Informed Prostate Cancer Support Group Inc.
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March 2020 NEWSLETTER

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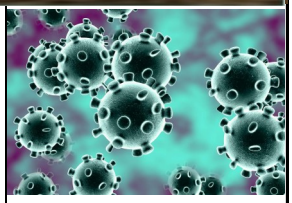

Thursday, March 12,

Volume 13 Issue 03

Next Meeting: MARCH 21st IPCSG Meeting Postponed

Due to rising public health concerns regarding COVID-19, the March 21st IPCSG meeting has been postponed. At this time we do not know when we will resume our normal meeting schedule at the Sanford Burnham Prebys Medical Discovery Institute auditorium, but we are looking into other avenues for live-streaming our presenters to your computer. Stay tuned!

- **For further Reading:** https://ipcsg.blogspot.com/
- **For Comments, Ideas and Questions,** email to Newsletter@ipcsg.org

February 2020 Informed Prostate Cancer Support Group Meeting:

Personal Experiences – a Panel of Experts

(Volunteers and Leaders of the Group)

Summary by Bill Lewis

George Johnson, the meeting facilitator, shared his good personal news. His PSA has gone down significantly, now that his is recovering from a year-long battle with C. Diff (a hospital-borne bacterium that causes diarrhea and colitis) involving five different treatments. He went off his anti-cancer medications to avoid interference. This week, his doctor wanted him to restart the medications, including Firmagon and Erleada. George surprised him by insisting that they wait, since his PSA had gone down somewhat. He noted the importance of heart and mind, in addition to necessary attention to the prostate/pelvic area of the body. Service, such as by group volunteers, himself included, provides an emotional boost. His good news provided him another boost. So he is doing well now at age 87. His experiences can be found on our website at https://ipcsg.org/personal-experience

Early detection is very important in prostate cancer (PCa). George is one who "waited too long." He had a PSA of 0.7 after treatment, so wasn't tested again for two years – and it wasn't by his request. His PSA was 14. In another year, it would have been over 200, and a year after that, it would have gone to 3,000.

He recommends high-definition imaging, such as MRI, not just a bone scan, and targeted biopsies, not "random" 12-core biopsies. From the Gleason score of the biopsy of the most suspicious lesion, the appropriate path for treatment is mainly determined. A Gleason score of 6 is understood to indicate that no treatment is needed at that time, permitting Active Surveillance – which avoids or delays the side effects that come with treatment. It's important to get a second opinion on the Gleason score and any proposed treatments.

Gene Van Vleet, age 81, reported on Lyle LaRosh (IPCSG President), then on himself. The IPCSG was formed in 1990. Lyle joined in 2000, and brought the group forward, particularly through contacts with local businessmen,

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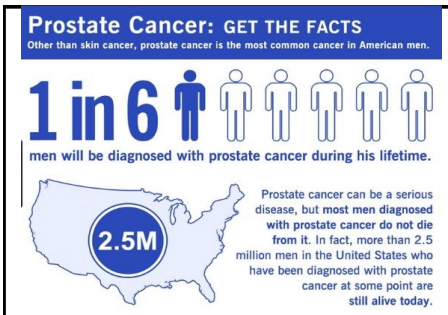

Organization

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

IPCSG

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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.

Be your own health manager!!

Meeting Video DVD's

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

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

From the Editor

Facilities for the meeting are not available due to the COVID-19 epidemic, so it is cancelled until further notice. We will continue to post and distribute the newsletter in the interim. Alternate web based meeting approaches such as zoom have been suggested and we will notify you via the newsletter and web site if such becomes available.

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; **Vice President** Gene Van Vleet @ 619-890-8447; or **Meeting facilitator** George Johnson @ 858-456-2492.

