MEMBERSHIP

FULL YEAR PHCSG MEMBERSHIP $20

Join our Monthly meetings on the third Tuesday (Feb – Dec) 10am – 12:30pm

EFT Payments to:
Prostate Heidelberg CSG
BSB 083 256
Acct 583244292

Prostate Heidelberg

June 2021 Issue 207

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 15 June (via Zoom)
10am – 12:30pm

Join Zoom Meeting: Copy link and paste into your browser
https://us02web.zoom.us/j/84254343542?pwd=cXl4ekFjSm1TaFRIcEdXN2MxU0J6QT09

Meeting ID: 842 5434 3542
Passcode: 091443

PHCSG June

After experiencing another lockdown it'll come as no surprise that our first planned face-to-face meeting since February 2020 is cancelled. However we have managed to secure our usual day and time at Ivanhoe Uniting Church and hopefully we can celebrate our return in July.

Our Guest Speaker this month is Dr Natalie Heynsbergh, Research Fellow at Deakin University who will be will be speaking at 10.30am about an online study on the value of mindfulness in managing the anxieties associated with cancer treatments.

In this month's newsletter we highlight:

If there is anything you want to talk through in relation to your treatment or wellbeing please don't hesitate to ring:

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

Every 30 minutes, one of our fathers, sons, or brothers hears the news they have prostate cancer. In fact, prostate cancer is the most common cancer present in Australia today, with nearly 230,000 men alive after a diagnosis.

By 2040, that number is set to increase by nearly 70%, to more than 370,000, with massively growing need for our services and support.

If you or your family have been affected, you'll know the toll that prostate cancer can take on men's physical and mental health. The good news is – we're here to help.

We provide support and care that no other organisation offers, and we can't do it without vital donations from Dry July:

• We send thousands of information kits to men, their families, and the community each year.
• We fund over 80 Prostate Cancer Specialist Nurses in hospitals Australia-wide, including 5 nurses funded by Dry July.
• We run Australia's only dedicated Prostate Cancer Specialist Telenursing Service, so you can call us from home when you need help.
• We facilitate a national Support Group Network and Online Community, bringing thousands of men together each year to overcome prostate cancer.

Over the past five years alone, we've funded more than $30 million in game-changing research.

Why go Dry this July for us?

With growing need for our services, and thousands of Australian men and families struggling with prostate cancer, we need your help.

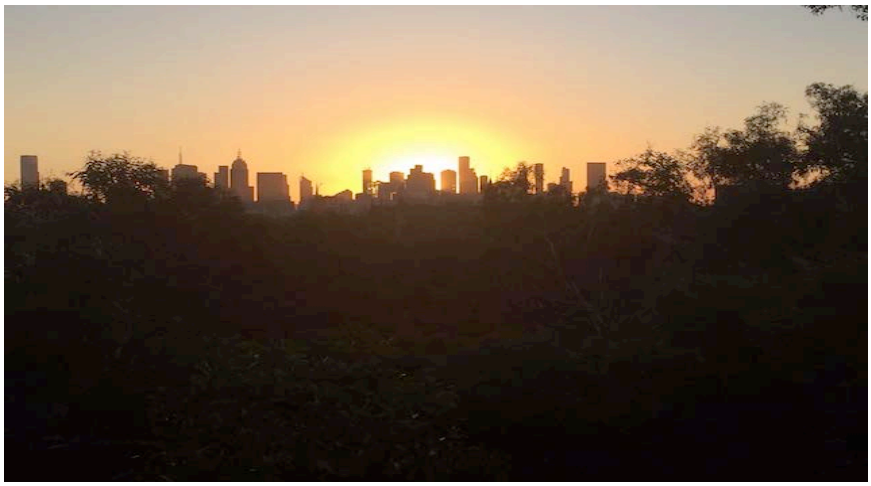
When you go Dry this July for PCFA, you'll be supporting our hospital-based Prostate Cancer Specialist Nurses, as well as funding our life-changing Prostate Cancer Specialist Telenursing Service.

Our Specialist Nurses provide vital outreach and care for families who have had their worlds turned upside down by prostate cancer. Better still, you can be guaranteed of our support from the day of your family's diagnosis and the years ahead.

Your donations go a long way

$25 can give a newly diagnosed man a tailored information pack to help explain the road ahead.
$50 can cover the cost of screening a newly diagnosed patient for depression and anxiety, ensuring he is referred for mental health support.
$100 can cover the cost of follow-up care and support, so that men and families have consistent care, throughout their treatment.
$250 can help to cover the cost of a community awareness presentation, so that we can educate Australian men about genetic and family risks.
$500 can cover the costs of training a new nurse on the harsh side-effects of treatment, so that we can help men through their toughest challenges.

https://www.dryjuly.com/?no_redirect=true



Hope for new prostate cancer treatment after breakthrough in understanding of disease's resistance to drugs

Source:
Tom Bawden
Science & Environment Correspondent
22 May 2021
https://inews.co.uk/news/science/new-prostate-cancer-treatment-hopes-breakthrough-understanding-

But scientists caution that much more research is needed before any drug becomes available – with no guarantee of success

A new treatment that may extend the lives of thousands of prostate cancer patients could be available within a decade after scientists identified a key cause of the resistance the disease develops to effective drugs.

Prostate cancer treatments work by reducing the level of testosterone and other male hormones the tumours rely on for growth.

However, over two to three years the cancer becomes resistant to the treatment, typically leaving the patient between 12 months and five years to live.

Now, researchers have identified a protein – known as JMJD6 – that causes the cancer to become resistant to the treatment by reducing its reliance on hormones – although it's not yet understand how the process works.

They are now working to develop a drug that effectively shuts down the activity of the protein, in the hope of prolonging the effectiveness of hormone reducing therapy and extending the lives of the patients.

They hope to have a drug ready for clinical trials within five years that, if all goes well, would be used on the health service within ten years. However, they strongly caution that it's still early days with far more research needed and no guarantee of success.

But with about 12,000 men in the UK dying from prostate cancer every year, the finding has raised hopes that thousands of people a year could have their lives extended by a new drug – in some cases potentially by years.

