Prostate Heidelberg Cancer Support Group

Prostate Heidelberg

July 2022 Issue 220

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

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 face-to-face PHCSG Meeting
Tuesday 19 July 10am – 12:30pm

To join via Zoom: Copy link and paste into your browser

https://us02web.zoom.us/j/83533743745?pwd=MjRodURvenpXbG9lOXhacmNrZWRsZz09

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MEMBERSHIP

FULL CALENDAR YEAR PHCSG MEMBERSHIP $20

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

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

Prostate Heidelberg Cancer Support Group Guest Speaker –

Tues 19 July

Debra Garroun

PCFA Network Support Officer

Member News

This month David Campbell, our Prostate Heidelberg member, has supplied photos of the PCFA Car Rally in May this year.

Many thanks David, co-driver son Joel, and all the other 37 drivers for raising funds for Prostate Cancer.

Prostate Cancer Foundation of Australia

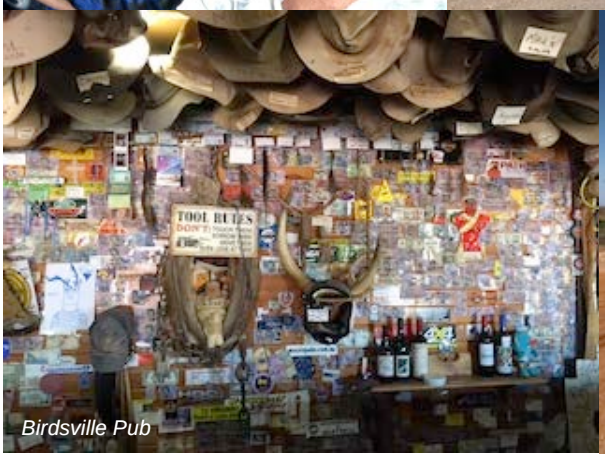
DRY JULY — Dry July 2022

the LONG run — The Long Run

David & Joel

En route to Bourke

Flinders Ranges



Birdsville Pub

Farina Ruins old railway town on way to Flinders Ranges

Prostate Heidelberg Cancer Guest Speaker

Tues 16 Aug

Professor Avni Sali AMMBBS, PhD, FRACS, FACS, FACNEM
Member of the Order of Australia
Founding Director of the National Institute of Integrative Medicine.
Professor Avni Sali AM is often referred to as the father of Integrative Medicine in Australia. In 1996 he was the Founding Head of the Graduate School of Integrative Medicine at the Swinburne University in Melbourne. In 2009 he established the not-for-profit, charitable National Institute of Integrative Medicine (NIIM), and became its founding Director. In the past he was also Head of the University of Melbourne Department of Surgery at Heidelberg Hospital.

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

My Cancer Care Record

SOURCE:: https://www.nemics.org.au/page/improving_cancer_care/My_Cancer_Care_Record/

NEMICS - *North Eastern Melbourne Integrated Cancer Service* have created a folder where PCa patients can keep details of their medical records.

My Cancer Care Record is a resource that helps people affected by cancer (patients, carers, families and support people) to manage the information related to their care and treatment. It has been developed by the Consumer Reference Group of the North Eastern Melbourne Integrated Cancer Service NEMICS). It provides tips on questions and information to ask health professionals. It can also assist you to record specific details that you may be frequently asked and find hard to remember.

The folder is aimed at helping with issues related to managing information when you have maultiple treatments provided by multiple people, across different services and over long periods of time. It can assist you to be able to communicate across the variety of health care professionals involved in your care.

My Cancer Care Record can also help the clinicians working with you. It can provide easy access to information they often require such as:

- copies of your test results and letters from other hospitals/doctors
- current medication, medical and family history, current treatment schedules
- details of side effects and symptoms you might have had since your last appointment
- contact details of other clinicians involved in your care

The folder has nine key sections to help you organise your medical information: Health Summary; Medication; Contacts; Appointments; Tests and test results; Treatment; Support; Financial and legal; My Tab.

