THE WALNUT

June 2017

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

Affiliated with the Prostate Cancer Foundation of Australia

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In this issue

Next monthly meeting

Our next monthly meeting will be on **Wednesday, 21 June** at our usual location and time (see below). Our guest speaker will be urologist Dr Hodo Haxhimolla. He will inform us about the following leading edge technologies as they relate to prostate cancer diagnosis and treatment: 3-Tesla MRI scanning which can be undertaken at the National Capital Private Hospital or through facilities of The Canberra Imaging Group, use of the Da Vinci robotic surgical system now available at the National Capital Private Hospital, and the Ga-68 prostate specific membrane antigen PET/CT scanning procedure that is also now available in Canberra.

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

Meetings of our support group are held on every **third Wednesday of the month** (except in December) at **6:30 pm for 7:00 pm**. The **usual location** is Room 22, Building 1, Pearce Community Centre, Collett Place, Pearce, ACT 2607. See our website here for details and map showing the location: http://tinyurl.com/8gkhysb.

Next coffee morning

10:00 am, Tuesday, 11 July 2017: Canberra Southern Cross Club at Jamison.

Personal support

For general information, please call SHOUT (Self Help Organisations United Together) during normal office hours on (02) 6290 1984, and their staff will arrange for someone from the Group to contact you. If you would like immediate advice, support or assistance, please contact any of the following people:

President: John McWilliam
Phone: 0416 008 299
Email: president@prostate-cancer-support-act.net

Secretary: David Hennessy
Phone: (02) 6154 4274
Email: secretary@prostate-cancer-support-act.net

Appreciation

The Group recognises and expresses its appreciation for the support provided over the past year by:

- *SHOUT staff*
- *the Canberra Southern Cross Club*
- *Holy Family School, Gowrie*
- *the Burra Patchwork and Quilters Group*
- *the Naval Association of Australia*
- *many individuals in its fund-raising activities.*

From the President

Our May meeting was again well attended and we were given a most interesting and informative presentation by Dr Simon

McCredie. There was the opportunity for many questions. Our coffee group was also well attended. These are a good way of meeting other members in a relaxed environment and getting to know each other a bit better. Do come along to these, if you can.

Again, this month, we can look forward to hearing more about the new robotic assisted surgery and PSMA-PET scans that are now available in Canberra, as well as developments in the treatment of prostate cancer, when Dr Hodo Haxhimolla speaks to us. I look forward to seeing you on 21 June.

We are still interested in attracting other members to join us on the Executive Committee, with a view to providing the opportunity for members to gain experience in the organisation of the Group and helping to ensure that there are members who may be able to assume formal positions on the committee 'down the track'. If you would be interested in joining us, please let me know.

John McWilliam
President

Previous meetings

May 2017 General Meeting

Our speaker in April was Dr Simon McCredie.

The treatment for a diagnosis of prostate cancer is uncertain owing to the difficulty in distinguishing 'lethal' from 'non-lethal' cancers. About 50 men are treated to find one lethal prostate cancer. For women, only 12 are treated to find one lethal breast cancer.

Two large scale screenings in the US and UK have led to targeted *active surveillance*, where those who are likely to die from prostate cancer are treated and those who are unlikely to die are monitored. Australia is increasingly adopting this approach. Patients ought to be alerted that they may have prostate cancer but that it may or may not be fatal and that treatment(s) always have side-effects. These factors should be considered in deciding the most appropriate treatment.

President John McWilliam with Dr Simon McCredie

Whether to treat or watch and wait is now aided by much more precise techniques. These include:

- Multiparametric MRIs, which detect alterations in blood flow and allow detection of 'suspicious' sites in men with elevated PSA levels. This technique eliminates the need for a biopsy of the gland. 'Fusion biopsy' i.e. combined Ultrasound/MRI scanning has allowed targeted biopsies which have increased the 'positive' detection of cancer from an accuracy of 45% to 85%.

- Genome mapping that is being undertaken in the USA. This allows specialists to recognise those genes in cancer cells which cause uncontrolled growth and become 'lethal'.

- PET/CT scans for the PSMA (prostate-specific membrane antigen) have become more precise and detection of higher metabolic activity due to cancers cells can be detected for PSAs as low as 0.2 µg/L.

