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

August 2021 Issue 209

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 17 August
10am – 12:30pm

To join via Zoom: Copy link and paste into your browser
https://us02web.zoom.us/j/87929234771?pwd=RlhTV3JrSWh1WkY2ME1RYUVhZFF0QT09

Meeting ID: 879 2923 4771
Passcode: 157807

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

PHCSG August

We had a record Zoom turnout for our guest speaker in July, Prof Ray Chan - see page 13 for more about his study. This month we welcome Ben Shemesh who will tell us about the development of the BroSupPORT portal.

I'd also like to hightlight promotions for two PHCSG members. David Campbell is raising funds for the PCFA by joining the Outback Rally in November and Michael Meszaros has an exhibition celebrating 50 years as a sculptor at Hawthorn Town Hall until 25 September. Let's hope Covid doesn't close these events down.

In this month's newsletter we highlight:

- 2 PCFA Outback Rally Fundraising / 50 Years a Sculptor
- 3 Free Webinar 30 Aug / Take Responsibility
- 4/5 What is the Role of Modern Imaging?
- 6 Reducing the Cost of Cancer
- 7/8 Observation vs SBRT for Oligometastatic PC
- 9 Combined High-dose Salvage RT & HT in Oligorecurrent Pelvic Node PCa
- 10 Long Term Urinary & Erectile Function following RP
- 11 Bone Resorption Inhibitors
- 12/13 Radiotherapy After RP
- 14 Trials / MOSES Study / Guest Speakers

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

Please support our Intrepid Outback PHCSG Adventurer David Campbell who will be embarking on this drive to raise money and awareness for Prostate Cancer.

David's Message:

"A diagnosis of metastatic prostate cancer seemed like a death sentence! I don't think you ever really accept it, but with support I realized I could have a quality of life… a different life!

To support [the PCFA event] I am working on my 1992 Landcruiser and 2004 youngest son to join me on this rally to raise funds today to save men's lives tomorrow.

Every dollar you donate will be a game-changer for 1 in 6 men and their families threatened with prostate cancer, boosting life-saving prostate cancer research and support provided by PCFA."

If you would like to make a donation please visit
https://fundraise.pcfa.org.au/fundraisers/davidcampbell

All monies raised by you go directly to the Prostate Cancer Foundation of Australia using funraisin
All donations over $2 tax deductible and go directly to the Prostate Cancer Foundation – no expenses are deducted from these donations, 100% of all donations go to assist with prostate cancer research.

Fifty Years as a Sculptor by Michael Meszaros

This exhibition celebrates local Boroondara sculptor Michael Meszaros' 50-year career as a full-time, self-supporting artist. Meszaros has produced a number of well-known public works throughout Melbourne, Australia and internationally. Working primarily in bronze, fabricated copper and stainless steel, his work includes portraits, relief sculptures, exhibition sculptures and his particular speciality, medals.

The origin of the modern art medal can be traced back to the coins of Ancient Greece, with symbolic designs representing cities and rulers. Today, medal as art is less restrictive, allowing for irregular shapes and a variety of materials and subject matter.

View a collection of Meszaros' commissioned medals created for prizes, awards, centenaries, and unveilings; as well as more personal works and portraits created for both private and institutional clients. Meszaros' medals have won a number of international awards, and he has received a range of local prizes for his sculptural works.

'50 years as a Sculptor' is on display at Hawthorn Town Hall Gallery from Tuesday 3 August until Saturday 25 September 2021.

Many of the artworks in this exhibition are for sale. You can purchase a selection of the artworks from our online shop: https://www.shop.boroondara.vic.gov.au/

BOROONDARA

AUG 30 10AM

LIVING WITH CANCER WEBINAR

for patients & carers

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

Addendum

The article titled *'Overall Survival of Men with Metachronous MHSPC Treated with Enzalutamide and Androgen Deprivation Therapy – Beyond the Abstract'* on page 7 of the July PHCSG Newsletter omitted to credit Professor Ian Davis. We apologise for the oversight.

Prof Ian Davis MB BS PhD FRACP FAChPM is a medical oncologist and Professor of Medicine & Head of the Easter Health clinical School, Monash University and Easter Health, in Melbourne. He is an NHMRC Practitioner Fellow.

He holds honorary appointments with the Olivia Newton-John Cancer Research Institute and Austin Health, is an Associate Professor of the University of Melbourne, and Associate of the University of Sydney.

His primary clinical interests are in urologic cancers and his primary research interests are in cancer immunology and biology of urologic cancers.

Take Responsibility!

Nobody Cares More About Your Health Than You

- Research and study the literature on your condition to assess your options so that you can participate in conversations with your doctor. The PCFA and PCF (USA) have helpful online literature.
- Interview at least two doctors – or more – until you find someone who listens to you and understands your concerns
- Take written questions to appointments with a copy for your doctor to ensure all your concerns are answered
- Take notes
- Ask somebody to accompany you to appointments to listen to the conversation. Debrief afterwards
- Follow-up with an email for anything that needs clarification
- Ensure that you put forward your preferences/point of view. You cannot expect your doctor to read your mind or know what is important to you.
- Always get copies of your test results. You can download and email a *Melbourne Path* form or take it with you to your PSA appointment. *Dorovitch* send your results to *My Health Record*.
- Always use the same lab for your PSA tests and don't do any vigorous exercise on or the day prior to your test as it may give a false (raised) reading. Some men have a routine using the same lab at the same time of day after eating the same meals.
- Take advantage of the PCa nurses who are there to help. (However you are only likely to find their services in the Public Hospital System).
- For support, phone a PCFA tele-nurse on 1800 22 00 99 or visit pcfa.org.au. You can also request a call back by registering at pcfa.org.au/telenursing-request-form
- Use your support group

De Novo vs Recurrent Metastatic mHSPC: What is the Role of Modern Imaging?

