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

May 2019 NEWSLETTER

P.O. Box 420142 San Diego, CA 92142
Phone: 619-890-8447 Web: http://ipcsg.org

We Meet Every Third Saturday (except December)

Thursday, May 09, 2019

Volume 12 Issue 54

Next Meeting— May 18, 2019-10:00 AM to Noon

Location: SBP Auditorium, 10905 Road to the Cure, San Diego, CA 92121

DR. T. Mike HSIEH, Urologist, UCSD - SEXUAL DYSFUNCTION

a board-certified urologist specializing in male fertility and men's health. He treats men with sexual dysfunction including low testosterone, erectile dysfunction, and Peyronie's disease. He also treats male infertility including men with ejaculatory disorder, hormone imbalance, sperm production impairment, cancer, and genetic causes of infertility.

In collaboration with doctors at Moores Cancer Center, he focuses on enabling male patients with cancer to preserve their fertility options before cancer therapy. He also helps cancer survivors preserve or regain their sexual function after they receive cancer treatment that has sexual side effects.

- **For further Reading:** https://spendergast.blogspot.com/2019/03/prostate-cancer-news-of-interest-for.html
- **For Comments, Ideas and Questions,** email to Newsletter@ipcsg.org

Last IPCSG Meeting Summary April 2019

Acoustic/Shock Wave Therapy for Erectile Dysfunction
Summary by Bill Lewis

Mitt Kocher, General Manager – Introduction and comments
Charles Downing, Development Manager – Slide presentation
Dr. Dan Keiller, Urologist – Comments and answers to questions
ARC Mens Health, in Mission Valley; arcmenshealth.com

At the ARC Mens Health clinic, about 400 men have been treated so far over the past year and a half, with 80% success rate. Typical patient history is that a man has used Viagra, beginning sometime after age 50, accepting the side effects of headaches, blurred vision, flushes, etc. That worked well for a couple of years, but by 4-5 years was becoming ineffective. This is due to poor blood flow.

Erections occur when the arteries in the penis expand, compressing the veins that would normally return the blood to the heart. Artery expansion is caused by Nitric Oxide, which the body makes from Arginine. As a man ages, plaque builds up in the arteries, so they are not able to expand as well, reducing the firmness and duration of the erection, and eventually leading to no erections at all. Another reason that 50% of men over the age of 50 have some degree of erectile dysfunction is that the endothelium (the lining of the blood vessels) begins to be diseased,

Acoustic/Shock Wave therapy uses focused sound pulses to soften the plaque in and around the arteries to improve blood flow. Shockwave Therapy has been used for years to treat kidney stones. It has recently been cleared

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Organization

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

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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

WE ARE SEEKING REPLACEMENT FOR SOME OF OUR IPCSG TEAM

If you consider the IPCSG to be valuable in your cancer journey, realize that we need people to step up. The current staff are aging in place, and someday the 3rd Saturday may see no meeting of the group. Serving in this team can be rewarding and is a way to pay it forward to the group. To offer your services and/or ask questions about functions, Contact any of the individuals at their listed phone number.

FUNCTIONS NEEDED:

1. **President**: IPCSG public relations, research and advice. Lyle LaRosh has performed for 18 years. 619-892-3888
2. **Vice President**: Support all team members, assist in monthly planning and speaker acquisition. *currently vacant* Gene Van Vleet has performed Functions 2, 4, 5 for 11 years. 619-890-8447.
3. **Meeting facilitator**: Monthly planning and speaker acquisition. George Johnson has performed for 8 years. 858-456-2492
4. **Treasurer/Secretary**: Handle banking, accounting, government reporting (see 2)
5. **Hot Line**: Communicate directly with newcomers and handle phone inquiries. (see 2)

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by the FDA for use on this and other human tissues in the US (such as for plantar fasciitis or joint pain), and has been used to treat ED (erectile dysfunction) in Europe for many years. Shockwave Therapy also helps to heal the endothelium. It stimulates the growth of new blood vessels, so new microcapillaries are formed.

When someone comes in to the clinic, the doctor does an examination and the blood flow is measured with a Doppler ultrasound machine in the three main arteries involved in erections.

This gives a reading as a percentage of optimal blood flow (for example, 60% blood flow function would be essentially 40% blockage) and indicates if there is a circulatory problem that could be helped by the treatment. 75-80% function is the goal for acceptable erections. As an example, if someone comes in at 60% function, six treatments should get him to 75-80%. Blood flow is measured again after treatments and it increases in virtually every case.

