THE WALNUT

OCTOBER 2018

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 held on **Wednesday 17 October 2018**.

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. Dr Buchanan spoke at our meeting in February, and it was clear that the meeting could have gone for twice as long as it did. It is therefore great that he has agreed to speak to us again.

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.

Next coffee morning

10:00 am, Tuesday 13 November at the Canberra Southern Cross Club, Woden.

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

In September, we held our Annual General Meeting. My thanks to the members of the committee who agreed to be nominated again to the committee for the coming year. I also welcome David Newman to the committee.

My thanks also to those who attended the AGM. There were 13 present, which is an increase on the number who attended in 2017. AGMs are never the most popular occasions, but they play an important role in the functioning of a group, such as ours.

We will be wanting other people to step up next year to allow some existing committee members to step down after a number of years on the committee. So, please give serious consideration to helping out in this way.

At our September meeting, Don Bradfield told us about a program called Navigate which is being run by the Peter MacCallum Cancer Centre in Melbourne. It is an information program for men who have been advised to undertake active surveillance (recommended for men with Gleason 6 and PSA (Prostate Specific Antigen) <10). This will be of interest to some members.

Those who enter active surveillance are eligible to enter the trial using their home computer, when they will be given information to help them make decisions in regard to treatment or continued active surveillance. An active surveillance program should be based on a minimum of three PSAs annually, with a further MRI (Magnetic Resonance Imaging) and a biopsy at a one-year follow-up.

Appreciation

The Group recognises and expresses its appreciation for the support provided by: the PCFA, SHOUT staff, staff of the Australian 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

In a one-year survey, only 17% of participants required further treatment as a result of being placed on active surveillance. After the initial one-year review, it appeared that those who did not revert to active treatment by the one-year mark had a very good chance of being able to continue the surveillance for an extended period, with a MRI and a further biopsy being advised if there was significant PSA change. In NSW and Victoria, an active surveillance approach has seen an increased participant rate from 9 per cent in 2003 to 42 per cent of suspected prostate cancer cases in 2018.

Click here for more information on the trial.

John McWilliam
President

October Executive Committee meeting

The Executive Committee met on 10 October for the first time by Skype. The Committee, among other things:

- agreed on steps to notify Access Canberra of the new committee members following the AGM in September;
- agreed to engage an accountant to resolve possible issues with the Group's ABN;
- noted that we have been invited to attend a short prostate awareness event at the Department of Defence on 19 November and agreed that John McWilliam, David Hennessy and Don Bradfield will attend the event;
- agreed that John McWilliam and Don Bradfield will represent the Group at the Southern Cross Club's grants presentation evening on Wednesday 24 October, when the Club will again be presenting the Group with a grant of $500;
- agreed not to participate in the mini Health Expo at Calvary Hospital this year;
- discussed arrangements for future meetings, noting that:
  - we have so far been unable to secure a speaker for our October meeting
  - we will have our usual end-of-year social gathering in November;
  - Paralympic athlete Michael Milton has agreed to speak at our February meeting; and
  - urologist Dr Kieran Hart will speak at our March meeting; and
- acknowledged with thanks that Paddywack Promotional Products had donated new signs to the Group and agreed to send the company a 'Certificate of Appreciation'.

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

- early supper associated with lower risk of breast and prostate cancer;
- does hormone therapy make prostate cancer worse?
- a hydrogel spacer can improve bowel symptoms from prostate radiotherapy; and
- comparing robotic-assisted to open prostate surgery: 2-year outcomes.

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

Max Gardner Award

Nominations are now open for the 2018 Max Gardner Award.

The Max Gardner Award for Distinguished Service is a prestigious award presented by PCFA. It is awarded to an individual member of the Network who has made an outstanding and significant contribution to reducing the impact of prostate cancer on Australian men, their partners and families, recognising the diversity of the Australian community.

This award is a peer-based form of recognition for PCFA Network members who are currently an official Ambassador, in a Support Group Leader role or an active member of an affiliated support group.

Nominations need to be submitted on the nomination form by COB Friday December 7th 2018 to supportnetwork@pcfa.org.au or

Att: Network Support
Prostate Cancer Foundation of Australia
Level 5, 437 St Kilda Road, Melbourne VIC 3004

Click here for further information.

You may make a nomination individually or you may recommend that the Group nominate someone by emailing any committee member.

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.