Source:
EAU 2021

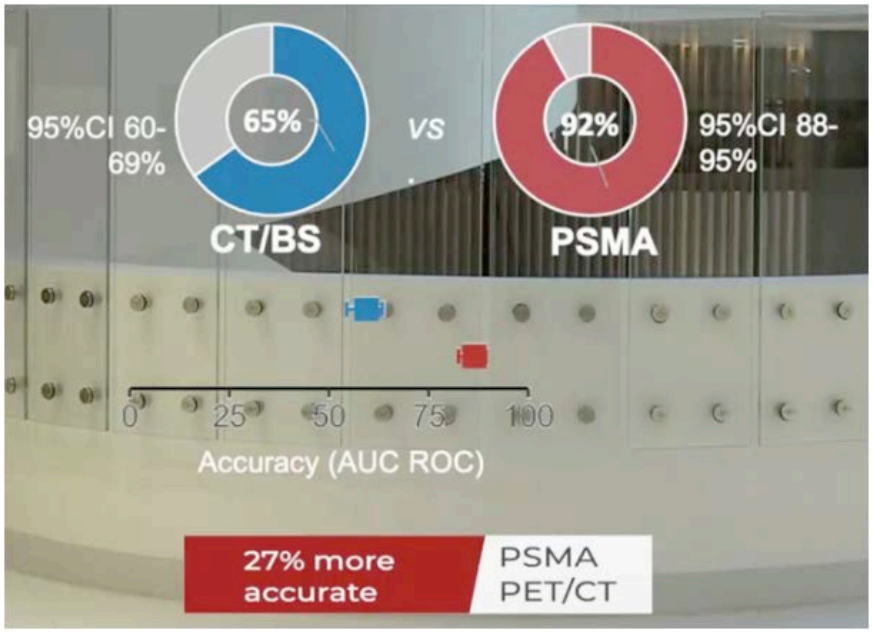
https://www.urotoday.com/conference-highlights/eau-2021/eau-2021-prostate-cancer/130757-eau-2021-state-of-the-art-lecture-de-novo-versus-recurrent-metastatic-mhspc-what-is-the-role-of-modern-imaging

(UroToday.com) At the European Association of Urology (EAU) 2021 Annual Meeting's plenary session on the treatment for metastatic hormone-sensitive prostate cancer, Dr Declan Murphy presented a state of the art lecture on the role of modern imaging for de novo versus recurrent metastatic hormone-sensitive prostate cancer (mHSPC).

Dr. Murphy started his presentation noting that conventional navigation would be akin to using the London A to Z atlas to map a route across London, whereas the novel navigation is akin to using Google maps on your smartphone to direct your journey. Similarly, bone scan and CT scan for staging are traditionally referred to as conventional imaging, while PSMA PET/CT is the latest novel imaging modality in advanced prostate cancer diagnostics. Dr. Murphy notes that PSMA PET/CT has established itself for its accuracy in regional disease, distant disease, and de novo and recurrent disease.

Dr. Murphy then proceeded to discuss the seminal proPSMA prospective, randomized, multi-center clinical trial [1]. To be eligible for inclusion in proPSMA, men must have had at least one high-risk factor including PSA >= 20 ng/mL, ISUP grade group 3-5, or clinical stage T3 or greater. Patients who had undergoing staging investigations (apart from prostate MRI) within eight weeks prior to randomization were excluded. Following enrollment, patients were randomly assigned in a 1:1 ratio to either conventional imaging performed using bone scan and CT or PSMA PET/CT. Patients who were randomized to conventional imaging underwent an abdominopelvic CT scan with contrast as well as a technetium-99m bone scan with SPECT CT of chest, abdomen, and pelvis in keeping with the standard of care. For patients randomized to PET/CT, gallium-68 PSMA-11 PET/CT was performed. In patients who had fewer than three unequivocal sites of metastasis, cross-over imaging for confirmation was performed within 14 days. Confirmatory testing following imaging was performed at the discretion of the treating physician and included biopsy confirmation.

Between 2017 and 2018, the trial randomly assigned 302 patients of whom 300 received assigned first-line imaging. In the primary outcome assessment, PSMA PET-CT had a 27% absolute greater AUC for accuracy compared to conventional imaging (95% CI 23-31): 92% (95% CI 88-95%) vs. 65% (60-69%):

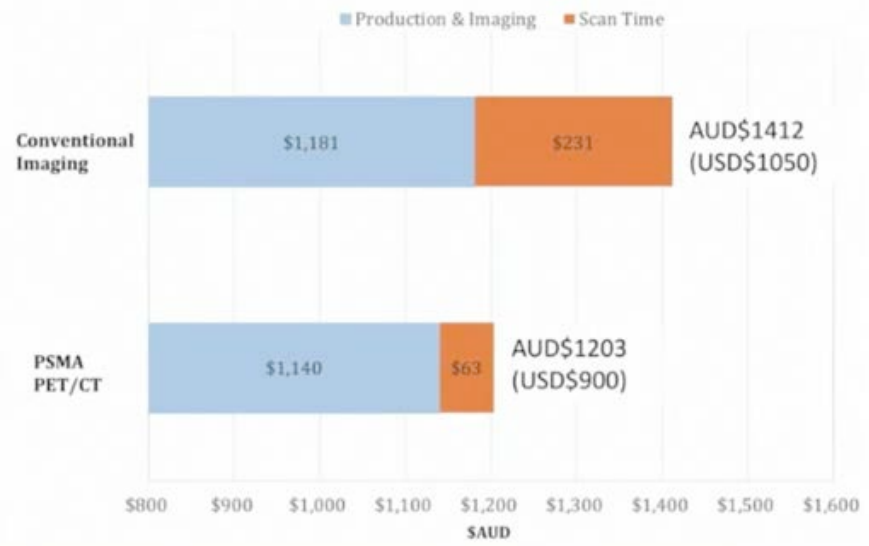


(continued page 5)

Conventional imaging had both a lower sensitivity (38% vs. 85%) and also a lower specificity (91% vs. 98%). Prior to treatment, the results of conventional imaging studies resulted in treatment change for 23 men (15%, 95% CI 10-22) while the results of PSMA PET-CT resulted in treatment change for 41 (28%, 95% confidence interval 21-36). These changes included both a transition from curative intent to palliative intent treatment in 20 patients (14%) and also a change in treatment approach in 22 (14%). Additionally, conventional imaging was associated with a higher radiation dose (19.2 mSv compared to 8.4 mSv; absolute difference 10.9 mSv, 95% CI 9.8-12.0 mSv0. PSMA PET-CT was not associated with any adverse events and reporter agreement was high for both nodal (kappa 0.87, 95% CI 0.81-0.94) and distant metastatic disease (kappa 0.88, 95% CI 0.94-0.92).