My Cancer Care Record can be used in either electronic or hard copy. More information on, including a link to request a free hard copy of the folder from NEMICS, is available here https://www.nemics.org.au/page/improving_cancer_care/My_Cancer_Care_Record/

Prostate cancer overtakes breast cancer as Australia's most common cancer

https://pcfa.org.au/news-media/news/prostate-cancer-overtakes-breast-cancer-as-australia-s-most-common-cancer/

By Professor Jeff Dunn AO Chief of Mission and Head of Research I Prostate Cancer Foundation of Australia President-Elect; Union for International Cancer Control Monday, July 11, 2022

Prostate cancer diagnosis has reached a crisis point. It is now the most common cancer diagnosed in Australia, overtaking breast cancer as the country's leading cause of cancer. To make matters worse, testing guidelines are based on outdated data and are likely contributing to the deaths of an increasing number of men. New data by the Australian Institute of Health and Welfare estimates 24,217 Australian men will be diagnosed with prostate cancer this year, compared to 20,640 women diagnosed with breast cancer. That's a 34 per cent increase on [the] previous year and a call to action for all Australians. For many men, this news comes as no surprise, confirming the growing number of cases they have seen among men in their community. For PCFA, this news confirms what we have been saying for some time - that prostate cancer is among the most significant challenges facing men's health in Australia, and simply cannot be ignored any longer by policy makers and practitioners who do not realise the significant toll the disease takes on our lives. Prostate cancer accounts for more hospitalisations than any other type of cancer in the country. This data provides further justification for an urgent review of the nation's Clinical Guidelines for PSA Testing, which measures prostate-specific antigen levels in the bloodstream. The fact is existing guidelines are now six years old and based on outdated data. We hold grave fears they are putting men's lives at risk, with 66 men now being diagnosed every day and more than 3500 men expected to die from prostate cancer this year - a toll we can avoid if the disease is diagnosed early. PCFA surveys have found three in every four Australians do not know about or understand the PSA test guidelines and it is this that impedes early detection and diminishes population-wide survival prospects. There are major concerns about the nation's capacity to provide best-practice care for the growing number of men being diagnosed with the killer disease.

Nationally, we have seen a fourfold increase in the proportion of men waiting for more than a year for a prostatectomy, with nearly 1 in 10 patients waiting 12 months or longer in areas where incidence and referrals are higher, as is the case in NSW. We cannot afford to underestimate the impact this will have on our health services, knowing that prostate cancer accounts for more hospitalisations than any other type of cancer in the country.

Combination of Docetaxel vs Nonsteroidal Antiandrogen With Androgen Deprivation Therapy for High-Volume Metastatic Hormone-Sensitive Prostate Cancer

The Alternative Route

While studies have clearly shown the benefit of chemotherapy in patients presenting with high-volume metastatic hormone-sensitive prostate cancer, in the real-world experience, many men continue to get combined androgen deprivation therapy (ADT) with bicalutamide. To understand the potential detrimental impact of this substandard regimen, this study used propensity score–matched analysis to evaluate the survival differences between patients receiving docetaxel and those receiving bicalutamide. The authors showed that docetaxel significantly improved the overall and cancer-specific survival of these patients. It also significantly extended the time to castration resistance by 10 months and prolonged the time to second-line progression. While some patients may not be candidates or decline docetaxel, this study adds to the growing literature that supports chemotherapy as a combined treatment for men presenting with high-volume hormone-sensitive metastatic prostate cancer. This study would also suggest that these men, who have been recently started on combined ADT with bicalutamide, could benefit from a more aggressive treatment regimen.

TAKE-HOME MESSAGE

- This retrospective study compared the oncological outcomes of docetaxel plus androgen deprivation therapy (ADT) versus nonsteroidal antiandrogens (NSAA) plus ADT in patients with high-volume metastatic hormone-sensitive prostate cancer (mHSPC). The docetaxel plus ADT group had a significantly longer median OS than the NSAA plus ADT group (not reached vs 49 months). Similarly, the median cancer-specific survival was significantly longer in the docetaxel plus ADT group than in the NSAA plus ADT group (not reached vs 55 months). Furthermore, the median time to castration-resistant prostate cancer and the median time to second-line progression (time from mHSPC diagnosis to progression after second-line therapy) was significantly longer among patients in the docetaxel plus ADT group than in the NSAA plus ADT group.
- This study suggests that the use of docetaxel plus ADT in patients with high-volume mHSPC results in a significantly prolonged OS and cancer-specific survival compared with the use of NSAA plus ADT.

