Informed Prostate Cancer Support Group Inc.

"A 501 C 3 CORPORATION ID # 54-2141691"

DECEMBER 2016 NEWSLETTER

P.O. Box 420142 San Diego, CA 92142
Phone: 619-890-8447 Web: http://ipcsg.org

We Meet Every Third Saturday (except December)

Sunday, January 15, 2017

Volume 9 Issue 11

Next Meeting
January 21, 2017
10:00AM to Noon

Meeting at

Sanford-Burnham-Prebys Auditorium

10905 Road to the Cure, San Diego CA 92121

SEE MAP ON THE LAST PAGE

What We Are About

Our Group offers the complete spectrum of information on prevention and treatment. We provide a forum where you can get all your questions answered in one place by men that have lived through the experience. Prostate cancer is very personal. Our goal is to make you more aware of your options before you begin a treatment that has serious side effects that were not properly explained. Impotence, incontinence, and a high rate of recurrence are very common side effects and may be for life. Men who are newly diagnosed with PCa are often overwhelmed by the frightening magnitude of their condition. Networking with our members will help identify what options are best suited for your life style.

Table of Contents

Editor: Stephen L Pendergast

PROSTATE CANCER IT'S ONLY 2 WORDS NOT A SENTENCE

Last Meeting Summary By Bill Lewis

Our Nov 19. Meeting featured Dr. Richard Lam, M.D., Research Director, Prostate Oncology Specialists. He gave a well attended overview of Updates and recent treatment developments. Dr. Lam's presentation was entitled "2016 Update on Prostate Cancer: New Standards to Individualize Treatment".

(Continued on page 2)

Video DVD's

DVD's of our meetings are available in our library for $10ea. Refer to the index available in the library. They can also be purchased through our website: http://ipcsg.org Click on the 'Purchase DVDs" button.

The DVD of each meeting is available by the next meeting date.

(Continued from page 1)

Low-risk Prostate Cancer:

A major study in the UK, called the ProtecT trial, was recently published. Over 1600 men, randomized to surgery, radiation (plus hormone therapy), or "active surveillance," were followed for ten years. Amazingly, only about 1% of the men died of prostate cancer. About 10% died from all causes, so these men were more than eight times as likely to die of something OTHER than their prostate cancer.

Results for surgery vs. radiation were very similar, but surgery had somewhat more side effects that affected quality of life. Side effects were least with active surveillance, but disease progression was more than twice as common vs. the active treatments. (As might be re-phrased as "only twice as common." That is, despite foregoing or postponing active treatment by surgery or radiation, only a fraction of the men on active surveillance had disease progression. Those who underwent active treatment still had disease progression in many cases.)

Active surveillance is approved by four major medical organizations, and is considered appropriate for about 68% of newly diagnosed cases of low-risk prostate cancer (i.e., PSA under 10, Gleason results mainly 3+3 or a little 3+4, no or small nodules - only in the prostate itself, and a "favorable" genetic profile).

Intermediate Risk (PSA 10-20, no or small nodules - only in the prostate, Gleason score = 7 with >50% of cores involved, etc.):

A study recently at the 5-year mark was aimed to compare the use of radioactive seeds alone vs. the currently offered therapy of EBRT (external beam radiation therapy) plus seeds. Results were at least as good with the seeds alone, and they gave less severe side effects. (Note: for Low Risk prostate cancer, seeds are already considered equivalent to external radiation or surgery, and are lower cost and easier to administer. A great talk on seeds was given by the late Dr. Peter Grimm at the 2015 PCRI conference, and the video is available in our IPCSG library for loan.)

High risk prostate cancer (PSA >20, Gleason 8-10, tumors extending outside the prostate capsule, but not metastatic to distant sites):

A retrospective study of almost 5 years compared EBRT and EBRT + Seeds vs. Surgery. More than half of those undergoing surgery had radiation later due to PSA relapse. Many of the men in the study also received hormone therapy, especially after EBRT, which probably reduced their relapse rate. The lowest incidence rate for metastases was with EBRT + Seeds.

