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
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Acct 583244292

Prostate Heidelberg

October 2021 Issue 211

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 19 October 10am – 12:30pm

To join via Zoom: Copy link and paste into your browser
https://us02web.zoom.us/j/84210688696?pwd=RUZvcHlJWDJTZ0NKV0dEbVRxZGNsQT09

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 September

Our August meeting was a round robin catching up with members. This month Professor Nikolajs Zeps joins us. The title of his talk is 'What will the treatment of Prostate Cancer be like in 10 years time?'

Unfortunately the PCFA Cancer Outback Rally has been postponed for a second time because of the covid lockdowns. But it does give everyone extra time to sponsor our member, David Campbell, for a course close to all our hearts. The rally is now set for 20-27May 2022!

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

Continuous vs Intermittent ADT Use for Prostate Cancer in Older Men

Source:
29 September 2021
https://www.practiceupdate.com/content/continuous-vs-intermittent-adt-use-for-prostate-cancer-in-older-men/124036/31/3/1

PURPOSE

Phase-III randomized control trial evidence suggests intermittent androgen deprivation therapy (IADT) is not significantly inferior to continuous androgen deprivation therapy (ADT) for patients with prostate cancer (PC). However, clinical practice and guidelines differ in their recommendations. We evaluate real-world utilization and practice patterns of IADT.

MATERIALS AND METHODS

Ontario men ≥65 years of age with PC who initiated ADT for ≥3 months were identified (1997-2017). Lapses in ADT ≥6 months (initial gap) and ≥3 months (subsequent gaps) were used to classify IADT. Neoadjuvant/adjuvant therapy was excluded. Disease stage adjustment was completed for patients with likely metastatic disease based on de novo presentation with ADT. Patient and physician predictors of IADT were analyzed using multivariable logistic regression.

RESULTS

We identified 8,544 patients with 1,715 having previously received local therapy. Among all patients, 16.4% received IADT. This ranged from 11.4%-24.8% across health-planning regions and increased to 26.6% in those with previous local therapy. Mean followup was 8.3 years. Patients with prior local therapy (OR 1.85, 95% CI 1.59-2.17, p <0.001) and those in the highest income quintile (OR 1.32, 95% CI 1.08-1.60, p=0.005) had increased odds of receiving IADT. Radiation oncologists were more likely to use IADT than urologists (OR 1.99, 95% CI 1.59-2.50, p <0.001), as were physicians with more experience (≥10 years in practice: OR 1.44, 95% CI 1.11-1.88, p=0.007). In specialty-stratified analyses, case volume was significantly associated with IADT for radiation oncologists (highest quartile: OR 1.73, 95% CI 1.14-2.62, p=0.009).

CONCLUSIONS

IADT remains underutilized for patients with PC who ≥65 years of age with only 1 in 4 to 1 in 6 eligible patients receiving this form of care. Clinical, sociodemographic and physician characteristics play an important role in treatment selection.

TAKE HOME MESSAGE

Intermittent androgen deprivation therapy (IADT) has been shown to be non-inferior to continuous ADT, but real-world utilization of this strategy is not well known. The authors of this retrospective study evaluated 8544 men older than 65 years with prostate cancer and undergoing ADT. Mean follow-up was 8.3 years. IADT was used in 16.4% of the population. Men more likely to undergo IADT included those with prior local therapy and those in the highest income quintile. At the provider level, radiation oncologists were more likely to use IADT as were providers with more than 10 years experience.

These data suggest that IADT may be an underutilized strategy, although this study is limited by the typical constraints of using an administrative database. Differences in utilization based on economic status may suggest that there are other ethnic or social differences between those undergoing continuous and intermittent ADT.

– Michael H. Johnson, MD

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

Predict Prostate Risk Communication Tool in Men Newly Diagnosed With Nonmetastatic Prostate Cancer

Source:
Martin G. Sanda MD &
Vikram M. Narayan MD
https://www.practiceupdate.com/content/predict-prostate-risk-communication-tool-in-men-newly-diagnosed-with-nonmetastatic-prostate-cancer/122420/15/3/1

Treatment decisions for prostate cancer are complex and particularly sensitive to factors such as provider bias and heterogenous patient medical literacy. Most guidelines recommend shared decision–making for prostate cancer treatment selection, although in practice this can be challenging, especially when attempting to counsel patients using lay language, avoiding paternalism, and minimizing oversimplification of a complex disease. In this study by Thurtle and colleagues, patients with newly diagnosed prostate cancer were randomized to receiving information either by standard of care or using the Predict Prostate online risk communication tool. The latter is a website that provides patients with a range of visual outputs to contextualize an individual's personalized prostate cancer–specific and overall survival estimates, along with information regarding potential harms of different treatment options. It has been endorsed by the UK National Institute for Health and Care Excellence (NICE). Patients who were randomized to receiving information using the tool were found to have markedly lower decisional conflict scores, as well as more accurate perceptions of 15-year prostate cancer–specific mortality risk and overall survival benefit when compared with patients receiving standard of care counseling—although patient anxiety and treatment selection were not different by whether or not patients received the Predict Prostate tool. These findings suggest that the Predict Prostate tool may help solidify treatment preferences, rather than guiding or modifying care decisions. Moreover, the majority of men in the study, including nearly half of men with unfavorable-intermediate or high-risk prostate cancer, opted for surveillance instead of definitive treatment—leaving unanswered questions about the utility of this tool for informing decisions in cancer severity settings where level I evidence supports definitive treatment. Nevertheless, this study highlights a helpful role that visual, patient-centered tools can have on patient counseling and in understanding their care options.

