Informed Prostate Cancer Support Group Inc.
"A 501 C 3 CORPORATION ID # 54-2141691"

January 2021 NEWSLETTER

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Monday, January 18,

Volume 14 Issue 1

- **Saturday, January 16th, 2021 IPCSG - Live-Stream Event, 10:00am PT**
  Dr. A.J. Mundt has assembled a fantastic panel for our first Webinar of 2021. Below is the list of speakers and an overview of their presentations. Dr. Mundt will give a short overview, then introduce the other presenters.
  1. Dr. Andrew Sharabi will discuss Oligometastases/Immunotherapy
  2. Dr. Carl Rossi will discuss treating prostate cancer patients with proton therapy
  3. Dr. Tyler Seibert will discuss a study of an advanced form of MRI and its ability to give faster answer to treatment response
  4. Dr. Brent Rose will discuss Active Surveillance
- Due to COVID-19, no in-person meetings at the Sanford Burnham Prebys Medical Discovery Institute will take place until further notice. This meeting will be live-streamed and will also be available on DVD.
  For further Reading: https://ipcsg.blogspot.com/
- **For Comments, Ideas and Questions,** email to Newsletter@ipcsg.org

2020 Meetings and Streaming Review

Following listing describes talks given each month last year either at meetings or by streaming. This should help members in accessing meeting recordings on the website, or picking newsletters to read. These are derived from the monthly notes taken by Bill Lewis, whose full summaries are published in the newsletters

January 2020 IPSG Meeting

Advances in Radiation Therapy By Arno J. Mundt MD FACRO FASTRO, John Einck MD FACRO and Brent Rose MD

Dr. Mundt began with an overview of prostate cancer (PCa) treatments. Surgery is now often done by robotic assistance, which he parenthetically noted makes possible remote surgeries where the surgeon is not in the same room – or continent – as the patient. Hormone therapy includes ADT (androgen deprivation therapy) and chemo-therapies. Radiation treatments can be given externally by photon or proton beams, or internally by "brachytherapy" – permanent or temporary introduction of radioactive "seeds" into the prostate. When radiation is given without surgery, it is called definitive treatment. It is called adjuvant treatment if it follows surgery.

New directions: A multidisciplinary clinic is beginning, for high risk and oligometastatic patients with prostate cancer, with Dr. Rose, Dr. Rana McKay and Dr. Kelly Parsons at UCSD. This puts different medical specialties into "the same room" to optimize patient care. UCSD has clinical trials including the Whole Body MRI trial, advanced hormonal therapy trials, genomic focused personalized medicine and targeted therapies like PARP inhibitors. As mentioned above, the new Varian Ethos treatment machine is coming soon to UCSD, and will help improve target-ing in sensitive areas of the body. Proton therapy is another increasingly used treatment for certain situations, de-pending on the patient.

Dr. Rose concluded by asking "What can you do?" Be your own advocate! Ask questions! If you only have a

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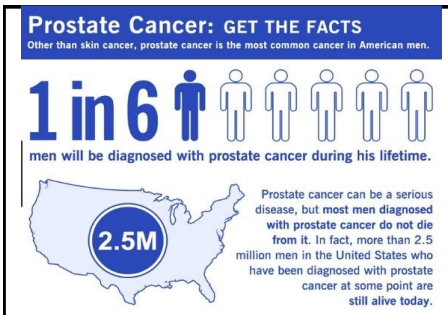

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NEWSLETTER
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PROSTATE CANCER—*2 WORDS, NOT A SENTENCE*

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.

Meeting Video DVD's

DVD's of our meetings are available for purchase on our website at https://ipcsg.org/purchase-dvds and are generally available by the next meeting date.

From the Editor

Due to COVID-19, no in-person meetings will be held until further notice. Our speaker this month will be broadcast via the IPCSG website at https://ipcsg.org/live-stream and can be watched by scrolling down and clicking on the "WATCH THE PRESENTATION" button. The broadcast will begin approximately 10 minutes before to the listed start time.

We will continue to post and distribute the newsletter in the interim. In order to include more articles of interest in this issue, we have included extra pages in the web distributed version of the newsletter. The mail version is limited to ten pages.. The January edition of the newsletter is a little different. Since there was no meeting last month, we provide a review of what was covered in all 11 meetings last year to help new members in particular in finding issues which are of interest.

Articles of Interest

- An unexpected, and novel, target for prostate cancer: Our biological clock
- Whole pelvic salvage radiation may be better than precisely targeted lymph node salvage radiation
- Higher coffee intake may be linked to lower prostate cancer risk
- Is This Really Cancer? "the hard 6"

Join the IPCSG TEAM

If you consider the IPCSG to be valuable in your cancer journey, realize that we need people to step up and HELP. Call **President** Lyle LaRosh @ 619-892-3888; or **Director** Gene Van Vleet @ 619-890-8447.

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bone scan, should you be getting a PET or whole-body MRI? Did your physician discuss SBRT? It's standard practice, not just experimental. Make sure your physician understands your goals. For example, do you want to use SBRT to avoid ADT or with ADT to maximize your chance of controlling your disease?

