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

JULY 2024 NEWSLETTER

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Wednesday, July 17, 2024

Volume 17 Issue 07

Next IPCSG Meeting *3rd* Saturday, July 20, 2024 — Member Roundtable

- **Roundtable—Three members of the IPCSG group Bill Manning, Mike McCarey and Herschel Kagan will share stories about their journey with Prostate Cancer. Bill Manning will also talk about Active Surveillance. This is your chance to get all your questions answered by people who have "been there, done that".**
- **May and June meetings were cancelled due to construction in meeting hall.**
- **For links to further Reading: https://ipcsg.blogspot.com/**
- **If you have Comments, Ideas or Questions,** email to Newsletter@ipcsg.org
- **For more information, please send email to bill@ipcsg.org or call Bill at (619) 591-8670**

ANCAN Online Forum Summary

7/1/2024 - Hi-Risk/Recurrent/Advanced PCa Men & Caregiver

If you missed any recent recordings, you'll find a full list either on our YouTube Playlist (click above) or visit the ANCAN Blog Post https://ancan.org/our-recent-blog-pos...

Sign up for the ANCAN Blog by checking the New Blog Box at https://ancan.org/contact-us/

AnCan respectfully notes that it does not accept sponsored promotion. Any drugs, protocols or devices recommended in our discussions are based solely on anecdotal peer experience or clinical evidence.

AnCan cannot and does not provide medical advice. We encourage you to discuss anything you hear in our sessions with your own medical team.

AnCan reminds all Participants that Adverse Events experienced from prescribed drugs or protocols should be reported to the pharmaceutical manufacturer or the FDA Adverse Event Reporting System (FAERS). To do so call 1-800-332-1066 or download interactive FDA Form 3500 https://www.fda.gov/media/76299/download

AnCan's Prostate Cancer Forum is back (https://ancan.org/forums). If you'd like to comment on anything you see in our Recordings or read in our Reminders, just sign up and go right ahead. You can also click on the Forum icon at the top right of the webpage. All AnCan's groups are free and drop-in … join us in person sometime!

You can find out more about our 12 monthly prostate cancer meetings at https://ancan.org/prostate-cancer/ Sign up to receive a weekly Reminder/Newsletter for this Group or others at https://ancan.org/contact-us/ Join our other free and drop in groups:

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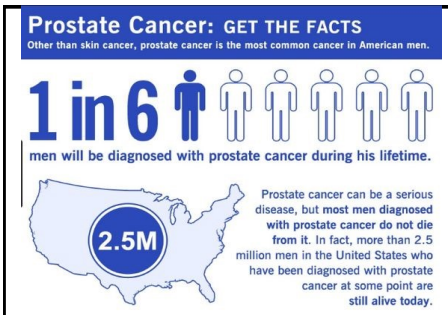

Organization

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

IPCSG

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Bill Lewis President
Stephen Pendergast—Secretary

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Bill Manning

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John Tassi, ...Webmaster
Bill Bailey, ...Librarian
Mike Corless,.....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 "bill@ipcsg.org"; or **Director** Gene Van Vleet @ 619-890-8447.

From the Editor (SLP)

In this issue:

For original articles see the blog at https://ipcsg.blogspot.com/ . First, since there were no IPCSG meetings, we have a claude.AI generated summary of the latest meeting of AnCan's online forum for advanced Prostate Cancer Patients, since we had no June meeting to report. The AnCan group is based in Arizona, and operates online support forums for cancerpatients, including a drop-in forum for men with advanced PCa.

This month, we include two important items of interest:

1. Study finds 1 in 12 patients labeled as having 'benign' results actually had high-risk prostate cancer—*a Gleason 6 Biopsy may miss aggressive cancer*
2. Circulating tumor extracellular vesicles to monitor metastatic prostate cancer genomics and transcriptomic evolution: Cancer Cell—*new blood test can tell if your cancer is progressing more accurately than PSA and less invasively than a Biopsy.*
3. .

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Summary

- **Importance of Continuity of Care and Second Opinions** The segment discusses the importance of continuity of care and seeking second opinions, as Richard, a patient, is considering switching from his current urologist to a GU medical oncologist due to the completion of his ADT treatment. Captain Jim suggests that Richard seek a GU medical oncologist to ensure continuity of care and to have a specialist who can monitor his PSA levels and provide guidance on his condition. Dr. John chimes in, suggesting that Richard consider Dr. Channing Pala, a GU medical oncologist, and mentions that there are other options available, including Dr. Argon Chen and Dr. Joshua Allen, who work with Dr. Marowski at Johns Hopkins.

