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

DECEMBER 2015 NEWSLETTER

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

We Meet Every Third Saturday (except December)

Tuesday, December 15, 2015 | Volume 8 Issue 11

Next Meeting
January 16, 2016
10:00AM to Noon

Meeting at

Sanford-Burnham-Prebys Auditorium

10905 Road to the Cure, San Diego CA 92121

SEE MAP ON THE LAST PAGE

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!!

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Editor: Gene Van Vleet

PROSTATE CANCER IT'S ONLY 2 WORDS NOT A SENTENCE

From the Editor

As the year draws to a close, it is fitting to reflect on our operations this last year. Our attendance averaged 91 per meeting which included 9 newcomers, 5 of which were newly diagnosed and the rest experiencing recurrence. What brings men to our meetings? Of the 9 newcomers, 4 come from referrals, 3 come from our ads and 2 from website and other. Your contributions continue to provide support to our outreach efforts.

We had leading edge speakers that provided the latest information about imaging techniques, new medications and treatment techniques. Visit

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" button.

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

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our website www.ipcsg.org and click on VIDEOS to view selected live videos or click on PURCHASE DVD'S to get copies of any meeting.

Our most urgent charge continues to be to increase our outreach efforts to get men to understand the need for regular PSA testing. Because of the recommendations of the US Preventative Services Task Force (USPSTF) to discontinue PSA testing, Urologists and Oncologists are already seeing men with more advanced disease at first diagnosis. By nature, many men don't want to test anyhow, so now they have more reason to procrastinate. Women are still authorized and reminded by their doctors to have a mammogram. Please do your part to help get out the message that men still need a "man-o-gram" (PSA test).

For our November meeting, Dr. Richard Lam, Research Director of Prostate Oncology Specialists, made his annual visit. **His presentation is one of the best and most complete you can find about our disease**. It covered the gamut from first sign of the disease through diagnosis, treatment options for newly diagnosed and recurrence, and updates on the latest developments and research. The DVD will show much more useful detail than is possible in this recap. The DVD also includes a file of the slides presented. Watch for it on our website http://ipcsg.org/shop/

As a matter of background, about 180,000 men are diagnosed each year and according to the latest available statistics (2013) about 27,000 will die from PCa . It is the most common cancer in men and it is 1/3 of all cancers diagnosed in men. The lifetime risk is about 1 out of 6. The common phrase still holds true, "most men will die with the disease, not of it"

The first sign is the PSA blood test, the second is what the doctor feels in a digital rectal exam and the third definitive test is a prostate biopsy. Imaging tests of the prostate as well as systemic tests such as the carbon 11 acetate PET/CT scan are ways to stage a prostate cancer patient.

The usual path is that a PSA test is performed and if found to be abnormal, the patient is referred to a Urologist to perform a biopsy which too often is a random 10-18 core biopsy which can lead to false positives (you have cancer) or false negatives (you don't have cancer). When you get the diagnosis--then what? This is where the controversies arise about what to do with the cancer. Going for treatment can change a man's quality of life by impacting impotency and/or incontinence. The question arises whether or not a man should be treated or not, considering age and other health issues. The US Preventative Services Task Force in 2011 said don't test at all because it leads to unnecessary treatment and expense and does not save enough lives. Recent surveys show that primary care physicians are doing 30% less testing. It is worrisome that the next generation of medical students will be unaware that PSA testing can be an effective tool, but simply that the PSA test should not be done. The argument for not testing is that we are detecting about 38% less low grade cancers that may not need to be treated, but conversely we are not detecting cancers that do need treatment. The Center for Medicare Services (CMS) is actually considering not paying for PSA testing. WRITE YOUR CONGRESSMAN TO PROTEST.

The overriding argument is that by doing the test we are detecting it at an earlier stage-before urination problems or metastases develop. In the last 30 years it has led to a 50% reduction in the prevalence of advanced disease. It does prolong life!