The blood flow measurement can help find out if there is circulation impairment which could be causing or contributing to ED. This would be a separate issue from possible nerve damage caused by prostate cancer treatments (such as surgery). Typically, if a man is benefitted by Viagra or the like, it indicates that nerve damage is not the cause of his poor erections, and the Acoustic/ Shock Wave therapy is likely to help him.

Study reports were shown that indicated retention of benefits through 9 months of retesting, and that additional treatments were necessary for (some) radical prostatectomy patients. Chances are better if the prostatectomy was "nerve sparing," or if the man has had erections after the surgery.

Cost is $2900 for six treatments (given over about a month), and this is not covered by insurance. A discount to $1900 was offered to IPCSG members who signed up right away.

A "clean bill of health" is required before treatment. They do NOT treat patients with active prostate cancer, out of concern about possibly spreading it.

Most men will need more than six treatments. Often that would be 18 treatments over the course of a year. Most men will have about five years persistence of the effect after 18 treatments. It significantly helps with confidence. Follow-on treatments are $150 each, after having the full course.

Questions:

Is the treatment done with the penis erect? No need for erections in their offices/treatments.

What about neuropathy and Reynaud's disease? These are both diseases of the nerves, and not expected to be helped. Except there has been some help for peripheral neuropathy in diabetics.

Can this therapy help with heart disease? Yes, in certain cases, especially due to new blood vessel growth stimulated by the treatment.

What about Peyronie's disease (scarring that causes curvature and pain in the erect penis)? Some success, particularly in avoiding the worsening of the disease.

What happens to the plaque? It isn't broken up, but its morphology changes, to make it softer.

What is the mechanism for nerve involvement? The brain sends messages through the nerves to initiate erections. If the nerves are damaged, then a main option would be injections to obtain erections.

Potential problems with injections? A too-large dose can cause a painfully persistent erection. The medicine is irritating, so the site of injection has to be moved around to avoid scarring (i.e., Peyronie's disease).

George Johnson concluded the meeting by asserting that the reason men generally don't have conversations with their urologist about ED, is that most urologists suffer from it – and are reluctant to touch on something that could bring that out! ED is more common than you hear about.

To schedule an exam, call:
Arc Men's Health
5030 Camino de la Siesta, Suite 206
San Diego, CA 92108
(619) 458-9270
www.arcmenshealth.com

More details are given in the video of this presentation, including the PowerPoint slides, which will be available for purchase via the website shortly before the next meeting, or at the May meeting on the 18th.

ON THE LIGHTER SIDE

Subject: PROSTATE (COCKROACH) ANALOGY - Prostate cancer

From: "Phil Eve"

Prostate cancer is similar to finding a cockroach in the middle of your kitchen table. You panic, knowing that where there is one there are probably more and they do multiply. You call several exterminators.

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The surgeon recommends removal. He'll use a chain saw and remove the kitchen from the rest of the house and repair the plumbing as best he can with what remains.

The external beam radiation exterminator wants to stand outside the kitchen and blast away with a twelve gauge shotgun hoping he will miss the plumbing.

The seed implant exterminator is really slick. He just wants to drill holes in the wall and toss in grenades.

The cryosurgery exterminator wants to drill holes in the walls and pump liquid nitrogen, hoping he doesn't freeze the plumbing.

The hormone guys...well, they just want to pump in sleeping gas. Knowing all too well that in a couple of years the cockroaches will wake up pissed off and hungry.

Chemotherapy boys will offer to poison everything in the kitchen and will promise you that if you eat the poison they will give you an antidote, which may or may not work.

The alternative medicine people will give you a bit of eye of newt and toe of frog plus a couple of other exotic ingredients and hope to hell that chases the cockroaches away.

There are the watchful waiting folks, some of whom are not real sure that there was a cockroach and some of whom think it may have been just an old bachelor roach with no kids that they saw.

Now, if there is only the one cockroach the odds are good--you can get rid of the infestation. However, if the little bugger laid eggs elsewhere or more of his buddies are lurking about in other places...well...you get the picture. In any case, life in the kitchen will never be the same. One of these days an exterminator will come along who just swats the cockroach and puts out poison bait for the others. You'll never know he was there. Until then, good luck on your choice of exterminators and low or non-existent PSA's to you all.

REMEMBER--Don't take life too seriously. You won't get out of it alive anyway!

