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 March 9.

The March meeting will be devoted to member round table discussions. Plan to attend this gathering with your list of questions/suggestions.

The session will be led by Board Member Stan Hanoski.

Time:
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.

Overview of Dr. Leong's Presentation on February 19, 2017

Dr. Nelson Leong completed his medical training and residency in radiation oncology in Edmonton at the Cross Cancer Institute. He then travelled to Victoria, BC and completed a fellowship covering Breast Cancers and Prostate Brachytherapy. Dr. Leong works at the Allan Blair Cancer Centre in Regina and has been performing HDR Prostate Brachytherapy as part of his practice. He has a keen interest in Men's survivorship, cancer education and medical informatics. He is working with Prostate Cancer Canada and the Movember foundation to create a teaching library for prostate patients.

His presentation provided a brief history of radiation. 1917 saw the use of Radon needle therapy to do temporary implants. 1926 progression to Radon seeds as permanent implants. Over the years treatment has progressed to computer controlled radiation therapy.

Brachytherapy is from the Greek word Brachy meaning short distance i.e. you place the radioactive material in the area of cancer.

His presentation also included an overview showing the Risk Spectrum ranging broadly from low through low/intermediate to intermediate/high to high using PSA and Gleason information. This indicated there is a lot of overlap and therefore the need for testing and consultation with the various caregivers. This helps determine the type of therapy from surveillance to brachytherapy alone or Brachytherapy and external radiation or external beam alone all with the possible option of surgery as another choice of treatment. He emphasized that everyone and their treatment are individual and it is very unlikely two people are the same even if they think their stories are the same.

The HDR Prostate Brachytherapy is computer controlled. This includes mapping of the internal pelvic region as to the area where the treatment is required and the rate of radiation required to eradicate the cancer.

The treatment takes 45 to 60 minutes under a general anesthetic.

Overview is submitted by Co-Chair Lawrence Ward.

PROSTATE HEALTH

How Effective Are Prostate Cancer Tests?

We are still waiting for a test that can—with complete accuracy—distinguish between men who have prostate cancer and those who are cancer-free. If prostate cancer is diagnosed, the test should also determine whether it's an aggressive form that requires prompt treatment or a slow-growing tumor that may only need close monitoring.

A number of companies have introduced tests that could take us closer to that goal, but there's still much to be learned about them and their proper role in the management of prostate cancer. Unfortunately, published studies are limited, and so far none of the tests has a long-term track record in the real world, where doctors screen, counsel, and treat patients.

Once a particular test has been approved by the Food and Drug Administration and is available, it can be marketed without proof of benefit. Furthermore, unsubstantiated claims abound for many tests. For now, all of these tests are intended to augment—not replace—a doctor's clinical judgment along with the existing proven tests currently used to screen for and monitor prostate cancer.

Time will tell if any of these new tests add information that will significantly affect treatment decisions. Here's an overview of the latest prostate cancer tests—and the questions we hope they can answer. All of the tests are available in the U.S. unless otherwise indicated.

Tests to Indicate the Need for a Prostate Biopsy

An elevated prostate-specific antigen (PSA) level can indicate that a man has prostate cancer; however, findings may also be elevated in men with less serious conditions, such as benign prostatic hyperplasia (BPH), also known as benign prostatic enlargement (BPE). Yet most men with elevated PSA levels end up having an anxiety-

provoking biopsy to rule out cancer. Two new tests show great promise in identifying appropriate biopsy candidates with greater accuracy:

• **The Prostate Health Index.** Commonly known as the phi test, measures blood levels of PSA, free PSA, and a precursor (or early form) of PSA, known as pro-PSA or p2PSA. Research suggests that pro-PSA levels are a better indicator of prostate cancer than total or free PSA levels and that men with elevated pro-PSA levels are at high risk for having an aggressive form of prostate cancer. Using a mathematical equation, the phi test combines all three variants to better determine whether prostate cancer is present.