"This protein could be a key to preventing resistance to treatment. It may allow us to discover and develop new drugs that could prevent, delay or even reverse resistance to current therapies and help improve the outcome for patients with advanced prostate cancer," said Adam Sharp, of The Institute of Cancer Research.

Any drug is likely to be used in combination with hormonal therapies such as enzalutamide and abiraterone and taken in the form of a pill.

"These results are highly promising and we hope will inform the development of new treatments," added Simon Grieveson, head of research at Prostate Cancer UK, which part funded the research.

Professor Charlotte Bevan, of Imperial College London, who was not involved in the research, said: "The major cause of death in prostate cancer is resistance to existing therapies, and so the holy grail is to find new therapies that can work when others fail. Excitingly, this shows that reducing JDJM6 reduces growth of prostate cancer cells. Targeting JDJM6 therapeutically is definitely an exciting option."

Michelle Mitchell, chief executive of Cancer Research UK, which also helped fund the study, said "Hormone treatments like abiraterone have extended the lives of thousands of men in the UK. But some cancers stop responding to these types of therapies, so finding newer and better treatments is vital."

"Although this is early research, it has revealed a new drug target that could become a promising treatment for prostate cancers that are no longer responding to current treatments," she said.

The research is published in the journal Cancer Research and used data from ICR's canSAR cancer drug discovery database.

Elevated levels of the protein in question – known as JMJD6 – also play a role in ovarian, breast, lung, glioblastoma and colon cancer and so blocking those may also help treat those forms of cancer further down the line.

How existing treatments work

Prostate cancer is treated by starving the cancer of testosterone and other male hormones, or androgens, which it needs to grow and spread. The treatment is known as androgen deprivation therapy.

The hormones trigger the growth of cells by binding to a protein called the androgen receptor and this therapy means these receptors have much less hormone to bind with.

But over time, the JMJD6 protein renders the hormone treatment ineffective.

The researchers found that that the protein has a 'cavity' that makes it amenable to small compound binding to potentially block its function – which means they should be able to develop a drug to block it. They also showed that if they produce mutations within that cavity, then JMJD6 is no longer able to function.

PyL PSMA PET Imaging: Shining the Spotlight on Tiny Bits of Cancer

Maybe you've been diagnosed with high-risk prostate cancer. Maybe you have already been treated for prostate cancer, but your PSA is starting to creep back up, which means that the treatment didn't get all of the cancer – but maybe it's just right there in the prostate area, easily targetable with radiation. Or maybe it's just in one lymph node, or it's in a transition state called oligometastasis: not widespread, but in just a few isolated spots outside the prostate. In other words, maybe the cancer can still be cured – if you can just find it.

It's called PSMA PET imaging, and it works kind of like a heat-seeking missile. A radioactive tracer that lights up in a PET scan is molecularly engineered to find one very specific target: PSMA (prostate-specific membrane antigen), a protein that lives in high concentrations on the surface of most prostate cancer cells. Because the tracer is injected systemically, it can shine a virtual spotlight on whatever it tags – even tiny bits of prostate cancer – anywhere in the body. Several of these tracers have been studied, and one, called 68Ga-PSMA-11, was recently FDA-approved for use at two hospitals in California: UCLA and UCSF [but has been available in Australia and Europe since 2015]. Another agent called 18F-DCFPyL (PyL), developed at Johns Hopkins by a team led by Martin G. Pomper, M.D., Ph.D., Director of Nuclear Medicine and Molecular Imaging, is the latest to receive FDA approval and will be more widely available.

Both of these PSMA-targeting agents got their start with PCF funding. "What we are seeing is decades of research now bearing clinical fruit," says medical oncologist and molecular biologist Jonathan Simons, M.D., CEO of PCF. "PCF has long believed in the promise of PSMA targeting – not only for imaging cancer, but for a revolution in how to treat it. Over nearly 30 years, since 1993, we have invested more than $28 million in research on PSMA, with the goal of finding cancer that has escaped the prostate when it is very early and at a very small volume, because we believe that this will help us change the course of metastatic prostate cancer."

PyL has proven itself in two important clinical trials: CONDOR, published in Clinical Cancer Research, and OSPREY; published in the Journal of Urology. In the OSPREY trial, PyL PET/CT was tested in two groups of patients: 1) men just diagnosed with high-risk prostate cancer who were set to undergo radical prostatectomy with pelvic lymphadenectomy, and 2) men with metastatic or recurrent cancer. In the first group, the ability of PyL to detect any metastases in pelvic lymph nodes or beyond was determined, and in the second group, PyL was used to detect distant metastases.

In the CONDOR study, men with a rising PSA after treatment for prostate cancer with surgery, radiation, or cryotherapy, who had no visible cancer on standard imaging were scanned with PyL PET/CT, which accomplished what researchers hoped it would: "PyL successfully localized sites of disease in 85% of men with biochemical recurrence," says Pomper, "even men with low PSA levels. It detected and localized disease in most men with biochemical recurrence presenting with negative or equivocal conventional (bone scan plus CT) imaging, and led to changes in management in the majority of patients."

For many doctors and patients, this new FDA approval of PyL can't come soon enough, says Pomper. "I've had patients for years asking me when we are going to be able to use this. It's taken a long time, but we are finally there."

Source:

May 27, 2021

By JANET FARRAR WORTHINGTON

https://www.pcf.org/c/pyl-psma-pet-imaging-shining-the-spotlight-on-tiny-bits-of-cancer/

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

The Prostate Cancer Foundation is a charitable organization in California, USA funding research to improve the prevention, detection and treatment of prostate cancer and ultimately cure it for good.

(continued page 5)

In 2002, Pomper was the first to figure out how to engineer a small-molecule, harmless radioactive tracer to PSMA. With PCF funding, he and his team went on to test the first PSMA-targeted PET agent in a clinical trial. This he refined into PyL, a more sensitive and specific second-generation agent that provides sharper images. "With standard imaging (bone scans and CT), we may suspect there is cancer outside the prostate area, but we often just can't see it in its earliest stages. Standard imaging is not good enough for detecting and characterizing disease in men with biochemically recurrent prostate cancer, particularly in men with a low PSA (less than 2). But 95 percent of prostate cancer has PSMA." And as Johns Hopkins radiation oncologist Phuoc Tran, M.D., Ph.D., and others are showing in clinical trials of oligometastasis, very small, isolated bits of prostate cancer are now being considered treatable – and possibly curable – targets.

