Prostate Heidelberg

July 2020 Issue 196

For Education, Information and Support

Meeting Hall: Ivanhoe Uniting Church 19 Seddon Street, Ivanhoe
POB 241 Ivanhoe Victoria 3079
Email: prostateheidelberg@gmail.com
Website: www.prostateheidelberg.info

Next PHCSG Meeting – Tues 21 July (via Zoom)

10am – 12:30pm

Join Zoom Meeting
https://us02web.zoom.us/j/89579689693?pwd=YWh5L0pZUmpYeGZ3Yzk0bVJwdlJQdz09

Please note that all face-to-face meetings have been cancelled until further notice. Please check your email regularly for updates from the PHSCG Committee.

Prostate Heidelberg Cancer Support Group

PHCSG provides information, education and support for those affected by Prostate Cancer. At our meetings we are committed to:

- showing respect to members, speakers and guests
- allowing members to speak without interruption
- respecting confidentiality

At our June Zoom meeting we welcomed Neil, a new member who recently moved to Melbourne from Queensland.

Our invited speaker: Professor Grant McArthur, CEO of the Victorian Comprehensive Cancer Centre gave a very informative talk. More details on page 8.

In this month's newsletter we have focused on articles on testosterone, as well as including the Memorial Sloan Kettering Cancer Center PCa nomograms.

Finally, as we all know, Melbourne has moved back into Stage 3 COVID 19 restrictions. We want to ensure that everyone stays physically and mentally as well as possible at this difficult time. So please don't hesitate to contact us if there is anything you want to talk through in relation to your treatment etc.

Max Shub	0413 777 342
Mike Waller	0438 616 240
Michael Meszaros	0407 837 538

Source: https://www.prostatecancer.news/2020/06/testosterone-therapy-does-not-increase.html

Testosterone Therapy does not Increase the Risks of PCR or Death after Definitive Treatment for Localised Disease

In the largest observational study so far, Sarkar et al. reported that men in the US Veterans Administration (VA) database who received surgery or radiation for localized prostate cancer and then received testosterone replacement therapy (TRT) for low testosterone were at no greater risk for recurrence than a matched sample of such men who received no TRT.

The VA database included 28,651 men treated with prostatectomy (RP) and 41,333 men treated with primary radiation (RT) between 2001-2015. Of those men:

- 469 of the RP group received TRT
- 543 of the RT group received TRT
- Median follow-up was 7 years

Comparing the men who received TRT to a matched group of men who didn't, they found:

- There was no difference in biochemical recurrence
- There was no difference in prostate cancer mortality
- There was no difference in overall mortality

The database did not include data on serum testosterone levels or duration of TRT.

This confirms a couple of smaller (sample size about 100) retrospective studies at Baylor College of Medicine on men who had received RP and RT.

Before treated men rush out to supplement testosterone, we should acknowledge that all of these studies are retrospective. Although the authors of the VA study made an effort to match the patient and disease characteristics of men who received TRT and those who did not, it is entirely possible that there were characteristics that were not included in the database. In other words, doctors may have been biased by other factors to select patients for treatment.

We should also acknowledge that in the Baylor studies and others, PSA did increase after TRT in both groups, although usually not to the extent that a biochemical recurrence was declared. This is expected in men who received RT because they still have intact prostates that may still secrete PSA from benign sources. However, it is more concerning in men who have had RP because benign prostate tissue should have been eliminated, and even Gleason score 6 prostate cancer may progress, albeit slowly.

Until we have a prospective randomized trial [results of a trial in the US are expected in 2024], patients and their doctors must make this decision based on available data and judgment. While it is undoubtedly true that castration levels of testosterone (below 50 ng/dl) discourage prostate cancer progression, Morgentaler's testosterone saturation theory says that above some minimal testosterone level (around 120 ng/dl), adding more testosterone does not further encourage prostate cancer progression. Many urologists now believe this. However, testosterone sold in the US is required to have a black box warning against its use in men who have had prostate cancer. Getting one's doctor to prescribe it may be challenging.