The test is indicated for use in men age 50 and older whose digital rectal exam showed no signs of cancer and who have a total PSA value between 4 ng/mL and 10 ng/mL—a gray zone that could indicate prostate cancer or a less serious condition such as BPH. Like the other tests described herein, the phi test doesn't deliver a definitive answer about what action to take—in this case, whether or not to have a biopsy.

Instead, the phi test's results, which are scored from 0 to 55 and above, reflect the probability that a biopsy will detect cancer. For example, a phi test score below 27 is associated with a 9.8 percent probability that prostate cancer is present, while a score of 55 or more suggests a likelihood of greater than 50 percent. As with all of the tests, phi test results must be considered in light of a man's other risk factors.

• **4Kscore.** This blood test (currently available in Europe and Mexico) measures levels of three PSA variants (total PSA, free PSA, and intact PSA), plus an enzyme called human kallikrein 2 (hK2), which is elevated in men with prostate cancer. Some scientists believe hK2 may promote the growth and spread of prostate cancer. The 4Kscore also uses a mathematical algorithm to calculate the risk of prostate cancer in a man with an elevated PSA level.

Tests to Rule Out a Repeat Biopsy

Some prostate biopsies produce inconclusive results. Others may be negative even in men with elevated PSA or other high-risk features. Typically, this means the procedure must be repeated even though only 10 to 36 percent of second biopsies detect cancer. The following tests can be used to help determine the need for a repeat biopsy.

• **Progensa.** This urine test detects the presence of a gene called prostate cancer antigen 3 (PCA3). This gene is overexpressed (or overactive) in 95 percent of men with prostate cancer, but not in men who have healthy prostates or BPH. Results are ranked from less than 5 to greater than 100, with a score of less than 25 indicating a decreased likelihood of a positive biopsy. Progensa is approved for use in men age 50 and older who have had one or more negative biopsies, but who a doctor nonetheless suspects may have prostate cancer.

• **ConfirmMDx.** Whether a particular gene is turned "off" or "on" can be determined by the presence or absence of specific chemical tags or methyl groups—methylation—of DNA, the building blocks of genes. When this process of DNA methylation turns off the activity of tumor suppressor genes, cancer may develop. Based on technology developed at Johns Hopkins and other institutions, ConfirmMDx analyzes the DNA methylation status of a man's biopsied prostate tissue. Test results indicate that the biopsy specimen is positive or negative for methylation. A positive finding, which is mapped on a diagram of the prostate, suggests the need for a repeat biopsy.

• **Prostate Core Mitomic Test.** This test analyzes a man's biopsied prostate tissue, looking for damage to mitochrondrial DNA (mtDNA) caused by cellular changes associated with prostate cancer development. A negative result suggests that the man is at low risk of undiagnosed prostate cancer and that a repeat biopsy can be deferred.

Tests to Determine the Need for Prostate Cancer Treatment

Many men with positive biopsies have low-risk tumors that won't spread to other organs and become deadly. For some of these men, active surveillance may be a reasonable alternative to immediate treatment, but standard diagnostic tools are imperfect at distinguishing between indolent and aggressive tumors. Results from the following tests, when combined with a Gleason score and other clinical information, are intended to help provide reassurance about the decision to forgo or institute immediate treatment.

• **Prolaris.** This test uses a sample of tumor tissue removed during a biopsy and measures how rapidly cells are dividing as a way to gauge whether the tumor is more or less likely to be deadly. Prolaris scores range from -1.3 to +4.7 and are stratified by risk, with higher scores indicating a greater risk of dying from prostate cancer.

• **ProstaVysion.** For this test, biopsied tissue is analyzed for the presence of two genetic biomarkers for prostate cancer. One biomarker, known as TMPRSS2:ERG, is a fusion of two genes and is associated with the presence of prostate cancer. The other biomarker, PTEN, is a "suppressor" gene that normally helps keep certain forms of cancer in check and is missing in 60 percent of men with metastatic prostate cancer. By examining those two markers, the test provides a molecular analysis of prostate cancer aggressiveness and the patient's long-term prognosis.