Survival results were complex: fewer died of prostate cancer in the EBRT + Seeds group, but more of this group died of all causes. All-causes deaths were lowest in the surgery group, probably because that group was younger by 8 years on average. It's not known why the EBRT + Seeds group had more all-causes deaths than the EBRT-alone group. Note that the report covered only the first 4.6 years of an ongoing study.

Metastatic prostate cancer:

It is known that systemic medicines (e.g., hormone therapy) improve survival. A retrospective study of about 6,000 men given hormone therapy as their first treatment showed that those who ALSO received radiation treatment of the prostate survived an average of 55 vs 37 months, and that after 8 years, 33% of the irradiated men were alive vs. 15% of those who received only hormone therapy.

There is precedence for such a benefit in treating the "mother ship" in kidney cancer (which is particularly sensitive immunologically), but there is no corresponding benefit seen in breast cancer. Radiation is considered relatively safe, and can provide some palliative effects related to obstruction, bleeding or pain. However, it does have side effects.

Oligometastatic prostate cancer, that is, relatively few metastases distant from the prostate and semi-

(Continued on page 3)

(Continued from page 2)

nal vesicles:

Interest is growing in the idea of treating these metastases (other than by systemic medicines), possibly for palliation, cancer remission, avoiding the need for Lupron (avoiding its side effects), and/or to improve survival. Rationale: If lymph node metastases are removed during surgery, 10-40% will not ever need additional treatment (-- best if only 1 node involved). Another option is radiation directed to one or a few spots in the lymph nodes or the bones.

Options for radiation treatment schedules range from 3-7 weeks (conventional schedule) through 1-2 weeks ("hypofractions") and even to 1-2 sessions ("Stereotactic radiosurgery").

A literature review of 15 studies of men who had relapsed after local therapy, who then had radiation or surgery directed at the metastases, gave encouraging results. Radiation "controlled" (killed or rendered inactive) 96% of the spots, and it took averages of 15-57 months in the various studies for new metastases to appear. Three years post-surgery, 42-64% of the men had stable disease (i.e., without progression). Most of the patients in the study also received hormone therapy (and longer use was beneficial, at least after radiation), so use of Lupron or the like was not avoided in most cases. Surgery results were better if the PSA was still "low" at the time of the operation. Unfortunately, these studies did not show a survival benefit (but remember that these men already were having disease progression after initial local therapy). More studies are needed.

Immunotherapy:

PD-1 Inhibition. Programmed Death-1 is a receptor on the T-cell. It binds to a site on tumor cells called PD-L1. This site is present in prostate cancer, especially in newly diagnosed patients (>50%), but less in CRPC (hormone therapy-resistant cancer). This binding allows the cancer cell to inhibit the T-cell's ability to kill the cancer. Blocking either of these sites improves or reestablishes the ability of the T-cell to kill the cancer. This blocking is thus an enhancement of the immune system.

A study of treating 23 men with CRPC (who had been heavily pre-treated with other therapies) using Keytruda (Pembrolizumab) resulted in 3 men "responding" (reversal of their PSA rise) for over 1 year and 9 men having "disease stabilization," with only relatively modest side effects. So about half of the men had a favorable result.

In another study of Keytruda, 20 men resistant to Xtandi (enzalutamide) and Lupron obtained similar results (regression or stabilization of the disease in 11 of them), with 5 men reporting significant side effects (from the immune system attacking other parts of the body).

Summary:

In Low and Intermediate Risk patients, the 10-year survival is about the same for surgery, radiation, and active surveillance. In Intermediate Risk patients, the 5-year success rate is about the same for seeds alone vs seeds + radiation. In High Risk patients, seeds + radiation might be the most effective treatment. In Metastatic disease, treating the prostate and/or oligometastases might improve outcomes, but more research is needed. Immunotherapy is the next frontier, and is producing encouraging results.

Future developments to watch for:

Combinations of two different immunotherapy agents, or of one such agent + treatment of oligometastases. More data on a "PARP inhibitor" called Olaparib, that was discussed last year, is expected. Perhaps traditional biopsies will be avoided. Next generation radionucleotides may include lutetium or actinium in analogues of Xofigo. More next year on testosterone supplementation issues.

Comments and questions:

January's speaker is an expert on radioactive seeds.

