

Prostate Cancer Canada Network - NEWMARKET

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**A support group that provides understanding,
hope and information to prostate cancer patients and their families**

In our April 17 meeting, we have two speakers, Dr. Louis Fenkell and Dr. Charles Cho. from the Stronach Cancer Centre at Southlake Hospital. Their talks will focus on "Prostate cancer update 2014; the Cancer Care Ontario guidelines, and New and Noteworthy, Controversies." They also plan to talk about radiation and toxicities in the question/discussion period. Be sure to come and get answers to your questions.

Meeting Date: April 17th, 2014

**Place: Newmarket Seniors Meeting Place,
474 Davis Drive, Newmarket (Side Entrance)**

Time: 6:30 pm to 9:00 pm

Speakers: Dr. Louis Fenkell And Dr. Charles Cho

Subject: Prostate Cancer Update 2014

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The Newmarket Prostate Cancer Support Group does not recommend products, treatment modalities, medications, or physicians. All information is, however, freely shared.

Dr. Preiner, Urologist, Southlake Regional Health Centre

Subject: February 20th, 2014 meeting talk



Dr. Preiner started his talk with a basic Prostate Cancer background. This was very helpful for the new members to get a clear impression of what prostate cancer is and some of the medical and diagnostic

terms which confront us. It was also a very good refresher course for some of us who have been dealing with this for many years. He began with the comments that Prostate Cancer is the most common cancer in Canadian men. It's the second largest cause of male cancer deaths in Canada. There are 23,600 new cases per year in Canada and almost 4000 deaths per year. There is a 1 in 6 lifetime risk of diagnosis of prostate cancer



Your prostate is a gland that produces fluid that enriches and protects sperm. It is just below the bladder, above the urinary sphincter, in front of the rectum. The urethra passes through the prostate, and the nerves to the penis adjacent to the prostate.

In considering the risk factors of prostate cancer and its treatment, age, family history, ethnicity and lifestyle are very important factors.

How do we screen and identify it as Prostate Cancer?

First there is a Digital Rectal Exam (DRE), a favourite with all men and a PSA blood test. PSA is a glycoprotein produced primarily by prostate epithelial cells that line the ducts and acini of the prostate. Disruption of the normal prostate architecture causes blood levels to increase. This may be due to prostate cancer and/or: Benign Prostate Hyperplasia, also called BPH, which is a non-cancerous condition in which the prostate expands outward but at the same time pushes inward and compresses the urethra; prostatitis - an inflammation of the prostate; urethral instrumentation; or prostate biopsy.

Urologists follow the Canadian Urologic Association Guidelines for Prostate Cancer screening, (PSA and DRE) which allows the detection of potentially lethal cancer at a point in time when it is more likely to be curable. Unfortunately, this can come at the expense of some patients being treated when their cancer poses no threat to their life. Therefore, the harms and benefits of screening must be explained to each patient so they understand all the factors to be considered in the shared decision-making about screening. Screening should be offered to all men 50 years of age with at least a 10-year life expectancy.

If there is a higher risk of prostate cancer, such as family history of prostate cancer or if the patient is of African descent, screening should be offered at age 40 years. There may also be some benefit in offering a baseline PSA for men 40 to 49 years of age to establish future prostate cancer risk. Initial screening should include DRE and PSA.

Ontario Ministry of Health 2012 Guidelines say that the PSA determination should not be used as a population-wide mass screening test for the early detection of prostate cancer in asymptomatic males. However, a PSA determination is recommended for any man, with a life expectancy of ten years or more, found to have: a prostatic nodule on DRE; an abnormal-feeling prostate, focal lesion; discrete change either in texture, fullness or symmetry which provokes increased suspicion of prostate cancer; and when investigating a secondary carcinoma of unknown origin.

The use of a PSA test is also recommended for men with moderate or severe symptoms of prostatism in whom treatment is contemplated.