• **Oncotype DX.** This test examines the interactions between 17 genes in a biopsy sample to predict whether a tumor is likely to be aggressive. The result, the Genomic Prostate Score, ranges from 0 to 100; a low score suggests that the tumor is less likely to grow and spread and aggressive treatment may not be necessary. Conversely, a higher score suggests a poorer prognosis and a greater need for immediate treatment.

Tests to Determine the Need for Treatment After Prostate Surgery

Some men who have had a radical prostatectomy are at risk for recurrence and would benefit from additional therapies, such as radiation or hormone therapy, but identifying them is a challenge. At least one of the tests discussed above, Prolaris, as well as the tests below, may be able to help with that challenge.

• **NADiA ProsVue.** This blood test measures the rate of tiny changes in PSA levels over time, which can suggest that a man is at risk for recurrence. Patients are categorized as at reduced risk, which indicates that a man is at a lower risk for clinical (not biochemical) cancer recurrence for several years following his prostatectomy, or not at reduced risk.

• **Decipher.** This test, which is not yet available in the U.S., analyzes tissue from the prostate tumor to look for 22 genes linked to prostate cancer metastasis. The results, which are presented as a percentage score, indicate whether a man is at high or low risk for metastases and, therefore, whether further treatment should be considered.

Test Costs

Since these tests are relatively new, you may need to pay out of pocket. While some insurers cover the costs of some tests, coverage varies. Before having one of these tests (which can run to four figures), check with your insurer first. Also be sure to check with the test's manufacturer; some offer assistance with test fees.

What to Know About a Prostate Biopsy

If the results of your digital rectal exam, prostate-specific-antigen (PSA) test, or both, suggest cancer, your doctor will ask for a transrectal ultrasound-guided biopsy. That will determine the size of the prostate, identify any areas that are suspicious for cancer, and direct the needles to be used for a prostate biopsy, which typically takes about 15 to 20 minutes and is performed on an outpatient basis.

What to Expect

Doctors routinely use a local anesthetic such as lidocaine (Xylocaine) to reduce discomfort during a prostate biopsy. The biopsy is performed with you lying on your side. The ultrasound probe (about the size of a finger) is gently inserted 3 to 4 inches into the rectum. The probe emits sound waves that are converted into images corresponding to the different prostate zones.

Small prostate cancers are usually not detectable by ultrasound examination. Fitted to the probe is a biopsy gun with a needle that is fired through the wall of the rectum. The needle extracts small pieces of prostate tissue in less than a second.

Ideally, at least 10 to 12 tissue samples ("cores") are taken from the prostate. A pathologist examines the samples under a microscope to determine whether cancer is present.

If the prostate biopsy shows no cancer but the physician still suspects that cancer is present because of an abnormality on the digital rectal exam or PSA test, a repeat biopsy may be performed.

Possibility of Cancer

Each year, approximately 1 million prostate biopsies are performed in the U.S., and of those, about 1 in 3 are cancerous. About 5 to 10 percent of men who have had a biopsy will be told they have high-grade prostatic intraepithelial neoplasia (PIN).

Formerly called dysplasia or atypical hyperplasia, PIN is believed to be a premalignant lesion. But recent studies suggest that the likelihood of finding cancer on a repeat biopsy is no greater in men with PIN than in men with normal biopsy findings. Therefore, a finding of PIN alone is not a reason to perform a repeat biopsy.

About 5 percent of prostate biopsies reveal abnormal or atypical cells that suggest the possibility of cancer but are not sufficient to make a diagnosis. In such cases, a repeat biopsy is usually recommended because there is a 50 percent chance of finding cancer on that second biopsy. If the biopsy results indicate cancer, other tests may need to be conducted to determine the extent of the disease.