TAKE HOME MESSAGE

In this study, men with newly diagnosed prostate cancer considering active surveillance or definitive therapy were randomized to standard of care or use of a standardized individualized risk prediction tool called Predict Prostate. Use of this tool significantly reduced decisional conflict and improved accuracy of patient perception 15-year cancer specific mortality and survival benefit associated with definitive therapy. Overall, 94% of patients would recommend its use to other patients.

No clear impact on final treatment decision-making was observed, an impact that may be observed in larger studies or in different clinical settings.

DOUBLING TIMES

Following on from a discussion at a recent meeting on PSA doubling times we hope the following information might be helpful.

PSA doubling time can be an indicator of biochemical & clinical progression. Memorial Sloan Kettering Institute has produced a tool that calculates the changes in PSA levels over time.

https://www.mskcc.org/nomograms/prostate/psa_doubling_time

You can also produce a hard copy chart by plotting your PSA on a log/linear graph so that a constant doubling time gives a straight-line graph.

A free download of graph paper is available on:

https://www.printablepaper.net/category/log

High Discontinuation Rate Found for Prostate Cancer Active Surveillance

Source:
24 September 2021
https://www.renalandurologynews.com/home/news/urology/prostate-cancer/half-of-low-risk-prostate-cancer-cases-on-active-surveillance-switch-definitive-treatment/

Natasha Persaud

Patients managed by radiation oncologists were more likely to discontinue prostate cancer active surveillance compared with patients managed by urologists, suggesting a degree of treatment bias, investigators reported.

Despite increasing adoption of active surveillance (AS) for low-risk prostate cancer, AS discontinuation rates are high, investigators report.

Among 16,852 men diagnosed with Gleason score 6 or lower prostate cancer from 2008 to 2014 in Ontario, Canada, 8541 (51%) chose AS for initial management. Use of AS significantly increased over the period from 38% to 69%. Men who selected AS at diagnosis were significantly older than men who selected initial treatment: mean 64 vs 62 years.

After a median 48 months, 4337 (51%) patients discontinued AS, Antonio Finelli, MD, of the University of Toronto in Ontario, Canada, and colleagues reported in *The Journal of Urology*. Median time to definitive treatment after initial AS was 16 months. Treatment-free survival rates for AS patients at 1, 3, and 5 years were 85%, 58% and 52%, respectively.

On multivariable analysis, patient factors significantly associated with greater AS discontinuation included age younger than 55 years at diagnosis, diagnosis in 2008-2011 vs 2012-2014, and higher comorbidity scores, the investigators reported. Treatment at an academic vs non-academic center was significantly associated with a significant 31% increased risk of discontinuation. Treatment by a radiation oncologist vs urologist was significantly associated with a 2.2-fold increased risk of AS discontinuation. Receiving treatment from physicians or institutions in the highest-volume tertile also correlated with a switch to definitive treatment.

With respect to disease characteristics, PSA higher than 4 ng/mL, more than 1 positive core, and more than 50% of the core involved by cancer at diagnosis all significantly associated with definitive treatment. Half of patients who went on to treatment experienced grade group progression.

"Our study demonstrated that, in a real-world setting across many institutions and providers, the long-term discontinuation rate is significant (52% at 5 years); whereas studies from single institution academic centers report lower discontinuation rates (24%–41%)," Dr Finelli's team wrote. "This has implications for patient counseling and setting realistic expectations."

The investigators were unable to assess the role of biomarkers and MRI in patient selection for AS. Patients who chose watchful waiting were excluded from the study.

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

Artificial Intelligence Program Helps Detect Prostate Cancer

Source:
22 Sept 2021
Alexander Otto, PA
https://www.webmd.com/prostate-cancer/news/20210929/new-tests-for-colon-prostate-cancer-show-promise?src=RSS_PUBLIC&utm_medium=email&utm_source=rasa_io&PostID=38680915&MessageRunDetailID=6602651576

The FDA has authorized the first artificial intelligence software to help doctors detect prostate cancer.

The program, called Paige Prostate, is the first approved AI system in pathology.

"We really believe this product can make a huge difference," Paige CEO Leo Grady, PhD, says.

The program was approved to help doctors, not to replace them.

"For a second opinion today, you ship a glass slide to somebody else or you do another stain that's really expensive or you do another molecular test," Grady says.

With the new tool, doctors digitally scan and upload biopsy slides to a computer, then import them into the program, which is a cloud-based service accessed through a Web browser.

The software compares the tissue patterns against a large database of tissue patterns collected at the Memorial Sloan Kettering Cancer Center, which created Paige as a company in 2018 from its work on digitizing biopsy slides.

The program looks for patterns that have been previously diagnosed as cancer. When it finds such patterns, it highlights them for the pathologists to key in on, so they "don't miss anything" and have "a lot more confidence in their diagnosis without having to send it out for additional consultation," Grady says.

Shortly after the FDA announced the authorization on Sept. 21, the FDA's acting commissioner, Janet Woodcock, MD, tweeted that she's "always pleased to see potentially life-saving advancements in medical device technology, such as using artificial intelligence to help identify prostate cancer."