- **Choosing a Center of Excellence for Prostate Cancer Care** The discussion highlights the importance of choosing a reputable center of excellence for prostate cancer care, especially for high-risk patients. Captain Jim advises Richard to reach out to Johns Hopkins, emphasizing that they would likely accept him as a patient due to his locally advanced prostate cancer. Dr. John clarifies that a center of excellence is a hospital with NCI or NCCN accreditation, not a community clinic. Captain Jim also mentions the departure of Dr. Collins to Tampa, where he will practice with his identical twin brother, which may be beneficial for patients in the area.

- **Buffer vs. No Buffer for High-Risk Prostate Cancer Patients** The discussion centers around the importance of considering a buffer (pre-treatment therapy) for high-risk prostate cancer patients, particularly those with denovo metastatic disease. Captain Jim and Dr. John share their personal experiences and opinions on the topic, with Captain Jim suggesting that playing the anxiety card may be effective in convincing doctors to consider a buffer. Dr. John advises that patients should prioritize quality of life and not delay treatment due to the inability to get a buffer. The conversation highlights the need for patients to be informed and advocate for themselves, as well as the limitations of the Kaiser system in handling advanced prostate cancer cases.

- **Managing Prostate Cancer Treatment and Genetic Testing** Captain Frank shares his personal experience with prostate cancer, discussing his switch from Advantage plans to gain access to other medical records and doctors. He also talks about his recent genetic testing and his doctor's recommendation to change to a PAR inhibitor. Dr. John elaborates on the importance of verifying genetic mutations, highlighting the possibility of reversion to a wild-type bracka. He also clarifies that germline genetic testing does not need to be repeated, as the results are stable throughout an individual's life. The discussion emphasizes the need for informed decision-making and seeking expert opinions in managing prostate cancer treatment and genetic testing.

- **Importance of Accurate Medical Records and Second Opinions** Captain Jim shares his experience with inaccurate medical records and the importance of seeking out second opinions. He recounts how his doctor missed a significant finding on his PSMA scan and how he had to fight to get a second opinion. Dr. Jeff and Dr. John also share their experiences with inaccurate medical records, highlighting the importance of reading reports and questioning any inconsistencies. They emphasize the need to be proactive in seeking out accurate information and to not rely solely on one doctor's opinion.

- **Importance of Accurate Medical Records** The discussion highlights the significance of carefully reviewing and verifying medical records to ensure accuracy. Dr. Jeff shares his personal experience of encountering errors in his own medical records, citing careless editing and typos. He advises listeners to double-check their records and offers to help review them. The conversation also touches on the importance of being proactive in managing one's health, even with treatments, and the need to remain vigilant in monitoring the progression of the disease.

- **PSMA Scan Validity and Prostate Cancer Diagnosis** The discussion revolves around the validity of PSMA scans in prostate cancer diagnosis and management. Rick highlights the importance of using the Memorial Sloan Kettering nomogram to assess the likelihood of successful surgery and the need for radiation and hormone therapy. Dr. Rick also emphasizes that PSMA can revert at late stages, especially when the disease progresses into a neuroendocrine state, making it challenging to determine whether the absence of PSMA on a rescan is due to progressive disease or treatment-induced necrosis. The conversation underscores the complexity of prostate cancer diagnosis and treatment, emphasizing the need for ongoing research and vigilant monitoring to ensure accurate assessments and effective care.

Wrapping Up the Meeting and Upcoming Plans The hosts and participants wrap up the meeting, thanking everyone for attending and announcing the next meeting schedule. They also remind viewers to check the blog for a recording reminder and slides, and express gratitude to Ben for his efforts. The tone is cordial and appreciative, marking the end of the meeting and the transition to the next week's session.