How is PyL different from 68Ga-PSMA-11? The differences are nearly negligible except for one: 68Ga-PSMA-11 requires special equipment to make, has a short half-life, and must [be] made in small batches on site in the medical center. 18F-DCFPyL has a longer half-life and thus can be made by a company and shipped to any medical center able to perform PET imaging. Although this is a radioactive compound, it is well-tolerated, says Pomper. "It doesn't affect you like a medicine; it's given in trace doses. It just binds to PSMA and goes away; it doesn't do anything else to your body."

PSMA-Targeting Can Kill Cancer, Too!

But wait! This is not all that PSMA-targeting can do! Instead of attaching the tracer molecule to "see" a cancer cell, you can attach a radioactive drug to kill the cancer. In Europe and Australia, and in international clinical trials, PSMA-targeting radionuclides, such as 177Lu-PSMA-617 are being used to target and kill cancer in just those tiny outposts, leaving nearby cells undamaged. This is killing prostate cancer cells at the level of hand-to-hand combat, and it is a bright spot on the horizon as a treatment option for men with metastatic prostate cancer.

What about the cancer cells that don't make PSMA? This, too, is on the horizon: Pomper is developing new molecules and therapies to target "PSMA-invisible" forms of prostate cancer. "It took a long time, but now we're seeing many exciting offshoots of our work in other forms of cancer, as well. Some pretty amazing things are happening. And PCF was there, funding this at the very beginning."

Does it Matter if Your Testosterone Level is Below 20ng/dL When on ADT?

And - Are there any clinical implications to how fast your testosterone recovers after stopping ADT?

May 31, 2021

There is a new study out of Spain, which looked at a variety of long-term outcomes for 177 patients on ADT, who managed to have their testosterone (T) levels suppressed well below what is normally considered the cut-off for castration.

The traditional target for castrate levels of T has been <50 ng/dL. However, some recent papers suggest that it is better if the T level can be suppressed even further; i.e., down to or below 20 ng/dL.

This new paper by Zapatero and colleagues addressed two questions. The first is whether it really matters, in terms of disease progression or survival, if patients' serum T level is <20 ng/dL when on ADT. The second question is whether it matters, in terms of disease progression or survival, if the T recovers slowly or quickly after ADT is stopped. Of note, the median follow-up time for the study was nine years.

The authors found that it did not matter whether the T was very low during ADT or recovered rapidly after stopping ADT. However, this is a small study involving only 177 patients. Moreover, other studies that have suggested "lower T is better" were looking at different populations with slightly different risk profiles for disease progression. Therefore, we still need more research involving larger samples of more diverse patients.

The paper does, in passing, address one other commonly asked question: How long does it take on average for the testosterone to recover after stopping ADT? This, of course, depends on the general health of the patient and how long they are on ADT, but in this study the average time turned out to be 16.3 months.

For patients who are on intermittent ADT in order to have breaks from the adverse effects of low T, they may be pleased to know that there is no particular risk associated with a rapid return to normal T levels when stopping ADT.

To read the full article, see: https://www.thegreenjournal.com/article/S0167-8140(21)06216-2/fulltext

Stay Bone-Healthy

Source:
May 10, 2021
By JANET FARRAR WORTHINGTON
https://www.pcf.org/c/stay-bone-healthy/

In addition to all the other rotten tricks advanced prostate cancer plays on a man, here's a biggie: It messes with your bones. Moreover, androgen deprivation therapy (ADT) and androgen receptor-blocking drugs can also raise your risk of bone fracture. But there's good news: you can do a lot to protect your bones!

Being bone-savvy is the key to staying bone-healthy.

The first thing to know is that prostate cancer really likes bone. In 90 percent of men who have metastatic prostate cancer, metastasis happens in the bone. Prostate cancer causes changes in two different types of bone cell that, confusingly, sound a lot alike: osteo*blasts* and osteo*clasts*.

Osteoblasts can make the bone thicker, denser, and hard, like concrete. But this doesn't mean the bone is stronger, says Harvard medical oncologist Matthew Smith, M.D., Ph.D., Director of the Genitourinary Oncology Program at Massachusetts General Hospital Cancer Center. "Even though it might seem dense on an X-ray, there are dents, also called sclerotic or osteoblastic bone lesions, and the bone is structurally weak." Osteoclasts also cause bone to become more brittle.

However: bone metastases can be treated. There are several good bone-targeting drugs that zero right in on these lesions, including radium-223 (Xofigo), as well as supportive care treatments such as zoledronic acid (Zometa), and denosumab (Xgeva). Bone metastases can also be treated with stereotactic body radiation therapy (SBRT), intense, highly precise doses of radiation. Treating the cancer in the bones not only improves life; it can improve survival, as well.

A second issue is that ADT raises your risk of osteoporosis. If you are on ADT, whether or not you have metastasis in the bone, "you are *separately* at risk for accelerated bone loss and greater risk for osteoporotic fractures from a fall or minor trauma," says Smith. So, to sum up: "Men who are on systemic treatment for prostate cancer are at risk for osteoporotic fractures, and patients with bone metastases, additionally, are at risk for skeletal complications."

By "systemic treatment," Smith doesn't just mean ADT, but androgen directed therapies such as enzalutamide, apalutamide, or abiraterone, which add their own wrinkle: "They increase the risk of falls, likely due to their effect on the central nervous system. It's kind of a bad setup: if you're on long-term ADT, you can lose bone mass and have a greater risk for fracture. Add a second drug – and these are meaningful and important drugs – and the unintended consequence is a greater risk for falls in men who are already vulnerable."

Oh, no! So, what's the plan? Should every man who starts ADT immediately start taking a bone-protective agent (such as zoledronic acid or denosumab) to prevent osteoporosis? No, says Smith. "If we did that, we would be overtreating, with a drug that many men don't need." And why is this? Because "osteoporosis and fractures are not an inevitable consequence of ADT. Not every man is going to develop osteoporosis and fractures." To repeat: Osteoporosis is not a done deal! "Osteoporosis drugs have their own side effects; we don't want to do more harm than good."