Radiation and surgery are the most commonly used techniques over the past 20 years. *Robotic surgery*, currently expensive, is likely to become more common in Australia. In eastern Australia, a register is being established to record all details of prostate treatments that will give specialists data to understand trends and success of treatment options.

There were a series of questions:

Q1. What is your opinion of symptomless PSA testing?

A1. PSA testing is low cost. The downside is that it doesn't distinguish 'lethal' from 'non-lethal' readings. When combined with new understandings from the genomic work it will enhance the usefulness of frequent or early testing.

Q2. ANZAAS studies suggest that men should start PSA testing at 45 years. What is your opinion?

A2. Yes, if the PSA is low (< 0.7 µg/L) at 45, the person is unlikely to succumb to prostate cancer, at least before 55 years. But again, the reliability of PSA testing will be increased when the gene markers are known.

June 2017 Executive Committee Meeting

At its June meeting, the Executive Committee, among other things:

- noted that our new pamphlets have now been printed;
- discussed possible speakers for future meetings;
- received reports from the Secretary and Treasurer, including possible financial support from the PCSG; and
- noted that we need to undertake a stocktake of materials stored at the Pearce Community Centre from an insurance point of view and that there is a need to replace some signage, which is damaged.

The next meeting of the committee will be held on Wednesday, 5 July.

Future Group events

July meeting: To be confirmed.

Men's Health Week — prostate cancer awareness

One of our members has received an email from the National Health Co-op, which describes itself as 'a not-for-profit, member owned co-operative that provides affordable medical and healthcare services to the communities where it operates'. The following content from that email may be of interest to members:

> *In support of Men's Health Week (12 to18 June 2017), the National Health Co-op is holding a free information session on prostate cancer awareness. All are welcome to attend. Ken Sullivan (Leader of the Goulburn Prostate Cancer Support Group) shares the facts on prostate cancer, including the risk factors, symptoms and diagnosis, as well as the importance of talking to your GP about changes to your health that may indicate the presence of a prostate-related issue.*

Details are:

When: Wednesday 14 June 2017 at 6:00pm.

Where: National Health Co-op Corporate Office – 5-7 Lawry Place, Macquarie, ACT.

Places are limited, so please register at: http://tinyurl.com/ycwz7v6l .

Stay up-to-date

Stay up-to-date by joining the PCFA Online Community. The PCFA Online Community is open to everyone who has been impacted by prostate cancer to share their experiences and connect with others. Through the Research Blog, PCFA Online Community members can also learn more about the latest prostate cancer research developments and findings.

It is free and easy to become a member of the PCFA Online Community. You can sign up at: http://onlinecommunity.pcfa.org.au.

In this month's PCFA *Community Digest*:

- urologic oncologist, Dr Ian Vela describes the clinical management of prostate cancer from PSA testing and diagnosis to treatment for localised and advanced cancer;
- Prof. Suzanne Chambers provides an overview of her current research, which is aimed at establishing effective delivery of

psychosocial and sexual care, integrating tailored exercise;

- PCFA CEO A/Prof Anthony Lowe provides an overview of the financial impact of prostate cancer and how patients can navigate the costs of treatment and managing side effects;
- Dr Olivia Wright, a leading dietitian and nutrition researcher from the University of Queensland outlines the many ways that improving diet can help men with prostate cancer;
- a review of the evidence on whether cannabis can affect the growth of prostate tumours; and
- articles on nutrition for a healthy prostate and addressing the misconceptions of palliative care.

Borrowing items from the Library

Don't forget that you can borrow items from the Group's Library. There is a wide range of materials, from books to videos. Those who are interested in borrowing items from the Library (such as the new *Cancer Recovery Guide* book that we have acquired) or finding out more about our collection can contact U.N. Bhati, email: unbhati@gmail.com.

Articles and reports of interest

The following articles that have appeared recently on web sites or other sources may be of interest to some members. Any opinions or conclusions expressed are those of the authors. See Disclaimer below.

