PCCN REGINA PROSTATE CANCER SUPPORT GROUP INC.
NEWSLETTER

The purpose of PCCN Regina is:

1. To increase awareness, knowledge and understanding about prostate cancer in the community we serve.

2. To arrange and conduct regular monthly meetings.

3. To provide education sessions and information to prostate cancer survivors, their families, friends, and the public.

4. To provide for sharing of experiences and concerns.

5. To provide counseling services these counseling services do not include recommendations for treatments, medicines or physicians.

6. To promote courage and hope.

7. To co-operate with other cancer agencies in the fight against cancer.

Our next meeting is on December 8.

Time:
Our meeting will be on Thursday December 8th 2016

The meeting will start at 7:00 p.m. and will end at 9:00 p.m.

Place:
Canadian Cancer Society building located at 1910 McIntyre St, Regina.

McIntyre St. is the next street East of Albert St. 1910 McIntyre is between Victoria Ave. and 12th Ave.

Meeting room is on the 2nd floor.

Free evening parking along McIntyre Street.

Visit our website!
www.pccnregina.ca

Our Mailing Address:

PCCN REGINA - PO Box 3726

REGINA, SK S4S 7K4

Please email us at pccn.regina@gmail.com if you have any questions.

Happy Holidays to Everyone from the Board of Directors – PCCN REGINA

Christmas is just around the corner and the start of the busy holiday season is upon us. As you reflect on the past year as a survivor, or for some it is just the beginning. Whatever your experience has been, take time to recognize the strength that you have inside of you, the family members and friends who have been by your side. While you celebrate the holidays this year, think about the little things that mean so much to you. What makes this time of year so meaningful to you? Maybe it is the importance of having family together, being part of your church choir to share the holiday carols, or just having family and friends around the table to share a meal and laughter together.

Steve and Lawrence attended the Yorkton Support Group meeting on Thursday November 17th

We were invited to speak to the Yorkton Support Group and share our journey; Steve's topic included an overview of the Prostate Patient Care Pathway and the role of the recently appointed Nurse Navigator. Steve also provided an overview of his own prostate cancer journey. The members in attendance appreciated the insight that both Steve and Lawrence provided during the table discussions.

December 8th and January 12th Meeting Presentations

The December 8th meeting will host Mr. Darin Anderson the Territorial Manager, Ostomy & Continence Care for Coloplast. Coloplast is one of the world's leading suppliers of intimate health care products. Mr. Anderson will be explaining and exhibiting products such as intermittent catheters, external condom catheters & leg bags. Questions and comments will be welcome.

The January 10th meeting will involve three of your local board members who attended the 4th Annual Urology Symposium, "Prostate Cancer: Survive & Thrive", at the Radisson Hotel in Saskatoon Nov. 5/16.

Gordon Kerfoot, Lawrence Ward, and Stan Hanoski will briefly outline the scheduled events of that day, including presenters, sponsors and networking opportunities.

"TrueNTH "Advance Care Planning Workbook Update

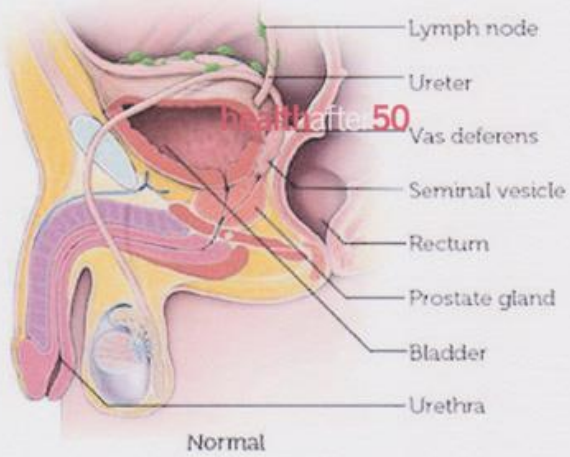
If you are working on the online Advance Care Planning workbook and require help or have a question feel free to call our contact: Chad Hammond at **800-668-2785 (ext 228)** or at **cHammond@chpca.net.**

