercising, and doing household work, researchers found that all- cause mortality was 37% lower while prostate cancer–specific mortality was 22% lower for men who had a total MET of 5 or more hours a day compared with those who had a total MET of less than 5 hours a day.*

*"I would recommend physicians advise men to follow the current recommendations for physical activity that are available, and to advise them to be as active as is possible for them to be," Bonn said.*

*"They need to find an activity that is enjoyable and remember that any physical activity is better than none and is likely to have positive health effects," Bonn added.*

(A MET represents the ratio between the energy expenditure from a specific activity and the energy expenditure from basal metabolism. For example, an activity with a MET of 1 (sitting still) does not result in any increased energy expenditure compared with basal metabolism, whereas an activity with a MET of 2 (standing) results in twice the energy expenditure. Ed.)

**Managing erectile dysfunction after prostatectomy**

One of our members has suggested that an article by J A Albaugh would be of interest to other members. This informative article is published in *Urological Nursing* 2010; 30(3) and is available here or here: http://tinyurl.com/pxh7t9f The Conclusion of the article is reproduced in full below.

There is a more recent *Journal of Research and Reports in Urology* article on the same topic, authored by Z Hamilton and M Mirza and published online in May 2014. That is available here or here: http://tinyurl.com/p9g3w6b The Abstract from that article is also reproduced below.

**Conclusion in the 2010 Albaugh article**

*Erectile dysfunction after radical prostatectomy remains one of the most common adverse side effects of treatment. Although some men might not be concerned about erectile function, many men are distressed about this problem and need assistance in determining the best way to move forward to promote and preserve erectile function. Each treatment option has both positive and negative aspects. Patients need to not only decide how and if they want to treat erectile dysfunction, but also make choices in terms of penile rehabilitation to promote blood flow to the penis to promote return of spontaneous erections. Each individual patient has his own unique sexual expression, and the patient and health care professional together can carefully determine how a potential treatment would work within that particular patient's life.*

*Treatment of erectile dysfunction after prostatectomy can be challenging since there is no definitive evidence to support a particular treatment option over the others. Generally, patients tend to start with less invasive or less cumbersome options. Most patients prefer oral agents because they are discreet and easy to utilize, and if appropriate, this can be a first line treatment. Since failure rates for oral agents remain very high post-prostatectomy, patients should be provided with other more efficacious options for use either instead of or in combination with oral agents to provide sufficient erectile function. Despite the fact that oral agents do not always provide sufficient erectile rigidity for penetrative sex, they have been shown to improve nocturnal erections and blood flow to the penis in post- prostatectomy men (Montorsi et al., 2000; Schwartz et al., 2004). It is crucial for the health care professional to provide appropriate education about the use of oral agents for penile rehabilitation, even if medication is not resulting in a full erection so patients will be encouraged to continue this therapy for penile rehabilitation. In addition, other treatments, such as the vacuum device or Muse, can be used in conjunction with the oral agents to enhance erections and penile rehabilitation. Although the vacuum device is associated with high efficacy and is the least invasive treatment option, it is cumbersome.*

*Another relatively simple treatment option is Muse. Important factors regarding Muse are the issue of pain with alprostadil use after radical prostatectomy and the cost factor. If a patient wants proven efficacy and is highly motivated to carefully use a treatment, penile injections may be the best choice. Finally, when medical treatments have failed, the patient may want to consider a penile implant. The implant provides an effective treatment associated with high patient and partner satisfaction, but not all men are willing to undergo this surgically invasive intervention.*

*It is critically important for patients to understand that not utilizing any treatment to promote cavernosal blood flow and oxygenation will have long-term ramifications for regaining erectile function in the future. Each year, more research continues to reveal the importance of using treatment for erectile dysfunction to promote corporal tissue health and diminish atrophic changes to the penile tissue. After prostate surgery, nitric oxide synthesis is diminished due to nerve trauma to the cavernosal nerve (Carrier et al., 1995). The lack of nitric oxide and neuropraxia lead to diminished blood flow and oxygenation of the penile tissue, which leads to cavernosal fibrosis and collagen synthesis (Leungwattanakij et al., 2003). Atrophy and penile fibrosis cause further erectile dysfunction after radical prostatectomy; therefore, re- establishing blood flow to the penis is important to preserve and promote optimal erectile function in these men.*

*By understanding each treatment option and determining the best choice for treatment, health care professionals can help patients find the optimal treatment option for erectile dysfunction and penile rehabilitation. The health care team can help each patient carefully consider their unique sexual lifestyle and how to incorporate erectile dysfunction treatment into their sexual experience so this important component of life need not be lost after prostatectomy.*

**Abstract from from the 2014 Hamilton and Mirza article**

*Success of cancer surgery often leads to life-changing side effects, and surgical treatment for malignant urologic disease often results in erectile dysfunction (ED). Patients that undergo surgical prostatectomy or cystoprostatectomy will often experience impairment of erections due to disruption of blood and nerve supply. Surgical technique, nerve sparing status, patient age, comorbid conditions, and pretreatment potency status all have an effect on post-surgical ED. Regardless of surgical technique, prostatectomy results in disruption of normal anatomy and nerve supply to the penis, which governs the functional aspects of erection.*

