

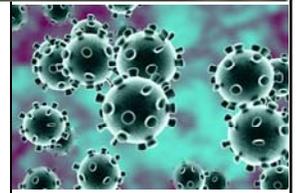


Informed Prostate Cancer Support Group Inc.

"A 501 C 3 CORPORATION ID # 54-2141691"



April 2020 NEWSLETTER
P.O. Box 420142 San Diego, CA 92142
Phone: 619-890-8447 Web: <http://ipcs.org>



Wednesday, April 15,

Volume 13 Issue 04

April 18th IPCSG Meeting Postponed

Due to the COVID-19 restrictions, IPCSG in-person meeting have 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. In the meantime, we will be live-streaming our presenters as close to the 3rd Saturday of every month as possible.

APRIL 19, Alan J. Hsu, MD - "HOW TO COPE WITH MOOD and ANXIETY"

(A pre-recorded presentation on our website will be available for viewing on **Sunday April 19, 2020**)

Dr. Hsu will discuss coping mechanisms and techniques on how to deal with Stress and Anxiety that have been brought on by a cancer diagnosis.

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

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

Troubled Times

These are troubled times beyond what most of us have previously experienced. The coronavirus or COVID-19 has caused unprecedented uncertainty and chaos. The best we can do, as men most likely susceptible, is stay at home, except for those providing authorized services, and maintain the six-foot distance when you must go out. Please do not hoard pertinent supplies! We must have faith that our medical and political teamwork will help us get through this pandemic.

Of course, we cannot hold our regular meetings until such time as it is deemed feasible. However, please continue to let others know the importance of testing and continued surveillance after treatment. With your extra time go to our informative website www.ipcs.org, DVD's of noted speakers www.ipcs.org/purchase-dvds and personal experiences of some of our members www.ipcs.org/personal-experience and lead others to it.

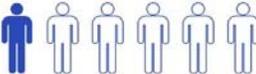
John Tassi and Bill Manning have developed a system that will allow broadcast of speakers. Watch for announcements from our website.

You can always make use of or refer others to our hotline 619-890-8447 or e-mail info@ipcs.org.

Gene Van Vleet, Director

Prostate Cancer: GET THE FACTS

Other than skin cancer, prostate cancer is the most common cancer in American men.

1 in 6  men will be diagnosed with prostate cancer during his lifetime.



Prostate cancer can be a serious disease, but most men diagnosed with prostate cancer do not die from it. In fact, more than 2.5 million men in the United States who have been diagnosed with prostate cancer at some point are still alive today.

Organization

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



Officers

Lyle LaRosh President

Additional Directors

- Gene Van Vleet
- George Johnson
- John Tassi
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- Chuck Grim, 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.

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://ipcs.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. Our first speaker this month will be recorded and broadcast via the group web site. 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; or **Vice President** Gene Van Vleet @ 619-890-8447.



IN MEMORY OF GEORGE JOHNSON

A GOOD MAN

George Johnson passed away April 2nd at the age of 87. Prostate Cancer was not the primary cause of his demise. He fought many forms of digestive and intestinal issues which were never satisfactorily resolved and caused intense pain over a long period of time.

George was a highly intelligent and personable man. He was involved in helping others in many ways in addition to what he did with our support group. He was active in his church, counseled prisoners in Otay Mesa Detention Center, Chaired a Good Will association, and helped mentor others in AA.

One of his hobbies was artistic painting. He often sold his work at the Del Mar Fair. I have seen some of his work and I always marvel at the ability to transfer what one sees and thinks to a beautiful painting.

George joined our support group in March, 2010 fourteen years after failing radiation treatment. He soon volunteered efforts to help us help others. He became a Director and the Facilitator of our meetings. He and I became very good friends and we jointly searched for and scheduled speakers. He organized our monthly meetings including what we call "round table" where others talk of their experiences in dealing with our common disease followed by break-out sessions to network by treatment type. He personally counselled many members that sought his help.

