THE WALNUT

JULY 2018

Newsletter of the Prostate Cancer Support Group—ACT Region

Affiliated with the Prostate Cancer Foundation of Australia (PCFA)
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Next monthly meeting

Our next monthly meeting will be held on **Wednesday 18 July 2018**.

Our guest speaker on 18 July is Dr Muhammad Kahloon of the Capital Urology Centre. Dr Kahloon is a Fellow of the Royal Australasian College of Surgeons (FRACS) and member of the Urological Society of Australia & New Zealand (USANZ) and the Australian Medical Association (AMA). He travels overseas regularly to provide medical care to charitable organisations in numerous developing countries. He is one of only a few specialists in Canberra trained in the use of the Da Vinci robotic system.

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.

Next coffee morning

10:00 am, Tuesday 14 August, Canberra Southern Cross Club, Jamison.

Coffee mornings are held at 10:00 am on the second Tuesday of each month and alternate between the Woden and Jamison venues of the Canberra Southern Cross Club.

President's Message

This month Dr Mohammad Kahloon will speak to the Group for the first time. Please come along and make him welcome.

Unfortunately, Canberra Hospital specialist prostate cancer nurse, Allison Turner, was unable to attend our meeting in June because of sickness. However, I am pleased to say that she will be joining us for our August meeting.

While Allison was unable to attend the June meeting, we did have a very useful discussion on prostate health issues. I would like to thank Don Bradfield for his guidance in this discussion and the members who attended for helping to make this a very worthwhile evening.

Our coffee mornings continue to be very enjoyable occasions. If you have not yet attended one of these gatherings, come and join us.

In September we will have our annual general meeting, at which the executive committee for the coming year will be appointed. We need a minimum of five people on the executive, but we would like a few more, as it helps to spread the workload and provide a range of views. Being on the committee is not a particularly onerous task and I encourage members to consider nominating for a position on the committee. If any member is willing to assist in this way, please contact David Hennessy or me. Our contact details are on page 2 of the newsletter.

John McWilliam
President

Our June meeting

At our meeting on 20 June, we had a very useful discussion about many prostate health issues. We were helped in this discussion by member Dr Don Bradfield.

We welcomed one new member. He had a robotic, radical prostatectomy in October 2017 and his current PSA is still undetectable. However, he has had some difficulty in regaining continence. Similar to many patients, he is considerably out-of-pocket owing to the non-recognition by his medical insurance provider of robotic surgery of the prostate.

There was a general discussion about prostate health issues and development in the treatment of prostate cancer. Tony B referred to an article in the British Press of a laser treatment to 'destroy' cancer cells in the prostate which has been accepted as a procedure on the National Health Scheme (UK). David N said that this referred to Laser Ablation Therapy in the treatment of localised prostate cancer (i.e. cancer that has spread or metastasised no farther than the tissue surrounding the prostate gland). Don B said that he had seen only a few reports of this technique, but that it relies on multi-parametric MRI guidance of the laser to direct extreme temperatures only to the targeted cells. There are insufficient data for its success, but incontinence is not an outcome. Note: An article in the UK *Telegraph* on the approval of this technique can be accessed at: https://tinyurl.com/y8hb3qpp.

July Executive Committee meeting

The Executive Committee met on 4 July. The Committee, among other things:

- discussed possible government departments and other groups that we might be approach to ascertain whether they would be interested in the Prostate Cancer Support Group giving a presentation on prostate cancer awareness to their staff or members;
- discussed arrangements for future meetings, noting that Canberra Hospital prostate cancer specialist nurse, Allison Turner, has agreed to speak at our August meeting;
- agreed to engage an accountant to assist us in sorting out whether there is a need for the Group to have a new ABN; and
- agreed to put regular notices of meetings in the *Chronicle*.

Appreciation

The Group recognises and expresses its appreciation for the support provided by: the PCFA, SHOUT staff, staff of the Department of Human Services (Chief Technology Office), 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.

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

Volunteers needed

SHOUT is seeking volunteers to help manage its shopping centre display for an hour or two on Thursday 16 August. If you are able to help, please email SHOUT at admin@shout.org.au or call SHOUT on 02 6290 1984.

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.

The July edition of the *PCFA Online Community Digest* has articles on:

- the Bowery Series: a tragic lesson for today's researchers;
- Olaparib and Abiraterone work well together;
- hormone therapy for prostate cancer affects relationship intimacy; and
- active surveillance is not so active.

