THE WALNUT

August 2017

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

Affiliated with the Prostate Cancer Foundation of Australia

Postal address
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In this issue

Next monthly meeting

Our next monthly meeting will be on **Wednesday, 16 August** at our usual location and time (see below). Our guest speaker will be Kellie Toohey, Clinical Assistant Professor (Exercise Physiology), Sport and Exercise Science, Faculty of Health, University of Canberra. Kellie's address will on the role of exercise in rehabilitation after treatment and in helping to promote good health in cancer survivors. We will also hear about the projects she is running in the cancer space at UC. Kellie is an Accredited Exercise Physiologist and completed her Masters' degree in Clinical Exercise Physiology. She is currently completing her PhD while working as a Lecturer and Clinical Education Co-ordinator (Exercise Physiology).

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, 12 September 2017: Canberra Southern Cross Club at Jamison.

All are welcome to attend, including partners and carers. No notice is required — simply come along and introduce yourself.

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 or so 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

We are very thankful to Dr Paul Craft for speaking to us at our Juy meeting. As you will see from the report below, it was a highly informative session.

This month we will hear from Kellie Toohey from the University of Canberra on the role of exercise in rehabilitation and the work that the university is doing in this area.

On Friday, 1 September, we will be the nominated charity at the Father's Day event being held at the Holy Family School, Gowrie. The school has been a generous supporter of the Group over many years, and we are grateful to them for being invited to be their nominated chairity again this year. If you are willing to help out with this event, please let me know.

On 20 September, we will be holding our annual general meeting. At this meeting, we will be appointing executive committee members for the coming year. We will be sending out a request for nominations to the committee and I encourage members to nominate for the committee. We are required to have a minimum of 5 members on the committee (President, Secretary, Treasurer and two others), but we like to have others on the committee in an *ex-officio* capacity. So, even if you do not wish to hold a formal position on the committee, we would very much like to have other volunteers on it. Please let David Hennessey or me know if you would be willing to serve on the committee (our contact details are on page 1 of the newsletter).

John McWilliam
President

Previous meetings

July 2017 General Meeting

Our speaker in April was Dr Paul Craft (Clinical Director, Canberra Region Cancer Centre Hospital, Senior Staff Specialist in Medical Oncology and Associate Professor ANU, Canberra). Dr Craft outlined the general principle of cancer cell growth (i.e uncontrolled growth of previously normal cells) and how this related to prostate cancer (PCa) in men.

Dr Paul Craft, speaking at our meeting

Among the many points Dr Craft made in his presentation were:

- PCa is the 6th most common cancer in the world and the risk for men >75 years is 1 in 8. PCa has the highest incidence of male cancer diagnosis in the ACT where there are 186 cases per annum and 142 deaths. In the ACT, the Pca death rate is fourth, behind lung, colorectal and breast cancers.

- In Australia the death rate from PCa has decreased slowly since 1970 and, despite more diagnoses, the mortality:diagnosis ratio has decreased markedly.

- The risk factors for PCa are: age, obesity, alcohol, dietary factors and heredity factors. However, an effective exercise program can reduce many of the factors leading to PCa by lowering the body hormone IGF-1 (insulin-like growth factor 1) thereby effectively "starving" the cells of their growth.

- Cancer cells require their own blood supply, which normal 'adult' cells do not (i.e neo-angiogenesis) and they become metastatic by firstly invading the lymphatic system. PCa cells 'live' by signalling from testosterone, controlled by the hypothalamus-pituitary axis. With

testosterone, the cells can survive outside the prostate.

Treatments being studied to treat PCa include:

- hormone treatment;
- chemotherapy;
- radionucleotide therapy;
- immunotherapy;
- PSA screening; and
- Specialist future studies.

The androgen depressing compound Abiraterone (which depresses testosterone from the Adrenal gland) is available through Medicare in Australia to men post chemotherapy. However, a very recent UK study indicates that Abiraterone-prednisolone is twice as effective (80% reduction in PSA compared to 40% with standard treatment) when given to men early in the treatment, rather than post-chemotherapy.