February 2020 Informed Prostate Cancer Support Group Meeting:

Personal Experiences – a Panel of Experts (Volunteers and Leaders of the Group)

March 2019 Informed Prostate Cancer Support Group Meeting:

Dr. Rana McKay – Evolving Paradigms of High-Risk and Advanced Prostate Cancer: Novel Trials and Genomics

The promise of "Precision Medicine" is that DNA analysis in blood, urine and/or tissue may show what therapy will be most beneficial to the patient, avoiding ineffective treatments. Current DNA analysis methods are called "Next Generation Sequencing (NGS)," and may be paid for by Medicare (but only once – so when to test needs to be decided!) in cases of recurrent/ relapsed, refractory, metastatic, or advanced (stages III or IV) cancer. Testing of the DNA from tumor cells (called "somatic"testing) is typically done on tissue or from a blood sample, and may involve sequencing the whole genome (the entire DNA sequence), the whole exome (the part that codes for proteins), or a "panel" of about 300-500 known cancer genes.

In conclusion, novel treatment strategies are evolving for men with high risk and advanced disease. Genetic profiling of tumor tissue and of normal tissue has the potential to improve prognosis and treatment. Clinical trial and database participation will advance the field, to improve survival and quality of life.

April 2020 IPCSG Meeting Postponed

Dr. Hsu's presentation is available at the **IPCSG website** to view. Alan John Hsu, MD, is a board-certified psychiatrist who specializes in treating cancer patients struggling with mood and anxiety issues brought on by cancer. He also sees individuals with cancer who have pre-existing mental health challenges. Dr. Hsu has subspecialty training in psychosomatic medicine, a subspecialty of psychiatry that focuses on the psychiatric treatment of patients with complex medical conditions, including cancer. His research interest is in better understanding cancer-related distress.

May 2020 Informed Prostate Cancer Support Group Online Presentation

"ASCO GU" Updates in Prostate Cancer by Munveer Bhangoo, MD Staff Physician / Medical Oncologist, Scripps MD Anderson Cancer Center

Dr. Bhangoo's talk and this summary relate to presentations given at the recent ASCO (Amer. Soc. Clinical Oncology) GU (Genitourinary) conference in San Francisco, in January 2020.

Prostate Cancer Specific COVID-19 Updates – "Prostate Cancer in the COVID-19 Era."

new drug approvals: Lynparza has been granted priority review for HRR-mutated (see below) mCRPC (metastatic castrate-resistant prostate cancer), but the decision has not yet been issued. Rubraca (rucaparib) has been approved as monotherapy treatment for patients with BRCA1/2-mutant MCRPCa who have been treated with advanced ADT (Zytiga, Xtandi or the like) and a taxane-based chemotherapy.

June 2020 Informed Prostate Cancer Support Group Online Presentations

Prostate Cancer Basic Science

Dr. Andrew Goldstein, PhD Professor-in-Residence of Urology, David Geffen School of Medicine at UCLA explained how healthy prostate cells develop into cancer, and how prostate cancer cells develop resistance to therapy, which is critical for improving disease diagnosis and identifying new treatment options. He presented some of his laboratory's basic science research that will enable us to better understand prostate cancer biology and may lead to new approaches for therapy in the future.

Sexual Side Effects of Treatments

Dr. Irwin Goldstein's practice is in sexual medicine, which is the study, diagnosis and treatment of sexual health concerns of men and women. His office contains specialists, including pelvic floor physical therapists, nurse practitioners for physiologic care, and a sex therapist trained at the McKinsey Institute, to address Sociocultural Influences, Interpersonal Relationship issues, and Psychological issues.

July 2020 Informed Prostate Cancer Support Group Online Presentations

Personal Experiences: GENE VAN VLEET; DICK HOWARD; RALPH HUGHES

August 2020 Informed Prostate Cancer Support Group Online Presentation

Social Security and Supplemental Plans – Get to Know Medicare by Richard Russell

For more information as well as videos, quizzes, downloadable guides, online tools and more Visit MedicareMadeClear.com . Sign up for the newsletter on the

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website and get practical, up-to-date articles delivered to your inbox. Follow on Facebook to stay current with Medicare news. Visit the YouTube page to watch videos on Medicare and health and wellness topics. The MedicareMadeClear.com website can be viewed in English, Spanish, Vietnamese and Chinese.

Get to Know Medicare: September 15–21, 2020, sponsored by United Healthcare and devoted to helping people: Learn about Medicare. Get answers to questions, Feel confident making Medicare decisions. You can participate through local educational events and online activities.

September 2020 Informed Prostate Cancer Support Group Online Presentation

Developments in Immunotherapy in Prostate Cancer by Dr. Sumit Subudhi, Assistant Professor, Genitourinary Medical Oncology, MD Anderson Cancer Center

The immune system can eradicate tumor cells. It has adaptability, specificity, and (most importantly) memory. In some cases, the cancer can be cured by the immune system. When prostate cancer is diagnosed, this means that the cancer has "evaded" the immune system and grown large enough to be detected. In immunosuppressed patients (such as those on drugs to prevent rejection of a transplanted organ), many more cases of cancer of various types – including prostate cancer – are found, vs. other patients.

The object of immunotherapy is to shift the balance toward more of the immune cells that fight the cancer. This can potentially be done through bacterial stimulants (as in Dr. Coley's toxin), cytokines (such as interleukin-2, which hasn't lived up to its initial hype), vaccines (such as Provenge (sipuleucel-T), which is made from a patient's own immune cells, and provides a modest average survival gain in patients with metastatic, castrate-resistant prostate cancer), or targeting immune checkpoints.

