MEMBERSHIP

HALF YEAR PHCSG MEMBERSHIP $10

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

July 2021 Issue 208

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 via Zoom – Tues 20 July

10am – 12:30pm

To join via Zoom: Copy link and paste into your browser
https://us02web.zoom.us/j/84884154035?pwd=eWJ5VTZOYXYwZnNNRUtPbkw4a1FSQT09

Meeting ID: 848 8415 4035
Passcode: 281438

PHCSG July

Unfortunately our first face-to-face meeting (for 16 months) is again delayed, but we can still meet, via Zoom.

In June we had a talk from Natalie Heynsbergh on the MindOnLine project she is running at Deakin University. More information and how to register on page 15.

Our guest speakers this month are Prof Ray Chan & Dr Nicholas Hart talking about the MOSES Trial, which will implement and evaluate an integrated model of follow up care shared between six acute cancer care centres and more than 800 general practices across Queensland, South Australia and Victoria.

Don't forget, if you need an explanation of the Prostate Cancer terminology, we have posted a PCa glossary on our website. Any suggestions for improvements - please let us know.

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

• EX-MED CANCER IS A NOT-FOR-PROFIT ORGANISATION THAT DELIVERS BEST PRACTICE EXERCISE MEDICINE TO PEOPLE WITH CANCER

- Individualised, evidence-based, safe exercise prescription specific to people with cancer
- Open to all patients regardless of their treatment status or functional abilities
- Simple way to help patients adhere with evidence-based exercise guidelines
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- No wait list
- Supervised by oncology specialist exercise physiologists
- 5 locations across metro Melbourne (CBD, Coburg, Box Hill, Caulfield, Sunshine
- Telehealth & referral services for regional patients
- ~$30/week patient fee for supervised 4 month program including exercise clinic access (60% cheaper than industry standard rates; data from 300 patient survey suggests that 3 in 4 people would be willing to pay)
- Specific program details available at https://www.exmedcancer.org.au
- Results from 200 patient research evaluation include: ↑10-23% physical function; ↓21% fatigue; ↓10% distress, depression and anxiety symptoms; ↑7-14% quality of life; no serious adverse events; 8% of participants discontinued the program
- COVID safe procedures
- Referral resources available (flyers, posters, prescription pad)

More information available at the EX-MED Cancer website: https://www.exmedcancer.org.au

Please feel free to contact the EX-MED Cancer team if you have any question whatsoever:

Phone – 1300 396 332 | Mobile – 0421 943 875 | Email – exmedcancer@exmedcancer.org.au

Groundbreaking Early Cancer Detection Test Studied at Mayo Clinic Introduced Nationally

Colette Gallagher
4 June 2021
https://individualizedmedicineblog.mayoclinic.org/2021/06/04/groundbreaking-early-cancer-detection-test-studied-at-mayo-clinic-introduced-nationally/

Mayo Clinic recognizes the debut of a groundbreaking multi-cancer early cancer detection (MCED) test called Galleri™ that can detect more than 50 types of cancers through a simple blood draw. The Galleri test is intended to complement U.S. guideline-recommended cancer screenings. Mayo Clinic Oncologist Minetta Liu, M.D. was involved in the development of the new test.

"Today, many cancers are found too late, leading to poor outcomes," says Dr. Liu. "The ability to detect cancer early is critical to successful treatment."

Cancer is expected to become the leading cause of death in the U.S. this year. Currently recommended cancer screening tests only cover five cancer types and screen for a single cancer at a time. In fact, there are no recommended early detection screening tests for other cancers, which account for 71% of cancer deaths. Researchers used the Galleri test in the Circulating Cell-free Genome Atlas (CCGA) Study, a prospective, observational, longitudinal study designed to characterize the landscape of genomic cancer signals in the blood of people with and without cancer. In the study, the Galleri test demonstrated the ability to detect more than 50 types of cancers — over 45 of which have no recommended screening tests today — with a low false-positive rate of less than 1%.

According to Dr. Liu, when a cancer signal is detected, the Galleri test can identify where in the body the cancer is located with high accuracy — a critical component to help enable health care providers to direct diagnostic next steps and care.

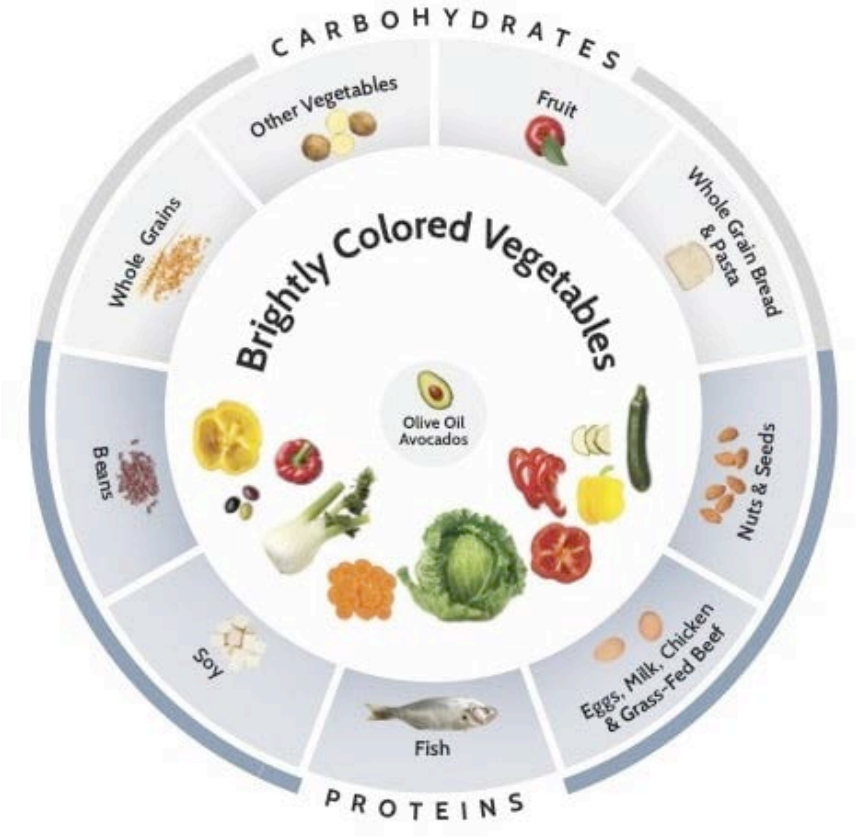
"We are grateful to Mayo Clinic for its dedication to advancing new technologies for early cancer detection and for playing a pivotal role in the development of Galleri," says Dr. Josh Ofman, chief medical officer and head of external affairs at GRAIL."A simple blood test capable of detecting more than 50 cancers is a ground-breaking advancement and could have a tremendous human and economic benefit."

