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 May 10, 2018

Program:
Dr Asim Amjad
Radiation Oncologist

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.

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.

To ensure you are receiving all of our newsletters and notices ensure pccn.regina@gmail.com is in your contact list.
If you would like to be removed from our newsletter and notices please use reply stating “Unsubscribe” in the subject line.

TAKE NOTE

Annual Meeting - Thursday, June 14

Program will be “Membership Appreciation” and our Annual Meeting. Plan to come out for the fellowship and to enjoy the traditional Pizza Buffet. This will also be an excellent opportunity for you to share your thoughts on future programing/speakers.

Walk For Dad 2018 - June 17

The Regina Walk For Dad in support of Prostate Cancer will be held on Father's Day June 17 at Wascana Park with Registration at 9:00 am in front of the Legislative Building. Please join us with your family and friends in a walk around beautiful Wascana Lake.

The best Father’s Day gift any Dad can receive is spending time with their kids, grandkids and friends. Especially so with a great cause in Prostate Cancer awareness.

Pledge sheets will be available for any contributions to our Regina Prostate Cancer Support Group. We sincerely thank Carmen Hanoski for organizing the past several Prostate Walks and activities.

If additional information is required please contact Jim Odling at: **306-522-7590 or golfer@sasktel.net**.

Volunteers Required

PCCN Regina Support Group has volunteered to help maintain the Cancer Survivor Garden in front of the Allan Blair Centre at Pasqua Hospital. Several volunteers are required from PCCN Regina to work with the Regina Qu'Appelle Health Region to assist with acquiring the plants and to organize the annual planting / clean up days.

We need your help. Green thumbs not required .

Contact Jim Odling at: **306-522-7590 or golfer@sasktel.net**
to volunteer or for more information.

Are you looking for an opportunity to give back to your community?

We need YOU! Your PCa Support Group leadership team is seeking two interested members (men with prostate cancer, partners and/or family members, friends and interested persons) to consider joining us by volunteering on our Board of Directors for 2018/19. The Board is responsible to focus our energies and talents as a support group. New directors bring important ideas and fresh perspectives that sustain and advance our mission.

The Board meets regularly (9:30am – 11:00am) two weeks prior to the Support Group Meeting which is the second Thursday evening (7:00pm – 9:00pm) of most months.

Our members and leaders freely share their own stories but do not give medical advice. In any and all future conversations, with an engaged membership and leadership we can reasonably expect to be treated with dignity and respect.

Please contact our Co-chairs, Bob Terichow (306) 581-9158 or Lawrence Ward (306) 543-8215 for more information about nomination as a director at our upcoming Membership Appreciation and Annual Meeting in June.

The Regina Prostate Cancer Support Group is a regional, community-based organization of volunteers whose mission is to increase awareness of prostate cancer, provide access to information, and promote courage and hope for people living with prostate cancer.

Statins and Prostate Cancer

Men with prostate cancer who take a statin drug to lower their cholesterol have reduced death rates, according to a new study in the Journal of Clinical Oncology. Researchers followed nearly 32,000 Danish men who were diagnosed with prostate cancer for an average of three years and found that statin users were 17 percent less likely to die from the cancer and 19 percent less likely to die from all causes than nonusers; they controlled for age, severity of the cancer (clinical stage and Gleason score), and other variables. Dose and type of statin and prediagnosis statin use did not affect the results.

This was just an observational study, which can find associations but not establish causality, but it confirms the results of many previous studies. For instance, in 2016, an analysis of 34 observational studies on the effect of statins in men with prostate cancer found a 22 percent reduction in the risk of metastases and 24 percent reduction in death rates among statin users. It was published in Prostate Cancer and Prostatic Diseases.

Why might statins help lower death rates among men with prostate cancer? Researchers hypothesize that statins may help reduce progression of the cancer, in part, by reducing inflammation, which has been linked to cancer and heart disease.

These studies did not focus on prevention, but so far there's no evidence that statins reduce the risk of developing prostate cancer in the first place.

GOOD TO KNOW

MRI Scan Could Spare Some from Prostate Biopsy

If your doctor suspects you have prostate cancer, undergoing a magnetic resonance imaging (MRI) scan immediately after an initial screening might spare you the medical risks of a prostate biopsy and improve your chances of an accurate diagnosis.