October 2020 Informed Prostate Cancer Support Group Meeting

Part 1: Introduction to Intensity-Modulated Proton Therapy - 2020 Update by Carl J. Rossi, Jr., MD Medical Director, California Protons Cancer Treatment Center, San Diego, CA

Particle Therapy is no longer "boutique", equipment is available from numerous manufacturers and becoming less expensive.

This will, in fashion analogous to the introduction of Cobalt 60 and Linac (linear particle accelerator), lead to increased utilization and optimization.

Published data demonstrates less toxicity with protons as compared to IMRT:

- Lower incidence of GI toxicity.
- Less bone marrow suppression.
- Less testosterone suppression.
- Lower incidence of radiation-induced second cancers

We ultimately need to get to the point that the cost to the payor of delivering particle therapy is similar to cost of x-ray treatment.

Part 2: Special Situations for the Use of Proton Therapy Dr. John P. Einck, of UC San Diego and California Protons.

The choice of treatment depends on the patient's own goals. Different forms of radiation are essentially "different shaped tools for accomplishing the same goal." There are clinical situations in some patients where protons are preferred, as discussed above. Consider SpaceOar with radiation for early stage prostate cancer.

November 2020 Informed Prostate Cancer Support Group Meeting

Role of Genetic Testing in Prostate Cancer by Richard Lam, MD, Prostate Oncology Specialists, Marina del Rey, CA

Uses of genetic testing, overview:

Screening to detect clinically significant prostate cancer-Is a biopsy needed?

Decision making regarding active surveillance

Access prognosis after treatment

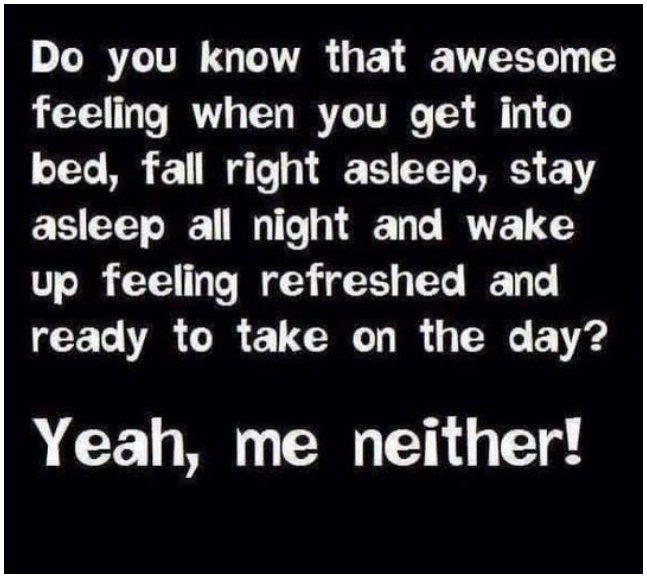
Guide treatment

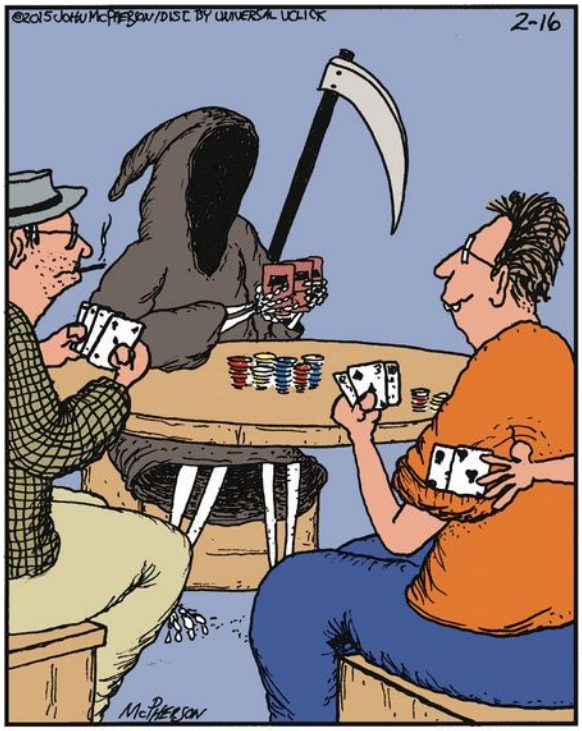
Hereditary genetics

Genetic testing involves analysis of abnormalities in the DNA of the patient. DNA segments called genes provide the molecular instructions for the creation of amino acids, which make up proteins, from which cells, tissues and organs of our bodies are made. Cancer arises from gene mutations, which can be of either of two categories. Germline mutations are heritable mutations that are present in the egg or sperm of the parents, and can cause hereditary cancer types. Somatic mutations can occur anytime in an individual's life, not by inheritance, but by some other cause, and can cause cancers, usually later-onset.