Initial results from the interventional PATHFINDER Study, which involved the return of Galleri test results to providers to communicate to participants, were presented at the 2021 American Society of Clinical Oncology Annual Meeting. They demonstrate Galleri's performance in the clinical setting was consistent with findings from previous observational studies, underscoring the potential real-world ability of Galleri to find deadly cancers earlier. The Galleri test is for those at an elevated risk of cancer, such as adults age 50 or older and is available by prescription only.

Dr. Liu is the co-director of the Genomics in Action Program within the Mayo Clinic Center for Individualized Medicine, research chair of the Department of Oncology, and a consultant in the Department of Laboratory Medicine and Pathology. Dr. Liu conducts patient-oriented research focused on developing clinically relevant molecular markers to allow for the most accurate prediction of treatment benefit and patient outcomes in solid tumor malignancies. She also researches multi-cancer early cancer detection through blood assays and develops novel therapeutics to improve survival in early-stage and metastatic breast cancer.

What Should You Eat?

Source: https://www.pcf.org/blog/what-should-you-eat/



In [primary] school, you may have learned about the "five food groups," the "food pyramid" or how to divide up your plate. There are many choices and recommendations out there—both historical and new—and it can be overwhelming.

The best approach is one that is simple, sustainable, and science-based. Imagine the eating wheel below as a dart board. If you were to throw a dart, it would most likely land on.....vegetables. Brightly colored vegetables should form the core of your diet.

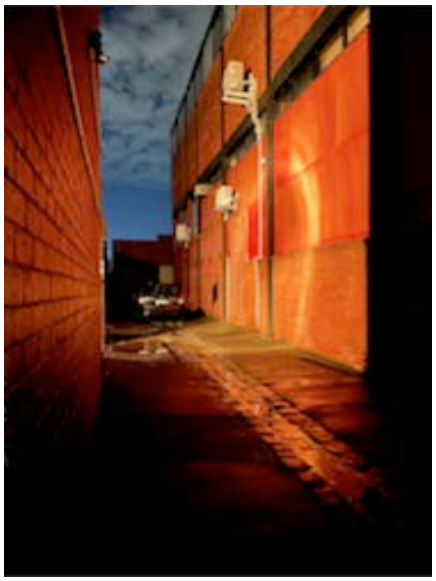
Why vegetables? All those bright colors come from natural compounds which help lower your risk of cancer at a cellular level. Another benefit of vegetables is their high fiber content. Fiber feeds the "good" bacteria naturally living in your gut. Eating a healthy mix of different plant-based foods can help foster the correct diversity of disease-fighting gut bacteria. For bacteria, food variety is the spice of life!

The foods around the rim of the wheel—from whole grains to fish—also contain important nutrients. Your body breaks down protein and carbohydrates to supply you with energy and the building blocks your cells need for growth and repair. Enjoy a small serving of whole grains (like brown rice) at each meal, and favor high-quality, plant-based proteins (like beans and soy). For most people, it's ok to pepper in some animal proteins, as long as they aren't the featured item on your plate.

The bull's eye represents healthy fats. If you're adding fat to your diet, focus on "good fats," including avocado and olive oil.

Healthy eating takes a bit of planning and preparation, but if time is tight some days, don't stress: a salad or side of roasted veggies when you're eating out counts, too.

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.



ADT: What You Really Need to Know

The only people who really like androgen deprivation therapy (also called ADT, or hormonal therapy) are the drug companies that make billions of dollars a year selling the drugs. Doctors don't like it, and men don't like being on these drugs.

So why do it?

There are very few specific situations when ADT therapy is the right thing to do. These are the most common:

* *Intermediate-risk men who are given six months of ADT plus external-beam radiation;*

* *High-risk men who are getting radiation therapy.* This is a finite course of ADT, and this combination – two or three years of ADT plus external-beam radiation – has been proven to cure cancer in many men.

* *Men with metastatic prostate cancer.* ADT can make a big difference in these men, in relieving their symptoms and dramatically improving their quality of life. It can also extend life – some men have been on ADT for 20 years and are still going strong.

Who should not get ADT? Anybody else with prostate cancer. If you just have a rising PSA after radiation therapy or radical prostatectomy, that is not a good enough reason for a doctor to put you on ADT. If your doctor wants to put you on ADT to "shrink your prostate" before brachytherapy, that's not a good enough reason.

ADT has never been shown to extend life if it's given too soon.

Why not just give it? At least it's

Andropause and the Treatment Nobody Talks About

Anrdogen Deprivation Therapy (ADT) causes andropause. It's like menopause, but it's the male version. Male hormones including testosterone are called androgens, and ADT basically shuts down all of those hormones. ADT has a of of side effects, including a higher risk of cognitive impairment, but the biggest elephant in the room is the fact that men on ADT lose their sex drive and ability to have an erection. This is not ED, where the desire is there but the performance is difficult. No, this is a total lack of libido. Women are very good at talking about the problems they're experiencing with treatment for breast cancer, including their own hormonal therapy. Men, not so much. "Men don't like to talk about a flaccid penis with another man," says medical oncologist Jonathan Simons, M.D., CEO of the Prostate Cancer Foundation. "Men just generally don't talk about hormonal therapy with each other. And doctors – we don't talk about it the right way. This is not an easy topic: 'We're going to extend the quantity of your life and try to keep up the quality of life, but we're going to take away your maleness.' That's not an easy conversation." Also, Simons adds: "Most men won't complain. We don't always know what they're going through." Another wrinkle in ADT: men can have vastly different responses. "Around three to four percent can be on hormonal therapy with advanced disease for 10 years and not progress. For the vast majority of men, the benefit in controlling their cancer is between three and 12 months, and then the disease no longer responds to the treatment, and we have to add something else." However – and this is a big however – some men are 'long-term exceptional responders to hormonal therapy." And are living for 20 years or longer with no apparent progression of their cancer. We don't know why this is. "We're not putting men on ADT just to make them miserable," says Simons. "We're doing it because the androgen receptor is a central part of what activates the 'on switch' for prostate cancer." That said, Simons, and the PCF, and many scientists around the world are working hard with the goal of not needing ADT anymore. Of finding another way to control or kill advanced cancer without needing to put men through these side effects. This is research the PCF* is actively funding, and this is something we should be talking about.