Topics Discussed

- · Solution to chafing from sweats;
- - put a GU med onc in place before you finish up at Fort Belvoir;
- · Promise germline test; advocating for yourself at KP;
- · play anxiety card to get Casodex buffer;
- · couple of Gents update us;
- · read your medical records carefully;
- · PSA creeps - possible post-RP recurrence – when to get PSMA PET?;
- · testing PSA in Panama and US;
- · how does PSMA change as disease advances;
- · responding well to HT;
- · good immune system can slow disease

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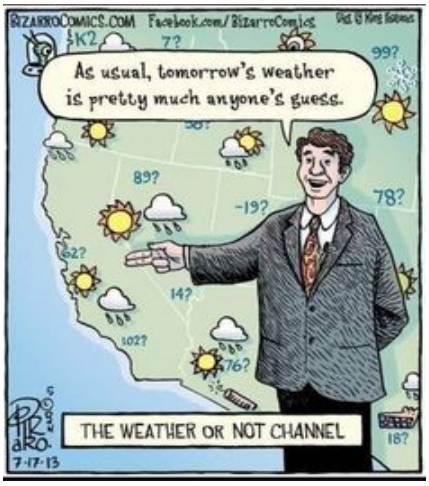
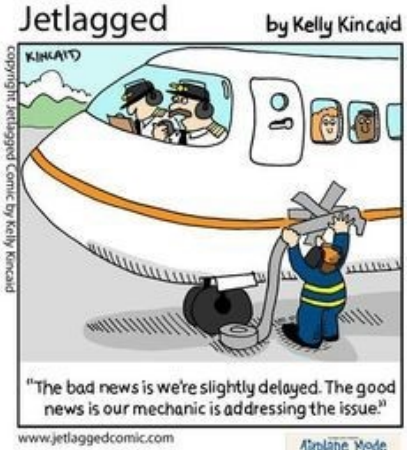
On The Lighter Side





Items of Interest

Study finds 1 in 12 patients labeled as having 'benign' results actually had high-risk prostate cancer | ScienceDaily

sciencedaily.com

Summary

Here's a summary of the key points in simple terms:

1. Researchers looked at over 10,000 men who were diagnosed with early-stage, low-grade prostate cancer (called Gleason Grade Group 1).

2. They found that about 1 in 12 of these men (8%) actually had more aggressive cancer than their initial biopsy showed. [your editor was one of these.]

3. Two factors helped identify which men were at higher risk of having more aggressive cancer:
   - High PSA levels (over 20 ng/ml)
   - Cancer found in more than 50% of their biopsy samples

4. Men with one or both of these risk factors were more likely to:
   - Have worse cancer discovered during surgery
   - Have their cancer come back sooner after treatment
   - Die from prostate cancer

5. The researchers argue that calling all low-grade prostate cancer "benign" (non-cancerous) could be risky, especially for men with these risk factors.

6. They suggest that men with these risk factors should be monitored more closely or consider additional testing to check for more aggressive cancer that might have been missed.

7. The study highlights the challenge of balancing overtreatment of slow-growing cancers with the risk of missing more dangerous cancers.

In essence, the study shows that not all "low-grade" prostate cancers are the same, and certain factors can help identify which men might need more careful follow-up or treatment.

Impact

These findings could have several significant impacts on clinical practice for prostate cancer diagnosis and management:

1. Risk stratification: Doctors may use PSA levels and the percentage of positive biopsy samples more actively to identify higher-risk patients among those initially diagnosed with low-grade (Gleason Grade Group 1) prostate cancer.

2. Enhanced monitoring: Patients with PSA >20 ng/ml or >50% positive biopsy samples might receive more frequent or intensive follow-up, even if their initial biopsy suggests low-grade cancer.

3. Additional testing: For patients with these risk factors, clinicians might recommend:
   - Repeat biopsies
   - More extensive sampling during biopsy

- Advanced imaging techniques like multiparametric MRI
- Genetic or molecular testing of tumor samples

4. Treatment decisions: These findings could influence the choice between active surveillance and immediate treatment. Patients with risk factors might be more likely to be offered or to choose active treatment rather than surveillance.

5. Patient counseling: Doctors may provide more nuanced information to patients about their risk, even if the initial biopsy shows low-grade cancer.

6. Terminology: There may be increased caution about labeling all Gleason Grade Group 1 cancers as "benign" or using terms that downplay the potential risks.

7. Guidelines updates: Professional organizations might update their guidelines to incorporate these risk factors into decision-making algorithms for prostate cancer management.

8. Research focus: This could stimulate more research into better ways to identify aggressive cancers that may be missed by current biopsy techniques.

9. Cost considerations: Healthcare systems might need to consider the cost implications of potentially increased testing and treatment for some patients previously considered low-risk.

10. Personalized medicine: These findings support a more personalized approach to prostate cancer management, considering multiple factors beyond just the biopsy grade.