The FDA approval was based on a study where 6 pathologists examined 527 digitally scanned prostate biopsy slides. Of them, 171 were cancerous, and 356 were benign. The pathologist made two assessments, one with and one without the program's help.

The software improved detection of cancer on individual slide images by 7.3% on average compared to unassisted reads. There was no impact on the reading of benign slides.

The FDA said that the risk for false negatives and false positives with the program is lessened because it is used along with a doctor and by the pathologists' consideration of patient history, laboratory studies, and other clinical information.

"Pathologists examine biopsies of tissue suspected for diseases, such as prostate cancer, every day," Tim Stenzel, MD, director of the Office of In Vitro Diagnostics and Radiological Health at the FDA, said in a statement. "The authorization of this AI-based software can help increase the number of identified prostate biopsy samples with cancerous tissue, which can ultimately save lives."

Glossary of Terms:

Prostate Cancer is full of acronyms.

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

www.prostateheidelberg.info

Plant-Based Diet Tied to Better Urological Health "Eat More Plants for Your Prostate and Erections"

Source:
21 Sept 2021
https://ustoo.org/PDFs/HotSheets/USTOO_HotSHEET_October_2021.pdf

Men interested in preserving their urological health may benefit from eating more vegetables and fruits, researchers reported.

A trio of studies presented at the American Urological Association (AUA) virtual meeting suggested that plant-based diets were associated with a decreased risk of erectile dysfunction (ED), lower PSA rates, and possibly a lower rate of total and fatal prostate cancer (PCa) among younger men.

"We can summarize this session succinctly," said AUA press conference moderator Stacy Loeb, MD, of NYU Langone Health in New York City, who also presented one of the studies. "Eat more plants for your prostate and your erections," she advised.

Investigators at the University of Miami (UMiami) Miller School of Medicine used the National Health and Nutrition Examination Survey (NHANES) to evaluate the association between a plantbased diet and PSA. Using Food Frequency Questionnaire dietary data they calculated a plant-based diet index (PDI) and healthful plantbased diet index (hPDI).

Ali Mouzannar, MD, reported that in a cohort of 1,399 men, those with a higher consumption of healthy plant-based diet (high hPDI scores) had a decreased probability of having an elevated PSA (OR 0.47, 95% CI 0.24-0.95).

"It seems plant-based diets have protective effects against PCa," Mouzannar said during the press session. "We still need more insight and more clinical trials to establish the causative effect, but there have been multiple associations between lower risk of PCa, lower risk of elevated PSA with a plant-based diet."

He added that "it also works the other way around – meat has been shown to be associated with a high rate of aggressive PCa, and high risk of recurrence."

Loeb and colleagues conducted a prospective study involving 27,243 men followed up to 28 years, in the Health Follow-up study.

They found that in men ages ≤65 at diagnosis, greater overall consumption of plantbased diet was associated with a lower risk of advanced PCa (HR 0.68, 95% CI 0.42- 1.10). Among younger men, it was associated with lower risks of PCa (HR 0.81 95% CI 0.70-0.95), and fatal disease (HR 0.53, 95% CI 0.32-0.90).

"This is really encouraging given the many health and environmental benefits of plant-based diets," Loeb said. "And we believe they should be recommended for men who are concerned about the risks of prostate cancer."

Mouzannar noted "There is a significant effect in following plant-based diets," he said. "Whether that's in individuals by promoting a healthy lifestyle and decreasing the risk of multiple cancers in addition to PCa."

"I see it as a win-win," Loeb said. "There's not really a downside here. You're going to decrease your risk of aggressive PCa and elevated PSA, and increase your chances of preserving erectile function, and it's just better for the planet."

Presented at the AUA 2021 virtual Annual Meeting; abstract PD20-05
MedPage Today 12 September 2021

Obesity Ups Survival in Metastatic Castration-Resistant Prostate Cancer

Source:
10 Sept 2021
Jody A Charnow
https://www.renalandurologynews.com/home/conference-highlights/aua-2021/obesity-linked-lower-mortality-metastatic-hormone-refractory-prostate-cancer-mcrpc

Among men with metastatic castration-resistant prostate cancer, obese men have a 29% decreased risk for death compared with overweight or normal-weight men, according to investigators.

Obesity is associated with better survival among men with metastatic castration-resistant prostate cancer (mCRPC), a protective effect that investigators are calling an "obesity paradox," study findings presented at the AUA2021 Virtual Experience suggest.

The findings could have implications for clinical trial design and development of novel therapeutics that target certain genes that modulate fat synthesis, according to investigators.

Alberto Martini, MD, of Vita Salute San Raffaele University, Milan, Italy, and colleagues studied 1577 patients with mCRPC who participated in the phase 3 randomized controlled ASCENT2, MAINSAL, and VENICE clinical trials. The investigators selected patients from these trials because they had similar inclusion criteria. Patients had a median age of 69 years. Dr Martini's team placed patients into 4 body mass index (BMI) categories: less than 20, 20-25, 25-30, and greater than 30 kg/m^2.

To exclude possible effects attributable to a higher dose of chemotherapy (titrated according to body surface area), the investigators looked for eventual interactions between BMI and chemotherapy dose.

Of the 1577 patients, 655 died by the end of the studies. The median follow-up duration for survivors was 12 months. In adjusted analyses, obesity, defined as a BMI greater than 30 kg/m^2, was significantly associated with a 29% decreased risk for death compared with overweight (BMI 25-30 kg/m^2) and normal weight (BMI 20-25 kg/m^2). Each 1 kg/m^2 increase in BMI was significantly associated with a 4% decreased risk for death.