A prostate biopsy usually causes only minor discomfort, but there is a small risk of infection. Common side effects include minor rectal bleeding; blood in the stool, urine, or semen; and soreness in the biopsied area. All of these side effects disappear with time.Although a minimal surgical volume for proficiency has yet to be established, it's generally accepted that in terms of complication rates and cancer control, most surgeons obtain proficiency with RALPs after 250 procedures. However, this study suggests that for a high percentage of doctors, it will be many years before they perform the number of surgeries needed for that level of proficiency.

Immunotherapy: A Promising Treatment for Prostate Cancer

Until recently, medicine had little to offer men with advanced prostate cancer that no longer responds to hormone therapy, known as castration-resistant prostate cancer.

That's rapidly changing, though, and men with castration-resistant prostate cancer have a growing number of treatment options to consider. That includes immunotherapy, which works by marshaling a man's own natural defenses to fight the disease.

The first immunotherapy drug for prostate cancer, sipuleucel-T (Provenge), was approved by the U.S. Food and Drug Administration (FDA) in 2010 for treating men with castration-resistant prostate cancer who have few or no symptoms. Sipuleucel-T doesn't cure prostate cancer, but appears to modestly prolong survival.

That success has helped to encourage other researchers to explore the potential of immune-boosting medicines. There are currently several other immunotherapy drugs in development for the treatment of castration-resistant prostate cancer, offering new hope for men faced with this diagnosis.

A Brief History of Immunotherapy

Immunotherapy is hardly a new idea. After all, vaccines, which were introduced in the late 18th century, are a form of immunotherapy. Vaccination is also known as immunization since it works by bolstering the body's immune system, the network of structures and cells that protects the body from germs and other harmful intruders.

A vaccine contains dead or weakened germs; when injected into a healthy person, the immune system learns to recognize and destroy those germs, which helps prevent infections. Vaccines have dramatically reduced the incidence of once-common diseases such as measles, mumps, and rubella.

The immune system learns to spot germs, which carry proteins called antigens that the body identifies as foreign objects that need to be eliminated. Many cancer cells, including those in malignant prostate tumors, carry antigens, too.

The immune system can detect so-called cancer-associated antigens and respond by mounting an attack on tumors. However, the assault may not be potent enough to destroy a tumor, and cancer cells have evolved mechanisms that help them elude detection.

While vaccines are most commonly administered to prevent disease, the idea of using them to treat cancer dates back to at least 1891, when a doctor named William B. Coley at Memorial Hospital in New York City began injecting cancer patients with bacteria in the belief that the resulting attack by the immune system would eliminate the bacterial infection and shrink or eliminate the tumors at the same time.

Coley reported success in treating more than a thousand cancer patients over the years, but few doctors believed his claims, and the concept of immunotherapy was largely forgotten for decades.

A Complex Process

The idea of immunotherapy was resurrected in the late 20th century, which eventually led to the development of sipuleucel-T. Interestingly, men who receive this treatment provide the raw materials needed to, in essence, activate the therapy.

Here's how it works: A patient is first connected to a device that draws T cells and other cancer-fighting immune-system cells from his blood. These cells are sent to a laboratory, where they're exposed to a protein called prostatic acid phosphatase (PAP), which occurs in most prostate cancers. This new formulation is infused back into the patient, with the goal of inducing the immune system to respond and attack the prostate tumor.

The benefit of sipuleucel-T was demonstrated in a 2010 clinical trial published in the New England Journal of Medicine. Researchers split 512 men with castration-resistant prostate cancer into two groups: About two-thirds of the volunteers were infused with sipuleucel-T treatments, while the remaining men received an inactive placebo treatment.

Although the drug didn't appear to slow the spread of cancer, men treated with sipuleucel-T survived for about 26 months, while others given placebo treatment lived roughly 22 months. Men treated with the drug reported only mild to moderate side effects, such as chills, fever, and headache.

Adding a few extra months of life could be a precious gift for a man with castration-resistant prostate cancer. Moreover, this drug's apparent benefit has helped to validate the concept of immunotherapy for treating prostate cancer, and the research continues.

