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 Thursday March 8, 2018

Program:

Members Round Table Discussion

Judy Kosloski, Early Detection Co-ordinator with Saskatchewan Cancer Agency came available for February so the earlier planned Members Round Table Discussion for February was postponed and is the program for March. Come prepared to participate.

Time:

Registration is at 6:45pm.
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.

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.

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If you would like to be removed from our newsletter and notices please use reply stating “Unsubscribe” in the subject line.

Early Detection Saves Lives: February 8th Meeting Presentation

A copy of Judy's presentation follows, although it deals with Breast, Cervical and Colorectal Cancers, early detection of Prostate Cancer is equally important.

With the increasing incidence of cancer, it is important for both men and women to play an active role in their health and that includes early detection of cancer through screening.

The Saskatchewan Cancer Agency operates three population based early detection programs: Screening Program for Breast Cancer, Screening Program for Cervical Cancer and the Screening Program for Colorectal Cancer. While the test and guidelines for each program are different, what is common to all three is the goal of finding and detecting early signs of cancer.

Screening is a vital part of an individual's healthcare plan because in its early stages, cancers may not present symptoms that people may notice. The earlier cancer is diagnosed, the greater the likelihood that it can be successfully treated or managed.

When and how often you participate in screening tests depend on your age, gender, risk factors like a family history or an abnormal screen, and the type of early detection program:

- Screening Program for Breast Cancer: Women aged 50 and older should get a regular mammogram every two years. Women with a family history of breast cancer should have a mammogram every year. For more information call 1-855-584-8228.
- Screening Program for Cervical Cancer: Women should have a Pap test stating at the age of 21 or three years after becoming sexually active, whichever occurs later. Pap test should be done every two years. Once a woman has had three consecutive normal results they can have the test every three years until the age of 69. For more information call 1-800-667-0017.
- Screening Program for Colorectal Cancer: Men and women between the ages of 50 and 74 should regularly be screened using the fecal immunochemical test (FIT). The test is easy to use and requires only one stool sample. The test detects blood in the stool that is not visible to the naked eye. For more information call 1-855-292-2202.

The Cancer Agency's early detection programs have tried to make screening easy and accessible:

- For the Screening Program for Breast Cancer, women can make an appointment in Regina or Saskatoon or at one of the six satellite offices (Lloydminster, Moose jaw, North Battleford, Prince Albert, Swift Current and Yorkton) or through the mobile bus that travels to rural areas. A schedule for the mobile locations is available at www.saskcancer.ca/spbc. More than 38,000 screening mammograms are performed annually with over 8,000 screens on the mobile bus.
- The Screening Program for Cervical Cancer invites women to participate in the program and encourages women to contact their doctor or nurse practitioner to make an appointment for a Pap test. A list of health clinics offering Pap tests is available at www.saskcancer.ca/spcc. Annually more than 90,000 Pap tests are completed in clinics throughout Saskatchewan.
- A FIT test is sent directly to eligible men and women by the Screening Program for Colorectal Cancer. Saskatchewan has one of the highest participation rates for this program at 51.1 per cent. That means that more than 160,000 people completed a FIT between April 1 2015 and March 31 2017.

While no test is 100 per cent effective, the screening programs offer a way for men and women to stay a step ahead of their health by making cancer screening part of a healthcare plan. Every person screened for cancer is a potential life saved and that is worth taking a few minutes to have a mammogram, a Pap test or to take the FIT.

TAKE NOTE

Taking a Dietary Supplement?

Be sure to ask about potential interactions

If you're taking medication and also take an herbal or other kind of dietary supplement, tell your doctor and/or pharmacist what you take and ask about possible interactions.