Part of the trial design was a built-in health economics perspective, and Dr. Murphy and colleagues recently published this analysis in *European Urology* [2]. They found that the estimated cost per scan for PSMA PET/CT was AUD$1203, which was less than the conventional imaging cost at AUD$1412.

PSMA PET/CT was thus dominant, having both better accuracy and a lower cost, resulting in a cost of AUD$959 saved per additional accurate detection of nodal disease, and AUD$1412 saved for additional accurate detection of distant metastases. Additionally, these results were most sensitive to variations in the number of men scanned for each ^{68}Ga-PSMA-11 production run. Dr. Murphy suggests that based on the proPSMA study, PSMA PET/CT



has established itself as having superior accuracy for staging compared to conventional imaging, as well as less equivocal findings, less radiation dose, greater management impact, and more cost-effective. As such, Dr. Murphy and his colleagues recommend that PSMA PET/CT should replace conventional imaging for high-risk disease staging.

With regards to PSMA PET/CT for recurrent disease, Dr. Murphy points to his group's systematic review and meta-analysis that showed the accuracy of PSMA PET/CT in the biochemical recurrent setting stratified by PSA level:

- 0-0.19 ng/mL: 33%
- 2-0.49 ng/mL: 42%
- 5-0.99 ng/mL: 59%
- 1-1.99 ng/mL: 75%
- >2 ng/mL: 95%

The most recent EAU guidelines suggest that PSMA PET/CT should be performed if the PSA level is >0.2 ng/mL and if the results will influence subsequent treatment decisions. Dr. Murphy concluded his presentation by emphasizing that novel imaging can cause disruption and uncertainty, as new research questions will emerge. At the crux of these questions is whether earlier detection of recurrent disease and changes in management will ultimately alter downstream prostate cancer specific outcomes.

Presented by: Declan Murphy, MB, BCH, BaO, FRACS, FRCS, Urol, Professor, Consultant urological surgeon at Peter MacCallum Cancer Centre and the Royal Melbourne Hospital, Melbourne, Australia and Director of Outcomes Research at the Australian Prostate Cancer Research Centre

Exercise & Weight Training

To help alleviate the side effects of ADT men should be encouraged to exercise everyday to combat fatigue, and to include weight bearing exercises to help with muscle loss. It requires dedication and determination. If you can afford it find a personal trainer to show you the best exercises and get the most out of your sessions. Ask your GP for a 'Health Care Plan' which may allow you to get access to a number of classes with a trainer through Medicare. Your Private Health Insurance 'Extras' may also give you access to training classes.

You can also join an Ex-Med Cancer Trial:

- 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)
- 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

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

Reducing the Cost of Cancer

Source: https://www.cancervic.org.au/about/policy-and-advocacy/cost-of-cancers

Despite Australia's universal health care system, cancer patients face many unexpected and hidden costs that can seriously impact them and their loved ones.

From diagnosis to treatment, recovery, follow-ups and ongoing care, costs can manifest in many ways. People may have to pay for medications, scans, tests and appointments. There are also additional, unanticipated costs like transport, parking and accommodation that add up.

Consultations we conducted with community members in 2019 as part of our submission to the State Government's Victorian Cancer Plan, identified 'the cost of cancer' as an ongoing and growing issue. This is why we are committed to reducing costs and improving transparency to help guide and inform decision making for people affected by cancer.

The impact

Out-of-pocket expenses can lead to 'financial toxicity' and 'bill shock' that can impact the health and wellbeing of patients and carers during an already vulnerable time.

'Financial toxicity' is the distress or hardship arising from the financial burden of cancer care and is increasingly considered a side effect of cancer treatment. Many people may have to stop work during their treatment, so paying for their medical care and usual life expenses can be difficult.

The main reason for connecting with Cancer Council Victoria's 13 11 20 information and support service relate to practical concerns including financial and legal issues, composing 37% of calls in March 2021. 1 in 6 people report skipping medications or delay seeing a specialist for concerns about cost.

At a time when people should be focused on their health, extra and often unavoidable costs can become a real source of stress and worry. Which is why we are working with Deakin University to gain a better understanding of Victorians' experiences of the cost of cancer care from diagnosis to follow-up care.

The cost of cancer in Australia

What you pay depends on the type of cancer you have, your care and how you access health services. Over the total lifetime of treatment, cancer patients pay about 15% of the cost of their cancer care from their own pocket. Many patients experience 'bill shock' in not knowing what these out-of-pocket costs will be prior to their treatment.

A Consumer Health Forum of Australia (CHF) survey found that more than a quarter of respondents having treatment for cancer incurred costs of more than $10,000 over a two-year period. It is estimated that between half and three-quarters of cancer survivors have experienced financial stress as a result of their treatment.

Those with private health insurance may face at least almost double the out-of-pocket costs for cancer treatment than those treated publicly, largely due to higher out-of-pocket costs for direct medical expenses including surgeries, chemotherapy, radiotherapy, diagnostic tests and specialists' visits.

Standard for Informed Financial Consent

We believe all patients have a right to know what costs they will incur following a diagnosis in Australia, which is why we worked with Cancer Council Australia and the McCabe Centre for Law & Cancer to develop a Standard for Informed Financial Consent. It provides clear and concise guidance to help healthcare practitioners ensure their patients clearly understand the costs of their treatment and the options available, enabling them to decide what is best and plan accordingly.

Our work to reduce the cost of cancer is multifaceted and currently focused on:

Hospital parking

Transport and accommodation costs

Raise the rate campaign

A cancer diagnosis is a stressful experience both for people living with cancer and their carers and many people need financial support from the government during this time.

