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

SEPTEMBER
Wednesday, September 14, 2022

SEPTEMBER 2022 NEWSLETTER

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

STREAMING ONLINE LIVE

Volume 15 Issue 09

- **Next Meeting Saturday, September 17, 2022 IPCSG— Maintaining Sexual Function — Recorded-Stream Event, 10:00am PT**.
- Dr. T. Mike Hsieh - Male Sexual Dysfunction— Dr. Hsieh is a Professor of Urology and Director, UCSD Men's Health Center. He specializes in male fertility and men's health. He treats men with sexual dysfunction including low testosterone, erectile dysfunction, and Peyronie's disease. He also treats male infertility including men with ejaculatory disorder, hormone imbalance, sperm production impairment, cancer, and genetic causes of infertility. In collaboration with doctors at Moores Cancer Center, he focuses on enabling male patients with cancer to preserve their fertility options before cancer therapy. He also helps cancer survivors preserve or regain their sexual function after they receive cancer treatment that has sexual side effects.
- 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 a be available on DVD.
- **For links to further Reading: https://ipcsg.blogspot.com/**
- **If you have Comments, Ideas and Questions,** email to Newsletter@ipcsg.org
- **If you would like some copies of our new brochure by mail for distribution to your friends or physicians, please send email to bill@ipcsg.org or call Bill at (619) 591-8670**

August 2022 Informed Prostate Cancer Support Group Meeting

Summary by Bill Lewis

Next Generation Cancer Treatment Using a Nontoxic Metabolic Therapy

Robert M. Hoffman, Professor Emeritus in the UCSD Dept. Of Surgery, taught us from his fifty years of research, "How to Starve Cancer Naturally." He was joined by Mark Simon, CN, of the Nutritional Oncology Research Institute. Dr. Hoffman's recommendations focus on starving cancer by limiting its access to the amino acid Methionine through diet and a methioninase supplement. His website is howtostarvecancernaturally.com. Email: meishale@gmail.com

Cancer cells have distinct nutritional requirements different from normal cells. The most outstanding difference is the absolute dependence on the amino acid, methionine. Through diet and other means, the availability of methionine to cancer cells can be reduced to near zero. Without methionine, cancer cells are unable to grow and divide.

Methionine restriction is a unique metabolic form of cancer therapy different from attempts to starve

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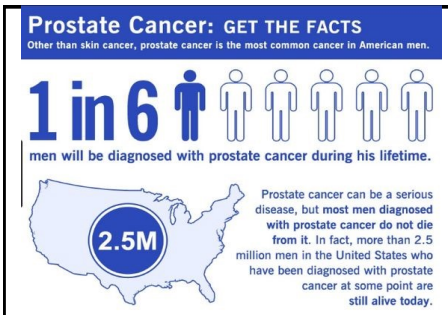

Organization

a 501c3 non-profit organization - all positions are performed gratis

IPCSG

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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.

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** Bill Lewis @ (619) 591-8670 ; or **Director** Gene Van Vleet @ 619-890-8447.

From the Editor

Due to COVID-19, no in-person meetings will be held until further notice. We will continue to post and distribute the newsletter in the interim. 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.

In this issue:

Bill Lewis produced a summary of the last stream video, Articles of interest include:.

1. **Survivorship in prostate cancer following robotic assisted radical prostatectomy–**the time to act is now! *NIH should provide Continuous follow-up after a radical prostatectomy—not just cut and run*
2. **Prostate cancer has high survival rate if detected early—** *overview of screening and treatment.*
3. Efficacy and safety of 177Lu-PNT2002 prostate-specific membrane antigen (PSMA) therapy in metastatic castration resistant prostate cancer (mCRPC): Initial results from SPLASH—abstract of presentation.
4. **Risk of progression following a negative biopsy in prostate cancer active surveillance | Prostate Cancer and Prostatic Diseases**—should you go on AS even if biopsy doesn't show cancer.

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cancer cells of glucose, glutamine or fatty acids. Starving cancer cells of energy substrates is extremely challenging because normal cells will be affected in the process. Methionine restriction does not affect normal cells in any detrimental manner.

Starving cancer cells of methionine represents a revolutionary approach to cancer therapy that will eventually lead to completely nontoxic cancer treatments. One can adopt a low methionine diet today and greatly enhance treatment effectiveness or help prevent recurrence. With the addition of methioninase, one can incorporate a powerful tool within their treatment plan. Oral methioninase is the result of intense research conducted by Dr. Robert Hoffman and associates. Dr. Robert Hoffman has studied and published numerous scientific papers on methionine dependence since 1976.