Higher BMI also was associated with reduced cancer-specific mortality (CSM). Obesity was significantly associated with a 35% decreased risk for CSM compared with overweight and normal weight. Each 1 kg/m^2 increase in BMI was significantly associated with a 6% decreased risk for CSM.

Dr Martini and colleagues found no interaction between BMI categories and docetaxel dose.

He explained that the protective effect of obesity might be attributed to some oncogenes that are downregulated as a result of obesity. For example, among patients with metastatic kidney cancer, obesity is associated with downregulation of the FASN oncogene, which is implicated in fatty acid synthesis. Further research is needed in the context of prostate cancer to better elucidate this phenomenon, he said.

The latest findings could be useful when designing clinical trials, such as for stratifying patients based on BMI categories, Dr Martini said. The findings also highlight a need to better understand prostate cancer as a disease because this could lead to new ways to manage it. "The fact that some oncogenes might be downregulated in cases of obesity can help identify novel potential therapeutic targets," said Dr Martini, adding that ongoing studies are examining a molecule that inhibits FASN.

Commenting on the study, Stephen J. Freedland, MD, professor of surgery and director of the Center for Integrated Research in Cancer and Lifestyle at Cedars-Sinai Medical Center in Los Angeles, who was not involved in the new research but has studied the relationship between obesity and prostate cancer, said another possibility is that obese men do not experience the muscle-wasting and weight loss that can accompany late-stage cancer and are thus in better health than those who do.

Abstract PD05-01.

Among men with metastatic castration-resistant prostate cancer, obese men have a 29% decreased risk for death compared with overweight or normal-weight men, according to investigators.

Reference

Martini A, Cirulli G, Gandaglia G, et al. The obesity paradox in metastatic castration resistant prostate cancer.. Presented at: AUA 2021, held September 10-13, 2021.

Source:
21 September 2021
Daniel E Spratt MD
https://www.practiceupdate.com/c/123657/67/11/?elsca1=emc_enews_weekinreview&elsca2=email&elsca3

Impact of Hypofractionated Radiotherapy on Patient-reported Outcomes in PCa

Long-Term Patient-Reported Quality of Life Confirms Safety of Moderately Hypofractionated Radiotherapy

Shared decision–making requires a strong understanding of the oncologic benefit of a treatment as well as the effect of treatment on patient-reported outcomes (PROs) relating to quality of life (QOL). Recently reported was the largest multicenter noninferiority trial (N=3216) that investigated hypofractionation in localized prostate cancer that incredibly collected robust PROs from the majority of patients long-term (n=2100). The results provide three important findings. First, modern radiotherapy using IMRT, even without rectal spacers or advanced image guidance, results in low long-term bowel and urinary symptoms (<10% prevalence of moderate to big bother were reported across both domains).

Second, bowel and urinary problems did not worsen from 6 month to 5 years, whereas sexual function continued to decline with time and patient age. Third, and most importantly, QOL endpoints were similar between conventional and hypofractionated regimens, further supporting the use of 20 fractions of radiotherapy over conventional radiotherapy in intermediate- and high-risk prostate cancer. In summary, as reflected by current National Comprehensive Cancer Network and many international guidelines, moderate hypofractionated radiotherapy should be preferred over conventionally fractionated radiotherapy as it has noninferior tumor control, physician-reported late toxicity, and similar PROs on QOL in localized prostate cancer.

Abstract

BACKGROUND

Moderate hypofractionation is the recommended standard of care for localised prostate cancer following the results of trials including Conventional or Hypofractionated High Dose Intensity Modulated Radiotherapy in Prostate Cancer (CHHiP). Evaluation of long-term patient-reported outcomes (PROs) is important to confirm safety and enhance patient information.

OBJECTIVE

To determine whether 5-yr PROs from the CHHiP quality of life (QoL) substudy confirm 2-yr findings and assess patterns over follow-up.

DESIGN, SETTING, AND PARTICIPANTS

A phase III randomised controlled trial recruited from 2002 to 2011. The QoL substudy completed accrual in 2009; participants were followed up to 5 yr after radiotherapy. Analyses used data snapshot taken on August 26, 2016. A total of 71 radiotherapy centres were included in the study (UK, Republic of Ireland, Switzerland, and New Zealand); all 57 UK centres participated in the QoL substudy. CHHiP recruited 3216 men with localised prostate cancer (cT1b-T3aN0M0).

INTERVENTION

Conventional (74 Gy/37 fractions/7.4 wk) or hypofractionated radiotherapy (60 Gy/20 fractions/4 wk or 57 Gy/19 fractions/3.8 wk) was delivered with intensity-modulated techniques.

OUTCOME MEASUREMENTS AND STATISTICAL ANALYSIS

University of California Los Angeles Prostate Cancer Index, Short Form 36 and Functional Assessment of Cancer Therapy-Prostate, or Expanded Prostate Cancer Index Composite and Short Form 12 questionnaires were administered at baseline, before radiotherapy, at 10 wk, and at 6, 12, 18, 24, 36, 48, and 60 mo after radiotherapy. The QoL primary endpoint was overall bowel bother.