A dietary supplement, by definition, is a substance taken by mouth in whatever form (gel, capsule, tablet, powder, and so on), but is not a food. Dietary supplements can interact with both prescription and nonprescription medications, making the drugs less or more potent. For example, a wide range of supplements, including garlic, ginkgo, dong quai, and licorice root, can boost the effect of such drugs as warfarin (Coumadin), thus increasing the risk of bleeding. On the other hand, supplements such as vitamin K and ginseng reduce warfarin's blood-thinning effect. Many other drugs may also have interactions with supplements.

In addition, if you take supplements, especially herbal ones, and are about to have surgery, talk to your doctor about whether you should stop taking them, since they can cause complications—just as prescription and over-the-counter drugs can.

Possible problems range from excessive bleeding to interaction with anesthetics. Your doctor may recommend stopping certain medications and supplements a week or even more before surgery. If surgery must be scheduled sooner, show all herbal products (in their packages) to your doctor beforehand.

TAKE NOTE

From PROSTATE CANCER CANADA

Androgen Deprivation Therapy (ADT) Educational Program

The ADT Educational Program is designed to help prostate cancer patients and their partners manage the side effects of ADT. It involves a 90 minute, live professional-taught class where participants learn about ADT side effects, how to manage them, and how to make successful lifestyle changes. The program is primary for patients about to start ADT (and their partners), but the program team is currently offering it to patients already on ADT.

The dates for the upcoming sessions are March 15th, and March 28th. Interested participants can register on www.LifeOnADT.com or send an email to LifeOnADT@gmail.com. This group of program providers received previous funding for the development of an ADT Educational Program and that work had been awarded by Prostate Cancer Canada and was proudly funded by the Movember Foundation.

GOOD TO KNOW

Do I Really Need THAT Exam?

Don’t Skip Your Rectal Exam

When men discuss screening for prostate cancer with their physicians, some ask: Do I really need the digital rectal exam (DRE)? This physical evaluation allows doctors to check for growths and other abnormalities on the prostate that could signal the presence of cancer, but it also causes anxiety in many men. What's more, some studies have questioned whether the DRE offers valuable diagnostic information beyond that provided by the prostate-specific antigen (PSA) blood test. Yet other research and the clinical experience of many physicians suggest that pairing these two tests remains the most effective way to screen asymptomatic men for prostate cancer. Here's a look at both sides of the debate.

A Powerful Combination

To perform the DRE, a doctor puts on an exam glove and applies lubricant to his or her index finger. Inserting the finger into the rectum, the doctor examines the prostate, feeling for signs of abnormal cell growth, such as nodules (small lumps) or hardened tissue. The exam is brief and painless, though some men find the test uncomfortable and embarrassing.

For many years, the DRE was the primary tool doctors had for detecting signs of prostate cancer. But in 1986, the U.S. Food and Drug Administration (FDA) approved the PSA test, which measures blood levels of an enzyme that rises in men who have prostate cancer, to monitor disease recurrence in patients who had undergone radical prostatectomy.

Research also showed that this simple blood test could more accurately detect prostate cancer at an earlier stage than the DRE—a finding that suggested it might make an effective screening tool. This idea was investigated in a landmark 1994 study published in The Journal of Urology. For the study, 6,630 men aged 50 or older had both a DRE and a PSA test. Men who had suspicious findings on either test had biopsies, which detected prostate cancer in 264 of the men. The PSA tests correctly identified 82 percent of the malignancies, while the DRE detected 55 percent of them. However, the greatest number of tumors could be detected by combining both tests. That same year, the FDA approved the PSA test to screen for prostate cancer in men over age 50 when used along with the DRE.

Soon, pairing the PSA test and DRE as part of a routine physical exam became an accepted strategy for early detection of prostate cancer. In 2012, however, the United States Preventive Services Task Force (USPSTF)—an independent advisory panel of experts in prevention and evidence-based medicine—discouraged routine use of the PSA test for screening. The recommendation was based on concerns that the risk associated with the PSA test outweighed its benefits. Rates of PSA testing fell soon after, and while the USPSTF made no formal recommendation about DREs, rates of that test declined in the United States, too—by 64 percent, according to a

2016 study in The Journal of Urology. In fact, the study found that doctors performed the DRE at less than 6 percent of office visits for preventive care for men 40 and older.