Making Sense of Prostate Cancer Tumor Stages

FROM HealthAfter50

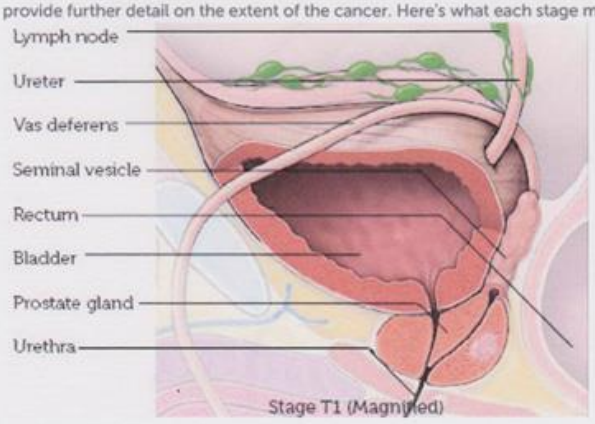
The TNM (tumor, nodes, metastasis) staging system is used to describe prostate cancer's clinical stage, or how far it has spread (metastasized), and helps determine appropriate treatment options.

PROSTATE



Normal

The staging system assigns a T number (T1 to T4) to describe the extent of the tumor as felt during a digital rectal exam. The N number (N0 to N1) indicates whether the cancer has spread to any lymph nodes, and the M number (M0 to M1) indicates the presence or absence of metastasis (spread to distant sites). The T and M designations are divided into subcategories (designated a, b, and c) that provide further detail on the extent of the cancer. Here's what each stage means:



Stage T1 (Magnified)

T1

The tumor cannot be felt during the digital rectal exam or seen with diagnostic imaging.

• **T1a**: Tumor found incidentally during surgery for benign prostatic hyperplasia (BPH) and is present in less than 5 percent of removed tissue. • **T1b**: Tumor found incidentally during BPH surgery but involves more than 5 percent of removed tissue. • **T1c**: Tumor found during needle biopsy for elevated prostate-specific antigen (PSA).

T2

The tumor can be felt during the digital rectal exam but is believed to be confined to the gland.

• **T2a**: Tumor involves one-half or less of one side of the prostate. • **T2b**: Tumor involves more than one-half of one side but not both sides. • **T2c**: Tumor involves both sides of the prostate.

T3

The tumor extends through the prostate capsule and may involve the seminal vesicles.

• **T3a**: Tumor extends through the capsule but does not involve the seminal vesicles. • **T3b**: Tumor has spread to the seminal vesicles.

T4

The tumor has invaded adjacent structures (other than the seminal vesicles), such as the bladder neck, rectum or pelvic wall.

N0

Cancer has not spread to any lymph nodes.

N1

Cancer has spread to one or more regional lymph nodes (nodes in the pelvic region).

M0

There is no distant metastasis.

M1

There is distant metastasis.

• **M1a**: Cancer has spread to distant lymph nodes. • **M1b**: Cancer has spread to the bones. • **M1c**: Cancer has spread to other organs, with or without bone involvement.

Androgen Deprivation Therapy for Prostate Cancer: What to Know

It may seem counterintuitive, but doctors sometimes ask patients to periodically skip doses of critical medications on purpose. Among other benefits, these so-called "drug holidays" can offer a break from a drug's side effects. And for some diseases like prostate cancer, an on-off treatment cycle may be used to boost a patient's response to a drug whose effectiveness has begun to wane.

This strategy is sometimes used to give prostate cancer patients who are undergoing hormone therapy extended breaks in their treatment regimens. Known as intermittent androgen deprivation (or intermittent androgen suppression), this treatment approach offers the prospect of a better quality of life, and though it is not curative, the hope of prolonged survival.

As a consequence, intermittent androgen deprivation has become increasingly popular since it was first described nearly 30 years ago. Despite its growing use, however, important questions remain. Can taking breaks from therapy truly extend a man's life, or might it actually cut his life short?

The Limits of Androgen Deprivation

To better appreciate the rationale for intermittent therapy, it helps to understand the role of androgens in prostate cancer development and the shortcomings of continuous androgen deprivation.

The growth of prostate tumors is stimulated by androgens, or male hormones. The two most common androgens are testosterone and dihydrotestosterone (DHT). Since the Nobel Prize-winning discovery that prostate tumors depend on these hormones to grow, reducing androgen levels or blocking the action of androgen has become the standard of care for men with cancer that has spread beyond the prostate to the bones and other organs.