RESULTS AND LIMITATIONS

The QoL substudy recruited 2100 patients; 1141 5-yr forms were available from 1957 patients still alive (58%). There were no statistically significant differences in 5-yr prevalence of overall "moderate or big" bowel bother: 19/349 (5.4%), 29/381 (7.6%), and 21/393 (5.3%) for 74, 60, and 57 Gy, respectively; overall urinary or sexual bother at 5 yr was similar between schedules. Bowel and urinary symptoms remained stable from 2 to 5 yr for all schedules. Some evidence of worsening overall sexual bother from baseline to 5 yr was less likely in the hypofractionated schedules compared with 74 Gy (odds ratios for increase in bother score vs 74 Gy: 0.55 [0.30-0.99], p = 0.009 for 60 Gy, and 0.52 [0.29-0.94], p = 0.004 for 57 Gy). General QoL scores were similar between schedules at 5 yr.

CONCLUSIONS

Longer follow-up confirms earlier findings, with similar patient-reported bowel, urinary, and sexual problems between schedules overall. The continued low incidence of moderate or high bother confirms that moderate hypofractionation should be the standard of care for intermediate-risk localised prostate cancer.

PATIENT SUMMARY

We looked at patient-reported outcomes up to 5 yr after treatment in a trial of different radiotherapy schedules for prostate cancer. The findings confirmed that shorter radiotherapy schedules were as safe as standard radiotherapy in terms of bowel, urinary, and sexual problems. TAKE HOME MESSAGE: Bowel, urinary, and sexual symptoms were similar between schedules up to 5 yr. The continued low incidence of moderate/high bother confirms that moderate hypofractionated radiotherapy should be considered the standard of care for men with intermediate-risk prostate cancer.

TAKE-HOME MESSAGE

- The authors present patient-reported outcomes of a phase III randomized controlled trial comparing conventional and hypofractionated high–dose intensity–modulated radiotherapy in prostate cancer. At 5 years of follow-up, there was a low incidence of moderate or high bother for bowel, urinary, and sexual symptoms. The hypofractionated high-dose radiotherapy schedules did not have a noticeable impact on patient-reported outcomes compared with conventional dosing.
- Short-course, high-dose radiotherapy for intermediate-risk prostate cancer is well-tolerated with limited impact on patient-reported outcomes when compared with conventional radiotherapy.
- – Amy N. Luckenbaugh, MD

The Controversy Around Testosterone Therapy

Source:
7 October 2021
Kalli Spencer (Urological Surgeon)
https://www.prostate.org.au/news-media/news/the-controversy-around-testosterone-therapy/

Like the ageing woman develops menopause due to the waning levels of oestrogen so too does the ageing man develop andropause or testosterone deficiency. Some men remain symptom free despite this change while others develop significant symptoms. These symptoms may include mood changes (depression), memory and sleep disturbances and lower energy levels. This condition may result in osteoporosis (increased risk of fractures), anaemia, loss of libido, sexual dysfunction and increased risk of metabolic syndrome (diabetes, cardiovascular disease, stroke, high cholesterol). Many other conditions can cause this group of symptoms and thorough investigation by a general practitioner is required. If a diagnosis is confirmed, then referral to an endocrinologist (doctor who manages conditions related to hormones) is required for testosterone replacement therapy.

As discussed in numerous blogs up until now, testosterone is thought to drive the growth and spread of prostate cancer. This is why androgen deprivation therapy is used to starve the cancer of testosterone by blocking its production and effect in those with advanced stages of disease or in combination with radiation therapy. However, the testosterone therapy used as treatment for testosterone deficiency is different to the testosterone naturally found in the body. For almost 80 years it has been believed that testosterone therapy could cause progression of cancer in those not diagnosed with prostate cancer yet or worsening of disease in those already diagnosed. Emerging evidence over the last decade says otherwise.

Morgentaler and Traish found that prostate cancer grows despite having low testosterone levels such as in those who are medically or surgically castrated or on oestrogen treatment1. Its also been shown that raising serum testosterone levels did not raise testosterone levels within the prostate2. Reports from men treated with testosterone therapy for localised cancer have shown low to absent recurrence rates3. Natale et al reported that those treated previously with either radical prostatectomy or radiation therapy don't seem to have an elevated risk of cancer recurrence or progression because of testosterone therapy2. Some evidence even suggests that a low testosterone state may have adverse effects on oncological outcomes with another study suggesting that bipolar androgen treatment may even be used to control prostate cancer through normalisation of testosterone concentrations4. Current thought is based on the saturation model which postulates that prostate cancer response to variations in testosterone levels at castration or near castration range reaches a point of maximal prostate stimulation beyond which further increases produce little or no further effect on the prostate4.

Testosterone therapy still remains controversial and a careful approach should be considered balancing risk of cancer with undue harm caused by failing to address sexual health, metabolic, cardiovascular, and other effects of testosterone deficiency. There is a need for long-term large-scale placebo-controlled trials to definitively assess the safety of this therapy.

Guidelines for Testosterone Therapy

1. Clinicians should confirm that the clinical history is consistent with a laboratory diagnosis of testosterone deficiency
2. Disclosure that there are limited data confirming testosterone safety and that the true risks are unknown
3. Confirm that there are no medical contraindications to therapy (e.g erythrocytosis [High red blood cell count])
4. PSA should be either undetectable (after prostatectomy) or stable (after radiation) for at least 6-12 months
5. Be aware there may be prostate cancer recurrence (this may or may not be related to the testosterone therapy)
6. It should be used with extreme caution in men at high risk for prostate cancer recurrence or progression
7. It should not be administered at the same time as ADT.