(continued page 5)

doing something, rather than sitting around waiting for the cancer to spread. Well, that sounds good. Please refer to the previous paragraph, and read the last sentence again. Now, if you have a rising PSA, there are other things you can do that may help a lot. These include:

- Salvage surgery or radiation, if your doctor thinks the cancer is still confined to the "prostate bed," the area around the prostate. (Note: In this case, if you get salvage radiation, your radiation oncologist may want to put you on a limited course of ADT, which is one of the two specific acceptable situations for ADT; see above.)
- Immunotherapy; a vaccine such as Provenge, designed to boost your body's ability to fight off the cancer.
- Early chemotherapy.
- A clinical trial testing a promising new drug.

Don't get us wrong; we're not hating on ADT. If you need it, you need it. But it's not just like taking a vitamin supplement or getting a flu shot. There are serious side effects with long-term ADT – things that testosterone normally helps protect you from – including thinning of bones, loss of muscle mass, weight gain, loss of libido, hot flashes, mood changes, depression and, our main subject here, the risk of cognitive impairment.

Before we get into that, let's take a brief detour into the metabolic syndrome.

"Metabolic syndrome" includes an unholy cluster of bad things that can lead to a heart attack or stroke. Elevated blood pressure; unhealthy levels of blood sugar, cholesterol, and triglycerides; and abdominal fat – a big jelly donut of visceral fat, also known as "heart attack fat," right around your belly, a cardiac spare tire. A big gut equals a bigger risk for diabetes, heart attack and stroke.

All of this is magnified with ADT.

Maybe you already have some of these risk factors; maybe you've already had a heart attack, or you've got diabetes. If you need ADT, you need it.

But hear these words: You will need to fight what it's doing to the rest of your body, even as it saves you from your prostate cancer.

You will need to get mad at it. Work hard to take back your life – work doubly hard, because not only will it try to turn you into a tub of butter, but you might get mildly depressed. Your brain will tell you that you're too tired to exercise. It's deceiving you. *You must not listen to it. Exercise anyway.*

Here's what you're up against: Normally, if a man wants to lose a pound, he needs to burn 3,500 calories. A man on ADT who wants to lose that same pound needs to burn 4,500 calories. He's slogging upstream with ankle weights. His metabolism is slower, his sugar metabolism is messed up, his blood pressure may be higher, and for many reasons, he probably feels like crap. Maybe he stops taking care of himself. *This is the worst thing he can do.*

You need to be aware of this, because it might not be on your doctor's radar.

Just as important, you need to enlist your family and friends, NOT ONLY to help push you to exercise and eat right – cut way down on the carbs and sugar, especially – but to tell you if you seem depressed, because depression might have snuck up on you, and you might not have noticed it.

All of these things can be fought. However, if you just go back to the urologist or oncologist for a 5-minute appointment and another Lupron shot, you are probably not getting the monitoring you need. Depression may not show up in a brief doctor's visit. Even if the scale shows that you've put on weight, your doctor might say, "Well, that's common with ADT."

Years ago, when doctors first started using ADT, men didn't live that long. Now, men are living for years or even decades on ADT, and if that stops working, there are other drugs that can help, and exciting new types of drugs showing amazing results for some men in clinical trials. This is very good news; however, the downside is that doctors might just think, "hey, it's great, he's still alive and his PSA is not moving up."

But we know that weight gain is not only a common side effect of ADT; it's bad. *It's also something you can help prevent*. You need to exercise, with cardio (walking, swimming, riding a bike, aerobics, jogging, etc.,) plus weights for strength. These can be light weights; you don't need to turn into Arnold Schwarzenegger and bench-press a Volkswagon Beetle or anything like that. You just need to keep your muscles working. Exercise will help with depression, with the cardiac risks, and with the risk to your brain. As University of Colorado radiation oncologist E. David Crawford, M.D., recently put it, "What's heart healthy is usually prostate-cancer healthy... I've got a number of (patients on ADT) who are in great shape and they're tolerating [treatment] quite well. These are the people who are out there, who continue to lift weights, they continue to exercise, they watch their diet."

The metabolic syndrome that ADT causes may be a major reason – nobody knows for certain yet – why some men who are on ADT have cognitive impairment.

*PCF – Prostate Cancer Foundation, USA

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

Anti-androgen therapy can fuel spread of bone tumours in advanced PCa

Source:
July 1, 2021
https://medicalxpress.com/news/2021-07-anti-androgen-therapy-fuel-bone-tumours.html

Anti-androgen therapy can fuel spread of bone tumours in advanced prostate cancer

- miniature 3D bone-like tissue models show effects of anti-androgens
- these models could be used by researchers to find more effective therapies
- the bone tumour model can be tested with patient-derived cells to find the best therapy for individual cases, saving time and harmful side-effects

Anti-androgen therapy is commonly used to treat patients with advanced prostate cancer at stages where the disease has spread to the bones. However, new research reveals that anti-androgen treatment can actually facilitate prostate cancer cells to adapt and grow in the bone tumour microenvironment model, which has been developed by QUT biomedical scientists led by Dr Nathalie Bock.

Dr Bock, under the mentorship of Distinguished Professor Dietmar Hutmacher, from QUT Centre for Biomedical Technologies, has focused her research on bone metastases from breast and prostate cancers.

She developed 3D miniature bone-like tissue models in which 3D printed biomimetic scaffolds are seeded with patient-derived bone cells and tumour cells to be used as clinical and preclinical drug testing tools.

The research team investigated their hypothesis that traditional anti-androgen therapy had limited effect in the microenvironment of prostate cancer bone tumours. The team's findings are published in Science Advances.

"We wanted to see if the therapy could be a contributor of cancer cells' adaptive responses that fuelled bone metastasis," Professor Hutmacher said.

"We developed an all-human, microtissue-engineered model of metastatic tissue using human bone-forming cells, prostate cancer cells and 3D printing."

Cancer biologist Distinguished Professor Judith Clements said the team bioengineered the microenvironment of a bone tumour to assess the effects of two clinically routinely used anti-androgen therapies – enzalutamide and bicalutamide - on the tumour cells.

"We found that the interactions between the cancer cells, the bone and the anti-androgens significantly impacted the progress of cancer in the mineralised microenvironment of bone tumours," Professor Clements said.

"This means that the efficacy of these therapies is compromised in the presence of the bone microenvironment."

Professor Hutmacher said an important outcome of the study was the need to upscale the bone tumour microenvironment model platform and make it available to other research groups.

