Informed Prostate Cancer Support Group Inc.
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OCTOBER 2024 NEWSLETTER

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Tuesday, October 15, 2024

Volume 17 Issue 10

Next IPCSG Meeting *3rd* Saturday, 10am

October 19, 2024

- **TREATMENTS FOR ADVANCED PROSTATE CANCER— Rana R. McKay, MD,** is a board-certified medical oncologist who specializes in treating people with urogenital cancers, including bladder, kidney, prostate and testicular cancer. Dr. McKay leads a multi-disciplinary prostate cancer clinic focused on delivering advanced cancer care through a coordinated team approach. Dr. McKay will be highlighting recent FDA approved treatments for advanced prostate cancer. Additionally, she will discuss current novel treatments that are in development and clinical trials of the next generation treatments for prostate cancer.
- **The will be a light lunch provided after the meeting**
- **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**

Meeting of the IPCSG, 9/21/2024

Dr. Ramesh Rengan - THE ROLE OF PROTON THERAPY IN THE MANAGEMENT OF SOLID TUMORS

Dr. Ramesh Rengan is currently the Peter Wootton Chair and Professor in the Department of Radiation Oncology at the University of Washington School of Medicine and the Senior Vice President and Director in Radiation Oncology Division at the Fred Hutchinson Cancer Center. He also holds a joint appointment as faculty of the Integrated Immunotherapy Research Center, Fred Hutchinson Cancer Center.

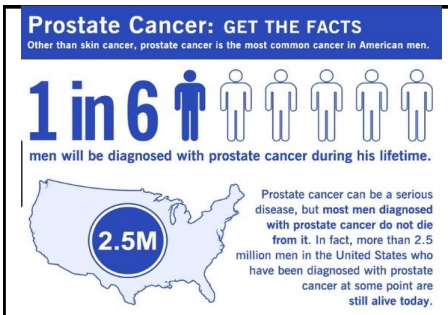
Summary

Here's a summary of Dr. Rengan's talk on proton beam radiotherapy in solid tumors:

Dr. Ramesh Rengan's presentation explores the role of proton beam radiotherapy in managing solid tumors, with a particular focus on prostate cancer. The talk begins by emphasizing the importance of asking the right questions in problem-solving, setting the stage for a critical examination of radiation therapy's evolution and the potential benefits of proton therapy.

Historical Context and Evolution:

(Continued on page 3)



Organization

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

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NEWSLETTER
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PROSTATE CANCER—*2 WORDS, NOT A SENTENCE*

What We Are About

Our Group offers the complete spectrum of information on prevention and treatment. We provide a forum where you can get all your questions answered in one place by men that have lived through the experience. Prostate cancer is very personal. Our goal is to make you more aware of your options before you begin a treatment that has serious side effects that were not properly explained. Impotence, incontinence, and a high rate of recurrence are very common side effects and may be for life. Men who are newly diagnosed with PCa are often overwhelmed by the frightening magnitude of their condition. Networking with our members will help identify what options are best suited for your life style.

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, we have a claude.AI generated summary of Dr Ramesh Rengan via remote from University of Washington Fred Hutchinson Cancer Center. The video of this talk is published online Youtube, and notes and transcript on the blogsite.

This month, we include a couple items of interest:

1. Management of Patients with Advanced Prostate Cancer. Report from the 2024 Advanced Prostate Cancer Consensus Conference (APCCC) - ScienceDirect—new standards of care
2. Pfizer's Cancer Drug Combo Improves Overall Survival in Late-stage Study
3. Prognostic value of PSMA PET in predicting long-term biochemical control following curative intent treatment for prostate cancer

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Dr. Rengan traces the development of radiation therapy from the 1960s to the present, highlighting how advancements have consistently aimed at improving local tumor control while reducing complications to surrounding healthy tissues. The progression from basic radiation techniques to more sophisticated methods like 3D conformal therapy and intensity-modulated radiation therapy (IMRT) is outlined. Proton therapy is presented as a logical next step in this evolution, offering more precise dose delivery and reduced exposure to healthy tissues due to its unique physical properties.

Early Evidence and Challenges:

The presentation discusses early evidence supporting the local control hypothesis in radiation therapy, citing studies in lung and prostate cancer that showed improved outcomes with dose escalation. The CHART trial in non-small cell lung cancer and dose escalation studies in prostate cancer are highlighted as key examples.

