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

FEBRUARY 2023 NEWSLETTER

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Wednesday, February 15,

Volume 16 Issue 02

- **Next Meeting Saturday, February 18, 2023 IPCSG—10:00am PT**.
- **IPCSG Roundtable**—.Members of the IPCSG group will share stories about their journey with Prostate Cancer, then YOU will have a chance to ask questions about your specific situation.

- **Darrell Dixon** will tell us how he has coped with prostate cancer for many years, including recent developments.
- **Dan Peddie** will share his journey, including radiation, Lupron, Zytiga, Xtandi and Lynparza, challenges with doctors and current decisions.
- **The third part** of our meeting will be an open mic session, focusing on attendees who are undecided about what to do next. A panel of experienced members including Gene Van Vleet, Bill Lewis, and Aaron Lamb will provide some answers, and the audience will provide more suggestions.
- **Fourth**, we will invite members to break into additional groups to ask questions on radiation, surgery, active surveillance, hormone therapy, and the rest of those who are undecided about what to do next.
- ***After the meeting a light lunch will be served in the foyer outside the meeting room.***
- **For links to further Reading: https://ipcsg.blogspot.com/ ; includes member suggested links.**
- **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**

January 2023 Informed Prostate Cancer Support Group Meeting

Summary by Bill Lewis

Speakers:

- Arno J Mundt MD FASTRO FACRO, Professor and Chair, UCSD Dept. of Radiation Medicine & Applied Sciences.
- Brent Rose MD, Assistant Professor, UCSD Dept. of Radiation Medicine & Applied Sciences; UCSD Department of Urology.
- Tyler M. Seibert, MD, PhD, Assistant Professor, Radiation Medicine | Radiology | Bioengineering, Center for Multimodal Imaging and Genetics, Center for Precision Radiation Medicine, University of California San Diego.
- Carl Rossi MD, Professor, UCSD Dept. of Radiation Medicine & Applied Sciences; California Proton Therapy Center.

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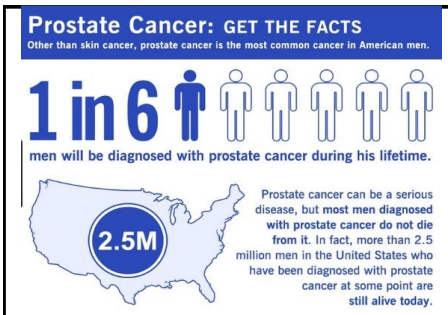

Organization

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

IPCSG

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Bill Lewis President

Additional Directors

Gene Van Vleet

Aaron Lamb

Bill Manning

Honorary Directors

Dr. Dick Gilbert

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Bill Bailey, ...Librarian
Mike Corliss, ...Greeter
Aaron Lamb, ... Meeting Set-up
Stephen Pendergast ..... Editor

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.

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

In this issue:

Bill Lewis produced a summary of the Mundt team last meeting presentation, Articles of interest include:.

1. New Blood Test for Prostate Cancer Is 94% Accurate | Technology Networks—A new blood test developed by researchers at the University of East Anglia (UEA) can detect prostate cancer with 94% accuracy
2. Omit Digital Rectal Exam in Prostate Cancer Surveillance?- PSA should be monitored every 3-6 months, whereas the timing of MRI may be more open-ended, according to the report. MRI should be done routinely, but less frequently than annually, the authors said. Routine DRE is not necessary
3. Understanding biochemical recurrence after radical prostatectomy: trust biology, not a number | Prostate Cancer and Prostatic Diseases—We must take the time to study and understand cancer biology, obtain the necessary information from the cancer and the patient, and be able to deliver the correct salvage therapy timely, yet with no rush
4. World Cancer Day 2023: Understanding the patient perspective regarding the use of AI in prostate cancer - On Medicine—One of the key findings from this survey was that when AI is used, it is key that it remains the pathologists – with their expertise and experience – who make the diagnosis of prostate cancer

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Dr. A. J. Mundt -- Introduction to Radiation Therapy in Prostate Cancer: Terminology, Approaches

Dr. Mundt began with an overview of prostate cancer (PCa) treatments. Surgery is now often done by robotic assistance. Hormone therapy includes ADT (androgen deprivation therapy) and chemotherapies. 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.