I talked with George several time as he was nearing the end and he never complained nor feared what was inevitable. He for sure is now in a place very fitting for this **good** man.

Respectfully,

Gene Van Vleet



with it, not from it.

George Johnson at our January meeting shared his good personal news. His PSA had gone down significantly, now that he was 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. He noted the importance of heart and mind, in addition to necessary attention to the prostate. He said that Service as a group volunteer provided an emotional boost. His good news provided him another boost. He said he was doing well at age 87, so we were all surprised to hear of his passing. His experiences fighting cancer can be found on our website at <https://ipcs.org/personal-experience>. You can also watch his presentation at our 2018 03 – IPCSG meeting -- "SUCCESSFUL LIVING WITH PROSTATE CANCER"

Stephen Pendergast

On the lighter side



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search ID: man2560

"You have an extremely rare, hard-to-treat disease — are you trying to make me look bad?"



"I want you to take one of these every day until I think of something else."



"I can't remember—do I work at home or do I live at work?"



"It's funny how two intelligent people can have such opposite interpretations of the tax code!"

Articles of Interest

cancernetwork.com

Managing Treatment for Patients with Prostate Cancer During the COVID-19 Pandemic

Matthew Fowler

April 6, 2020

A group of radiation oncologists from the United States and United Kingdom developed a framework to assist in the decision-making process in regard to radiation treatment for patients with prostate cancer during the global COVID-19 pandemic, according to a study pre-printed in *Advances in Radiation Oncology*.¹

The framework, deemed the “RADS framework,” stands for “Remote visits, and Avoidance, Deferment, and Shortening of radiotherapy.” It was determined that all aspects of patient visits, treatment, and overall resource utilization should be reduced when possible for all stages of radiotherapy, but not to the detriment of the patient.

“We issued these recommendations assuming that the pandemic will last for at least several months, with multiple waves of varying length, and place new overall stress on hospital systems, along with causing disruptions to hospital staffing from illness, quarantine and family responsibilities,” corresponding study author Daniel Spratt, MD, said in a news article.²

The framework recommends protecting patients, care providers and society through “increased use of telemedicine consultations,” while also avoiding, deferring and shortening radiotherapy whenever possible. The four main components of the RADS recommendations include remote visits, avoiding radiation, delaying treatment, and shorten radiotherapy treatments.

Rather than in-person visits, the researchers recommend conducting remote visits between doctors and patients to determine treatment whenever possible. More, when the evidence suggests there is little to no benefit, the researchers recommend patients avoid radiation.

Depending on each individual patient’s circumstances, delaying treatment would be beneficial for patients to avoid potential exposure to the COVID-19 virus. For patients whose disease is rapidly progressing, the re-

searchers stress weighing the treatment against potential COVID-19 complications. Finally, the researchers recommend shortening radiotherapy treatment to the minimum number that is safe and effective for each particular patient.

“The complexity of treatment of prostate cancer has increased with more frequent use of advanced imaging, including MRI and molecular PET imaging, image guidance with fiducial markers, and rectal spacers, most of which require extra procedures or visits, and some of which require extra use of PPE,” wrote the researchers. “Thus, prostate cancer patients represent an important population that radiation oncology departments need to efficiently manage in times when resources are limited.”

The researchers found that consultation and return visits could safely be delayed between 1-6 months according to stage of the disease. For patients with very low, low, and favorable intermediate-risk disease, treatment can be avoided or delayed until the pandemic subsides.

The development of new recommendations came from analyzing national guidelines, systematic reviews, and previous or ongoing clinical trial data. The researchers were sure to stress that these new guidelines apply only to patients who have not yet tested positive for the COVID-19 virus. Those who have tested positive should continue following instructions from their local caretakers and health officials.

The researchers explained that these recommendations are possible because prostate cancer is a unique disease compared to other forms of cancer. Most prognoses are not aggressive, but for those that are, androgen deprivation therapy (ADT) can delay the start of radiotherapy for months. This allows for patients with prostate cancer to successfully wait for the pandemic to subside before resuming treatment.