PET-CT scans for using the ^{68}Ga-ligand are being used for PSMA (prostate specific margin analysis). This ligand is a beta emitter which attaches to the PCa, allowing for detection and then radiation. A new approach being trialled is Lutetium-177 PSMA (LuPSMA) to deliver high doses of targeted radiation to sites of prostate cancer while sparing most normal tissues.

Immunotherapy treatment is quite advanced for Melanoma cancer suffers but there is more work required for this to be effective for PCa men. Government grants are directed at present for the melanoma studies.

Questions included:

Q1. Do we know the genetic susceptibility to fatal PCa?

A1. Yes, already we know that for some men there is a 25% risk of PCa. Knowing the genome of people raises the prospect of being able to determine the most appropriate treatment for each genome. The cost to karyotype is now down to around $1300 but interpreting the 'mass' of data is difficult.

Q2. How many types of PCa are there?

A2 There are a number of types, but 90% are of a single type, and there are two subtypes for which ADT is ineffective.

Q3. Can we distinguish aggressive from non-aggressive PCa?

A3. There have been continuing studies on doing this, but we still rely on the Gleeson score and grading to make the distinction.

Q4. What about the Polaris Pharmaceutical trials?

A4. This is a US based company that examines new drugs to treat cancer. One aspect of their work is to predict the reoccurrence of PCa but their work is in its early stages.

August 2017 Executive Committee Meeting

At its meeting on 2 August, the Executive Committee, among other things:

- received an update on the future of SHOUT and to a response to be provided to SHOUT on the options canvassed with the Group;
- considered arrangements for Group meetings for the remainder of 2017;
- agreed to call for nominations for executive committee positions for the coming year (to be considered at the Group's annual general meeting in September);
- noted that we were likely to be invited by Holy Family School Gowrie to be its charity at its Father's Day event on Friday, 1 September, and that wre will need to ask for volunteers for it; and
- noted with appreciation that we had received a donation of $500 from a Griffith, ACT resident.

The next meeting of the committee will be held on Wednesday, 6 September.

Future Group events

1 September: Call for volunteers to assist with our stall at the Holy Family School's Father's Day event. Responses **by 25 August** to John McWilliam at:

president@prostate-cancer-support-act.net.

20 September: Annual general meeting and round-table discussion on member experiences in prostate cancer treatment and recovery.

Nominations for the Executive Committee for 2017–18

Nominations are sought from members for the Executive Committee of the Group for 2017–18.

Under the Group's Constitution we are required to have at least five members on the Exectutice Committee—the President, the Secretary, the Treasurer and two other members. We can also appoint *ex officio* members.

We rely on the voluntary support of our members to continue our activities. If you are willing to take on a position on the committee, please complete the nomination form attached to this newsletter and return it to our Secretary, David Hennessey at: secretary@prostate-cancer-support-act.net

It would be helpful if nominations could be received as soon as you can, but they can be received up to the start of the AGM.

If you would like to discuss what participation on the committee would involve, please contact David Hennessy on (02) 6154 4274 or John McWilliam on 0416 008 299.

Future of SHOUT

A decision by the Government on future funding for SHOUT is expected by the end of August. We are hopeful that SHOUT will continue operating and that we will continue to be able to meet at Pearce.

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.

This month's PCFA *Community Digest* includes articles on:

- highlights from the 2017 ANZUP (Australia and New Zealand Urogenital and Prostate) Annual Scientific Meeting;
- side effects after treatment for localised prostate cancer; and
- one year of prostate cancer research blogs.

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.

With thanks to Don Bradfield for these summaries.

Comparisons of radical prostatectomy and active surveillance for treatment of prostate cancer

Active surveillance has become standard of care for low-risk prostate cancer in the United States. Recent articles from prospective, community-based registries have shown uptake of active surveillance skyrocketing to 40% to 50% for low-risk disease in the current decade, up from rates that historically rarely exceeded 10%. A growing body of evidence indicates that active surveillance can preserve quality of life without posing substantial short- to intermediate-term oncologic risk. Based on this evidence, a recent guideline endorsed by the American

Society of Clinical Oncology (ASCO) now states that surveillance is not merely an option for men with low-risk disease but rather is the preferred alternative for any clinically localized, Gleason 3 + 3 cancer.