" What do you mean you know how I feel? Like you've had a hell of a day with your hormones !"

Articles of Interest

Highly accurate test reveals recurring prostate cancer

- Harvard Health Blog - https://www.health.harvard.edu/blog -

Posted By Charlie Schmidt On April 29, 2019 @ 5:30 pm In Living With Prostate Cancer | No Comments

After being treated for prostate cancer, some men will experience a rise in PSA levels suggesting that new tumors lurk somewhere in the body. Finding these tiny cancerous deposits before they grow and spread any further is crucially important. But it's also a challenge, since the budding tumors might be too small to see with standard tools such as magnetic resonance imaging.

Now scientists in California have published results with an experimental imaging technique that detects recurring prostate cancer with high accuracy. Importantly, some of the unveiled tumors were "still curable with targeted radiation therapy," said Dr. Thomas Hope, a radiologist at the University of California, San Francisco School of Medicine, who led the study. "That's what makes the research so exciting."

How the test works

The technique used in the study is a modified form of positron emission tomography, or PET scanning. When performing a PET scan, doctors will first give an intravenous injection of a minimally radioactive tracer that travels through the bloodstream and attaches to proteins on cancer cells. The PET scanning technology detects this radiation, and thus allows specially trained experts to see where the cancer cells are located.

Two tracers have been approved so far by the FDA for use in prostate cancer diagnostics: one called choline C11 and another called fluciclovine-18-F. Dr. Hope's team, however, used an alternative tracer called gallium-68, which has yet to win regulatory approval in the United States. Gallium-68 has the advantage of binding specifically to a protein called prostate-specific membrane antigen (PSMA), which is highly expressed on metastatic cells.

During the study, USCF researchers and their colleagues at the University of California, Los Angeles enrolled 635 men with rising PSA levels after prostate cancer treatment. The men were each injected with gallium-68, and then given a whole-body PET scan. Importantly, the images were interpreted by independent readers who had no other knowledge of a patient's clinical status.

What it found

Gallium-68 PET scans produced positive results in 75% of the men, and the likelihood of a positive hit grew as their PSA levels increased. For instance, 38% of men with PSA levels of 0.5 nanograms per milliliter (ng/mL) or less were flagged by PET scanning, compared to 97% of the men with PSA levels of 5 ng/mL or higher.

The test's positive predictive value (PPV) — meaning the probability that it would correctly identify existing cancer — ranged between 84% and 92%. According to Dr. Hope, PET scans from the pelvic lymph nodes had the highest PPVs, while scans of the lower ribs, which are prone to features that mimic cancer, had the lowest.

"As we gain more experience with gallium-68/PSMA scanning, we'll lower the false positive rate and increase the test's accuracy even further," said Dr. Hope, who is now working with UCLA on efforts to win FDA approval for the tracer.

According to Dr. Marc Garnick, Gorman Brothers Professor of Medicine at Harvard Medical School and Beth Israel Deaconess Medical Center, and editor in chief of HarvardProstateKnowledge.org, the incremental value added by gallium-68/PSMA scanning still needs further research. "Comparative cost considerations will also be a determining factor to its overall utilization if and when it is approved," he said.

URL to article: https://www.health.harvard.edu/blog/highly-accurate-test-reveals-recurring-prostate-cancer-2019042916546

Early Aggressive Treatment Urged for Metastatic Prostate Cancer

www.medscape.com Pam Harrison May 01, 2019

Early initiation of life-prolonging treatment for men with high-risk metastatic castration-sensitive prostate cancer (mCSPC) appears to be critical. This is the main lesson from the final analysis of the LATITUDE study, which clearly shows the value of managing rapidly progressive disease aggressively, suggests editorialist Fred Saad, MD, University of Montreal, Quebec, Canada.

The LATITUDE trial showed the impact of adding abiraterone acetate (Zytiga, DCS Pharma) plus prednisone to standard androgen deprivation therapy (ADT) for men with newly diagnosed mCSPC.

It significantly improved overall survival (OS) to a median of 53.3 months compared to only 36.5 months with ADT alone ($P < .0001$).

These are the final study results, reported by Karim Fizazi, MD, University of Paris Sud, Villejuif, France, and colleagues. They were published online April 12 in the Lancet Oncology.

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These results "support the use of abiraterone acetate plus prednisone as a standard of care in patients with high-risk mCSPC," the authors conclude.