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

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 for his assistance with this segment.

[^{177}Lu]-PSMA-617 radionuclide treatment in patients with metastatic castration-resistant prostate cancer

Prof Michael S Hofman, MBBS et al, "[177Lu]-PSMA-617 radionuclide treatment in patients with metastatic castration-resistant prostate cancer (LuPSMA trial): a single-centre, single-arm, phase 2 study", *The Lancet–Oncology*, 8 May 2018, https://tinyurl.com/ya8qq292. [Subscription required to access the full article. This summary is taken from the report abstract.]

Progressive metastatic castration-resistant prostate cancer is a highly lethal disorder and new effective therapeutic agents that improve patient outcomes are urgently needed. Lutetium-177 [^{177}Lu]-PSMA-617, a radiolabelled small molecule, binds with high affinity to prostate-specific membrane antigen (PSMA) enabling beta particle therapy targeted to metastatic castration-resistant prostate cancer. The researchers aimed to investigate the safety, efficacy, and effect on quality of life of [^{177}Lu]-PSMA-617 in men with metastatic castration-resistant prostate cancer who progressed after standard treatments.

Between 26 August 2015 and 8 December 2016, 43 men from the Peter MacCallum Cancer Centre in Melbourne (aged 18 years and older) with metastatic castration-resistant prostate cancer and progressive disease after standard treatments were screened to identify 30 patients eligible for treatment. 26 (87%) had received at least one line of previous chemotherapy (80% Docetaxel and 47% Cabazitaxel) and 25 (83%) received prior Abiraterone acetate, Enzalutamide, or both. The mean administered radioactivity was 7·5 GBq per cycle.

17 (57%) of the 30 patients (95% CI 37–75) achieved a PSA decline of 50% or more. There were no treatment-related deaths. The most common toxic effects related to [^{177}Lu]-PSMA-617 were grade 1 dry mouth recorded in 26 (87%) patients, grade 1 and 2 transient nausea in 15

(50%), and G1–2 fatigue in 15 (50%). Grade 3 or 4 thrombocytopenia possibly attributed to [^{177}Lu]-PSMA-617 occurred in four (13%) patients. Objective response in nodal or visceral disease was reported in 14 (82%) of 17 patients with measurable disease. Clinically meaningful improvements in pain severity and interference scores were recorded at all timepoints. 11 (37%) patients experienced a ten point or more improvement in global health score by the second cycle of treatment.

The researchers concluded that radionuclide treatment with [^{177}Lu]-PSMA-617 has high response rates, low toxic effects and reduction of pain in men with metastatic castration-resistant prostate cancer who have progressed after conventional treatments. They indicated that the evidence supports the need for randomised controlled trials to further assess efficacy compared with current standards of care.

Outcomes and prognostic factors in men receiving ADT for prostate cancer recurrence after radical prostatectomy

Praful Ravi, R. Jeffrey Karnes, Laureano J. Rangel, Lance C. Pagliaro, "Outcomes and prognostic factors in men receiving ADT for prostate cancer recurrence after radical prostatectomy", *The Journal of Urology*, 4 July 2018, http://tinyurl.com/y89ksbrc. [Subscription required to access the full article. This summary is taken from the report abstract.]

The purpose of this study was to determine clinico-pathologic factors associated with early progression on androgen deprivation therapy (ADT), as well as cancer-specific survival and overall survival, and to assess whether certain prostate specific antigen (PSA) thresholds at ADT initiation are associated with poorer outcomes.

The study's conclusions were that a PSA doubling time of less than 3 months and PSA ≥5ng/ml are adverse prognostic factors for early progression and cancer specific survival in men initiating ADT for relapse after radical prostatectomy — with PSA ≥5ng/ml also predicting shorter overall survival. Longer doubling time and PSA <5ng/ml are associated with a lower risk and these men may not require immediate ADT.

Commenting on the study in *Practice Update* (http://tinyurl.com/y9k8e2bj), Maxwell V Meng MD FACS said that:

In this retrospective, single-institution series, all patients underwent radical prostatectomy and received ADT for biochemical recurrence. Similar to the findings of other reports, the authors concluded that salvage ADT may be of benefit in some men with more aggressive cancers, and identification may be based on PSA characteristics (doubling time <3 months and PSA >5 ng/mL at initiation).