Recent ADT Data after SRT

JAMA Oncol. 2020;6(5):735-743.
doi:10.1001/jamaoncol.2020.0109
Trial Registration
ClinicalTrials.gov Identifier:
NCT00002874

Key Points

Question

For men with recurrent prostate cancer after radical prostatectomy, can prostate-specific antigen (PSA) level be used to help predict outcomes of long-term antiandrogen treatment added to salvage radiotherapy (SRT)?

Findings

In this secondary analysis of the RTOG 9601 trial, pre-SRT PSA level of higher than 1.5 ng/mL was associated with an overall survival benefit with long-term antiandrogen therapy. Patients treated at a PSA of 0.6 ng/mL or less had no overall survival improvement, but had a greater than 3-fold increase in high-grade cardiac and neurologic events and a 2-fold increase in other cause mortality with 2 years of bicalutamide.

Meaning

Antiandrogen treatment has morbidity, and pre-SRT PSA can be used to personalize who derives net benefit of hormone therapy with SRT.

Abstract

Importance

In men with recurrent prostate cancer, addition of long-term antiandrogen therapy to salvage radiotherapy (SRT) was associated with overall survival (OS) in the NRG/RTOG 9601 study. However, hormone therapy has associated morbidity, and there are no validated predictive biomarkers to identify which patients derive most benefit from treatment.

Objective

To examine the role of pre-SRT prostate-specific antigen (PSA) levels to personalize hormone therapy use with SRT.

Interventions

Men were randomized to SRT plus high-dose nonsteroidal antiandrogen (bicalutamide, 150 mg/d) or placebo for 2 years.

Design, Setting, and Participants

In this secondary analysis of the multicenter RTOG 9601 double-blind, placebo-controlled randomized clinical trial conducted from 1998 to 2003 by a multinational cooperative group, men with a positive surgical margin or pathologic T3 disease after radical

Association of Pre-Salvage Radiotherapy PSA Levels after Prostatectomy with Outcomes of Long-term Antiandrogen Therapy in Men with Prostate Cancer

26 March 2020

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prostatectomy with pre-SRT PSA of 0.2 to 4.0 ng/mL were included. Analysis was performed between March 4, 2019, and December 20, 2019.

Main Outcomes and Measures

The primary outcome was overall survival (OS). Secondary end points included distant metastasis (DM), other-cause mortality (OCM), and grades 3 to 5 cardiac and neurologic toxic effects. Subgroup analyses were performed using the protocol-specified PSA stratification variable (1.5 ng/mL) and additional PSA cut points, including test for interaction. Competing risk analyses were performed for DM and other-cause mortality (OCM).

Results

Overall, 760 men with PSA elevation after radical prostatectomy for prostate cancer were included. The median (range) age of participants was 65 (40-83) years. Antiandrogen assignment was associated with an OS benefit in the PSA stratum greater than 1.5 ng/mL (n = 118) with a 25% 12-year absolute benefit (hazard ratio [HR], 0.45; 95% CI, 0.25-0.81), but not in the PSA of 1.5 ng/mL or less stratum (n = 642) (1% 12-year absolute difference; HR, 0.87; 95% CI, 0.66-1.16). In a subanalysis of men with PSA of 0.61 to 1.5 (n = 253), there was an OS benefit associated with antiandrogen assignment (HR, 0.61; 95% CI, 0.39-0.94). In those receiving early SRT (PSA ≤0.6 ng/mL, n = 389), there was no improvement in OS (HR, 1.16; 95% CI, 0.79-1.70), an increased OCM hazard (subdistribution HR, 1.94; 95% CI, 1.17-3.20; *P* = .01), and an increased odds of late grades 3 to 5 cardiac and neurologic toxic effects (odds ratio, 3.57; 95% CI, 1.09-15.97; *P* = .05).