In an accompanying editorial, Saad takes that conclusion a step further, stating that if a patient who is diagnosed with either mCSPC or metastatic castration-resistant prostate cancer (mCRPC) does not receive at least one additional life-prolonging therapy such as abiraterone in addition to ADT, "that should now be considered suboptimal care," he writes.

However, in the real-world setting, treatment of high-risk disease is more often than not delayed, Saad commented to Medscape Medical News.

"It's human nature to wait until patients become symptomatic, until they progress, or because you don't want to increase the cost or side effects from treatment, so for all sorts of reasons in the real-world setting, treatment is delayed, and then you end up having dismal survival in these patients," Saad commented in an interview.

He emphasized that "if you don't start up front early, you end up starting too late."

If you don't start up front early, you end up starting too late. Dr Fred Saad

As the control arm in LATITUDE clearly demonstrated, "patients who didn't get up-front treatment progressed quite quickly," he added.

Therefore, either abiraterone or docetaxel should always be considered in addition to ADT in patients with high-risk prostate cancer, such as the ones included in LATITUDE, Saad noted.

This advice follows the recommendation in the latest clinical practice guidelines for the treatment of metastatic noncastrate prostate cancer from the American Society of Clinical Oncology, which describe treatment with either abiraterone or docetaxel as standard of care.

Poorer Outcomes on ADT Alone

Saad told Medscape Medical News that his reasoning is supported by the details of the LATITUDE study.

"Looking at the results, I was struck by several important findings," he writes.

First, the median OS in men who initially received placebo plus ADT in LATITUDE was only about 3 years, he points out. This OS rate is "strikingly" similar to that seen in men with mCRPC treated with either abiraterone or enzalutamide (Xtandi, Astellas Pharma) in the phase 3 registration trials.

This means that patients who were treated with ADT alone survived only 3 years from the time of diagnosis, although, Saad points out, they could have been treated with life-prolonging therapies when they transitioned to the state of castration resistance.

"Looking closely at the data, we realise that the patients in LATITUDE actually became castration resistant in only 7 months on ADT alone," Saad emphasizes.

Because subsequent therapy was only initiated some 14 months later, these patients ended up dying less than a year after that.

"Clearly, patients with high-risk metastatic prostate cancer are likely to progress quickly and die from, rather than with, prostate cancer," Saad observes.

This fact necessitates the immediate introduction of life-prolonging therapies, including treatment with abiraterone and docetaxel in the setting of high-risk metastatic disease, because early use maximizes the desired therapeutic benefit before castration resistance develops, he argues.

Once castration resistance develops, it is very unlikely that these therapies will be as effective, he adds.

This was proven by data from LATITUDE, in which almost half of patients who were slated to receive abiraterone after ADT died of the disease and never received the drug at all, he maintains.

Furthermore, median progression-free survival — a secondary endpoint in LATITUDE — was only 30.1 months in the group that initially received placebo, compared to 53.3 months for the group that received abiraterone plus prednisone.

"[This finding] suggests that patients who did receive subsequent therapy at a median time to subsequent therapy of 21.2 months...did not respond for very long, given the short time (about 9 months) between these events," Saad elaborates.

Abiraterone or Docetaxel?

In an interview about the new ASCO guidelines, lead author Michael J. Morris, MD, a medical oncologist at Memorial Sloan Kettering Cancer Center, New York City, told Medscape Medical News that in choosing between docetaxel and abiraterone, many factors should be considered.

He said that "on the practical side, six doses of chemotherapy takes about 18 weeks to achieve," whereas abiraterone is taken continuously.

Patients who want to finish their treatment quickly may prefer docetaxel, said Morris.

The second consideration is financial and relates to the healthcare system under which the patient receives care.

He explained: "For patients who don't have drug coverage, the chemotherapy option could be quite a bit cheaper than the abiraterone option."

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As previously reported by Medscape Medical News, 10 cycles of generic docetaxel plus ancillary costs amount to $14,839, whereas 6 months of abiraterone plus prednisolone costs $30,000.

Morris continued: "From a scientific standpoint, we don't actually know which is better, but there are some patients who have disease which may not be entirely driven by the androgen receptor; that is, patients may have quite a bit of metastatic disease, in which case chemotherapy might be the more biologically appropriate option."

He added: "We don't know that for certain, but for patients who either have very high-grade disease, are poor prostate-specific antigen producers, have a neuroendocrine component or a small cell component, they may do better with chemotherapy than with abiraterone."