There has also been increasing interest in using it in men whose prostate-specific antigen (PSA) level has begun to rise after treatment with surgery or radiation (biochemical recurrence). Biochemical recurrence is an early sign that the cancer has not been eradicated.

Today, androgen deprivation is usually achieved with drugs that block the signals for androgen production by the testicles (luteinizing hormone-releasing hormone agonists, LHRHa) or block their action (receptor blockers and antiandrogens), or drugs that directly block the synthesis of androgens. Therapy is typically administered on a daily basis, and initially it is very effective.

Unfortunately, however, its effects fade over a period of months or years as prostate cancer cells become capable of growing on their own without exposure to male hormones.

Furthermore, men on androgen deprivation therapy may experience a variety of adverse effects on their physical and mental health and quality of life, including hot flashes, ED, osteoporosis, muscle loss, weight gain, and depression.

Why Intermittent Therapy?

Interrupting treatment causes a man's testosterone level to rise, re-exposing the prostate tumor to androgens. Some research has suggested that this may trigger cellular changes that make the cancer vulnerable to hormone therapy for a longer time. Although intermittent androgen deprivation regimens vary, a typical cycle might be six to nine months on medication, then an equal period off treatment. A patient will be monitored closely during his break from therapy, however, and any signs that his cancer is worsening (such as rising PSA levels) would indicate the need to resume treatment.

To learn more about on-and-off hormonal treatment, doctors in Canada launched an international study comparing 690 men who underwent intermittent androgen deprivation with another 696 men who received standard continuous hormone treatment.

The men selected to participate had undergone radiation therapy for cancer that was localized—that is, confined to the prostate—but had experienced a biochemical recurrence. (Some of the men initially had surgery to remove their prostates, but required follow-up radiation therapy.)

None of the men reported having prostate cancer symptoms. For the study, most of the participants received injections of an LHRHa, plus an antiandrogen drug. Men in the intermittent group received therapy for eight months at a time before taking breaks.

The results of this study were published in 2012 in The New England Journal of Medicine. On the pressing question of survival time, the investigators found the two groups to be similar: The typical man receiving intermittent therapy lived 8.8 years, compared with 9.1 years in the continuous-therapy group, a small difference that may have occurred by chance.

A little more than a half year after publication of the Canadian study's findings, The New England Journal of Medicine published the results of another large trial comparing intermittent androgen deprivation and continuous therapy in prostate cancer patients. This study was overseen by doctors in the United States, but like the Canadian-led study it also involved a large number of men from clinics in several countries.

Included were 770 men who received intermittent therapy and 765 men who had continuous hormone treatment. However, in contrast to the Canadian investigation, the men in this study had more advanced cancer that had begun to metastasize, or spread, to the bones and other organs.

In the U.S.-led study, men who received continuous therapy lived longer than their counterparts in the intermittent therapy group: 5.8 years, compared to 5.1 years, a modest but significant difference. Further, the authors estimated that men in the intermittent therapy group were about 10 percent more likely to die than the continuously treated men, though they argue that the actual risk might really be twice that.

The authors of this study speculated that if the Canadian trial had lasted longer, it might also have found that men in the continuous therapy group lived longer. On the other hand, a 2013 review of nine trials found no overall difference in

survival rates between men receiving intermittent or continuous androgen deprivation for localized, advanced or metastatic prostate cancer.

Interestingly, data from this review show that while men who opt for intermittent therapy are more likely to die of prostate cancer, those numbers are offset by equally high rates of deaths from other causes in men who have continuous hormone treatment.

A Better Life?

A perhaps less vexing question about intermittent therapy: Does it improve a man's quality of life? For clarification, both the Canadian and U.S. New England Journal studies examined this question.

In the Canadian study, which looked at men with prostate-confined cancer, those who received intermittent therapy reported significantly fewer problems associated with hormone treatments, such as hot flashes, ED, low libido (or desire for sexual activity), and fatigue.

In the study of men with metastatic prostate cancer, those who received intermittent therapy reported better erectile function and mental health at first, but after three months there was little difference between the two groups.

Many other studies also show that patients have fewer side effects and enjoy better quality of life during the off-treatment phase of intermittent androgen deprivation. Some research suggests that men may derive certain long-term benefits from scheduled breaks in hormone treatments.

For instance, a few studies offer clues that intermittent therapy might reduce a man's risk for developing conditions such as heart disease and osteoporosis. However, data to support those claims are limited.