“The goal was to provide guidance and a framework of thinking of how numerous programs are approaching the care of patients with prostate cancer at their own clinics, who are all at various stages of impact and restrictions from the COVID-19 global pandemic,” wrote the researchers.

References:

Zaorsky NG, Yu JB, McBride SM, et al. Prostate Cancer Radiotherapy Recommendations in Response to COVID-19. *Advances in Radiation Oncology*.

Demsky I. How Should Radiation Oncologists Manage Prostate Cancer Patients During the COVID-19 Pandemic? *University of Michigan Health*. March 26, 2020. <https://>

(Continued from page 5)

labblog.uofmhealth.org/rounds/how-should-radiation-oncologists-manage-prostate-cancer-patients-during-covid-19-pandemic. Accessed March 31, 2020.

medpagetoday.com

'MultiD': Taking the Bias Out of Prostate Cancer Treatment

Over the past decade, there has been significant growth in the percentage of men with low- and very-low risk prostate cancer (PCa) opting for active surveillance (AS).

Ten years ago, when I was diagnosed with very-low-risk prostate cancer and chose AS, the vast majority of men like me, 84%-90%, chose radical prostatectomy or radiation therapy. This meant that men were more comfortable with accepting the risks of incontinence, impotence, and other side effects from "definitive" treatments. I was not, and chose AS after getting a second opinion.

Since then, other American men increasingly have been opting for AS over aggressive treatment -- somewhere around 40%-60% of low-risk candidates. This is a sea change in care for patients, though well below the approximately 80% who choose AS in Sweden.

But some new research suggests that Swedish levels are attainable in the U.S.

The secret ingredient? It's overcoming treatment bias using multidisciplinary (MultiD) care. In these scenarios, typically in major cancer centers, patients get opinions from experts in multiple specialties rather than just seeing a series of urologists.

Centers offering multi-disciplinary care aim for a one-stop-shop involving a urologist and a radiation oncologist, and sometimes a medical oncologist, who has no skin in the game and can act as an umpire. The doctors from different specialties attempt to reach a consensus in a single patient visit. The patient's family doctor also can help the patient find a comfortable path.

Researchers at MD Anderson Cancer Center in Houston [reported in the journal *Cancer*](#) in February that their MultiD clinic had dramatically increased the proportion of men choosing AS.

Radiation oncologist Deborah Kuban, MD, one of the co-authors and vice president for clinical operations with the MD Anderson Cancer Network, said, "In our clinic, in 2004, about 10% of these men chose active surveillance. In 2016, the last year of our study, 80% of these patients chose active surveillance."

The study is the largest to date involving a MultiD clinic. A total of 4,451 men with prostate cancer presented to the

clinic from 2004 to 2016. The Anderson clinic model includes a urologist and a radiation oncologist.

Similar results were found in a [study in the *Journal of Clinical Oncology*](#) in September 2012 of the MultiD clinic at Massachusetts General Hospital in Boston. In a four-year study, the first of its kind, researchers compared the choice of active surveillance or definitive treatment in 701 men who had gone to a MultiD clinic versus seeing a single practitioner.

Mass General radiation oncologist Jason Efstathiou, MD, PhD, said the proportion of men opting for AS was 43% in those presenting in a MultiD clinic versus 22% who presented to an individual urologist or radiation oncologist. In the intervening years, the proportion of men opting for AS had grown to 70%-80%, comparable to the Anderson findings, he said.

The results in men attending MultiD clinics are impressive.

Why does that happen? It involves a number of factors, including the elimination of bias on the doctors' part and patients having their confidence in accepting AS increased with opinions from doctors in competing specialties.

Kuban and Efstathiou agreed that, by having doctors from competing disciplines review the cases at the same time, the natural prejudice in favor of a physician's own tools falls by the wayside.