When definitive external beam radiation treatment (EBRT) is given – either by photons (X-rays) or protons – it can be given in different numbers of doses, referred to as fractionation. Conventional fractionation involves small daily doses over about 8 weeks. Beginning about 5 years ago, "hypofractionation" accelerates the treatment with moderate daily doses over 5-6 weeks. And SBRT (stereotactic body radiation therapy) gives high doses daily over one week or less. The choice is tailored to the patient.

In some cases, EBRT (protons or photons, with conventional fractionation) is combined with brachytherapy (permanent or temporary seeds), giving better cancer control or cure. Definitive radiation therapy is also often combined with a period of hormone therapy to good effect.

Adjuvant radiation therapy is always given by EBRT (photons or protons, with only conventional fractionation used up until now). Brachytherapy cannot be used, since there is no longer a prostate present in which to introduce seeds.

Salvage RT (radiation therapy) is adjuvant RT given to patients with a rising PSA (which indicates that not all of the cancer was removed by the surgery). Salvage RT may be combined with hormone therapy.

Brent Rose MD -- Prostate Cancer 101 "What You Need to Know to Make the Best Decisions for your Body"

Dr. Rose gave and overview of prostate anatomy and function, then addressed the value and limitations of PSA testing. biopsies, MRI imaging, possible metastasis sites, staging, genetic testing and common questions that patients may have.

Tyler Seibert MD PhD -- Targeted radiation therapy for prostate cancer

In the first world, standard of care is to get an MRI before a prostate biopsy. The FLAME phase 3 (randomized) trial (Kerkmeijer et al. JCO 2020) showed that a radiation boost (about 42%) to a tumor within a prostate gave better results than merely radiating the whole prostate at the usual dose. The trial limited the boost dose to individual men to what did not cause significant (additional) side effects. So not all the "boosted" men got the full boost dose. Even so, the average result was about twice the "progression-free survival," or about half as likely to have a recurrence. With the limit on boost dosing to "sensitive" men (e.g., the tumor was too close to the bladder or rectum for a full boost) there was no difference in urinary or rectal toxicity between the treated group and the controls. This is BIG! Better cancer control without increased side effects.!

The following year (Groen et al. European Urology 2021), local recurrence was shown to be reduced by two-thirds, and distant metastases were reduced by about half.

BUT here we are, three years after the FLAME trial was published, and less than half of radiation oncologists are giving boosts. A big problem is knowing where to target the boost. Radiologists reading MRI's are only accurate in predicting a positive biopsy about 35% of the time. Actually, it matters very much where you go, because accuracy varies from 20% to 75% between institutions! Predictive quality also varies a lot between doctors within individual institutions.

Restriction Spectrum Imaging MRI (rsi-MRI) developed at UCSD solves this problem by looking beyond simple DWI (water diffusion imaging) to separate out the diffusion within the cancer cells. For patients at UCSD, where rsi-MRI is available now, this means safe, effective, precise therapy, fewer men with cancer

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recurrence, and fewer men with metastatic cancer.

Carl Rossi MD – Introduction to Intensity-Modulated Proton Therapy, 2023 Update

Basic tenets of all radiation therapy: There is no such thing as "Radiation Resistance", it is purely a question of the dose required to kill a cell. In general, malignant cells are less able to repair radiation injury -- which means they can be killed by radiation doses which will not kill their healthy, normal counterparts. Radiation damages the DNA of cells, so they cannot reproduce and eventually die.

Fundamentally, all advances in radiation therapy technology have been stimulated by the desire to LIMIT radiation dose to normal tissue while INCREASING dose to the target. This is true of IMRT, Protons, Brachytherapy and Radioimmunotherapy. We understand the physics of radiation therapy far better than we understand the basic radiation biology -- hence we have all focused our R & D on methods which exploit physics as opposed to radiation biology.

IMRT is a development of X-Ray therapy in which the radiation dose's Intensity is modulated to create normal-tissue sparing while increasing dose to target. "Cyberknife", "Tru-Beam", VMAT and "TomoTherapy" are all variations of IMRT and all employ x-rays to deliver treatment.