Active Surveillance has been criticized for higher mortality in the ProtecT study, but those who

on page 4)

(Continued from page 3)

died started with a higher PSA and a higher Gleason score.

Prostvac – waiting for randomized trial to be published.

Supplements update – some data on Vitamin B or multivitamins being bad for prostate cancer.

In the ProtecT study, about half of the men on active surveillance did eventually get some kind of active treatment during the 10 years of the study. But side effects are avoided during the non-treatment period.

In Dr. Lam's office, they are doing some trials with Keytruda (4 doses, hoping for 20-30% benefitting) and with Opdivo, using drugs supplied at no cost by the manufacturers.

After local therapy, if the PSA rises, there is a judgement call as to when to look for where it is, and to decide whether to treat it. A key indicator is the rate of rise.

How often to do a biopsy – depends on the aggressiveness of the cancer during the first few years. There is more reliance on imaging and directed biopsies.

Dr. John Kurhanewicz, Phd of UCSF in San Francisco, who helped originate the mpMRI procedure, now thinks he can fairly accurately determine the Gleason score from the MRI alone, without a biopsy. Dr. Lam envisions the possibility of liquid biopsies (blood tests) in combination with mpMRI. But there is a reluctance to treat without a biopsy, which they preferentially do as a targeted biopsy, not a random biopsy.

Proton Therapy will be discussed by Dr. Mundt in January.

Effect of hormone therapy on oligometastatic disease: Not likely a cure.

The PSA test is 98-99% effective in showing whether the disease is progressing. It can detect invisible, asymptomatic cancer.

Use of Xtandi before the cancer is metastatic – studies are underway. Dr. Lam expects it to be mildly beneficial. Zytiga has not been very helpful. Xtandi as a monotherapy (like Casodex monotherapy) looks promising.

Gallium-based PET scans at UCLA have started. Cost is about $1000. Also being done in Australia for the past two years at that same price.

Use of liquid biopsies – used a few times to decide whether to do a needle biopsy, in Dr. Lam's office.

Usefulness of Docetaxel or Taxotere in high risk patients receiving radiation and hormone therapy – Six doses of chemotherapy gave about a 5% difference in remission at the three-year mark. In such patients in his office, Dr. Lam recommends radiation + seeds + chemo when he thinks there may be a benefit. Leads to hair loss and more fatigue.

(Continued on page 5)

FUTURE MEETINGS

December - No Meeting

Jan. 21, 2017 - AJ Mundt, MD and John P Einck MD, Department of Radiation Medicine & Applied Sciences UCSD will speak on new advances in radiation treatments and brachytherapy.

(Continued from page 4)

ON THE LIGHTER SIDE

"Don't worry. We still have a few more treatment options available."

The things they don't tell you about life after prostate surgery

https://goo.gl/MmLfGw By Garret Mathews Chicago Tribune

You should allow as much time as possible between diagnosis and surgery. This is in case you are not married. Post-operation, you will smell like the toilet at the bus station. It is imperative that you find a partner willing to have, to hold and to change your catheter bag.

The first time you go out to a restaurant you will eschew the smaller leg casing in favor of the full-sized urinary catheter. You will smugly think you have fashioned a purse-like sack that will hide the offending 2-foot tube that, often, is more red than yellow. A woman at the next table will notice and start to gag. You will duck out before the waiter arrives. Lesson learned. Attach the leg bag.

You will experience bladder spasms. It will feel like someone — or something — has issued the order to squeeze to kill. If you even think about doing 3 percent of a situp, your lower abdomen will seize up and surrender to the other side.

Your urologist will say you can't go to the gym until he says so. You will think, hey, the fool was wrong about driving and walking. What's the harm of doing 15 minutes' worth of light bending and stretching to make sure I stay off TLC?

Plenty. Your Ooze-O-Meter will spike. You will be dizzy. When you return to your car, you will not so much climb in the front seat as fall in. Listen to the guy on this one.

How many days did you have to wear the catheter and Ooze-O-Meter? Twenty. We are becoming old friends.

How have you adjusted to wearing Depends? The only way possible. I get to experience being 88 years old without actually being 88.

(Continued on page 6)

(Continued from page 5)

How many times a day do you tell your wife that you love her? I try not to get below a dozen, 15 if she's having trouble with the catheter.