SOURCE:
14 June 2022
World Journal of Urology
https://www.practiceupdate.com/c/136669/67/11/?elsca1=emc_enews_weekinreview&elsca2=email&elsca3=practiceupdate_advancedprostat

A Fleet of 38 unwashed vehicles

Treatment Intensification in Metastatic Hormone-Sensitive

SOURCE:
10 May 2022
Zachary Klaassen MD MSC
https://www.pcf.org/c/treatment-intensification-in-metastatic-hormone-sensitive-prostate-cancer/?utm_source=NewsPulse&utm_medium=email&utm_campaign=JUN22NP

If you've been diagnosed with metastatic hormone-sensitive prostate cancer (mHSPC), you have many treatment options. Doctors and researchers at the Advanced Prostate Cancer Consensus Conference held in April 2022 in Lugano, Switzerland reviewed the latest clinical trial information and highlighted key points for clinicians.

Metastatic prostate cancer means that prostate cancer has spread outside of the prostate gland to other organs, most commonly the lymph nodes and bones, but also not uncommonly to the liver and lungs. mHSPC may manifest in two main ways: the cancer is metastatic at the time of diagnosis ("de novo"), or it has recurred after treatment ("metachronous") for localized disease (typically after radiation or surgical removal of the prostate gland). Patients with mHSPC are started on androgen deprivation therapy (ADT or "hormone therapy"), and see their PSA drop as the tumor shrinks.

While historically testosterone was reduced (to very low or "castrate" levels) by removing both testicles (termed bilateral simple orchiectomy), today, most men who need ADT receive medications that accomplish this medically, rather than undergoing surgery. There is a complex signaling pathway between parts of the brain, the pituitary gland, and the testicles that leads to testosterone production. This pathway may be disrupted by medications that affect the signals between the brain and pituitary glands – groups of medications called GnRH (LHRH) agonists (i.e., leuprolide) or antagonists (i.e., degarelix).

Treatment Intensification: Doublet Therapy
Until recently, ADT alone was the mainstay of treatment. Starting in 2015, data from large clinical trials (the GETUG-AFU15, STAMPEDE and CHAARTED trials) demonstrated that adding chemotherapy (docetaxel) to ADT improved survival in men with mHSPC to nearly 4 years from their initial diagnosis. Shortly thereafter, other trials showed that adding other oral medications such as abiraterone (the STAMPEDE and LATITUDE trials), apalutamide (the TITAN trial), and enzalutamide (the ENZAMET and ARCHES trials) could also significantly prolong life beyond just ADT alone. Furthermore, additional data from the STAMPEDE trial showed that adding radiation therapy to the prostate gland, even in patients with metastatic disease, prolonged survival.

Currently, doublet treatment intensification is standard of care per all of the prostate cancer guidelines. However, in practice, data from the Veterans Affairs health care system, as well as from Medicare claims data suggests that ~45%-80% of men do not receive treatment intensification beyond ADT alone. The reason(s) for this lack of intensification are unknown and is an active area of research to provide further clarity.

Treatment Intensification: Triplet Therapy
Two recent clinical trials have provided further evidence that treatment intensification with "triplet therapy" may improve survival even beyond standard of care doublet therapy. The PEACE-1 trial tested mHSPC patients treated with the "triplet" of ADT + abiraterone + docetaxel and found that they were 25% less likely to die versus patients treated with docetaxel + ADT (no abiraterone). The addition of abiraterone also prolonged the time to cancer progression by 2.5 years. The second trial was the ARASENS trial which tested the "triplet" of ADT + docetaxel + darolutamide (another oral second-generation anti-androgen) versus ADT + docetaxel ("doublet" therapy) in mHSPC patients. This trial found that patients treated with triplet intensification had a 32% decreased risk of death compared to doublet therapy patients. These patients also had improved time to castration resistance (when the PSA increases and disease worsens, despite hormone therapy), time to pain progression, time to symptomatic skeletal related events (i.e., bone fractures, needing radiation to the bones, etc.), and time to next cancer therapy. Importantly, for both trials, these improved outcomes of triplet therapy intensification were associated with only a modest increase in adverse events.

The decision on which therapies to combine can be complex and is influenced by several factors, including:

- Whether the patient is newly diagnosed with metastatic prostate cancer or has prostate cancer recurrence
- The amount of metastatic disease, classified as low vs. high volume
- Other patient health factors

Ultimately, if you are newly diagnosed with metastatic prostate cancer or have a new recurrence of your cancer that has spread (mHSPC), talk to your doctor about your treatment options. Ask if additional therapies beyond ADT alone may be right for you.