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.

Some Medications for ADT-Induced Hot Flashes

Source:
http://www.lifeonadt.com

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

Some Medications for ADT-Induced Hot Flashes

Generic Name	Trade Name	How Is the Drug Given?	How Often Is the Drug Given?
Estradiol	EstroGel®	Gel	Rubbed on the arm, abdomen (avoid belly button area), or thigh once a day
	Alora®	Patch	Applied weekly or twice weekly on the lower abdomen or buttocks
	Climara® Dermestril® Elleste Solo® Esclim® Menostar® Vivelle-Dot®		
Venlafaxine (SNRI)	Effexor	Pill	Depends on the dose and formulation
Desvenlafaxine (SNRI)	Pristiq®	Pill	Depends on the dose and formulation
Paroxetine (SSRI)	Paxil, Pexeva®	Pill	Depends on the dose and formulation
Fluoxetine (SSRI)	Prozac, Sarafem®, Selfemra®	Pill	Depends on the dose and formulation
Gabapentin	Neurontin	Pill	Depends on the dose and formulation
Medroxyprogesterone	Provera	Intramuscular injection into the thigh, abdomen, or arm	One injection every 3 mo
Megestrol	Megace	Pill	Depends on the dose and formulation

SNRI, serotonin norepinephrine reuptake inhibitor; SSRI, selective serotonin reuptake inhibitor.

Best Way to Recover Urinary Continence After Prostatectomy?

Nerve-Sparing Prostatectomy, Not Rehab or Duloxetine, Most Important Factor

Source:
13 September 2021
Mike Bassett, Staff Writer
https://www.medpagetoday.com/meetingcoverage/aua/94494

Pelvic floor muscle training (PFMT) and the use of duloxetine (Cymbalta) may not be the best options for recovering urinary continence after robotic-assisted radical prostatectomy, according to the randomized IMPROVE trial.

Of patients who received no treatment at all, 53% recovered urinary continence 6 months after surgery compared with 35% of patients in the PFMT arm (*P*=0.07) and 39% of patients in the duloxetine arm (*P*=0.2). A fourth arm combining PFMT and duloxetine had even poorer results, with just 27% of those patients achieving urinary continence at 6 months (*P*=0.009), reported Rafael Sanchez-Salas, MD, of McGill University in Montreal, during a late-breaking abstract session at the American Urological Association virtual annual meeting.

Among the patients who achieved urinary continence recovery, there was no difference in the time to recovery between the four arms, he added.

Of note, neurovascular bundle preservation was the only factor associated with urinary continence recovery in the study (OR 3.5, interquartile range 1.2-10.3, *P*=0.02), he said.

"Most people talk about how nerve-sparing robotic prostatectomy can help preserve sexual function," Ash Tewari, MD, of the Icahn School of Medicine at Mount Sinai in New York City, told *MedPage Today*. "The important finding of this study is that it is also important for improving urinary continence outcomes as well."

"Both pelvic floor muscle training and duloxetine have shown benefits in improving post-radical prostatectomy urinary incontinence, but this is mostly the result of retrospective series," Sanchez-Salas noted. The objective here was to assess the efficacy of PFMT and duloxetine in continence recovery after robotic-assisted radical prostatectomy in a prospective randomized controlled trial.

From 2015 to 2018, the IMPROVE study evaluated 240 patients with organ-confined prostate cancer who had urinary incontinence after surgery. They were randomized to four arms of 60 patients each: one with no treatment (control arm), one with duloxetine alone (60 mg at bedtime nightly for 3 months), one with PFMT alone (consisting of pelvic muscle contractions with biofeedback weekly for 3 months), and one combining PFMT with duloxetine.

The primary endpoint of the study was continence rates at 6 months, defined as no leakage of urine during 3 consecutive days on the 24-hour pad test. Secondary endpoints included urinary symptoms and quality of life, as assessed by a visual analog scale (VAS), the International Prostate Symptom Score (IPSS), and the King's Health Questionnaire.

Of the patients in the study, 89% completed a year of follow-up. Among the patients in the duloxetine arms, 58% had properly taken the drug, while 38% of patients in the PFMT arms performed at least 10 weeks of training.

NB The role for drug therapy in stress incontinence is very limited. Duloxetine, which is a serotonin and noradrenaline reuptake inhibitor, has some effects on increasing bladder outlet resistance. It has been effective in controlling mild urinary stress incontinence in women, but it is not approved for this indication in Australia.

An evaluation of symptoms using the IPSS showed that a greater proportion of patients in the treatment arms had moderate to severe urinary symptoms: 30% in the duloxetine alone arm, 27% in the PFMT arm, and 24% in the combination arm compared with 11% in the control arm.

As for quality of life as assessed with the VAS, 17% of patients in the control group reported being uncomfortable or worse compared with 45%, 44%, and 38% of patients in the duloxetine, PFMT, and combined arms, respectively.

"Based on our results we do not recommend routinely indicating these interventions for patients after robotic radical prostatectomy," Sanchez-Salas concluded. "Neurovascular bundle preservation was the only factor found to be associated with continence recovery, and we go back to the idea of the importance of a clean and precise surgical intervention to improve functional outcomes."