Overall, these findings could lead to a more nuanced and personalized approach to managing low-grade prostate cancer, potentially improving outcomes by identifying and treating aggressive cancers earlier while still avoiding overtreatment of truly indolent disease.

Q&A

Based on these findings, a man newly diagnosed with Gleason 6 (Grade Group 1) prostate cancer should consider asking his urologist the following questions:

1. What is my PSA level, and how does it relate to the 20 ng/ml threshold mentioned in the study?

Expected answer: The urologist should provide the exact PSA level and explain its significance. If it's over 20 ng/ml, they should discuss the potentially higher risk and what it means.

2. What percentage of my biopsy samples were positive for cancer?

Expected answer: The doctor should provide the specific percentage and explain whether it's above or below the 50% threshold mentioned in the study, and what that might mean for risk assessment.

3. Given my PSA level and percentage of positive biopsies, what is my risk of having more aggressive cancer that wasn't detected in the initial biopsy?

Expected answer: The urologist should explain the patient's individual risk based on these factors, referencing the study's findings about increased odds of adverse pathology and early PSA failure for those with high-risk factors.

4. Should I consider additional testing, such as an MRI or genomic testing, to better assess my cancer?

Expected answer: The doctor should discuss whether additional tests are recommended based on the patient's risk factors, explaining potential benefits and limitations.

5. How might these risk factors influence the choice between active surveillance and immediate treatment?

Expected answer: The urologist should explain how these factors might shift the balance between surveillance and treatment, discussing pros and cons of each approach given the patient's specific risk profile.

6. If we choose active surveillance, how will my monitoring plan be adjusted based on these risk factors?

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Expected answer: The doctor should outline a surveillance plan, potentially including more frequent PSA tests or repeat biopsies if risk factors are present.

7. What is the likelihood of my cancer progressing or recurring based on these risk factors?

Expected answer: The urologist should provide information on increased risks of progression or recurrence associated with these factors, based on the study's findings about PSA failure and mortality risks.

8. How do these findings change the way you view my prognosis compared to other Gleason 6 cancers?

Expected answer: The doctor should explain how these risk factors might differentiate this case from other low-grade cancers, potentially indicating a more guarded prognosis.

9. Are there any lifestyle changes or interventions I should consider given these risk factors?

Expected answer: The urologist might discuss general health recommendations and any specific interventions that could be beneficial given the patient's risk profile.

10. How often should we reassess my risk and treatment plan?

Expected answer: The doctor should propose a follow-up schedule, potentially more frequent if risk factors are present, to regularly reassess the situation and adjust the approach as needed.

Remember, the urologist's answers should be tailored to the individual patient's specific situation, considering all aspects of their health and personal preferences, not just these two risk factors.

Circulating tumor extracellular vesicles to monitor metastatic prostate cancer genomics and transcriptomic evolution: Cancer Cell

cell.com

Highlights

- EV profiling enables longitudinal interrogation of metastatic PC using liquid biopsy
- EV-DNA genomic profiling recapitulates tumor features and associates with progression
- RExCuE allows mRNA analysis in circulating EVs for liquid biopsies transcriptomic profiling

EV-RNA indicates early tumor adaptation changes during therapy in a non-invasive manner

Summary

Extracellular vesicles (EVs) secreted by tumors are abundant in plasma, but their potential for interrogating the molecular features of tumors through multi-omic profiling remains widely unexplored. Genomic and transcriptomic profiling of circulating EV-DNA and EV-RNA isolated from *in vitro* and *in vivo* models of metastatic prostate cancer (mPC) reveal a high contribution of tumor material to EV-loaded DNA/RNA, validating the findings in two cohorts

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of longitudinal plasma samples collected from patients during androgen receptor signaling inhibitor (ARSI) or taxane -based therapy. EV-DNA genomic features recapitulate matched-patient biopsies and circulating tumor DNA (ctDNA) and associate with clinical progression. We develop a novel approach to enable transcriptomic profiling of EV-RNA (RExCuE). We report how the transcriptome of circulating EVs is enriched for tumor-associated transcripts, captures certain patient and tumor features, and reflects on-therapy tumor adaptation changes. Altogether, we show that EV profiling enables longitudinal transcriptomic and genomic profiling of mPC in liquid biopsy.

