THE WALNUT

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Newsletter of the Prostate Cancer Support Group—ACT Region

Affiliated with the Prostate Cancer Foundation of Australia (PCFA)
Postal address: PO Box 650, Mawson ACT 2607
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Next monthly meeting

Our next monthly meeting will be on **Wednesday 21 February** at our usual location and time (see below).

Our speaker will be Dr Grant Buchanan, Registrar, Radiation Oncology at the Canberra Hospital. Dr Buchanan is a former cancer genetics scientist and head of laboratory at the University of Adelaide, and has been doing prostate cancer research since 1993. He has received both fellowships and grants from the Prostate Cancer foundation of Australia, ARC and NHMRC, and spoke twice a year to the PCFA support groups in SA for many years. In 2010 he was awarded PCFA's national young researcher of the year.

All are welcome to attend our regular monthly meetings and coffee mornings, including partners and carers. No notice is required – simply come along and introduce yourself, or contact one of the people listed on page 2 of this newsletter.

Meetings of our support group are held on the 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.

President's Message

Our first meeting of the year provided a good opportunity to meet three new members and for other members to provide updates on their prostate cancer treatment journey. We aim to provide support to men in their prostate cancer treatment journey and these discussions at our meetings, and the opportunity for more informal discussions at our coffee mornings, are good ways of doing this.

At our meeting, we had a very informative and useful presentation by member, Dr Don Bradfield, on developments in research into prostate cancer and the likely implications for changes in the treatment of it. I think that we all benefitted from this. Thanks, Don, for this great session.

We have two very informative meetings coming up. As shown opposite, Dr Grant Buchanan, who has a very interesting background, will be speaking at our February meeting. Then, in March (21 March) we will visit the John Curtin School of Medical Research at the Australian National University, where we we will hear about the research that the School is undertaking and have the opportunity to visit the laboratories. Both of these meetings should provide valuable insights, so make sure you don't miss them.

Please note that the next coffee morning is on Tuesday, 13 February (i.e.the second Tuesday of the month), not 6 February, as indicated in the January newsletter. I apologise for the error in the January newsletter.

We are looking for a member who would be prepared to help organise our meetings program. Please email me if you would be prepared to assist in this task. My email address is: president@prostate-cancer-support-act.net

John McWilliam

Appreciation

The Group recognises and expresses its appreciation for the support provided by: the PCFA, SHOUT staff, the Canberra Southern Cross Club, Holy Family School Gowrie, ACT Veterans' Hockey Association Inc, Paddywack Promotional Products, the Naval Association of Australia, German Auto Day and the many individuals who have assisted in our fund-raising activities.

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 to contact you. After hours, please call 0490 784 151.

If you would like immediate advice, support or assistance, please contact one of the following two 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

Next coffee morning

10:00 am, Tuesday, 13 February, Canberra Southern Cross Club, Jamison.

PCFA patient guide

This useful patient guide can be downloaded at:
https://tinyurl.com/y75p72nz

Our January Meeting

There were 19 who attended our January meeting – a good attendance for the first meeting of the year.

Member, Dr Don Bradfield, outlined recent developments in research into prostate cancer and the potential implications for the treatment of it.

Don reminded us that the Prostate Specific Antigen (PSA) test is a measure of a substance from the prostate gland and, while it increases gradually with age, it is affected by many factors, including cancer and infections. Hence, it is only a guide in the diagnosis of prostate cancer and there have been continuing efforts to improve its usefulness. To this end, in the USA there has been research examining IsoPSA (isoforms of the PSA). Recent research findings indicate that it has the potential to reduce the need for a biopsy by 50% over conventional PSA readings.

The Prostate Health Index (PHI) is another measure that is being used to help diagnose the severity of a prostate cancer. It is calculated from the IsoPSA + PSA + freePSA, and this index can reduce the need for a biopsy. The current screening system uses just PSA and freePSA. The abnormal range of PSA is age related and a freePSA ratio of <10 % is more likely to be a malignancy while freePSA of >25% is more likely to be benign. This obviously gave a very unreliable estimate.

MRIs are now used regularly to assist in a biopsy. The MRIs help to identify the location of a possible cancer and to guide the biopsy. This is referred to as 'fusion biopsy'.

Previously only available for Canberra residents in Sydney and Melbourne, PSMA-PET scans are now available in Canberra. These help to identify any secondaries in the lymph nodes or hard tissues. PSMA-PET scans are mainly used after a prostatectomy where PSA readings start to increase again, but can in some instances also be used before treatment to check on possible spread of the cancer.