Top Prostate Cancer News of 2016

https://goo.gl/de4iNr November 18, 2016 | Prostate Cancer Year in Review 2016
By Cancer Network Editors

Aspirin May Lower Risk of Dying From Prostate Cancer: A study found that regular aspirin use in prostate cancer patients, defined as taking aspirin more than three times a week, was associated with a 39% lower risk of dying from the disease compared with men who reported less frequent aspirin use or no aspirin use (hazard ratio, 0.61). The study evaluated data from 22,071 men who took part in the Physicians' Health Study. Men enrolled in this cohort were tracked from 1982 until 2009. After more than 27 years of follow-up, 3,193 men were diagnosed with prostate cancer and, of those, 403 developed either metastatic prostate cancer or died from the disease. https://goo.gl/zOwQIZ

Liquid Biopsy Cell Diversity Could Indicate Poor Prostate Cancer Prognosis: A study of 150 prostate cancer patients found that those who have a more heterogeneous set of detectable circulating tumor cells (CTCs) are more likely to develop resistance to anti-androgen therapy. Patients with the high heterogeneity score prior to enzalutamide or abiraterone treatment had a median progression-free survival of 5 months compared with 17 months in patients with a low heterogeneity score (hazard ratio [HR], 2.2; $P = .00182$). The high heterogeneity score patients also had shorter median overall survival compared with patients with a low heterogeneity score (9 months vs not reached; HR, 5.51; $P < .0001$).

Radiation Therapy in Prostate Cancer Linked With Low Risk of Secondary Cancers: Men who receive radiation therapy as treatment for their prostate cancer may have an increased risk of developing a subsequent, secondary cancer, according to a meta-analysis of 21 observational studies. Among the prostate cancer patients who underwent radiation therapy, the highest absolute rates of bladder, colorectal, and rectal cancers were 3.8%, 4.2%, and 1.2%, respectively. The lowest reported rates for the same cancers were 0.1%, 0.3%, and 0.3%, respectively. The results do not warrant changes to current therapeutic regimen decisions for most men with high-grade prostate cancer. There was no consistent link between radiotherapy for prostate cancer and secondary lung cancer or hematologic malignancies.

PSA Testing Declining Faster With Primary Care Physicians Than Urologists: The 2012 change in guidelines regarding prostate-specific antigen (PSA) testing for prostate cancer had a different effect on testing rates depending on which physician specialty was doing the testing. Primary care physicians (PCPs) showed a marked decline in PSA tests administered, while urologists had only a slight drop. The study included 113 patient visits to urologists and 1,109 to PCPs. Among the PCP visits, the use of PSA testing declined from 36.5% in 2010 to 16.4% in 2012, for an odds ratio of 0.43 ($P = .009$). The rate only decreased among urologists from 38.7% to 34.5%, for an odds ratio of 0.34 ($P = .09$). The difference between physician-specific testing practices was statistically significant ($P < .001$).

Prostate Cancer Survivors Have Elevated Colorectal Cancer Risk: A large cohort study showed that the risk of colorectal cancer is increased following a diagnosis of prostate cancer. This suggests colorectal cancer screening should be considered following a prostate cancer diagnosis, especially among those undergoing radiotherapy. The researchers conducted a historical cohort study based on data col-

(Continued on page 7)

(Continued from page 6)

lected in Manitoba, Canada, covering a total of 14,164 men with prostate cancer and 69,051 controls without prostate cancer. Over the course of the follow-up period, 2.8% of the prostate cancer survivors were diagnosed with colorectal cancer, compared with 2.6% of the non–prostate cancer cohort. The hazard ratio (HR) for prostate cancer survivors being diagnosed with colorectal cancer was 1.14 (95% CI, 1.02–1.27; *P* = .021), with the highest risk seen within the first 30 days of diagnosis (HR, 3.04; 95% CI, 1.42–6.51; *P* = .004).