The USPSTF changed its position in 2017 and now advises men 55 to 69 to discuss screening with their physicians, but it's too early to say whether the new recommendation has had any impact on use of the DRE.

Questions about the DRE

Over the years, some doctors have questioned the DRE's value as a screening tool for prostate cancer. The test can miss malignant growths that arise on the front or top of the prostate, which are beyond the physician's reach. What's more, the DRE is an inherently subjective medical test, since it relies on a doctor's sense of touch and his or her interpretation of what feels abnormal, which studies suggest can vary widely from one physician to another.

In a 2008 study published in The Prostate, Dutch researchers analyzed data from a large trial that evaluated the benefits of prostate cancer screening. They focused on a half dozen physicians participating in the trial and found that some identified suspicious bumps or spots in relatively few prostates when they performed the DRE, while others found reason for concern in more than a quarter of the men they examined. That suggests a lack of agreement among doctors regarding what constitutes a suspicious DRE finding. Yet this study confirmed the DRE's value in an important way: All suspicious findings in this study, regardless of which clinician reported them, had a similar likelihood of being identified as cancer by biopsies.

Another large study that examined early detection of prostate cancer, the Prostate, Lung, Colorectal, and Ovarian (PLCO) Screening Trial, also afforded researchers an opportunity to evaluate the DRE. The PLCO included 38,340 men who had annual PSA and DRE exams. Men who had suspicious results on either test were referred for prostate biopsies. Researchers wanted to know how accurately a positive DRE identified men with clinically significant prostate cancer (CSPC), meaning a tumor that posed an intermediate or high risk. They found that 5,064 of the men had abnormal DREs, but normal PSA tests. Of these men, 99 were found to have CSPC. This means that performing the DRE on a man who has a normal PSA test result will only identify an additional 2 percent of serious prostate tumors. Stated another way, the PLCO trial found that a doctor would need to perform the DRE on 1,372 men as part of routine screening to detect one intermediate or high-risk prostate cancer that PSA testing would have missed. The authors concluded that the DRE wasn't worth performing in men undergoing PSA testing, and the study's results were widely reported as evidence that men should skip the test.

Catching Cancers PSA Misses

It's worth noting that the results of the PLCO trial should be viewed with caution, since it has been criticized for various shortcomings, including the fact that many men who had positive test results never got biopsies and that it included relatively few African-Americans—a group that presumably would benefit from a DRE at screening because they are at increased risk for prostate cancer and tend to have a more aggressive form.

Meanwhile, a 2012 study published in the Canadian Journal of Urology suggests that the DRE sometimes identifies cancers that the PSA test may miss. Researchers analyzed the medical charts of 806 men who were referred for needle biopsies due to an abnormal DRE, elevated PSA results (according to age-specific criteria,

which use higher values for older men) or both. Biopsies detected prostate cancer in 306 of the men; 136 had abnormal DREs, but 43 had normal PSA tests. This means that using age-specific PSA values missed 31 percent of prostate cancers in men with suspicious DREs.

DRE Still Has a Role

Because the DRE can find some cancers missed by PSA testing, the American Cancer Society says the test may be included in prostate cancer screening. But other experts, including the author of the UC Berkeley Prostate Disorders White Paper and the UC Berkeley Editorial Board, say the DRE should always be conducted with a PSA test. While a man who has a very low PSA level is unlikely to have prostate cancer, a suspicious DRE may, nonetheless, indicate the presence of a tumor. Thus, the DRE results provide additional information that is important to consider when discussing whether a man should have a biopsy.

Another benefit: The DRE can also detect rectal cancer (though it's not a replacement for standard screening for colorectal cancer).

Advice About PSA Testing

When the influential U.S. Preventive Services Task Force recommended against routine screening for prostate cancer in 2012, many men were surprised, confused, or even angry. Some men followed the advice and stopped getting screened or didn't start, while others ignored it.