"Patients have actually told us that they feel comfortable because they have more than one doctor telling them what their best choice is, explaining it to them, giving them the reasons behind it, setting up a program for them to do it," said Kuban. "Doctors in MultiD clinics try to be objective and not serve their personal agendas."

She noted that doctors at academic medical centers don't have an incentive to push their personal approach for treatment because they're salaried. "I don't get paid for each patient I see. So if I put a patient on active surveillance, and I don't radiate them and don't generate that radiation income, it doesn't matter to me. I'm going to get my paycheck at the end of the day."

Efstathiou said bias by urologists and radiation oncologists toward recommending their own tools is well-documented. To a carpenter with a hammer in hand, everything looks like a nail.

Doctors may deny favoring their own bank accounts over patient well-being. But Efstathiou noted that research years ago showed that when urologists owned radiation clinics, their patients disproportionately tended to undergo more expensive courses of radiation therapy.

Kuban said this is natural: "We have a bias toward what we do. We know it best. We know how it works, and some people tend to think that what they do works best. I don't tend to think that. I think that radiation is a good option for some patients, not a good option for others, and there are other options. And so, a lot has to be known about the patient, their cancer, their particular circumstances."

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She contended that having all specialties represented in MultiD clinics eliminates bias: "This approach keeps doctors honest and objective."

So if MultiD serves patients' interests, why isn't it more commonly used?

One of the key reasons relates to the logistics of having the patient meet at one time with all specialists, if possible, or squeezing appointments on the same day under one roof.

Efstathiou said it's nearly impossible outside the academic setting to schedule all specialists to be in the same room at the same time. But for the patient, it accomplishes in an hour what otherwise might take three hours with sequential visits.

He added: "And whenever you're in the room with your colleagues, I think there's a greater potential to reach a consensus. And I also think it rids itself further of any potential bias that an individual provider might have when they're alone with a patient versus in front of their colleagues."

Efstathiou said medical centers potentially could market their MultiD clinics as a point of distinction. He noted that Mass General offers MultiD clinics for all cancers.

For that matter, MD Anderson is spreading the gospel of AS to affiliated clinics throughout the country, for quality assurance and oversight, said Kuban. She said Banner Health, the system based in Phoenix; Scripps Health, based in San Diego; and Cooper University Hospital in Camden, New Jersey -- all Anderson network members -- have or will have MultiD clinics.

"We are committed to the idea," Kuban said.

MultiD sounds like a vitamin that will spare many patients from the side effects of overtreatment of low-risk prostate cancer. MultiD doesn't work under the models used by most clinics, but it's worth a try. It gives patients with low-risk disease the confidence and peace-of-mind they need to take a leap of faith to follow AS and learn to live with their cancer.

Howard Wolinsky is a medical journalist based in the Chicago area. He has been blogging for MedPage Today about his experiences with active surveillance for low-risk prostate cancer since February 2016. Read [more of his posts here](#).

medpagetoday.com

PSMA PET/CT Better Detects Prostate Cancer Spread

In men with high-risk prostate cancer, imaging with prostate-specific membrane antigen (PSMA) PET-CT prior to curative surgery or radiotherapy proved far more accurate than conventional imaging for detecting metastatic disease, a randomized trial found.

Among 295 evaluable patients, gallium-68 PSMA-11 PET-CT imaging had an accuracy of 92% (area under the curve [AUC] of the receiver operating characteristic curve) versus 65% with standard CT imaging and bone scans ($P < 0.0001$), reported Michael Hofman, MBBS, of the Peter MacCallum Cancer Centre in Melbourne, Australia, and colleagues in [The Lancet](#).

There were fewer equivocal cases of metastatic disease with PSMA PET/CT (7% vs 23% with conventional imaging), and the novel imaging method altered the course of disease management for twice as many men following first-line imaging (28% vs 15%, $P = 0.008$). In those who underwent second-line imaging -- for men with no more than two unequivocal metastases -- change in treatment occurred in 27% of those that crossed over to PSMA PET/CT, but just 5% of those switching to conventional imaging.