Methionine is an amino acid found in all whole foods. It is not present in oils, refined sugar, highly and refined carbohydrates. Chicken and fish contain the most methionine while fruits contain the lowest levels of methionine. A plant-based diet is generally much lower in methionine than a diet that includes animal products. However, this is not always the case because there are plant-based foods which have a high methionine content, and it is the amount of high and low methionine foods that matters most. To design a diet lowest in methionine while obtaining sufficient calories, fruits must be the main staple. Potato is the next best food with low methionine and high calories. Vegetables vary greatly in methionine content. Nuts, seeds, grains and beans are the plant foods highest in methionine. Refer to the methionine chart on the howtostarvecancernaturally.com website for detailed information on how to design a low methionine diet. A low methionine diet is a very healthy diet since it is centered around fruits and vegetables. Adequate protein is present within a low methionine diet and this diet can be cycled to help prevent excessive weight loss or any nutritional deficiencies.

By combining a low methionine diet with an enzyme that degrades methionine, a near zero methionine diet becomes practical, safe and highly therapeutic. Achieving near zero plasma methionine has profound therapeutic potential for the treatment of cancer and other conditions. Methioninase is such an enzyme that when taken orally degrades methionine from food within the intestinal tract. Methioninase does not enter the blood stream.

Furthermore, a combination of a methionine restricted diet, methioninase and oxidative therapies represents a potentially universal and very potent system for treating malignancies. By combining a low or restricted methionine diet with methioninase we can deplete the blood stream of methionine. Without methionine, cancer cells enter cell cycle arrest, meaning that they stop growing and dividing. Without methionine, cancer cells cannot synthesize glutathione – which is essential for cancer cells to maintain redox balance. Therefore, the combination of diet and methioninase renders the cancer cells highly vulnerable to elevations of oxidative stress. This effect has been demonstrated in various in vitro and in vivo experimental models. This system is essentially nontoxic and harmless to normal cells. Methionine restriction causes a reduction in glutathione which elevates oxidative stress in the cancer cell. This is a very useful bonus of methionine restriction.

See the video online for the talk and slides: https://www.youtube.com/watch?v=WAgZfpWt6es

A dvd of the talk will be available for purchase from the IPCSG by the time of next month's meeting. Order online from the IPCSG.org website.

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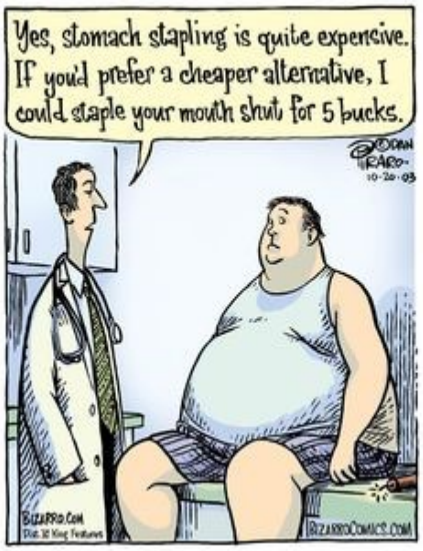
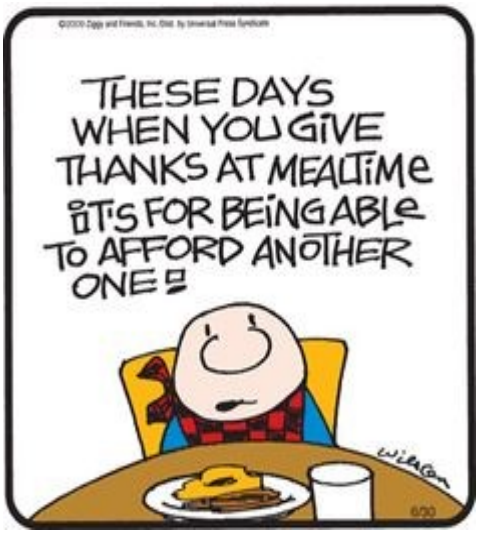
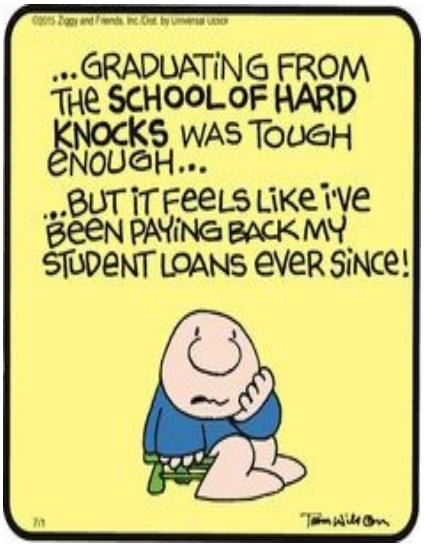
On the Lighter Side

"How much do I owe you so far?"