Cancer Council has contributed to government submissions addressing the inadequacy of current payments and is continuing to advocate directly to policy makers through the Raise the Rate campaign. It forms part of our broader plan to call for a more flexible and holistic income support system that considers an individual's healthcare needs when accessing support.

We would also like to see better access to support workers who specialise in cancer and a case management approach to Centrelink trialled, to help people living with cancer and their carers better navigate the welfare system and avoid the demands of the current system which can be difficult if a person is ill.

Outcomes of Observation vs Stereotactic Ablative Radiation for Oligometastatic Prostate Cancer

Source:
March 26 2020
https://jamanetwork.com/journals/jamaoncology/fullarticle/2763312

KEY POINTS

Question How effectively does stereotactic ablative radiotherapy prevent progression of disease compared with observation in men with recurrent hormone-sensitive prostate cancer with 1 to 3 metastases?

Findings In this phase 2 randomized clinical trial of 54 men, progression of disease at 6 months occurred in 7 of 36 participants (19%) treated with stereotactic ablative radiotherapy and in 11 of 18 participants (61%) undergoing observation, a statistically significant difference.

Meaning Stereotactic ablative radiotherapy is a promising treatment approach for men with recurrent hormone-sensitive oligometastatic prostate cancer who wish to delay initiation of androgen deprivation therapy.

OMPC – Oligmetastatic Prostate Cancer
SABR – Stereotactic Ablative Radiotherapy
MDT – Metastasis-directed Therapy
ADT – Androgen Deprivation Therapy
ctDNA – Circulating Tumour DNA

Glossary of Terms:

Prostate Cancer is full of accronyms.

To help you navigate all the terms we have produced a list on our Website:

www.prostateheidelberg.info

The ORIOLE Phase 2 Randomized Clinical Trial

JAMA Oncol. 2020;6(5):650-659. doi:10.1001/jamaoncol.2020.0147

Discussion

This phase 2 randomized clinical trial showed that among men with Oligometastatic Prostate Cancer (OMPC), those treated with SABR were significantly less likely to have disease progression than those undergoing observation alone. Local control for SABR-treated lesions was excellent, and the adverse effects associated with SABR were mild and did not appear to affect quality of life. These results are consistent with prior reports validating the existence of the oligometastatic state in prostate cancer and the utility of SABR as MDT in this condition.

With a median (interquartile range) follow-up of 3.0 (2.3-3.8) years, Ost et al reported a median ADT-free survival of 21 months (80% CI, 14-29 months) with SABR compared with 13 months (80% CI, 12-17 months) with observation (HR, 0.60; 80% CI, 0.40-0.90; log-rank $P = .11$). Criteria for initiation of ADT were defined as "symptomatic progression, progression to more than three metastases, or local progression of baseline-detected metastases. Importantly, progression by PSA increase alone was not an indication to start ADT, nor was development of additional metastases amenable to MDT as long as the patient still had 3 or fewer total metastases.[9] In the present cohort, 2 of 7 men with disease progression in the SABR arm and 7 of 11 men with disease progression in the observation arm experienced biochemical progression alone. Furthermore, additional SABR was the next intervention in 14 of 15 men in the observation arm who ultimately received subsequent treatment and 6 of 14 men in the SABR arm. These differences inform the limitations of direct comparison of these trials.

Another important consideration is that SABR in the STOMP trial[9] included all concerning lesions identified by choline PET-CT. The ORIOLE trial enrolled participants with less-sensitive conventional imaging and still demonstrated a positive benefit for MDT, suggesting that the oligometastatic state is heterogeneous and that better biomarkers are needed to define participants who would benefit most from MDT. Post hoc analysis of PFS based on extent of disease appreciable by PSMA-targeted PET-CT found significant PFS and distant metastasis–free survival advantages among men who received consolidation of all detectable disease. These data support the use of molecular imaging in conjunction with MDT for patients with OMPC.

The key question that remains incompletely answered is whether we can alter the natural history of OMPC with MDT. Clearly, SABR is a safe and effective way to forestall progression of treated metastases and improves oncologic outcomes in certain patients. Furthermore, complete consolidation of detectable metastases improves time to progression. Most men with oligometastatic disease do not experience a complete PSA response after SABR, which suggests that residual micrometastases are present but undetectable. The consolidation of macroscopic disease may simply reset the clock on time to detectable metastases, and micrometastatic disease may continue to grow unchecked until it reaches sufficient size to become clinically actionable. Alternatively, consolidation of macroscopic metastases may remove or significantly affect signals that promote the development of remaining micrometastases. Our finding that total consolidation of disease detectable by PSMA-targeted PET-CT

(continued page 8)

was associated with lower risk of new metastases at 6 months is consistent with this latter explanation, as is the recent overall survival improvement observed in the SABR-COMET trial.[7] A deeper understanding of this process may be obtained through sequencing of biopsy or liquid biopsy specimens to explore the relationships and lineages of specific metastases in these patients or through advances in analysis of circulating readouts, such as circulating tumor cells, ctDNA, and exosomes.

Our analysis of ctDNA revealed several key findings. First, ctDNA concentrations in patients with OMPC were significantly lower than those reported in prior studies[17,27] of more advanced metastatic castration-resistant or hormone-sensitive prostate cancer. This suggests that ultrasensitive strategies, such as tumor-informed ctDNA monitoring, will be required for reliable detection and monitoring of ctDNA in patients with OMPC. Second, we did not find an association of baseline ctDNA concentration with outcome. However, our analysis was limited by the small fraction of participants with detectable ctDNA, so further exploration in future cohorts using tumor-informed monitoring or alternative methods is warranted. Third, the results of the study suggest that the presence of mutations associated with worse prognosis may identify a subset of patients who do not benefit from MDT. If these findings are confirmed in independent cohorts, the absence of high-risk mutations could potentially serve as a predictive biomarker for benefit from MDT.