Conclusions and Relevance

These results suggest that pre-SRT PSA level may be a prognostic biomarker for outcomes of antiandrogen treatment with SRT. In patients receiving late SRT (PSA >0.6 ng/mL, hormone therapy was associated with improved outcomes. In men receiving early SRT (PSA ≤0.6 ng/mL), long-term antiandrogen treatment was not associated with improved OS. Future randomized clinical trials are needed to determine hormonal therapy benefit in this population.

Testosterone Replacement Therapy Improves Potency Recovery Following Robot-Assisted Radical Prostatectomy

Source:
Written by: Linda My Huynh, a Senior Clinical Research Coordinator (Department of Urology, University of California-Irvine) and medical writer for UroToday.com

Barcelona, Spain (UroToday.com) Sexual dysfunction is a significant problem for men undergoing radical prostatectomy, regardless of surgical technique, preoperative age, or baseline sexual function. Hypogonadism (i.e. a low total or free testosterone) further prevents recovery of postoperative erectile function.

Dr. Farouk El-Khatib, a clinical research fellow from the University of California, Irvine, presented his group's efforts for testosterone replacement therapy and potency recovery following radical prostatectomy for local prostate cancer. The primary outcome was a recovery of erections sufficient for intercourse, assessed via two questions demonstrating erections sufficient intercourse and satisfactory for intercourse.

Dr. El-Khatib mentions the group's rigorous criteria: preoperative normal sexual function (as defined as an IIEF-5 score between 22 and 25), preoperative hypogonadal levels of free testosterone, and strict responses to questionnaires at 3 and 24 months postoperative. Starting from a cohort of 442 men, he isolated and matched 13 men receiving testosterone replacement therapy within one year of surgery, compared to 49 men who did not.

His results show promising data on the benefit of testosterone replacement therapy. Although the groups had similar clinicodemographic, the patients on testosterone replacement therapy were significantly more likely to have recovered erectile function by 24 months post-radical prostatectomy. This is despite having started a much lower baseline (with less than half reporting erections sufficient for intercourse at 3 months post-surgery).

While the study is perhaps limited by a small sample size and lack of multivariate analysis, Dr. El-Khatib states that these results have broad impact for all patients undergoing radical prostatectomy. Since free and total testosterone levels are not normally screened for in men (with prostate cancer or otherwise), screening may allow for preventative measures and/or prophylactic, preoperative therapies to reduce the impact of hypogonadism on the recovery of functional outcomes.

In the discussion, Dr. El-Khatib mentions a 40-year-old benchmark for screening men, maintaining that these men should be screened from the primary care level, rather than waiting for diagnosis by a urologic specialist.

Presented by: Farouk el-Khatib, MD, Department of Urology, University of California, Irvine, California

The Impact of Testosterone on Prostate Cancer Cells

https://www.urotoday.com/video-lectures/prostate-cancer-foundati...

Testosterone Replacement in the Treatment of Advanced Prostate Cancer

Sam Denmeade and Michael Schweizer join Charles Ryan at the 2019 Prostate Cancer Foundation Retreat (PCF 2019) to discuss testosterone replacement in advanced prostate cancer and the risks and benefits of adding this therapy to one's treatment plan for prostate cancer patients.

Charles Ryan: Hello from PCF 2019. Today, we're going to talk about testosterone replacement in the context of advanced prostate cancer. And I have two people doing the research on that issue with me now. The first is Sam Denmead, who's from Johns Hopkins where he's a Professor of Oncology and the Director of the Genito-Urinary Oncology Program there. And then Mike Schweizer is an Assistant Professor at the University of Washington in Seattle. And so you're both doing clinical trials with testosterone as sort of the foundation of the treatment. And these are in men essentially with castration-resistant prostate cancer. So Sam, start with telling me why we would think about doing this. What's the rationale and how did you get to this point?