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

Cooper Creek

Clinically Localised Prostate Cancer: AUA/ASTRO

SOURCE:
Issue 5 Prostate Cancer Practice Review 2022

Guideline

The American Urological Association (AUA) and the American Society for Radiation Oncology (ASTRO) have updated their recommendations for active surveillance for patients with low-risk prostate cancer.

In the guideline, low-risk patients and very-low-risk patients are combined into a single category of "low-risk," because the treatment for the two groups of patients is consistent.

Although radical prostatectomy and radiotherapy remain the preferred options for men who choose treatment for their disease, for patients with low-risk prostate cancer, active surveillance is recommended as the preferred management option. For the first time, active surveillance is also the recommended treatment for select patients with favourable intermediate-risk prostate cancer; clinicians should also discuss radiation therapy and radical prostatectomy with favourable intermediate- risk patients. Guidance is provided on how such patients should be selected for active surveillance.

Other updates to the guideline include:

- Shared decision making, with the understanding that for a decision to be made, both patient and physician need appropriate information regarding the risk posed by the cancer and the risk posed by treatment;

- A new section on the use of genetic markers to individualise treatment of men with advanced or metastatic prostate cancer.
- Updates to pretreatment evaluation for patients, primarily the role of imaging and the utility of next-generation imaging, such as prostate-specific membrane antigen-based PET scans. The increased sensitivity and specificity of this modality allows better upfront staging of newly diagnosed patients and earlier identification and treatment of metastatic disease.
- Aspects of both radiotherapy and surgery, including nerve sparing, pelvic lymph node dissection, and adjuvant/neoadjuvant therapy, such as chemotherapy or hormone therapy delivered before or after the primary treatment.
- The most recent information regarding the occurrence and management of urinary incontinence, erectile dysfunction and other adverse events associated with more invasive treatment choices.

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

A frog hiding in the dunny! On the way from Bourke to Tibooburra

ASCO 2022: ENZAMET Update Confirms Overall Survival Benefit to Adding Enzalutamide to Testosterone Suppression for Metastatic PCa

SOURCE:
5 June 2022
Ian D Davis PhD MBBS
https://www.practiceupdate.com/c/137403/67/11/?elsca1=emc_enews_weekinreview&elsca2=email&elsca3=practiceupdate_advancedprostatecancer&elsca4=advancedprostatecancer&elsca5=newsletter&rid=NTMyMjc0MDc4NjM0S0&lid=20849595

Benefits were apparent even among patients who received docetaxel

The addition of enzalutamide to testosterone suppression therapy improves overall survival (OS) outcomes among patients with metastatic hormone sensitive prostate cancer, even if they received docetaxel, according to an updated analysis of ENZAMET, presented at the annual meeting of the American Society of Clinical Oncology, which took place here and online from June 3 to 7.

"ENZAMET adds to the body of knowledge from other clinical trials that now inform best practice for metastatic hormone sensitive prostate cancer," said lead author Ian D. Davis, PhD, MBBS, of Monash University in Melbourne, Australia, during his presentation of the data. "When testosterone suppression alone is used, we see better outcomes for patients with low volume disease than for high volume, and those with metachronous presentation of metastasis tend to do better than those with synchronous presentation at the time of diagnosis."

Various combinations of therapies with testosterone suppression have been shown to improve OS in these patients. The first planned interim analysis of ENZAMET revealed a clinically meaningful OS benefit with the addition of enzalutamide. However, there was no evidence of additional OS benefit for enzalutamide among patients who received docetaxel. Enzalutamide also resulted in additional toxicity, particularly early in treatment, but patient-reported outcomes suggested this was outweighed by clinical benefit. At ASCO 2022, Dr. Davis presented results of a planned analysis following 470 events, with data cutoff occurring on January 19, 2022.

ENZAMET is an international, open-label, active control clinical trial in which 1125 patients with metastatic hormone sensitive prostate cancer recruited from 83 centers in Australia, New Zealand, Ireland, the United Kingdom, Canada, and the United States were randomized to testosterone suppression therapy plus a standard nonsteroidal antiandrogen (bicalutamide, nilutamide, or flutamide) or to testosterone suppression plus enzalutamide 160 mg/day. Patients were evaluated every 12 weeks, and the addition of docetaxel was permitted at the discretion of the investigators. The primary endpoint of the study was OS.