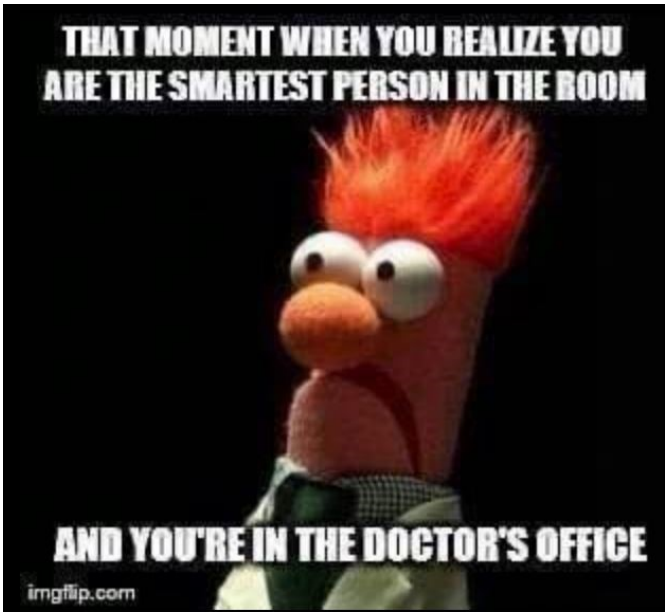
No Meeting in December 2020

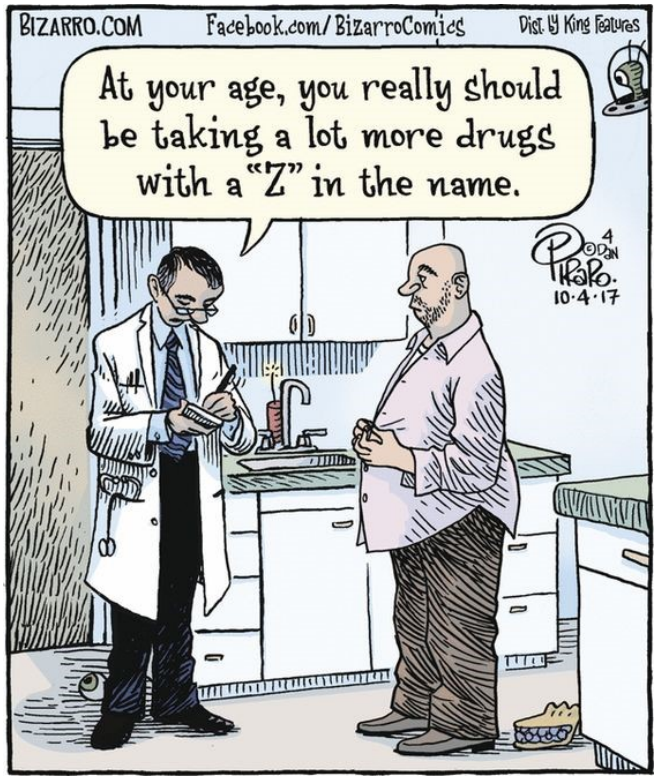
On the Lighter Side

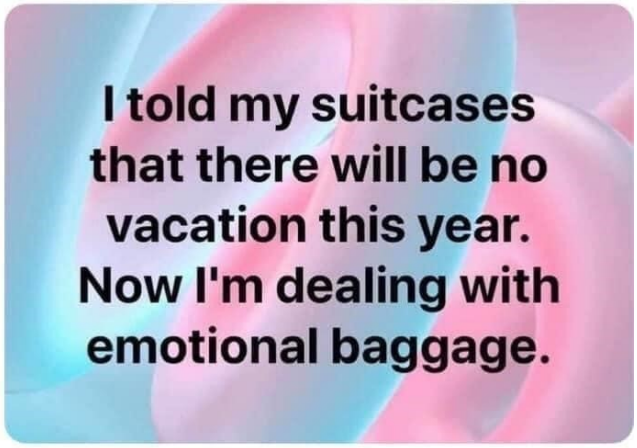




Foolishly, Randy tries to cheat death.







Articles of Interest

An unexpected, and novel, target for prostate cancer: Our biological clock

sciencedaily.com

Our biological or circadian clock synchronizes all our bodily processes to the natural rhythms of light and dark. It's no wonder then that disrupting the clock can wreak havoc on our body. In fact, studies have shown that when circadian rhythms are disturbed through sleep deprivation, jet lag, or shift work, there is an increased incidence of some cancers including prostate cancer, which is the second leading cause of cancer death for men in the U.S. With an urgent need to develop novel therapeutic targets for prostate cancer, researchers at the Sidney Kimmel Cancer -- Jefferson Health (SKCC) explored the circadian clock and found an unexpected role for the clock gene CRY-1 in cancer progression. The study was published on January 15th in *Nature Communications*.

"When we analyzed human cancer data, the circadian factor CRY-1 was found to increase in late stage prostate cancers, and is strongly associated with poor outcomes," explains Karen Knudsen, MBA PhD, executive vice president of oncology services for Jefferson Health and enterprise director of SKCC, and senior author of the study. "However, the role CRY-1 in human cancers has not been explored."

A common therapy for prostate cancer involves suppressing the male hormone androgen and/or the androgen receptor, as prostate tumors require androgens to develop and progress to advanced disease. With their collaborators in the U.S. and Europe, the researchers found that CRY-1 is induced by the androgen receptor in prostate tumor tissue obtained from patients, thus explaining in part the high levels of CRY-1 observed in human disease.