The benefit of early ADT initiation remains a controversial question, and rigorous evaluation of men who undergo multiple rounds of MDT rather than proceeding to systemic therapy at first progression may shed light on the effect of SABR on the natural history of this disease. If a single round of MDT arrests the progression of some but not all lesions, subsequent rounds of MDT might salvage the remaining disease until what remains is inadequate to support a metastatic phenotype. The utility of repeated MDT may also vary by patient and the response of individual; therefore, well-selected patients for MDT may have intrinsic predictive value for guiding subsequent management.

The effect of radiotherapy on the immune system is also an area of interest with the promise of using SABR to induce an in situ vaccine response. We observed enhanced differential clonotype expansion, clusters of similar expanded T-cell receptors, and a clinical benefit to greater baseline clonality seen only in participants treated with SABR. Future studies assessing the association of these findings with T-cell characteristics or relatedness to tumor-infiltrating lymphocytes may help further characterize this systemic immune response.

Soldatov et al described patterns of failure following PSMA-ligand–based, conventionally fractionated radiotherapy for OMPC and found that recurrences are bone trophic. This suggests a role for aggressive management of micrometastatic osseous disease with ADT and/or radium 223, the latter of which will be the center of investigation for the Radium-223 and SABR vs SABR for Oligometastatic Prostate Cancers (RAVENS) trial (ClinicalTrials.gov identifier: NCT04037358). Soldatov et al[32] also found that 17% of recurrences after MDT were in pelvic nodes. The best management approach for pelvic recurrences is currently being studied in the Salvage Treatment of Oligorecurrent Nodal Prostate Cancer Metastases (STORM) trial (ClinicalTrials.gov identifier: NCT03569241).

Limitations

While these results are promising, this trial is limited by its relatively small sample size; subsequent phase 3 validation would strengthen the argument in favor of this approach. Additionally, our ability to study the long-term implications of this treatment approach was limited by high rates of crossover occurring after the predefined 6-month primary end point, with 15 of 18 men randomized to observation ultimately seeking SABR.

It should also be noted that the correlative data presented herein are hypothesis generating and require further prospective validation. Although we have identified a systemic immune response to SABR, we do not yet understand the nature of this response, and additional studies are needed to better characterize the interactions between immune cells, tumor, and the microenvironment. A limitation of our ctDNA analysis was the lack of available biopsy specimens to confirm the presence or absence of mutations. Thus, although we sequenced matched leukocyte DNA to identify mutations owing to clonal hematopoiesis, it is possible that some of the mutations we detected did not originate from tumor cells. Future studies in this area should prioritize acquisition of tissue samples for molecular analysis.

Conclusions

In conclusion, SABR is a safe and effective modality for MDT in OMPC that improves PFS compared with observation and results in a systemic adaptive immune response. Complete consolidation of metastatic disease detectable by molecular imaging decreases the risk of subsequent metastases, suggesting an alteration in the natural history. Finally, baseline immune phenotype and a tumor mutation signature may predict clinical response to SABR, pending validation in independent cohorts. Although SABR alone may or may not be sufficient as curative management, the combination of SABR with systemic therapies may provide the multipronged attack required to cure this disease.

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.

European Urology
July 29, 2021
https://www.practiceupdate.com/content/combined-high-dose-salvage-radiotherapy-and-hormone-therapy-in-oligorecurrent-pelvic-node-relapses-in-prostate-cancer/120771/37/3/1

Combined High-Dose Salvage Radiotherapy and Hormone Therapy in Oligorecurrent Pelvic Node Relapses in PCa

- This phase II study had progression–free survival as its primary outcome measure among patients with oligorecurrent pelvic nodal prostate cancer identified on fluorocholine PET–CT treated with androgen deprivation therapy and salvage radiation. The 2- and 3-year progression–free survival rates among the 67 enrolled patients were 81% and 58%, respectively, and median biochemical recurrence–free survival 26 months. In all, 46% were in complete remission at 3 years.
- While promising, these results require further evaluation in a randomized controlled trial.
- – Joshua A. Cohn, MD

BACKGROUND

Oligorecurrent pelvic nodal relapse in prostatic cancer is a challenge for regional salvage treatments. Androgen depriving therapies (ADTs) are a mainstay in metastatic prostate cancer, and salvage pelvic radiotherapy may offer long ADT-free intervals for patients harboring regional nodal relapses.

OBJECTIVE

To assess the efficacy of the combination of ADT and salvage radiotherapy in men with oligorecurrent pelvic node relapses of prostate cancer.

DESIGN, SETTING, AND PARTICIPANTS

We performed an open-label, phase II trial of combined high-dose intensity-modulated radiotherapy and ADT (6 mo) in oligorecurrent (five or fewer) pelvic node relapses in prostate cancer, detected by fluorocholine positron-emission tomography computed tomography imaging.

OUTCOME MEASUREMENTS AND STATISTICAL ANALYSIS

The primary endpoint was 2-yr progression-free survival defined as two consecutive prostate-specific antigen levels above the level at inclusion and/or clinical evidence of progression as per RECIST 1.1 and/or death from any cause.

RESULTS AND LIMITATIONS

Between August 2014 and July 2016, 67 patients were recruited in 15 centers. Half of the patients had received prior prostatic irradiation. The median age was 67.7 yr. After a median follow-up of 49.4 mo, 2- and 3-yr progression-free survival rates were 81% and 58%, respectively. Median progression-free survival was 45.3 mo. The median biochemical relapse-free survival (BRFS) was 25.9 mo. At 2 and 3 yr, the BRFS rates were 58% and 46%, respectively. Grade 2 + 2-yr genitourinary and gastrointestinal toxicities were 10% and 2%, respectively.

CONCLUSIONS

Combined high-dose salvage pelvic radiotherapy and ADT appeared to prolong tumor control in oligorecurrent pelvic node relapses in prostate cancer with limited toxicity. After 3 yr, nearly half of patients were in complete remission. Our study showed initial evidence of benefit, but a randomized trial is required to confirm this result.