IMRT has become the de facto standard of care for external beam treatment of prostate cancer, not based upon Phase III data (there is none) but because of a) Physics and b) Widespread availability.

Robert R. Wilson, Ph.D. (1914-2000) conceived the idea of proton beam radiation therapy in 1946 with publication of "Radiological Use of Fast Protons" paper in Radiology.

Pencil beam scanning now allows treating both complex and simple shapes with protons by "painting" the dose in thin layers across the target area.

There are more than 40 proton centers operational in the U.S., mostly in the East, with 18 more under construction or in planning. The first Carbon Ion center is under construction at the Mayo Clinic in Jacksonville, Florida.

In 2021, the FDA approved Pylarify (18F-DCFPyl) as the first PSMA PET imaging agent for prostate cancer. The FDA indication and usage for Pylarify are: With suspected metastasis who are candidates for initial definitive therapy or with suspected recurrence based on elevated serum prostate-specific antigen (PSA) levels. This includes initial staging of unfavorable intermediate, high and very high-risk patients.

Recent data comparing proton beam therapy with IMRT showed favorable results with proton beam therapy, although the IMRT data was from 2000 to 2005, and the technology has since improved.

A study of proton therapy vs. IMRT in locally advanced prostate cancer showed less GI toxicity with the proton beam therapy, over a 15 month average follow-up period.

Secondary cancer risk after primary treatment, based on 9 million cancer patients (2004-2019), of whom 65% got IMRT and 1.3% got proton therapy, was found to be reduced to 31% for proton therapy patients vs. IMRT. However, the overall rate of second malignancies was very low.

The FLAME trial discussed by Dr. Seibert (see above) was also mentioned. Practice-changing results!

In summary, 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. Dose-escalation with any modality appears to be important in terms of reducing risk of local/regional/distant failure.

Questions:

If the PSA stays undetectable after treatment, is there still a chance there is cancer present, that might be detected by some kind of scan? The short answer is "No."

What's the difference in value of the Axumin vs. the Pylarify scan? Dr. Seibert and most radiologists prefer the Pylarify scan if you can get it. However, the person interpreting the scan is an important variable, though it's a bit hard to know how good he/she is.

Is it hard to get a copy of your PSMA (or other) scan? No, you just ask for it, and legally, they have to

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give it to you. But getting someone else to re-read it is more difficult, because reimbursements are low. When you go for a second opinion on treatment, if the second doctor thinks that the fine points of the scan may alter treatment decisions, the scan may be sent to an expert for re-evaluation.

Duration of adjuvant hormonal therapy after radiation treatment? It's the same whether photons or protons were used. For unfavorable intermediate risk, duration is typically 4-6 months, starting two months before treatment. It's to try to make the cancer more susceptible to the radiation. For higher risk patients, the time can be 18-36 months.

Can patients with bilateral artificial hips get radiation therapy? It's a question of getting good imaging. The technology has improved so much that Dr. Rossi is comfortable going ahead. However, some other centers decline to treat.

DNA damage from radiation only kills the cells when they try to divide? Basically, yes, but with the very high doses of SBRT, it appears that there is also an effect of damage to cell membranes.

Does UCSD have Pluvicto (LU-177)? Yes, recently started.

Does persistent fatigue after proton therapy come from the treatments or from the hormone therapy previously received? The fatigue from the radiation depends on the volume of tissue treated, and should go away relatively quickly. Fatigue from hormone therapy can persist for years after treatment ends.

Is cumulative radiation received due to scans and treatments a big concern? It's of most concern for young patients. Not so much for older patients, and radiating one part of the body does not preclude radiating another part of the body.

What about getting treatment outside of your normal network? Call the doctor's office and they can advise you, and often go to bat for you to get a second opinion or special treatment.

See the video online for the talk and slides: https://www.youtube.com/watch?v=HIUTPAq1gbw

On the Lighter Side

Articles of Interest

New Blood Test for Prostate Cancer Is 94% Accurate | Technology Networks technologynetworks.com

Molly Campbell

A new blood test developed by researchers at the University of East Anglia (UEA) can detect prostate cancer with 94% accuracy.