Thus, Smith says, what makes the most sense for men on ADT is to evaluate everyone, and intervene *only* in patients at risk, "for whom osteoporosis treatments would do more good than harm. In my opinion, the best method of doing that is using the very thoughtful guidelines developed by the National Osteoporosis Foundation for fracture prevention in men. We don't have to reinvent the wheel. There are abundant evidence-based recommendations; we just need to apply those principles."

Are you at higher risk? A good place to begin is an assessment tool called FRAX.

or

https://start.knowyourbones.org.au/summar

Smith notes that "it just takes a couple minutes to put in the information and get results, and then you'll have a good idea of your risk based on clinical features: your age, height, and weight, and your bone mineral density measurement, if you know it." Smith recommends that men get a baseline bone density scan at the time they start ADT. "Some patients should have prompt intervention to reduce their risk of fractures. Others would do better just to be followed. I typically repeat the bone density scan after a patient has been on ADT for a couple of years." Note: "If you are only undergoing a short course of ADT, your risk is basically the same as that of the general population," says Smith. "The risks of short-term ADT are very different from those of lifelong ADT."

What else can you do? Should you be taking a horse-pill-sized dose of calcium? Smith says no; it's better to help your bones through a good diet. "Diet, not supplements, and vegetables rather than lots of dairy." Dark and leafy greens, such as kale, collard greens, and bok choy, have calcium. They also have bone-strengthening vitamin K. Sweet potatoes have magnesium and potassium, which your bones need. Fatty fish, like salmon, has vitamin D, which helps your bones absorb calcium, and the omega-3 fatty acids are also good for bones. Conversely: Drinking alcohol and smoking cigarettes both increase your risk of falling.

"Another issue with ADT is that men tend to gain weight and lose muscle," says Smith. But you can fight what ADT does to your metabolism with regular physical activity, "30 minutes a day, five days a week at least." Don't be alarmed: you don't have to start training for a triathlon! Just walking or riding an exercise bike can help a lot! "Some weight-bearing exercise will have a beneficial effect on your bone mass, but more importantly, it will reduce your risk for a fall." The key here, he adds, is "use it or lose it. If you spend most of your time being sedentary, when you do walk, you are at a greater risk of having a fall."

Take vitamin D. Vitamin D helps your body absorb calcium. Smith says this is the one dietary supplement that he *does* recommend: 2000 IU a day.

And, take heart: "Osteoporosis and fractures are not inevitable, and for patients at greater risk, they are preventable. If necessary, we can intervene with medicine to reduce the risk for fractures." Lifestyle changes – eating bone-strengthening foods and exercising, cutting out smoking and alcohol – can make a big difference, too. "It is not at all the case that there's nothing you can do. You can do a lot!"

ADT and the risk of cardiovascular disease and mortality – A moving target

Source: http://www.lifeonadt.com/life-on-adt-blog/2021/5/25/adt-and-the-risk-of-cardiovascular-disease-and-mortality-a-moving-target

Late last month, two papers were published within a day of each other discussing the risk of cardiovascular disease (CVD) for patients on ADT. They both had many prestigious coauthors and were published in high impact journals. One of the journals was *Cancer*. The other was *Circulation: genomics and precision medicine* and was an official statement from the American Heart Association (AHA).

Note what we have bolded in the following two paragraphs...

The AHA review stated that "patients with prostate cancer and baseline CVD and cardiovascular risk factors experience increased rates of cardiovascular events when treated with androgen deprivation therapy." The statement then continued with: "prolonged use of some hormonal therapies worsens cardiovascular risk factors and metabolic syndrome..."

The paper published in *Cancer* was a bit narrower in its focus and looked at patients who received radiotherapy (RT) for prostate cancer with or without adjuvant ADT. There the authors concluded that "the use of ADT with RT, compared with RT alone, is not associated with an increased risk of cardiovascular-specific mortality, even among sub groups of men with pre-existing comorbidities, including cardiovascular disease."

These conclusions are almost completely opposite to each other. How is this possible?

The paper suggesting little or no cardiovascular risk was a retrospective analysis of data collected on 1463 men between 1993 and 2001. The other paper was a comprehensive review of all the studies published to date. It explored the impact of different drug treatments, many of which were not available before 2001. The AHA paper reviewed possible mechanisms to account for how ADT could increase cardiovascular risk based on data from the different drugs.

We cannot be sure why the study in *Cancer* found no impact of ADT on CVD risk, but there are a couple of reasons why this may be the case. First, the data were collected a long time ago when more men were smoking. Today, with fewer men smoking and with newer drug treatments available, men starting on ADT are likely to live longer; therefore, the risk of death from causes other than prostate cancer is higher. Second, the study in *Cancer* only followed the men for five years. Now many men on ADT live much longer than that. The study's conclusions may not reflect the long term CVD risks for men now starting on ADT.

Given the commonality of CVD we still need to be concerned about the risk of cardiovascular disease for men on ADT.

Both papers acknowledge that the data are not consistent across all studies and that more research is necessary to sort out the long-term impact of ADT on CVD. Both papers also recognize the serious risk of metabolic syndrome for men on ADT long term. Both note the importance of men making lifestyle adjustments to reduce the chances of developing metabolic syndrome, which can lead not only to CVD but also to diabetes. Both papers agree on that point.

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

Did Your Doctor Mention the Pros and Cons of an Orchiectomy?

May 18, 2021

Before there were drugs to suppress androgen levels, ADT was achieved by surgical removal of the testes. This is formally called an orchiectomy. Orchiectomies are now uncommon in the more affluent portions of the world, but they're still a standard treatment for androgen suppression in poor countries where many patients cannot afford the expensive ADT drugs.

It is often assumed by both patients and physicians that a surgical castration is more traumatic than getting the depot injections of the commonly used ADT agents. Interestingly though, two papers actually show the opposite. For patients who are going on ADT long-term, an orchiectomy is not only cost effective, but is associated with higher health-related quality of life compared to men on the depot injections (e.g., Lupron). A question, though, is: "How often are patients even told about the surgical option?"

There is a new study out of Iowa that asked two related questions of 68 men on standard ADT drugs:

1. Do you recall having a discussion with your physicians about surgical castration as an alternative to the drugs you are now taking?

