While face to face meetings have been put on hold during Covid, many members have found our zoom meetings beneficial. We therefore hope that, when we are able to regroup in Ivanhoe, the technology will also allow us to welcome anyone not able to attend in person.

Prostate Heidelberg

November 2020 Issue 200

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 17 Nov (via Zoom)

10am – 12:30pm

Join Zoom Meeting

https://us02web.zoom.us/j/82870880049?pwd=Tjc4S1YxTzR1ZmJTamtMR2tBdmlwZz09

This month…

We had a great Zoom turnout for our guest speaker Renu Eapen who gave a talk covering incontinence, erectile dysfunction & penile rehabilitation. If you missed the meeting you can watch Renu's presentation on our website.

This month we thank Peter Anderson for taking over the role of PHCSG Treasurer from Mike Waller, as Mike moves into the role of convenor for our sessions.

In this month's newsletter we highlight:

I'm sure we're all happy to be out of lockdown and able to catch up with friends and family in Victoria but, as always, please don't hesitate to contact us if there is anything you want to talk through in relation to your treatment or wellbeing.

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

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

Congratulations to Professor Jeff Dunn President elect of the UICC

Professor Jeff Dunn AO is the CEO of Prostate Cancer Foundation of Australia and President-Elect of the Union for International Cancer Control.

His work in cancer control spans 30 years, in which time he has dedicated his career to the development of strategies that underpin cancer survival and improve awareness of the disease. He is a recognised World Cancer Leader and prior to his appointment as UICC President-Elect served as Treasurer of the UICC for four years and as an Elected Director for six.

Professor Dunn also serves as the Professor and Chair of Social and Behavioural Science at the University of Southern Queensland, where his work has a central focus on the social and behavioural aspects of cancer, covering the continuum of research, prevention, early detection, supportive care, and quality of life. He is actively involved in research in this field and is also a Director of the West Moreton Hospital and Health Service Board and Chair of the Risk and Audit Committee.

He holds appointment as an Officer in the Order of Australia for distinguished service to medical administration through leadership of cancer control organisations and promotion of innovative and integrated cancer care programmes.

Life Insurance & Genetic Testing

Source:
John Berrill from Berrill & Watson Pr-Bono Superannuation & Insurance Lawyers with Cancer Council

Genetic Testing
The rules around genetic testing and life insurance have changed a few times over the years.
Approximately 10 years ago, the life insurance industry adopted a practice that they would not require life insurance applicants to do a genetic test, although they could rely on existing genetic test to decide whether to insure someone.
But a big change came into effect in July 2019.
From 1 July 2019 to 30 June 2024, life insurers have agreed NOT to use genetic test results as part of life insurance application assessments for death and Total & Permanent Disability (TPD) policies upto $500,000, trauma policies upto $200,000 and income protection policies upto $4,000 per month. For policies with values above these amounts, genetic test results can be used to determine on what terms to cover you.

What Life Insurance is Covered by the Moratorium?

Superannuation
Most Australians have life insurance as part of their employment superannuation.
You might be covered for death, TPD or terminal illness lump sums and monthly income protection payments. Trauma benefit lump sums aren't part of super.
Most insurance in super is provided on an 'automatic acceptance' basis upto monetary limits.
This means that you don't have to fill in a health questionnaire to get cover and you wont be asked questions about any pre-existing conditions, genetic tests or family history. The only eligibility question is usually whether you are 'at work' when you joined the fund.
If you want to get extra cover, you may then have to fill in a questionnaire and genetic test questions might be asked.

Insurance
If you have private insurance sold by a broker, agent or online, you will usually have to provide information about your health for the insurer to work out if you are an acceptable risk.
This may include questions about your age, sex, medical history, lifestyle and immediate family history.
If you have group insurance provided by your employer or an association, you may not have to fill in a health questionnaire but under some group policies, pre-existing conditions are excluded.