"This would enable the prostate cancer research community to develop therapies for a more effective treatment of advanced prostate cancer."

In future, Dr Bock will use her model with patient-derived cells from patients undergoing prostatectomy, so that it could be used as a personalised preclinical diagnostic and drug testing tool.

"By screening existing and novel drugs using the bone tumour model in the laboratory, doctors will be able to treat individual patients with an anti-cancer therapy that can best suits their clinical need," Dr Bock said.

"This has the potential to considerably improve the quality of life of patients, because patients will not have to trial a succession of drugs, each of which carry the potential of severe side-effects, and which may not work for them."

This research was supported by the National Health & Medical Research Council of Australia, Australian Research Council and the Prostate Cancer Foundation of Australia.

Prostate Cancer Foundation of Australia CEO Professor Jeff Dunn AO said the findings were significant.

"This is an important discovery that will help us to better target treatments for men with different types of prostate cancer," he said.

"The findings also demonstrate the importance of ongoing research to improve our understanding of how different treatments impact disease progression and spread.

"Notably, Australia has one of the highest incidence rates of prostate cancer internationally, with 1 in every 6 Australian men likely to be diagnosed during their lifetime and around 17,000 men diagnosed each year.

"While survival rates for prostate cancer are high, with over 95% of men likely to survive at least five years, we must keep up the pace of work to find curative treatments, especially for advanced disease in the bone.

"There can be no doubt that this research will build on previous discoveries to help us save lives by stopping cancer from spreading and claiming the lives of more than 3,000 men a year, as is currently the case.

"We commend the research team and congratulate PCFA grant recipient Dr Nathalie Bock for her research achievements.

"This is Australian research excellence at its finest," he said.

The study, In vitro engineering of a bone metastases model allows us to study the effects of antiandrogen therapies in advanced prostate cancer, was published in Science Advances

Source: https://research.monash.edu/en/publications/overall-survival-of-men-with-metachronous-metastatic-hormone-sens

Professor Ian D Davis
Eastern Health Clinical School
Research

Overall Survival of Men with Metachronous MHSPC Treated with Enzalutamide and Androgen Deprivation Therapy - Beyond the Abstract

Evidence has been presented in the last seven years that has transformed the management of metastatic hormone-sensitive prostate cancer (mHSPC). The principles of management for about seven decades had fundamentally been around testosterone suppression. We now have clear data for the benefit of docetaxel (CHAARTED, STAMPEDE), abiraterone (LATITUDE, STAMPEDE), apalutamide (TITAN), and enzalutamide (ARCHES, ENZAMET).

All these approaches have been shown to improve survival substantially, but they have also provided new clues to previously undefined biology. The most obvious point is the stark difference in benefit when these agents are used in the mHSPC setting compared to patients with castrate-resistant prostate cancer (CRPC). There is something fundamentally different about how these agents work in cancers that have not yet experienced the selection pressure of testosterone suppression. Additionally, the pattern of disease is now known to be very important: for example, the benefits of adding docetaxel to testosterone suppression are mainly seen in patients with high burden of disease and who have so-called “de novo” metastatic disease, ie have synchronous metastases at the time of their initial diagnosis.[1] Patients who have previously had definitive treatment for their primary prostate cancer in the setting of no known metastases on conventional imaging (CT abdomen/pelvis and ^{99m}Tc bone scan), and who later develop metachronous metastatic disease (also as assessed by conventional imaging), have cancers that behave differently. Those patients often have lower burdens of disease, and treatment with testosterone suppression alone is associated with longer survival compared to those with de novo/synchronous metastatic prostate cancer at the time of diagnosis.

The reasons underlying this observation are not clear. It might at first be thought that it relates to patterns of clinical management: patients who have had prior definitive therapy might be watched more carefully, and have metastatic disease diagnosed earlier and at a lower volume than those whose unsuspected cancer has progressed until metastases become clinically evident. This idea does not hold up to scrutiny. For example, it does not align with the observation that patients with de novo low volume metastases by conventional imaging have a median overall survival of about 4.5 years, compared to about 8 years for those with metachronous relapsing mHSPC. Patients who develop mHSPC after prior definitive therapy are usually monitored and are hence more likely to be diagnosed by PSA relapse. They often commence testosterone suppression at that point even if conventional imaging is negative and, in that case, subsequent metastatic disease is in the setting of castration resistance. In contrast, widespread de facto PSA screening means that clinically silent prostate cancers are more likely to be found earlier than later, and be less likely to be metastatic by conventional imaging at time of first diagnosis. Timing of progression and response will likely shift due to lead time bias, particularly if novel imaging technologies such as ^{68}Ga-PSMA PET or similar are used, but otherwise, these cancers would be expected to behave similarly if the underlying biology is the same. Other as-yet-unknown factors must be contributing to the observed biological differences.

These observations have led to considerable controversy about which agent might be optimal for use for mHSPC. The benefits of the

(continued page 8)

addition of docetaxel to testosterone suppression are clear for patients with high burdens of metastatic disease, defined in various ways, but are inconsistent: the benefit of docetaxel treatment is lower for those with de novo/synchronous or low disease burden mHSPC, and there is little evidence of benefit for metachronous low volume mHSPC. Patients with metachronous high volume mHSPC derive benefits from docetaxel comparable to those with de novo high volume disease.[2] In contrast, the agents targeting androgen receptor signaling more directly (abiraterone, apalutamide, enzalutamide) all clearly show benefit in low burden mHSPC.[3-7] However, until recently there has been a gap in the evidence: can outcomes be improved specifically in the group of patients with metachronous low volume/low burden mHSPC?

Work from the TITAN[8] and ENZAMET[7] trials now gives insight into this question.[9] An unplanned subgroup analysis of ENZAMET data from its first interim analysis found 312 men with no metastatic disease documented at the time of original diagnosis, and metachronous mHSPC at the time of entry to ENZAMET. Most (205/312, 66%) had low-volume disease. The addition of enzalutamide to testosterone suppression gave a hazard ratio for death of 0.56 (95% CI: 0.29–1.06) for all men with metachronous metastases, and 0.40 (95% CI: 0.16–0.97) for those with low-volume metastases. This was reflected in the 3-year landmark analyses, with 3-year overall survival of 83% (95% CI: 0.74–0.89) and 89% (95% CI: 0.80– 0.94) for those with metachronous disease, and 83% (95% CI: 0.71–0.90) and 92% (95% CI: 0.82–0.96) for those low-volume disease. Only a small proportion (31/205, 15%) of these patients received concurrent docetaxel. In contrast, for those with metachronous high-volume disease, most (64, 60%) received docetaxel, and the benefit of additional enzalutamide was not evident at this analysis for this group or for the group of all patients with high volume metachronous disease.