Here are the key points:

- The study investigated the potential of circulating extracellular vesicles (EVs) in plasma as a source of tumor DNA and RNA for liquid biopsy analysis in metastatic prostate cancer (mPC).
- Key findings:
  - EV-DNA contained genomic information representative of the tumor, with copy number profiles matching tumor biopsies.
  - Higher EV-DNA tumor fraction was associated with worse prognosis in patients starting systemic therapies.
  - A new method called RExCuE was developed to analyze mRNA in EVs.
  - EV-RNA profiles reflected tumor-specific features, including gene expression patterns associated with copy number alterations.
  - EV-RNA analysis detected transcriptomic changes associated with drug response and resistance to androgen receptor signaling inhibitors (ARSIs) and taxane chemotherapy.
  - EV-RNA signatures at baseline and early on-treatment were associated with clinical outcomes.
- The researchers concluded that comprehensive EV profiling enables longitudinal genomic and transcriptomic analysis of mPC via liquid biopsy, with potential applications in studying tumor evolution, drug response, and resistance mechanisms.
- Limitations included the need for further validation in larger cohorts and earlier disease stages, as well as technical challenges in isolating tumor-specific EV material from circulation.

In summary, the study demonstrates the feasibility and potential clinical utility of analyzing both DNA and RNA in circulating EVs as a non-invasive approach to monitor mPC.

Clinical Impact

If validated in larger trials, this EV-based liquid biopsy technique could have significant impacts on clinical care for men with metastatic castration-resistant prostate cancer (mCRPC):

1. Non-invasive monitoring: It would allow frequent, non-invasive assessment of tumor genomics and transcriptomics through simple blood draws, reducing the need for invasive tissue biopsies.

2. Early detection of treatment resistance: By monitoring changes in EV-DNA and EV-RNA profiles, clinicians could potentially detect signs of treatment resistance earlier than current methods allow.

3. Personalized treatment selection: The genomic and transcriptomic information obtained could help guide more personalized treatment choices, potentially improving outcomes.

4. Real-time treatment response assessment: Clinicians could assess treatment effectiveness in real-time, allowing for quicker adjustments if a therapy is not working.

5. Identification of new drug targets: The transcriptomic data could reveal new potential drug targets or resistance mechanisms, informing drug development.

6. Improved prognostication: The prognostic value of EV-DNA could help provide more accurate predictions of disease course and survival.

7. Clinical trial stratification: This technology could be used to better select and stratify patients for clinical trials of new therapies.

8. Reduction in imaging frequency: If validated as a reliable biomarker, it might reduce the need for frequent imaging studies.

9. Earlier treatment changes: The ability to detect molecular changes before clinical or radiographic progression could allow for earlier switches in therapy.

10. Heterogeneity assessment: This approach could provide insights into tumor heterogeneity that are difficult to obtain from single-site biopsies.

Overall, this technique has the potential to enable more precise, adaptive, and personalized management of mCRPC, potentially improving patient outcomes and quality of life. However, it's important to note that extensive validation and standardization would be required before widespread clinical implementation.

Questions and Answers

As a man with mCRPC, you could ask your oncologist the following questions based on this study, along with potential answers you might expect:

1. Question: "Is EV-based liquid biopsy testing available for mCRPC patients like me?"

Expected Answer: Your oncologist might say this is still primarily a research tool and not yet widely available for routine clinical use. However, they may be aware of clinical trials or specialized centers offering this technology.

2. Question: "How could EV analysis benefit my treatment compared to current methods?"

Expected Answer: They might explain that EV analysis could potentially offer more frequent and comprehensive monitoring of your cancer without invasive procedures, possibly detecting treatment resistance earlier or guiding more personalized treatment choices.

3. Question: "Are there any clinical trials using this EV analysis technique that I could participate in?"

Expected Answer: Your oncologist should be able to check if there are any relevant trials. If not locally available, they might refer you to larger cancer centers conducting such studies.

4. Question: "How does this compare to other liquid biopsy techniques I've heard about, like circulating tumor DNA (ctDNA) testing?"

Expected Answer: They might explain that EV analysis potentially offers both genomic (DNA) and transcriptomic (RNA) information, which could provide more comprehensive insights than ctDNA alone.

5. Question: "If this becomes clinically available, how often would I need blood draws?"

Expected Answer: The optimal frequency is still being determined, but it could potentially be more frequent than current monitoring methods, possibly every few weeks or months.

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 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 MEETINGS

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

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