The Moratorium
Because of the self-imposed restrictions, life insurers won't:
· ask you to undergo a genetic test or
· use existing genetic test results for any applications upto $500,000 for death, terminal illness or TPD cover, $200,000 for trauma insurance and upto $4,000 per month for income protection.

Existing Policies
If you have an existing life insurance policy which started before 1 July 2019, the moratorium does not apply. But nor do you have to tell the insurer about any genetic test results or changes to your health after the life insurance policy starts.
As long as you keep paying the premiums, the insurer must keep covering you and not cancel the cover if your situation changes.
If you get a genetic test after the policy starts and the test result shows you don't have a faulty gene, you may be able to get the policy modified.

Help
If you have any questions about genetic testing and any life insurance application, or need help with a claim, contact John Berrill for FREE advice.
Contact Details:
Mobile: 0408 322 979
Email: john@berrillwatson.com.au

World first surgery at Tauranga Hospital could pave way to new way of treating prostate cancer

Source:
Bay of Plenty Times, New Zealend
21 October 2020

A world first surgery undertaken at Tauranga Hospital could represent a major advance in the treatment of prostate cancer, say medical experts.

The surgery, successfully conducted by urologist Dr Mark Fraundorfer, uses a pioneering localised drug delivery technology to deliver slow-release drugs (eg, bicalutamide) directly into cancerous tumours.

The surgery was part of a clinical study being carried out by US-based company Alessa Therapeutics, which has developed the slow-release technology called Biolen.

"I am honoured to be the first in the world to enrol a patient in this study," Fraundorfer, of Tauranga Urology Research, said.

"The introduction of the device delivering bicalutamide selectively to the prostate of my patient with a sizable tumour was a very straightforward procedure."

Bay of Plenty District Health Board head of clinical campus Professor Peter Gilling, and chairman of the Data and Safety Monitoring Committee for the global clinical study said the technique could prove a major advance.

"It's a very promising technology and also a proof of concept for the technique of delivering these drugs straight into the tumour.

"We use MRI scans to diagnose prostate cancers in our patients. Once identified, using this technology we can administer drugs straight to it, in the form of slow-release pellets.

"It should open up a whole new way of treating prostate and potentially other cancers," he said.

The surgery took place on October 8 and all members of the Tauranga urology team, whose combined efforts helped make it possible, were thanked for their work.

The rate of prostate cancer in New Zealand is 103 cases per 100,000 men resulting in more than 3700 annual cases.

In Australia, the rate of prostate cancer is one of the highest among developed countries at 110 cases/100,000 men.

While some men with low-risk tumours choose to monitor their disease, most prostate cancer patients are treated with surgery to remove their prostate or with radiation therapy.

Both surgery and radiation treatment can have complications including urinary incontinence and erectile dysfunction.

Alessa's Biolen implant is designed to deliver an anti-androgen drug to the target tissue in the prostate, eliminating significant side effects and improving quality of life for men living with prostate cancer while avoiding surgery or radiation therapy.

"We are excited to be conducting the first-in-man study of our revolutionary technology in patients with prostate cancer," Alessa Therapeutics founder Dr Pamela Munster said.

"I am grateful for the dedicated efforts of our University of California and Alessa teams together with the research group at Tauranga Urology for reaching this important milestone.

"The findings from the Biolen-PC study will be used to support our US IND [Investigational New Drug] submission to the FDA [Food and Drug Administration] for our Phase 2 trial.

"We believe this novel implant therapy will increase the treatment options for men diagnosed with prostate cancer and provide a higher quality of life while under treatment."

The company received approval in Australia and New Zealand for the study earlier this year. The Biolen-PC study will treat a total of up to 20 men scheduled for prostate surgery for treatment of non-metastatic prostate cancer.

In addition to Fraundorfer at Tauranga Urology, Professor Henry Woo, Associate Professor Peter Chin, Associate Professor Daniel Moon and Associate Professor Jeremy Grummet are all participating in the Biolen-PC study at their respective centres in Australasia.

