# 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, October 10, 2019**

**Speaker:**
Dr. Dilip Panjwani
Radiation Oncologist

**Time:**
Registration – 6:15pm
Meeting – 6:30pm – 8:30pm

The time change is to accommodate one on one discussions and to have the meeting room cleared for lock up by 9:00pm.

**New Location:**
Saskatchewan Cancer Agency
200-4545– Parliament Ave.

West of Lewvan Drive in Harbour Landing.

Meeting room is on ground level.

Use south entrance.

Free parking on-site.

Visit our website!
www.pccnregina.ca

**Our Mailing Address:**
PCCN REGINA - PO Box 37264
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

**On October 10th, we will be switching over to a new Newsletter host. This means your email will be deleted off our current host and moved over to our secure Mailchimp server. On that day, you will receive an email letting you know that you've been added to our new newsletter system.**

**The new format will open you directly to the newsletter in your email. No more need to click on the site to open the newsletter; it will be there for you. Regina Prostate Support Group (pccn.regina@gmail.com) will be the sender as before.**

**If you do not receive that email on October 10th, please let us know. It's important that we know you have received the new format as it will be used going forward with the November newsletter. If you have any questions, do not hesitate to email us.**

## TAKE NOTE

## New for 2019-2020

We will now be meeting at the Saskatchewan Cancer Agency offices at
**200-4545 - Parliament Ave.** which is just west of Lewvan Drive in Harbour Landing.

We will meet in the meeting room on the main floor, to the right as you enter.
**Entrance is through the south doors.**

Doors will open at 6:00pm and lock at 7:30pm for security reasons. Free parking is available on site, other than in the reserved spots for SaskTel/Energy/Power as they have employees working after 6:00pm.

## TAKE NOTE

- Come prepared to ask questions of our presenter about your concerns or issues dealing with Prostate Cancer

- December Program on the PCa Assessment Pathway will include a Saskatoon Nurse Navigator via Telehealth hookup

**62 Canadian men are diagnosed with Prostate Cancer each day. 11 men will die each day from PCa. Early detection of PCa is key. When detected early the survival rate is 97%.**

**75% will die if not detected early and caught in later stages. Encourage your family and friends to have male members establish their PSA base line number in their mid 50's.**

## October's Presenter: Dr. Dilip Panjwani

### Radiation Oncologist

Dr. Panjwani has been practicing Radiation Oncology in Canada since 1990. He has held administrative positions in Ontario and BC. Dr. Panjwani trained in Radiation Oncology at Queen's University in Kingston, ON.

He launched an innovative method of treating Prostate Ca with 'Pure Hypofractionation' when in Kitchener, ON, in 2006. Long term results of this approach have recently been published, and show that the acute and late toxicities are very low, and success in curing the disease is maintained. This study was supported by 'Ride for Dad'.

Dr. Panjwani has also participated in a study on SBRT (stereotactic body radiotherapy) for Prostate Cancer along with colleagues at Toronto a few years ago, and looks forward to launching a study with innovation within SBRT here in Regina.

Extra-curricular: He Is in the process of publishing a book on 'Anatomy of the soul' explaining the nature of 'consciousness'… (it is currently being proof-read by his son who has a gold medal from Oxford, England in 'Philosophy of Physics')

**We welcome Dr. Panjwani to share his time with us.**

**From Last Month's Presentation by Nora Yeates, CEO**

Cancer Foundation of Saskatchewan

Case for Support

# OUR REASON WHY

*The Time is Now... to Support Cancer Care in our Province*

# Summary

## We are the fundraising partner of the Saskatchewan Cancer Agency, devoted to raising funds for cancer care.

"You have cancer."

These are some of the most difficult words for a patient and their loved ones to hear.

To many, they are a reminder that life is fragile.

To us, they are the words that inspire us every day to champion the cause and rally support for cancer patients in our province!

### Supporting Cancer Care Right Here at Home

The Cancer Foundation of Saskatchewan (Foundation) was created to be the fundraising arm of the Saskatchewan Cancer Agency (Agency), and support their incredible work of providing cancer control to the province's 1.2 million residents. This includes providing the very best in cancer treatment, health promotion, cancer screening and research.

