KELOWNA PROSTATE CANCER SUPPORT & AWARENESS GROUP NEWSLETTER

OKANAGAN PROSTATE RESOURCE CENTRE SOCIETY

Okanagan Prostate Resource Centre

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Our Prostate Cancer Support Group meeting was an extremely interesting and I think educational meeting for all those in attendance. We did something that we haven't done for quite a while and that was to have everyone in the room give their name, how their cancer was diagnosed and what type of treatment they had for their prostate cancer. Everyone in the room participated and it was extremely interesting to find out the different treatments that the men had to treat their prostate cancers. The treatments varied from surgery, to external beam radiotherapy, to low dose brachytherapy to high dose brachytherapy. A couple of men mentioned that in addition to the standard low dose brachytherapy and high dose brachytherapy it was also combined with an external beam radiation boost. It was also interesting to find out that the majority of the men present were sent to the urologists because of an elevated PSA reading and not for any other reason.

I mentioned that it would be nice if we were able to convince some of the local GPs to come out to our meetings and listen to our stories, maybe then they would have a different approach regarding the PSA.

How do you Develop Prostate Cancer?

The following information was obtained from the Internet and originated with *MedicineNet.com* with information from *UpToDate.com*

Doctor's Response -

The exact causes of prostate cancer are not known. Several risk factors for developing prostate cancer have been identified, but which of these risk factors cause a prostate cell to become cancerous is not fully known. For a cancer to develop, changes must occur in the chemicals
that make up the DNA, which makes up the genes in the cell. The genes control how the cell works, for example, how quickly the cell grows, divides into new cells, and dies, as well as correcting any mistakes that occur in the DNA of the cell to keep the cell working normally. Cancer occurs when certain genes that either control the growth or death of the cell are affected, which results in abnormal cell growth and/or death. Genes are inherited (passed on from parents to their children) and thus some changes in the genes (gene mutations) that increase the risk of developing cancer may be inherited. For prostate cancer, approximately 5%-10% of prostate cancers are due to inherited gene changes. Several inherited genes have been identified that increase the risk of prostate cancer including: RNASEL, BRCA1, and BRCA2, DNA mismatch genes and HoxB13. Gene changes may also be acquired (developed during the course of your life). These changes are not passed on to children. Such changes may occur when a cell is normally undergoing growth and division. It is thought that at times during normal cell growth, risk factors may affect the DNA of the cell.

Prostate Cancer Risk Factors –

Certain risk factors may predispose a person to prostate cancer. These include:

- **Age:** Sixty percent of cases prostate cancer arise in men over 65 years of age. The disease is rare in men under 40.

- **Race or Ethnicity:** African-American men and Jamaican men of African ancestry are diagnosed with prostate cancer more often than men of other races and ethnicities. Asian and Hispanic men are less likely to develop prostate cancer than are non-Hispanic white males.

- **Family History:** Prostate cancer can run in families. A man whose father or brother has had prostate cancer is twice as likely to develop the disease. If several family members have had prostate cancer, and particularly if it was found at a young age in those relatives, the risk may be even higher.

- **Nationality:** Prostate cancer is more common in North America, Europe (especially

northwestern countries in Europe), the Caribbean, and Australia. It is less common in Asia, Africa, and South and Central America. Multiple factors, such as **diet** and **lifestyle,** may account for this.

- **Genetic Factors:** Mutations in a portion of the DNA called the BRCA2 gene can increase a man's risk for getting prostate cancer, as well as other cancers. This same mutation in female family members may increase their risk of developing breast or ovarian cancer. However, very few cases of prostate cancer can be directly attributed to presently identifiable genetic changes.

- **Other Factors:** Diets high in red meats and fatty foods and low in fruits and vegetables appear to be associated with a higher risk of developing prostate cancer. **Obesity** is also linked to a higher risk of the disease.

Smoking, a history of sexually transmitted diseases, a history of prostatitis (inflammation of the prostate), and a history of vasectomy have NOT been proven to play a role in causing prostate cancer. The role of fish oil in risk of prostate cancer remains under investigation.

Analysis of Clinical Trials Concludes that PSA Screening Lowers Mortality –

The following is an edited version from an article by *Magdalena Kegel of Https://Prostatecancernewstoday* that appeared in the October 2017 Manitoba Prostate Cancer Support Group Newsletter.

Prostate cancer screening using Prostate-specific antigen (PSA) does reduce mortality in prostate cancer, according to a review that used a new approach to analyze data from large clinical trials.

The findings suggest that current recommendations, which advise against PSA-based screening, might need to be revised, researchers write in their report, which was published in the journal *Annals of Internal Medicine.*

Interestingly, the study "Reconciling the Effects of Screening on Prostate Cancer Mortality and the ERSPC [European Randomized Study of Screening for Prostate Cancer] and the PLCO [Prostate, Lung, Colorectal and Ovarian Cancer] Screening Trials" used the same source data that the U.S. Preventative Services Task Force (USPSTF) had employed to issue recommendations against screening.

The ERSPC trial reported a 21 percent drop in prostate cancer mortality with screening, while the PLCO trial found no difference.

But researchers from *Fred Hutchinson Cancer Research Center* in Seattle and the University of Michigan, among many others, noted that the studies differed in key factors, including study design and adherence.

For instance, the PLCO screened annually, while the ERSPC screened participants every two to four years. The PLCO also had a higher threshold for referring patients for a biopsy and stopped screening after six rounds, researchers said.

These and other factors made researchers conclude that the PLCO "compared the effects of an organized screening program versus opportunistic screening rather than screening versus no screening."

To overcome these differences, the research team built a mathematical model that took these differences in "screening intensity" into account.

Using the analysis, they discovered that the PLCO control group had been exposed to more intensive screening than controls used in the ERSPC study.