Oncotarget: Melatonin increases overall survival of prostate cancer patients

Source:
13 Oct 2020
https://www.oncotarget.com/news/pr/melatonin-increases-overall-

Oncotarget recently published "*Melatonin increases overall survival of prostate cancer patients with poor prognosis after combined hormone radiation treatment*" which reported that a retrospective study included 955 patients of various stages of prostate cancer who received combined hormone radiation treatment from 2000 to 2019. Comprehensive statistical methods were used to analyze the overall survival rate of PCa patients treated with melatonin in various prognosis groups.

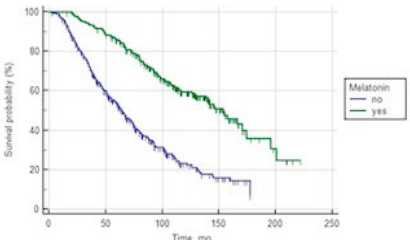
The overall survival rate of PCa patients with favorable and intermediate prognoses treated or not treated with melatonin was not statistically significantly different.

In the poor prognosis group, the median overall survival in patients taking the drug was 153.5 months versus 64.0 months in patients not using it.

In a multivariate analysis, melatonin administration proved to be an independent prognostic factor and reduced the risk of death of PCa patients by more than twice.

The multicomponent antitumor effect of melatonin is fully realized and clearly demonstrated in treatment of PCa patients with poor prognosis with a set of unfavorable factors of the tumor progression.

Dr. Vladimir N. Anisimov from The N.N. Petrov National Medical Research Center of Oncology said, "*Melatonin is the main hormone of the pineal gland.*"



Overall survival curves of patients with poor prognosis PCa depending on the intake of melatonin (log rank test < 0.0001)

Melatonin is most widely used in clinical practice to treat hormone-dependent tumors, and primarily in the combined treatment of breast cancer.

Some possible points of inhibition of tumor growth by melatonin included activation of T helper type 1; increased production of several cytokines; inhibition of angiogenesis; reduced expression of the VEGF receptors; activation of apoptosis in tumor cells; and a decrease in telomerase activity.

The results of the use of melatonin drugs in palliative treatment of patients with end-stage prostate cancer are shown.

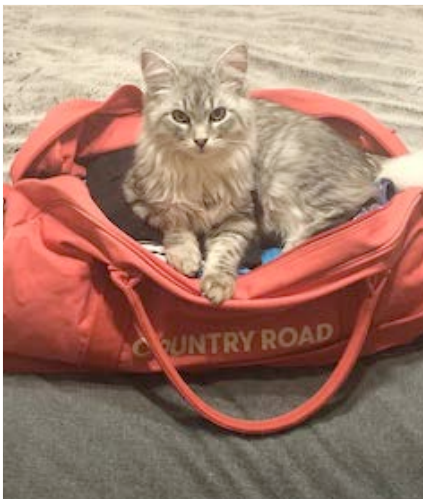
Thus, the assessment of long-term results of wide clinical use of melatonin in the combined treatment of patients with prostate cancer of various risk groups is an urgent and relevant task.

The aim of the study was to improve the effectiveness of treatment of patients with prostate cancer by long-term use of melatonin drugs after a course of combined hormone-radiation treatment.

The Anisimov Research Team concluded in their Oncotarget Research Paper that "*the results of our study are in agreement with the data on favorable antitumor effect melatonin treatment of patients with advanced cancer of various localization, mainly in the breast, uterus, colon, etc., .*

Taking into consideration the optimistic conclusions obtained in our work, based on large clinical material, it is advisable to conduct prospective randomized studies with an assessment of survival rates in patients with PCa of various prognosis groups."

PLEASE NOTE:
Treatments may vary in Australia. Please ensure you discuss your diagnosis and treatment options with your consulting specialist



Source: https://interventionalnews.com/sbrt-disease-control/

SBRT offers good disease control out to five years in men with locally recurrent

Stereotactic body radiation therapy (SBRT) in previously irradiated patients "appears clinically feasible", and provides good disease control out to five years for men with locally recurrent prostate cancer. This is the conclusion of a recent prospective study from Donald Fuller (Genesis Health Care Partners, San Diego, USA), published in the *International Journal of Radiation Oncology Biology Physics*.