Androgen Deprivation Therapy can make prostate cancer more aggressive, study finds

Rajeev Mishra et al, 'Stromal epigenetic alterations drive metabolic and neuroendocrine prostate cancer

reprogramming', Journal of Clinical Investigation., 2018;128(10):4472-4484, http://tinyurl.com/y9o7naq8.

While androgen deprivation therapy (ADT) is an important treatment for prostate cancer, this study has found that it sometimes promotes the transformation of prostate cancer cells into a more aggressive type, which is resistant to treatment. However, the findings also suggest that a simple blood test could help predict when ADT resistance would occur.

Prostate adenocarcinoma, the most common type of prostate cancer, generally responds well to ADT. The therapy aims to reduce levels of the male sex hormone androgen or stop it from stimulating tumour growth. However, certain patients develop resistance to the hormone therapy, which causes cancer to return or spread. Possible explanations for this include the expansion of a resistant cell population as other cells die and the support of tumour survival by cells from the tumour microenvironment.

Epigenetic changes—which are changes in gene expression rather than in the gene itself—in prostatic cancer-associated fibroblasts (CAFs) can be used to predict disease progression. CAFs are cells that are responsible for generating connective tissue and are able to induce tumour development.

A research team at Cedars-Sinai assessed ADT-related epigenetic changes in cells from the tumour's surrounding environment to understand how they could affect tumour growth and treatment resistance.

Using fibroblasts from prostate cancer patients and mouse prostates, researchers found that ADT changes the epigenetics of cells in the tumour environment, and the therapy's interaction with cancer cells led some adenocarcinoma cells to become neuroendocrine cancer cells, a rare type that appears in less than one per cent of prostate cancer patients.

By observing the interaction between CAFs and cancer cells, the team found that ADT caused CAFs to produce high levels of the amino acid glutamine. This rise in glutamine supported the high energy requirements of cancer cells, favouring their survival and proliferation. The team found that blocking the uptake of glutamine restored sensitivity to ADT in mice with castration-resistant prostate cancer.

"Our data suggested that plasma glutamine can be used as a prognostic marker following ADT response and development of resistance," the scientists wrote.

The study raises the possibility that a simple blood test measuring glutamine might be able to pinpoint when ADT is failing in a prostate cancer patient and even predict when therapy resistance will occur.

Comment by Don Bradfield:
This study is exploring the reason as to why some prostate cancers develop ADT resistance. Androgen deprivation treatment is the common management when there is evidence that the cancer has spread beyond the prostate itself. The study is suggesting that Glutamine testing may assist in managing ADT resistance but further research is needed in this regard.

Prostate cancer webinar sponsored by the Royal College of General Practitioners

The following are notes taken by Don Bradfield on a webinar on managing prostate cancer in general practice which took place on 16 September 2018. Don stresses that they are his notes and have not been checked for accuracy with the webinar organisers.

Optimal care pathways define best care practice for various tumour diagnoses. The aim is to raise the standard of care in primary care, noting that the risk of prostate cancer increases from the age of 50.

Prostate cancer is the most common cancer in men—estimated to be around 23 per cent of cancer diagnoses in 2018. However, there is a

95 per cent 5-year survival rate. At the end of 2013 there were 90,000 prostate cancer survivors.

RISK FACTORS

The risk of men getting prostate cancer increases with age, with a peak in diagnosis at age 65 related to testing. Risk increases from the age of 50 onwards and is higher for men with a family history of prostate cancer (especially if the man's father or brother has had prostate cancer) and for men of African descent.

Mutations in the BRCA1 or BRCA2 genes are known to be related to breast and ovarian cancer. There is also an association with Lynch syndrome, which is an inherited condition causing colonic polyposis and cancer.

PSA TESTING AND EARLY MANAGEMENT OF PROSTATE CANCER

The Cancer Council has released consensus guidelines on PSA testing.

There have been conflicting results from PSA screening trials. The US Prostate, Lung, Colorectal and Ovarian Screening Trial showed no difference between the control and prevention arms. However, a high degree of testing in control patients invalidated the survey.

The European Randomized Study of Screening for Prostate Cancer (ERPSC) trial showed PSA screening resulted in a 21% reduction in prostate cancer mortality over 13 years. The trial showed the number needed to be invited to be tested to avoid one death was 1056 at 11 years and 781 at 13 years . The number needed to detect a cancer were 37 at 11 years and 27 at 13 years.

All men should be offered the opportunity to discuss the benefits and potential harms of screening prior to PSA testing. The harm of PSA testing may outweigh the benefits, especially for patients over 70 whose general health indicates they may have a short life expectancy.