No single test for prostate cancer

Prostate cancer affects approximately 1 in 6 men, with 1 person dying every 45 minutes from the disease.

Current screening and diagnostic methods for prostate cancer include the prostate-specific antigen (PSA) test, among other, more invasive approaches.

PSA is produced by cancerous and noncancerous cells in the prostate, with small amounts circulating in the blood of healthy individuals. If a patient presents with high levels of PSA in the blood, it can be indicative of cancer. However, it might also be indicative of inflammation or enlargement of the prostate, affecting the reliability of the PSA test.

"There is currently no single test for prostate cancer, but PSA blood tests are among the most used, alongside physical examinations, MRI scans and biopsies," says Professor Dmitry Pshezhetskiy from UEA's Norwich Medical School. "Only about a quarter of people who have a prostate biopsy due to an elevated PSA level are found to have prostate cancer."

Developing a new blood test that has greater accuracy, and is also non-invasive and inexpensive, is a focus for researchers.

Combining the PSA test with epigenetic testing

In *Cancer*, Pshezhetskiy and colleagues present: the Prostate Screening EpiSwitch (PSE) test, which combines the PSA test with epigenetic testing.

Over recent years, epigenetic testing capabilities have advanced significantly. During this time, it has become clear that aberrant DNA methylation and histone acetylation – examples of epigenetic marks – are associated with prostate cancer onset.

"The purpose of this study was to determine whether combining the Episwitch prostate cancer test with the PSA test will increase its diagnostic accuracy," the research team write.

Pshezhetskiy and colleagues recruited 147 participants that were either enrolled in the PROSTAGRAM screening pilot study, diagnosed with prostate cancer or a healthy control. They compared the performance of the standard PSA test with the PSE test, discovering that the latter significantly enhances detection accuracy for at-risk men. Overall, the PSE test was 94% accurate.

"When tested in the context of screening a population at risk, the PSE test yields a rapid and minimally invasive prostate cancer diagnosis with impressive performance. This suggests a real benefit for both diagnostic and screening purposes," says Pshezhetskiy.

For PSE to be adopted widely in prostate cancer screening, it will require further validation in a cohort with low cancer prevalence, the researchers say.

Reference: Pchejetski D, Hunter E, Dezfouli M, et al. Circulating chromosome conformation signatures significantly enhance PSA positive predicting value and overall accuracy for prostate cancer detection. *Cancers*. 2023;15 (3). doi:10.3390/cancers15030821.

This article is a rework of a press release issued by the University of East Anglia. Material has been edited for length and content.

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Omit Digital Rectal Exam in Prostate Cancer Surveillance?

medscape.com

Jake Remaly

Routine use of MRI during active surveillance of men with prostate cancer allows patients to skip digital rectal examinations and some biopsies, and this approach is best practice, according to an international panel of experts.

Guidelines do not yet reflect this tack, but some centers already use it.

"Some people are doing the digital rectal examination [DRE] even though they are getting an MRI," said Caroline M. Moore, MD, professor of urology at University College London, who led the review. "I've had doctors say that the patient expects that."

The problem is that DRE is not especially accurate, she said. "If it was useful but mildly uncomfortable, then fine," Moore told *Medscape Medical News*. "But it's actually not very useful."

So the panel of experts agreed that DRE is not needed "if you are doing a much more accurate test, the MRI scan, instead," Moore said.

DREs cost little — a pair of latex gloves, a squirt of lubricant, and tissues for cleaning up — and occasionally can help detect disease but may have limited reliability. "Given the lack of cost and side effects," the exam "should still be considered," researchers have said.

Meanwhile, prostate MRI is more reliable and useful but more expensive. One study found that the median cost of a prostate MRI was $4400. Another found that insurance coverage for prostate MRI can vary widely and depend on overly restrictive criteria.

Movember, a men's health charity that funds prostate cancer research, commissioned the new report to gauge expert consensus on best practice and research priorities in active surveillance. The report was published online January 27 in *European Urology Oncology*.