The investigators set out to evaluate the use of SBRT retreatment for biopsy-proven local persistence in prostate postradiation therapy, evaluating efficacy and toxicity. For this patient cohort, the authors explain how a number of local salvage methods have been described, but say that none have been widely used, "primarily owing to elevated toxicity concerns".

Analysing outcomes in the 50 patients enrolled in the study from February 2009 to March 2018 from two community-based radiation oncology centres, Fuller *et al* assessed toxicities before and after SBRT salvage using CTCAE v.3 criteria and International Prostate Symptom Score (I-IPSS). SBRT was performed with the CyberKnife system from Accuray.

The authors report that 69% of the patients required no androgen deprivation therapy (ADT) treatment within the first five years following CyberKnife prostate SBRT. There were also low overall rates of toxicity among the patients, all of whom had undergone radiation therapy treatment prior to SBRT.

"Most men, if treated, receive only ADT, which has the potential for long-lasting whole-body side effects while rarely eradicating the tumour completely," Fuller comments. "Without effective local retreatment, it is likely that most, if not all of them [the patients treated in this study], would have needed ADT treatment at a far earlier point in their history. Because ADT has many long-lasting detrimental 'whole body' symptoms, effective SBRT local salvage thus preserves better quality of life, greatly delaying or avoiding ADT systemic effects for most patients."

Furthermore, at five years, the disease-free survival rate was 60%, indicating patients experienced no signs or symptoms of their cancer during that time. The authors write: "In spite of the relatively high-risk patient population described herein, the five-year biochemical relapse-free survival rate of 60% confirms extended disease-free survival in the majority of SBRT salvage cases."

Comparing SBRT favourably to radical prostatectomy, Fuller and colleagues say: "We also report a biochemical relapse-free efficacy rate that appears at least comparable to that reported with salvage radical prostatectomy; 60% five-year biochemical relapse-free survival in the present series versus 57% three-year biochemical relapse-free survival in a contemporary salvage radical prostatectomy series of similar size and similar median follow-up. This suggests a definite role for salvage SBRT, particularly well-suited for those who either do not desire to or are not physically able to withstand the rigors and potential complications of a salvage radical prostatectomy procedure."

The median prostate-specific antigen decreased to 0.16ng/mL at five years, similar to initial treatment with brachytherapy and lower than typical conventional fractionation, based on results from other studies.

No grade two or higher gastrointestinal events were reported. Genitourinary toxicity also was lower than reported rates for salvage radical prostatectomy and seems less frequent after prior standard external radiation treatment.

"Our results suggest that efficacious salvage of locally recurrent prostate cancer with SBRT is possible, with an acceptable toxicity risk, in appropriately selected patients," Fuller *et al* conclude.

Learn to be your own researcher to make the best treatment decisions, by being proactive and an advocate for your own health

Public vs Private Hospitals For Prostate Cancer Treatment

Source: https://www.abc.net.au/radionational/programs/healthreport/public-vs-private-hospitals-for-prostate-cancer-treatment/12639512

In the *Medical Journal of Australia* there is a study of nearly 30,000 men diagnosed with prostate cancer to see whether their treatment varied when they had the more controversial stage of the disease - when it's early and localised in the prostate gland. When surveillance, watching and waiting, can avoid unnecessary treatment, but also where radiation therapy can be just as curative, probably with fewer side effects such as incontinence and impotence. The findings were that how you got treated varied according to whether you were a public patient or a private one. Associate Professor Ian Haines a medical oncologist at Monash University and the Cabrini, led the study and discussed the findings with Dr Norman Swan on the ABC Health Report.

The study looked back at all the diagnoses registered with Cancer Victoria over the previous six years. They looked at all biopsies within three months of the registration of the diagnosis to work out whether they were done in private or public hospitals, and then matched treatment over the 12 months after the diagnosis to see how patients were treated.