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Articles of Interest

Survivorship in prostate cancer following robotic assisted radical prostatectomy–the time to act is now!

nature.com

Sahai, Arun

Most patients diagnosed with prostate cancer tend to have local disease and survive for more than 10 years following surgery. Preparations for cancer survivorship must begin at diagnosis and should not have a set endpoint. Despite advances in robotic-assisted radical prostatectomy (RARP), studies still report significant treatment regret exists, largely centered on the disparity between the expectation of better functional recovery and the actual functional outcome achieved [1]. In addition to the physical impact of surgery, the impact of functional changes on psychosocial wellbeing and relationships can be significant and is often overlooked. It is important that personalized care pathways ameliorate the patients' cancer experience and provides them with a roadmap back to living life as normal.

Despite this, there are no specific RARP cancer survivorship guidelines in the UK and Europe, with management guidelines focusing primarily on oncological outcomes. The American Cancer Society (ACS) Prostate Cancer Survivorship guidelines were published in 2014 and the NHS launched the National Cancer Survivorship Initiative: A 'how to guide' (NCSI) in 2015 with generic advice on how to approach building pathways [2, 3]. Recommendations were primarily based on expert opinion, but recent work by Dunn et al utilized patient input to structure RARP care pathways [4]. Little is known about the structure of UK or European Centers' post RARP care pathways and this uncertainty leads to variations in care, patient's survivorship outcomes and treatment experience.

There are several core areas that need to be considered and addressed when designing and delivering post RARP care promoted by ACS, NCSI and Dunn et al [2,3,4]. These include;

Patient-centered care

A RARP pathway should be structured to be personalized to the need of the patient. Prior to any decision to undergo RARP, a detailed functional assessment should occur and personalized risk factors for poorer outcomes explained. Current research should focus on creating better pre-operative predictive nomograms to generate improved decision tools that can aid understanding of potential outcomes. Furthermore, we should utilize data already obtained, such as the pre-biopsy MRI, to investigate if information gained relates to outcomes [5].

A useful tool we have developed to aid empowerment is a 'care passport', similar to an antenatal record. This passport becomes a core document containing records of functional, psychological and oncological outcomes during the cancer treatment pathway, initiated before surgery. With a better educated, more resilient, and informed patient, the burden on the healthcare provider should be reduced as patients have many of the tools required to aid their recovery. They can be better supported even with more limited healthcare provider input [4].

Health promotion

Healthcare information needs to tailor to the individual. The survivorship program should adapt as the patients' survivorship experience evolves. The program should focus on specific areas of functional recovery relevant to their surgery but should also focus on their general physical and psychological wellbeing, to provide opportunistic holistic care. Improving personal health and performance status improves quality of life through reducing fatigue, anxiety and depressive symptoms [2]. Information provided needs to accommodate health literacy and patients' preferred route to access healthcare. Work should focus on improving access to those from LGBTQ + communities and those from minority cultures to ensure equity in healthcare outcomes.

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Surveillance

Following RARP, the rehabilitation phase of up to two years should not mark the end of aftercare. Rather than just having remote PSA monitoring, patients should have yearly survivorship 'check-ins', focusing on; [2, 4].

- maintenance of mental health
- monitoring and managing the physical effects of treatment
- surveillance of any co-morbidities
- assessing for any disease recurrence

The use of validated patient reported-outcomes measures (PROMs) can assist in healthcare surveillance, but should be used in a way that impacts patient care, rather than just informing on research [2, 6]. There has been a positive increase in use of PROMs to track survivorship care but the ones in current use do not fully encompass the entirety of the survivorship experience [7]. Additionally, much needed work is still required to ensure PROMs is relevant to minorities as well. Only by producing holistic PROMs will we truly capture the impact of treatment of functional recovery.

Communication

The benefits of increasing digitisation of healthcare are clear, careful attention should be given to those without access to the internet or smartphones. Digital literacy should not be a new barrier for quality of life. Access to the service should be through multiple avenues of communication and there should be timely expert response to queries.