Hormone Therapy for Prostate Cancer Linked to Depression: An analysis of the Surveillance, Epidemiology, and End Results (SEER) database found that men who receive androgen deprivation therapy (ADT) as part of their treatment for prostate cancer may be at higher risk for depression. The researchers analyzed a cohort of men with stage I–III prostate cancer who were over the age of 65. Longer exposure to ADT resulted in an increased risk of depression, from 12% among patients with less than 6 months of therapy to 26% in those with 7 to 11 months of therapy, and up to 37% among those treated for 12 months or longer (*P* < .001). Cumulative incidence of newly diagnosed depression from 6 to 36 months after a prostate cancer diagnosis was higher among the men who were treated with ADT (7.1% vs 5.2%; *P* < .001).

Maintaining High Physical Activity Improves Prostate Cancer Survival: A study found that prostate cancer patients who kept up a moderate to high level of physical activity had better survival prognoses compared with their more sedentary counterparts. After a prostate cancer diagnosis, men who exercised for 17.5 or more metabolic equivalent of task (MET) hours per week prior to their diagnosis had a 30% lower risk of prostate cancer mortality compared with men who exercised for fewer than 3.5 MET hours per week (comparable to less than an hour of moderately paced walking per week). Men who were the most physically active had a 34% lower risk of dying from prostate cancer compared with men who exercised the least

Robotic Surgery On Par With Open Surgery for Prostate Cancer: A randomized controlled trial found that robot-assisted and open radical surgeries for prostate cancer have similar outcomes for patients at 3 months. Patients who underwent robotic surgery or open surgery had similar quality-of-life outcomes at 3 months, including sexual and urinary function. These results are the initial results of a 2-year follow-up of patients on the trial. Urinary function was not different between the two surgical groups. At 6 weeks after surgery, urinary function scores were 74.50 and 71.10 in the open and robotic surgery arms, respectively (*P* = .09). At 12 weeks, urinary function scores were 83.80 and 82.50, respectively (*P* = .48). Sexual function scores were also similar between the two surgical groups: at 12 weeks, the scores were 35.00 and 38.90 in the open and robotic surgery arms, respectively (*P* = .18).

Reserve ADT for African-American Men With High-Risk Prostate Cancer? Androgen-deprivation therapy (ADT) is associated with shortened survival in African American (AA) men with favorable-risk prostate cancer, according to a study in *Cancer*, suggesting that ADT should be reserved for those with higher risk disease. The new study included 7,252 men with low- or favorable intermediate-risk prostate cancer treated with brachytherapy and ADT or no ADT. In total, 869 men died during the follow-up period (median, 8.04 years), 48 from prostate cancer. On a multivariate analysis, AA race was significantly associated with an increased risk of all-cause mortality (adjusted hazard ratio, 1.77; *P* = .028) and other-cause mortality (HR, 1.86; *P* = .024) among men who received ADT.

Test Can Predict Post-Op Radiotherapy Outcomes in Prostate Cancer: A study showed that a 24-gene signature called the Post-Operative Radiation Therapy Outcomes Score (PORTOS) can predict outcomes following postoperative radiotherapy (RT) in patients with prostate adenocarcinoma who underwent radical prostatectomy. The study included a training cohort of 196 patients and a larger valida-

(Continued on page 8)

(Continued from page 7)

tion cohort. In the training cohort, among patients with a high PORTOS, those who had RT had a 10-year distant metastasis rate of 5%, compared with 63% in those who did not receive RT, for a hazard ratio (HR) of 0.12 ($P < .0001$). Among those with a low PORTOS, the opposite was seen. Those who underwent postoperative RT had a 10-year distant metastasis rate of 57%, compared with 31% in those who did not undergo RT (HR, 2.5; $P < .0001$). The validation cohort confirmed these findings.