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including Malin Burnham – who had PCa, and agreed to IPCSG's use of the current meeting place at no charge. Lyle had a tumor in his prostate, and insisted that only that spot be irradiated. He has needed no further treatments for PCa, but has had other health problems: throat cancer and loss of sight in one eye. Now spends time at a property in Baja California. Encouraged Gene to join IPCSG 13 years ago. Gene is a retired CFO and has helped put the group on a solid financial footing. There are now 950 people on the member list. 880 emails went out last month, and only 3 did not go through. See a video of Lyle via the website at https://ipcsg.org/personal-experience

Gene was diagnosed with PCa eighteen years ago, in 2002. He credits his survival to the IPCSG, which got him to go see Dr. Lam in Marina del Rey. He's been through eight treatments, and is currently taking seven drugs. Surgery failed for him, because of a lack of imaging. Pathology of the removed prostate showed that cancer was already outside the prostate. His treatments have each lasted a few years, then some new treatment was needed. Fortunately, new developments brought a new treatment each time he was in need of something new. Going forward, men can look to genetic testing to help with the selection of the treatment most likely to work for them. His PSA is currently only 1.3. But after one failure, his PSA shot up to 15 in only three months. Dr. Lam convinced him of the value of exercise, and he has worked out an hour a day, six days a week, for ten years. It helps him to not have side effects. He's currently on Lynparza, based on genetic testing. He feels that prior treatments with Provenge and Keytruda helped boost his immune system. Additional details are in the March 2018 and August 2019 newsletters/videos as well as in Personal Experience on our website: https://ipcsg.org/personal-experience.

John Tassi was 44 years old in 1999, and his PSA was 1.1. In 2002, his PSA was 2.4, with a "normal" DRE (digital rectal exam). In 2004, he was diagnosed with BPH (medicine helped urination, but he feels his growing PCa was again missed). In 2007, with no PSA tests since 2004, his doctor finally suggested he be tested. The result was 19. A random biopsy showed 3+3 on the right side, but 3+4 on the left. The urologist insisted on surgery, and "conveniently" had an opening in two weeks, for robotic surgery, in February 2008. He didn't get all of the cancer. Starting about six months later, his PSA started doubling every 2-1/2 months. Based on an IPCSG recommendation, he went to see Dr. Lam, who explained that if John did nothing, there would be an 80% chance that he would be dead in eight years. He said a combination of treatments would likely get him ten years. A third option was "everything, including the kitchen sink." He had chemotherapy with Taxotere (docetaxel), but with doses of 250 instead of the usual 75 mg. It was thought that since he was young, he could handle it. Then he had 37 treatments with IMRT (a form of external radiation), followed by ADT (hormone therapy) for 13 months. His PSA gradually became undetectable. Today, more than ten years later, his PSA is still undetectable. He feels that the chemo treatment was a key element of his recovery. What about side effects? He has them all. Neuropathy, failing eyesight and brain fog from chemo. Bladder and rectal problems from the radiation, which is also likely the cause of his hip problems. But he is still here. Additional details are in the March 2019 newsletter and video as well as in Personal Experience on our website: https://ipcsg.org/personal-experience

Stephen Pendergast was diagnosed with BPH at age 62, and had a PSA over 4. A DRE showed a lump, so he had a random biopsy. One needle of 16 had a little bit of possible cancer, or precancerous tissue. He concluded he could wait, so went back only after three years. His PSA was about 7. The DRE again showed a bump, leading to another biopsy. This showed Gleason 7, with both sides of the prostate diseased. Then he found the IPCSG, and a good surgeon, Dr. Kane, who did a robotic prostatectomy. He had no incontinence problems. But the pathology report showed "positive margins," indicating that not all the cancer was removed. Within six months, his PSA started to rise. So he had 32 radiation treatments, but no specific imaging of where the cancer actually was. After two years, the cancer came back. He went to Phoenix AZ for a C-11 CT scan, which showed many active spots, all the way up to near his heart. So he went on Lupron injections, and has been on that intermittently. The internet led him to Zytiga as a supplement to the Lupron, for about a year. He has been off the treatment for about two years, but recently his PSA has been rising again, from undetectable to 0.06. He's undecided about the next step. Current age is 75.

Bill Lewis got the "modern approach" to diagnosing PCa. When his PSA was found to be elevated (~ 9), he got mpMRI scanning to look for suspicious areas in the prostate, followed by an in-bore MRI-guided biopsy (3 needles each into two spots,

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and very little pain). The Gleason score was 8, later revised to 9, based on a review of the core samples at Johns Hopkins. A bone scan showed there were already a dozen metastases in the bones. He tried a few elements of "alternative medicine," and ended up with over 100 metastases six months later. Such a bone scan is called a "super scan," and the life expectancy of such a patient is 6 to 9 months. So he began the "Triple Blockade" ADT treatment he read about on the internet, and also ramped up his use of supplements and procedures selected with the help of a comprehensive-medicine doctor-friend. After nine months of this combination treatment, the cancer was not detectable anywhere by mpMRI or bone scan, and his PSA had dropped from 73 to 0.2. (More details in the March 2017 & November 2018 newsletters/videos)