Sam Denmeade: In the laboratory, it's been known for a long time that if you take prostate cancer cells from patients that can grow in a dish and give testosterone, paradoxically instead of growing better, they can be growth inhibited. And there was a lot of research in that area, but nobody ever did really any clinical work. And so we decided based on a small grant that we received from a grateful patient to do a trial and we did a pilot trial and not expecting really much to happen. And to our great surprise, a number of patients had really good responses. Their tumors shrunk, their PSA tests went down. And that allowed us to kind of apply for funding and get some grants. And now we've done some larger studies to try to establish how does it work, how well does it work? What's actually going on there.

Charles Ryan: So what do you think mechanistically is actually happening in the cancer cell?

Sam Denmeade: Well the testosterone does a lot of different things to the cell. We have some evidence that it can cause breaks in the DNA that might be a mechanism. It changes the cell replication. It affects a lot of different survival pathways that are important. It's probably a combination of things that it's doing cause it does so many profound things to the cell that...

Charles Ryan: What do patients actually do? Are these patients who are getting LHRH analog shots and then taking testosterone at the same time? Or do you do discontinue their LHRH, Mike, and then have them take it? How do they do it?

Mike Schweizer: Well, the way that we've modeled it in the clinic was this idea that we tried to cycle the testosterone between extremes. The idea being that if you have a high dose of testosterone, that's going to be a therapeutic liability for cells that are adapted to survive low testosterone conditions. And then after a

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period of time of it being exposed to the high testosterone conditions, we switch it up and allow the testosterone to fall back to castrate again. Again, trying to stay ahead of that adaptation that can lead to cell survival. And so the way we've modeled this is bipolar androgen therapy. So we keep patients on LHRH analog therapy to clamp androgenous testosterone and z. So you get these rapid fluctuations between sort of super physiologic to near castrate levels.

Charles Ryan: So for those listening, a man who's on an LHRH therapy is likely to have a testosterone level, let's say 35 nanograms per deciliter or something like that. A normal situation for a 65-year-old would be 350, about 10 fold. So when you give super physiologic, what do the levels go up to?

Mike Schweizer: They go up to above the upper limit of the assay. So over 1500 typically speaking.

Sam Denmeade: Two to 3000 usually.

Charles Ryan: Well, that's high.

Sam Denmeade: The way that they get a shot, it goes two to 3000 and then over a week or two it starts to come down. And by the end of the cycle, we're back close to castrate again.

Charles Ryan: How are patients feeling when you're doing this?

Sam Denmeade: Initially I thought it would be an emotional wreck by going high and low over and over again. But most men don't notice that change. A lot of the guys feel really good. Some of the guys, they get a lot of their libido back. Some folks can have return of their sexual function, so most of the guys feel kind of a boost, an energy boost. Not everybody, but a lot of the guys are very happy. Sometimes they don't want to come off the therapy because they feel so good.

Charles Ryan: Any toxicity, like standard toxicity we would think of with this?

Sam Denmeade: Yeah. The one thing we've tried to avoid is... there was some prior data and then we've had some experience where, if you give a testosterone injection to men who have pain from prostate cancer, it can make the pain get worse very quickly. So we've tried very hard to avoid anybody with symptoms from pain. The main toxicity though, it's been pretty well tolerated. I would say more than we even thought. People get a little bit of swelling they feel it in their legs. They feel a little achy sometimes. A little bit of sexual side effects, they can get tenderness in their breast, maybe a little hot flashes, but they're really not very much.

Mike Schweizer: There are rare with some of the testosterone. That's something to be cognizant of.

Charles Ryan: Do you exclude patients with a prior history of thromboembolic phenomena?

Mike Schweizer: If they're on sort of stable anticoagulation, then I think it's likely safe. In some of my studies we've excluded patients who think are at high risk for those types of events.

Charles Ryan: You've now completed the TRANSFORMER study, which is a study that included bipolar androgen therapy and enzalutamide and we're waiting for those results to be readout. And that's going to look at progression-free survival. I believe in the castration.....

Sam Denmeade: The trial was looking at men progressing after abiraterone who had castrate disease and we compared head-to-head testosterone and enzalutamide, kind of a strange design. Sort of the exact opposite treatments. We've got all the data now, we've got a manuscript prepared and we expect in the next few months to at least submit that manuscript, hopefully. We've been disseminating the information at meetings and talking about it. And we've seen some interesting things and we're excited to build on this data and kind of go forward with the next step.