2. Would you be interested in an orchiectomy, if the alternative was presented to you?

In terms of the first question, only a third of the patients recalled having any discussion about the option of an orchiectomy. However, 40% of those patients said that they would have been interested, if the option had been presented to them.

If you are a patient who is going to be on ADT long-term and your oncologist has not discussed with you the option of an orchiectomy, you might want to raise the question about what they see as the pros and cons of this option for androgen suppression.

To read the study abstract, see: https://pubmed.ncbi.nlm.nih.gov/33971188/

Serial Prostate Biopsies are Associated With an Increased Risk of Erectile Dysfunction in Men With Prostate Cancer on Active Surveillance

Purpose:

We determined whether serial prostate needle biopsies predispose men to erectile dysfunction and/or lower urinary tract symptoms over time.

Materials and Methods:

Men with prostate cancer on an active surveillance protocol were administered the 5-item Sexual Health Inventory for Men and International Prostate Symptom Score questionnaires on protocol entry, and at a cross-sectional point in 2008. All men had at least 1, 10 to 12-core prostate biopsy at protocol entry and yearly surveillance biopsies thereafter were recommended.

Results:

Of 333 men 231 returned the follow up questionnaires. Correlations were found between biopsy number and erectile dysfunction, with increasing biopsy number associated with a decrease in Sexual Health Inventory for Men score ($p = 0.04$) and a history of 3 or more biopsies associated with a greater decrease in Sexual Health Inventory for Men score than after 2 or fewer biopsies ($p = 0.02$). Multivariable analysis for biopsy number, age, prostate volume and prostate specific antigen showed that only biopsy number was associated with decreasing Sexual Health Inventory for Men score ($p = 0.02$). When men were stratified by baseline Sexual Health Inventory for Men, those without preexisting erectile dysfunction (Sexual Health Inventory for Men score 22 to 25) trended toward steeper decreases in Sexual Health Inventory for Men score after 3 or more biopsies ($p = 0.06$) than did men with baseline mild to moderate erectile dysfunction (Sexual Health Inventory for Men score 8 to 21). No correlation was found between biopsy number and International Prostate Symptom Score.

Conclusions:

Serial prostate biopsies appear to have an adverse effect on erectile function in men with prostate cancer on active surveillance but do not affect lower urinary tract symptoms.

Brady Urological Institute, The Johns Hopkins University, Baltimore, Maryland

https://www.auajournals.org/doi/10.1016/j.juro.2009.08.044

Reflections on 10 years on Active Surveillance for low-risk PCa

Source:
Howard Wolinsky
May 6, 2021
https://aspatients.org/blog/reflection-on-10-years-on-active-surveillance-for-low-risk-pca/

What a difference a decade makes. In 2010, 217,000 American men were diagnosed with prostate cancer. About half — 105,5000 — had low-risk cancer. Of the 105,500 with low-risk cancer, 90-94% then opted for treatment, primarily radical prostatectomies, putting themselves at risk for erectile dysfunction and urinary incontinence.
Only 6-10% opted for the then relatively new approach known as Active Surveillance (AS): careful monitoring of the prostate gland with blood tests for PSA levels and digital exams every six months and random biopsies annually.

There has been a great deal of change in the intervening years.

AS now considered standard of care.
AS now is considered the preferred "treatment" for men with low-risk cancer. Now, about 60% of men with Gleason 6 cancers opt for AS — a 10-fold increase in a decade. That represents amazing progress in slow-moving surgical practice for a slow-growing cancer. Nonetheless, there's still a long way to go.
And more than 90% of those with very low-risk cancer choose AS. This is a dramatic change in a short period in a conservative field such as surgery.
Annual biopsies should now be a thing of the past as urologists try to space out them to reduce infections and also reduce risks for nerve damage that can cause erectile dysfunction. Many recommend two- to four- or five-year intervals between biopsies.
Urologists are moving away from transrectal biopsies–or "transfecal" biopsies, as some wits call them– which carry risks for infections and even sepsis and require antibiotics. Transperineal biopsies through the skin of the 'taint are finally catching on.

Off the biopsy train?
Peter Carroll, MD, of UCSF, another pioneer in AS, has declared he wants to get out of the "biopsy business." Other urologists have told me the same thing. European experts speak about the differences in AS between countries and how incentives led American physicians to conduct so many radical prostatectomies.
A decade ago, mpMRIs were just starting to be used for targeted biopsies and to monitor known prostate cancer. There were no genomic tests yet. Now mpMRIs and genomic testing are routine.

Other changes coming for AS.
In the coming years, big changes are in store for men on AS. These include greater use of transperineal biopsies to avoid infection and reduce the use of antibiotics; the micro-ultrasound that could displace mpMRI; new, safe contrast agents replacing gadolinium used with mpMRI; maybe liquid biopsies to help avoid needle biopsies altogether; the potential use of PMSA (prostate-specific membrane antigen) to help light up tiny cancers, and likely the first vaccines to "cure" low-risk prostate cancer.
Research is underway on immunotherapy and also a med for low-risk prostate cancer.
Maybe in the years ahead, there'll be definitive word on diet, supplements, and exercise. Meanwhile, they don't hurt and may help.

That's a lot of change for sleepy Gleason 6 cancers. Active surveillance as we know it will not be the same.
The biggest change of all may be the offing as well. With a lot of research, editorials, and arm-twisting, Gleason 6 prostate cancer may be redefined as NOT CANCER! at all. This has happened previously with bladder and thyroid tumors and even with Gleason scores lower than 6 that once were considered cancerous.
There are leaders in the field planning a coup of sorts by working to reclassify Gleason 6 as a non-cancer or a pre-cancer.

Some men, especially those with a history of anxiety, find they can't coexist with cancer and opt for "definitive," aggressive treatments for an otherwise benign cancer. A redefinition of Gleason 6 could help them.

In the future, if Eggener and his group succeed, men who today are diagnosed with Gleason 6 may not be diagnosed at all and will just live their lives free of the cancer label.
What a difference a decade makes.

Howard Wolinsky is a co-founder of Active Surveillance Patients International (ASPI) and is a moderator for AnCan and UsToo Support Groups for Active Surveillance.