There have recently been some studies published on this topic. Here we summarise some of those articles, which were also reported in 14 July edition of *Australian Doctor*. We have drawn on the reports in *Australian Doctor* in preparing these summaries.

Report title: Follow-up of prostectomy versus observation for early prostate cancer
Authors: Wilt TJ Jones KM, Barry MJ et al
Publication: New England Journal of Medicine
Date: 13 July 2017
View abstract at: http://tinyurl.com/ya65pz8n

Renal and Urology News (13 July 2017) contained a report by Natasha Persaud of a study in the *New England Journal of Medicine* that found that, for patients with non-agrressive early stage prostate cancer, active observation may be just as effective as radical prostatectomy in terms of survivability. This summary can be read at: http://tinyurl.com/yaxuo39**.**

This study—the PIVOT (Prostate Cancer Intervention versus Observation Trial)—involved a randomised group of 731 men with localised prostate cancer. Of these, 364 were assigned to have RP and 367 underwent observation. They were then followed up for 19.5 years.

The study found that there were no significant differences in mortality between men who underwent surgery for localised prostate cancer and those who were treated with observation only. During the 19.5 years of follow-up, deaths due to prostate cancer occurred in 7.4% of men who had surgery and 11.4% of men who had observation. But for men with low-risk disease, who accounted for most cases, the absolute difference in mortality was less than 1%.

Lower all-cause mortality was found for men with intermediate-risk prostate cancer treated with RP (59.7% vs 74.2%), but not for those with low-risk or high-risk disease.

"It would be a disservice to dismiss surgery as a viable option for patients with intermediate-risk prostate cancer," co-author Dr Gerald L Andriole MD, Director of Washington University's Division of Urologic Surgery, said in a news release issued by his university. "For these patients, and for some men with high-risk prostate cancer, surgery is often beneficial, as are other treatments such as radiation."

Men who opted for prostatectomy had high rates of adverse effects such as incontinence and erectile and sexual dysfunction compared with observation.

"This study confirms that aggressive treatment usually is not necessary," Dr Andriole said. "We hope the findings will steer doctors away from recommending surgery or radiation to their patients with nonaggressive early-stage prostate cancer and patients away from thinking it's necessary."

Professor Mark Frydenberg, a urologist at Monash Medical Centre, Melbourne, was reported in the Australian Doctor review as saying that the management of prostate cancer had changed in the 20 years of the PIVOT study, and there was now more emphasis on observation rather than surgery.

"Active surveillance is becoming far more popular now and really becoming the standard of care for low-risk disease," he said.

Victorian data showed that around 80-90% of men with low-risk disease were now managed by active surveillance or observation, compared with 20-30% five years ago, he added.

Report title: Adverse pathologic findings for men electing immediate radical prostatectomy—defining a favourable intermediate-risk group
Authors: Hiten D Patel, MD, MPD, Jeffrey J Tosoian, MD, MPH, H Ballentine Carter, MD, et al
Publication: JAMA Oncology
Date: 13 July 2017
View at: http://tinyurl.com/y8kurjym

Active surveillance is currently recommended to patients with very-low-risk (VLR) and low-

risk (LR) prostate cancer. But more recent clinical guidelines have suggested that active surveillance also may be considered in men with low-volume intermediate-risk (LVIR) disease, a *decision that remains controversial*.

In active surveillance, patients do not undergo immediate radical treatment, which includes surgery or radiation therapy. Instead, they are monitored carefully over time for signs of disease progression.

Now, researchers at Johns Hopkins University School of Medicine performed a retrospective cohort study and compared the rate of signs of disease among VLR, LR, and LVIR men undergoing radical prostatectomy and evaluated retrospectively at Johns Hopkins Hospital.

Specifically, researchers asked, "Is there a subset of men with Gleason 3+4=7 intermediate-risk prostate cancer with favorable characteristics to minimise risk of adverse pathologic findings at surgery?"

During the time frame, Johns Hopkins was following 2,052 men with VLR and LR prostate cancer on active surveillance — but their active surveillance cohort excluded any men with LVIR prostate cancer.