PATIENT SUMMARY

In this report, we looked at the outcomes of combined high-dose salvage pelvic radiotherapy and 6-mo-long hormone therapy in oligorecurrent pelvic nodal relapse in prostatic cancer. We found that 46% of patients presenting with oligorecurrent pelvic node relapses in prostate cancer were in complete remission after 3 yr following combined treatment at the cost of limited toxicity.

Unexpected Long-term Improvements in Urinary and Erectile Function in a Large Cohort of Men with Self-reported Outcomes Following RP

Source:
17 Aug 2015
https://pubmed.ncbi.nlm.nih.gov/26887741/

Sadly many doctors do not adequately counsel their patients on the effects of RP and RT on their urinary and erectile function. Make sure you do your own research and find out where you can get advice before you have your treatment.

Pre-operative exercises and counseling may help improve long term erectile and urinary function.

Background
It is generally assumed that if a man does not regain urinary continence or erectile function within 12 mo of radical prostatectomy (RP), then the chance of subsequent recovery is low.

Objective
To determine the probability of achieving good urinary function (UF) or erectile function (EF) up to 48 mo postoperatively in men who reported poor UF or EF at 12 mo after RP.

Design, setting, and participants
We identified 3187 patients who underwent RP from 2007 through 2013 at a tertiary institution and had extended multidisciplinary follow-up with patient-reported UF and EF scores at ≥12 mo.

Intervention
Open or minimally invasive RP.

Outcome measurements and statistical analysis
Primary outcome was good UF as defined by a urinary score ≥17 (range: 0–21) or good EF as defined by a modified International Index of Erectile Function-6 score ≥22 (range: 1–30). The probability of functional recovery beyond 12 mo was determined by Kaplan-Meier analyses.

Results and limitation
Among patients incontinent at 12 mo, the probability of achieving good UF at 24, 36, and 48 mo was 30%, 49%, and 59%. In patients experiencing erectile dysfunction at 12 mo, the probability of recovering EF at 24, 36, and 48 mo was 22%, 32%, and 40%. On multivariable analyses, 12-mo functional score and age were associated with recovery, but only score was consistently significant.

Conclusions
Men with incontinence or erectile dysfunction at 12 mo have higher than anticipated rates of subsequent functional improvement. Probability of recovery is strongly influenced by score at 12 mo. Further research should address the impact of ongoing multidisciplinary follow-up care on our observed rates of recovery.

Patient summary
Many prostate cancer patients continue to recover urinary and erectile function after 12 mo. The level of functional recovery by 12 mo is associated with long-term recovery and should be discussed by the physician and patient when deciding on rehabilitative interventions.

Association of Concomitant Bone Resorption Inhibitors With Overall Survival Among Patients With Metastatic Castration-Resistant Prostate Cancer and Bone Metastases Receiving Abiraterone Acetate With Prednisone as First-Line Therapy

Source:
22 July 2021
https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2782159

Key Points

Question Do patients receiving abiraterone acetate with prednisone as first-line therapy for the treatment of metastatic castration-resistant prostate cancer with bone metastases benefit from the addition of bone resorption inhibitors?

Findings In this cohort study of 745 patients receiving first-line abiraterone acetate with prednisone for the treatment of metastatic castration-resistant prostate cancer with bone metastases, the use of concomitant bone resorption inhibitors was associated with improvements in overall survival, particularly among those with a high volume of disease.

Meaning These findings suggest that the addition of bone resorption inhibitors to abiraterone acetate with prednisone as first-line therapy could be beneficial for the treatment of patients with metastatic castration-resistant prostate cancer with bone metastases.

Abstract

Importance: Bone resorption inhibitors (BRIs) are recommended by international guidelines to prevent skeletal-related events (SREs) among patients with metastatic castration-resistant prostate cancer (mCRPC) and bone metastases. Abiraterone acetate with prednisone is currently the most common first-line therapy for the treatment of patients with mCRPC; however, the clinical impact of the addition of BRIs to abiraterone acetate with prednisone in this disease setting is unknown.

Objective: To evaluate the association of the use of concomitant BRIs with overall survival (OS) and time to first SRE among patients with mCRPC and bone metastases receiving abiraterone acetate with prednisone as first-line therapy.

Design, setting, and participants: This retrospective cohort study collected data from 745 consecutive patients who began receiving abiraterone acetate with prednisone as first-line therapy for mCRPC with bone metastases between January 1, 2013, and December 31, 2016. Data were collected from 8 hospitals in Canada, Europe, and the US from June 15 to September 15, 2019.

Exposures: Patients were classified by receipt vs nonreceipt of concomitant BRIs and subclassified by volume of disease (high volume or low volume, using definitions from the Chemohormonal Therapy Vs Androgen Ablation Randomized Trial for Extensive Disease in Prostate Cancer [CHAARTED] E3805 study) at the initiation of abiraterone acetate with prednisone therapy.

Main outcomes and measures: The primary end point was OS. The secondary end point was time to first SRE. The Kaplan-Meier method and Cox proportional hazards models were used.

Results: Of the 745 men (median age, 77.6 years [interquartile range, 68.1-83.6 years]; 699 White individuals [93.8%]) included in the analysis, 529 men (71.0%) received abiraterone acetate with prednisone alone (abiraterone acetate cohort), and 216 men (29.0%) received abiraterone acetate with prednisone plus BRIs (BRI cohort). A total of 420 men (56.4%) had high-volume disease, and 276 men (37.0%) had low-volume disease. The median follow-up was 23.5 months (95% CI, 19.8-24.9 months). Patients in the BRI cohort experienced significantly longer OS compared with those in the abiraterone acetate cohort (31.8 vs 23.0 months; hazard ratio [HR], 0.65; 95% CI, 0.54-0.79; P < .001). The OS benefit in the BRI cohort was greater for patients with high-volume vs low-volume disease (33.6 vs 19.7 months; HR, 0.51; 95% CI, 0.38-0.68; P < .001). The BRI cohort also had a significantly shorter time to first SRE compared with the abiraterone acetate cohort (32.4 vs 42.7 months; HR, 1.27; 95% CI, 1.00-1.60; P = .04), and the risk of a first SRE was more than double in the subgroup with low-volume disease (HR, 2.29; 95% CI, 1.57-3.35; P < .001). In the multivariable analysis, concomitant BRIs use was independently associated with longer OS (HR, 0.64; 95% CI, 0.52-0.79; P < .001).