All funds raised by the Cancer Foundation of Saskatchewan stay in Saskatchewan.

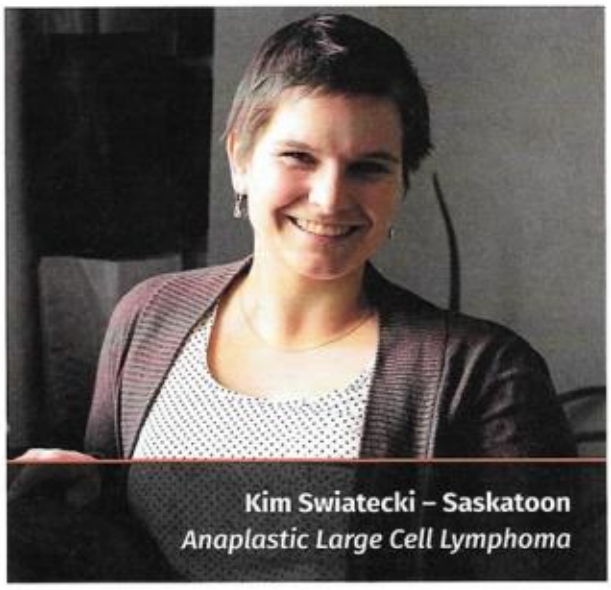
The Foundation received charitable status on May 14, 2018. There are now four full-time staff members and a dedicated volunteer board of directors whose members are from across Saskatchewan.

We are now ready to take on the fundraising role that supports the work of the Agency in providing high quality cancer care to the people of Saskatchewan.

### The Need for a Fundraising Foundation

For many years, Saskatchewan people have generously donated to the Agency. While they accepted donations and administered tax receipts, it was felt the development of an arms-length foundation would present an opportunity to further engage the community in assisting the work of the Agency.

We already know the other three western provinces have had foundations for upwards of 50 years. There has never been a cancer foundation in Saskatchewan - until now. The Foundation will focus on fundraising, allowing the Saskatchewan Cancer Agency to carry out their mandate of taking care of cancer patients.



**Kim Swiatecki – Saskatoon**
***Anaplastic Large Cell Lymphoma***

GOOD TO KNOW


# Two Lesser-Known Treatments for Prostate Cancer

Active surveillance, radical prostatectomy, and radiation therapy are well known strategies to manage and treat prostate cancer. This brief overview takes a look at two treatments that are not as familiar: cryotherapy and high-intensity focused ultrasound (HIFU).

**Cryotherapy.** Also known as cryoablation or cryosurgery, cryotherapy is a treatment that kills cancer cells by freezing them. In the procedure, thin needles (cryoprobes) are inserted through the perineum (the area between the scrotum and anus) and into the prostate. Needle placement is guided with an ultrasound probe placed in the rectum. Freezing gases drop the temperature of the cryoprobes to about –40°C. The extremely low temperatures create ice balls that freeze the entire prostate and some of the nearby tissue. Warm saline is circulated through the urethra and bladder to protect them from the freezing temperatures.

**HIFU.** This is a relatively new technique whereby sound waves are directed at the prostate using a probe placed in the rectum. The directed sound waves heat the prostate to a high temperature, destroying cancerous tissue.

**Potential candidates.** Both cryotherapy and HIFU may be reasonable options for some men whose cancer is contained within the prostate, and they are sometimes used when radiation therapy has failed to destroy the cancer. It's important to note that neither option has been as well studied as other forms of treatment.

GOOD TO KNOW


## Brachytherapy Basics

In brachytherapy, a type of radiation treatment for prostate cancer, 80 to 120 radioactive seeds (tiny metal pellets) are implanted directly into the prostate through the skin between the scrotum and rectum under ultrasound guidance. The pellets emit radiation for several months. After their radioactive energy is spent, they remain harmlessly in the body. Since the pellets are not removed and emit radioactivity over months, this approach is called permanent low-dose-rate brachytherapy.