He found Dr. Robert Leibowitz and his partner Shahrooz Eshaghian in L.A. for outside-the-box thinking and treatments, and has been under their care for two years (at the Compassionate Oncology Medical Group). His current PSA is 6 and steady, and he has a few reactivated metastases, that are being followed. He feels that supplements and exercise are a big help, along with the unique selection of drugs Leibowitz and Eshaghian have prescribed: Proscar (finasteride), Avodart (dutasteride), Thalidomide (the drug that caused deformed babies in the 1950's, but which prevents metastases from developing their own blood supply, which they need if they are to grow larger than 2 mm diameter), Leukine (an injected immune system stimulator), and several repurposed drugs normally used for other purposes, but have been shown to be helpful against PCa: metformin, celecoxib, atorvastatin, losartan, Vitamin D, Vitamin B-12 and aspirin. His supplements include turmeric (with black pepper for better absorption), an immune-system stimulating mushroom extract called Agaricus Blazei, bee propolis, flaxseed oil (intimately blended with cottage cheese for absorption), oxaloacetate (sold as benaGene) and a variety of seeds, nuts, dried berries, etc.

Bill has begun to write a book about prostate cancer. He will be presenting information both about traditional as well as alternative therapies, including supplements. The first two chapters are available now by request (lewis.bill@gmail.com). He also recommends an organization called Imerman Angels, which matches men with others who have similar disease and age, for mentoring and encouragement. He currently is mentor for 3 men.

Bill Manning was diagnosed in 2009 at age 57 with Gleason 6 in one core. Surgery was recommended but refused. He wasn't in favor of radiation either. Through his research, he found this group and its focus on education. Despite his wife's qualms about not doing surgery, she agreed to further information gathering. A Color Doppler ultrasound showed no urgency for treatment, so he went on Active Surveillance. After four annual repeats of the scan, a biopsy was strongly recommended. He reluctantly agreed, since there was "something suspicious" in the scan. A targeted biopsy showed only minor abnormalities that didn't look like cancer, in both the original and in a second-opinion report. He did have BPH (enlarged prostate), and his PSA bounced (and continues to range) between 5 and 8.

His Active Surveillance continued, with three periodic mpMRI's, which all yielded the same assessment – that his abnormalities still don't look like cancer. So he continues with twice-annual PSA's, an annual DRE, and an mpMRI every two years. He tried dutasteride for a year, for the BPH, but it didn't help. He does use Flomax. He altered his diet, and went about 90% vegan, and feels it may have helped prevent the development of cancer, and that it has general health benefits. Supplements: D3 with magnesium and turmeric; Vitamin B-12 (because of not eating meat). More details about Bill Manning's prostate journey are in the March 2018 Newsletter and video, including his report on losing his home in the "Lilac" wildfire a few months earlier. His experience can also be found on our website: https://ipcsg.org/personal-experience

George Johnson shared how a Lupron shot ten years ago gave him bad side effects, especially hot flashes. Instead, he followed Gene Van Vleet's suggestion that he try Casodex and Avodart (which knocks out the production of dihydrotestosterone, the 5-10X more active derivative), which worked for him for 8 years. Then he

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went on Firmagon, later adding Erleada, and looks ahead to other future treatments.

Aaron Lamb (45-46 years old) has had surgery, radiation, and ADT with Zytiga. See the August 2019 newsletter/video for more details. He's currently off the Lupron & Zytiga, and feels his cognition and other health factors recovering. He did exercise 3 days a week. He had some bone issues, and regrets not doing more impact-type exercise, and not taking enough calcium (because his blood values were normal). He got a PSA at age 39, and it was 9, but was told he was too young for prostate cancer. The doctor tried Saw Palmetto, a bunch of nutraceuticals, and dietary changes, but his PSA rose to 12 in four months. Since he didn't feel well with all the stuff he was taking, he stopped it, and resolved to wait until symptoms would drive him back to a urologist. When he did, due to urination problems, his PSA was 16. Surgery was done by a "good" doctor, but cancer was found in his seminal vesicles and lymph nodes, so he had radiation. He doesn't regret the journey, since for example, he is much more empathetic and thoughtful of others – and has been motivated to volunteer with the IPCSG. He will begin facilitating our meetings in March.