The results of a new British study suggest that MRI scans identified aggressive prostate cancers in men with the disease nearly twice as often as a transrectal ultrasound (TRUS)-directed prostate biopsy. However, among men without aggressive prostate cancers, the MRI incorrectly classified the disease more than twice as often as a TRUS-directed prostate biopsy. The study's authors contend that if an MRI was used before biopsy to diagnose prostate cancer:

- Nearly one in five deadly cancers missed with current testing methods would be detected
- Unnecessary prostate biopsies would be reduced by 27 percent
- Diagnosis of non-aggressive cancers also would be reduced.

The authors, whose findings were published online in January 2017 in The Lancet, note that an MRI scan provides a detailed, computerized image of the prostate and surrounding tissue. By contrast, 12 cores of prostate tissue are taken at random during a TRUS-directed biopsy, so tissue that contains an aggressive cancer elsewhere in the prostate can be missed. They add that biopsies are uncomfortable and can cause bleeding and serious infections, so avoiding some of those procedures would prevent those risks.

In the United States, limited access to qualified personnel to interpret prostate MRIs and the added expense of the scan has discouraged many doctors from ordering the test and third-party payers from covering the cost. And an MRI still may not be effective enough to be used routinely to detect—and rule out—malignant prostate cancers.

What the Study Found

In The Lancet study, 576 men suspected of having prostate cancer, based on initial screenings or family history, had a standard MRI followed by two types of prostate biopsy—a TRUS-directed biopsy and a prostate-mapping biopsy. The test was performed at hospitals and radiology labs throughout the United Kingdom.

The study's authors note that an MRI scan "tends to detect higher-risk disease and systematically overlooks low-risk disease." For men who had prostate cancer that most physicians would recommend treating, the MRI missed 12 percent of the cases while the TRUS-directed biopsy missed 52 percent. But for nonaggressive cancers, the MRI missed 55 percent while the TRUS-directed prostate biopsy misclassified them just 1 percent of the time.

"Detecting prostate cancers that need to be treated is a real clinical issue for those of us in the trenches treating prostate disease," says Joel Piser, M.D., a urologist in Berkeley, Calif. "The primary concern in evaluating prostate

or bladder symptoms is to rule out a significant malignancy. PSA (prostate-specific antigen) testing has helped but is far from perfect."

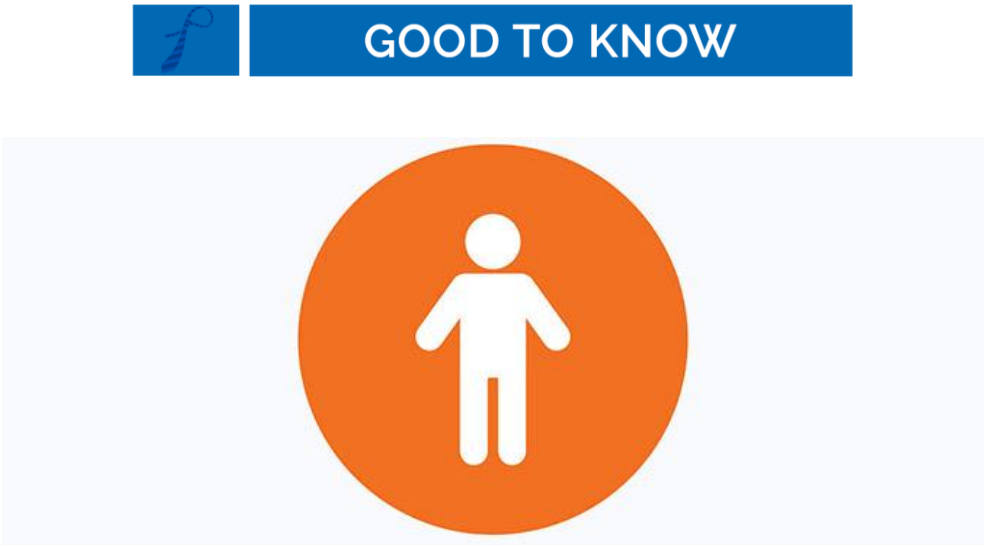
Piser says he uses the MRI to stage all newly diagnosed prostate cancer patients to gain valuable information on the extent of the disease and to help predict which patients will benefit from treatment versus active surveillance.