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BE YOUR OWN ADVOCATE

Remember that you need to be your own advocate and take the time to learn as much as you can about treatment options available to you. Understand as much as you can so that you are in a position to ask your doctors all the relevant questions. With study and determination you can find the best treatment for your situation.

Charles Ryan: So before we talk about the next two trials. People hearing these data thinking, okay enzalutamide is out there, I can get testosterone, my patients might feel better. Is this something people should be doing off of a clinical trial or where are we there?

Sam Denmeade: That's a challenging question. I get a lot of emails about this from all over the world. And my response has been, I can't say no because you can do it. I try to educate the docs about this is what we're doing, caution them that people with symptoms shouldn't get this. Kind of giving them my experience, I've even written a little blurb to send to folks about this. It's kind of what we've seen cause they get so many emails. So I haven't given it to patients off trial at Hopkins, partly because we have trials. I think we've proven it's safe. And I think we've proven there's some efficacy and some potential for re-sensitizing. I think if folks wanted to do it and they, educated themselves a bit about, what's in the literature. If they wanted to email me and talk to me about it. I think it would be a reasonable thing.

Charles Ryan: So tell us about what you're doing next. You've got a couple of combination studies, one with immunotherapy briefly. What's the rationale for combining immunotherapy and where are you?

Sam Denmeade: In the process of doing the trials, we noticed a couple men after being on testosterone and enzalutamide kind of hormonal sequencing. We had some guys end up on immunotherapy for various reasons. We had a couple of men respond very dramatically to that immunotherapy. And we thought, well maybe there's something about the testosterone. And then in the laboratory, we've been doing some research to look at that. And what we found in the lab is that some prostate cancer cells, when you give testosterone, activate an immune response. They turn on pathways that would stimulate the immune system. So based on that we thought there's enough here that maybe we should try this in combination. And we were fortunate enough that one of the pharmaceutical companies that makes an immunotherapy, kind of agreed to go and sponsor a trial for us. And so we've opened a trial where we give testosterone for a couple of doses and then we add, in this case it's nivolumab, the immunotherapy drug. We have a couple of other ideas about how to build on that also. But so, for now, that's the trial we have at Hopkins that's ongoing. About halfway through.

Charles Ryan: And you're doing a study of testosterone with PARP inhibition.

Mike Schweizer: That's right. So as Sam mentioned earlier, one of the mechanisms that we think underlies these effects is the ability of testosterone to induce DNA damage. And so we had some preclinical models that showed that when you combine testosterone with PARP inhibitors, you can actually increase the ability for testosterone to kill cancer cells. Interestingly, testosterone also down-regulates BRCA and other related proteins. That's sort of the rationale for it. And I think from the clinical side, we've actually observed that in men that have mutations in homologous recombination genes, we actually see higher response rates to testosterone. And so it starts to build this rationale for maybe doing the combo trial. And we're making good headway in accruing that.

Charles Ryan: Good. Well, good luck in your trials. It's great to hear about this interesting work and different mechanistic probabilities or possibilities for how a testosterone supplementation in this setting can help patients and serve as a platform really for a combination of approaches. So thank you for taking the time to sit with us today and I enjoyed your presentations here at PCF, and we're looking forward to seeing your data.

Mike Schweizer: Thank you so much, Chuck.