Panelists addressed nearly 300 questions. They agreed that clinical factors and patient preferences should inform whether a patient is a candidate for active surveillance. Gleason grade and MRI findings were deemed the most important criteria for prompting escalation to active treatment, followed by changes in the density and level of prostate-specific antigen (PSA). MRI and the Gleason score indicate the volume of a tumor and how aggressive the cancer may be.

For men on active surveillance, a change in PSA kinetics, PSA density, or the findings on DRE should lead to MRI and possibly a biopsy before any discussion about moving to treatment, the panelists agreed.

Variations in Practice

Guidelines call for clinical staging of prostate cancer by DRE, the report notes. But "it is common in some centers for MRI to be used for staging, with DRE not done where MRI is used," the authors wrote. "We know that there is significant variation in adherence to different protocols."

Not all urologists intend to forgo performing routine rectal exams, however, because they can identify lesions that otherwise might be missed.

The report was authored by a panel of 27 healthcare and research professionals and a group of 12 men who are on active surveillance or have had treatment for prostate cancer. Participants were from Europe, Australia, and North America.

When PSA levels and MRI are stable, physicians may be able to avoid performing further prostate biopsies, the experts agreed. Biopsies entail risk for infection.

PSA should be monitored every 3-6 months, whereas the timing of MRI may be more open-ended, according to the report. MRI should be done routinely, but less frequently than annually, the authors said.

Routine DRE is not necessary, although the exam may be done for reasons other than assessing progression of prostate cancer. "There was strong agreement that DRE is unnecessary if multiparametric MRI or other

(Continued on page 8)

routine imaging (eg, transrectal ultrasonography) is being carried out," they wrote.

Understanding biochemical recurrence after radical prostatectomy: trust biology, not a number | Prostate Cancer and Prostatic Diseases

nature.com

Diamand, Romain

In the current issue of Prostate Cancer Prostatic Diseases, Szymaniak and colleagues from UCSF present long term oncologic outcomes of patients who presented a non-detectable PSA after radical prostatectomy and then experienced biochemical recurrence (BCR), defined here as two consecutive PSA ≥0.03 ng/ml, at least 6 months after surgery (REF). In a large contemporary cohort of 3348 men, the authors identified 642 patients exhibiting such characteristic; the study then gives the readers a clear picture of the long-term outcomes of these patients, reporting an excellent metastatic free survival (MFS) rate of 92%, prostate cancer specific mortality (PCSM) of 3% and all-cause mortality (ACM) of 6% at ten years. Not surprisingly, the patients experiencing BCR had more aggressive PCa features, globally expressed by a higher CAPRA and CAPRA-S score. Of note, across the 642 patients experiencing BCR after a negative post-op PSA, 46% received salvage therapy, with PSA doubling time <6mo, elevated CAPRA-S score and higher Decipher score being significantly associated to receiving salvage therapy on multivariable cox regression. The patients that did receive salvage therapy, mainly by radiotherapy ± ADT, exhibited worst MFS (86% vs 97%), worst PCSM (5% vs 1%) and a similar ACM (7% vs 5%) compared to patients not receiving salvage therapy, confirming the intrinsic differences across these two patient groups.

We commend the investigators for the precision in the follow-up, for the long-term data and for the rigorous methodology of the UCSF Urologic Outcomes Database, allowing such elegant studies. The presented results should prompt some reflection:

First, considering a PSA value of ≥0.03 ng/ml as BCR is subject to debate. Current guidelines recommend withholding any salvage treatment after surgery before PSA has reached a value of 0.20-0.40 ng/ml [1]. There is great variability in PSA testing kits: [2] as such, PSA velocity or doubling time interpretation at such low values must be cautious. The authors report a median PSA at treatment of 0.08 ng/ml, which is way lower than that supported by the EAU or established in recent RCTs as RADICALS or RAVES trials [3]. Considering that roughly 50% of patients may increase their PSA after surgery, yet never reach the critical value of 0.20 ng/ml [4], triggering treatment before such threshold may determine overtreatment.