Continence Products

- Depend starter Packs by Kimberly-Clark are available from: www.dependcare.com.au
- Tena samples are available from: https://tena.com.au

All products are available from supermarkets and pharmacies

Source:
8 October 2021
http://www.lifeonadt.com/life-on-adt-blog/2021/10/8/on-diabetic-risk-and-adt

On Diabetic Risk & Androgen Deprivation Therapy

Among the more serious side effects of ADT is the increased risk of diabetes. Here are two new papers that advance our understanding of the relationship between prostate cancer and diabetes...as well as the implications of treating the diabetes itself.

The first paper, out of Japan, focuses on 230 patients on ADT. The patients were divided into those who either had pre-existing diabetes or developed it while on ADT. What the authors show is that the patients who developed diabetes while on ADT were more likely to experience their cancer progressing to the more aggressive, castrate resistant form. What this means is that ADT not only increases the risk of diabetes, but acquiring diabetes while on ADT is an unfavourable sign for managing the cancer itself.

The other paper is a small study out of Egypt, which did not look at pre-existing versus newly acquired diabetes. Rather, it asked the simple question of whether using one of the standard drugs for treating diabetes, namely metformin, significantly improved the patients' cancer control.

The sample size was small, with only 48 and 47 patients in the metformin-treated and non-metformin control groups, respectively. The study showed on overall survival benefit to treating the diabetes with metformin, although it was not quite statistically significant. The study did show that metformin significantly helped the men on ADT keep their waist circumference from growing, which is itself a feature of metabolic syndrome. And metabolic syndrome, when it emerges for men on ADT, is a sign of increased diabetic risk.

Together these two papers provide more reasons why prostate cancer patients on ADT need to manage their lifestyle to reduce the risk of diabetes. It is not only good for avoiding the damage that diabetes can cause, but it may be good for controlling the cancer itself.

To read the full paper about newly acquired versus pre-existing diabetes, see:

https://pubmed.ncbi.nlm.nih.gov/34433857/

To read the study abstract about treating diabetes with metformin, see:

https://pubmed.ncbi.nlm.nih.gov/34428740/

Source:
Neil Osterwell
23 September 2021
https://www.medscape.com/viewarticle/959340

Abiraterone Also Ups Survival in Nonmetastatic Prostate Cancer

Abiraterone should feature in the new standard of care for nonmetastatic prostate cancer, in addition to having recently been hailed as such for metastatic castration-resistant prostate cancer. Both calls were made by experts in presentations at the European Society for Medical Oncology (ESMO) Annual Meeting 2021.

The latest claim is for the combination of abiraterone acetate (Zytiga) and androgen deprivation therapy (ADT) for the treatment of men with high-risk, nonmetastatic prostate cancer.

It is based on the most recent results from the multi-arm, multistage STAMPEDE (Systemic Therapy in Advancing or Metastatic Prostate Cancer: Evaluation of Drug Efficacy) trial.

Those results show that for men with high-risk cancer that had not yet metastasized, 2 years of therapy with abiraterone and ADT resulted in a 47% reduction in the risk for metastasis and a 40% reduction in the risk for death compared with ADT alone.

Adding enzalutamide (Xtandi) to the abiraterone/ADT combination increased toxicity but did not improve efficacy.

"We show that 2 years of abiraterone-based therapy significantly improves metastasis-free survival and overall survival of high-risk nonmetastatic prostate cancer [patients] starting androgen deprivation therapy and should be now considered a new standard of care," commented lead investigator Gerhardt Attard, MD, PhD, from University College London, London, United Kingdom.

At the meeting, this presentation followed presentation of results from the PEACE-1 trial, which showed that the addition of abiraterone to standard of care produced a "clinically meaningful improvement in survival" for men with de novo metastatic castration-sensitive prostate cancer, as reported by Medscape Medical News.

Sat for 15 Years on the Shelf

Attard noted that abiraterone, which was developed three decades ago, "had a bumpy ride initially; it spent 15 years on the shelf." But in the ensuing years, "tens of thousands of men's lives have been improved by the work of the chemists and biologists that developed this drug."

Prostate Heidelberg Cancer Support Group Meetings

Guest Speakers:

Tues 19 October 10:30am

Professor Nikolajs Zeps

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

A cancer biologist by background Nik has most recently led national initiatives to develop and implement research infrastructure, policy and practice. He has been an expert adviser to the TGA, served on the Research Committee and Australian Health Ethics Committee of the NHMRC and serves on national and International advisory boards across a diverse range of clinical trials and biomedical research activities. His expertise includes a deep practical knowledge of conducting research in health services and a demonstrated capability of implementing functional change in organisations that improve productivity through positive and sustainable cultural change.

Nik retains an academic role through the Eastern Health Clinical School of Monash University where he is an adjunct Professor and is Clinical Research Lead of Monash Partners through engagement with Chrysalis. He is a current Chief Investigator on grants of over $5million and still co-supervises post graduate students and publishes academic papers. Most recently Chrysalis have partnered with Movember to assist with the upgrading of the Prostate Cancer Outcomes Registry-ANZ.

Tues 14 December 10:30am

TBA

"Prostate Cancer Treatment Progress over the last 10 years"

When to use Chemo

In the September issue of *Prostateapedia* Charles E Myers, Jr., MD reported on when to use Taxotere (docetaxel) chemotherapy.