The next issue that arises is that if the PSA is elevated should a biopsy be done considering risks of infection, bleeding or temporary loss of sex drive. Some of the criteria for determining the need for a biopsy are if the PSA density (score in relation to prostate size) is high, the PSA score is progressing upward over time, a lump is felt when doing the digital rectal exam, and/or imaging shows a problem area. There is a new 4K test which can predict the likelihood of having higher grade PCa. He called it a super

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PSA test. Other factors include family history and previous suspicious biopsies. There is a new genetic test under study, STHLM3, which is a blood test that will tell if the patient has a high risk PCa. This might become available in 2016. There Is also a liquid biopsy under study which is a blood test looking at a panel of genes that will predict a low or high grade of PCa presence or not. He doesn't think this will reach approval for at least 18-24 months.

He turned his discussion to treatment options. Rather that invasive treatment, it is becoming more and more popular for patients to choose active surveillance. In a recent study published in the Journal of Urology in September, 2015, 68% of men are candidates for active surveillance. From 2000 to 2012, the number of men choosing active surveillance has risen from 11% to 35%. How are patients selected for active surveillance? They are patients who have been biopsied and have low risk disease. One set of criteria for low risk PCa is Stage T1c/T2a, PSA <10 and Gleason score of 6 or less. Criteria for very low risk PCa is Stage T1c, PSA density of <15, Gleason score of 6 or less, <3 cores with cancer and <50% core involvement. In their practice they use the added assurance of MRI, Ultrasound and genetic testing such as Oncotype or Prolaris.

Can we forgo random biopsies where 10-18 needles are place in a matrix looking for cancer without any specific target? With the advent of newer imaging technologies, yes we can. One of the earlier technologies is the Color Doppler Ultrasound (which they do in their offices). This is an easy procedure that takes less than 15 minutes and is done on site. (Slide samples were shown which do not view well in print). Another method is the MRI (Magnetic Resonance Imaging) which creates a picture of the prostate. It is done at a MRI facility and takes longer, usually 45 minutes to an hour, with results usually in 2 days. You are placed in a tunnel, so claustrophobia might be an issue although your eyes are outside the tunnel unless you are quite short. (Again, slide samples were shown.) An advantage of MRI's is that it shows the front of the prostate. He noted that random biopsy needles only go about half-way thus cancers can be missed. He believes the MRI will be more and more accepted as a procedure before doing a biopsy. It is already the case in England. Targeted biopsies detect more high grade cancers requiring action and they detect fewer low grade cancers that don't need treatment.

Dr. Lam then discussed various treatments:

- Robotic Prostatectomy is a procedure where a surgeon operates using a console with a 3D view and a bedside surgical assistant is next to the patient. Instruments move like a human wrist with dexterity and precision.
- Intensity Modulated Radiation (IMRT) where doctors precisely target the affected area and consciously try to spare the surrounding areas. The radiation beams come from various angles minimizing radiation of outlying areas and focusing intensely on the prostate target. There is low risk of short term side effects, cure rates are comparable to surgery, it can be combined with other therapies and it is noninvasive. It requires daily visits for 8 or 9 weeks, there is a low risk of impotence, rectal burn (proctitis) or secondary malignancies. There is a recent development wherein a hydrogel called SpaceOAR is inserted between the prostate and the rectum which slightly reduces the rate of nearby burns in the area. The hydrogel dissipates naturally in a short time.
- Radioactive Seed Implant. Minute radioactive seeds are implanted in the prostate via a needle. It thus radiates from within, which is a very precise and effective treatment. The procedure usually takes about 1 hour, either outpatient or overnight and success rates are at least as good as surgery or IMRT.
- For Intermediate to High Risk Disease, Adding Seeds to IMRT. A recent study determined that this

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method increases the remission rate scaling upward to 25% at 9 years, but it may have more urinary side effects.