A serum PSA determination may be considered for any man over the age of 40 years with a life expectancy of 10 years or more, who has a higher risk of prostate cancer. Within the context of higher risk is included a family history (first degree relative) of prostate cancer or men of African ancestry.

U.S. Preventive Services Task Force (USPSTF) Recommendation Statement *Annals of Internal Medicine* (May 2012) reported that: PSA based screening prevents only 1 death per 1000 men screened and that screening can cause harm including pain, complications from biopsy, anxiety, and complications from treatment.

For men of any age, the USPSTF recommends that doctors and patients do not screen for prostate cancer because the potential benefits do not outweigh the harms

From 1986 to 2005, one million men in the U.S. received surgery, radiation or both, who would not have been treated without a PSA test. 5,000 died soon after surgery, 10,000 to 70,000 had serious complications,

200,000 to 300,000 suffered impotence, incontinence or both.

In the U.S. there is a trend toward inappropriate screening and over treatment. The Canadian solution is Active Surveillance to avoid un-necessary harm to patients with low risk disease (small volume, low grade tumours with low PSA). So a decreased number of men are being screened and treated. Will we see an increase in prostate cancer death as a result of this?

Dr Rob Nam, published his study on the Incidence of complications after Radical Prostatectomy or Radiation for Prostate Cancer in The Lancet, in January 17, 2014. It excluded urinary incontinence and erectile dysfunction. This was a population based cohort study using hospital data, physician billing codes and cancer registry data. It focussed on men treated with surgery or radiation for prostate cancer in Ontario from 2002 to 2009. It reviewed five endpoints: hospital admissions, urological, rectal or anal procedures, open surgical procedures and secondary cancers.

There were 32,465 patients included. The 5 year cumulative incidence was:

Admission to hospital 22%; Urologic procedure 32%; Rectal or anal procedure 14%; Open surgical procedure 1%; Second primary malignancy 3%

Age and co-morbidities at the time of initial treatment were strong predictors for a complication. The type of treatment was the strongest predictor. The need for urologic procedure was higher in the surgery group. All other complications were higher in the radiation group.

Problems: This was a cohort study and groups may not be similar. The surgery groups were followed by Urologists, therefore they were more likely to have urologic procedure. The radiation group would be followed by Radiation Oncologists, therefore they would be seen at a cancer centre and may be more likely to be screened for other cancers.



Dr. Priener reviewed the facts of the study: The most common predictor of whether men in the study needed another treatment was the age of the men at the time of their initial treatment for the prostate cancer and how healthy they were. So again, if they're older and sicker they are most likely to go into hospital with another problem. What's really surprising, as well, was that

the type of treatment was a strong predictor, in that your likelihood to need some sort of urologic procedure is higher in the surgery group. If someone comes in and

claims that they are waking up at night and they have a slow stream, those that are followed by urologists are most likely to have a cystoscopy, so that's not surprising. All of the complications were higher in the radiation group. That would be: a likelihood of needing admission to hospital; the need of a colonoscopy; likely to need a surgical procedure; or of developing a second primary cancer.

Again, given that this is a retrospective cohort study, in some ways there are some potential flaws. The groups may not be similar. Men treated with radiation tend to be older and sicker. The surgery group are followed by urologists and they are more likely to recommend a scope, if we sense that there's something not right. Radiation oncologists work in cancer centres, so those patients in the radiation group being followed up in the cancer centre, are more likely to be screened for secondary cancers. Whether it's a blood test to check for colon cancer or an annual chest X-ray to look for a shadow on your lung, which is potentially a source area as well. In some ways it doesn't make sense. They did find an increase of lung cancers in that group. If you're having radiation in your pelvis and the radiation is pretty well targeted, there's very little exposure to the surrounding structures. It kind of doesn't make sense that you would form cancers of the head and back and the chest.