(This article has been edited for length and relevant content)

Combining 68Ga-PSMA-PET/CT-Directed and Elective Radiation Therapy Improves Outcome in Oligo-recurrent Prostate Cancer:

A Retrospective Multicentre Study

Source:
https://www.urotoday.com/recent-abstracts/urologic-oncology/prostate-cancer/129836-combining-68ga-psma-pet-ct-directed-and-elective-radiation-therapy-improves-outcome-in-oligorecurrent-prostate-cancer-a-retrospective-multicenter-study.html?cl=l(EMAIL_CAM

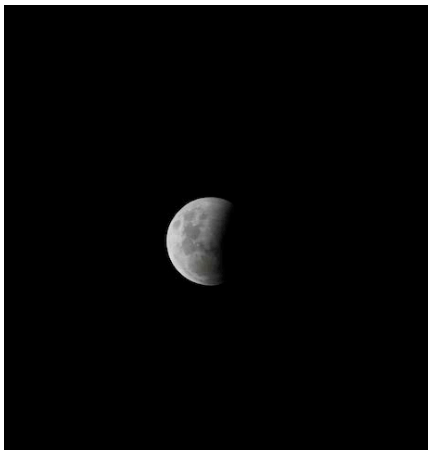
In case of oligo-recurrent prostate cancer (PC) following prostatectomy, 68Ga-PSMA-PET/CT can be used to detect a specific site of recurrence and to initiate metastasis-directed radiation therapy (MDT). However, large heterogeneities exist concerning doses, treatment fields and radiation techniques, with some studies reporting focal radiotherapy (RT) to PSMA-PET/CT positive lesions only and other studies using elective RT strategies. We aimed to compare oncological outcomes and toxicity between PET/CT-directed RT (PDRT) and PDRT plus elective RT (eRT; i.e. prostate bed, pelvic or paraaortal nodes) in a large retrospective multicenter study.

Data of 394 patients with oligo-recurrent 68Ga-PSMA-PET/CT-positive PC treated between 04/2013 and 01/2018 in six different academic institutions were evaluated. Primary endpoint was biochemical-recurrence-free survival (bRFS). bRFS was analyzed using Kaplan-Meier survival curves and log rank testing. Uni- and multivariate analyses were performed to determine influence of treatment parameters.

In 204 patients (51.8%) RT was directed only to lesions seen on 68Ga-PSMA-PET/CT (PDRT), 190 patients (48.2%) received PDRT plus eRT. PDRT plus eRT was associated with a significantly improved 3-year bRFS compared to PDRT alone (53 vs. 37%; p = 0.001) and remained an independent factor in multivariate analysis (p = 0.006, HR 0.29, 95% CI 0.12-0.68). This effect was more pronounced in the subgroup of patients who were treated with PDRT and elective prostate bed radiotherapy (ePBRT) with a 3-year bRFS of 61% versus 22% (p <0.001). Acute and late toxicity grade ≥3 was 0.8% and 3% after PDRT plus eRT versus no toxicity grade ≥3 after PDRT alone.

In this large cohort of patients with oligo-recurrent prostate cancer, elective irradiation of the pelvic lymphatics and the prostatic bed significantly improved bRFS when added to 68Ga-PSMA-PET/CT-guided focal radiotherapy. These findings need to be evaluated in a randomized controlled trial.

Like all treatment decisions, you have to weigh how you feel about the potential benefits against the potential risks. No one can do that for you.



Time pressure predicts decisional regret in men with localized prostate cancer:
data from a longitudinal multicentre

Source: https://www.urotoday.com/recent-abstracts/urologic-oncology/prostate-cancer/129801-time-pressure-predicts-decisional-regret-in-men-with-localized-prostate-cancer-data-from-a-longitudinal-multicenter-study.html?ct=r(EMAIL_CAMPAIGN_6_4_2021_10_2)&mc_cid=21

A substantial proportion of men with localized prostate cancer (lPCa) later regret their treatment decision. We aimed to identify factors contributing to decisional regret.

We conducted a longitudinal study, in which men with lPCa were surveyed at four measurement points: T0 (baseline) = prior to treatment; T1 = 6; T2 = 12; T3 = 18 months after baseline. χ2-tests and independent t-tests were used to compare men undergoing different treatments [Active Surveillance (AS) vs. local treatment]. Logistic regression models were fitted to investigate the associations between predictors (time pressure, information provided by the urologist, impairment of erectile functioning, satisfaction with sexual life) and the criterion decisional regret.

At baseline, the sample included N = 176 men (AS: n = 100; local treatment: n = 76). At T2 and T3, men after local therapies reported higher regret than men under AS. Decisional regret at T3 was predicted by time pressure at baseline (OR 2.28; CI 1.04-4.99; $p < 0.05$), erectile dysfunction at T2 and T3 (OR 3.40; CI 1.56-7.42; $p < 0.01$), and satisfaction with sexual life at T1-T3 (OR 0.44; CI 0.20-0.96; $p < 0.05$).

Time pressure, erectile dysfunction, and satisfaction with sexual life predict decisional regret in men with lPCa. Mitigating time pressure and realistic expectations concerning treatment side effects may help to prevent decisional regret in PCa survivors.

DRKS00009510; date of registration: 2015/10/28.

World journal of urology. 2021 May 22 [Epub ahead of print]

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

Cell mechanics research is making chemotherapy friendlier

Source:
The Henryk Niewodniczński Institute of Nuclear Physics Polish Academy of Sciences
https://ecancer.org/en/news/20368-cell-mechanics-research-is-making-chemotherapy-friendlier

Malignant tumour cells undergo mechanical deformation more easily than normal cells, allowing them to migrate throughout the body. The mechanical properties of prostate cancer cells treated with the most commonly used anti-cancer drugs have been investigated at the Institute of Nuclear Physics of the Polish Academy of Sciences in Cracow. According to the researchers, current drugs can be used more effectively and at lower doses.