The Bottom Line

There will undoubtedly be further debate over the benefits of intermittent androgen deprivation. Future research is likely to examine strategies involving different timing and different drugs from those investigated in the New England Journal studies.

For now, however, it's probably safe to say that this treatment strategy doesn't prolong survival. For most men with advanced metastatic prostate cancer, continuous therapy is likely to remain the standard of care. It's worth noting that there is no consensus regarding the use of androgen deprivation—continuous or intermittent—in men who have had a biochemical recurrence following surgery or radiation.

Studies have shown that it is not uncommon for some men in this situation to live metastasis-free for a decade or more. Thus for men who are at low risk of developing metastatic disease (PSA doubling time after treatment greater than 12 months and a PSA at diagnosis below 10 ng/mL), the risks of hormonal treatment before signs of metastasis may outweigh the benefits.

But for men at high risk of developing metastatic disease (PSADT after treatment less than 9 months and a PSA above 20 ng/mL at diagnosis), androgen deprivation—even intermittent suppression—may be a reasonable option; the latter appears to minimize the side effects of hormone treatment without compromising a man's chances for survival.

Hormone Therapy for Prostate Cancer: What to Know

Q. What should I know about Lupron Depot as a hormone therapy for prostate cancer?

A. Lupron Depot is the brand name for leuprolide, one of several hormonal drugs used to treat prostate cancer. It works by suppressing production of testosterone, a male hormone that can fuel the progression of the disease.

Leuprolide falls into a class of drugs called luteinizing hormone-releasing hormone (LHRH) agonists. Other drugs in this class include goserelin (Zoladex), triptorelin (Trelstar), and histrelin (Vantas).

Hormone therapy was once reserved for men whose prostate cancer had spread to other sites, but now it's often given preemptively to men whose cancer hasn't spread but is expected to. For men with advanced cancer, it's used to prolong life and relieve symptoms.

Lupron Depot is given as an injection in intervals of either one, three, four, or six months, depending on the formulation. An effective weapon in controlling prostate cancer, as a hormone therapy it does come with some serious side effects.

For one, right after the shot, it can cause a surge of testosterone lasting about two weeks, which may result in increased bone pain and swelling of the prostate, blocking urine flow. Your doctor may prescribe another drug, called an antiandrogen, to prevent this reaction.

The most common side effects are hot flashes, loss of sex drive, ED,), and weight gain, but they're usually reversible after treatment ends.

Hormone therapy can also raise your risk for metabolic syndrome, a group of five conditions—high blood glucose; high blood pressure; low HDL cholesterol, or good cholesterol; high triglycerides; and abdominal obesity, which makes you more likely to develop heart disease, diabetes,and stroke. Work with your doctor to make sure these factors are kept in check.

PCCN REGINA PROSTATE CANCER SUPPORT GROUP INC.

PCCN REGINA PROSTATE CANCER SUPPORT GROUP TAX DEDUCTIBLE DONATION

PCCN Regina is a volunteer support group for men diagnosed with prostate cancer and their families.
We are a registered charity that relies on the generosity of its members, supporters and friends to fund its programs.
Charitable deduction receipts for income tax purposes are issued for amounts of $10.00.

You can donate by sending a cheque to:

PCCN – Regina: PO Box 37264

Regina, SK S4S 7K4

Donor's Name: _____

Donor's Address: _____

_____

Postal Code: _____

If this gift is in memory/honor of someone, please provide mailing address information if you wish us to provide a notification.

This gift is in memory/honor of: _____

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2016-2017 MONTHLY PROGRAM DATES

Support Group meeting dates are the second Thursday of each month. Monthly Programs are being developed and will be announced in future newsletters.

2016

September 08 – Open Forum

October 13 – Dale Dirkse on Well Being After PCa

November 10 – Mikki Robicheau, Nurse Navigator at Prostate Assessment Centre

December 08 – Darin Anderson on Colopast Products

2017

January 12 – Board Members: November 5th Oncology Symposium Report

February 09 - Speaker Dr. Nelson Leong Radiation Oncologist

March 09
April 06
May 11

June 08
Annual Meeting

July and August
No meetings

Pending for 2017:

- UofR RN Professor on PCa Patient Care
- Oncologist Presentation
- Pathologist Presentation
- Advance Care Planning Workshop