"This was a clear indication of CRY-1's link to prostate cancer," says Ayesha Shafi, PhD, a postdoctoral researcher in Dr. Knudsen's lab and first author of the study. "As we looked further into the role of CRY1, we unexpectedly found that the circadian factor was altering the way that cancer cells repair DNA."

Cancer treatments aim to damage the DNA in cancer cells and cause defects in repair mechanisms; eventually the cells self-destruct when the damage is severe. The researchers probed CRY-1's possible role in DNA repair in cultured cells, animal models and tissue harvested from prostate cancer patients. They first induced DNA damage by exposing cancer cells to radiation and found that CRY-1 levels became elevated, indicating that it was responding to this type of damage. They also found that CRY-1 directly regulates the availability of factors essential for the DNA repair process, and alters the means by which cancer cells respond to DNA damage. The findings suggest that CRY-1 may offer a protective effect against damaging therapies.

"The fact that CRY-1 is elevated in late-stage prostate cancer may explain why androgen-targeting treatments become ineffective at those later stages," says Dr. Shafi. "It also tells us that if a tumor has high levels of CRY-1, DNA repair targeting treatments may be less effective for them."

"Not only have we outlined a role for CRY-1 outside of its canonical function in circadian rhythms, Dr. Shafi's findings are the first to reveal the means by which CRY1 contributes to aggressive disease," adds Dr. Knudsen. "It's notable that the pro-tumor functions of CRY1 may be viable targets to treat prostate cancer, and this is a direction that Dr. Shafi's future work will explore."

Looking ahead, the team plans to explore how best to target and block CRY-1 and what other existing therapies may work synergistically to hinder DNA repair in prostate cancer cells. They also plan to study more circadian rhythm genes and determine how circadian disruption may affect cancer treatment.

"It's been shown that circadian disruptions can affect efficacy of treatment, but also that aligning treatment with the body's natural rhythms or giving therapy at certain times of the day can be beneficial," explains Dr. Knudsen. "Our findings open up a multitude of important research questions exploring the link between the circadian clock and cancer."

This work was supported by a Young Investigator Award and Challenge Award from the Prostate Cancer Foundation to Dr. Shafi and Dr. Knudsen respectively, NCI grant F99CA212225, NCI R01-CA182569, The KWF Dutch Cancer Society, SKCC Support Grant (5P30CA056036). Drs. Shafi and Knudsen thank lead collaborators and their research groups -- Dr. Felix Feng, Dr. Michael Brunner, and Dr. Wilbert Zwart. The authors report no conflict of interest.

Story Source:

Materials provided by **Thomas Jefferson University**. Original written by Karuna Meda. *Note: Content may be edited for style and length.*

Whole pelvic salvage radiation may be better than precisely targeted lymph node salvage radiation

prostatecancerinfolink.net

Last week, I looked at a retrospective study of metastasis-directed therapy (MDT) at the Mayo Clinic among oligorecurrent patients (see this link). Oligorecurrent means that they had already received primary therapy (mostly prostatectomy) and some had received salvage radiation as well, but there were only 1 to 5 metastases detected. They found there was no benefit if there were any bone metastases, but there may have been a benefit if the metastases were in the lymph nodes only. Lymph nodes were treated with either surgery (called pelvic lymph node dissection — PLND) or radiation to a small area around the detected (by C-11 choline PET/CT) cancerous lymph nodes. I ended the analysis with this statement:

Another open question is whether whole pelvic salvage radiation might have been more effective than the limited margins they used at Mayo. With the more accurate PSMA PET scans, ROs are able to treat the entire PLN area with radiation boosts given to the detected ones. The RTOG-consensus treatment area has recently been expanded (see this link). It's important that patients understand the detection limits of even the best PSMA PET scan: metastases smaller than 4 mm, and those that put out only small amounts of PSA remain invisible.

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De Bleser et al. reported the results of a retrospective study to examine precisely this question among 506 oligorecurrent patients conducted at 15 different institutions throughout Europe. Patients were selected and treated as follows:

Detection of cancerous lymph nodes (LNs) was primarily (85%) with C-11 Choline PET/CT (a few with PSMA, FDG, or conventional imaging).

309 patients were treated with SBRT (at least 5 Gy per fraction, up to 10 fractions). A margin of 2-6 mm was treated also.

197 patients were treated with "Elective Nodal Radiation Therapy" (ENRT) of at least 45 Gy in 25 fractions to the entire pelvic lymph node area. Boost doses to detected LNs were allowed. A margin of 5-7 mm was treated. 60 patients also had their prostate bed simultaneously treated.

About half had already had salvage radiation to the prostate bed.

About half had already had PLND at the time of prostatectomy. The SBRT group had an average (median) of 1 positive LN at pathology, the ENRT group had 2.

Patients with adjuvant ADT for more than a year were excluded. Seventy-seven percent of the SBRT had no ADT; 40 percent of the ENRT group had no ADT. Those who had ADT, had it for an average (median) of 6 months.

Seventy-two percent had pelvic LNs only; 28 percent had extrapelvic LNs (retroperitoneal) at imaging.

Seventy-two of the SBRT group had only one LN at imaging; 50 percent of the ENRT group had 2 to 5 LNs at imaging.

Patients with bone or visceral metastases at relapse were excluded, as were patients already using ADT, and those with detected metastases before primary therapy.