- Focal Therapies are methods of treating only the cancerous areas within the prostate as opposed to treating the entire prostate. So far, freezing or planting temporary seeds in half the prostate have been done with some success but as yet are not widespread options. This will likely change as more people choose active surveillance. HIFU (High Intensity Focused Ultrasound) was recently approved by the FDA. Rather than using ultrasound to look at the prostate, the intensity is turned up to heat an area of the prostate. This needs longer term follow-up to determine its effectiveness. So far, side effects are worrisome.
- Hypofractionated Radiation Therapy. The concept is to have fewer visits with higher dosage. Previously there weren't studies that looked at the long term benefits. This year there were two studies that may move this field forward
    - RTOG phase 3 trial (Oct 2015) where early stage men (Gleason 3+3, PSA<10) had treatment over 28 visits that was equivalent to 41 visits. Control rates showed equaled side effects. It could be argued such treatment was not needed.
    - HYPRO phase 3 trial (March 2015) where intermediate to high risk men had treatment over19 visits that was non-inferior to 39 visits, Overall side effects were about the same with slightly more bowel and urinary frequency.
- Systemic Therapies. They are used in conjunction with radiation to improve remission or when the cancer has relapsed after local therapy and PSA is rising and/or metastatic disease has developed. He confidently stated that relapse does not always mean death, but usually can be managed for many years.
    - Androgen deprivation (ADT-aka hormone therapy). It is necessary to understand what causes the cancer to replicate. About 90% of testosterone or dihydrotestosterone is created in the testicles with the rest being created in the adrenal glands. Prostate cancer cells take up the testosterone and replicate. ADT drugs such as Lupron chemically stop the production of testosterone. A VA study showed that ADT lasts on average up to 11 years.
        - Newer drugs approved once ADT has stopped working:
            - Aberatrone (Zytiga) is like super Lupron that decreases testosterone production better
            - Enzalutamide (Xtandi) is like a super Casodex that blocks the receptors in the cancer cells better.
        - Success is being achieved by using these newer drugs before or after chemotherapy. They are now starting to use them at the first sign of relapse.
        - Unfortunately the cancer cells may still find a way to grow or mutate and the PSA drop will not occur or be less dramatic. One discovered mutation is the AR-V7 mutation, but there is still no way to detect it. Hopefully studies will make this available before too long.
    - Chemotherapy is typically used for castrate resistant end-state disease and can add 6-18 months of survival.
        - Docetaxel (Taxotere)
        - Cabazitaxel (Jevtana)
        - New studies are showing that using these drugs earlier may prolong survival

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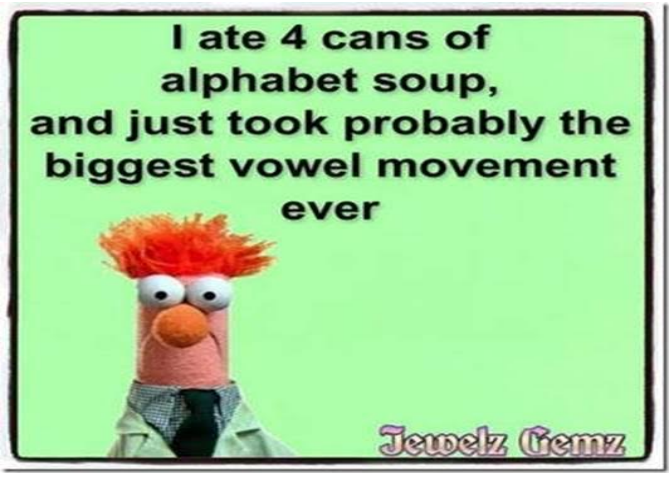
  - Radionucleotides. Alpharadin-radium 223 (Xofigo) was approved in 2013 based on the original studies which showed it reduced bone pain but is has also now been shown that men that have been treated with it live longer. They have been recently combining this with Zytiga or Xtandi with good results. Some new studies are indicating that Xofigo and chemotherapy might be beneficially compatible.
- Prostate Cancer -2016 and Beyond.
  - Less random biopsies
  - More data on targeted biopsy
  - Improved MRI (7T) technology
  - New drugs that target the AR-V7 mutation
  - Oral Lupron (TAK-385) on the way?
  - Update on immunotherapy. These two drugs look favorable to be approved in 2016.
    - Ipilimumab
    - Prost-Vac

ON THE LIGHTER SIDE



When you consider Christmas, there are four stages in your life:-
1) You believe in Santa
2) You don't believe in Santa
3) You are Santa
4) You look like Santa

Oxymoron's:
Synthetic natural gas, Passive aggression, Taped live, Clearly misunderstood, Peace force, Extinct Life, Temporary tax increase, Plastic glasses, Tight slacks, Twelve-ounce pound cake, Diet ice cream, Working vacation, Exact estimate

Brains of older people are slow because they know so much . Scientists believe people do not decline mentally with age, it just takes them longer to recall facts because they have more information in their brains. The seek time is longer. Much like a computer struggles as the hard drive gets full, so, too, hu-

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mans take longer to access information when their brains are full.