National outcomes measurements

There is a shift to monitoring more than oncological outcomes and for better reporting of continence and sexual dysfunction following RARP. It is also vital that this data is registered in national databases. Outcome data should be freely available and there should be structures in place for teams to learn from better performing centres. The goal should be to have clearly defined standards nationally, with an infrastructure in place to ensure the provision of an equitable and high standard of care irrespective of geography.

Evidence-based Survivorship Interventions

It is essential that patients are supported with the best evidence-based interventions to ensure maximal chance of attaining their quality-of-life. An example of areas to be improved was showcased in the EUROPROMs study [8]. It showed that a small percentage of patients had tried the different erectile dysfunction management options following prostate cancer treatment. It is essential that management of the expectant side effects of surgery, are standardised with quick escalation of treatments. This will give patients the best chance irrespective of where, or by whom, they are treated.

Conclusion

It has been eight years since ACS published its initial survivorship guidelines, and 7 years since the NHS NCSI launched its initiative. During this time, the diagnosis and management of prostate cancer has advanced greatly on the wings of well-funded research and technological innovation, but we are still way behind on defined guidance on optimised post RARP care. The development of clear standardised guideline recommendations for RARP survivorship care are essential to improve quality of life outcomes and ensure equitable, high quality clinical care.

Cite this article

MacAskill, F., Shabbir, M., Sahai, A. *et al.* Survivorship in prostate cancer following robotic assisted radical prostatectomy–the time to act is now!. *Prostate Cancer Prostatic Dis* (2022). https://doi.org/10.1038/s41391-022-00589-4

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Prostate cancer has high survival rate if detected early

floridatoday.com

Dr. Mourad Abouelleil

Prostate cancer is one of the most common cancers found in men. According to Cancer.Net, in 2022, 268,490 men in the United States will be diagnosed with prostate cancer. Around 60% of all cases will be diagnosed in people over the age of 65, but when detected early, there is an overall five- and 10-year survival rate of 98%. Screenings, early detection and advanced treatments are keys to these high survival rates.

There are five types of prostate cancer. They include Adenocarcinoma, small cell carcinomas, neuroendocrine tumors, transitional cell carcinomas and sarcomas. Some of these cancers can grow and spread quickly, but most grow slowly.

Risk factors can include:

- Age, with men over the age of 65 having a higher rate of incidence.
- Genetics.
- Family history.
- Race or ethnicity.

Always discuss your risk factors with your physician.

Screening for prostate cancer

Prostate cancer often can be found early by testing for prostate-specific antigen in a man's blood.

In addition, a digital rectal exam performed by a physician or qualified medical personnel can be performed.

The American Cancer Society (ACS) recommends that men should make an informed decision with their health care provider about whether to be screened for prostate cancer.

The decision should be made after getting information about the uncertainties, risks and potential benefits of prostate cancer screening.

The discussion about screening should take place at:

Age 50 for men who are at average risk of prostate cancer and are expected to live at least 10 more years.

Age 45 for men at high risk of developing prostate cancer. This includes African Americans and men who have a first-degree relative (father or brother) diagnosed with prostate cancer at an early age (younger than age 65).

Age 40 for men at even higher risk. This group includes those with more than one first-degree relative who had prostate cancer at an early age.

Diagnosing prostate cancer

If the results of a PSA or an exam suggest the possibility of prostate cancer, a biopsy is typically the next step.

A small sample of the prostate is removed through a core needle biopsy, usually performed by a urologist, and is viewed under a microscope.

During the biopsy, the urologist will also look at the prostate in real-time with an imaging test like a transrectal ultrasound.

The urologist can sometimes elect to perform a prostate MRI instead of biopsy; however, a biopsy may still be indicated in the future.

The biopsy is sent to the laboratory, and it is tested.

If cancer is found, it is assigned a grade called the Gleason Score, or Grade Group.

The American Cancer Society explains the Gleason System assigns grades based on how much the cancer looks like normal prostate tissue.

If the cancer looks a lot like normal prostate tissue, a grade of 1 is assigned. If the cancer looks very abnormal, it is given a grade of 5.

Grades 2 through 4 have features in between these extremes.

Prostate cancer often has areas with different grades so a grade is assigned to the two areas that make up most of the cancer.

The two grades are added together to yield the Gleason Score. The first number assigned is the grade that is

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most common in the tumor.