Another thing that wasn't included in the study was the incidence of erectile dysfunction or incontinence after treatment and those are very common complications but they didn't look at that at all. The radiation specialists will argue that those issues are very important and should be considered. A lot of people have been asking about this study and it may be a source of worry for men and it may be an unnecessary worry. The way radiation works, it sort of chokes the blood supply to the tumour and chokes the oxygen deliverance by clipping the microscopic blood vessels and capillaries that feed the tumour. Over time this leads to scarring. When they try to focus the radiation just to the prostate, there's some exposure to the surrounding structure, like the bladder and occasionally we do see secondary cancers in that area. That's to be expected but it tends to be delayed 15 or 20 years later and this was a study that covered from 2002 to 2009.

Q. Recently the headlines in the papers were saying that radiation causes secondary cancers. Is this what they are talking about?

A. The press picks up on things that they can sensationalize and draw people's attention. Radiation is a good treatment and there are men for whom that is the right choice. This item in the press might be a source of unnecessary anxiety or stress for a lot of men who have chosen radiation and they think, "OMG, now I'm going to get some other cancer somewhere." and I don't know if that's an exact truth.

Q. Are you involved in hands-on surgery or are you more involved in robotics?

A. We've looked at all that and I'm a big fan of technology. Within my group, I'm the only one who does laproscopic surgery. I've done probably three or four hundred lap kidney operations and about 15 laproscopic prostate surgeries. What I found, for me is it was more difficult and longer hours and I didn't see that there was a huge benefit over open. I think there is more evidence now looking at robotic surgery that's it more glamorous but I don't know if the outcomes are really any better. They're probably close and again, the outcomes have more to do with the number of cases that the surgeon has done than anything else. If you're in a business centre where you're doing a lot of surgeries, you're going to have good outcomes. A surgeon in Hamilton has done probably 1500 laproscopic prostate surgeries, he's really slick. Here, we do about 70 a year, we assist each other, we find that that works for us. The incisions we make are getting smaller and smaller. We split the muscle, we don't cut it. It's a low abdominal incision versus multiple keyhole incisions in robotics. So I don't know if there's a huge benefit. Moving forward, I'm sure there will come a time where we're going to have to get a robot to stay in the game here at Southlake. It would cost 5 million dollars to just purchase the robot and run it for five years. The machine itself is 2 million and it takes another 3 million to service it for five years. With our health services being squeezed so much, it's hard to justify that kind of expenditure unless there's a clear overwhelming benefit in the results. If there was a huge improvement in the way we do things, one could argue that this is the way it should be done. The outcomes are pretty similar. If anything, there's more evidence right now that the outcomes may, in fact, be a little bit worse in terms of cancer control, in terms of potency, incontinence, etc. We don't want to be the first to jump on board and we don't want to be the last, so we're just going to wait and see how things play out.

Q. In the last six years, is the number of surgeries for prostate cancer less because of early detection?

A. I think, in the next few years, we're going to see there will be a decline. I think there's been a huge upswing in the number of men being treated because of the screening and now, with this negative press about PSA screening, fewer family doctors are doing it. I know anecdotally, from my own practice and urologists I've talked to, we're doing fewer surgeries. In part, perhaps more men are being treated with radiation. There are now more cancer centres in the province than before. There is a push towards putting men on surveillance. Men who we might have operated on ten years ago, now perhaps we're more likely to recommend that they do watchful waiting. Those are things that are having an

impact but I think screening is going to have a bigger influence on the number of surgeries done than anything else.

Q. I had open surgery but when you do laproscopic, you have a camera in there. Does that mean you can see better?

A. With laproscopic or robotic surgery, everything is magnified on the screen, so the theory is, it should be better. The open surgery is a tiny incision and we're operating down behind the pubic bone, so it's analogous to operating at the bottom of a Campbell's soup can. That's about the size of the incision and the prostate's sitting at the bottom. Again, in doing big volumes, and I must have done about 300 to 400 laproscopies, 25 a year for the last 12 years, the surgeries we're doing now, compared to when I finished my training in 2001, I think are much better. I recall routinely using two or three litres of blood on the surgery and big scars, right up above their belly button. Now it's a tiny cut and we only lose 200 to 300 cc on average. With open surgery, we have the advantage of the "surgeon's feel" when we cut the urethra and dissect the prostate from the rectum, it just sort of peels away. We can do that with the robotic instruments but we won't have that tactile sensation. The theory is that robotics should be better, the reality is that it's pretty close. If anything there is a quicker return to work and returning to your baseline activities should be quicker.