More details are given in the video of this presentation, which includes the introductory PowerPoint slides, and which will be available for purchase via the website shortly before the next meeting, or at the March meeting on the 21st.

Member Suggested Items:

F*rom Lyle LaRosh :*

San Diego Sexual Medicine, under the leadership of Dr. Irwin Goldstein, is planning a clinical trial in the near future in men with incontinence. They will be studying a device called BTL Emsella®, which is intended to provide entirely non-invasive electromagnetic stimulation of pelvic floor musculature for the purpose of rehabilitation of weak pelvic muscles and restoration of neuromuscular control for the treatment of male (or female) urinary incontinence. The patient sits on a chair-like device, fully clothed, and receives over 10,000 muscle stimulations in a 30 -minute session. See https://bodybybtl.com/solutions/pelvic-suite/btl-emsella/ for more information about the device.

Men aged 21-80 who have stress urinary incontinence (leaking with sneezing/coughing/jumping), urge urinary incontinence (can't hold it in as you approach the bathroom), or mixed incontinence may be interested in participating. They have to be sexually active at the time of the trial and willing to continue being sexually active. They cannot have surgery planned for the time of the trial, or have an untreated malignancy. Because the device is essentially a magnet, they cannot have a pacemaker or implanted device that can be damaged by the magnet, such as a defibrillator, neurostimulator or drug pump.

If anyone is interested in participating, they should reach out directly to JoAnna at 619-265-7695. She can discuss the trial and ask specific questions to see if the person qualifies to come in to screen. But simply put, each potential subject would be screened, and if qualified move into treatment 4 weeks later. Treatment would be twice a week for 3 weeks in a row. Then he would come back 4 weeks later and again 8 weeks after that. At that point (18 weeks after screening), he would be unblinded. Two out of three men will be on active treatment the first time around. Those people who had been treated with sham would then start their real treatments, twice a week for 3 weeks, then come back for the 2 follow up visits. So everyone gets treated in the end. And anyone interested in this therapy but not through a clinical trial can pay for treatment as a patient.

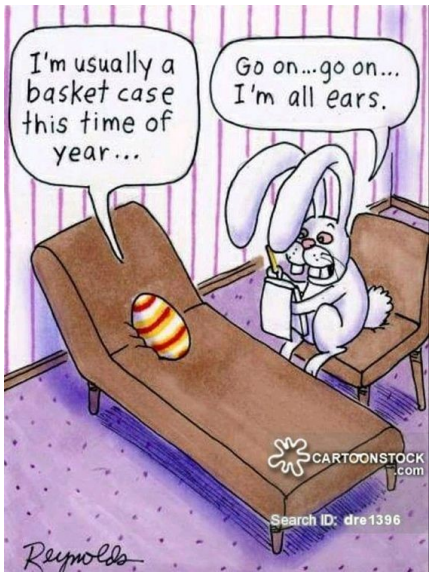
Information provided by Sue W. Goldstein, CCRC, CSE, IF (Certified Clinical Research Coordinator and Certified Sexuality Educator); Clinical Research Manager at San Diego Sexual Medicine, 5555 Reservoir Drive, Suite 300, San Diego, CA 92120 Phone: 619 265-8865 suewgoldstein@gmail.com http://www.SanDiegoSexualMedicine.com

F*rom Joel Pointon:*

GoodRX.com—My Primary Care Doctor at Sharp told me about it when I found a 30 day supply of a medication to be $400 with insurance at CVS....but less than $60 for the same drug and a 90 day supply via a mail-order pharmacy. I have also found Pricing at 25% at a Walgreen's across the street from my CVS.

Prostate Cancer Foundation - Wellness Guide https://res.cloudinary.com/pcf/image/upload/v1567177703/PCF-WellnessGuide-Single-Med_f4q1m0.pdf

On the Lighter Side



Articles of Interest

New study compares long-term side effects from different prostate cancer treatments

by *Charlie Schmidt* via Harvard Health Blog

Prostate cancer therapies are improving over time. But how do the long-term side effects from the various options available today compare? Results from a newly published study are providing some valuable insights.

Investigators at Vanderbilt University and the University of Texas MD Anderson Cancer Center spent five years tracking the sexual, bowel, urinary, and hormonal status of nearly 2,000 men after they had been treated for prostate cancer, or monitored with active surveillance (which entails checking the tumor periodically and treating it only if it begins to grow). Cancers in all the men were still confined to the prostate when diagnosed.