Their analysis further showed that when differences were taken into account there was no difference in the outcome of screening between the trials, which in fact, showed that screening was beneficial.

Screening was linked to a 7 percent to 9 percent decrease in risk for prostate cancer death for each year of the standardized screening measure.

This translated into estimates ranging between 25 percent and 31 percent lower risk of death in screened patients in the ERSPC study, and between 27 percent and 32 percent in the PLCO intervention group, when compared to no screening.

Researchers argued that their study overcame the limitations of traditional statistical analysis, and might act to compliment study results from the trial when the benefits and harms of screening are considered.

Editor's Note: We recently had a great discussion at the Kelowna Prostate Cancer Support Group that included how those present were originally diagnosed with their prostate cancer the vast majority indicated that they were sent to the urologist because of an elevated PSA reading. Also, following some discussion with a couple of the local urologists they indicated that they never receive a reading of no cancer following sending someone for a biopsy. The biopsies always come back positive for cancer.

WITT'S WIT (ON THE LIGHTER SIDE) –

A Few Short Snappers by Phillis Diller

I want my kids to have all the things I couldn't afford. Then I want to move in with them.

We spend the first twelve months of our children's lives teaching them to walk and talk and the next twelve years telling them to sit down and shut up.

The reason the golf pro tells you to keep your head down is so you can't see him laughing.

Sleep Disturbance in Men Receiving Androgen Deprivation Therapy for Prostate Cancer: The Role of Hot Flashes and Nocturia

The following information was published in Oct. 2017 by the *American Cancer Society*. The Authors of the article were *Brian Gonzalez PhD, Brent Small PhD, Mallory G. Cases MPH, CPH, Noelle L. Williams MD, Mayer Fishman MD, PhD, Paul B. Jacobsen PhD., and Heather S. L. Jim PhD.*

Abstract:

Background:

Patients with prostate cancer receiving androgen deprivation therapy (ADT) are at risk of sleep disturbance; however, to the authors' knowledge, the mechanisms by which ADT may affect sleep are not well understood. The current study compared objective and subjective sleep disturbance in ADT recipients and controls and examined whether sleep Disturbance in ADT recipients is attributable to the influence of ADT on hot flashes and nocturia.

Methods:

Patients with prostate cancer were assessed before or within 1 month after the initiation of ADT as well as 6 months and 12 months later (78) patients. Patients with prostate cancer were treated with prostatectomy only (99 patients) and men with no history of cancer (108 men) were assessed at similar intervals. Participants self-reported their sleep disturbance (Insomnia, Severity Index) and interference from hot flashes (Hot Flash Related Daily Interference Scale). One hundred participants also wore actigraphs for 3 days and the 6-month assessment to measure objective sleep disturbance and reported their nocturia frequency.

Results:

ADT recipients reported worse sleep disturbance, higher rates of clinically significant sleep disturbance and greater hot flash interference than controls. In cross section analyses among those with actigraphy data, ADT recipients had greater objective sleep disturbance and more episodes of nocturia. Cross-sectional mediation analyses demonstrated that the association between ADT and objectively measures sleep disturbance was partly attributable to nocturia and hot flashes.

Conclusions:

The results of the current study suggest that the association between ADT and sleep may be partly explained by nocturia and hot flash interference. Future studies should examine behavioral and pharmacologic interventions to address these symptoms among ADT recipients.

Editor's Note: *Nocturia* is the medical term for excessive urination at night. During sleep time, your body produces less urine that is more concentrated. This means that most people don't need to wake up during the night to urinate and can sleep uninterrupted for 6 to 8 hours.

B.C. Cancer Scientists Receive Millions to Develop Novel Cancer Therapies

The following information was received from the BC Cancer Agency on Nov. 8, 2017

BC Cancer scientists were recently awarded millions of dollars in infrastructure funding from the Canadian Foundation of Innovation to bring their world-leading research to the clinic.

The therapies will revolutionize treatment for hard- to-treat cancers such as pancreatic, prostate and lung among others.

BC recipients include Dr. Francois Benard, Dr. Brad Nelson and, through a project led by the Vancouver Prostate Centre and the University of British Columbia, Dr. Marcel Bally.

Dr. Benard's work in the production of rare isotopes for cancer therapy at TRIUMF – Canada's national laboratory for particle and nuclear physics and accelerator-based science located at UBC – will receive $3.95 million. Dr. Nelson's project, Engineering Preceision Immunotherapies for Cancer (EPIC), will receive $4 million. Dr. Cherksov's work will receive $9 million for Accelerated Drug Discovery Using Clinical Translation (ADDUCT), which is led by the Vancouver Prostate Centre.

The funds were announced on October 12 and come from the Canadian Foundation for Innovation through the Ministry of Science.

Both Drs. Francois Benard and Brad Nelson's research into rare isotopes and immunotherapy were originally supported donors to the BC Cancer Foundation and leveraged to develop the projects that received the grant funding from the Federal Government.

Generous support from donors at the BC Cancer Foundation is critical in leveraging competitive grants and moving transformational research projects that take place at BC Cancer from the lab to the clinic, bringing new hope to families across the province.

*The Kelowna Prostate Cancer Suppo*rt & Awareness Group would like to thank Janssen - manufacturer of Zytiga® - Abiraterone for their support in producing this newsletter.

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UP COMING MEETING DATES FOR 2017 & 2018 –

December 9th – January 13th – February 10th - March 11th – April 8th – May 13th

Meeting Location:

Our meetings will be taking place in the Harvest Room at the Trinity Baptist Church located at the corner of Springfield Rd. and Spall Rd. enter through the South Entrance. The meeting begins at 9:00A.M. The Harvest Room is located on the second floor and there is elevator access if required.