According to guidelines from the National Comprehensive Cancer Network (NCCN), brachytherapy is an option for men with intermediate-, high-, and very-high-risk disease. Some physicians recommend a combination of brachytherapy and another type of radiation treatment known as external beam radiation therapy (EBRT) for men with more advanced disease. However, the combination may increase the risk of bowel-related side effects.

The side effects of brachytherapy—urinary and bowel problems—are similar to those of EBRT, but these complications may occur more often with brachytherapy among men with very large or very small prostates, those with lower urinary tract symptoms that are bothersome, and those who have previously had a transurethral prostatectomy (TURP). In addition, the radioactive seeds can migrate to other parts of the body, such as the lungs, although research suggests that seed migration has no negative consequences.

Another technique, which is known as high-dose-rate brachytherapy, is a refinement of low-dose-rate brachytherapy. In high-dose-rate brachytherapy, radioactive pellets are delivered to the prostate via hollow plastic needles. The pellets emit a high dose of radiation over a 24- to 48-hour period, after which they are removed.

Available research suggests that outcomes are similar among men treated with high- or low-dose-rate brachytherapy. But men treated with the newer technique experienced fewer side effects, including less urinary frequency, incontinence, blood in the urine, and rectal pain.

When radiation therapy is used to treat intermediate- or high-risk prostate cancer, adding hormone therapy has been shown to increase survival when compared to the use of radiotherapy alone. The timing of the hormone therapy is usually short term (four to six months) during and after radiation treatment of intermediate-risk disease, and longer (two to three years) during and after treatment of high-risk disease. Disease recurrence rates

may be lower in men with high-risk cancers treated with a combination of EBRT and brachytherapy. Hormone therapy is sometimes given to men with larger prostates (greater than 1.5 oz.) who are scheduled to start brachytherapy, with the aim of shrinking the prostate before the radioactive pellets are implanted.


## Can Diet Help Control Prostate Cancer Spread?

If you have prostate cancer that is confined to the prostate gland, a recent study suggests that the foods you choose to eat could help prevent the prostate cancer from spreading. The study was published in JAMA Internal Medicine (Volume 173, page 1318).

Researchers looked at the diets of 4,577 men diagnosed with prostate cancer that had not metastasized. Using data from food questionnaires, the researchers estimated how much fat and what types of fat each man ate.

Men who consumed the most fat from vegetable sources after being diagnosed with prostate cancer were least likely to have the disease progress and become deadly. The main sources of vegetable fats in their diets were oils (such as olive oil) and nuts. The authors estimate that replacing 10 percent of calories consumed in the form of carbohydrates (such as white bread, white rice or soda) with vegetable fats could lower the risk for lethal prostate cancer by 29 percent.

This was an observational study, so while it shows a link between fat consumption and prostate cancer metastasis, it doesn't prove that consuming more vegetable fats will stop prostate cancer spread. But all things considered, there's no harm in replacing animal fat and some carbs with vegetable fat.

Ask your doctor to refer you to a nutritionist to help you plan a healthy diet that meets your nutritional needs during and after your prostate cancer treatment.


## 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.

GOOD TO KNOW

# More Reasons to Eat More Fiber

A high intake of dietary fiber is associated with a wide array of health benefits, including a reduced mortality rate, according to a massive systematic review and meta-analysis in the Lancet earlier this year.

Researchers analyzed data from 59 clinical trials and 185 observational studies from around the world and found that people who consumed the most fiber (at least 25 to 30 grams a day) had a 15 to 30 percent lower death rate and incidence of heart disease, stroke, diabetes, and colorectal cancer than people who ate the least fiber (less than about 15 grams a day). High fiber intake was also linked to lower blood cholesterol, blood pressure, and body weight. Similar benefits were seen for higher intakes of whole grains, which are rich in fiber.

The average American consumes about 15 grams of fiber a day. To boost your intake, take these three steps:

1. Focus on high-fiber plant foods—vegetables, fruits, legumes, and whole grains. These are the "good" carbohydrates—nutritious, filling, and relatively low in calories. They should supply the roughly 20 to 35 grams of dietary fiber you need each day. Among other benefits, fiber slows the absorption of carbohydrates, so they have less effect on insulin and blood sugar. High-fiber foods also supply important vitamins, minerals, and potentially beneficial phytochemicals (plant chemicals).