Conclusions and relevance: In this study, the addition of BRIs to abiraterone acetate with prednisone as first-line therapy for the treatment of patients with mCRPC and bone metastases was associated with longer OS, particularly in patients with high-volume disease. These results suggest that the use of BRIs in combination with abiraterone acetate with prednisone as first-line therapy for the treatment of mCRPC with bone metastases could be beneficial.

Radiotherapy After Radical Prostatectomy in the PSMA-PET Era

Source: https://www.urotoday.com/conference-highlights/eau-2021/eau-2021-prostate-cancer/130796-eau-2021-radiotherapy-after-radical-prostatectomy-in-the-psma-pet-era.html?acm=_9351

(UroToday.com) At the controversies in Onco-Urology session of the European Association of Urology 2021 annual meeting, Dr. Alberto Bossi discussed radiotherapy after radical prostatectomy in the PSMA-PET era. Adjuvant radiotherapy is defined as immediate postoperative radiation in the case of extraprostatic extension, positive margins, seminal vesicle infiltration, high Gleason score, or pN+ disease. Salvage radiotherapy is defined as a wait-and-see policy in that radiation is only given in the case of a rising postoperative PSA.

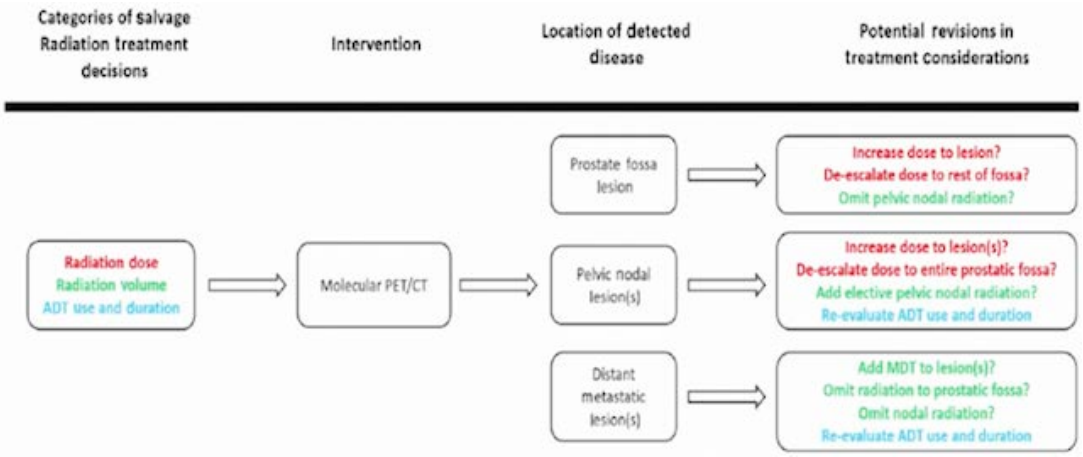
The ARTISTIC meta-analysis was published in 2020, combining data from RADICALS, GETUG-AFU 17, and RAVES showing no difference in PSA-driven event-free survival with a hazard ratio of 1.12 (95% CI 0.88-1.42), and a potential absolute difference of 1% at 5-years in favor of early salvage radiotherapy[1]. As such, Dr. Bossi notes that these results essentially nullify the notion of adjuvant radiotherapy.

The EAU/ESUR/ESTRO/SIOG 2020 guidelines relating to PSMA PET scan suggest that men with a persistent PSA > 0.2 ng/mL after radical prostatectomy should be offered a PSMA PET/CT to exclude metastatic disease (weak recommendation). Additionally, PSMA PET/T should be offered to men after a radical prostatectomy if the PSA level is rising above >0.2 ng/mL and if the results will influence subsequent treatment decisions (2b; weak recommendation). Finally, PSMA PET/CT should be offered in patients fit for curative salvage treatment with PSA recurrence after radiotherapy (2b; strong recommendation). The reason for waiting for the PSA to reach >0.2 ng/mL is the poor detection rate of 33% for PSMA PET/CT positivity in patients with a PSA <0.2 ng/mL. As follows are additional governing body's guideline recommendations for the utilization of PSMA PET/CT:

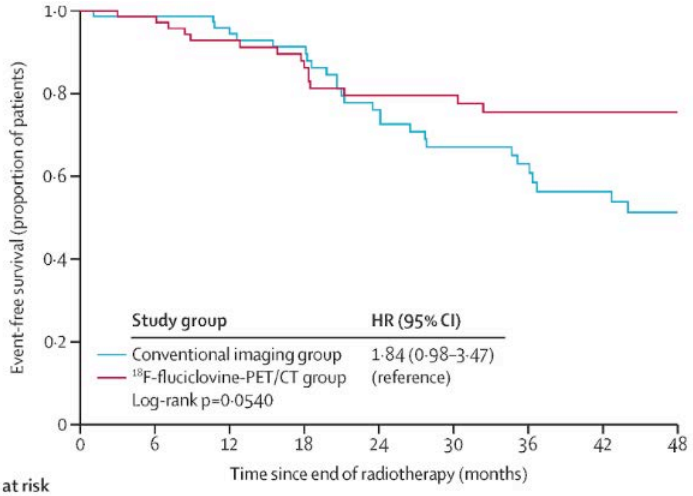
AUA/ASTRO/SUO Advanced PCa Guidelines (2020)	• Clinicians may utilize novel PET-CT scans (e.g., fluciclovine, choline, PSMA) in patients with PSA recurrence after failure of local therapy as an alternative to conventional imaging or in the setting of negative conventional imaging (Expert Opinion)
GGPO 2019	• In the recurrent prostate cancer setting, imaging with PSMA PET had a higher sensitivity and specificity compared to standard imaging, especially with PSA<0.5 ng/mL, with a considerable rate of therapy strategy decision changes. These findings were however not confirmed histologically, and no evidence of an improvement in patient outcome is available. • In the context of biochemical recurrence (after curative-intent therapies), PSMA PET can be performed to assess the extent of the tumor, provided the findings have a consequence on therapeutic strategy. A negative PSMA PET shall not delay any salvage therapy
AFU 2020	• Perform PSMA PET/CT if the PSA is <1 ng/ml after radical prostatectomy • Perform PSMA or Choline PET/CT if the PSA is >1 ng/ml after radical prostatectomy • Perform PET/CT for recurrence after radiotherapy