Dr Swan asked if they were able to measure surveillance, in other words people who didn't get treatment at all and who got watchful waiting?

Assoc Prof Haines replied, "Only by supposition really, Norman, and we found that a certain percentage had radiation therapy initially, a certain percentage had radical prostatectomy, plus or minus radiation, and the presumption would be that a lot of the other men would be managed by watchful waiting or active surveillance."

The trial adjusted for age, comorbidities, and the grade of the tumour, although they weren't able to adjust for the size of the cancer and PSA, and came up with five different grade groups.

They found that men treated in private hospitals in Victoria in that six-year period were treated more regularly with radical prostatectomy than those treated in the public system. And those in the public system were more likely to be treated with radiation therapy - when correcting for age and correcting for comorbidities.

Does that have any impact on cure rates? The evidence would suggest that both external beam radiation and radical prostatectomy treatments were equally effective at cure.

Unfortunately we weren't able to look at outcomes in this particular retrospective study, but would like to do so in the future.

Norman Swan observed that one of the arguments from radiation oncologists is that too few men get a second opinion from them. The GP automatically refers men to a urological surgeon, who knows how to remove prostates. In the public hospital there's a multidisciplinary team and radiation therapy is free with no waiting list and with the chance of fewer side effects.

Ian Haines said the urologist, as the gatekeeper in the Australian private system has a one-on-one relationship with the patient, and is responsible for the outcome. It's a big decision for the urologist to pursue active surveillance. Although many now work in multidisciplinary team meetings, where the decision is borne by the whole team. Multidisciplinary meetings are becoming the standard of treatment around Australia and starting to happen much more in the private system.

Norman Swan said that one of the first questions a man should ask his GP when they are referring them is are you referring me to a team or an individual because you get better outcomes if it's a team of people; a radiation oncologist, surgeon, pathologist, psychologist even and others.

And if you are a man with prostate cancer, ask for a second opinion.

Early ADT for Recurrent Prostate Cancer

Source:
01 Dec 2019
https://www.renalandurologynews.com/home/news/urology/prostate-cancer/early-adt-for-recurrent-prostate-cancer-challenged/

Findings from a recent study may challenge the early use of androgen deprivation therapy (ADT) for men who experience biochemical recurrence of prostate cancer following radical prostatectomy (RP).

"We found that the median overall survival and metastasis-free survival from time of diagnosis of prostate cancer is quite long in men with biochemically recurrent prostate cancer and is comparable to the overall survival estimated in contemporary clinical trials," lead investigator Catherine Handy Marshall, MD, of Johns Hopkins University School of Medicine in Baltimore, told *Renal & Urology News*. "Early ADT, at time of biochemical relapse, does not clearly prolong overall survival or improve quality of life, and when to start this therapy is still a matter of debate."

Kevin Courtney, MD, PhD, Associate Professor of Internal Medicine in the Division of Hematology/Oncology and Co-Leader of the Genitourinary Oncology Disease Oriented Team at the University of Texas Southwestern Medical Center in Dallas, said 81% of the men in this study had low- or intermediate-risk disease, which may need to be taken into account in future analyses. Various studies have looked at whether ADT should be started in patients with biochemical recurrence in the absence of tumor. "This [study] shows you can safely delay ADT in men with biochemical recurrence after prostatectomy. That is consistent with what has been found in previous work. However, there are challenges in extrapolating these findings to patients with nonmetastatic castration-resistant prostate cancer (M0 CRPC). Further work is needed to validate metastasis-free survival as an end point for those patients."

Paul Mathew, MD, a genitourinary oncologist at Tufts Medical Center in Boston, said the findings of Dr Handy Marshall's group are relevant, but he is concerned that the men in the study may not be biologically comparable to the men who participated in the trials of novel antiandrogens. "It is difficult to know if these populations are equivalent," Dr Mathew said. "There is probably a subgroup of patients with BCR for whom early implementation of ADT would impact overall survival favorably, but this is likely to be a small fraction of the overall population for which we do not have reliable tools for definition."