After a median follow-up of 3 years:

3-year Metastasis-free survival (MFS) was 68 percent at 3 years, but only distant metastases (M1) were counted.

>Among patients who were detected with only one positive LN at baseline, MFS was twice as long with ENRT compared to SBRT

There was no difference among patients with more than one positive node at baseline.

Fifty-seven percent of patients were detected with metastases (N1 and M1) in the SBRT group — 55 percent in pelvic LNs, 19 percent in extrapelvic LNs only, 20 percent in bone, and 6 percent in visceral organs.

Thirty-eight percent of patients were detected with metastases (N1 and M1) in the ENRT group — 11 percent in pelvic LNs, 43 percent in extrapelvic LNs only, 35 percent in bone, and 8 percent in visceral organs.

ENRT provided longer-lasting N1 control, but did not delay M1 control any more than SBRT.

Castration-free survival did not differ between the two types of treatments.

There was no acute toxicity reported for 99 percent of men receiving SBRT and 94 percent of men receiving ENRT. Grade 3 (serious) toxicity was reported for five men receiving ENRT and none receiving SBRT.

Similarly, there was no serious late-term toxicity reported for SBRT, and 2.5 percent for ENRT.

We conclude that ENRT provided better local (pelvic lymph node) control than SBRT, but neither seemed to delay distant metastases better. MFS was only improved by ENRT if there was just one LN metastasis detected at baseline. Reported toxicity (acute and late-term) was low, but was lower with SBRT.

Of course, this retrospective study leaves many questions unanswered:

Does either treatment improve MFS over ADT alone

What would have happened if long-term ADT were allowed rather than just 6 months (see this link)?

What if all patients received the same radiation dose, the same treatment margins, and a standard treatment area (up through the aortic bifurcation) were used?

What would have happened if LN metastases were detected with PSMA PET/CTs rather than C-11 choline PET/CT?

What were the patient-reported quality of life outcomes?

These questions will be addressed in two ongoing randomized clinical trials:

OLIGOPELVIS2 (in France) is randomizing oligorecurrent patients to intermittent ADT with or without whole-pelvic IG/IMRT with a boost to PSMA-identified LNs (completion expected mid-2026).

PEACE V (a.k.a STORM; in Europe and Australia) is randomizing oligorecurrent patients to MDT by either SBRT/salvage PLND or ENRT. C-11 choline, PSMA or Axumin PET scans will be used for detection (completion expected end of 2023).

Higher coffee intake may be linked to lower prostate cancer risk

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bmj.com

Each additional daily cup associated with reduction in risk of nearly 1%

Drinking several cups of coffee every day may be linked to a lower risk of developing prostate cancer, suggests a pooled data analysis of the available evidence, published in the online journal ***BMJ Open***.

Each additional daily cup of the brew was associated with a reduction in relative risk of nearly 1%, the findings indicate.

Prostate cancer is the second most common cancer, and the sixth leading cause of cancer death in men. Nearly three out of four cases occur in the developed world, and since the 1970s, new cases of the disease have risen sharply in Asian countries, including Japan, Singapore, and China.

Coffee consumption has been linked to a lower relative risk of liver, bowel, and breast cancers, but as yet, there is no conclusive evidence for its potential role in prostate cancer risk reduction.

In a bid to advance understanding of the issue, the researchers trawled research databases for relevant cohort studies published up to September 2020.

They pooled the data from 16: 15 reported on the risk of prostate cancer associated with the highest, compared with the lowest, coffee consumption; 13 reported on the risk associated with an additional daily cup. The highest level of consumption ranged from 2 to 9 or more cups a day; the lowest level ranged from none to fewer than 2 cups a day.

The included studies were carried out in North America (7), Europe (7) and Japan (2). They included more than 1 million men (1,081, 586) of whom 57,732 developed prostate cancer.

Compared with the lowest category of coffee consumption, the highest category was associated with a reduction in prostate cancer risk of 9%. And each additional daily cup was associated with a reduction in risk of 1%.

Further refining the analysis to localised and advanced prostate cancer, showed that compared with the lowest intake, the highest intake was associated with a 7% lower risk of localised prostate cancer, and a 12%-16% lower risk for advanced and fatal prostate cancer, respectively.

The researchers acknowledge that because of the observational design of the included cohort studies, unmeasured or uncontrolled factors in the original studies may have skewed the pooled risk estimate.

The amount of coffee drunk may also have been misclassified as it depended on recall. And the type of coffee and brewing methods varied among the studies. The design and methods of the included studies also varied, so caution in interpreting the findings is warranted, they say.

Nevertheless, there are plausible biological explanations for their findings, they highlight.

Coffee improves glucose metabolism, has anti-inflammatory and antioxidant effects, and affects sex hormone levels, all of which may influence the initiation, development and progression of prostate cancer, they point out.

And they conclude: "This study suggests that increased coffee consumption may be associated with a reduced risk of prostate cancer. Further research is still warranted to explore the underlying mechanisms and active compounds in coffee.

"If the association is further proved to be a causal effect, men might be encouraged to increase their coffee consumption to potentially decrease the risk of prostate cancer."