Testing in men of average risk

PSA testing is advised every two years for men between 50 and 69 years, with investigation threshold of PSA > 3 ng/ml.

- If a man has a raised PSA of 3 to 3.5, the test should be repeated within 3 months. Including free PSA, if the PSA level is above 5.5, then the patient should immediately be referred to a urologist.
- If test shows a PSA of 3 to 3.5 and the free-to-total ratio is <25 %, the patient should be referred to a urologist.

If 1000 patients are tested, this will result in 165 who will have a raised result and be referred for biopsy.

- 93 of the 165 will not have cancer and 35 of the 93 will need treatment for side effect of the biopsy.
- 72 of the165 will have cancer, of whom 25 will have a Gleason score of 6 or less and who will be offered active surveillance. Of these 18 will have no treatment but two will later be treated.
- 56 men will elect to have treatment. Of these 23 will have side effects at 12 months, such as erectile dysfunction, urinary problems or bowel side effects.
- 2 men will avoid presenting with metastatic disease as a result of screening and 1-2 deaths will be avoided from prostate cancer as a result.

A digital rectal examination has traditionally been offered. However, screening guidelines now indicate that this examination is insensitive in detecting early cancer. Nonetheless it can have some degree of sensitivity in asymptomatic men.

Testing if there is a family history of prostate cancer

If there is one first-degree relative under the age of 60 with prostate cancer, testing should be offered from the age of 45 and then every two years.

If there are two or more first-degree relatives with prostate cancer, testing is advised from the age 40 and then every two years.

SYMPTOMS

Most early prostate cancer is asymptomatic. Most lower urinary tract symptoms (LUTS)—loss of weight, nocturia and hesitancy—are an indicator for a digital rectal examination to detect a possible enlarged or malignant prostate, but generally LUTS do not indicate prostate cancer.

ACTIVE SURVEILLANCE

The previously mentioned 'Navigate' study at the Peter MacCallum Cancer Centre in Melbourne lists principles of active surveillance/avoidance of intervention FOR localised cancer without progression.

The use of active surveillance is increasing and is now widely accepted as a treatment option for some patients:

- for low risk cancers, active surveillance has increased from 6% to 40% since 2012;
- between 2009 and 2013, 37% of men with a Gleason score of 6 or PSA under 10 had a low risk and 8.9 % had an intermediate risk on active surveillance;
- between 2009 and 2013, at the one year mark 17% of patients on active surveillance will convert to intervention due to reclassification (usually with follow up biopsy)—about 85% stay on surveillance;
- in 2018 55% of patients who are low risk are now on surveillance and 15% of intermediate risk (3129 patients in 2018);
- after15 years, there is a 62% overall survival rate and 94% cancer specific survival; and
- after 15 years, 2.5% of patients, who were initially on active surveillance had metastatic disease, including 7 very low risk patients and there was 1.5 per cent mortality.

There are some concerns over monitoring. Active surveillance requires at least three PSA tests and at least one additional biopsy over two years. 75% of men do NOT meet this bar. This may be a failure on behalf of the clinician and patients in not arranging the necessary follow up.

A shared care model with nurses would help to provide better active surveillance.

DIAGNOSIS OF PROSTATE CANCER

Initial management of men with a raised PSA is now to investigate with a MRI and NOT a biopsy. The MRI is now rebatable if the MRI is ordered by a urologist.

MRIs would be better done on higher powered 3 TESLA magnets.

- Active surveillance protocols: PSA <10 Gleason 6 and <3 positive cores;
- Progression criteria—rising PSA and increase in Gleason score—indicates a possible need for the patient to come start treatment.
- If the MRI result is good at one year, further MRI tests can be stretched out, with interval PSAs.

Urologists are using MRI scans to avoid rebiopsy. There is some risk of missing reclassification if the MRI is used to monitor progress rather than a repeat biopsy.

Over 50% of biopsies are now transperineal, as they reach parts of the prostate that the transrectal misses, and has a much lower sepsis risk. A transrectal biopsy has a higher risk of infection and it may miss the anterior lobe and apex of the prostate.

There is almost a zero sepsis with transperineal biopses. Accuracy is better with 29% upgraded on a immediate repeat biopsy following a previous transrectal biopsy. A transperineal biopsy should be indicated for patients considering active surveillance.

SUPPORTIVE CARE RESOURCES

Live Lighter program: www.livelighter.com.au

The Cancer Council: 13 11 20. The Cancer Council's Optimal Care Pathways have quick guideline pathways listed.

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.