The good news is coffee

Report title: Reduction by coffee consumption of prostate cancer risk: Evidence from the Moli-sani cohort and cellular model
Authors: Pounis G et al
Publication: International Journal of Cancer
Date: 24 April 2017
View at: http://tinyurl.com/yaseffqj

New research suggests that drinking more than three cups a day of Italian-style coffee may reduce the risk of prostate cancer. The role of caffeine in preventing prostate cancer has been a controversial topic among scientists. Some recent studies have suggested that caffeine may have a protective effect on the prostate. Other research, however, has been insufficient to draw conclusions or altogether contradictory.

Italian researchers conducted a 4.2-year epidemiological study of about 7,000 men. Researchers analysed the coffee consumption of the enrolled participants and compared the results against the number of cases of prostate cancer in the group. Interestingly, researchers found that those who drank more than three cups a day of caffeinated coffee had a 53 per cent reduction in prostate cancer compared to non-coffee drinkers.

Researchers performed confirmatory lab testing on prostate cancer cells and found that only coffee extracts containing caffeine were effective in reducing cancer cell proliferation and inhibiting their ability to metastasise. This effect was not observed with decaffeinated coffee. "The observations on cancer cells allow us to say that the beneficial effect observed among the seven thousand participants is most likely due to caffeine, rather than to the many other substances contained in coffee," said Maria Benedetta Donati, head of Laboratory of Translational Medicine.

An earlier study by a different group and undertaken as part of the Health professional follow up study in the US showed similar benefits but attributed the benefit to both caffeinated and decaffeinated coffee. This article, published in June 2011 in the Journal of the National Cancer Institute (Vol 103, Issue 11) is here: http://tinyurl.com/y9pdrtj5

Abiraterone therapy (Brand name Zytiga)—new indications

Report title: Chemohormonal therapy in metastatic hormone-sensitive prostate cancer
Authors: Christopher J Sweeney, MB, BS, et al
Publication: New England Journal of Medicine
Date: 20 August 2015
View at: http://tinyurl.com/yd2jbyju

Androgen-deprivation therapy (ADT) has been the backbone of treatment for metastatic

prostate cancer since the 1940s. This journal article reported on a study, which assessed whether, concomitant treatment with ADT plus docetaxel, would result in longer overall survival than that with ADT alone.

Results from the LATITUDE Clinical Trial show that giving abiraterone plus low-dose prednisone along with Lupron to 'hormone-naïve' men, who are just starting ADT, delayed cancer progression by an average of 18 months. The study also found that adding abiraterone plus prednisone to ADT reduced the risk of death by 38%, compared with adding a placebo.

In a phase III clinical trial of 1,200 men, abiraterone also more than doubled the median time until the cancer worsened, from 14.8 months to 33 months. The study was presented at the 2017 American Society of Clincical Oncology (ASCO) Annual Meeting.

Prostate cancer growth is fueled by testosterone. ADT is active against prostate cancer by preventing testicles from making testosterone. Despite ADT, the adrenal glands and prostate cancer cells continue making small amounts of androgens. Abiraterone stops production of testosterone throughout the body by blocking an enzyme that converts other hormones to testosterone.

Corticosteroid prednisone is routinely given with abiraterone to manage certain side effects of abiraterone, such as low potassium or high blood pressure. Several severe side effects were more common with abiraterone acetate and prednisone than the placebo: high blood pressure (in 20% vs. 10% of men), low potassium level (10.4% vs 1.3%), and liver enzyme abnormalities (in 5.5% vs. 1.3% of men).

"We need to be cautious when using abiraterone in men who have an increased risk for heart problems, such as those with diabetes … We had been treating metastatic prostate cancer the same way for 70 years until docetaxel chemotherapy was shown to improve survival in 2015, and now in 2017 we show abiraterone is also helping patients live longer," said Dr. Fizazi from the research team.

It may be that abiraterone does not just stop cancer from proliferating, but it also stops, or significantly delays, cancer from mutating and becoming more resistant to treatment.

"The survival outcome appears to be similar for men on ADT who take Docotexal (Taxotere) as it is for men on ADT who take abiraterone," says medical oncologist and PCF-funded investigator Christopher Sweeney, M.B.B.S.