Clinicians already are concerned about using the novel antiandrogens because they are extremely expensive and can adversely impact quality of life with adverse effects such as chronic fatigue. "Another criticism is that there is no overall survival advantage documented, although this may materialize with more mature follow-up," Dr Mathew said. "If I had started a patient on ADT for BCR, and their PSA was rising rapidly, I would use a first-generation antiandrogen such as bicalutamide first because it is cheap and has few side-effects."

"It is going to take better head-to-head trials looking at deferred ADT and defining the true benefits of these novel agents and at what stage they should be implemented in terms of overall survival," said Soroush Rais-Bahrami, MD, Associate Professor of Urology and Radiology at the University of Alabama at Birmingham and Co-Director of the UAB Program for Personalized Prostate Cancer Care. Advances in targeted imaging techniques, such as prostate-specific positron emission tomography tracers, that pinpoint tumor sites also could help clinicians decide when to begin ADT, he said.

Amar U. Kishan, MD, Assistant Professor in the Department of Radiation Oncology at the University of California, Los Angeles, said an important finding from the new study is that many men who have BCR after RP and are managed expectantly until developing metastases still have excellent overall survival outcomes, suggesting that a large proportion of men may be "overtreated" if they are started on hormonal therapy.

"I think the guidelines as they currently are, which do not mandate ADT, but rather allow either ADT or observation depending the clinical circumstance and patient preference, are reasonable, though this work certainly underscores that most men may not need ADT," Dr Kishan said.

ANZUP's ENZAMET trial results recognised as one of the most important clinical research advances of the past

Source: https://www.anzup.org.au/docview.aspx?id=1143

The Australian and New Zealand Urogenital and Prostate Cancer Trials Group (ANZUP) announced their landmark Australian led clinical trial, ENZAMET, *"Enzalutamide with Standard First-Line Therapy in Metastatic Prostate Cancer,"* earlier this year showing that hormone therapy with a drug called enzalutamide can improve the survival of some men with advanced, hormone-sensitive prostate cancer.

Findings from the ENZAMET trial, led by ANZUP, showed that men with this sort of cancer who receive enzalutamide with standard treatment have a 33% improvement in survival compared to men receiving standard treatment alone.

ANZUP Chair, Professor Ian Davis, said metastatic prostate cancer was still the second-leading cause of cancer death in Australian men after lung cancer.

"The benefits of enzalutamide had already been established for prostate cancers that are no longer responding to hormonal therapy. ENZAMET showed that adding enzalutamide to standard treatment for men starting hormonal therapy for prostate cancer led to 33% reduction in the chance of dying of prostate cancer, and a 60% improvement in the time it takes to detect the cancer growing again. These results were much better than we thought they might be when we started the trial.

"Prostate cancer is complex and so are the benefits, side effects and risks of multiple treatments.

"Clinical trials are the most effective way of determining which treatments, alone or in combination, will provide the greatest survival benefit to the patient with the least adverse outcomes."

Professor Christopher Sweeney, co-chair with Professor Davis of the ENZAMET trial, said, "Inclusion in ASCO's Annual Report is testament to the fact that this is one of the most significant findings yet in clinical trials for men with metastatic hormone-sensitive prostate cancer – and a great example of effective international collaboration."

Metastatic prostate cancer is cancer that has spread from the prostate to other parts of the body which can be seen on conventional CT and/or bone scans. Patients with metastatic hormone sensitive prostate cancer are patients who are starting treatment for metastatic disease and will most likely respond to suppression of the male sex hormone testosterone. Recent advances have shown some patients live longer when docetaxel or abiraterone (an agent that suppresses other male hormones) are added to the testosterone suppression. ENZAMET is the first trial to show a survival benefit from addition of enzalutamide, and the first to include patients receiving docetaxel chemotherapy at the same time.