Salvage radiotherapy has been done in the past to irradiate the area of the prostate when the PSA rises after surgery. A PET-CT scan is now used increasingly to locate secondaries in the hard tissues and to be targeted with radiotherapy.

'Watchful Waiting' is the advice now offered after ultrasound scans that determine the size of the prostate and an MRI to indicate cancer cells. A biopsy normally

follows to establish a Gleeson score. The need for treatment is based on a combination of the PSA ,Gleason score and MRI results. Waiting may be advised if there is a low Gleason score on biopsy and low PSA. Radiotherapy is also a preferred treatment for some patients, rather than a prostatectomy, and men who have been diagnosed with prostate cancer should investigate this before deciding on their preferred treatment.

Genetics or inheritance is getting increasing attention in the USA but the cost associated with determining the likelihood of 'inheriting' lethal prostate cancer are not yet justified owing to a lack of precision. Don reminded us that both a mother (BRAC1 and 2 mutation) and father's genes have to be considered owing to the association of the genes in prostate cancer.

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 .

The February PCFA *Community Digest* includes articles on:

- new Australian research targets neuroendocrine prostate tumours;
- how prostate cancer scientists are taking advantage of breast cancer research;
- exercise as medicine for men with advanced prostate cancer;
- can aspirin prevent prostate cancer? and
- top ten prostate cancer research stories from 2017.

TheraP trial

In July 2017 PCFA and ANZUP launched the first Australian trial of a ground-breaking nuclear medicine treatment (Lutetium – 177 PSMA radionuclide therapy) for men with advanced prostate cancer, the **TheraP Trial.** The trial's official name is 'A Trial of 177Lu-PSMA617 Theranostic Versus Cabazitaxel in Progressive Metastatic Castration Resistant Prostate Cancer'.

This trial is now open at Peter MacCallum Cancer Centre in Melbourne with additional sites to open in the following months.

This treatment won't be suitable for all those who have prostate cancer. As such, for further details and advice regarding eligibility, please ask anyone interested to print off the trial and contact details from the Australian and New Zealand Clinical Trials Registry (https://tinyurl.com/y7v68frp) and speak with their treating physician.

To learn more, please view the information page via ANZUP here: https://tinyurl.com/y99j4dq7.

Routine quality assurance trial

MyHealthTest Pty Ltd is conducting routine quality assurance trials to make its tests remain of the highest quality. It is looking for 30 male volunteers to participate in a routine quality assurance trial for our prostate test service.

Participation would involve taking a blood sample from your arm. It would take no more than 20 minutes of your time, and the company will reimburse you for any parking fees. At the conclusion of the trial, your results will be sent through to your GP with your consent.

Details of the next trial are:

- *Suitable Participants*: Males who are over the age of 50 and/or currently have prostatitis and/or currently have a known raised PSA level

- *Date*: Tuesday 13th March 2018 Trial Time: 8:00am - 11:00am
- *Location*: City, ACT
- *Contact*: sophia.mobbs@myhealthtest.com
- *Phone*: 02 6145 2147
- *Website*: www.myhealthtest.com.

Seeking prostate cancer patients and survivors for an online study

Queen's University, Ontario, Canada is conducting an online study investigating the experiences of prostate cancer patients, under the supervision Dr. Caroline Pukall in the Sexual Health Research Laboratory (SexLab). The SexLab is dedicated to understanding human sexuality and sexual health. If you would like to learn more about the SexLab and the research it does, please visit its website: www.sexlab.ca.

Participant criteria are:

- Diagnosed with non-metastatic prostate cancer within the past 5 years
- No other cancer diagnosis
- 18 years of age or older
- Fluent in English
- Access to the Internet.

For questions about the research, contact the SexLab at: sex.lab@queensu.ca.

Borrowing items from the library

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 or finding out more about our collection can contact U.N. Bhati, email: librarian@prostate-cancer-support-act.net

Articles and reports of interest

The following articles which 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 and Mike Boesen for their assistance with this segment.

Obesity makes prostate cancer recurrence after surgery more likely, study reports

Recurrence of prostate cancer after surgery is more likely in men who are obese or who have a metabolic condition. This is according to the American Association for Cancer Research, which issued the following press release (26 January 2018, https://tinyurl.com/y7faxzqb).

Among men with prostate cancer who underwent radical prostatectomy (RP), those who were obese had a higher risk of biochemical recurrence, according to data presented at the American Association for Cancer Research Special Conference Obesity and Cancer: Mechanisms Underlying Etiology and Outcomes, held Jan. 27-30.