However, Dr. Rengan also presents data challenging this hypothesis, noting that improved local control doesn't always translate to better overall survival, particularly in prostate cancer. Long-term follow-up studies have shown limited survival benefits in some cases, and there are risks associated with treatment intensification. This balanced approach sets the stage for a nuanced discussion of proton therapy's potential benefits and limitations.

The Value of Toxicity Mitigation:

A key theme in the presentation is the importance of toxicity mitigation in cancer treatment. Dr. Rengan cites a study showing improved survival in lung cancer patients receiving early palliative care, underscoring the significance of quality of life considerations in cancer management. This perspective informs the subsequent discussion of proton therapy's potential advantages.

Applications of Proton Therapy:

The talk focuses on three main areas where proton therapy may offer particular advantages:

1. Pediatric cancers: Proton therapy's potential to reduce long-term side effects, especially neurocognitive impacts in medulloblastoma treatment, is discussed. Data from meta-analyses showing potential benefits in neurocognitive outcomes for pediatric patients treated with proton therapy compared to conventional photon therapy are presented.

2. Leptomeningeal carcinomatosis: Dr. Rengan explains how proton therapy may allow for effective treatment with reduced toxicity compared to conventional radiotherapy in this challenging condition. Data showing improved survival and reduced toxicity with proton craniospinal irradiation are presented.

3. Prostate cancer: The presentation delves into the potential benefits of proton therapy in prostate cancer treatment. Dr. Rengan discusses the ProtecT trial results, which compared active surveillance, surgery, and radiotherapy in prostate cancer, and explains how these findings inform the potential role of proton therapy. While proton therapy offers dosimetric advantages, the talk emphasizes that long-term clinical benefits are still being evaluated.

Clinical Evidence and Challenges:

Dr. Rengan addresses the challenges in generating clinical evidence for proton therapy, including the need for long follow-up periods to assess late effects and the difficulties in conducting randomized trials. He discusses the appropriate use of proton therapy in different patient populations, noting that younger patients with prostate cancer might benefit more due to the potential reduction in long-term side effects.

Future Directions - FLASH Radiotherapy:

The presentation introduces FLASH radiotherapy, an ultra-high dose rate technique that shows promise in maintaining tumor control while potentially reducing normal tissue toxicity. Dr. Rengan presents early preclinical studies showing encouraging results, including improved survival and reduced toxicity in animal models. He details the FLASH-RT setup at the University of Washington and the Fred Hutchinson Cancer Center, demonstrating ongoing research in this cutting-edge area.

Conclusions:

Dr. Rengan concludes by emphasizing that while proton therapy may provide clinical value for a subset of patients with narrow therapeutic spectrum tumors, ongoing prospective trials in various cancer types will be crucial in defining its role in cancer treatment. He highlights several ongoing trials in breast cancer, hepatocellular carcinoma,

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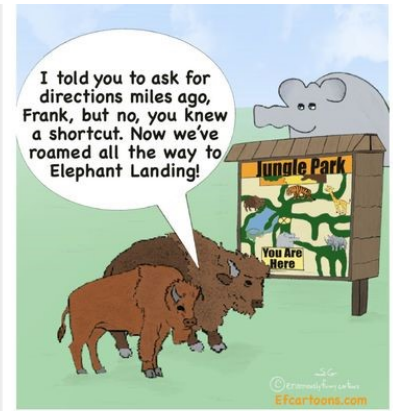
prostate cancer, and lung cancer that will provide important data on the efficacy and toxicity of proton therapy compared to conventional radiotherapy.

The presentation underscores the importance of continuous research, careful patient selection, and the need to balance the potential benefits of advanced radiation techniques with their costs and complexity. Dr. Rengan provides a balanced view of the current state of proton therapy, acknowledging its potential benefits while also recognizing the need for more robust clinical evidence to guide its optimal use in cancer treatment.

Overall, the talk offers a comprehensive overview of proton therapy's role in oncology, grounded in historical context and looking ahead to future innovations. It emphasizes the importance of evidence-based medicine and patient-centered care in advancing cancer treatment technologies.

On the Lighter Side



Items of Interest

Management of Patients with Advanced Prostate Cancer. Report from the 2024 Advanced Prostate Cancer Consensus Conference (APCCC) - ScienceDirect

https://doi.org/10.1016/j.eururo.2024.09.017

Summary of Results

Here are the key takeaways for prostate cancer patients from this expert consensus report:

1. Treatment options are expanding for advanced prostate cancer, but there is still uncertainty about optimal management in many situations. This report provides expert opinions to help guide decisions where high-level evidence is lacking.