Top 5 prostate cancer articles of 2016 https://goo.gl/JU5d3b
December 13, 2016
The debate over PSA screening remained a key topic in prostate cancer this year. Other topics that resonated with you included biomarkers and genomic tests, active surveillance, and the first randomized trial comparing robotic and open radical prostatectomy. Here are Urology Times' most-read prostate cancer articles of 2016:
Markers redefining prostate cancer care In this interview, Daniel W. Lin, MD, of the Washington, Seattle discusses the practical use of currently available molecular and genomic tests, cost and reimbursement considerations, the role of MRI, and what the future holds for biomarkers. https://goo.gl/sppPmL
Can BPH and prostate cancer be prevented? Benign prostatic hyperplasia (BPH) and prostate cancer are two of the most common and costly diseases of older men (J Urol 2005; 173:1309-13; J Urol 2005; 173:1256-61; J Urol 2011; 186:971-6; CA Cancer J Clin 2016; 66:7-30; Curr Opin Urol 2013; 23:331-6). While timely diagnosis and appropriate treatment are important strategies for mitigating morbidity and mortality, BPH and prostate cancer are also potentially preventable, writes J. Kellogg Parons, MD, MHS, of Moores UC San Diego Comprehensive Cancer Center and Section of Urology, San Diego Veterans Affairs Medical Center, La Jolla, CA. https://goo.gl/og3U9n
Study: PCa genomic test reduces decisional conflict For men with high-risk pathology at radical prostatectomy, exposure to results of a genomic test that classifies 5-year risk of metastasis reduces decisional conflict, according to findings of a prospective study presented at the American Society of Clinical Oncology annual meeting in Chicago. The research also demonstrated that information from the genomic test, Decipher, lowers provider uncertainty about treatment recommendations and alters treatment intensity recommendations. https://goo.gl/aXj6gT
Prostate Ca: PSA drop, active surveillance are key themes Fusion biopsy, salvage versus adjuvant radiation therapy, and superextended versus extended pelvic lymph node dissection are also covered in the take home messages on prostate cancer from the 2016 AUA annual meeting. The prostate cancer take homes were presented by Robert Abouassaly, MD, MSc, of University Hospitals Case Medical Center, Cleveland. https://goo.gl/67iwlJ
Robotic vs. open RP: Experts react to first randomized trial
The first published randomized controlled trial comparing robot-assisted laparoscopic prostatectomy with open radical retropubic prostatectomy was published in The Lancet (2016; 388:1057-66). Urology Times reached out to several key opinion leaders for their interpretation of the results. Their analyses centered on postoperative complications between the surgical approaches, the need to account for findings from other studies, oncologic outcomes, and cost differences. https://goo.gl/b1cMLM

Additional news links can be found at: https://goo.gl/6dWGJF

NETWORKING

The original and most valuable activity of the INFORMED PROSTATE CANCER SUPPORT GROUP is "networking". We share our experiences and information about prevention and treatment. We offer our support to men recently diagnosed as well as survivors at any stage. Networking with others for the good of all. Many aspects of prostate cancer are complex and confusing. But by sharing our knowledge and experiences we learn the best means of prevention as well as the latest treatments for survival of this disease. So bring your concerns and join us.

Please help us in our outreach efforts. Our speakers bureau consisting of Lyle LaRosh, Gene Van Vleet and George Johnson are available to speak to organizations of which you might be a member. Contact Gene 619-890-8447 or gene@ipcsg.org to coordinate.

Member and Director, John Tassi is the webmaster of our website and welcomes any suggestions to make our website simple and easy to navigate. Check out the Personal Experiences page and send us your story. Go to: http://ipcsg.org

Our brochure provides the group philosophy and explains our goals. Copies may be obtained at our meetings. Please pass them along to friends and contacts.