Another consideration is toxicity. Morris said that the "major force that is in favor of abiraterone is that it's really well tolerated. It's easy to take."

He summarized: "There are practical concerns, quality-of-life concerns, financial concerns, and biological concerns why a doctor and a patient might put their heads together and decide on one option vs another."

Saad points out that there may be situations in which docetaxel is the only option, such as in countries where abiraterone is not available, is too expensive, or is not an option even if approved for hormone-sensitive prostate cancer.

In these situations, Saad suggests that patients be closely monitored for a suboptimal treatment response after 6 to 8 months of therapy. A suboptimal response is reflected by a prostate-specific antigen nadir >0.2 ng/mL, he states.

"Since these patients will probably have earlier progression and mortality, immediate therapy could be considered or patients should at least by monitored closely," Saad writes.

However, in countries where abiraterone is an option, "it's become almost unethical to do only ADT unless there is a really compelling reason why you can't do something more," he emphasized.

Saad also emphasized that once patients develop mCRPC, early introduction of an approved mCRPC drug, including both abiraterone and enzalutamide, is also warranted.

Saad received grants and personal fees from Janssen, Astellas, and Sanofi during the conduct of the study, as well as grants and personal fees from Bayer for outside research.

Lancet Oncol. Published online April 12, 2019. Abstract, Editorial

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Men Open to Starting Physical Activity Prior to Prostate Cancer Treatment

Leah Lawrence April 14, 2019 ONS, Prostate Cancer

Providing men with prostate cancer with a choice of physical activity interventions increased their willingness to participate in studies, which could help to narrow down what physical activity interventions will be best sustained over time.

“For men on treatment for prostate cancer, especially those on androgen deprivation therapy, one of the main side effects of cancer treatment is fatigue,” explained Nicole Scholl, BSN, RN, OCN, of Duke University Hospital. “Incorporating physical activity, even moderate activity, into their daily lifestyle can help to combat some of that fatigue.”

At the Oncology Nursing Society (ONS) 44th Annual Congress, held April 11–14 in Anaheim, California, Scholl presented a poster detailing the results of a study looking at the feasibility of a 2-week physical activity intervention among men with prostate cancer during the pretreatment period.

During this period, the researchers explored implementation of physical activity preferences for 15 men recently diagnosed with prostate cancer. Men were measured for functional capacity, including a 6-minute walk test, balance, timed up-and-go test, current physical activity, and symptom impact; all were measured again at 2 weeks post-intervention.

Nurses were asked to discuss with each participant some potential physical activities to perform in order to meet their individualized intervention prescription. The choice of activity was left to the patient.

“This can be challenging after a cancer diagnosis,” Scholl said. “The last thing many patients want to think about is exercise.”

However, nurses were challenged to explain to patients that engaging in physical activity did not have to mean running on a treadmill or other strenuous activity,

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Scholl explained. Instead, participants were challenged to engage in intervals of activity like stretching or walking, or increasing simple activities like yard work.

Eleven men completed the study; the average age of participants was 66.8 years. A variety of physical activities were completed. The most commonly reported were lifting weights, moderate walking, and yard work.

After the 2-week intervention, both the distance of the 6-minute walking test and the ability to maintain balance had numerical improvements from pre- to post-test, but they were not statistically significant. There was an improved speed in the performance of the timed up-and-go test ($P < .05$).

In addition, participating men increased their functional capacity and had less exertion, fatigue, and shortness of breath after performing physical activity for a 2-week duration.

One challenge the researchers discovered was that study recruitment slowed during colder winter months.

In the future, Scholl hopes to broaden the study to include more patients and look at the effects of physical activity as men begin to get treatment for their disease.

Clinical guidance for radiation therapy after prostatectomy

Date: May 1, 2019 Source: American Society for Radiation Oncology

Summary:

Scientists have announced updates to their joint clinical guideline on adjuvant and salvage radiotherapy after prostatectomy in patients with and without evidence of prostate cancer recurrence to include new published research related to adjuvant radiotherapy.

Share:

FULL STORY

The American Society for Radiation Oncology (ASTRO) and the American Urological Association (AUA) today announced updates to their joint clinical guideline on adjuvant and salvage radiotherapy after prostatectomy in patients with and without evidence of prostate cancer recurrence to include new published research related to adjuvant radiotherapy.