In cancer, a key factor contributing to the formation of metastasis is the ability of the neoplastic cells to undergo mechanical deformation. At the Institute of Nuclear Physics of the Polish Academy of Sciences (IFJ PAN) in Cracow, research on the mechanical properties of cells has been conducted for a quarter of a century. The latest study, carried out in cooperation with the Department of Medical Biochemistry of the Jagiellonian University Medical College, concerned several drugs currently used in prostate cancer chemotherapy, and specifically their impact on the mechanical properties of cancer cells. The results are optimistic: everything indicates that the doses of some drugs can be reduced without the risk of reducing their effectiveness.

Chemotherapy is an extremely brutal attack not only on the patient's cancer cells but on all the cells in the body. By using it, doctors hope that the more sensitive tumour cells will die before the healthy ones begin to die. In this situation, it is crucial to know how to choose the optimal drug in a given case and how to determine its minimum dose, which on the one hand will guarantee the effectiveness of the treatment and on the other hand will minimize the adverse effects of the therapy.

As early as 1999, physicists from the IFJ PAN showed that cancer cells deform mechanically more easily. In practice, this fact means that they can squeeze through the narrow vessels of the circulatory and/or lymphatic systems with greater efficiency.

"The mechanical properties of a cell are determined by elements of its cytoskeleton such as the microtubules we examine, built of tubulin (a protein), actin filaments and intermediate filaments made of proteins such as keratin or vimentin," says Prof. Malgorzata Lekka from the Department of Biophysical Microstructures IFJ PAN and adds: "Biomechanical measurements of cells are carried out using an atomic force microscope. Depending on the needs, we can press the probe more or less onto the cell, and in this way we obtain a mechanical response coming from structures lying either at its surface, i.e. at the cell membrane, or deeper, even at the cell nucleus. However, in order to obtain information about the effects of a drug, we must evaluate what contribution each type of cytoskeleton fibre makes to the mechanical properties of the cell."

In the currently reported results, the Cracow-based physicists presented experiments using the commercially available DU145 human prostate cancer cell line. This line was chosen for its drug resistance. Undergoing long-term drug exposure, these cells become resistant to the drugs over time and not only do not die but even begin to divide.

"We focused on the effects of three commonly used drugs: vinflunine, colchicine and docetaxel. They all act on the microtubules, which is desirable since these fibres are essential for cell division. Docetaxel stabilizes the microtubules and therefore also increases the rigidity of the tumour cells and makes it difficult for them to migrate throughout the body. The other two drugs destabilize the microtubules, so cancer cells can migrate, but due to the disturbed functions of the cytoskeleton, they are unable to divide," says PhD student Andrzej Kubiak, the first author of the article published in the prestigious *Nanoscale*.

(continued page 13)

The researchers from Cracow analysed the viability and mechanical properties of cells 24, 48 and 72 hours after drug treatment, and it turned out that the greatest changes were observed three days after drug exposure. This allowed them to determine two concentrations of drugs: one higher, which destroyed cells, and one lower, at which although cells survived, their mechanical properties were found to be altered. For obvious reasons, what happened to the cells in the latter case was of particular interest. The precise interpretation of some of the results required several tools, such as a confocal microscope and flow cytometry. Their use was possible thanks to cooperation with the Institute of Pharmacology of the Polish Academy of Sciences in Cracow, the Department of Cell Biology at the Faculty of Biochemistry, Biophysics and Biotechnology of the Jagiellonian University and the University of Milan (Department of Physics, Universita degli Studi di Milano).

"It has been known for some time that when microtubules are damaged, some of their functions are taken over by actin filaments. The combination of measurements of the mechanical properties of cells with images from confocal and fluorescence microscopes allowed us to observe this effect. We were able to accurately determine the areas in the cell affected by a given drug and understand how its impact changes over time," emphasised PhD student Kubiak.

Practical conclusions can be drawn from the research of the Cracow physicists. For example, the effect of vinflunine is clearly visible in the nuclear region but is compensated by the actin filaments. As a result, the cell remains rigid enough to continue to multiply. On the other hand, 48 hours after the administration of the drug, the effects of docetaxel are most visible, mainly at the cell periphery. This fact also alerts us to the increased role of actin filaments and means that the therapy should be supported with a drug that acts on these filaments.

"Until now, there has been little research into the effectiveness of low concentrations of anti-cancer drugs. We show that the issue is really worth taking an interest in. For if we understand the mechanisms of action of individual drugs, we can maintain - and sometimes even increase - their current effectiveness while at the same time reducing the side effects of chemotherapy. In this way, chemotherapy can become more patient-friendly,

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

Trial Results

Good randomized trial of supervised intensive exercise for 12 weeks improves risks for BCR progression

From the ASCO2021 programs.

A phase II randomized controlled trial of exercise on biochemical progression in men with prostate cancer on active surveillance.

Background:

Men with prostate cancer (PCa) undergoing active surveillance (AS) are at increased risks of cardiovascular death and disease progression. Any intervention that can address these issues during AS would be highly beneficial. Clinical and preclinical studies have demonstrated the benefits of exercise to improve cardiovascular health in cancer patients and suggested the potential role of exercise in suppressing PCa progression in men with PCa undergoing AS. Therefore, the purpose of this study was to investigate the effects of exercise on cardiorespiratory fitness and biochemical progress of PCa in men with PCa on AS.

Methods:

The Exercise During Active Surveillance for Prostate Cancer (ERASE) Trial was a single-centre, two-armed, randomized controlled trial in Edmonton, Canada. 52 men with localized PCa who were undergoing AS were randomized to high-intensity interval training (HIIT; n = 26) or usual care (UC; n = 26). The HIIT group performed thrice-weekly, supervised, aerobic HIIT on a treadmill at 85-95% of peak cardiorespiratory fitness (VO2peak) for 12 weeks. The primary outcome was VO2peak, and the secondary and exploratory outcomes included biochemical progression of PCa (prostate-specific antigen [PSA]), PSA kinetics, and growth of prostate cancer cell line LNCaP.

Results:

46/52 participants (88%) completed the post intervention VO2peak assessment and adherence to HIIT was 96%. Compared to UC, HIIT significantly improved VO2peak (adjusted between-group mean difference, 1.6 ml·kg-1·min-1; 95% confidence interval [CI], 0.3 to 2.9; p= 0.014). HIIT also significantly reduced PSA level (adjusted between-group mean difference, -1.1 ug/L; 95% CI, -2.1 to 0.0; p= 0.043) and PSA velocity (p= 0.040), and suppressed LNCaP cell growth (p =0.024). No significant differences were found in PSA doubling time (p= 0.10) and testosterone (p= 0.24).