"Taken together, our findings indicate that PSMA-PET/CT scans offer greater accuracy than conventional imaging and can better inform treatment decisions," Hofman said in a statement. "We recommend that clinical guidelines should be updated to include PSMA PET/CT as part of the diagnostic pathway for men with high-risk prostate cancer."

PSMA "is a cell-surface glycoprotein overexpressed on prostate cancer cells," according to background information in the paper. Using radiolabelled small molecules that bind to these cells, PSMA PET/CT can detect tumor presence throughout the body.

Patients receiving PSMA PET/CT were also exposed to significantly lower levels of radiation than with conventional imaging (8.4 vs 19.2 millisieverts, respectively).

"Current medical imaging techniques often fail to detect when the cancer has spread, which means some men are not given the additional treatments they need," co-author Declan Murphy, MBChB, also of Peter MacCallum, said in a statement. "Our findings suggest PSMA-PET/CT could help identify these men sooner, so they get the most appropriate care."

In an [accompanying editorial](#), Caroline Moore, MD, of University College London, pointed to one limitation in the study -- the way metastasis was defined -- that may have biased the results in favor of PSMA PET/CT.

Metastatic disease was defined as either a bone lesion changing to sclerotic or blastic on follow-up imaging, or histologic confirmation of a metastatic site -- this

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"hard criteria" was met in just 23% of the 87 men in the study with metastases. Alternatively, metastasis could also be established via three "soft criteria," which included rising prostate-specific antigen (PSA) levels at 6 months, increases or decreases in lesion number or size on subsequent imaging, a lesion associated with clinical symptoms, and others.

"Although these criteria reflect a real-world approach, in which men having radiotherapy will not have histological confirmation of nodal disease, some men might have had microscopic disease that was not detected by either modality," wrote Moore. "Also, some men might have had false-positive findings, which were never further assessed."

She noted that in the study, a small group of men still went on to radical treatment despite the presence of metastatic disease on PSMA PET/CT.

"Introduction of new imaging modalities, such as PSMA PET-CT, with improved sensitivity in detecting small-volume metastases, brings both challenges and opportunities," she continued. "In particular, when men test negative on conventional imaging, and PSMA PET-CT shows small-volume metastatic disease, what should we do?"

From 2017 to 2019, the [proPSMA study](#) randomized 302 men with high-risk prostate cancer 1:1 to either standard CT imaging plus a bone scan or to PSMA PET-CT across 10 sites in Australia. Median participant age was 68. High-risk disease was defined as one of the following: clinical stage $\geq T3$, a PSA level ≥ 20 ng/mL in the 12 weeks prior to randomization, or International Society of Uro pathology grade group 3-5.

Of the 295 men with follow-up, 30% had either pelvic nodal metastases or distant metastases. Sensitivity was improved with PSMA PET/CT, at 85% compared to 38% with conventional imaging. As was specificity (91% vs 98%, respectively).

In subgroup analyses, PSMA PET/CT was more accurate at detecting both pelvic nodal metastases (91% vs 59% with conventional imaging) and distant metastases (95% vs 74%).

Disclosures

The study was funded by Movember and the Prostate Cancer Foundation of Australia.

Hofman disclosed grants from the Prostate Cancer Foundation of Australia, Movember, the Peter Mac-Callum Foundation, the U.S. Department of Defense, and the Victorian Cancer Agency; and other relationships with Ipsen, Sanofi Genzyme, and Janssen. Coauthors re-

ported grants from or financial relationships with the Prostate Cancer Foundation of Australia, Mundipharma, Janssen, Ferring, Telix Pharmaceuticals, Astellas, Janssen, Bayer, and Ipsen.