Researchers say this slowing down process is not the same as cognitive decline. The human brain works slower in old age, said Dr. Michael Ramscar, but only because over time we have more stored information to search through. The brains of older people do not get weak. On the contrary, they simply know more.

Also, older people often go to another room to get something and when they get there, they stand there wondering what they came for. This is NOT a memory problem, it is nature's way of making older people get more exercise!

SO THERE!!

Now when I mentally reach for a word or a name, I won't excuse myself by saying "I'm having a senior moment". Now, I'll say, "My disk is full!"

FUTURE MEETINGS

December - No Meeting

Jan. 16, 2016 - AJ Mundt M.D., Professor and Chair, Department of Radiation Oncology, UCSD & Carl Rossi Jr., M.D. Medical Director of the Scripps Proton Therapy Center. Facets of radiation and proton beam therapy are presented.

February 20, 2016. Round Table. A panel of members talk of their experiences followed by Q&A, then break-out sessions by treatment type for networking.

INTERESTING ARTICLES

Sir Spheres for Liver Metastases from Prostate Cancer

Posted: 02 Dec 2015

BY MARK SCHOLZ, MD

Cancer that spreads outside the prostate gland is what makes prostate cancer dangerous. Metastatic prostate cancer cells cause malfunction by impeding normal function. Some organs, like lymph nodes for example, continue to function quite nicely, even if the degree of cancer spread is extensive. Lymph node spread, therefore, is the least dangerous form of prostate cancer metastases. At the other end of the spectrum is the liver, which is far less tolerant. The seriousness of bone metastases, the most common site of prostate cancer spread, lies about half way between that of node metastases and liver metastases.

The earliest stages of metastases are microscopic and therefore invisible even with the best available technology. To be detected with the best available PET scan technology, small tumors must measure more than 1/8 of an inch across. For detection with standard CT scans and MRI scans, more than a half-inch sized tumor is necessary. Since the presence of metastases is such a defining issue when describing a cancer's character, men who are newly-diagnosed are labeled as low, intermediate or high-risk depending on their estimated likelihood of micro-metastatic disease. Liver metastases are extremely rare at the time of initial diagnosis of prostate cancer. When they occur it is usually after many years of ongoing treatment

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for known metastatic disease in the bone.

Prophylactic treatment with hormone therapy, chemotherapy or radiation to treat the possibility of micro-metastases is common for high-risk prostate cancer and occurs maybe half the time in intermediate -risk prostate cancer. The goal is to cure the micro-metastases at an early stage when they are most susceptible to eradication, thus preventing the future development of detectable metastases which is what makes cancer life threatening.

When talking about prostate cancer, even though this is a blog about metastases, it should always be remembered that many common types of prostate cancer never spread. These low grade "cancers" are genetically distinct and represent a totally different category of disease. However, when discussing the type of prostate cancer that is capable of metastasis, the following factors impact how dangerous it is:

1. The site of spread.
2. The extent of spread
3. The tumor cell growth rate
4. The efficacy of available treatment

As noted above, the liver is far less tolerant to metastatic invasion than bone or lymph nodes. In addition, because liver metastases tend to occur in men with advanced disease, tumor growth rates tend to be brisk. Also, the most commonly administered treatments, hormone therapies and chemotherapy, have often already been tried before liver metastases first develop. The advent of liver metastases, therefore, usually represents a very serious and life threatening issue.

Liver metastases may first be suspected when standard blood tests such as ALT, AST or ALP which are components of a hepatic panel blood test, register outside the normal range. Investigation into their cause often leads to doing a CT scan or MRI scan of the abdomen and pelvis to confirm the presence of disease in the liver. Alternatively, a scan may detect abnormal spots in the liver during routine periodic scanning that is being performed as regular surveillance.