Conclusions:

The ERASE Trial is the first randomized controlled trial to demonstrate the impact of HIIT exercise for improving physical fitness and inhibiting biochemical progression of PCa in men with localized PCa on AS. Our findings suggest that supervised aerobic HIIT may be a promising intervention in this clinical setting. Larger-scale randomized controlled trials are warranted to determine if improvements in physical fitness and PCa-related markers translate into improved long-term clinical outcomes in these men such as disease progression, receipt of radical treatments, post treatment complications, and survival. Clinical trial information: NCT03203460

https://meetings.asco.org/abstracts-presentations/197824

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:

Tues 15 June 10:30am

Dr Natalie Heynsbergh,

Research Fellow, Deakin University School of Nursing and Midwifery, Faculty of Health

Dr Heynsbergh will be speaking at 10.30am about an online study Deakin are undertaking on the value of mindfulness in managing the anxieties associated with cancer treatments. Men living with local or locally advanced prostate cancer, or those under active surveillance (watch and wait), are eligible. The session will cover the scope and nature of the study and answer members' questions.

At our 18 May meeting, Angela Mellerick presented on the role of the Symptom and Urgent Review Clinic (SURC), a nurse led care service to support patients receiving cancer treatments (chemotherapy, immunotherapy, targeted therapy) in a day care environment. The service model comprises: telephone advice/triage; a physical setting for evaluation/advice/prescribing for patients experiencing adverse effects of treatment, and; patient education on the side effects of treatment and how best to manage them. Following an initial pilot at Western Health, SURCs have been established around metropolitan Melbourne at Western Health, Austin Health (Olivia Newton-John Cancer Wellness and Research Centre), Eastern Health, Monash Health (Dandenong) and Royal Children's Hospital, as well as a number of regional locations. Angela explained that the incidence of adverse events presenting to SURCs involving prostate cancer patients was materially above the average rate for all cancers, potentially driven by a higher incidence of treatments and toxicities of treatments (e.g. immunotherapy). Currently, the services are generally only available to patients receiving primary treatment at the hospital at which the SURC is based.

More details can be found here

https://www2.health.vic.gov.au/about/health-strategies/cancer-care/cancer-projects/symptom-urgent-review-clinic-initiative

Internet Resources

Members have found the following websites useful

Prostate Cancer Foundation of Australia for guides & help
https://www.pcfa.org.au
https://onlinecommunity.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/

A Touchy Subject
https://www.youtube.com/channel/UCdyuxGuAuCWJbe-kZvwVSzQ

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.

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PHCSG Correspondence

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

PHCSG Meetings 2021 10am – 12:30pm

Tues 16 Feb
Tues 16 March
Tues 20 April
Tues 18 May
Tues 15 June
Tues 20 July
Tues 17 August
Tues 21 September
Tues 19 October
Tues 16 November
Tues 14 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.

2021 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

January 2021

- Exercise Infographic
- Sexual Dysfunction & Shared Decision Making
- FDA Approves first Oral Hormone Therapy
- Prolonged ADT Reduces Cardio Fitness
- Reducing the Burden of Out-of-Pocket Expenses
- BAT Sensitizes CRPCa to Subsequent Therapy
- Targeting Bone Mets with Radiation in Oligorecurrent Men

Prostate Cancer Trials

- PEACE V:STORM
- UpFront PSMA Phase II
- NINJA

February 2021

- Advantages of Coffee
- Our Biological Clock
- Statins tied to Better Outcomes
- What's New in Inflammation
- New PC Management Techniques
- About the Patch Trial
- Eating a Colourful Diet
- Dose Painting
- Advancement in Focal Therapy

Prostate Cancer Trials

- Enza-P
- DASL-HiCaP Trial
- Lu-177-PSMA-617
- Adding Apalutamide to Radiotherapy & LHRH Agonist

March 2021

- Challenging Your Private Health Provider
- How Research is Prioritised – Norman Swan podcast
- Metastatic PCa – Don't Accept Complacency
- An mRNA Vaccine for Cancer
- Life After Treatment – Wellness Program
- Focal Therapy – If It Sounds Too Good to be True
- Immune Checkpoints on CTCs

April 2021

- Study finds cancer cells evade chemo by going dormant
- High Risk Localised PCa: Changing the rules
- Automated Pathological Assessment of PCa Biopsy Slides
- Final Results from TITAN Study
- SBRT for High Risk Patients
- Benefit of taking 1year of ADT after radiation for high risk PCa
- Novel Radiopharmaceutical beats Cabazitaxel in MCRPC
- Novatis announces phase III positive results
- Estrogen – Our Sister Hormone

Prostate Cancer Trials

- Enzalutamide With Lu PSMA-617 Versus Enzalutamide Alone
- Darolutamide Augments Standard Therapy for Localised Very High-Risk Cancer

May 2021

- Full on Kitchen Sink for High Risk Localized PCa
- Calcium & Vitamin D Supplements
- Favourable prognosis with adjuvant ADT after RT
- Healthy Lifestyle may offset Genetic Risk
- Additional Treatment Option
- New Type of Treatment could reawaken Immune Response
- Penile Rehabilitation
- Prostate Cancer Trial Results

June 2021

- Dry July
- Breakthrough in Disease resistance to drugs
- PyL PSMA Pet Imaging
- Does thel level of your Testosterone matter when on ADT?
- Stay Bone-Healthy
- ADT and the risk of Cariovascular Disease
- The Pros & Cons of Orchiectomy
- Risk of Serial Biopsies
- Reflections on 10 years on AS
- Improvements on Oligo-recurrent Therapies
- Time Pressure Decisions
- Research making Chemo Friendlier
- Trial Results on Exercise

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

December 2020
- ACTA Trial Award
- Rethinking Metastasis
- ESMO Phase 1 AMG160
- Five Ways to Get it Right
- Immunotherapy Offers Hope
- SBRT Doubles Pain Response
- Elevated Streess Hormone Levels

Prostate Cancer Trials