Moore reported financial or advisory board relationships with Janssen, Astellas, Sonablate, Steba Biotech, and Genomic Health.

newatlas.com

New diagnostic tools aim to catch aggressive prostate cancer early

By Rich Haridy

Two newly published studies are presenting novel diagnostic techniques to help catch the most aggressive forms of prostate cancer at an early stage. A University of East Anglia study presents an innovative way to measure gene expression in tumor samples and predict disease severity, while an Australian study details a new kind of imaging technique promising to detect metastasized prostate cancer with greater accuracy than ever before.

"Prostate cancer is the most common cancer in men in the UK," explains Colin Cooper, lead researcher on a new study from the University of East Anglia. "It usually develops slowly and the majority of cancers will not require treatment in a man's lifetime. However, doctors struggle to predict which tumors will become aggressive, making it hard to decide on treatment for many men."

In order to develop a way for doctors to better identify the most aggressive tumors the researchers examined different gene expression patterns in nearly 2,000 prostate tumor samples. Applying a mathematical model called Latent Process Decomposition, the study homed in on a particular pattern of gene expression associated with the most aggressive clinical cases.

The pattern relates to a subtype of cells the team has labeled DESNT, and suggest the more tumor cells in a sample that are of that DESNT subtype, the faster a patient will progress through the disease. The hope is that this can act as a biomarker to stratify prostate cancer patients, identifying those needing more urgent invasive treatments.

"If you have a tumor that is majority DESNT you are more likely to get metastatic disease, in other words it is more likely to spread to other parts of your body,"

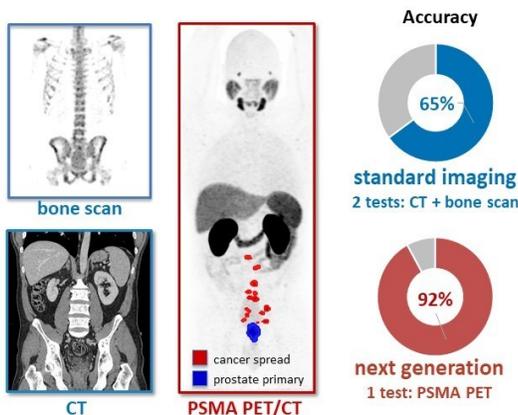
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says Daniel Brewer, co-lead researcher on the project. "This is a much better indication of aggressive disease."

Identifying when prostate cancer has metastasized is obviously of vital importance in guiding treatment. A team of Australian researchers just published the results of a clinical trial evaluating the efficacy of a new imaging technique developed to provide detailed data on the spread of the disease.

"Around one in three prostate cancer patients will experience a disease relapse after surgery or radiotherapy," says Declan Murphy, senior author on the new imaging study. "This is partly because current medical imaging techniques often fail to detect when the cancer has spread, which means some men are not given the additional treatments they need."

Traditional prostate cancer imaging involves a combination of bone and CT scans. The new technique utilizes two different types of imaging, CT and PET. Patients are administered a molecule called Prostate Specific Membrane Antigen (PSMA), which lights up any circulating prostate cancer cells under a PET scan, whereas the CT scan delivers detailed body structure data. So the two imaging techniques combined offer a detailed picture of where in the body prostate cancer cells may be.



Comparing the traditional bone/CT scan method with the new PSMA PET/CT technique
Peter MacCallum Cancer Centre

The clinical trial results revealed the new technique to be a significant improvement on traditional imaging methods. The PSMA-PET/CT scan effectively detected metastatic cancer spread in 92 percent of patients, compared to the traditional method detecting spread in only 65 percent of patients.

Even more impressively, the new scan delivered low levels of false negatives compared to the traditional method. In 29 patients metastatic cancer was missed by the traditional imaging method, but the PSMA-PET/CT scan only missed metastasis in six patients.

"Taken together, our findings indicate that PSMA-PET/CT scans offer greater accuracy than conventional imaging and can better inform treatment decisions," says Michael Hofman, study lead from the Peter MacCallum Cancer Centre in Australia. "We recommend that clinical guidelines should be updated to include PSMA PET/CT as part of the diagnostic pathway for men with high risk prostate cancer."