He says the MRI is a great clinical test to help reduce the chance of missing significant cancers in men who have excessive risk factors for biopsies, such as those with prosthetic heart valves, men taking anticoagulation medication, and for those who have an extreme fear of biopsies.

However, not all doctors who treat prostate cancer are convinced that MRI testing will become a part of regular prostate screening just yet. "For that to happen, MRI testing would have to show improved performance in identifying high-grade cancer and would have to be able to exclude high-grade cancer in men without the disease," says H. Ballentine Carter, M.D., professor of urology and oncology at Johns Hopkins School of Medicine in Baltimore. "Further evaluation is needed. In addition, the performance and interpretation of MRIs would need to be standardized."

Bottom Line

If initial screening results from a blood test or digital rectal exam suggest you might have prostate cancer, make an appointment with a urologist for a follow-up evaluation. Make sure it includes a digital rectal exam and a repeat prostate-specific antigen (PSA) test and/or other special blood tests, such as the PHI (prostate health index) or the 4Kscore Test, to determine whether you need a prostate biopsy, Carter says. If the results suggest that a clinically significant prostate cancer may be present, you may want to consider getting an MRI scan to help inform and guide a prostate biopsy



Prostatectomy and Incontinence: What to Expect

Many men, upon receiving a diagnosis of prostate cancer, fail to register anything else their urologist tells them. Thoughts of impending death block out any additional information provided. And if they are to undergo surgery, many men focus on ED as the major complication of radical prostatectomy.

But recovery of urinary control is far more important. If that happens slowly, or never happens at all, incontinence will cast a far greater shadow on their lives than impotence would. Hence, many men are surprised and embarrassed by the urinary incontinence they typically encounter following prostate surgery.

Prostate surgery is a shock to the system, and incontinence—the inability to contain urine—affects both quality of life and self-esteem. Although the incontinence itself isn't life threatening, the stigma attached to wet clothing and offensive odor can have profound consequences that may lead to humiliation and social withdrawal.

Causes of Incontinence

The reason incontinence develops is because the healthy tissue responsible for urinary control is at high risk during a prostate procedure due to its nearness to the prostate itself. Surgically removing the prostate entails separating the part of the urethra that passes through the prostate at the point where it joins the remaining sphincter located just downstream. It also may mean removal of part of the sphincter muscles when the tumor is extensive and possible damage to the nerves that control sphincter action if the operation is difficult to perform because of prostatic size or variations in anatomy.

Depending on how extensive the tumor is, the surgeon may also remove tissue at the bladder neck, which adjoins the prostate. The bladder neck is a tapering ring of muscles that act as shut-off valves, and these muscles funnel down to the urethra and can affect how well the new connections between the bladder and the urethra form. Experienced surgeons are certainly aware of these technical aspects of the surgery and generally keep this in mind when counseling patients about the relative safety of radical prostatectomy as opposed to other forms of treatment for the disease.

After the prostate has been removed, the surgeon reattaches the bladder to the urethra. When the sphincter has been damaged, it remains partially or fully open after healing is complete. Even when the surgery is performed expertly, there may be strain or damage to these muscles and leakage can result.

After Surgery

After almost all prostate surgeries, a urethral catheter is left in place for a few days to a few weeks, depending on the type and nature of surgery. In the first few weeks after removal of the catheter, most patients will experience temporary urinary frequency and incontinence. It doesn't matter whether a robot or a scalpel was used in the surgery. No one escapes from some degree of urinary leakage. A few drops of urine may leak out after getting up from a chair, during a walk in the park, or after lifting a bag of groceries. This is called stress incontinence. Others experience urgency—the sudden need to urinate—with many leaking uncontrollably before making it to the bathroom. A small subset of men experience a combination of stress and urge incontinence.