The TITAN trial was similar in concept, although the experimental drug was apalutamide, and concurrent docetaxel was not administered. Nevertheless, similar patterns were seen for those with metachronous disease with a low and high volume combined, and a pooled analysis of data from both TITAN and ENZAMET showed HR 0.46 (95% CI 0.30–0.70) for these patients.

What does this mean for practice? Although these analyses were unplanned, they are consistent with previous observations and give more confidence that patients with metachronous low-volume mHSPC should be offered treatment additional to testosterone suppression, with the strongest evidence for benefit lying with either apalutamide or enzalutamide. It is possible this could also be true for abiraterone, another strategy to target AR more potently with evidence of benefit regardless of volume of disease, but these patients were either not included or accounted for <10% of participants in the respective studies.[3,4] Translational work and longer follow-up from these trials might shed light on the underlying mechanisms for these observed biological differences and might offer clues as to more reliable ways of selecting which patients should receive which treatment in addition to testosterone suppression. This will result in optimal use of these medications and can only improve patient outcomes. Details of the collaborative clinical and biological harmonization projects in localized and metastatic hormone-sensitive prostate cancer can be found at icecap.movember.com.

None of this information will benefit our patients if the evidence is not taken up into practice. Recent work from Australia showed a clear and rapid uptake of the use of docetaxel in mHSPC after the CHAARTED data were presented in 2014,[10] although almost 80% of men aged 70 or more did not receive it. It is now clear that men aged 70 or older who are able to receive docetaxel in this setting have benefits similar to those aged younger than 70.[11] Data presented at ASCO 2021[12,13] show that less than one-third of patients with mHSPC received treatment additional to testosterone suppression by 2018, with substantial disparities across racial classifications.

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.

Perhaps there is a view that patients with better prognoses, such as those with metachronous low volume mHSPC, do not require systemic treatment intensification. We now know that such a view is not supported by the available evidence. It is incumbent upon all of us to understand the data and to have conversations with our patients to ensure they are offered the best and most appropriate treatments.

New Guidelines for Salvage Radiation Dimensions

Source:
May 18, 2021
https://www.prostatecancer.news/2021/05/new-guidelines-for-salvage-radiation.html

It has always been troubling that only about half of all salvage radiation treatments after prostatectomy failure are successful. Usually, only the prostate bed is treated. But sometimes recurrent patients (or those with persistently elevated PSA) receive salvage radiation to the pelvic lymph nodes as well, or subsequently. Radiation oncologists usually follow RTOG (now called NRG Oncology) guidelines on what constitutes the dimensions of the prostate bed and the pelvic lymph nodes.

Prostate Bed Coverage

Often, the cancer has only penetrated into the bed or fossa. This is especially suspected if there are significant positive surgical margins. The 2010 RTOG consensus guidelines were updated in 2020 by the Francophone Group of Urological Radiotherapy (GFRU) based on standard imaging (MRI and CT). Harmon et al. reported on 45 patients within the LOCATE trial who received a positive Axumin PET/CT upon recurrence or persistent PSA after prostatectomy.

- 30 patients had cancer in the prostate fossa
- The 2010 RTOG guidelines completely or partially missed cancer in 33% of the patients
- The 2020 GFRU guidelines completely or partially missed cancer in 10% of the patients
- The new GFRU guidelines are clearly superior in terms of oncological outcomes, but toxicity must be considered as well.

Pelvic Lymph Node Coverage

In 2020, NRG Oncology revised its previous 2009 RTOG pelvic lymph node coverage consensus guidelines based on MRI and PET scans. They recommended coverage as high as the aortic bifurcation or common iliac lymph nodes (whichever is higher, depending on patient anatomy), which is about the level of the L4-L5 vertebrae. The expanded coverage area extends down to the pre-sacral nodes at the bottom of vertebra S3. Harmon et al. also validated the expanded NRG Oncology guidelines based on Axumin PET/CT scans. They found:

- There were 43 sites of cancer in the pelvic lymph nodes
- The 2009 RTOG guidelines completely or partially missed 32% of the nodal cancers
- The 2020 NRG Oncology guidelines completely or partially missed *none* of the nodal cancers

The SPPORT trial found that treating pelvic lymph nodes prophylactically improved outcomes, but wasn't necessary in patients with low PSA. This study did not examine the toxicity of the expanded coverage. The wider margins of the prostate bed will probably increase genitourinary toxicity. Careful contouring of the pelvic lymph node area to exclude bowel, bone, bladder, and muscle seems to prevent excess toxicity at the doses usually used (45-50.4 Gy). In one recent study of high-risk patients, a pelvic lymph node dose as high as 56 Gy was used without extra toxicity. Boosted site doses can also be utilized where PET/CT or MRI has identified specific tumors. However, treatment should not be delayed until such tumors become apparent on imaging.

Help for ED after Prostate Surgery: The Basics

Source:
By JANET FARRAR WORTHINGTON

https://www.pcf.org/c/help-for-ed-after-prostate-surgery-the-basics/

What's the secret to having a good sex life after prostate cancer? It's very simple, says Johns Hopkins urologist Trinity Bivalacqua, M.D., Ph.D. "You use prescription erection pills. If they don't work, you move to injectable medications. If they don't work, you get a penile prosthesis. Also, having a loving and understanding partner always helps." There's also the vacuum erection device (VED). It is not a first-line treatment for ED because there's a high drop-out rate, Bivalacqua says. However, *the VED can play a very important role in another aspect of surgical recovery: penile rehabilitation* (see below).

First, the pills: "When one of my patients leaves the hospital after a radical prostatectomy, he takes home a prescription for Viagra," says Bivalacqua. Does he take it every day, like a vitamin? No. Although some doctors prescribe the pills this way, it's not what physicians call an "evidence-based" practice; that is, the medical literature doesn't back it up conclusively. Instead, Bivalacqua tells his patients to take it *as needed*. "It is very difficult for me to tell a man that he should spend $600 a month to take a daily erection drug, because the evidence of a quicker return of erections is just not there." However, he adds, "taking a pill daily may provide a benefit, and a lot of prostate cancer patients want to take a proactive approach. If that's the case, then I encourage them to go ahead."