Prostate Heidelberg Cancer Support Group Meetings

While we are having to distance ourselves and unable to hold face to face group meetings we are engaging speakers via video conferencing

In June we invited Professor Grant McArthur to join our Zoom meeting where he told of his own diagnosis with Prostate Cancer. Slides relating to his treatment and diagnosis and an overview of treatment options were included in a powerpoint presentation. He also summarized the work at the Peter Mac on Molecular imaging shown more specifically on the PCFA website webinar of 17 June with Professors Declan Murphy & Michael Hofman:

'Personalised prostate cancer treatment of the future; bringing together imaging, diagnostics, and therapy to stop cancer's spread.'

https:onlinecommunity.pcfa.org.au/15/Video-Gallery/bg-p/VideoGallery

Memorial Sloan Kettering Cancer Center PCa Nomograms

Prediction Tools

(1) Our pre-radical prostatectomy nomogram is for patients diagnosed with prostate cancer who have not yet begun treatment. This nomogram predicts the extent of the cancer and long-term results following radical prostatectomy (surgery to remove the prostate gland and surrounding lymph nodes). Using a dynamic statistical formula, this nomogram draws on data from more than 10,000 prostate cancer patients treated at MSK.
https://www.mskcc.org/nomograms/prostate/pre-op

(2) Our post-radical prostatectomy nomogram can be used by patients after their surgical treatment for prostate cancer. Using a dynamic statistical formula, this nomogram predicts the probability of remaining cancer recurrence-free at two, five, seven, and ten years following surgery. This nomogram also predicts 15-year cancer-specific survival, meaning the likelihood that you will NOT die of prostate cancer within 15 years following surgery.
https://www.mskcc.org/nomograms/prostate/post-op

(3) Our salvage radiation therapy nomogram predicts whether a recurrence of prostate cancer after radical prostatectomy can be treated successfully with salvage radiation therapy (external-beam radiation given after the prostate cancer returns). It calculates the probability that the cancer will be controlled and PSA level undetectable six years after salvage therapy. You can use this nomogram for applicable results if your post-radical prostatectomy serum PSA level was at first undetectable (less than 0.05 ng/mL) and then rose steadily, indicating a recurrence.
https://www.mskcc.org/nomograms/prostate/ salvage-radiation-therapy

(4) This nomogram can be used by patients to estimate the risk of dying of prostate cancer if their cancer recurs, signaled by a rising PSA, after radical prostatectomy. The nomogram predicts the likelihood, in a man initially treated with surgery, that he will die of prostate cancer five, ten, and 15 years from the time his PSA begins to rise.
https://www.mskcc.org/nomograms/prostate/biochemical-recurrence

(5) This tool is designed to calculate the likelihood of having high-grade prostate cancer in men who have been considered eligible for prostate biopsy by a urologist. If you have not been examined by a urologist, the results produced by this calculator will be a considerable overestimation of your risk for prostate cancer (that is, it will give a risk that is too high). This tool is not applicable for men who have already been diagnosed with prostate cancer.
https://www.mskcc.org/nomograms/prostate/ biopsy-risk-dynamic

(6) Using inputs of current age and race, this tool calculates average life expectancy, which can be used for comparison when considering the survival probabilities of various treatment options.
https://webcore.mskcc.org/survey/surveyform.aspx?preview=true&ex...

(7) This tool calculates prostate tumor volume.
https://www.mskcc.org/nomograms/prostate/volume

(8) This tool can be used to calculate the rate of rise of PSA, expressed as the velocity in nanograms/mL/year, or the PSA doubling time, in months or years.
https://www.mskcc.org/nomograms/prostate/psa-doubling-time

PLEASE NOTE:

These Prostate Cancer nomograms are prediction tools designed to help patients & their physicians understand the nature of their PC, assess risk based on specific characteristics of a patient & their disease & predict the likely outcome of treatment.

Nomogram results are based on data from studies at a high volume academic medical centre by surgical investigators with high-volume practices. Nomograms should not be evaluated in relation to one another or be used to compare different types of treatment by looking at their respective outcomes.

Internet Resources

Members have found the following websites useful

PCFA ONLINE COMMUNITY

The new PCFA Online Community is now live.

Log in to contact the online community with any questions –

onlinecommunity@pcfa.org.au

The internet is a good source for research but it should not be trusted to give you answers for your personal care. Always speak to your doctor to clarify any medical advice.