Dr. Karen Hoffman, a radiation oncologist at MD Anderson and the study's first author, said the intent was to provide information that could help men choose from among the various therapeutic options. "Surgical and radiation techniques have changed significantly in the last few decades, and at the same time, active surveillance has become an increasingly acceptable strategy," she said. "We wanted to understand the adverse events associated with contemporary approaches from the patient's perspective."

Roughly two-thirds of the men enrolled in the study had "favorable risk" cancer, which is nonaggressive and slow-growing. A quarter of these men chose active surveillance, and the rest were treated with one of three different methods:

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nerve-sparing prostatectomy (an operation to remove the prostate with the intent of sparing the nerves required for erections)
external beam radiation therapy (EBRT)
low-dose rate brachytherapy, which is a method for destroying cancerous tissues with tiny radioactive beads implanted inside the prostate gland.

Men with favorable risk cancer who chose EBRT or active surveillance tended to be older than men who choose surgery, likely because increasing age and illness make prostatectomy harder to tolerate.

The rest of the men in the study were diagnosed with "unfavorable risk" tumors that were more likely to spread. These men were treated either with prostatectomy, or with EBRT combined with drugs that block testosterone (a hormone that fuels growing prostate tumors).

What the results showed

After five years, there were no significant differences in survival associated with any of the selected treatments. Just one man in the favorable risk category died from prostate cancer during the study, and there were eight deaths from the disease in the unfavorable risk group.

Many men in the study had initial problems with sexual, bowel, urinary, and hormonal functioning. Brachytherapy caused more irritative urinary problems during the initial six months than the other treatments, but then those symptoms steadily improved. Brachytherapy and EBRT were associated with minor bowel symptoms such as urgency, bleeding, frequency, and pain that resolved within a year in men from both risk groups.

After five years, differences in side effects between the treatment options had disappeared, with a notable exception: about half the surgically treated men in both the favorable and unfavorable risk groups still had difficulty achieving erections sufficient for intercourse, and between 10% and 13% of them reported ongoing problems with urinary leakage and incontinence. "However, I don't want anyone to walk away from this analysis thinking they should not get a prostatectomy," Dr. Hoffman emphasized. "Side effects will differ from person to person." Furthermore, radiation side effects may still develop even after five years, "and this is something we're continuing to monitor," she said. "Our hope is that doctors will use this information to counsel men on expected side effects so they can make an informed choice that is right for them."

Dr. Marc Garnick, Gorman Brothers Professor of Medicine at Harvard Medical School and Beth Israel Deaconess Medical Center, and editor in chief of Harvard-ProstateKnowledge.org, agreed the study provides a valuable resource that adds to existing information. Yet he cautioned against brachytherapy, warning that this particular treatment in some cases has long-term urinary side effects that can significantly alter a patient's quality of life. "I do not routinely recommend brachytherapy," Garnick said. "This is especially true in patients with a pre-existing history of urinary tract infections or prostatitis."

The post New study compares long-term side effects from different prostate cancer treatments appeared first on Harvard Health Blog.

nih.gov

Progress in developing an accurate, noninvasive urine test for prostate cancer

Mahal BA, et al.,

sciencedaily.com

Researchers at the Johns Hopkins Kimmel Cancer Center have made significant progress toward development of a simple, noninvasive liquid biopsy test that detects prostate cancer from RNA and other specific metabolic chemicals in the urine.

A description of their findings appears in the Feb. 28 issue of the journal *Scientific Reports*. *Integrated RNA and metabolite profiling of urine liquid biopsies for prostate cancer biomarker discovery | Scientific Reports: Sensitive and specific diagnostic and prognostic biomarkers for prostate cancer (PCa) are urgently needed. Urine samples are a non-invasive means to obtain abundant and readily accessible "liquid biopsies".*

The investigators emphasize that this is a proof-of-principle study for the urine test, and it must be validated in additional, larger studies before it is ready for clinical use.

The researchers used RNA deep-sequencing and mass spectrometry to identify a previously unknown profile of RNAs and dietary byproducts, known as metabolites, among 126 patients and healthy, normal people. The cohort included 64 patients with prostate cancer, 31 with benign prostatic hyperplasia and prostatitis diseases, and 31 healthy people with none of these conditions. RNA alone was not sufficient to positively identify the cancer, but addition of a group of disease-specific metabolites provided separation of cancer from other diseases and healthy people.