Taking a pill like Viagra can boost confidence as well as help with erections, but even so, the first try might be frustrating. "I tell men that it *often takes three or four attempts with Viagra to have a true response that will allow penetrative sex."* This doesn't usually occur within the first couple of months after surgery, "but usually men see the most meaningful recovery around 9 to 12 months after surgery," Bivalacqua notes. Just to recap here: Don't be discouraged if the first time after surgery is not that great.

And don't give up.

Hear these words: "The penis works. The blood supply to the penis is still good." So basically, it's like a car that is having trouble starting. What you may need is a jump-start to get it going. That doesn't mean you will always need this. Your body is going to continue to recover. It just means that at least right now, you might need a little help.

Now, here's a question Bivalacqua asks all of his patients a couple months after surgery, when they are healing and are no longer having any problems with urinary leakage. (Note: not every man has urine leakage after surgery, but some men do and it is usually temporary.) "How important is it to you to have penetrative sex?" If that is very important to the man and his partner, "then I ask how often he has tried Viagra over the last four weeks." If the man has tried it multiple times with no success, "I recommend that he start injection therapy immediately."
Remember, the penis works. "By injecting a medication will increase the blood flow to that area, the man has a very good chance to restore erections and get that important part of his and his partner's life back."

Injection therapy? You mean, sticking a needle in the penis? Well, yes. But it's

(continued page 11)

a tiny needle, and your doctor won't just hand it to you and say, "Good luck, buddy." You will be taught how to use it. "Injection therapy allows a man to have sexual intercourse again," says Bivalacqua. Very important: "We know that the more blood flow there is throughout the penis following a nerve-sparing radical prostatectomy, either with a pill like Viagra or with an injection of a pharmacological agent, the better the chances of regaining erections."

Bivalacqua explains: "If you don't have enough blood flow within the penis after surgery, it becomes ischemic; it does not get the nutrients it needs to stay healthy."

Let's take a moment to think about rehabilitation – say, after a bad injury. Maybe a man needs to learn to walk again, or use his hands, or how to talk again. If that guy just sits around and *hopes it will happen and gets frustrated when it doesn't*, you may agree that he's not taking the approach most likely to guarantee success. To put it bluntly, your penis needs rehab, too: "By increasing the flow of oxygenated blood to the penis, whether it is from a pill or an injection, we are able to preserve the erectile bodies (called the corpora cavernosa; these are chambers where blood flows to provide a rigid erection), so they will respond once those nerves start to work again."

How injection therapy works: As its name suggests, Tri-mix is actually three drugs (papaverine, phentolamine, and prostaglandin E-1). "The specific formulation of these drugs is based on the type of erection achieved with test dosages in the doctor's office," says Bivalacqua. "We teach the patient how to self-inject," and understandably, this may take some getting used to. "The medication is shot into the base of the penis with a small hypodermic syringe," and it works pretty quickly – within five to 20 minutes. What happens is that the Tri-mix causes the smooth muscle tissue in the penis to relax; it also dilates the main arteries and allows blood to fill the penis. "The erection can last between 30 and 90 minutes, and it becomes more rigid with sexual stimulation." However, it may not always disappear right away after orgasm. (Note: *After prostatectomy, there is no ejaculation, because the organs that contribute fluid for semen are gone*.)

How well does it work? Pretty well; the success rate is between 70 and 80 percent. However, the main cause of failure is poor blood flow to the penis, Bivalacqua says. "Sometimes, although the shot produces an initial erection, it doesn't last because the veins in the penis are damaged," because of heart disease, diabetes, or other health problems, in addition to the surgery.

Each shot costs about $7, and even though it works, about half of men abandon it within a year. Bivalacqua speculates that one reason is that these men didn't get good or detailed enough instruction for them to feel confident injecting themselves. Also, it may take two or three visits for an experienced urologist to determine the optimum combination and dosage of the medication.

The Vacuum Erection Device (VED) and penis-stretching: *One fact about the penis: It needs activity.* The nerves in those neurovascular bundles are also responsible for nighttime erections (in your sleep), and those "are responsible for penile health and strength." Think of tiny push-ups happening in your sleep. After surgery – temporarily if one or both nerve bundles (the nerves to the penis) are spared – these erections don't happen. If these bundles are damaged or removed during surgery, scar tissue can develop. When any part of the body is injured, a scar forms. This is because as it heals, tissue gets fibrosis (it hardens; this is the more rigid tissue that makes up a scar). There is extra collagen in there, and this contracts over time. This contraction can shrink the penis by as much as half an inch. Now, before you say, "That's it! I'd rather have the cancer!" or make any hasty decisions, please read this next sentence: "The good news is that there is a way to prevent the loss of length in the penis: using a vacuum erection device," Bivalacqua says.

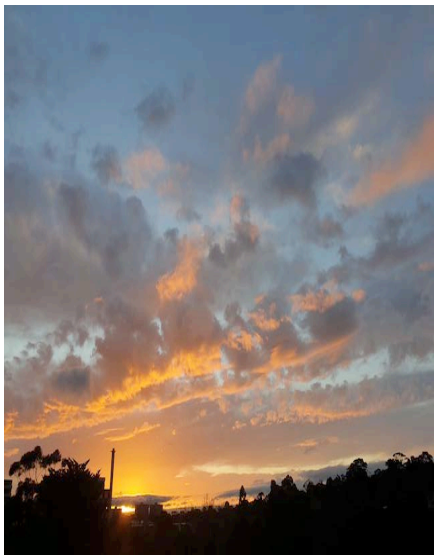
Please note this important point: We're focusing on stretching, not shrinking.

Briefly, the VED is what you might suspect; an actual vacuum. The device costs between $200 and $500, and is available from the pharmacy with a prescription. You place a clear plastic cylinder over the penis, and use either a manual or electrical pump to create negative air pressure (a vacuum). It takes about two minutes to achieve an erection; then you slip a flexible tension ring from the bottom of the cylinder around the base of the penis. This keeps the blood from flowing back out. "No matter what is specifically causing the erection, the vacuum causes the vessels in the penis to fill with blood, just as they would during a normal erection." There's a downside, though: "The big complaint of all men using the VED is that the penis becomes cold and semi-rigid, and this makes intercourse difficult."