The Adjuvant and Salvage Radiotherapy after Prostatectomy: ASTRO/AUA Guideline (available online in the Journal of Urology and in Practical Radiation Oncology was amended as follows:

Guideline Statement 2 was modified to account for the latest data from three randomized controlled trials evaluating the use of adjuvant radiotherapy, including new long-term data from the ARO 96-02 trial, which was incorporated to update the existing evidence base.

Statement 2: Patients with adverse pathologic findings including seminal vesicle invasion, positive surgical margins, and extraprostatic extension should be informed that adjuvant radiotherapy, compared to radical prostatectomy only, reduces the risk of biochemical (PSA) recurrence, local recurrence, and clinical progression of cancer. They should also be informed that the impact of adjuvant radiotherapy on subsequent metastases and overall survival is less clear; one of three randomized controlled trials addressing these outcomes indicated a benefit, but the other two trials did not demonstrate a benefit. However, these two trials were not designed to identify a significant reduction in metastasis or death with adjuvant radiotherapy.

Guideline Statement 9 is a new guideline statement written to include outcome data from two randomized controlled trials (RTOG 9601 and GETUG-AFU 16), which evaluate the effects of hormonal therapy on overall survival, and on biochemical and clinical progression among patients who received salvage radiotherapy after prostatectomy. Based on findings from these randomized controlled trials, it was concluded there was sufficiently strong evidence overall to encourage hormonal therapy to be offered to patients who are candidates for salvage radiotherapy. When offered, the clinician must provide information about benefits and harms associated with this therapy, particularly discussing the improved freedom from disease progression documented in both trials, and improved overall survival as reported in RTOG 9601.

Statement 9: Clinicians should offer hormonal therapy with radiotherapy to patients who are candidates for salvage radiation therapy. Ongoing research may someday allow personalized selection of hormonal or other therapies within patient subsets.

In addition to the guideline statements, new information related to genomic classifiers, as predictors of treatment effectiveness, was added to the guideline future research needs. Further study in this area is needed to determine whether a genomic classifier is predictive of outcomes in a yet to be treated patient, and whether it is predictive for efficacy of a particular treatment.

"Evidence from three, well-established randomized trials now confirm significant improvements in biochemi-

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cal recurrence-free survival among patients with adverse pathological features with the use of adjuvant radiotherapy," said Ian Thompson, MD, co-chair of the guideline panel and professor and chairman of the urology division at the University of Texas Health Sciences Center at San Antonio, Texas. "Our expectation is this guideline is fully aligned to the latest science and provides physicians with a relevant blueprint for the use of radiotherapy after prostatectomy."

"As research in prostate cancer evolves and improves, data continue to accumulate in support of radiotherapy following radical prostatectomy. We now know that radiotherapy and the combination of hormone therapy with radiation, following radical prostatectomy, have contributed to even more favorable outcomes for patients than seen previously," said Richard K. Valicenti, MD, FASTRO, co-chair of the guideline panel and professor and chairman of radiation oncology at the University of California-Davis Comprehensive Cancer Center in Sacramento, California. "With the current update, this collaborative guideline now reflects nearly three decades of multidisciplinary research."

Story Source:

Materials provided by American Society for Radiation Oncology. Note: Content may be edited for style and length.

Journal Reference:

Thomas M. Pisansky, Ian M. Thompson, Richard K. Valicenti, Anthony V. D'Amico, Shalini Selvarajah. Adjuvant and Salvage Radiotherapy After Prostatectomy:ASTRO/AUA Guideline Amendment Executive Summary 2018. Practical Radiation Oncology, 2019; DOI: 10.1016/j.prro.2019.04.008

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MLA
APA
Chicago

American Society for Radiation Oncology. "Clinical guidance for radiation therapy after prostatectomy." ScienceDaily. ScienceDaily, 1 May 2019. <www.sciencedaily.com/releases/2019/05/190501114337.htm>.

Radionuclide Treatment Yields Responses in mCRPC

DOI: 10.1158/2159-8290.CD-NB2019-028 Published April 2019

In a phase II, single-arm prospective trial, a novel, targeted radionuclide called Lutetium-177 PSMA-617 (LuPSMA) extended survival and improved quality of life in men with metastatic, castration-resistant prostate cancer (mCRPC) whose disease advanced despite standard therapy. Initial results of the trial were published last year; updated findings from a larger cohort of patients were presented in February at the 2019 Genitourinary Cancers Symposium in San Francisco, CA (Lancet Oncol 2018;19:825–33; Clin Oncol 37, 2019 [suppl 7S; abstr 228]).