Biochemical recurrence was defined as two consecutive prostate-specific antigen (PSA) measurements of ≥ 0.2 ng/mL after prostatectomy, which is indicative of recurrent prostate cancer.

"Obesity and metabolic syndrome have become increasingly widespread in our society," said Arash Samiei, MD, basic scientist and clinical researcher at the Department of Urology at the Allegheny Health Network in Pittsburgh. "Prostate cancer is the most common cancer in men, and up to 30 percent of patients will develop recurrence after RP. We wanted to investigate the association between obesity and metabolic syndrome with the oncological outcome following prostate removal."

Samiei explained that previous studies linking high body mass index (BMI) and metabolic syndrome to increased risk of recurrence following RP have been controversial. To build upon previous research, Samiei and colleagues performed a large study with long-term follow-up to conduct a more comprehensive analysis.

Samiei and colleagues conducted a retrospective study of all RPs (1,100 surgeries) performed by two surgeons at Allegheny General Hospital in Pittsburgh between 2003 and 2013. They analyzed Gleason score, pathologic stage, pre-operative PSA, biochemical recurrence time, surgical margin status, and metabolic factors, such as fasting glucose, triglycerides, cholesterol levels, including HDL, pre-operative BMI, and blood pressure.

Patients were categorized as having low-, intermediate-, or high-risk prostate cancer based on pathological staging and grading of the disease. Metabolic syndrome positivity was determined using the World Health Organization (WHO) classification, where at least three out of the following five factors are simultaneously present in an individual - insulin resistance or type 2 diabetes, obesity, high cholesterol or low HDL levels, high triglycerides, and hypertension. The average age of the patient at diagnosis was 60 years, and the average follow-up time was 48 months.

Among the patients studied, 34 percent were obese, as defined by BMI, and 19 percent had metabolic syndrome.

Samiei and colleagues found a higher percentage of obese patients in the high-risk group (41.2 percent of high-risk patients) compared to obese patients in the low/intermediate group (32 percent of low/intermediate risk patients). Additionally, biochemical recurrence was higher in patients with BMI ≥ 30 (32.4 percent) compared to patients with BMI <30 (16.9 percent). Finally, patients with metabolic syndrome had more than four-fold increased risk of biochemical recurrence compared to those without metabolic syndrome.

"Our study indicates that prostate cancer patients who are obese or have metabolic syndrome undergoing RP may have a higher chance for recurrence of the disease, and these individuals should have more focused follow-up care," said Samiei. "By preventing metabolic syndrome, men with prostate cancer may have a higher chance of a favorable oncological outcome following surgery."

Samiei noted that because this was an observational, retrospective study, future work should include the design of large, multi-center prospective studies.

This study was sponsored by the Western Pennsylvania Prostate Cancer Foundation. Samiei declares no conflicts of interest.

Low PSA on ADT remains prognostic in new treatment era

Reported in:	Medscape, 23 Jan 2018, Nick Mulcahy https://tinyurl.com/y97tsl9w
Original article:	Seven-Month Prostate-Specific Antigen Is Prognostic in Metastatic Hormone-Sensitive Prostate Cancer Treated With Androgen Deprivation With or Without Docetaxel
Authors:	Lauren C. Harshman, Yu-Hui Chen, Glenn Liu, Michael A. Carducci, David Jarrard, Robert Dreicer, Noah Hahn, Jorge A. Garcia, Maha Hussain, Daniel Shevrin, Mario Eisenberger, Manish Kohli, Elizabeth R. Plimack, Matthew Cooney, Nicholas J. Vogelzang, Joel Picus, Robert Dipaola, Christopher J. Sweeney, and on behalf of the ECOG-ACRIN 3805 Investigators
Journal:	Journal of Medical Oncology, 2018 36:4, 376-382
Abstract:	https://tinyurl.com/ya9clsat

A low prostate specific antigen (PSA) value continues to be a helpful prognostic marker in the setting of hormone sensitive metastatic prostate cancer, even as standard treatment evolves.

The finding comes from a retrospective analysis published online December 20, 2017, in the Journal of Clinical Oncology .

Among oncologists and urologists, it is well known that a PSA level of 0.2 ng/mL or less in these men at 7 months after the initiation of androgen deprivation therapy (ADT) portends a significantly longer survival than seen in men with PSA values above this cut-off point.

But that insight comes from a study published more than 10 years ago, the Southwest Oncology Group 9346 trial (J ClinOncol. 2006;24:39843990). At that time, ADT alone was the mainstay of treatment. But times and treatments change.