Research: Coffee consumption and risk of prostate cancer: a systematic review and meta analysis
doi:10.1136/bmjopen-2020-038902
Journal: ***BMJ Open***

Funding: Natural Science Foundation of Liaoning Province, China

Is This Really Cancer?

Howard Wolinsky,

medpagetoday.com

In prostate cancer, as in life, you roll the dice.

In craps, 3+3 is called a "hard six." It's hard because you can only win if you repeat with a combination of 3+3. Any other sixes you roll -- 4+2, 5+1 -- are losers.

Gleason 3+3 is a hard six in prostate cancer. It is the lowest grade cancer in the traditional Gleason scoring system. Still, to the eye of a pathologist, a Gleason 6 looks like a malignancy.

Now, a few experts are questioning whether this hard six is a cancer at all. Some urologists see a Gleason 6 as a noncancerous growth that has the potential to be invasive, but most likely will never spread to other organs or end up killing a man.

To a patient like me, who has been on active surveillance (AS) for 10 years, a Gleason 6 can create a big medical fuss lasting years with regular prostate-specific antigen (PSA) blood tests, digital rectal exams (DREs), biopsies, and MRIs. It can cause "anxious surveillance" that prompts them to drop AS and undergo unnecessary radical prostatectomy, which poses a potential risk of impotence and urinary incontinence.

The Gleason 6 diagnosis can yield polar opposite recommendations from urologists. Ten years ago, I found this to be the case in the matter of a day.

On December 14, 2010, a local urologist recommended I undergo a radical prostatectomy within the week. When asked, he said he didn't support active AS, then a relatively new approach for monitoring low-grade prostate cancer.

Only about 6%-10% of candidates in those days opted for AS.

From all 14 of my biopsy samples, there was only one millimeter of Gleason 6, which elicited panic from my urologist and internist.

The next day, I saw Scott Eggener, MD, of the University of Chicago, who had started offering AS only a few years earlier. He told me I really didn't need surgery and was the "poster boy" for AS.

He shared some research by Laurence Klotz, MD, an AS pioneer from Toronto, showing great outcomes for many men like me who chose to hop on the AS train. I was sold and never looked back.

Eggener predicted my cancer may one day progress where more aggressive treatment may be beneficial but also explained my cancer may ultimately be the same in 10 years, a slow-moving turtle best managed with AS. In fact, four subsequent biopsies failed to find any tumor at all.

These days, about 60% of AS candidates nationwide opt for it, with rates as high as 95% for those with very low-risk prostate cancer and 75% of those with low-risk when cared for by certain urologists or medical practices, said Eggener.

Over the years, he has mentioned to me and others that he thought dropping the "cancer" classification for Gleason 6 was reasonable. He felt Gleason 6 be considered a "precancerous" lesion.

Eggener is now taking it a step further, seeking to change the rules of this game of biopsy craps.

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'The right thing to do'

He told me recently he has decided to dedicate himself to eliminating the cancer diagnosis as a "career goal." He has recruited Klotz and others, including pathologists, radiation oncologists and radiologists to his team advocating what many may feel is an impossible dream. Eggener knows there is often resistance to change, and it doesn't happen overnight. However, being in mid-career, he has time on his side.

"I used to whisper the idea after a couple of beers to friends in quiet places, where no one could hear me or impugn me for it. Then, I would start mentioning it to wider audiences, and now I will stand at a podium and tell thousands of people if they're willing to listen, why I think it's the right thing to do."

Eggener said the time to act is now because the evidence overwhelmingly supports his position.

He said while Gleason 6 absolutely meets the histologic criteria of cancer, it doesn't meet the clinical definition of cancer. It's not a malignancy that might eventually spread and kill the patient.

"In Gleason 6, it's basically impossible to spread to other parts of the body. And there's overwhelming evidence of that," he said. "I am convinced there's never been a man in the history of time who's died from pure Gleason 6 prostate cancer. There's never even been a case report of it, and for that reason I think men would be better served if Gleason 6 was downgraded, as we've done with Gleason 2 through 5."

If Gleason 6 was considered a precancerous or noncancerous lesion, doctors would monitor patients with PSA or other biomarkers, DREs, and/or MRI in regular check-ups.

"I submit the hypothesis we would ultimately have hundreds of thousands fewer men burdened with the diagnosis of prostate cancer or needing treatment that could impact their quality of life, billions of fewer dollars expended by the healthcare system, and highly likely there would be no increase in prostate cancer deaths across the country as long as men and their doctors continue appropriate follow-up," Eggener said. "To me, there is clarity. It's the right thing for public health and for individual men."

As an example, Eggener said his group at the University of Chicago collaborated with colleagues across town at Northwestern University to study outcomes in 7,800 men who underwent prostatectomies. Of them, 2,500 had prostates with only Gleason 6.

"We couldn't find a single patient with Gleason 6 growing into the seminal vesicle, and the likelihood of it extending outside of the lining or the capsule of the prostate was 0.28%," he said.

He cited a study led by Jonathan Epstein, MD, director of surgical pathology at Johns Hopkins in Baltimore, of more than 14,000 men. He said none of those with Gleason 6 had cancer identified in the lymph nodes.

Klotz divides the Gleason 6 nomenclature issue into two parts: the social/political and the scientific.