Conversely, many men with less aggressive cancer do not benefit from ADT with respect to cancer-specific and overall survival, and they could be potentially spared (at least for some duration) the short- and long-term side effects of ADT.

Data from the CaPSURE prostate cancer registry also suggest no significant benefit of early ADT when using a time definition (within 3 months of biochemical recurrence) in men treated with both surgery and radiotherapy. However, in the studies to date, the devil is in the detail where granularity regarding duration of ADT, use of ultra-sensitive PSA, calculation of PSA doubling time, use of radiotherapy and ADT-related morbidity is lacking.

Ultimately, I suspect that there will be a very high-risk cohort for whom very early ADT will be warranted based on PSA thresholds lower than 0.2 ng/mL, likely in combination with other treatments; identification of these men using genomic signatures should be the goal. In addition, the availability of novel antiandrogens such as abiraterone, enzalutamide, and apalutamide will change the paradigm of timing and strategy of ADT in men with biochemical recurrence.

Trials on treatment of metastatic prostate cancer

The following are based on interviews with Dr Neeraj Agarwal by Dr Sumanta Kumar Pal at ASCO 2018, published in *Practice Update*, 11 June 2018.

Trials of PARP inhibitors in prostate cancer

http://tinyurl.com/yclygtjh

Many advanced prostate cancer patients have DNA repair gene mutations in their cells so that they cannot repair double strand breaks and are dependent on the repair of single strand break repair pathways, which are controlled by the

enzyme PARP (poly ADP repair polymerase). That makes developing PARP inhibitors a potential treatment pathway. PARP inhibitors have been developed for use in breast cancer .

Dr Agarwal is developing a trial involving patients with castrate resistant prostate cancer who harbour mutations in their DNA repair genes or their gene line. The trial is comparing Enzalutamide treatment with combined Enzalutamide treatment plus a PARP inhibitor. [Note: Enzalutamide, sold under the brand name Xtandi, is a nonsteroidal antiandrogen medication which is used in the treatment of prostate cancer.] The trial is for newly diagnosed castrate resistant patients with mutations in DNA repair genes.

Contemporary approaches to castration sensitive prostate cancer

http://tinyurl.com/ycuuk5lt

Five years ago we were discussing whether continuous or intermittent androgen deprivation therapy was better for patients with castration sensitive prostate cancer. In 2018 we have multiple trials such as the LATITUDE, STAMPEDE and CHAARTED studies, showing that there is improved survival with ADT combined with other agents, such as ADT with Abiraterone and ADT with Docitaxel. The question is which approach is better.

Docitaxel is associated with intra-venous chemotherapy. It is more intensive and the side effects may be more intensive and can be more acute or chronic, compared with Abiraterone, which is an oral pill that needs to be taken for a much longer period (about three years) and has fewer side effects (but some unique side effects, such as hypertension, such that patients with cardiovascular disease may not be good candidates for Abiraterone). [*Comment*: Prednisone is administered with Abiraterone, subjecting the patient to associated steroid side effects.]

Biomarkers , when they become available, may make it easier to predict which option will be better for an individual patient. Currently, the choice may be driven primarily by patient preference and the financial burden of treatments. There are now multiple clinical trials occurring, using agents such as Enzalutamide, Apalutamide and Daralutamide.

Dr Agarwal is conducting a trial using an agent similar to Abiraterone, but without the need for Prednisone. A number of drugs may be approved in the next few years.

One study is assessing whether Abiraterone should be combined with Docitaxel, but this would have a significant financial and side effect burden.

PCFA Facebook page — new drug to treat prostate cancer

Good news: a new drug is approved to treat prostate cancer in Australia. Apalutamide (Erlyand) can be prescribed to men with prostate cancer that has not spread (non-metastatic), but that continues to progress despite treatment with hormone therapy. A unique joint initiative between Australian and Canadian health regulators meant that this decision took less than half the time it normally takes for a new medicine to be approved in Australia. The supplier of the drug is working towards filing a submission to the Pharmaceutical Benefits Advisory Committee for the reimbursement of Apalutamide and intends to have the treatment available to eligible patients prior to then via private prescription.

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, we would 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 to our distribution list, 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.

John McWilliam

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 does 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 Group. 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 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.