Next Up

Another form of immunotherapy in development that has shown promise in early clinical trials as a potential treatment for men with castration-resistant prostate cancer is known as PROSTVAC.

PROSTVAC is made with an inactivated virus, which has been genetically modified to carry prostate specific antigen (PSA), a protein produced by prostate cancer cells, as well as three other types of molecules designed to stimulate the immune system. In theory, the presence of PSA in PROSTVAC helps immune cells recognize prostate tumors and target them for attack.

In 2010, researchers from Boston's Dana-Farber Cancer Institute and several other medical centers reported on the results of a preliminary trial of PROSTVAC in the Journal of Clinical Oncology. In the study, 82 men with castration-resistant prostate cancer were randomly chosen to receive PROSTVAC injections, while 40 other patients were given a placebo. Here again, the drug appeared not to affect tumor growth.

Yet three years later, 30 percent of the patients treated with PROSTVAC had survived, compared to 17 percent of men in the control group. Overall, the drug appeared to extend a man's life by 8.5 months, on average.

A larger study of PROSTVAC is underway to confirm these findings, with results expected later in 2017.

Checkpoint Inhibitors

Investigators are also studying whether immunotherapies currently used to treat other cancers may help vanquish prostate tumors. One candidate is ipilimumab (Yervoy), which is already approved for treating melanoma, a form of skin cancer.

Ipilimumab belongs to a new class of drugs called immune checkpoint inhibitors. Just as the immune system must turn on to attack an invader, it must also know how to turn off so that it doesn't damage healthy tissue.

Molecules called immune checkpoints put the brakes on the body's response when a potentially harmful invader has been eliminated. Some cancer cells are canny enough to take advantage of this braking mechanism by

attaching themselves to receptors on T cells, causing them to turn off. Immune checkpoint inhibitors block cancer cells' ability to shut down T cells, allowing the latter to go on attacking malignant tumors.

Ipilimumab targets a checkpoint called CTLA-4. A 2014 trial reported in Lancet Oncology included 799 men with castration-resistant prostate cancer whose cancer had spread to at least one bone after treatment with chemotherapy (docetaxel).

All the men had their bone metastases treated with radiation, but only half received ipilimumab treatment; the remaining men got inactive placebos. Men treated with ipilimumab did not live significantly longer than the others, but they experienced drops in PSA levels and growth of their tumors slowed. The drug also seemed to confer a greater benefit on men with less-advanced cancer. These promising clues have led to further research on ipilimumab for castration-resistant prostate cancer.

Several other approved melanoma drugs—pembrolizumab (Keytruda) and nivolumab (Opdivo)—target a different checkpoint, called PD-1. Studies show that both drugs can shrink solid malignant tumors, and each is currently in the early stages of testing in men with castration-resistant prostate cancer.

On the Horizon

A number of other immunotherapy drugs for prostate cancer are in preliminary testing. What's more, investigators are combining immunotherapies described here to see if they have complementary benefits.

For example, one early stage trial presented at a medical conference in 2015 suggested that pairing PROSTVAC and ipilimumab may extend survival in men with castration-resistant prostate cancer. Doctors are also studying whether immunotherapy might curb prostate cancer at an earlier stage, before it has spread to other organs.

If you have castration-resistant prostate cancer, be sure to discuss whether you're a candidate for sipuleucel-T or experimental forms of immunotherapy with your doctor.

New UBC website walks men through prostate cancer

ERIN ELLIS

Gary Johnston

A bit of theatre combined with medical expertise and human experience are part of a new website about prostate cancer launched this week by researchers at the University of British Columbia.

John Oliffe, head of Men's Health Research and a professor in the School of Nursing, shared with the Sun a few details about the interactive website called If I Were Tom (ifiweretom.ubc.ca).

1. Five years in the making.
Starting in 2012, researchers surveyed health specialists and patients to find out what they most want to discuss. Another two years of video interviews followed, using $400,000 from the Canadian Institutes of Health Research. There are 30 videos on the website, with more ready to be swapped in "to keep it fresh."