Granted, it may not be the best way for you to have sex. However, you may want to think of it more in the *category of an exercise bike*: It can help you get back in shape. A study from the Cleveland Clinic evaluated the early use of a VED after radical prostatectomy. There were 109 men in the study. "One group of 74 men used the VED at least twice a week, starting one month after surgery, for a total of nine months," says Bivalacqua. "The second group of 35 men did not receive any erection treatment." The study's investigators found that "only about 23 percent of men who used the VED properly complained of decreased length and girth of the penis, compared with 85 percent in the group who did not use it as directed, twice weekly. And 63 percent of the men in the control group – who didn't use a VED at all – reported a decrease in the length and girth of the penis. To sum up: *"What the VED does is stretch the penis. It is this stretching that will prevent the penis from contracting, or shrinking, after surgery."*

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

Germline Testing



Source: https://www1.racgp.org.au/ajgp/2020/april/advances-in-prostate-cancer

There is growing interest in genetic testing for risk stratification and treatment selection in prostate cancer. Patients who harbour germline defects in genes involved in the repair of DNA damage (such as *BRCA2*) are at an increased risk of developing certain cancers, including prostate cancer, when compared with patients without defects. Accumulating data indicate that such mutations are more commonly seen in patients with metastatic disease, suggesting that testing may be useful to determine the risk of progression early in the disease course. For example, patients with germline *BRCA2* with low-risk prostate cancer may be unsuitable for active surveillance because of a risk of high rates of DNA damage accumulation leading to rapid clinical progression. Patients with these defects also respond better than those without defects to certain systemic therapies such as PARP inhibitors (eg olaparib), which show promise but have yet to be approved.

Genetic testing is not yet a part of routine prostate cancer care in Australia, and although several commercially available genetic biomarkers exist, their routine use in clinical practice is not supported by urological guidelines. As yet, there is no consensus regarding who should be tested and when testing should be offered. Some suggest consideration of genetic testing in those with prostate cancer diagnosed under the age of 65 years, or patients with relevant family history such as cancers related to hereditary breast and ovarian cancer syndrome or Lynch syndrome (hereditary non-polyposis colorectal cancer).

Identification of germline mutations has significant implications for the families of patients, as this DNA is passed on to children. Referral to a genetic counsellor for assessment, and to provide patients with information to determine if testing is right for them and their families, is important. Patients should be aware that testing may have insurance implications, highlight the risk of other cancers (that the patient may not anticipate) and identify variants of unknown significance that require ongoing follow-up in case they are revealed to be important at a later date.

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.

PCa Clinical Trials

ENZA-p

Enzalutamide is a potent hormone therapy that prevents testosterone from reaching prostate cancer cells, thereby stopping cancer growth. It is already widely used in men with prostate cancer that has stopped responding to standard hormone treatments (castration-resistant prostate cancer). However, most cancers become resistant to enzalutamide over time, with almost 1 in 4 being resistant from the start of treatment.

Lutetium-177 PSMA (Lu-PSMA for short) is a new treatment in advanced prostate cancer. Lu-PSMA is a radioactive molecule that attaches to the surface of prostate cancer cells throughout the body. This drug is given as an injection through the vein and allows targeted radiation to be delivered directly to prostate cancer cells.

The ENZA-p clinical trial aims to compare the effectiveness of enzalutamide in combination with Lu-PSMA, versus enzalutamide alone for the treatment of prostate cancer. This is a randomised study, so half the men in this trial will be randomly allocated to receive Lu-PSMA and enzalutamide, and the other half will be randomly allocated to receive enzalutamide alone. We plan to enroll 160 participants across Australia.

All trials are current and recruiting. For further information visit:

https://www.anzup.org.au/content.aspx?page=prostatecancertrialdetails

DASL-HiCaP Trial

The purpose of this study is to see if a new tablet drug, darolutamide, combined with the current best treatments, can improve outcomes for men with high risk prostate cancer that has not spread beyond the prostate area. Previous studies have shown promising results for darolutamide preventing disease progression and improving survival for men with advanced prostate cancer. This is a randomised controlled trial, which means that, in addition to best standard treatments, half the participants on the study will receive darolutamide, and the other half will receive placebo. The trial is being led from Australia by ANZUP in collaboration with the NHMRC Clinical Trials Centre. We plan to enrol 1,100 men from Australia, New Zealand, Canada, the US, Ireland, and the UK.

NINJA Trial

The NINJA clinical trial aims to compare two emerging schedules of radiotherapy in the treatment of intermediate or high risk prostate cancer. Participants will be randomly assigned to one of two radiotherapy schedules as part of this study. In schedule 1 (called Stereotactic Body Radiotherapy) participants will receive 5 radiotherapy treatments over 2 weeks, and in schedule 2, (called Virtual High Dose Rate Boost), participants will receive Stereotactic Body Radiotherapy delivered in 2 treatments over 1 week followed by 12 treatments of conventional external beam radiotherapy over 2 and a half weeks. It is hoped this research will potentially improve the accuracy and quality of radiotherapy treatment in prostate cancer.

UpFrontPSMA Trial

Most prostate cancer cells have a molecule on their surface called prostate cancer specific membrane antigen (PSMA). PSMA can be targeted with Lutetium-177 PSMA (Lu-PSMA), a radioactive drug that kills prostate cancer cells anywhere in the body. This investigational drug is not approved for use in Australia by the Federal Government's Therapeutic Goods Administration (TGA). It is a new form of treatment that is effective in some patients with metastatic prostate cancer. It is a radioactive substance that, after injection into a vein, attaches to prostate specific membrane antigen (PSMA). The treatment enables delivery of highly targeted radiation to cancer cells. The emitted radiation only travels about 1mm, which means it mainly causes the killing of cancer cells, while avoiding healthy cells, and seems to be well tolerated with few side effects. This is called radionuclide therapy or theranostic therapy.

The purpose of this randomised controlled clinical trial is to compare the effectiveness of Lu-PSMA therapy followed by docetaxel chemotherapy versus docetaxel chemotherapy on its own. Previous clinical trials have shown promising activity of Lu-PSMA in treatment of patients with metastatic prostate cancer.

Docetaxel is a chemotherapy drug that is approved by the TGA to treat prostate cancer and has been used for many years in the treatment of metastatic prostate cancer.

Since Lu-PSMA radiotherapy and docetaxel chemotherapy are both effective in treating metastatic prostate cancer, it is possible that using Lu-PSMA in addition to standard docetaxel chemotherapy at the beginning of the treatment course may improve patient outcomes when compared to treatment with docetaxel alone. A recent phase 2 clinical trial, showed the effectiveness of Lu-PSMA when used as a last treatment option and helped control disease progression. This study brings the use of Lu-PSMA forward as a first option to patients, with the hope of disease eradication and potential cure.