In response to a question about inducing an erection just before surgery in the hopes of improving erectile functioning after the operation, Dr. Preiner responded by saying: That makes sense. Unless the blood vessels in the penis are getting engorged, the tiny capillaries may shrink, and this is a way of stimulating blood flow to the penis. The hope is that the erections should be better, after the operation. There have been studies on the use of Cialis and Viagra. One in particular was where, after surgery, men took Viagra or a placebo once a day for a month, then neither group took anything for a year. A year later, the men who took Viagra regularly right after the surgery had better erections.

Responding to an inquiry about HIFU, (High Intensity Focussed Ultrasound) Dr. Preiner commented that it is recommended to be used only as part of a clinical trial at the present time. I believe that that technology is definitely the future. In the years to come, as we're better able to deliver energy, whether it's HIFU or microwave therapy or radiation or whatever, in a more precise manner, to target the cancer cells and spare all the other adjacent organs, technology will be at the forefront. The concept of hacking out somebody's "bits" for cancer, we're going to think that's barbaric 25 years from now. I don't think it's quite ready for prime time yet. But, it's coming.

March 20th Meeting Notes of Group Sessions

During this meeting, we broke up into several groups, according to the subjects the members wanted to discuss. Each group was chaired by members of the executive, who reported back to all present at the end of the meeting. Here's what they had to say.



Phil and Ulli's group: Our group was talking about radiation, primarily. It is really remarkable how much the technology has changed over the last few years. Some of us who had not chosen radiation might be in a different position to rethink that, these days, given the more precise nature of radiation and external beam therapy and so on. We had one member who was undecided about what to do and we spent a lot of time talking with him about the path that he might take. Another thing that was discussed is that a big part of the value of the group is the peer to peer talk that we get and we don't get enough of it really. Because there are other guys that are in the same boat as you are, when you come to these meetings, you get some of the nervousness out of the whole procedure and the facts start to appear and you can put yourself in a situation that makes more sense to you.



Frank and Mike's group: Our group really stayed on topic. We talked about hormone therapy pretty well all the way through the session. A lot of it was very interesting because of the different attitudes about hormone treatments. I think we kind of frightened every body in our group about the side effects that they might get. I would emphasize might, because in most cases it

doesn't happen. In most cases you can survive quite comfortably with hormone treatment and it doesn't really change your life that much. It was interesting to hear the different paths that we were taking to deal with it. Mike talked about his treatment which included a type of brachytherapy along with hormone therapy. His talk opened up a discussion with the rest of the group joining in with their journeys. We really enjoyed getting into each individual case and how they were coping with it. Glen talked about a lot of the treatments he was taking. His emphasis was more on more natural approaches, such as pomegranate juice and a few other things that he was taking to deal with it. It became a real open forum on how we were looking at our cancers and I was pleased with the fact that people were getting into it and not letting it take over their lives.



Jane's group: We talked about Prostate Cancer and how it was affecting us and our husbands and the rest of the family. We talked about the support group and different speakers coming in. We like the speakers that keep us more upbeat and not the ones that are thrilled when they can extend our husband's life for a few months longer. We liked a selection of topics such as nutrition, exercise, naturopathic and the information on prostate cancer. We talked a bit about diet, so we covered a lot of ground.

Walt wrapped up the meeting by asking: What about this session tonight? Is this something you'd like to see more of? In the Markham group they do it every other month,

The general consensus was that people enjoyed this kind of meeting and would like to do it certainly once and possibly twice a year.