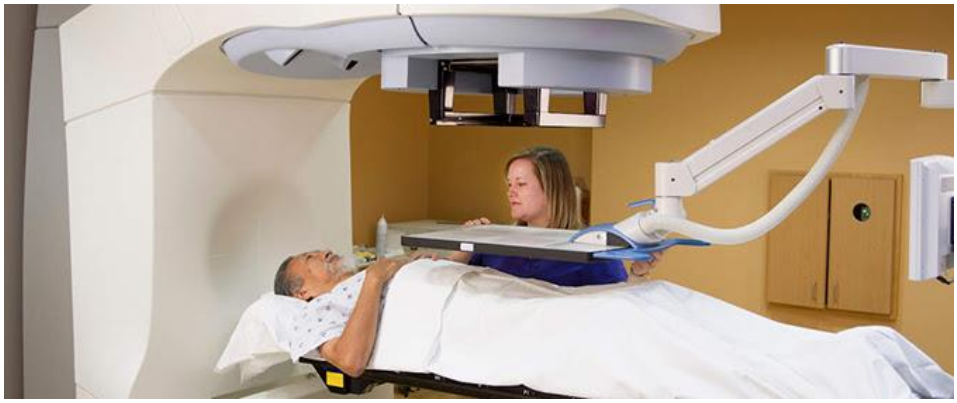
How common is incontinence following a radical prostatectomy? At medical centers of excellence, incidence of serious incontinence appears to be low, in the 3 percent range. However, if you look at overall national patient survey data, the incontinence numbers are dramatically higher, in the range of 50 to 60 percent.

When Incontinence Persists

Most incontinence, fortunately, is temporary. As the pelvic floor that supports your bladder heals and the external sphincter muscle that controls urine flow becomes more efficient, continence typically returns within a few weeks or months after catheter removal. (Even at this early stage, it is important that your doctor exclude two treatable conditions—urinary tract infection and urinary retention—that may be causing the problem.) The time frame varies, depending on the extent of the surgery, your age, and the surgeon's experience in rebuilding the urinary tract and preserving the urinary sphincter.

GOOD TO KNOW

PROSTATE HEALTH



Evolution of Radiation Therapy for Prostate Cancer

Hugh Hampton Young, M.D., performed the first radical prostatectomy—the surgery to remove a cancerous prostate—at Johns Hopkins Hospital more than a century ago in 1904. Although hailed as a success, the operation was difficult to perform because doctors had to operate in a virtual sea of blood, which made it extremely hard to see what they were doing.

In addition, the surgery came with two devastating side effects. One in four men experienced severe problems with urinary control, and every man lost the ability to have an erection.

The result was that both doctor and patient felt that the side effects from the surgery were almost worse than having prostate cancer. In the ensuing decades, not many men opted for prostate surgery.

The Beginnings of Radiation Therapy

Young was not daunted in his quest in finding a prostate cancer cure. In the early 1900s, while perfecting surgical techniques, he also began experimenting with placing radioactive radium pellets into the prostate as a treatment for prostate cancer. Unfortunately, radiation injury to patients and physicians limited the application of those initial attempts.

Still, he saw the real potential of the therapy. He noted, "In radium we undoubtedly have a therapeutic agent of great value in urology and with improved apparatus many brilliant results should be obtainable."

Fast forward to the 1990s, and Young's prophecy came to be. Thanks to a much better understanding of radiation and improved technology that saw the advent of three-dimensional imaging using computed tomography (CT) scanners, combined with linear accelerators that could produce a high-energy photon beam, it became possible to deliver high dosages of radiation more precisely to the prostate deep within the pelvis.

Computer programs were developed to plan radiation dosages based on a three-dimensional image of the prostate. Now referred to as three-dimensional conformal radiotherapy, or 3DCRT, it allowed the use of precisely directed high-radiation dosages and at the same time reduced the injury to nearby healthy rectal and bladder tissue from the radiation.

Many More Choices Exist

The good news today for men with localized prostate cancer is that there are now many ways to successfully treat the cancer. And the bad news is that there are now many ways to successfully treat prostate cancer. Deciding what therapy to choose is often very difficult for most men.