"A simple and noninvasive urine test for prostate cancer would be a significant step forward in diagnosis. Tissue biopsies are invasive and notoriously difficult because they often miss cancer cells, and

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existing tests, such as PSA (prostate-specific antigen) elevation, are not very helpful in identifying cancer," says Ranjan Perera, Ph.D., the study's senior author. Perera is also the director of the Center for RNA Biology at Johns Hopkins All Children's Hospital, a senior scientist at the Johns Hopkins All Children's Cancer & Blood Disorders Institute and the Johns Hopkins All Children's Institute for Fundamental Biomedical Research, and an associate professor of oncology at the Johns Hopkins University School of Medicine and Johns Hopkins Kimmel Cancer Center member.

"We discovered cancer-specific changes in urinary RNAs and metabolites that -- if confirmed in a larger, separate group of patients -- will allow us to develop a urinary test for prostate cancer in the future," says Bongyong Lee, Ph.D., the study's first author and a senior scientist at the Cancer & Blood Disorders Institute.

Story Source:

Materials provided by **Johns Hopkins Medicine**. *Note: Content may be edited for style and length.*

cebp.aacrjournals.org

Novel MRI-guided ultrasound treatment destroys prostate cancer

Levin PD et al.,
https://www.sciencedaily.com/releases/2019/12/191202081638.htm
sciencedaily.com

A novel MRI-guided procedure that uses therapeutic ultrasound effectively treats prostate cancer with minimal side effects, according to a new study presented today at the annual meeting of the Radiological Society of North America (RSNA). Researchers said the incision-free technique could also be used to treat benign enlargement of the prostate gland.

Prostate cancer is the second-leading cause of cancer death in men after lung cancer. Treating disease in the small gland that surrounds the urethra just outside the bladder is challenging. Surgery and radiation are not always effective and can result in incontinence, impotence and bowel dysfunction. Other currently available techniques lack sophisticated imaging guidance and temperature monitoring.

In recent years, a minimally invasive method called MRI-guided transurethral ultrasound ablation (TULSA) has emerged as a promising treatment option. TULSA works by delivering precise doses of sound waves to diseased prostate tissue while sparing the healthy nerve tissue surrounding the prostate.

TULSA relies on a rod-shaped device that is inserted into the urethra. The novel device has 10 ultrasound-generating elements that can cover the entire prostate gland. One or more of the elements are used to send out sound waves that heat and destroy the target prostate tissue. The elements are controlled automatically by a software algorithm that can adjust the shape, direction and strength of the therapeutic ultrasound beam. The entire procedure takes place in an MRI scanner so that doctors can closely monitor treatment and assess the degree and location of heating.

"Unlike with other ultrasound systems on the market, you can monitor the ultrasound ablation process in real time and get immediate MRI feedback of the thermal dose and efficacy," said study co-author Steven S. Raman, M.D., professor of radiology and urology, and director of Prostate MR Imaging and Interventions and Prostate MR Imaging Research at the University of California at Los Angeles (UCLA). "It's an outpatient procedure with minimal recovery time."

In the new multicenter study, researchers reported on the 12-month outcomes from the TULSA-PRO® ablation clinical trial (TACT). The trial enrolled 115 men, median age 65, with localized low or intermediate risk, gland-confined prostate cancer. Clinicians delivered TULSA treatment to the entire gland. Treatment time averaged 51 minutes.

Prostate volume in the study group decreased on average from 39 cubic centimeters pre-treatment to 3.8 cubic centimeters a year after treatment. Overall, clinically significant cancer was eliminated in 80% of the study participants. Seventy-two out of 111 men, or 65%, had no evidence of any cancer at biopsy after one year. Blood levels of prostate-specific antigen (PSA), a marker of prostate cancer, fell by a median of 95%. There were low rates of severe toxicity and no bowel complications.

"We saw very good results in the patients, with a dramatic reduction of over 90 percent in prostate volume and low rates of impotence with almost no incontinence," Dr. Raman said.

Approved for clinical use in Europe, TULSA has just received FDA 510(k) clearance for prostate tissue ablation in the United States. Assuming follow-up studies support the preliminary results, the technique could develop into an important tool for treating both prostate cancer and benign prostatic hyperplasia, or enlargement of the prostate.