The rates of adverse pathological findings were:

- 60/1,264 (4.7 percent) among the men with VLR prostate cancer;
- 280/4,849 (5.8 percent) among the men with LR prostate cancer; and
- 150/608 (24.7 percent) among the men with LVIR prostate cancer.

This means that men with LVIR had almost a 4.5-fold increase in the risk of adverse pathologic findings compared with men who had LR disease, and a 5.2-fold increase compared with men with VLR disease.

"Our observations suggest use of active surveillance may place similar men with Gleason 3+4=7 (GG2) cancer at risk of adverse outcomes that could have potentially been avoided with immediate intervention. This study could have important implications for men with LVIR prostate cancer electing [active surveillance], and further study is clearly needed," researchers wrote.

In an attempt to stratify the risk of the LVIR group, researchers analysed both preoperative clinical and pathologic criteria. However, none of these could define a favorable subgroup within the LVIR group with a rate of adverse pathologic findings as low as those of VLR and LR patients.

Overall, these results do not support the presence of a 'favorable' subgroup among men with intermediate-risk prostate cancer.

"Men with Gleason 3+4=7 prostate cancer otherwise eligible for curative intervention should be fully informed as to the avoidable risk associated with use of active surveillance," the study concluded.

A critique of this report was included in *The "New" Prostate Cancer Infolink* of 22 July 2017. It can be found at: http://tinyurl.com/yathoz3q

Some points from this critique are included below.

The authors are also very careful to point out two things that did not happen 'routinely enough' among this cohort of patients it studies — magnetic resonance imaging (MRI) and molecular/genetic/genomic testing.

In addition, there is no suggestion in this paper that any of the 6,721 patients underwent a repeat biopsy prior to their surgery to try to confirm the presence or absence of Gleason 4 + 3 = 7 tissue *(*something that is strongly recommended for all men who enter a well-conducted active surveillance protocol, and ideally by use of an MRI- or MRI/TRUS fusion-guided biopsy).

The "New" Prostate Cancer Infolink noted that any man with low volume, intermediate-risk prostate cancer, including a Gleason score of 3 + 4 = 7, who decides that he wants to go on active surveillance as a first-line management option should be thoroughly informed that his risk for progressive disease is notably higher than that of a man with Gleason 3 + 3 = 6 disease. These should include at least two of the following three additional tests:

- a high-quality multiparametric MRI scan to look for any indication that there may be cancerous lesions that did not appear on the original diagnostic biopsy;

- a repeat biopsy under MRI- or MRI/TRUS fusion-guided biopsy to assure the physician and the patient that there is no evidence of Gleason 4 + 3 prostate cancer; and

- some form of molecular/genetic/genomic test to assess other types of risk for more aggressive forms of prostate cancer.

Another way to look at the data presented by Patel et al. is that *75.3 percent* of the men diagnosed with LVIR prostate cancer in this study *did not* have adverse pathological findings at radical prostatectomy.

Hopefully, the appropriate use of MRI scanning, repeat biopsies, and molecular/genetic/genomic testing can assist us to define such subsets of patients so that we can better inform LVIR patients whether they are or are not potentially good candidates for active surveillance.

At the end of the day, whether to treat or to monitor any form of localised prostate cancer remains the patient's, after a thorough discussion and a shared decision-making process between doctor and patient.

What Patel et al. do *not* state in this paper is that every man with a low volume, intermediate-risk prostate cancer and a Gleason score of 3 + 4 = 7 should be discouraged from considering active surveillance.

What they *are*, very appropriately, saying is that — based on this study — they cannot as yet define a 'favorable' subset of men who would be better candidates for active surveillance and that therefore all men with these characteristics who wish to consider active surveillance need to be well and thoroughly advised of the risks involved.

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.

Nomination for the Executive Committee

We, …… and
……. ,

being members of the Prostate Cancer Support Group (ACT Region), hereby nominate:

……
……

to be a member of the Executive Committee of the Group for 2017-18. I nominate this person for the following position (check box):

	President
	Secretary
	Treasurer
	Other position

Member 1's signature
Date:

Member 2's signature
Date:

Acceptance of nomination

I hereby accept this nomination.

Signature of member being nominated
Date:

Please send to secretary@prostate-cancer-support-act.net or hand to the AGM chair before the start of the AGM.