There is no scientific evidence that any one treatment for localized prostate cancer—whether radiation or surgery—will result in a better cancer-free outcome than another. This means that a man and his family will have to play a much larger role in decision making. The same men who are candidates for surgical treatment of stage T1 and T2 cancers are also eligible for radiation therapy.

Radiation therapy has some advantages, including no hospital stay or lengthy at-home rehabilitation. External radiation treatments are administered daily but are brief, and men can lead relatively normal lives around their treatment times. But there are some side effects, including fatigue, bladder irritation, and loose, frequent stools, though they are generally mild and can be eased with medication and changes in diet.

A More Precise Therapy

Radiation therapy for prostate cancer continues to evolve. Radiation oncologists and medical physicists have made a number of improvements in external beam radiation therapy in an attempt to increase cure rates and reduce the risk of complications.

These improvements include three-dimensional conformal radiation therapy (3DCRT), intensity modulated radiation therapy (IMRT), and image-guided radiation therapy (IGRT).

We are now in the era of IGRT, since the patient can be moved to realign his anatomy, ensuring that the radiation is precisely focused on the target at every treatment session. Treatment can also be adapted if the patient loses weight, for example, which results in changes in anatomy.

IGRT uses daily computed tomography (CT) scanning to create three-dimensional images that pinpoint the exact size and location of the prostate just before treatment. This information is then transmitted to a computer, allowing doctors to compare the current image with earlier images taken on previous treatment days.

During IGRT, doctors continually compare those images to see if the treatment area needs to be adjusted. Radiation specialists use IGRT to deliver more radiation to the tumor, ultimately leading to higher cure rates and more tolerable side effects.

How Radiation Kills Cancer Cells

Normal cells in the body divide and replace themselves in an orderly process, keeping you healthy and repairing structures as needed. However, cancer develops when the cells lose the ability to control their own growth. The cancer cells keep dividing, eventually forming clumps of tissue called tumors, or sometimes infiltrating throughout normal tissue and spreading beyond the organ where they originated—a process called metastasis.

DNA is the genetic information inside the cell necessary for life. Radiation therapy kills cells by damaging their DNA—either directly or by creating the charged particles called free radicals that can cause DNA damage.

When the injured DNA cannot be repaired, cells die. But radiation kills normal cells as well as cancerous cells, and so treatment must be directed precisely at the tumor. Since the prostate is a dispensable organ, radiation can be given at doses that will destroy all prostate tissue, normal and cancerous.

However, radiation dosages are limited by the damage caused to surrounding structures. So the radiation oncologist must achieve a delicate balance between delivering enough radiation that it destroys all the cancer but without causing collateral damage to neighbors such as the bladder and rectum, which can bring about serious side effects—some of them permanent if great care is not taken.

These can include urinary and bowel frequency and urgency, pain with urination and bowel movements, and bleeding. And, just as with radical prostatectomy, there is the potential for the radiation to damage the erectogenic nerves and vessels, resulting in ED.

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: _____

Send Notification to:

Name: _____

Address: _____

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Postal Code: _____

BOARD STRUCTURE 2017/2018

pccn.regina@gmail.com

Co-Chair - Bob Terichow
Phone: (306) 581-9158

Co- Chair - Lawrence Ward
Phone: (306) 543-8215

Treasurer - Larry Smart
Phone: (306) 757-4959

Secretary - Dwaine Snowfield
Phone: (306) 586-1403

Monthly Program
Jim Odling
Phone: (306) 522-7590

James Froh
Phone: (306) 450-0909

Peer Sharing
Lawrence Ward or any member of our Board
Phone: (306) 543-8215

Out Reach Program
Jim Odling
Phone: (306) 522-7590

Dwaine Snowfield
Phone: (306) 586-1403

Sieg Hodel
Phone: (306) 569-1957

Steve Pillipow
Phone: (306) 586-9345

Grant Rathwell
Phone: (306) 766-2372

Stan Hanoski
Phone: (306) 529-1322

James Froh
Phone: (306) 450-0909

Dennis Auger
dauger@sasktel.net

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 12 - Options Sexually After PCa

May 10 - Dr Asim Amjad
Allen Blair Cancer Clinic

June 14 - AGM

July – August - No Meetings

Pending for 2018-2019

- 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