*A variety of different treatment options are available for men who develop ED after prostatectomy, including vacuum erection device, oral phosphodiesterase 5 inhibitors (PDE5I), intracorporal injections, and penile prosthesis. The vacuum erection device creates an artificial erection by forming a vacuum via suction of air to draw blood into the penis. The majority of men using the vacuum erection device daily after prostatectomy, regardless of nerve-sparing status, have erections sufficient for intercourse. Phosphodiesterase 5 inhibitors remain a common treatment option for post-surgical ED and are the mainstay of therapy. They work through cyclic adenosine monophosphate and cyclic guanine monophosphate pathways and are recommended in all forms of ED. Intracorporal injections or intraurethral use of vasoactive substances may be a good second-line therapy in men who do not experience improvement with oral medications. Surgical placement of a penile prosthesis is typically the treatment strategy of choice after other options have failed. Semi-rigid and inflatable devices are available with high satisfaction rates.*

*With careful patient counseling and proper treatment selection, patient satisfaction and improved erectile function can be achieved. We advise that patients use a vacuum erection device daily in the early postoperative period in combination with an oral PDE5I. For patients who do not respond to a vacuum erection device or PDE5I, consideration should be given to*

*intraurethral alprostadil, intracorporal injections, or a penile prosthesis.*

**Other recent articles noted but not summarised**

A good source of recent articles is the prostate cancer archives page of Renal and Urology News. That archive can be accessed here:
http://tinyurl.com/ndjqdy7

From that source and others, I have listed below recent articles that will be of interest to some members. However, because of lack of time I have not been able to create summaries of them. To access some articles (e.g. those from MedScape) you may be required to register with the publisher, but that can be done easily, safely and at no cost - you do not have to be a doctor or health worker to register. Please let me know if you have any problems in accessing the articles.

**Mike Boesen**
**Editor**

**Two prostate cancer tests 'not clinically useful,' says NICE. (Tests referred to are for PCA3 and PHI)**
L Davenport 22 December 2014
http://tinyurl.com/nd6mjg3

**Increased Cardiovascular Risk With Androgen Deprivation Therapy for Prostate Cancer**.
W Boggs, 16 December 2014.
http://tinyurl.com/pym36zr

**Robotic prostate surgery offers good long-term results.**
J A Charnow, 8 December 2014
http://tinyurl.com/n5cyx5o

**Prostate cancer radiotherapy outcomes worse in smokers**.
J A Charnow, 29 October 2014
http://tinyurl.com/oa55qww

**Prolonged prostate cancer hormone therapy raises fracture risk.**
J A Charnow, 12 November 2014
http://tinyurl.com/mrbkpk9

**Androgen deprivation therapy and Radiotherapy combo offers better outcomes.**
J A Charnow 7 January 2015
http://tinyurl.com/m6xdxo5

**Prostate cancer death risk higher after external beam radiation therapy (EBRT) than surgery**
J A Charnow 9 October 2014
http://tinyurl.com/kwap7yr

**More evidence of harm from selenium in prostate cancer.**
P Harrison, 8 January 2015
http://tinyurl.com/mrj22p5

**More vegetables, less alcohol for prostate cancer prevention.**
Renal & Urology News, 8 January 2015
http://tinyurl.com/n3rpedt

**Advances in prostate cancer: 2014**
G Chodak, 11 December 2014
Interesting headings in this article: Prostate cancer prevention, Screening and early detection, Treatment of localised disease, Treatment of locally advanced disease, Treatment of metastatic disease.
http://tinyurl.com/l79h3sh

**Surveillance May Be Safest Option for Low-Risk Prostate Cancer.**
K Doyle 22 December 2014
http://tinyurl.com/l5g7azp

**Overtreatment of prostate cancer despite limited life expectancy.**
A M Castellino 11 December 2014
http://tinyurl.com/k6q7qzv

**Long-term active surveillance may be safe in low-risk prostate cancer.**
M Parks and D C Wang 20 December 2014
http://tinyurl.com/n473ods

**Early-Stage Prostate Cancer Frequently Overtreated**
N Persaud 4 December 2014
http://tinyurl.com/lyfo4hk

**Ageism causes prostate cancer undertreatment, say critics.**
N Mulcahy, 8 January 2015
http://tinyurl.com/mzxdfnb

**Disclaimer**

From time to time in our newsletters we provide information about developments in the diagnosis and treatment of prostate cancer, research articles, documents, audiovisual products, presentations and other interesting materials. However, the Group's Executive and the editor of this newsletter do not have the medical expertise required to make an informed evaluation of the conclusions and recommendations presented in such materials, and we have not verified such conclusions and recommendations through appropriately qualified medical professionals. The information presented in this newsletter must not be interpreted as being endorsed or recommended by the Executive or the editor. Any recommendations made in such materials may not be applicable in your particular case. Before implementing any recommendations made in the materials that are reported, it is essential that you obtain advice from appropriately qualified medical professionals. The view of the Group's Executive is that no two prostate cancer cases are alike and that no single treatment option is better than any other in all cases. While the information in this newsletter should be of interest, there is no substitute for getting informed medical advice from your own GP, specialists and other medical professionals.