On the other hand, the present data confirm that the outcomes of patients receiving salvage therapy are excellent [5], with 5% PCSM at 10 years from surgery. Again, these patients were treated at low PSA values and this remains a crucial variable in determining outcome of salvage therapy [6, 7]. We are witnessing the rise of next generation imaging, with PSMA PET/CT on the rise, especially in the setting of recurrent disease [8]. The data of the present manuscript highlight the need to administer salvage therapy at low PSA threshold and avoid waiting time for PSA to rise and eventually obtain a positive PSMA scan. Especially for these patients who had an initial negative PSA after surgery, the information needed to trigger and plan salvage therapy is already there, on the pathologic specimen analysis and clinical characteristics before surgery [9]. At PSA levels <0.20 ng/ml, nomograms and clinical reflection are probably superior to next generation imaging. We must understand cancer biology rather than just irradiate the pelvis when PSA rises: the data presented by the authors confirms that the timing of BCR is different in different types of PCa. As such, also the prescription of Next Generation Imaging should be judicious and done when results are likely to modify our clinical strategy.

The long-term data presented by the authors must also remember us that PCa is a slowly progressing disease and that only a third of patients with BCR will progress to metastatic disease: [10] across the 642 patients studied, 38% did not receive salvage therapy and in this group PCSM was only 1%. Each patient requires personalized care and therapy must be administered if life expectancy is adequate. Geriatric evaluation is paramount and as ACM remains superior to PCSM, for some patient the best treatment is no treatment.

“When managing prostate cancer (PCa), one should never rush” used to say Professor Miano, former chair of the Urology department of the University of Rome. Recurrent PCa, especially after an initial PSA drop <0.03 ng/ml after radical prostatectomy, is a slowly progressing disease. If treated adequately, patients can also be cured: a true rarity in surgical oncology. We must take the time to study and understand cancer biology, obtain the necessary information from the cancer and the patient, and be able to deliver the correct salvage therapy timely, yet with no

rush.

World Cancer Day 2023: Understanding the patient perspective regarding the use of AI in prostate cancer - On Medicine

blogs.biomedcentral.com

Monica Dolton, Margaret Horton, PhD & Professor Clare Verrill 3 Feb 2023

The news about how artificial intelligence (AI) has progressed to closely mimic human thought and behavior has sparked diverse reactions. While some wonder how human intelligence and the economy may be affected, others ponder how we will handle the broad potential reach of AI.

One question of particular interest in the healthcare space is how AI might potentially help cancer patients receive a timely diagnosis, and importantly *how the public would feel about AI* being used this way. This is precisely the question we hope to answer as part of the ARTICULATE PRO study (Artificial Intelligence for Cellular Pathology Transformation in Prostate Practice).

ARTICULATE PRO is a multicenter study led by the University of Oxford that is evaluating the use of Paige Prostate*+, an AI-based software designed to help pathologists diagnose prostate cancer. Typically, men who may have prostate cancer undergo a biopsy and thin slices of the biopsied tissue are prepared in a histopathology laboratory so that pathologists can examine the tissue using a microscope to determine if the patient does in fact have cancer.

In recent years, however, digitization in pathology has made it possible for tissue samples to be scanned and turned into digital images, which has opened the door for AI to assist pathologists in the evaluation of the tissue. Paige Prostate is one such AI – it analyzes digital images of biopsy tissue and draws attention to areas of tissue that the AI has identified to be suspicious for harboring cancer to help pathologists make their diagnosis, including determining the severity and size of tumors. As part of the ARTICULATE PRO study, pathologists will utilize Paige Prostate during their routine diagnosis to assess its impact on their efficiency and confidence.

Public and patient perspectives on AI

This brings us to the next study stage, which evaluates how patients and the broader public really feel about the use of AI like Paige Prostate in pathology and what their perceptions and concerns are surrounding AI.

We began in a small setting, with a focus group of prostate cancer patients and survivors and posed these questions to them. We were encouraged to hear them express strong vocal support for anything that helps to make the most precise and accurate diagnosis, including the use of AI. We then sought to bring this topic to a broader group to even better gauge the perceptions of using a technology such as Paige Prostate in patient diagnostic pathways. ARTICULATE PRO administered a survey to supporters of Prostate Cancer UK (a leading UK-based prostate cancer charity), who themselves had undergone prostate biopsy, asking questions around their concerns and how they viewed AI's potential benefits. The results of this survey demonstrated that the majority of patients are supportive of using AI in pathology, with only a small minority (<1%) not in favor of testing this technology.