2. It's interactive.
The viewer can predict what Tom — actor Gary Johnston — will do at each step along the way from diagnosis to recovery.

"Will I need to wear these stupid underpants that make you look like you're walking around with a load of crap in your pants?" Tom asks himself when worrying about potential side-effects of surgery.

"We've found with guys that, if a character resonates with them, they're drawn into the content in a more interactive way. You look at the video and put in what you would do next. You might be plotting what Tom's doing, but chances are you're plotting what you did or what you think you'd do," said Oliffe.

3. Like a group support session, but online.
There's already a mountain of information available about prostate cancer, concedes Oliffe, and the website isn't trying to duplicate that. Instead, each topic area includes video from a specialist — oncologist, urologist, psychologist — and men with prostate cancer talking about their real experiences. It includes no-holds-barred discussion on sexual problems and hormonal changes.

"We're really trying to create a resource that was similar for all those guys who don't want to go to a group because of privacy issues or who can't get there because of transport."

4. You can't have too much information.
There are different types of prostate cancer — slow-growing or aggressive — with various treatments including surgery to cut out the cancer tumour, radiation, anti-hormone treatment or doing nothing but watching for changes. Age and other health problems will also play into each man's choice of treatment.

"They might be disappointed with the outcome, but if you go in knowing the potential side-effects and having thoughtfully considered those, taking your time rather than feeling rushed ... you're less likely to make a decision quickly about a treatment you may regret."

5. The research continues.
Oliffe's team is collecting more data through the website with surveys.

The current survey is about symptoms of depression among patients. Future ones will ask about exercise and nutrition.

It joins to another "interactive video drama" website about quitting smoking (men.quitnow.ca.) and headsupguys.org, which is dedicated to depression.

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A Strong Message from the "Hitman" Bret Hart

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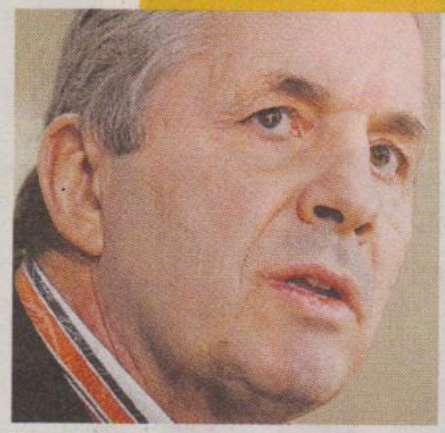

Bret Hart

Hitman Hart pins prostate cancer

Legendary professional wrestler Bret "Hitman" Hart says he's 100 per cent recovered and back in the gym a year after surgery for prostate cancer. Hart says it was a tough battle and he feared the worst, but he benefited from early detection. Hart, 59, has had serious health issues before — he suffered a stroke in 2002 that left him partly paralyzed, but he made a successful recovery. "You know, it's so critical for me to stress ... that it's just a blood test," Hart said as he urged men to get screened for prostate cancer. "If you're a man over 40, you need to go in."

TAKE NOTE

Two copies of "**PROSTATE FOR DUMMIES**" have been added to our library and are available for takeout by members.

Plans are taking place for an informal public forum in September during Prostate Awareness Month. More later.

A donation of $1000.00 was received from an anonymous donor via The Donald and Claire Kramer Foundation.

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:

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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.

2017

January 12 – Board Members November 5th Oncology Symposium Report

February 09 - Speaker Dr. Nelson Leong Radiation Oncologist

March 09 - Round Table Member Discussions

April 13 - Dr Venugopa from the UofS returns to give us an update on the PCa research we are partially funding.

May 11 - Lana Van Dijk of Body Fuel Organics and Barry Bremner, a PCa survivor; on the Importance of Proper Nutrition.

June 08
Annual Meeting

July and August
No meetings

Pending for 2017:

- UofR RN Professor on PCa Patient Care
- Advance Care Planning Workshop
- Update on UofR PCa Research Program we are partially funding