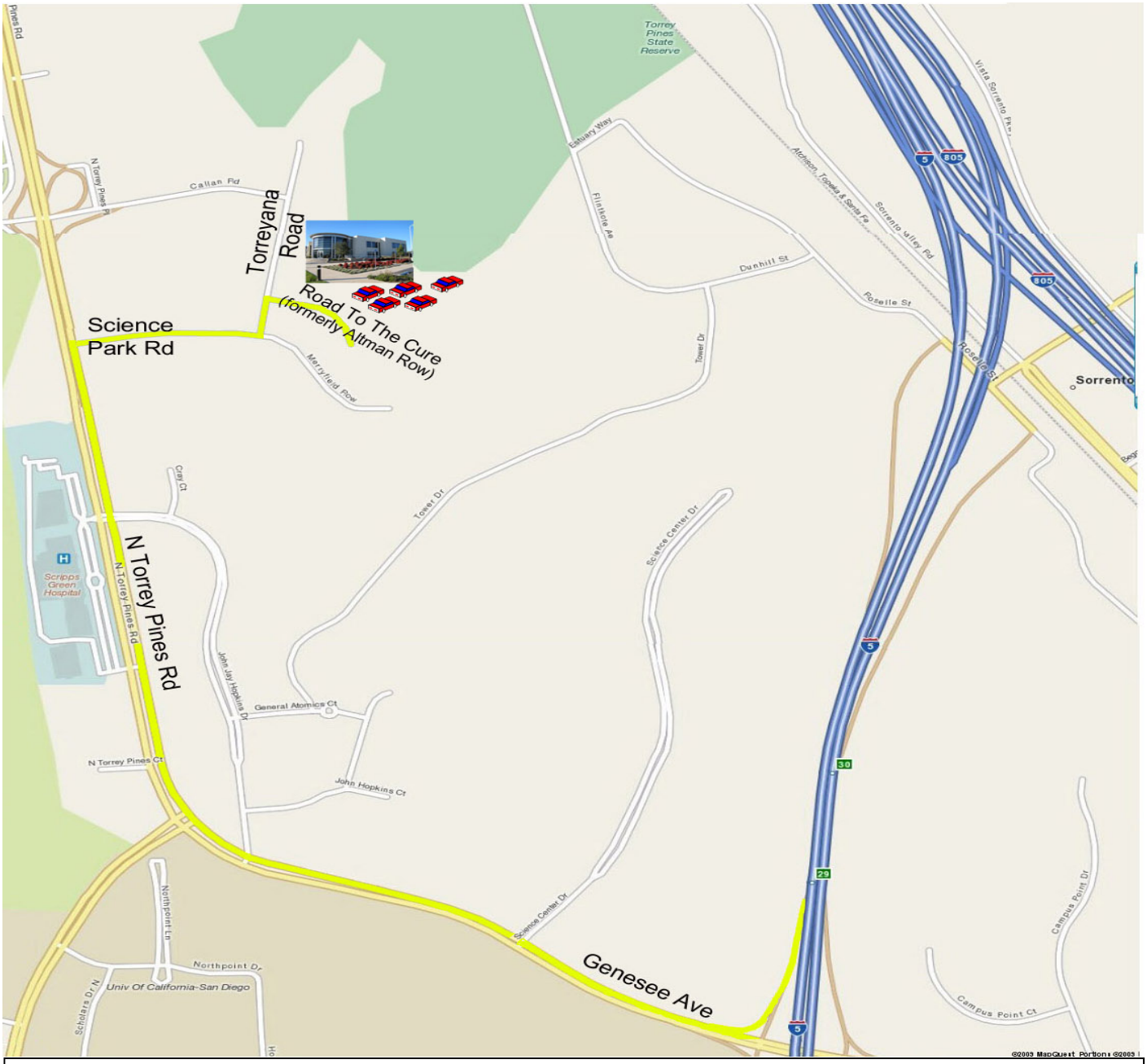
Ads about our Group are in the Union Tribune 2 times prior to a meeting. Watch for them.

FINANCES

We want to thank those of you who have made special donations to IPCSG. Remember that your gifts are tax deductible because we are a 501(c)(3) non-profit organization.

We again are reminding our members and friends to consider giving a large financial contribution to the IPCSG. This can include estate giving as well as giving in memory of a loved one. You can also have a distribution from your IRA made to our account. We need your support. We will, in turn, make contributions from our group to Prostate Cancer researchers and other groups as appropriate for a non-profit organization. Our group ID number is 54-2141691. Corporate donors are welcome!

If you have the internet you can contribute easily by going to our website, http://ipcsg.org and clicking on "Donate" Follow the instructions on that page. OR just mail a check to: IPCSG, P. O. Box 4201042, San Diego CA 92142



Directions to Sanford-Burnham-Prebys Auditorium
10905 Road to the Cure, San Diego, CA 92121

Take I-5 (north or south) to the Genesee exit (west).
Follow Genesee up the hill, staying right.
Genesee rounds right onto North Torrey Pines Road.
Do not turn into the Sanford-Burnham-Prebys Medical Discovery Institute or Fishman Auditorium
Turn right on Science Park Road. Watch for our sign here.
Turn Left on Torreyana Road. Watch for our sign here.
Turn Right on Road to the Cure (formerly Altman Row). Watch for our sign here.