2. For high-risk localized/locally advanced prostate cancer:

- There was strong consensus to treat based on MRI findings if MRI shows more advanced disease than digital rectal exam.
- Most experts recommend radiation therapy plus long-term androgen deprivation therapy (ADT), with or without abiraterone, for high-risk localized disease.
- There was no consensus on the role of surgery for very high-risk disease.

3. For rising PSA after surgery (biochemical recurrence):

- Early salvage radiation is generally preferred over immediate adjuvant radiation.
- Adding short-term ADT to salvage radiation is recommended by many experts.
- Genomic testing to guide treatment decisions is not routinely recommended by most experts at this time.

4. For metastatic hormone-sensitive prostate cancer:

- Combination therapy with ADT plus other agents is recommended.
- For high-volume disease, many experts recommend ADT + docetaxel + an AR pathway inhibitor.
- For low-volume disease, ADT + an AR pathway inhibitor is commonly recommended.

5. For metastatic castration-resistant prostate cancer:

- Genetic/genomic testing is recommended to guide treatment selection.
- PARP inhibitors are recommended for patients with certain genetic mutations.
- Experts do not recommend routinely switching between AR pathway inhibitors due to limited benefit.

6. Lutetium-PSMA therapy is recommended by most experts after patients have received an AR inhibitor and docetaxel.

7. Bone health:

- Bone-protecting agents are recommended for most patients on long-term ADT.
- Experts were split on whether to use monthly or every 3 month dosing for bone-targeted agents in metastatic disease.

8. Side effect management:

- Cardiovascular risk assessment is recommended, especially for patients with risk factors.
- Various options exist for managing hot flashes, but there was no consensus on optimal treatment.

9. Genetic testing:

- Most experts recommend some form of genetic/genomic testing for metastatic disease.
- Results currently influence treatment decisions for castration-resistant but not hormone-sensitive metastatic disease.

The report emphasizes that these are expert opinions to help guide decisions where evidence is lacking. Patients should discuss their individual situation with their doctors to determine the most appropriate treatment approach.

Summary

This document reports on the 2024 Advanced Prostate Cancer Consensus Conference (APCCC), which gathered

expert opinions on controversial areas in the management of advanced prostate cancer. Key points include:

1. The conference addressed 8 major topic areas, including high-risk localized/locally advanced disease, biochemical recurrence, metastatic hormone-sensitive and castration-resistant disease, radioligand therapy, side effects of hormonal therapy, bone health, and genetics/genomics.

2. 183 questions were voted on by 106 prostate cancer experts from around the world. Consensus was defined as ≥75% agreement, with strong consensus at ≥90%.

3. Key areas of consensus included:
- Using MRI findings over DRE for T-staging
- Recommending PSMA PET/CT imaging before considering PARP inhibitor therapy
- Using 177Lu-PSMA therapy in mCRPC after progression on an ARPI and taxane chemotherapy
- Recommending baseline cardiovascular risk assessment for patients starting ADT

4. Areas lacking consensus included optimal use of triplet therapy in mHSPC, sequencing of therapies in mCRPC, and management of oligometastatic disease.

5. The results aim to help guide clinical decision-making where high-level evidence is lacking, while also highlighting important knowledge gaps that require further research.

6. The report emphasizes that consensus does not equate to evidence and that treatment decisions should be individualized based on patient and disease characteristics.

The document provides a comprehensive overview of current expert opinions on managing advanced prostate cancer, reflecting evolving practices and areas of ongoing uncertainty in the field.

Clinical Impact

Based on the consensus voting results reported in this article, some key potential impacts on clinical care for advanced prostate cancer include:

1. Greater use of MRI findings over digital rectal exam for tumor staging, as there was strong consensus to treat based on MRI evidence of T3 disease even if DRE indicated T2.

2. Increased use of PSMA PET/CT imaging for staging and treatment selection, though with some caution about relying solely on PSMA PET without correlative imaging.

3. Preference for radiation therapy plus long-term ADT +/- abiraterone over surgery for very high-risk localized disease.

4. Trend toward using triplet therapy (ADT + docetaxel + ARPI) for high-volume metastatic hormone-sensitive prostate cancer, at least in selected patients.

5. Growing use of metastasis-directed therapy in oligometastatic disease, especially when detected on next-generation imaging.