Taxotere (docetaxel) is most commonly used after hormonal therapy options have lost their effectiveness. However, the CHAARTED trial showed that this is not necessarily the best option for all patients. This trial involved randomizing newly diagnosed men with metastatic prostate cancer to Lupron (leuprorelin) alone versus Lupron (leuprorelin) plus Taxotere (docetaxel) chemotherapy. Patients in both groups were divided into those with extensive disease versus those without extensive disease. The results showed a dramatic survival benefit for Taxotere (docetaxel) for those with extensive disease, but not in those patients with less extensive disease. The overall survival for those with extensive disease on Lupron (leuprorelin) plus Taxotere (docetaxel) versus those on Lupron (leuprorelin) alone showed a dramatic improvement.

The results of the CHAARTED trial were subsequently confirmed by the STAMPEDE trial. Despite the clear survival benefit to early Taxotere (docetaxel), many patients with extensive disease do not receive early Taxotere (docetaxel), but rather proceed to exhaust all hormonal therapy options first. Perhaps the major reason for this is that many prostate cancer patients are very reluctant to go on chemotherapy. First, many have family or friends who have received aggressive multi-drug chemotherapy for other cancers that was extremely toxic. Second, many men think that going on chemotherapy means that the end is near. Neither of these objections reflect the reality of Taxotere (docetaxel) treatment.

If the many advantages to early Taxotere (docetaxel) administration are reviewed he hopes it would leads more patients with extensive disease to taking advantage of Taxotere (docetaxel) as part of their initial treatment.

For more information https://online.flippingbook.com/view/485103127/2-3/

PCa Clinical Trials

For Further information on current and recruiting trials visit:

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

"What are your thoughts on filling out health forms?

Researchers at the University of Sydney are running a study to explore your thoughts on a pictorial version of a scale that measures health symptoms.

If you:

- Are aged 18 years and older
- Have low English health literacy levels OR are from a culturally and linguistically diverse background (i.e. non-English-speaking background)
- Have existing or previous cancer experience
- Are able to provide informed consent

We would like to talk to you!

To find out more, visit:
< https://redcap.sydney.edu.au/surveys/?s=THFKFWHW74>"

For Arabic: https://redcap.sydney.edu.au/surveys/?s=ERFR4NY8R8

For Chinese: https://redcap.sydney.edu.au/surveys/?s=CXXCDHXJWX

For Vietnamese: https://redcap.sydney.

Advanced Prostate Cancer Experimental Radioactive Treatment – Clinical Trial Decision Making: Patient Experiences

Abstract

Objectives Nested qualitative studies within clinical trials provide the opportunity to better understand participant experiences of participation and identify areas where improved support is required. The purpose of this qualitative study is to describe the lived experiences of men with advanced prostate cancer participating in the TheraP trial; a randomised trial of ^{177}Lu-PSMA-617 compared with cabazitaxel chemotherapy.

Methods Fifteen men with advanced prostate cancer were recruited from the TheraP clinical trial and interviewed at three time points during the trial. Interviews were inductively analysed using thematic analysis. This research paper reports the results from the baseline interview at commencement of the trial, focusing specifically on participants' enrolment experiences.

Results Four themes were identified representing the lived experiences of men with advanced prostate cancer deciding to participate in the TheraP trial: (1) hoping to survive; (2) needing to feel informed; (3) choosing to participate and (4) being randomised. The process of deciding to enrol in a clinical trial is filled with indecision, emotional difficulties and focused on a desire to live.

Conclusions For men with advanced prostate cancer, the experience of deciding to enrol in a clinical trial is principally driven by a desire to survive but interlinked with the need to make an informed decision as participants in this study expressed a preference for allocation to the experimental arm. Men seeking to enrol in clinical trials of new prostate cancer treatments would benefit from improved informational and decision support.

Trial registration number NCT03392428, ANZUP1603.

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
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 – (subject to COVID)

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
- Targeting PSMA
- What is the Role of Modern Imaging
- 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
- Take Responsibility

Prostate Cancer Trials
- UpFront PSMA & MOSES Study

September 2021
- Targeting PSMA
- PEEK Study
- Skeletal Events & Bone Modifying Agents in Castration Resistant PC
- Abiraterone +docetaxel+ADT for Newly Diagnoses Metastatic PC
- Brief, Intense Radiation & Hormone Therapy for Very High Risk PCa
- Progression-directed Therapy for Oligoprogression
- Insights into PC metabolism
- Diagnostic Accuracy of PSMA 18F-DCFPyL PET/CT
- Risk of PC in relatives of PC
- 11/12 Relugolix – Expected to Alter Treatment
- Whole-pelvic radiation Therapy for High-Risk Patients
- It's time to Retire a Common Biopsy
- Cognitive Function / Marital Status & PC Incidence
- Covid Passports
- Medical Bills: Out of Pocket Costs
- Prostate Cancer Trials
- UpFront PSMA & ENZAp

October 2021
- Continuous vs Intermittant ADT
- Predict Risk Tool
- Doubling Time Tool
- High Discontinuation Rate in AS
- AI Program Helps Detect PCa
- Plant Based Diet
- Obesity Ups MCRPCa Survival
- Impact of Hypofractionated RT on Patient Outcomes
- Controversy Around Testosterone Therapy
- Medications for ADT Hot Flashes
- Best Way to recover Urinary Continence after PR
- Diabetic Risk & ADT
- Abiraterone for NMPC
- When to Use Chemo

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