Now the Task Force has changed its collective mind. It has revisited the subject, as it does every five years, and issued new draft guidelines that leave the decision about prostate cancer screening to individual men, ages 55 to 69, depending on their "values and preferences" and in consultation with their doctors.

It still recommends against screening men 70 and older. (Note: Prostate cancer screening means testing men without signs, symptoms, or history of the disease.) The new guidelines align with those of the American Cancer Society, American Urological Association, and American Academy of Physicians, though those groups say the discussion about the pros and cons of screening should begin around age 50 or even 45 and that most men should stop at 75, which is what we have also advised.

Some groups, such as the American Academy of Family Physicians and the Canadian Task Force on Preventive Health Care, still recommend against routine screening.

In some ways, the Task Force is going back to its pre-2012 guidelines, which said there was insufficient evidence to recommend for or against screening.

Why the Change?

The test measures blood levels of prostate-specific antigen (PSA), a protein produced by prostate cells. PSA testing has long been a contentious issue because, though it is likely to benefit some men, it's not clear how many lives it actually saves.

Meanwhile, the risks are well known, including overdiagnosis, overtreatment, and the serious adverse effects that treatment may entail. Thus, experts have had difficulty in advising men about what to do.

The Task Force is changing course largely because it now sees the benefit/risk ratio somewhat more favorably. It says that while research is still inconsistent, longer-term follow-up data from a key European study strengthen the case that screening slightly reduces the risk of dying from prostate cancer.

It cites estimates that for every 1,000 screened men (ages 55 to 69) over a 10 to 15-year period, 240 will get a positive PSA result, leading to 100 positive biopsy results and ultimately one or two fewer deaths from prostate cancer.

In addition, the Task Force notes there are now better ways to reduce the potential harms. For instance, improvements in how PSA results are interpreted and utilized allow doctors to better predict which cancers will behave aggressively and spread and which don't need to be treated.

What's more, treatment options are now better and more clearly understood. Notably, recent studies have confirmed that active surveillance (also called watchful waiting) can safely allow most men diagnosed with less-aggressive prostate cancer to monitor it for years without rushing into treatment. More men are now opting for that, reducing the potential harms of unnecessary treatment.

PSA Ups and Downs

PSA is not a cancer test per se. Blood levels can rise as a result of a variety of prostate disorders—such as infection, benign enlargement, or cancer—or sometimes for no apparent reason.

The test, which is easy to do and inexpensive, was introduced in the 1980s to monitor men already diagnosed with prostate cancer. But doctors soon began using it to screen millions of healthy men.

Even though the PSA test can detect cancer early, that isn't always a good thing. Age greatly increases the risk of prostate cancer—about 90 percent of cases are diagnosed in men over age 55, and 70 percent of deaths occur after age 75.

However, the great majority of prostate tumors, especially in older men, remain small, develop very slowly or not at all, do not spread, and cause no symptoms. Far more men die with prostate cancer than from it. In fact, autopsy studies reveal that more than one-third of men in their 50s and three-quarters of those over 75 had prostate cancer—usually small and harmless—and the vast majority never knew they had it and died from something else.

Unfortunately, PSA is not a very good screening test because it produces lots of false alarms and misses many cancers (since some men with prostate cancer have normal PSA levels).

The only way to determine which men with elevated PSA have cancer is with a biopsy. Fewer than half of them turn out to have cancer. (Newer imaging techniques may improve the accuracy of biopsies.)

Among men who are diagnosed with prostate cancer, the Task Force estimates that up to half have cancer that would never affect their health—this is called overdiagnosis. But abnormal biopsy results often lead to the treatment of small, slow-growing cancers. And standard treatments such as radiation and surgery to remove the prostate often produce impotence, urinary incontinence, and other complications.

The good news is that death rates from prostate cancer have been declining since 1990, and some of this improvement can be attributed to PSA screening, though better treatments probably deserve much of the credit.