6. Increasing use of PARP inhibitors in combination with ARPIs as first-line treatment for mCRPC in patients with BRCA mutations.

7. Strong preference for using lutetium-PSMA therapy after progression on an ARPI and taxane chemotherapy in mCRPC.

8. More routine cardiovascular risk assessment and monitoring in patients starting ADT +/- ARPIs.

9. Greater consideration of bone-protective therapy in patients on long-term ADT.

10. Increased genetic/genomic testing in metastatic disease to guide treatment decisions, especially for mCRPC.

The consensus results highlight many areas still lacking clear evidence, but provide expert guidance to help clinicians navigate controversial management decisions. Overall, they point toward more personalized treatment approaches incorporating newer imaging, biomarkers, and targeted therapies.

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Q&A

Based on this report, here are some key questions you could ask your oncologist about mCRPC treatment, along with the types of answers you might expect:

1. Question: Should I have genetic/genomic testing done? If so, what kind?
Expected answer: The oncologist will likely recommend both germline (inherited) and somatic (tumor) genetic testing, as 95% of experts voted for some form of testing in mCRPC patients. This can help guide treatment decisions.

2. Question: How will the results of genetic testing influence my treatment options?
Expected answer: The oncologist will likely say that genetic test results, especially findings related to DNA repair genes like BRCA1/2, can inform whether PARP inhibitors may be beneficial as part of your treatment.

3. Question: What are the options for first-line treatment of my mCRPC?
Expected answer: The oncologist will likely discuss options like androgen receptor pathway inhibitors (ARPIs), chemotherapy, or PARP inhibitors, depending on your prior treatments and genetic test results. They may recommend an ARPI if you haven't had one before.

4. Question: Should I consider 177Lu-PSMA therapy? If so, when?
Expected answer: The oncologist will likely say 177Lu-PSMA is an option to consider after you've progressed on an ARPI and chemotherapy. They may recommend PSMA PET imaging to determine if you're a good candidate.

5. Question: What can be done to protect my bones during treatment?
Expected answer: The oncologist will likely recommend bone-protecting agents like denosumab or zoledronic acid, especially if you have bone metastases. They may discuss different dosing schedules.

6. Question: How will you monitor my cardiovascular health during treatment?
Expected answer: The oncologist should discuss monitoring your blood pressure regularly, especially if you're on abiraterone. They may also recommend baseline cardiac evaluation, especially if you have risk factors.

7. Question: What can be done to manage side effects like hot flashes?
Expected answer: The oncologist may recommend lifestyle changes, exercise, and possibly medications like venlafaxine if hot flashes become bothersome.

Remember, these are general responses based on expert consensus. Your oncologist's specific recommendations may differ based on your individual case and their clinical judgment.

Pfizer's Cancer Drug Combo Improves Overall Survival in Late-stage Study

medscape.com

Short Summary for Patients

Here's a summary tailored for patients with metastatic castration-resistant prostate cancer (mCRPC):

1. New Treatment Option:
- Pfizer has developed a new combination treatment for mCRPC.
- It combines two drugs: TALZENNA (talazoparib) and XTANDI (enzalutamide).

2. Who It's For:
- This treatment is for men with mCRPC, which means prostate cancer that:
  - Has spread to other parts of the body
  - No longer responds to hormone therapy or surgery to lower testosterone

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3. How It Works:
  - TALZENNA is a type of drug called a PARP inhibitor.
- XTANDI blocks the effects of male hormones on prostate cancer.
- Together, they attack cancer in two different ways.

4. Effectiveness:
- In clinical trials, this combination showed significant benefits:
  - It helped patients live longer overall.
  - It slowed down the progression of cancer.
  - It works for many patients, but it's especially effective for those with certain genetic changes (mutations in genes like BRCA1, BRCA2, or CDK12).

5. Availability:
- This combination is approved for use in the United States and Europe.
- Your doctor can determine if it's right for you.

6. Important Considerations:
- Like all treatments, it can have side effects. Common ones include low blood cell counts and fatigue.
- Regular blood tests are needed to monitor your health during treatment.
- Discuss all potential benefits and risks with your healthcare provider.

7. Future Developments:
- Pfizer is working to make this treatment available to more patients with prostate cancer.

This new combination offers hope for many mCRPC patients, potentially extending life and slowing cancer progression. It's important to discuss this option with your oncologist to see if it's appropriate for your specific situation.