There are two big advantages to taking abiraterone with ADT instead of docetaxel:

- a difference in side effects. The side effects of abiraterone are minimal, if prednisone is taken (low-dose prednisone is necessary with abiraterone to help the adrenal gland make sufficient amounts of cortisol), while there many side effects of docetaxel (including weakness, nausea, vomiting, confusion, fluid retention, anemia and hair loss); and

- the potential, if the abiraterone-ADT combination stops working, to add docetaxel at that time.

Two years ago, a separate trial called the CHAARTED Trial found that for men who have metastatic cancer that responds to ADT (this is called hormone-sensitive prostate cancer), adding docetaxel to ADT extended the average survival from three years to nearly five (this trial tended to have men with a higher level of disease).

Editor: *Australian PBS regulations are not yet based on this research. Zytiga (Abiraterone) is expensive— at least $3,600 per month — and the PBAC reconsidered the guidelines earlier this year. At present, the guidelines for use in Australia are for castration resistant metastatic carcinoma of the prostate, to be used in combination with prednisolone or prednisone, NOT to be used in combination with chemotherapy AND must have failed treatment with docotexal due to resistance or intolerance or unsuitable for docotexal) AND be mobile and ambulatory most of day (WHO performance status of 2 or less). Subsidy will not be continued if progression develops whilst using Abiraterone. ALSO must NOT have had prior treatment with Enzalutamide (Xtandi), unless Enzalutamide ceased due to intolerance.*

Currently the Pharmaceutical Benefits Scheme provides that Abiraterone (Brand name Zytiga) must be taken with Prednisone or Prednisolone.

At its March 2017 meeting the PBAC approved an application that, while Abiraterone must be taken with a corticosteroid, the corticosteroid does not necessarily have to be prednisone or prednisolone.

Patients and their doctors are now able to choose the corticosteroid that they use with Abiraterone. There has been evidence that corticosteroids other than Prednisone or Prednisolone may have fewer side effects or greater benefits.

Study showing food significantly affects absorption of Abiraterone

Article title: Taking a high-priced cancer drug with a low-fat meal can cut cost by 75%
Publication: Science Daily, with article sourced from University of Chicago Medical Center
Date: 13 February 2017
View at: http://tinyurl.com/zlbq75v

This study has reported that taking one-fourth the standard dose of Abiraterone with a low-fat breakfast can be as effective — and four times less expensive — as taking the standard dose as recommended, namely on an empty stomach. In the study, 36 patients who took 250 milligrams of the drug with a low-fat breakfast had outcomes that were virtually identical to 36 patients who took the standard dose —1,000 milligrams of the drug on an empty stomach.

Many drugs taken by mouth have a 'food effect', which can alter how the drug is absorbed. Abiraterone has one of the most dramatic food effects. Blood levels of the drug can be up to 17 times higher when taken with a high-fat meal. Taking the drug with a low-fat meal is more predictable. It increases blood levels four- to seven-fold.

Editor: Currently this information conflicts with Australian prescribing guidelines, which advise a dosage of 1,000 mg to be taken on an empty stomach. Before making any changes as to how you take this medication, discuss the matter with your prescribing doctor.

Bowel and bladder quality of life after brachytherapy

Report title: Long-term quality of life in prostate cancer patients treated with Cesium-131
Authors: Scott M Glaser, MD, et al
Publication: International Journal of Radiation Oncology
Date: 31 March 2017
View at: http://tinyurl.com/yb94ktly

Brachytherapy involves inserting radioactive seeds in or near tumour to kill it. Prostate cancer patients treated with Cesium-131 brachytherapy maintained their urinary- and bowel-related quality of life years afterward, according to this recent study). But, researchers found a statistical worsening in EPIC (Expanded Prostate Cancer Index Composite) scores for urinary incontinence.

While patients reported a decline in these quality of life measures immediately after brachytherapy, they achieved a full recovery within six months.

"This is especially important as multiple studies are emerging that strongly suggest that the inclusion of brachytherapy must be considered for the treatment of high-risk prostate cancer —the toughest localised prostate cancer to cure," Bill Cavanagh, chief scientific officer of the brachytherapy company, IsoRay, was reported as saying in *Prostate Cancer News Today* (http://tinyurl.com/y6ujjrk6).

Prostate brachytherapy alone, or combined with external beam radiation therapy, is a widely-used treatment for men with prostate cancer. By placing radioactive seeds in or near the tumour, brachytherapy spares surrounding, healthy tissues from radiation damage.