But even data showing that screening saves lives present a sobering picture. It's estimated that for every man whose life is prolonged because of PSA screening, somewhere between 30 and 100 men end up being treated for a cancer that was never going to harm them.

Most men treated with radiation or surgery will have potentially serious complications, according to the Task Force. Such numbers are improving, however, thanks to more men opting for active surveillance.

And, of course, some men with fast-growing prostate cancer will die from it even if PSA screening detects it early and they are treated for it.

Our Advice

We agree with the Task Force's new draft recommendation that PSA screening should be a personal decision and that men should discuss the pros and cons with their doctors.

But like the American Cancer Society, we think this should start at about age 50 (not 55, as the Task Force advises), and even earlier for men who are at higher risk. Keep in mind, for men who decide to be screened, no one knows what screening intervals are optimal (some studies suggest once every two to four years if PSA level is low).

Even if they get screened, we think that men can stop at age 75 (not 70), since further testing is unlikely to prolong lives. But this too is a personal decision, based on a man's preferences and overall health.

Ultimately, it's up to you how you want to play the odds, but it should be an informed decision. You may decide to be screened, for example, if you place greater value on finding cancer early, despite the uncertain benefits and known risks. In contrast, you may decide against it if you fear that getting abnormal PSA results will land you on the "slippery slope" of overdiagnosis and overtreatment.

Several organizations and medical groups offer decision aids to help men decide about PSA screening. These include the American Society of Clinical Oncology and the American Cancer Society.

Who's at Higher Risk?

Besides increasing age, several factors boost the risk of prostate cancer:

- Family history. Having a brother or father with prostate cancer more than doubles your risk (brother more so than father). Your risk is even higher if several of your relatives have had the cancer, especially if they were young when it was found.
- Race. Black men are 60 percent more likely to develop it than white men, and more than twice as likely to die from it.
- Genes. Men who inherit certain genetic mutations (notably of the BRCA gene, best known for increasing the risk of breast and ovarian cancer) have elevated rates of prostate cancer.

Nevertheless, the Task Force does not single out any of these higher-risk groups for screening, saying that more research is needed. Other experts, however, do advise such men to get screened and start earlier.

Doc, Let's Talk

To make an informed decision about PSA screening, men need to have a balanced discussion about the pros and cons with their doctors or other health care providers. Only a minority of men have such a discussion.

This was seen in a study published online in the journal Urology in March, which looked at a nationwide survey database of 217,000 men. Only 30 percent said that their health care providers discussed both the advantages and disadvantages of PSA screening with them.

Meanwhile, 36 percent of men reported that only the advantages were discussed; 1 percent, only the disadvantages; and 34 percent reported that neither had been discussed. Men who discussed only the disadvantages or who had no discussion about screening were least likely to get the PSA test.

Previous studies have shown that when the pros and cons of PSA testing are fully discussed with men who have not yet made up their minds, they are more likely to decide against it, though this new study did not find that a balanced discussion dissuaded men.

Many doctors include the PSA test in routine blood work without asking, or even telling, their patients. Possible explanations include lack of time during office visits, disinclination to discuss a confusing topic, or doctors' belief that the benefits of screening outweigh the harm

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

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

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2017-2018 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.

2017

September 16 - Prostate Cancer Seminar
October 12 - Heather Rodrigues
November 9 - Clear Health Inn
December 14 - Best Buds Society

2018

January 11 - Compassionate Care
February 8 - Saskatchewan Cancer Agency
March 8 - Members Round Table Discussion

April 11 - TBA
May 10 - TBA
June 14 - AGM
July – August - No Meetings

Pending for 2018

- UofR RN Professor on PCa Patient Care
- Advance Care Planning Workshop
- Update on UofR PCa Research Program we are partially funding
- Prostate Assessment Centre
- Pathologist from Cancer Clinic
- Members Round Table Discussion