Hormone therapy with Lupron, Zytiga and Xtandi, or chemotherapy with Taxotere, Jevtana and Carboplatin, is the standard approach to treatment for liver metastasis. However, these treatments may have already been tried or may no longer be effective. Since liver failure is tantamount to death, prostate cancer growth in the liver needs to be stopped immediately, regardless of how the disease is faring in the bones or nodes.

Much that has been learned about the treatment of liver metastases comes from reviewing common methods for managing metastatic colon cancer. The liver is the cancer's preferred site of metastatic spread for colon cancer. Treatments that have been employed include surgery, radiation and blockage of the blood supply to the liver by embolization of the arteries, all with variable success. More recently, radioactive microspheres injected directly into the tumor, called SIR-Spheres, have shown notable efficacy with very tolerable side effects.

Prostate cancer and colon cancer are similar in that they are both adenocarcinomas which means they are derived from glands. Therefore, they are likely to have similar susceptibility to radiation. As such, we have been administering SIR-Spheres to a limited number of prostate cancer patients with liver metastases. Results have been encouraging with a notable improvement of survival compared to our historical experience treatment patients with liver metastases without SIR-Spheres. Our preliminary results using SIR-Spheres in six patients is being presented at the 2016 Genitourinary Cancers Symposium - San Francisco in January 2016.

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The Faces of Stress

Prostate Snatchers Blog By Ralph Blum
Posted: 30 Nov 2015

Whether you are newly diagnosed with prostate cancer, or coping with bone metastases, learning about chronic stress and its negative impact on your body is almost as critical to your healing as whatever treatment you choose.

Short-term stress, a single episode of acute stress, generally doesn't cause problems. However, chronic emotional stress, caused by situations or events that last over a period of time, takes a significant toll on the body. Furthermore, this kind of prolonged stress suppresses the immune system, profoundly affecting its ability to detect defective or cancerous cells and destroy them.

Persistent feelings of fear, anxiety and unrelieved stress trigger the fight-or-flight response system that our ancestors relied upon. When a threat is recognized, heart rate and blood pressure skyrocket, sugar pours into the blood, muscles tense for quick action, and the whole metabolism goes into survival mode. This is great if you're on the African savannah and you hear a lion growling outside your tent. However, Nature never intended this "On your mark! Get set! Go!" response to last more than a moment or two.

So when the brain sends a threat message for which there is no swift resolution, the fight-or-flight system stays stuck on "Get set!." As a result, the immune system is locked into protection mode and is no longer capable of performing the remedial function that is our most powerful defense against cancer.

So when we feel unable to manage or control the changes in our lives caused by prostate cancer, it not only reduces our quality of life, but it is associated with poorer clinical outcomes. In fact, studies in mice, and in tests in human cancer cells grown in the laboratory have found that prolonged psychological stress can enhance a tumor's ability to grow and spread.

There is always the temptation to alleviate the stress overload of a potentially life-threatening diagnosis with risky behaviors such as drinking alcohol in excess, taking drugs, and over-eating. But this kind of "stress management" only further inhibits immune function. However, maintaining a healthy lifestyle—which means eating well and staying physically active--supports the immune system. As do coping strategies such as relaxation techniques, meditation, yoga, and visualization. And don't forget laughter—the ultimate antioxidant.

Here's how the Discovery Health Web describes the impact of laughter on the immune system: "When we laugh, natural killer cells which destroy tumors and viruses increase, along with Gamma-interferon (a disease-fighting protein), T cells (important for our immune system) and B cells (which make disease-fighting antibodies). As well as lowering blood pressure, laughter increases oxygen in the blood, which also encourages healing."

So find out what works for you so that stress does not get the best of you. If you can't seem to get a handle on it, laugh your way back to health!

NETWORKING

The original and most valuable activity of the INFORMED PROSTATE CANCER SUPPORT GROUP is "networking". We share our experiences and information about prevention and treatment. We offer our support to men recently diagnosed as well as survivors at any stage. Networking with others for the good of all. Many aspects of prostate cancer are complex and confusing. But by sharing our knowledge and experiences we learn the best means of prevention as well as the latest treatments for survival of this disease. So bring your concerns and join us.