After a median follow-up of 68 months, median OS was 73.2 months in the control arm and was not reached in the enzalutamide arm, for a hazard ratio of 0.70 (95% confidence interval 0.58–0.84, P < .001). Five-year OS was 57% versus 67%, respectively. Analyses by prespecified subgroups revealed that benefits of enzalutamide were fairly consistent across subgroups, including those based on prior use of docetaxel, presence of high volume disease, and presence of synchronous disease. Nevertheless, there was a suggestion that benefits of enzalutamide may have been lower among patients who received early docetaxel and among those with high volume disease. Dr. Davis noted that the findings relating to docetaxel use may be confounded by the reasons for which patients were deemed good candidates for early docetaxel therapy in the first place.

Patients assigned to enzalutamide remained on this treatment for a median of 58 months, compared with 23 months among those in the control group. At 5 years, 48% of patients on enzalutamide remained on the study drug, compared with 22% in the control group. Notably, there was much higher use of enzalutamide or abiraterone in the control group beyond progression, compared with the enzalutamide group. At the time of the analysis, 76% of patients in the control arm had received one of these two agents after progression, compared with 26% in the enzalutamide arm. Among patients randomized to enzalutamide, 39% had no further treatment recorded after cancer progression. Thus, "the survival benefit of enzalutamide was not due to lack of access to effective therapies in the control group," said Dr. Davis.

These findings, concluded Dr. Davis, "confirm the benefits of enzalutamide when added to best practice standard of care. ... No major differences in the effects of enzalutamide were detectable in subgroup analyses, and the benefits of enzalutamide were particularly evident among those with low volume disease. The exploratory analyses support the claim that enzalutamide is beneficial when added to testosterone suppression plus docetaxel."

The ENZAMET trial is ongoing.

ENZAMET received funding from and was conducted in collaboration with Astellas Pharma.

Cordillo Downs Shearing Shed

The Role of Radiotherapy in Oligometastatic Hormone-Sensitive Prostate Cancer

This paper reviews the role of radiotherapy in the management of oligometastatic hormone- sensitive prostate cancer. Oligometastatic hormone-sensitive disease is defined by the number of metastatic lesions on standard imaging (CT/MRI and isotope bone scan). Prostate-specific membrane antigen PET/CT provides better accuracy compared with conventional imaging, but its role in determining subsequent clinical outcomes is yet to be defined. Recent trials have shown that radiotherapy improves survival in newly diagnosed oligometastatic hormone-sensitive prostate cancer; radiotherapy combined with systemic therapy is now the standard of care. The role of stereotactic ablative radiotherapy in newly-diagnosed oligometastatic hormone-sensitive prostate cancer remains unclear.

SOURCE:
Prostate Cancer Practice Review issue 5

Sunset drinks on Big Red before returning to Birdsville

Systematic Review of the Impact of a Plant-based Diet on Prostate Cancer Incidence and Outcomes

SOURCE:
Prostate_Cancer_Practice_Review_Issue_5.pdf
J Urol. 2002;207(supp 5):e42

This was a systematic review of the benefits of plant-based diets on prostate cancer.

A systematic search was conducted of PubMed, Embase, the Cochrane Library, Scopus, the Web of Science, AMED, Nursing and Allied Health, and CINAHL Plus in June 2020. Studies were eligible if they reported primary data on full vegan or vegetarian diets and incidence of prostate cancer among at-risk men, or oncologic, general health/nutrition, or quality of life outcomes among patients with prostate cancer or their caregivers.

A total of 31 studies were included. Interventional studies showed a benefit of a plant-based diet for men on active surveillance for localised prostate cancer or with biochemical recurrence after treatment; benefits in short-term oncologic outcomes as well as improvements in nutrition and general health were observed.

Epidemiologic studies demonstrated either protective or null associations for a plant-based diet. A vegan diet consistently showed a benefit for risk and/or outcomes.

Of note, no studies evaluated the impact of a plant-based diet on long-term prostate cancer outcomes.