"There are two very unique things about this system," Dr. Raman said. "First, you can control with much more finesse where you're going to treat, preserving continence and sexual function. Second, you can do this for both diffuse and localized prostate cancer and benign diseases, including benign hyperplasia."

TULSA also has the benefit of allowing further treatment if needed, Dr. Raman said. If it fails, then the procedure can be repeated, and more aggressive invasive approaches like surgery and radiation therapy can still be used. Alternatively, TULSA may enable noninvasive treatment for localized radiation failure.

The study also supports the use of MRI for post-treatment monitoring of patients who undergo TULSA. MRI at one year after treatment had a negative predictive value of 93 to 96% for detecting residual cancer, meaning it was very accurate for ruling out disease recurrence in patients.

Prostate cancer: Home urine test could 'revolutionize diagnosis'

medicalnewstoday.com

https://www.medicalnewstoday.com/articles/327215.php#1

A new pilot study concludes that at-home urine tests could make prostate cancer diagnoses shorter, simpler, and possibly even more accurate.

The possibility of a home urine test for prostate cancer moves one step closer.

Prostate cancer is common, affecting nearly half of males over 50. However, it tends to develop slowly, and in many cases, health professionals do not consider it clinically significantTrusted Source. In other words, it is not likely to shorten the male's life.

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This poses a real problem for medical professionals, as it becomes difficult to know who to treat and when. On the one hand, it is important not to begin treatment if someone does not need it, but on the other hand, they must make sure that someone who is likely to develop aggressive prostate cancer receives the best care.

Currently, the two most common diagnostic tools are digital rectal exams and blood tests for prostate-specific antigen (PSA). Although PSA is useful, there are issues. The National Cancer Institute provide an exampleTrusted Source:

"[O]nly about 25% of men who have a prostate biopsy due to an elevated PSA level actually are found to have prostate cancer when a biopsy is done."

For this reason and others, researchers are investigating other ways of testing for prostate cancer, and some are looking to urine.

Prostate urine risk tests

As fluid moves from the prostate through the urethra, it carries cancer cells and RNA with it. Once the body has passed this genetic and cellular information out in the urine, scientists can use it to detect clues about the presence of prostate cancer.

These tests are called prostate urine risk (PUR) tests, and studiesTrusted Source have demonstrated that they can help predictTrusted Source whether or not prostate cancer will become aggressive.

In earlier studies of PUR tests, before researchers collected a urine sample, they conducted a digital rectal exam. As the authors of the new study explain, during the exam, a doctor will "firmly stroke" one side of the prostate. This encourages cellular and genetic material to move from the prostate to the urine sample.

Medical News Today Newsletter

Digital rectal exams are unpopular and require a trip to the doctor's office. Researchers from the University of East Anglia in the United Kingdom wanted to determine whether or not it would be possible to skip this procedure while still yielding accurate PUR results.

Their recent study investigated an at-home version of the PUR test. At-home testing allows participants to take a urine sample at home and mail it to the laboratory. This is ideal, because it means that the person can capture the first urination of the day.

As lead researcher Dr. Jeremy Clark explains, "Because the prostate is constantly secreting, the collection of urine from men's first urination of the day means that the biomarker levels from the prostate are much higher and more consistent."

A simpler methodology

To investigate whether or not this home-based approach might be viable, the scientists recruited 14 participants. Each used an at-home urine sampling kit to collect the first urination of the day. They also provided a sample 1 hour after their first urination and another after a digital rectal examination in the clinic (on a different day). This allowed the scientists to compare the results.

They have recently published their findings in the journal *BioTechniques*.

"We found that the urine samples taken at home showed the biomarkers for prostate cancer much more clearly than after a rectal examination," explains Dr. Clark, "And feedback from the participants showed that the at-home test was preferable."

The study authors now believe that the at-home PUR test could make a substantial difference in the diagnosis of prostate cancer. Dr. Clark explains that, in the future, it could "revolutionize how those on 'active surveillance' are monitored for disease progression."

Currently, these males must visit a clinic once every 6–12 months, where they undergo painful biopsies. This new method would mean that they only need to mail a urine sample to the laboratory.

"It means that men would not have to undergo a digital rectal examination, so it would be much less stressful and should result in a lot more patients being tested."