The quality of life of patients treated with external beam radiotherapy or alpha-blocker therapy (ABT) improved over time, according to a subset analysis. There was no change in patients treated with androgen deprivation therapy (ADT).

Overall, the study showed that there were minimal long-term changes in patients' urinary and bowel quality of life after brachytherapy.

Discussion of benefits treatment of oligometastatic prostatic cancer

Report title: Unwarranted conclusions about treatment of oligometastatic prostate cancer
Author: Allen Edel
Publication: *The "New" Prostate Cancer Infolink*
Date: 4 May 2017
View at: http://tinyurl.com/ycyjemrx

Oligometastatic cancer refers to the development of several (usually <5) distant metastases (for example, in bone or a lymphnode) demonstrated on scanning. Controversy has arisen because newer scanning techniques are capable showing these metastases at a much smaller size than previously. Does treatment of these lesions defer further development? OR are they merely the first signs of a more widespread disease, where systemic therapy may be more appropriate?

Many patients wonder, if they just have a couple of metastases, why can't those be 'zapped' by a few quick SBRT (Stereotactic Body Radiation Therapy) treatments and they can't thereby be cured of their prostate cancer? Or, even if they can't be cured, can't the cancer's progression be slowed?

At some point, they need to undergo a genetic transition called epithelial-to-mesenchymal transition (EMT), after which they can freely move throughout the body in the lymph, the blood or the spaces around nerves, and plant themselves and accumulate in distant locations. Sometimes those microscopic metastases can circulate for a long time before planting themselves somewhere new. Sometimes they can plant themselves but do not proliferate appreciably for a long time.

To be *detectably* metastatic with today's best imaging technology, a clump of tumour cells must be at least 4mm long. The cancer cell may be about 10μm in diameter, so there must be at least 200 million of them before the smallest metastasis becomes detectable. Cancer cells may be circulating, clumping, and growing for a long time before they form a big enough clump to be detectable.

How long does it take to go from the first microscopic metastasis to the point where it is detectably metastatic? That's impossible to know with any accuracy for a given individual. What we do know is that, on average, it takes 9 years from the time a man is biochemically recurrent after prostatectomy to the time when the first bone metastases are detected on a bone scan. That represents the accumulation of perhaps a billion cells in one place. It may be years more before the next bone metastasis is detected. Lymph node metastases are the most slowly progressing of all the kinds that prostate cancer causes. It is not unusual for many years to pass between new, detectable lymph node metastases. The new PET scans detect metastases much earlier, when the tumours are 80 per cent smaller, i.e. the newer PSMA-based PET/CT scans may detect metastases even earlier, say at about 0.5 ng/ml. rather than 20 ng/ml for a bone scan.

So, if *any* treatment is given when metastases are detected this early, and then we find that it takes a very long time — many years — to detect subsequent metastases, did the treatment really delay progression? This effect is called 'lead-time bias'.

Adding to the confusion is the fact that those big clumps of detectable cancer cells are the source of much of the PSA. When those detected metastases are 'zapped', the cancer cells in them no longer secrete PSA and the cancer is controlled locally. We also know that old clumps of cancer are a rich source for new tumour cells. Is it possible that reducing at least that local source of metastatic cells will slow progression?

The only way to answer this question with any assurance is to conduct a randomised clinical trial.

The article discusses studies of treatment of these Oligo metastatic patients with local radiotherapy but comments that the results have only been monitored to show improvement at the 2-year mark BUT it may take 3-5 years of follow up to determine if this benefit is real or only reflects the natural slow progression of the disease.

A further conclusion was that, despite the lack of evidence, if a radiation oncologist looking at the patient's anatomy finds metastatic radiation to be safe, then there is little reason other than cost to abstain from it. However, a patient is taking a survival risk if he puts off hormone therapy in order to find metastases, especially in light of early evidence from the TOAD study.

From the editor

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 like to be informed of them. If you have received this newsletter indirectly and would like to be emailed a copy direct, or if you would like to add any of your friends or carers, or if you no longer wish to receive copies of the newsletter, please send me an email through the form here: http://tinyurl.com/grshy8s.

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 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.