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: http://ipcsg.org

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.

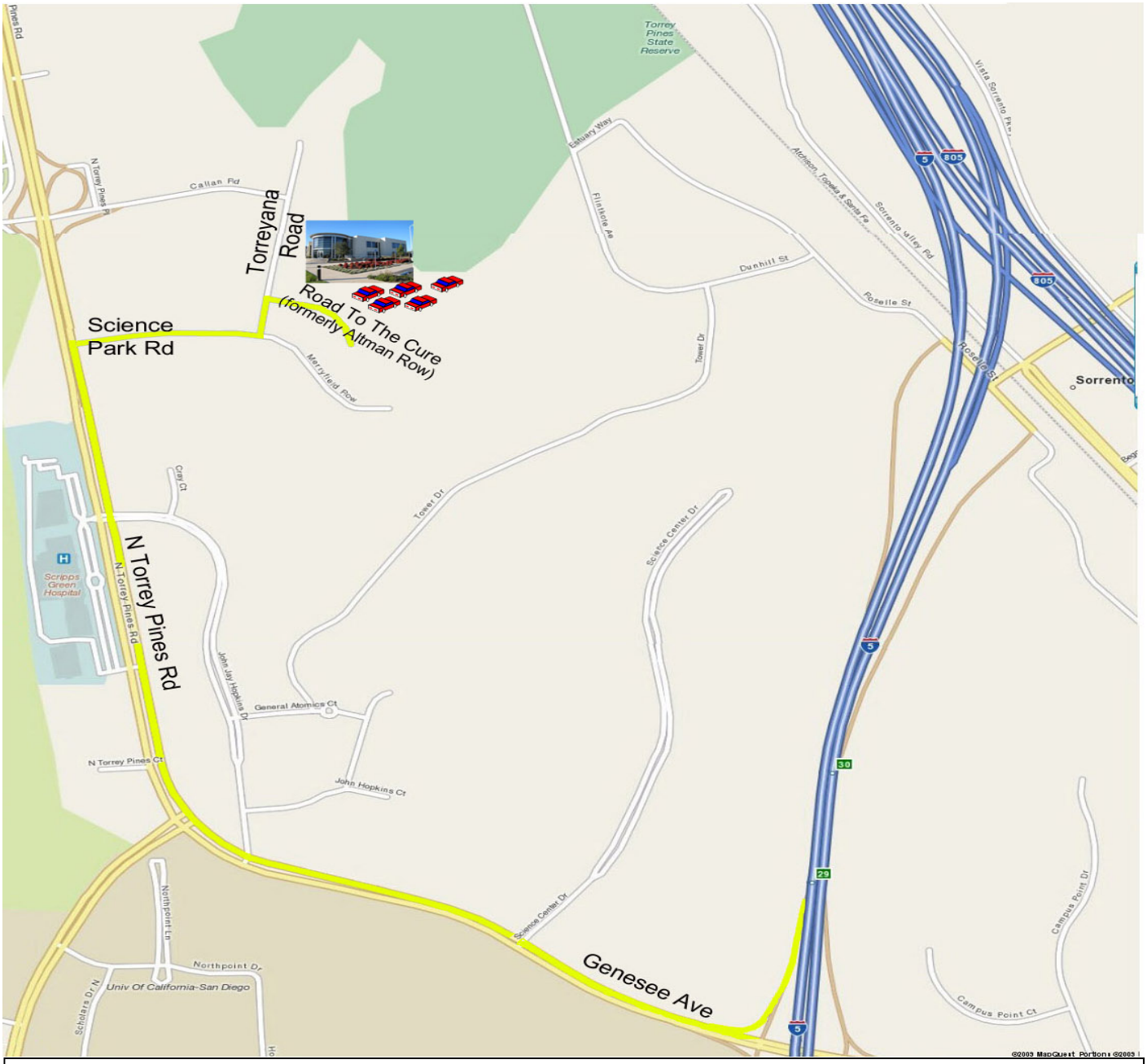
Ads about our Group are in the Union Tribune 2 times prior to a meeting. Watch for them.

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!

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.