Prostate Heidelberg Cancer Support Group Meetings

Face to face & via Zoom

Guest Speakers:

Tues 20 July 10:30am

Professor Ray Chan
Professor in Cancer Nursing Faculty of Health
School of Nursing Queensland University of Technology

Dr Nicolas Hart
Senior Research Fellow in Cancer Survivorship Faculty of Health, School of Nursing

The Cancer Survivorship program focuses on improving patient outcomes from the time of their diagnosis and for the rest of their life. The research programs focus on developing and evaluating health innovations delivered by high-quality, sustainable health services that promote the best outcomes for patients.

Professor in Cancer Nursing, Ray Chan from the QUT Cancer and Palliative Care Outcomes Centre will lead a four-year $1.62 million MOSES Trial, a shared-care Model for prostate cancer Survivors.

About 890 men will participate in the MOSES Trial, which will implement and evaluate an integrated model of follow-up care shared between six acute cancer care centres and more than 800 general practices across Queensland, South Australia and Victoria.

Study Results

Patterns of care for men with prostate cancer: The 45 and Up Study

Summary: This analysis of data from the Australian 45 and Up Study sought to describe patterns of care in NSW for 4003 men with prostate cancer first diagnosed during 2006-13 and factors associated with receiving different treatments. Overall, 1619 (40%) patients received radical prostatectomy, 893 (22%) received external beam radiotherapy (EBRT), 373 (9%) ADT alone, 183 (5%) brachytherapy, 87 (2%) chemotherapy, and 848 (21%) received no treatment. Among those receiving radical prostatectomies, 205 (13%) received radiation oncology consultations prior to surgery. Radical prostatectomy was more common in those aged 45-59 years, with regional stage disease, living ≥100 km from the nearest radiotherapy centre, with partners, or with private health insurance. Radical prostatectomy was less common in those with lower physical functioning, obesity, and living in socio-economically disadvantaged areas. EBRT was more common in those aged 70-79 years, with non-localised or unknown stage disease, living <100 km from the nearest radiotherapy centre, or without private health insurance. EBRT was less common in those aged 45-59 years or >80 years or with several comorbid conditions.
Comment: The treatment landscape of clinically localised prostate cancer has shifted signifcantly in the last decade and a half, with Prostate Cancer Outcomes Registry data demonstrating increasing utilisation of active surveillance in low- and favourable intermediate-risk disease, a signifcant increase in radical prostatectomy associated with the introduction of robot-assisted laparoscopy, and a slow decline in the use of low-dose-rate brachytherapy. This large prospective cohort study from NSW essentially mirrors these findings, with 60% of men eligible for curative management being treated with surgery. Men who had surgery were more likely to be younger and fitter and have private health insurance compared to those treated with radiotherapy. Interestingly only 13% of patients who underwent prostatectomy had a radiation oncology consultation prior to surgery, which seems quite low given oncological equiva lence for the majority of patients.

Reference: Med J Aust. 2021;214(6):271-278 Yap ML et al.

https://onlinelibrary.wiley.com/doi/10.5694/mja2.50966

MindOnLine

Men living with prostate cancer have described many benefits from mindfulness, including a reduction in symptoms of anxiety and depression and worries associated with cancer returning.

We have developed an online mindfulness program (MindOnLine) and would like to test if it can help people with prostate, breast or colorectal cancer.

Men living with local or locally advanced prostate cancer, or those under active surveillance* or watch and wait* are eligible.

The project is a 9-week online mindfulness program for men living with prostate cancer and we would appreciate your help reaching men in your support groups.

We will ask you to complete surveys at the beginning of the study, around 9 weeks later and again 6 months later.

People in the control group will be able to access MindOnLine after they complete the last survey.

For more information or to register please visit https://mindonline.org.au

or contact Natalie Heynsbergh Tel: (03) 9246 8225, Mobile: 0419 263 117 or Email n.heynsbergh@deakin.edu.au

This project is being conducted by Deakin University in association with Peter Mac; Barwon Health; Epworth; Western Health; Smiling Mind; PCFA; Breast Cancer Network Australia; Vic Gov.

An interactive webinar with experienced health professionals to help people affected by cancer

Living with Cancer is a webinar series for cancer patients, their family and friends.

You may find that you see the world differently after a cancer diagnosis. Perhaps you feel that others don't understand your experience and expect you to 'get back to normal'.

Cancer and its treatment can bring a host of practical challenges, from changes in appearance and body function to managing the emotional and social impacts.

Living with Cancer webinar series is a free community education program. This two hour webinar includes practical information and open discussion for people who are undergoing active cancer treatment, carers, family, friends and work colleagues. As a participant, you will learn about the possible changes, challenges and opportunities you may face during cancer treatment.

You will also have the opportunity to connect with others on a similar journey, and share tips, ideas and activities to help you live your life well.

Free Webinar Mon 30 Aug 2021 10:00am – 12:00pm

- Cancer & Treatment Presentation
- Emotions and communication
- Nutrition and Tretment

Followed by a live Q&A session with the presenters

Hosted by WCMICS & Cancer Council Victoria

https://www.eventbrite.com.au/e/living-with-cancer-a-webinar-for-people-affected-by-cancer-tickets-16071325065

Watchful Waiting or Active Surveillance?

A member last month noted that the terms Active Surveillance & Watchful Waiting are often, mistakenly, used interchangeably.

So, let's clear up the definitions.

The terms Active Surveillance & Watchful Waiting mean something slightly different.

Because prostate cancer often grows very slowly, some men, especially those with other serious health problems, may benefit from Watchful Waiting to avoid the many treatment and surveillance-related risks, problems and side effects. Doctors will rely on changes to symptoms to decide if treatment is needed to control those symptoms - but not cure it.

Watchful Waiting is best used for men with prostate cancer who do not want or cannot have treatment therapies, especially those men with other life-threatening medical conditions.

Active Surveillance is usually used for men with small, low-risk tumours without symptoms, to closely monitor the cancer with routine PSA tests, DREs, biopsies and imaging to determine if the cancer is growing or getting more aggressive. It is also good for men who are at a higher risk from surgery or radiation or who prefer to avoid possible sexual, urinary or bowel side effects from treatments for as long as possible.

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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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

July 2021
- Ground Breaking Early Cancer Detection
- What Should You Eat
- ADT What You Really Need to Know
- Anti Androgen Therapy
- Overall Survival with Metachronous MHSPC
- New Guidelines for Salvage Radiation
- Help for ED after RP
- Germline Testing

Prostate Cancer Trials
- Enz-P; DASL HiCaP; NINJA; Upfront PSMA
- 45 & Up Study Results

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