Prostate Cancer Foundation of Australia for guides & help
www.PCFA.org.au

Australian Cancer Trials
Information on clinical trials
www.australiancancertrials.gov.au

USA Prostate Cancer Foundation (Guide) PDF guide for men newly diagnosed with PC
www.PCF.org/guid

Us TOO International PCa Education (USA) USA PC support groups' information & newsletter
www.UsToo.org

Cancer Council Victoria for general support services
www.CancerVic.org.au

ExMed Cancer Program
Melbourne based 'best practice' exercise medicine program
www.EXMedCancer.org.au

ProstMate (PCFA) A companion to record PC results

Beyond Blue for help with depression and anxiety
HELPLINE 1300 22 4636

Continence Foundation of Australia for assistance with incontinence aids
HELPLINE 1800 33 0066

Australian Advanced Prostate Cancer Support Group for men diagnosed with advanced metastatic PC
www.JimJimJimJim.com

PCRI Prostate Digest (USA) Prostate Cancer Research Institute supporting research and disseminating information to educate and empower patients, families and the medical community www.pcri.org/insights

PAACT Newsletter (USA) Patient Advocates for Advanced Cancer Treatments
www.paact.help/newsletter/

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PHCSG Correspondance

Max Shub	Facilitator
Mike Waller	Treasurer
Spiros Haldas	Library
David Bellair	Web Site
Michael Meszaros	Welfare Officer
Sue Lawes	Secretary/ Newsletter

PHCSG Meetings 2020 10am – 12:30pm

Tues 18 Feb (guest speaker)
Tues 17 March
Tues 21 April
Tues 19 May
Tues 16 June (guest speaker)
Tues 21 July
Tues 18 August
Tues 15 September
Tues 20 October
Tues 17 November
Tues 15 December (including Xmas lunch)

Please note that all face-to-face meetings have been cancelled until further notice. Please check your email regularly for updates from the PHSCG Committee.

2020 PHCSG Articles

If you have any feedback or wish to include articles on specific aspects of Prostate Cancer please contact Sue at: prostateheidelberg@gmail.com

March 2020

- PCFA Consumer Advisory- Coronavirus and Cancer

April 2020

- Telehealth & Delayed Hospital Treatments due to COVID-19
- Fexapotide Triflutate (FT) injection – a new kind of focal treatment to extend time on active surveillance

Prostate Cancer Trials

- DASL-HiCaP Trial
- Evaluation of a mainstream model of genetic testing for men with prostate cancer

May 2020

- ADT May Offer Some Protection From COVID-19 in Men with Prostate Cancer
- TULSA – Novel MRI-guided ultrasound treatment destroys prostate cancer
- Whack-a-Mole A Treatment of Oligometastasis
- Long-term adjuvant ADT improves results of brachy boost therapy in unfavorable-risk prostate cancer patients
- Harnessing the immune system to control prostate cancer spread to the bone

Prostate Cancer Trials

- A study to see whether PET scans using a chemical called Exendin can detect metastatic prostate cancer
- Evaluation of a mainstream model of genetic testing for men with prostate cancer

June 2020

- Evaluating the Outcomes of AS in Gleason Grade 2 Prostate Cancer
- Advancing precision medicine for metastatic prostate cancer
- Impact of Primary Prostate Cancer Treatment with Subsequent Metastatic Disease
- Comparative Analysis & Survival Outcomes in a Real-World Practice Setting
- Fexapotide Triflutate (FT) injection – a new kind of focal treatment to extend time on AS

Prostate Cancer Trials

- Impact of 18F-DCFPyL PET scanning in patients undergoing post-prostatectomy Radiotherapy

July 2020

- Testosterone Therapy does not Increase the Risks of PCR or Death after Definitive Treatment for Localised Disease
- Association of Pre-Salvage Radiotherapy PSA Levels after Prostatectomy with Outcomes of Long-term Antiandrogen Therapy in Men with Prostate Cancer
- Testosterone Replacement in the treatment of Advanced Prostate Cancer
- Memorial Sloan Kettering Cancer Center PCa nomograms Prediction Tools