Following the survey, ARTICULATE PRO engaged patient representatives to work as part of our study team. They provide further rich insights from their lived experience with prostate cancer, which we have applied to help the investigators define the shape and scope of the study to ensure it best serves physician and patient interests.

Human-led use of AI

One of the key findings from this survey was that *when AI is used, it is key that it remains the pathologists – with their expertise and experience – who make the diagnosis of prostate cancer*. This is straightforward for our study and system to address, as Paige Prostate is an adjunctive system, and pathologists who use the system always make the final interpretation. This finding has also led to a more profound consideration of human factors, such as how the pathologists interact with the AI platform and the considerations around how AI outputs can influence decision-making. Our study continues to investigate these topics through workshops and data gathering amongst other things.

On World Cancer Day, the study team honors prostate cancer patients and endeavors to bring them the best diagnostic experience that is possible by evaluating the potential of powerful AI technology in ARTICULATE PRO. Understanding the views of and engaging with patients is central to our efforts.

For links to further Reading: https://ipcsg.blogspot.com/ ; includes member suggested links

NETWORKING

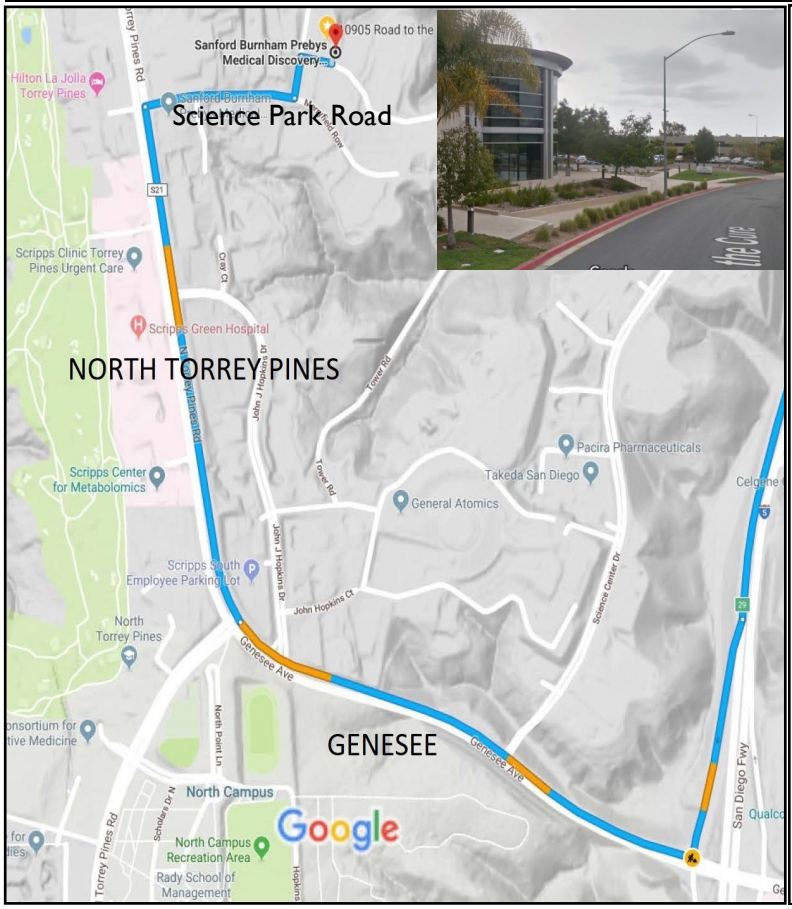
Please help us in our outreach efforts. Our speakers bureau consisting of Gene Van Vleet and Bill Lewis is available to speak to organizations of which you might be a member. Contact Gene 619-890-8447 or gene@ipcsg.org or Bill 619-591-8670 (bill@ipcsg.org) to coordinate.

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

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!



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

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

DIRECTIONS TO MEETINGS