Dr. Jeremy Clark

The University of East Anglia researchers designed this new study to test the efficacy of at-home urine collection. Now they know that this methodology works, they plan to use it more widely to investigate aggressive prostate cancer in the near future.

The study authors believe that this protocol might also be useful when "screening for other urinary cancers, such as bladder and kidney." Because the process is simple and cost effective, it will speed up clinical trials studying prostate cancer and make it easier to recruit a greater numbers of participants.

MRI-Guided TULSA Shows Efficacy in Prostate Cancer

Nancy A. Melville

medscape.com

CHICAGO — The novel approach of MRI-guided transurethral ultrasound ablation (TULSA) shows efficacy in the treatment of localized prostate cancer that can be performed on an outpatient basis, inducing substantial reductions in prostate-specific antigen (PSA) as well as prostate volume over 12 months.

"This is a paradigm-changing treatment that is rapid and noninvasive, with potentially high efficacy and low side effects," study coauthor Steven S. Raman, MD, professor of radiology and urology, University of California at Los Angeles, told *Medscape Medical News*.

"It's an example of technology that is disruptive and requires disruptive thinking," he said.

In presenting on the 12-month findings from the TULSA-PRO Ablation Clinical Trial (TACT) study here at the Radiological Society of North America (RSNA), Raman reported that TULSA was effective in the overall elimination of clinically significant cancer in 79% of patients, with serum PSA declining by a median of 95%.

The new approach is one of many innovations in the field, as companies seek to create alternatives to current approaches. The limitations of standard treatment of prostate cancer with surgery and radiation include the risk of side effects such as impotence and bowel dysfunction.

The TULSA method specifically utilizes a transurethral device (Profound Medical, Inc) with 10 ultrasound-generating elements that can cover the entire prostate gland.

Using a software algorithm and MR guidance, precise doses of ultrasound waves are delivered to diseased prostate tissue while sparing healthy nerve tissue around the prostate.

The treatment is approved for clinical use in Europe and received US Food and Drug Administration (FDA) 510(k) clearance in August for the indication of prostate tissue ablation in the US.

The RSNA presentation is similar to data presented on TULSA earlier this year at the annual meeting of the American Urological Association.

TACT Study 12-Month Outcomes

NETWORKING

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

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

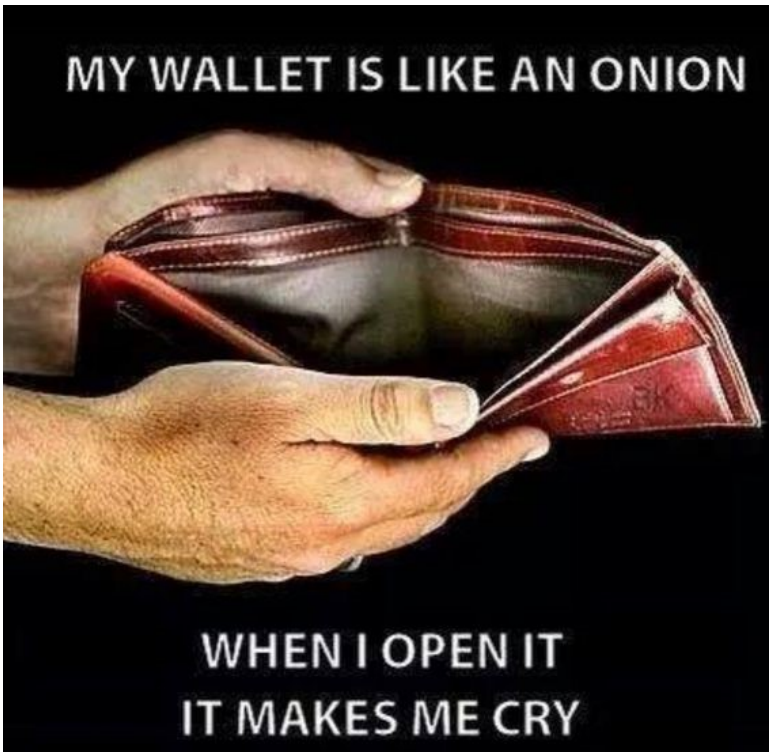
Our brochure provides the group philosophy and explains our goals. Copies may be obtained by mail or email on request. Please pass them along to friends and contacts.

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 4201042, San Diego CA 92142