Prognostic value of PSMA PET in predicting long-term biochemical control following curative intent treatment for prostate cancer - Ades - Journal of Medical Imaging and Radiation Oncology - Wiley Online Library

Patient Oriented Summary

Here's a patient-oriented summary of how PSMA PET/CT scans can help in prostate cancer care:

What is a PSMA PET/CT scan?

A PSMA PET/CT scan is an advanced imaging test that combines two types of scans: PET (Positron Emission Tomography) and CT (Computed Tomography). It uses a special tracer that attaches to prostate cancer cells, making them visible on the scan.

How can PSMA PET/CT scans help me?

1. More accurate diagnosis:
- These scans can detect prostate cancer more accurately than traditional scans, even when it has spread to other parts of the body.
- This means your doctors can have a clearer picture of your cancer's extent, helping them choose the most appropriate treatment for you.
2. Better treatment planning:
- If you're newly diagnosed, the scan results can help decide if surgery, radiation, or other treatments are best for you.
- If your cancer has returned after initial treatment, the scan can pinpoint where it has come back, guiding decisions about further treatment.
3. Predicting treatment outcomes:
- The amount and intensity of cancer seen on the scan can give clues about how aggressive your cancer might be.

- This information helps doctors estimate how well different treatments might work for you.
4. Monitoring treatment effectiveness:
- PSMA PET/CT scans can show if your treatment is working by comparing scans before and after treatment.
- This allows your doctors to change your treatment plan if needed, rather than waiting for other signs that it might not be working.
5. Guiding specialized treatments:
- Some new treatments target the same protein (PSMA) that these scans detect. The scan results can show if you're likely to benefit from these treatments.
6. Avoiding unnecessary procedures:
- By providing detailed information, these scans might help you avoid unnecessary surgeries or treatments that are unlikely to help.
7. Personalizing your care:
- The scan results, combined with other tests, help create a more complete picture of your specific cancer, allowing for more personalized treatment plans.
What should I know about getting a PSMA PET/CT scan?
- It's a painless procedure that usually takes about 2 hours.
- You'll receive an injection of a small amount of radioactive tracer before the scan.
- Not all hospitals offer these scans yet, and they may not be covered by all insurance plans.
- While very helpful, these scans are not perfect. Your doctor will use the results along with other tests and examinations to make treatment decisions.
Remember, PSMA PET/CT scans are a powerful tool, but they're just one part of prostate cancer care. Always discuss the results and their implications with your healthcare team to understand how they apply to your specific situation.

Q&A

Here's a list of potential questions and likely answers from an oncologist:
Q1: Why are you recommending this scan for me now?
A1: "Based on your recent PSA test showing a slight increase, we want to check if there's any detectable recurrence of your prostate cancer. The PSMA PET/CT scan can detect very small areas of cancer activity that might not show up on conventional scans."
Q2: What specific information do you hope to gain from this scan?
A2: "We're looking to see if there are any areas where cancer cells are active. This could be in the area where your prostate was, in nearby lymph nodes, or potentially in other parts of your body. This information will help us determine if your cancer has recurred and, if so, where exactly it's located."
Q3: How might the results of this scan change my treatment plan?
A3: "If the scan is negative, we might continue with close monitoring. If it shows localized recurrence, we might consider targeted radiation therapy. If it shows more widespread disease, we might need to discuss systemic treatments like hormone therapy. The scan results will help us tailor the best approach for your specific situation."
Q4: How accurate is this scan in detecting recurrent prostate cancer?
A4: "PSMA PET/CT is currently one of the most sensitive tools we have for detecting recurrent prostate cancer. It can detect cancer when PSA levels are as low as 0.2-0.5 ng/mL. However, like all tests, it's not perfect. Very small areas of cancer or those with low PSMA expression might be missed."
Q5: Are there any alternatives to this scan? If so, why do you prefer the PSMA PET/CT?
A5: "There are alternatives like conventional CT, bone scans, or MRI. However, PSMA PET/CT is more sensitive and can detect smaller areas of cancer activity. This gives us more precise information to guide treatment decisions."
Q6: What does the scan involve? How should I prepare for it?
A6: "The scan takes about 2 hours. You'll receive an injection of a radioactive tracer, then wait about an hour before the actual scan, which takes 30-45 minutes. You don't need to fast, but stay hydrated and avoid strenuous exercise 24 hours before the scan. We'll give you detailed instructions."

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.