Administered intravenously, LuPSMA consists of the radiopharmaceutical Lutetium-177 conjugated to PSMA-617, a prostate-specific membrane antigen (PSMA) ligand that guides Lutetium-177 to PSMA-expressing tumor cells. (For the trial, PSMA-617 was supplied by Endocyte and Lutetium-177 by the Australian Nuclear Science and Technology Organisation.)

The most recent study findings, presented by lead author Michael Hofman, MBBS, of the Peter MacCallum Cancer Centre in Melbourne, Australia, included data on 50 patients who no longer responded to docetaxel or antiandrogen therapies, such as abiraterone (Zytiga; Janssen) and enzalutamide (Xtandi; Astellas/Pfizer). Nearly half had also received second-line cabazitaxel (Jevtana; Sanofi) chemotherapy. With few, if any, therapeutic options remaining, the patients were quite sick, experienced significant pain, and had trouble managing daily activities, explained Hofman.

"Whilst there's been some major advances in the past few years, with several drugs that prolong survival in these men, the disease remains fatal in a relatively short period of time, and there is an urgent need for new effective therapies," he said.

In the trial, LuPSMA treatment yielded a median overall survival (OS) of 13.3 months. Among the 32 patients whose prostate-specific antigen (PSA) level declined by at least half, median OS was longer—18 months versus 8.7 months. Further, 14 patients whose disease progressed after the study concluded were treated again with LuPSMA. The median OS in that group was 33 months, with a 64% response rate among those with a PSA drop of at least 50%, "which is widely regarded as a highly favorable response," he noted. In general, patients who responded to treatment reported improved quality of life.

One limitation of the study was that it did not include a comparison arm, said Anthony D'Amico, MD, PhD, chief of genitourinary radiation oncology at Brigham and Women's Hospital in Boston, MA.

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

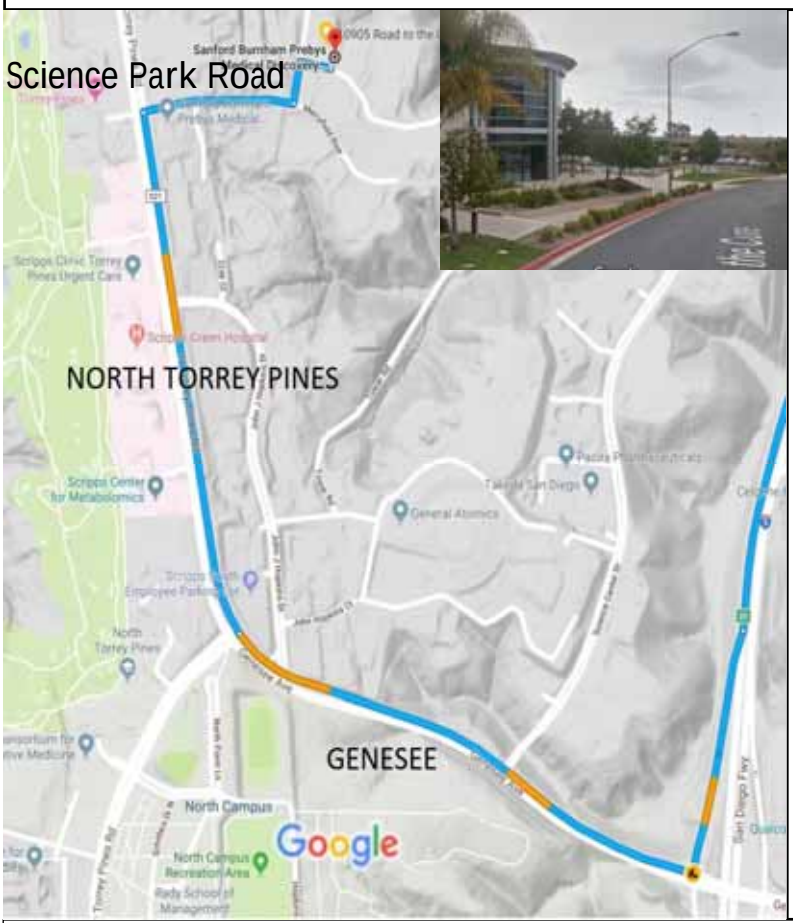
Our brochure provides the group philosophy and explains our goals. Copies may be obtained at our meetings. Please pass them along to friends and contacts.

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!

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



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.