Based on the Gleason score, prostate cancers are assigned to three groups:

- Gleason Score of 6 or less — well-differentiated or low-grade
- Gleason Score of 7 — moderately-differentiated or intermediate-grade
- Gleason Score of 8 to 10 — poorly-differentiated or high grade.

The American Cancer Society reports that in recent years, the Gleason Score might not always be the best way to describe the grade of cancer because prostate cancer outcomes can be divided into more groups than just the three groups mentioned above, and the scale of the Gleason Score can be misleading for patients.

Because of these reasons physicians have developed Grade Groups ranging from 1 (most likely to grow and spread slowly) to 4 (most likely to grow and spread quickly).

- Grade Group 1 — Gleason 6 or less
- Grade Group 2 — Gleason 3+4=7
- Grade Group 3 — Gleason 4+3=7
- Grade Group 4 — Gleason 8
- Grade Group 4 — Gleason 9-10

A patient may see a Gleason Score and/or Grade Group on their laboratory results.

Some results may reveal that cells may not look like cancer but they are not quite normal either.

These results are called prostatic intraepithelial neoplasia (PIN). In PIN, there are changes in how the cells of the prostate look, but the abnormal cells don't appear to grow into other parts of the prostate as cancer cells would.

PIN is often divided into two groups:

Low-grade PIN. The patterns of prostate cells appear almost normal

High-grade PIN. The patterns of prostate cells look more abnormal.

In both circumstances your urologist will continue prostate cancer screening, however, if an atypical finding is discovered (ASAP), a repeat biopsy or MRI of the prostate may be indicated.

For more information on your risks of prostate cancer, and to schedule your screening, please contact your physician. If you need a primary care physician or a urologist, visit https://providers.steward.org/s/.

Dr. Mourad Abouelleil is a urology specialist for Steward Urology Associates in Viera. Contact his office at (321) 255-8080.

Efficacy and safety of 177Lu-PNT2002 prostate-specific membrane antigen (PSMA) therapy in metastatic castration resistant prostate cancer (mCRPC): Initial results from SPLASH

e-Posters - ESMO Congress 2022

Presentation Number 1400P

Speakers Aaron R. Hansen (Woolloongabba, Australia)

Date Sun, 11.09.2022

Abstract

Background

Preliminary results of the SPLASH https://www.splashtrial.com/ (NCT04647526) lead-in, a phase 3 study evaluating the PSMA targeted radioligand, ^{177}Lu-PNT2002 (also known as ^{177}Lu-PSMA I&T), in PSMA-positive patients with mCRPC who progressed after treatment with androgen receptor axis-targeted therapy (ARAT), are herein presented.

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Methods

This multi-national, open-label study commenced with a 27-patient lead-in prior to the randomization. Patients were enrolled with tumors exhibiting high-PSMA uptake on positron emission tomography–computed tomography (PSMA PET/CT) per blinded independent central review (BICR), chemotherapy naïve for CRPC, progressing on an ARAT, and adequate bone marrow and end organ reserve. Patients received up to four cycles of ^{177}Lu-PNT2002 at 6.8 GBq per cycle every 8 weeks and were followed for key endpoints of radiographic progression-free survival (rPFS) per BICR, overall survival, PSA response, dosimetry and safety.

Results

33 men underwent PSMA PET/CT to identify 27 (81.8%) eligible for treatment, of which 5 (15.2%) failed due to PSMA avidity criteria. Patients received a median 4 cycles of ^{177}Lu-PNT2002, with a median dose of 6.9 (6.2-7.5) GBq/cycle. Six (22%) patients who underwent treatment received a prior taxane for hormone-sensitive disease. Based on a median rPFS follow-up of 7.5 months at data cut-off, 21 (78%) remained event-free with a rPFS rate at 9 months of 75.4%. There was one death reported (non-treatment related) and 11 (42%) patients achieved a PSA50 response. Grade ≥3 treatment emergent adverse events (TEAEs) occurred in 8 (29.6%) patients, of which anaemia (3, 11.1%) and haematuria (3,11.1%) occurred in >10% of patients. Treatment-related TEAEs in > 10% patients included dry mouth (7, 25.9%), nausea (5, 18.5%), fatigue (5, 18.5%), haematuria and anaemia (3, 11.1%).

Conclusions

In mCRPC patients post-ARAT failure, ^{177}Lu-PNT2002 was associated with a favorable rPFS and was well-tolerated. Anti-neoplastic efficacy was exhibited based on PSA50 response. These results support the advancement of ^{177}Lu-PNT2002 to the randomized portion of the SPLASH registrational trial.