New Prostate Cancer Trials

Upfront PSMA : A Randomised Phase 2 Study of Sequential 177Lu-PSMA617 and Docetaxel

Sponsor:

Peter MacCallum Cancer Centre, Australia

Brief Summary:

This phase 2 randomised clinical trial will compare the effectiveness of Lu-PSMA therapy followed by docetaxel chemotherapy versus docetaxel chemotherapy on its own in patients with newly-diagnosed high-volume metastatic hormone-naive prostate cancer (mHNPC).

Detailed Description:

This is an open label, randomised, stratified, 2-Arm, multi-centre, phase 2 clinical trial recruiting 140 newly-diagnosed high-volume mHNPC patients at 11 Australian centres over a period of 18 months. Patients will be randomised to the experimental Arm (177Lu-PSMA followed by docetaxel) or standard-of-care Arm (docetaxel) in a 1:1 ratio. All patients will receive ADT continuously throughout the trial. Patients will be stratified according to disease volume by conventional imaging (low-volume vs. high-volume) and duration of ADT at time of registration (≤ 28 days vs. > 28 days).

Exercise for heart health in prostate cancer

Published August 20, 2018

Everyday more than 45 men are diagnosed with prostate cancer in Australia. Androgen deprivation therapy (ADT) is an efficacious anti-cancer therapy that reduces prostate cancer mortality. However, ADT may increase the risk of cardiovascular morbidity and mortality. Improvements in prostate cancer treatment means that patients are living long enough to experience the late effects associated with ADT. Thus, cardiovascular disease is a significant issue faced by many men with prostate cancer. Against this background, there is a plethora of evidence in the cardiovascular medicine that may highlight the potential mechanisms contributing to cardiovascular disease, key diagnostic methods to identify those at the highest risk and the potential efficacy of exercise medicine to modify cardiovascular risk. The purpose of this pilot research study is to evaluate the impact of ADT on cardiovascular structure and function, as well as the impact of exercise training during ADT on cardiovascular structure and function.

Who is this trial for?

- Men diagnosed with prostate cancer
- 40 years or older
- Scheduled or within one-month of ADT
- All screening is performed by Ex-HEART trial staff at Australian Catholic University and Baker Heart and Diabetes Institute

What does participation involve?

- Comprehensive cardiovascular screening including echocardiography, cardiac magnetic resonance imaging and cardiopulmonary exercise test
- 3-month best practice exercise intervention
- Supervised by an accredited exercise physiologist who specialises in prostate cancer
- Individualised exercise prescriptions
- Small group exercise sessions
- Delivered at one of four fitness centres around Melbourne
- All screening and training is provided free of charge to participants
- All participants will receive the exercise intervention with the control group offered a delayed intervention (wait list control)

Where are the exercise clinics?

- Genesis Health and Fitness, Melbourne CBD
- Coburg Leisure Centre, Coburg
- Hawthorn Leisure Centre, Hawthorn
- Monash University, Caufield

How do I get involved?

To find out more, please

- Contact our team 03 9230 8268
- ashley.bigaran@myacu.edu.au
- exerciseoncology@acu.edu.au

Register your interest to participate in the trial

Prostate Heidelberg Cancer Support Group Meetings

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

Guest Speaker

Tuesday 15 December 2020

Dr Cleola Anderiesz is an experienced senior executive with 18 years of experience in health across the research, not-for-profit, and government public sector.

Committed to quality in healthcare, Dr Anderiesz holds a PhD in Medicine and a Senior Executive MBA. She is skilled in policy, strategy, innovation, program development and implementation, stakeholder engagement, and evidence-based decision making.

Dr Cleola Anderiesz
Deputy Chief Executive Officer at Cancer Australia

Gather my crew

An online rostering tool to support individuals during times of personal trauma and crisis.

21st century support

Gather My Crew was developed after the Bourke Street incident in January 2017.