While this new imaging technique can theoretically be implemented around the world relatively quickly, the method is more expensive than traditional diagnostic processes. The researchers are aware of the potential challenges in broadly delivering this new test and are planning an economic analysis to understand how cost-effective this new technique could be. Obviously catching cancer spread early lowers longer term health care costs.

"Costs associated with PSMA-PET/CT vary in different regions of the world but this approach may offer savings over conventional imaging techniques," says co-author on the new imaging study, Roslyn Francis. "A full health-economic analysis will help to determine the cost effectiveness of introducing PSMA-PET/CT, both from a patient and a healthcare perspective".

The new genetic expression study was published in the *British Journal of Cancer*.

The new imaging study was published in the journal *The Lancet*.

Sources: [Peter MacCallum Cancer Centre](#), [University of East Anglia](#)

Prostate cancer: Home urine test could 'revolutionize diagnosis'

<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.

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 studies have demonstrated that they can help predict whether or not prostate cancer will become aggressive.

NETWORKING

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

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

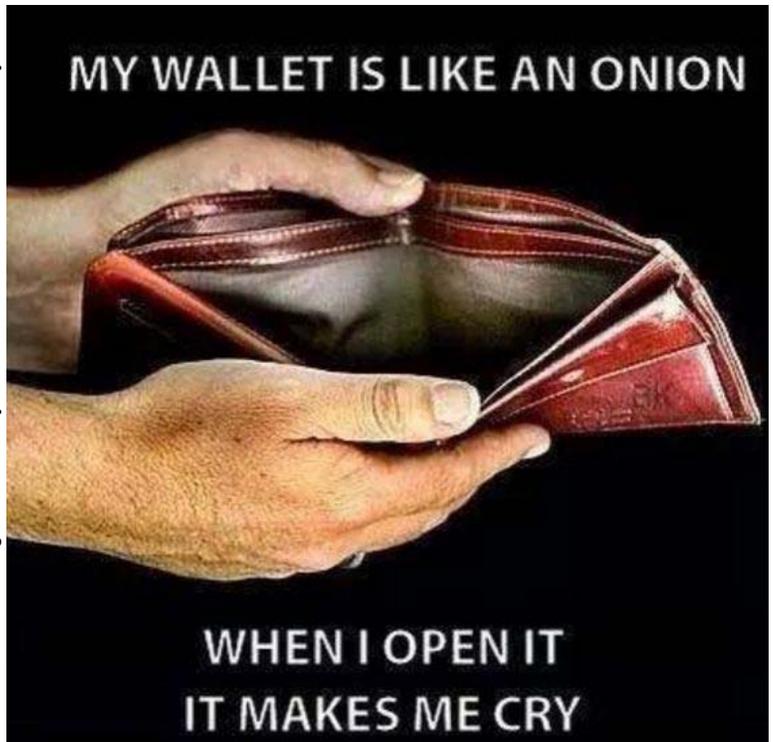
Our brochure provides the group philosophy and explains our goals. Copies may be obtained by mail or email on request. Please pass them along to friends and contacts.

Ads about our Group are in the Union Tribune **the week** prior to a meeting. Watch for them.

FINANCES

We want to thank those of you who have made special donations to IPCSG. Remember that your gifts are tax deductible because we are a 501(c)(3) non-profit organization.

We again are reminding our members and friends to consider giving a large financial contribution to the IPCSG. This can include estate giving as well as giving in memory of a loved one. You can also have a distribution from your IRA made to our account. We need your support. We will, in turn, make contributions from our group to Prostate Cancer researchers and other groups as appropriate for a non-profit organization. Our group ID number is 54-2141691. Corporate donors are welcome!



While our monthly meetings are suspended, we still have continuing needs, but no monthly collection. If you have the internet you can contribute easily by going to our website, <http://ipcsg.org> and clicking on "Donate" Follow the instructions on that page. OR just mail a check to: IPCSG, P. O. Box 420142, San Diego CA_92142