Risk of progression following a negative biopsy in prostate cancer active surveillance | Prostate Cancer and Prostatic Diseases

nature.com Elhage, Oussama

Abstract

Background

Currently, follow-up protocols are applied equally to men on active surveillance (AS) for prostate cancer (PCa) regardless of findings at their initial follow-up biopsy. To determine whether less intensive follow-up is suitable following negative biopsy findings, we assessed the risk of converting to active treatment, any subsequent upgrading, volume progression (>33% positive cores), and serious upgrading (grade group >2) for negative compared with positive findings on initial follow-up biopsy.

Methods

13,161 men from 24 centres participating in the Global Action Plan Active Surveillance Prostate Cancer [GAP3] consortium database, with baseline grade group ≤2, PSA ≤ 20 ng/mL, cT-stage 1–2, diagnosed after 1995, and ≥1 follow-up biopsy, were included in this study. Risk of converting to treatment was assessed using multivariable mixed-effects survival regression. Odds of volume progression, any upgrading and serious upgrading were assessed using mix-effects binary logistic regression for men with ≥2 surveillance biopsies.

Results

27% of the cohort (*n* = 3590) had no evidence of PCa at their initial biopsy. Over 50% of subsequent biopsies in this group were also negative. A negative initial biopsy was associated with lower risk of conversion (adjusted hazard ratio: 0.45; 95% confidence interval [CI]: 0.42–0.49), subsequent upgrading (adjusted odds ratio [OR]: 0.52; 95%CI: 0.45–0.62) and serious upgrading (OR: 0.74; 95%CI: 0.59–92). Radiological progression was not assessed due to limited imaging data.

Conclusion

Despite heterogeneity in follow-up schedules, findings from this global study indicated reduced risk of converting to treatment, volume progression, any upgrading and serious upgrading among men whose initial biopsy findings were negative compared with positive. Given the low risk of progression and high likelihood of further negative biopsy findings, consideration should be given to decreasing follow-up intensity for this group to reduce unnecessary invasive biopsies.

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NETWORKING

Please help us in our outreach efforts. Our speakers bureau consisting of Gene Van Vleet and Bill Lewis is available to speak to organizations of which you might be a member. Contact Gene 619-890-8447 or gene@ipcsg.org or Bill 619-591-8670 (bill@ipcsg.org) to coordinate.

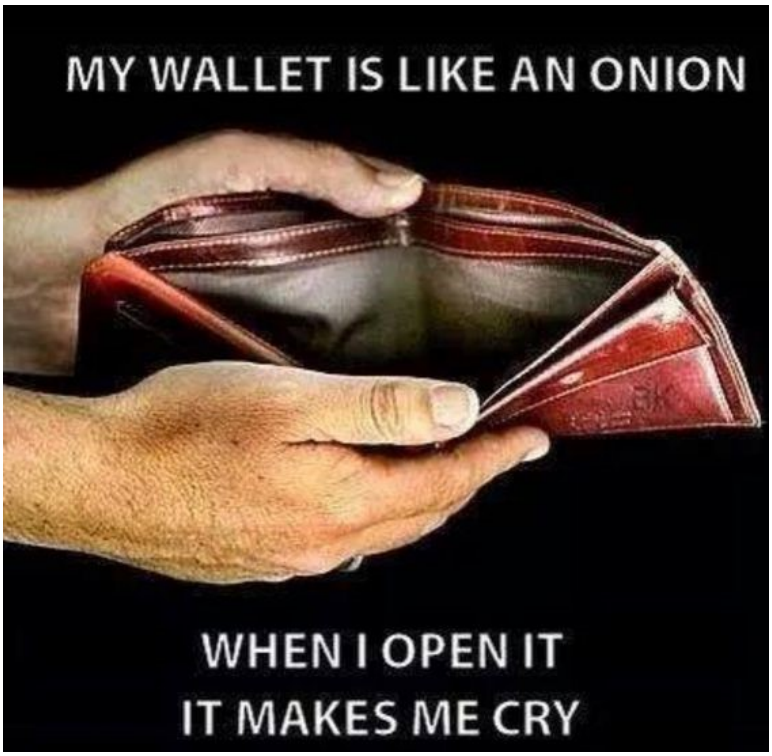
Member John Tassi is the webmaster of our website and welcomes any suggestions to make our website simple and easy to navigate. Check out the Personal Experiences page and send us your story. Go to: https://ipcsg.org/personal-experience

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.

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

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