The idea is simple, the person in need of support creates a schedule of activities they require practical help with, which could include cooking meals and shopping, support during medical appointments, childcare and school pick-ups, or home cleaning, garden maintenance and pet care. The schedule then becomes an online roster that family and friends can sign-up to and nominate themselves for certain activities. The person receives the practical support they need at the most difficult time in their life, while their friends and family – their crew – know that they are making a positive and practical difference.

The Foundation's first grant supported the launch and rollout of the Gather My Crew platform to the wider community, especially the medical and not-for-profit sectors, to create and build awareness of this innovative online resource.

To date 18,000 people have registered a 'crew', with 100,000 hours of support logged as well as a growing network of referral partners around Australia, including national organisations such as Cancer Council, Red Cross, Palliative Care Australia, Stroke Foundation and Heart Foundation.

Positive personal impact
For the team at Gather My Crew, measuring impact is not just about gathering and analysing data but also about the impact a support crew can have on each individual person seeking help.

Dr Susan Palmer, founder of *Gather My Crew* believes that Australians are stoic and find it hard to ask for help. "We make it easy for people to ask for help, and the help received is meaningful, sustainable and it becomes ongoing."

If you, or anyone you know needs that extra help visit:

https://www.gathermycrew.org.au

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 –

https://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
https://www.pcfa.org.au

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

USA Prostate Cancer Foundation (Guide) PDF guide for men newly diagnosed with PC
https://www.pcf.org/guide/

Us TOO International PCa Education (USA) USA PC support groups' information & newsletter
https://www.ustoo.org

Cancer Council Victoria for general support services
https://www.cancervic.org.au

ExMed Cancer Program Melbourne based 'best practice' exercise medicine program
https://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

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

PAACT Newsletter (USA) Patient Advocates for Advanced Cancer Treatments
http://paact.help/newsletter-signup/

PHCSG Correspondance

Prostate Heidelberg
POB 241 Ivanhoe Vic 3079
prostateheidelberg@gmail.com
prostateheidelberg.info

PHCSG Correspondance

Mike Waller Convenor
Max Shub Co-Facilitator
Peter Anderson 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 (guest speaker)
Tues 15 September
Tues 20 October (guest speaker)
Tues 17 November
Tues 15 December (including Xmas lunch) (guest speaker)

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 PC
- 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

August 2020

- Advanced Prostate Cancer Algorithm
- Blood Test Predicts Response to PC Treatment (liquid biopsy)
- The Perils and Pitfalls of Treating PSA in PCa
- Reprogramming Immune Cells could Switch Defence into Attack in PCa
- Maintenance of Sexual Activity Following ADT

September 2020

- ProtecT Trial showing patient outcomes after AM, RP & EBRT
- Changes in Penile Length after RP
- Active Surveillance for PC – is it right for you?
- The final part of The Perils and Pitfalls of "Treating PSA" in Advanced Prostate Cancer
- Managing Erectile Dysfunction – A Patient Guide

Prostate Cancer Trials

- Efficacy and Safety of Pembrolizumab (MK-3475) Plus Enzalutamide Plus Androgen Deprivation Therapy (ADT) Versus Placebo Plus Enzalutamide Plus ADT in Participants with (mHSPC)
- Navigate: An online treatment decision aid

October 2020

- World Osteoporosis Day
- Lifestyle Factors and Chronic Disease
- Hormone Therapy for PC
- Early ADT for Recurrent PC Challenged
- Unexpected aPC weakness can be targeted by drugs
- Hijacking an Epigenetic Program
- New PC Research: Immunotherapy; Gut Microbiome
- Veyonda New Research on Survival Rates

Prostate Cancer Trials

- MIndonline - mindfulness

November 2020

- Life insurance & Genetic Testing
- World First Surgery in NZ
- Melatonin increases survival
- SBRT disease control
- Public vs Private Hospitals
- Early ADT for Recurrent PC challenged
- Enzamet trial results

Prostate Cancer Trials

- Randomised Phase 2 of sequential 177Lu-PSMA & Docetaxel
- Exercise for Heart Health