On the former, he said: "Imagine how much easier life would be if you didn't have to explain to a patient that he had cancer but didn't need treatment. And probably the result would be less overtreatment insofar as there's still a controversy in some people's minds about whether these patients should be treated or not. So, that's the driver."

He said the science is complex. Everyone agrees that Gleason 6 resembles a cancer under the microscope.

Generally, a hallmark of cancer is metastases. Gleason 6 doesn't metastasize, but, Klotz said, neither do basal cell carcinoma of the skin nor gliomas in the brain.

"The lack of metastasis is not by itself a reason to say it's not cancer. So then the second clinical parameter is invasion. It's not common but you do see invasion outside the prostate occasionally with Gleason 6 prostate cancer. So, that's a problem," Klotz said.

He said about 2% of patients with low-grade Gleason 6 have serious genetic aberrations in their cancer cells, suggesting the cancers may be more aggressive. "It's a small proportion but it's not zero," he said. These cells probably mutate to a higher Gleason pattern before they metastasize.

On the other hand, some tumors have been reclassified as noncancerous. Klotz said papillary urothelial neoplasm of low malignant potential (PUNLMP) is probably the best model of cancer being redefined as a noncancer. Eggener said it has also occurred in thyroid cancer (follicular variant of papillary thyroid cancer) and been debated for ductal breast carcinoma in situ.

Mixed reactions

Will dropping the "cancer label" from Gleason 6 be accepted by urologists, let alone by genitourinary pathologists? Others have proposed such a change in the past but failed because of opposition from the pathologists -- the umpire in biopsy reading -- but also many urologists.

I asked several experts and got a mixed response.

Bert Vorstman, MD, a retired Florida urologist and outspoken critic of the "prostate cancer industry," said, "We cannot keep the Gleason label as it is associated with the cancer word, and we can't keep the cancer tag as it is bogus [as he wrote in 2016] and needlessly terrorizing." He favors renaming Gleason 6 as age-related prostatic neoplasia.

Urologist Peter Carroll, of the University of California San Francisco, another AS pioneer, favors leaving Gleason 6 as cancer, taking a philosophical view about cancer and society.

"I always point out that some men with 3+3 disease are harboring higher-risk tumors. Telling a patient he does not have cancer risks incomplete follow-up and the risk of significant progression over time which could be a real problem. All AS series, including our own at UCSF, have identified predictors of progression and its likelihood. You simply can't write the diagnosis off. But to me, it's a larger issue that confronts society's perception of cancer in general, not just prostate cancer," he said.

"We can try and rename low-grade prostate cancer, but I think it just confuses the issue rather than confronts the need for society to recognize that cancer is a spectrum of disease. We have taken a similar approach to heart disease, diabetes and other diseases. Not everyone with diabetes needs insulin and not everyone with cardiac disease needs a stent or bypass surgery. For many it is lifestyle change only.

"We also have to realize that we are rapidly changing early detection strategies to try and minimize the detection of very low-grade, low-volume cancers in the first place," he said.

NETWORKING

Please help us in our outreach efforts. Our speakers bureau consisting of Lyle LaRosh, and Gene Van Vleet 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: https://ipcsg.org/personal-experience

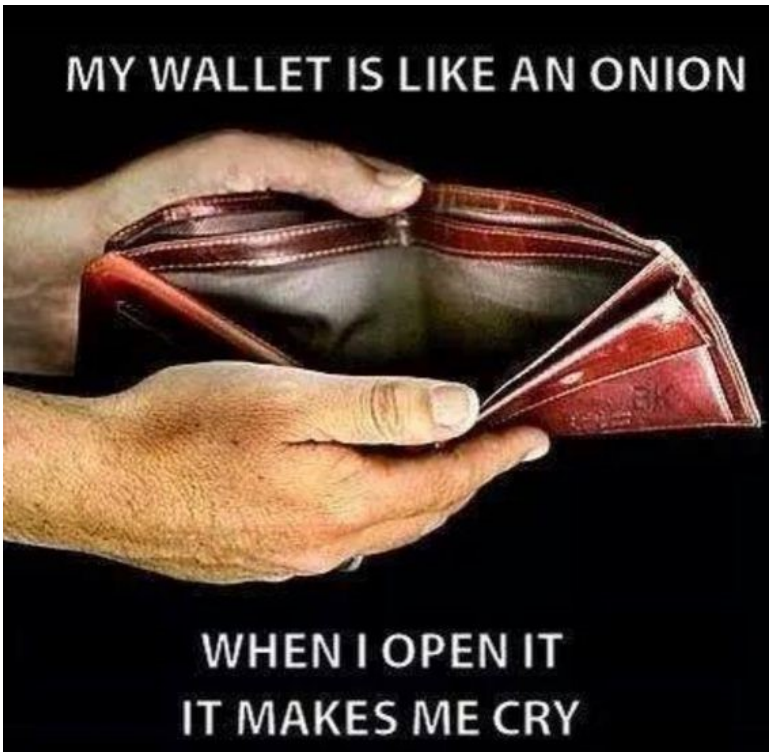
Our brochure provides the group philosophy and explains our goals. Copies may be obtained by mail or email on request. Please pass them along to friends and contacts.

Ads about our Group are in the Union Tribune the week 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!



While our monthly meetings are suspended, we still have continuing needs, but no monthly collection. 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 420142, San Diego CA 92142