(continued 13)

Utilization of PSMA PET/CT for recurrent disease certainly may change management (upwards of 40-75%) based on the location of detected disease, summarized in the following figure:



Dr. Bossi then discussed the recently published EMPIRE-1 trial[2], which was a single-center, open-label, phase 2/3 randomized controlled trial of patients with prostate cancer with detectable PSA after prostatectomy and negative conventional imaging (no extrapelvic or bone findings). Patients were randomly assigned in a 1:1 ratio to radiotherapy directed by conventional imaging alone or to conventional imaging plus ^{18}F-fluciclovine-PET/CT. The primary endpoint was 3-year event-free survival, with events defined as biochemical or clinical recurrence or progression, or the initiation of systemic therapy. There were 165 patients randomly assigned, with a median follow-up of 3.52 years (95% CI 2.98-3.95). The 3 year event-free survival rate was 63.0% (95% CI 49.2-74.0) in the conventional imaging group versus 75.5% (95% CI 62.5-84.6) for ^{18}F-fluciclovine-PET/CT (difference 12.5; 95% CI 4.3-20.8; p=0.0028):
Dr. Bossi concluded his presentation of radiotherapy after radical prostatectomy in the PSMA PET/CT era with the following take-home messages:



Number at risk (number censored)									
Conventional imaging group	81 (1)	76 (4)	66 (13)	54 (21)	44 (22)	36 (25)	28 (31)	23 (33)	19 (54)
^{18}F-fluciclovine-PET/CT group	76 (1)	71 (4)	59 (13)	53 (15)	46 (19)	41 (22)	35 (26)	30 (32)	21 (61)

- PSMA PET/CT before salvage radiotherapy should be performed if the results will possibly change the subsequent management strategy
- PSMA PET/CT should be considered for postop persistent elevated PSA or for post-op rising PSA of at least 0.2 ng/mL
- Currently, there is no place for delaying early salvage radiotherapy until PSMA reveals the origin of the rising PSA: we may miss the window of curability of early salvage radiotherapy
- For the time being, adopting changes in the management of patients based on a positive PSMA should be preferably done in the framework of 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.

Prostate Heidelberg Cancer Support Group Meetings

Guest Speakers:

Tues 17 Aug 10:30am

Ben Shemesh BroSupPORT

At our August meeting, Ben Shemesh, Project Officer, Monash University will present on the development of the BroSupPORT portal. The portal is intended to support men living with prostate cancer by helping them to understand how the side effects they might be experiencing compare with men of similar age and risk profile who have received the same treatment. The portal includes information on issues that have a big impact on a man's quality of life, like urinary incontinence, sexual and bowel function. The project is sponsored by the Victorian Agency for Health Information (VAHI) and has been developed in collaboration with Monash University as the managers of the Prostate Cancer Outcome Registry-Victoria (PCOR-Vic); Movember as funders of PCOR-Vic; and Alfred Health as the nominated lead Victorian public health service.

Tues 19 October 10:30am

Nikolajs Zeps

'What will the treatment of Prostate Cancer be like in 10 years time?'

PCa Clinical Trials

UpFront PSMA

In Men With Metastatic Prostate Cancer, What is the Safety and Benefit of Lutetium-177 PSMA Radionuclide Treatment in Addition to Chemotherapy

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

Locations

- NSW St Vincents, Sydney
- QLD Royal Brisbane & Women's,
- SA Royal Adelaide
- VIC Peter Mac, Melbourne

For Further information on current and recruiting trials visit:

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

MOSES Study

At our July meeting, Professor Ray Chan, Professor in Cancer Nursing Faculty of Health, School of Nursing, Queensland University of Technology presented on a the four year MOSES Trial, a shared care model between GPs and specialist clinicians for prostate cancer survivors.

Members were highly supportive of the underlying concept that offers the prospect of a much improved treatment path for prostate cancer patients. This was reflected in a desire for group members to provide stories about their experiences with current treatment pathways etc.

As a first step, we agreed to convene a separate internal session as a basis for feedback to the project via Max Shub who is an associate investigator on the project.

Shared-care trial for men with prostate cancer

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.

Prostate cancer is the most common cancer among Australian men. It has a 95 per cent 5-year relative survival rate and there are 211,000 men in Australia currently living with the disease. Last year, there were 16,741 new diagnoses.

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.

"General Practitioners (GPs) may only treat a few patients a year, so we need to facilitate shared care in a way that one day it will become usual practice like how they are delivering antenatal shared-care," Professor Chan said.

"This is a next logical step to create volume and momentum in shared care for cancer survivors," he said.

QUT will partner with the Prostate Cancer Foundation of Australia (PCFA) Prostate Cancer Specialist Nurses, who will have a vital role in coordinating care and linking patients with their GPs and practice nurses.

The MOSES trial is a collaboration between QUT, University of Melbourne, Prostate Cancer Foundation of Australia, Flinders University, The Council of the Queensland Institute of Medical Research, and Peter MacCallum Cancer Centre.

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

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

August 2021
- Take Responsibility
- What id the role of modern imaging?
- Reducing The Cost of Cancer
- Observation Vs SBRT for Oligometastatic PC
- Combined High-dose Salvage RT & HT in Oligorecurrent Pelvic Nodes
- Long Term Urinary & Erectile Function following RP
- Bone Resportion Inhibitors
- RT After RP

Prostate Cancer Trials
- UpFront PSMA & MOSES Study

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