Now, thanks to findings from the more recent CHAARTED and STAMPEDE trials, many of these patients receive chemotherapy with Docetaxel in addition to ADT, especially if they have high volume metastatic disease. Both of these major trials showed significantly improved overall survival when chemotherapy was added to androgen blockade in advanced prostate cancer.

But it has not been known, in the current treatment era, whether the PSA biomarker remained prognostic when Docetaxel was added to ADT. So the CHAARTED investigators performed a retrospective 'landmark survival analysis' at 7 months using the database from their trial.

They conclude that 'PSA ≤ 0.2 ng/dL at 7 months is prognostic for longer overall survival with ADT for metastatic hormone sensitive prostate cancer irrespective of Docetaxel administration.'

The addition of Docetaxel increased the likelihood of achieving a PSA level of 0.2 ng/dL or less at 7 months (45.3% vs 28.8% of patients receiving ADT alone).

However, the patients who had the best median overall survival in the study (72.8 months) were those receiving ADT alone who achieved a 7 month PSA level of 0.2 ng/dL or less. (These men were also more likely to have low-volume disease, at 56.7%).

Dr Harshman and Dr Sweeney pointed out that the timing of receipt of Docetaxel was variable in the study. Notably, they also observed that, "Getting Docetaxel around the time of ADT initiation increased the chances of achieving this good prognostic feature, and there was evidence patients may have been more likely to achieve this endpoint, the closer the Docetaxel was given to the ADT start."

However, the pair cautioned clinicians not to make too much of the new findings in terms of making upfront treatment decisions.

"While intriguing, given the study's retrospective nature, clinicians should not make treatment decisions based on the PSA level at 7 months (eg, defer adding Docetaxel based on the 7 month PSA level)," they said.

The Dana-Farber–based investigators also said that their results raise other questions about managing these patients.

"Our results are prompting many questions about whether these patients would benefit from therapy intensification prior to PSA or radiologic progression with the newer androgen-receptor targeted agents," they said. These newer agents include Abiraterone acetate (Zytiga, Janssen) and Enzalutamide (Xtandi, Astellas).

Is it safe to avoid biopsy in men with elevated PSA?

Article:	Is It Safe to Avoid Biopsy in Men With Elevated PSA?
Authors:	Jonathan B. Bloom, MD, Graham R. Hale, BS, Samuel A. Gold, BA, and 6 others
Journal:	Renal and Urology News
Date:	9 January 2018
View article at:	https://tinyurl.com/yagqjw97

Prostate specific antigen (PSA) screening was widely adopted almost 30 years ago, and while it has benefited many men, it still has inherent drawbacks (such as, limitations in sensitivity leading to unnecessary prostate biopsies and the detection of clinically insignificant prostate cancer.

Multiparametric magnetic resonance imaging (mpMRI) is an additional test that is now incorporated into the workup of patients with elevated PSA to not only rule out clinically significant disease and thus avoiding biopsy, but also to guide biopsies toward lesions, enhancing biopsy effectiveness and increasing the detection rate of clinically significant disease. However, mpMRIs also have some limitations, such as difficulty visualising small tumours (<0.5 mL) and frequently underestimating the size of lesions.

This article provides a useful review of this topic. It summarises its findings, as follows:

Although experts already recommend mpMRI for patients with a continued suspicion of cancer and a previous negative biopsy, there appear to be tremendous benefits associated with incorporating mpMRI into PSA screening for biopsy-naïve patients. At the same time, urologists will avoid over-diagnosing and treatment of low-grade PCa and will also avoid procedural complications by reducing TRUS biopsies. The results of the PROMIS trial show that mpMRI significantly outperforms systematic biopsies in the ability to rule out clinically significant disease. Upfront mpMRI not only can rule out high-grade disease in the majority of men and spare them unnecessary biopsies, but men with evidence of PCa can undergo targeted MRI/US fusion biopsy with better accuracy than standard TRUS. The argument against upfront mpMRI has always centered on cost. However, after factoring in the cost of missed high-grade disease, multiple modeling studies have now shown that when adjusting for quality of life, upfront mpMRI is more cost-effective. These studies demonstrate the supporting evidence for incorporating mpMRI into the screening protocol for patients with an elevated PSA or suspicion for PCa for better diagnosis both before and during a targeted biopsy. Negative mpMRIs should discourage prostate biopsy due to the low yield for significant disease and to avoid the increasing rate of infectious complications.

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 us an email through the form here:

http://tinyurl.com/ybkxnlg4.

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.