2. In particular, eat lots of produce. Aim for 2 and a half cups of vegetables and 2 cups of fruit a day. That's based on a daily 2,000-calorie diet. If you consume more calories, aim for more produce. Include green, orange, red, blue/purple, and yellow vegetables and fruits—such as broccoli, carrots, tomatoes, berries, and citrus fruits. In addition to the fiber, the nutrients and phytochemicals in these foods may help protect against certain types of cancer and other diseases. Legumes, rich in fiber, can count as vegetables (though they have more calories than most vegetables). Choose whole fruits over juice for more fiber. Frozen and canned fruits and vegetables are good options (but watch out for added sugar and salt).

3. Eat more whole grains. At least half your grains should be whole grains (such as whole wheat and oats). Servings are small—a slice of whole-wheat bread, for instance, or a half-cup of cooked oatmeal or brown rice. Voluntary seals from the Whole Grains Council, found on some packages, can help you identify good sources. Keep in mind that many grain products that don't carry a seal may still be excellent choic

GOOD TO KNOW

# August 2019 – 1st Annual Smoke Off Fundraiser

Thanks to Board Member Stan for sharing

Colin Hanoski & Justin Symes, over a few drinks were talking about their respective meat smoking adventures. As one-story lead to another, it was only a matter of time before they challenged each other to a smoke off and as the night wore on, the 1st annual smoke off was born.

In their infinite wisdom they decided to charge each of their quests a fee and agreed that all proceeds raised would go to the winners, charity of choice.

Well , the smoke off was a hit, they prepared candied pork belly as an appetizer, pulled pork shoulder mixed with beans and smoked to perfection, lardy potatoes (lots of lard), the potatoes were sliced and fried in a large open skillet, (no exaggeration, 2 feet across and a 3-4 foot handle) over an open fire. They were sooo good.

Finally, they each prepared approx. a 20 lb. brisket which they smoked in their own smokers, with their own secret rub.

There was also plenty of salads and for dessert, smoked apple cobbler.

These briskets were tasted and judged by secret ballet.

As a result of the judging, Colin Hanoski squeaked out a win. They were both excellent, with very little left by the end of dinner.

**As a result of this hair brain idea, $950.00 was raised and Colin gratefully elected to donate the proceeds to The Regina Prostate Cancer Support Group (PCCN Regina). As a member of the group, a board member and his father, I am humbled that he would choose a charity near and dear to me.**

I would like to thank both Colin and Justin for the great meal, the judged Briskets as they were both excellent, the company was second to none and the overall result of collecting funds for charity was an excellent touch.

Thank you again for considering us as your charity of choice.

- Stan Hanoski

Also a big Thank You from all the Board members.

# 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: _____

_____

Postal Code: _____

## BOARD STRUCTURE 2019/2020

pccn.regina@gmail.com

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Peter Tyerman
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## 2019-2020 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.

### 2019

**September 12**
Nora Yeates, CEO
Cancer Foundation of Saskatchewan

**October 10**
Dr. Dilip Panjwani - Radiation Oncologist
Prostate Cancer Treatment

**November 14**
Andrew Kletcho & Nikkoli Hubic
"MOVEMBER" Programming on Men's Health

**December 12**
Mikkie Robicheau – Nurse Navigator
Prostate Assessment Pathway Update

### 2020

**January 09**
Family Doctors - PCa Diagnoses & Treatment

**February 13**
Wills and Estate Planning

**March 12**
Men's Sexual Health

**April 09**
Incontinence and Pelvic Floor Therapy

**May 14**
Mental Health and Cancer

**June 11**
Member Appreciation and AGM

### Pending for 2020

- UofR Nursing Research on Aging and Cancer
- Androgen Deprivation Therapy (ADT)
- Chemotherapy and PCa
- Medical Cannabis
- Wellness, Fitness, Nutrition – Paul Schwann
- Breast/Prostate Cancer Connections