Big Red the largest of 110 sand dunes in the Simpson Desert

Recent Advances in the Management of Metastatic Prostate Cancer

SOURCE:
2 September 2021
https://ascopubs.org/doi/full/10.1200/OP.21.00206

ABSTRACT

Management of metastatic prostate cancer has undergone a revolution over the past decade with the introduction of several novel agents and repurposing of others. Several clinical trials reported improved outcomes with the intensification of androgen deprivation therapy by the addition of docetaxel chemotherapy or novel hormonal agents (abiraterone, enzalutamide, or apalutamide) in the metastatic castration-sensitive state. Relugolix has been recently approved as the first oral gonadotropin-releasing hormone receptor antagonist agent with a superior cardiovascular side-effect profile, and serum testosterone suppression compared with a gonadotropin-releasing hormone agonist, leuprolide. Poly-ADP ribose polymerase inhibitors (olaparib and rucaparib) have demonstrated significant clinical benefit for patients harboring deleterious mutations in genes belonging to the homologous recombination repair pathway and have received Food and Drug Administration approval. Recently, lutetium-177-prostate-specific membrane antigen-617 with standard of care treatment has shown to improve overall survival in men with advanced-stage prostate-specific membrane antigen–positive metastatic castration-resistant prostate cancer. These recent approvals, successes, and the ongoing investigation of multiple novel agents are expected to continue to dramatically improve survival outcomes of men with metastatic prostate cancer in the coming years.

INTRODUCTION

In 2021, it is estimated that 26% of new noncutaneous cancer cases will be because of prostate cancer resulting in 11% of cancer-related deaths in the United States, making it the most common malignancy in men and the second leading cause of cancer mortality.[1] Following onset of metastatic disease, the disease is invariably fatal with a 5-year survival rate of only 30%. Furthermore, the incidence of metastatic prostate cancer seems to have increased in all races and age groups over the past decade.[1]

Herein, we discuss the most recent advances in the management of metastatic prostate cancer and highlight recently approved agents and ongoing clinical trials. We will review the mechanism of action of recently approved agents. We also present principles for optimal therapy selection based on clinical and molecular criteria, current roadblocks regarding treatment intensification in the castrate-sensitive stage, and challenges with treatment sequencing. Finally, we summarize promising therapies currently under development.

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.

Birdsville Pub – icon of the Australian Outback

New Study Shows Multivitamin Use Is Not Linked To PCa

SOURCE:
13 June 2022
https://www.pcf.org/c/multivitamins-prostate-cancer-risk/?utm_source=HWlist&utm_medium=Email&utm_campaign=JUN22HW

In a large study of nearly 50,000 men, regular or long-duration multivitamin use did not increase or decrease prostate cancer risk.

When it comes to cancer – prostate or otherwise – people often have questions about what could have caused it, if there's anything they could have done to prevent it, or whether certain dietary changes or supplements can cure it.

Why Study Multivitamins?

Multivitamin use is very common: 34%-49% of older adults report regular use, and thus it's important to know what effect this might have on the development of various conditions, including prostate cancer.

In prostate cancer, there has been conflicting information. One large randomized clinical trial showed no link between multivitamin use and risk of developing prostate cancer overall. Other studies following large numbers of men over time showed inconsistent results, with some studies finding no association and others suggesting an increased risk of advanced prostate cancer.

Now, results of a new study led by Dr. Yiwen Zhang of the Harvard T.H. Chan School of Public Health, along with PCF-funded researcher Dr. Lorelei Mucci, are shedding new light on the relationship between multivitamin use and the development of prostate cancer.

Zhang and team analyzed data on more than 48,000 men in the Health Professionals' Follow-Up Study, which has followed male health professionals since 1986. The study collects detailed information on health conditions and lifestyle habits, including the key variables (multivitamin use and frequency, and diagnosis of prostate cancer), other dietary supplement use, intake of foods such as tomatoes and fish, body mass index (BMI), PSA testing, family history of prostate cancer, and more.

Among the 48,000 men, about 30,000 were current or past users of multivitamins. There were approximately 7,000 cases of prostate cancer over 30 years of follow-up. Using mathematical modeling, Zhang and team found no association between multivitamin use and risk of prostate cancer overall or of advanced or fatal prostate cancer. In other words, men who reported regular use of multivitamins (7 or more tablets per week) had a similar risk of prostate cancer compared with men who never took multivitamins. Long-term multivitamin use of 15 years or more was also not linked to diagnosis of or death from prostate cancer. The researchers further considered how other factors (e.g., other supplement use, BMI, PSA testing) may also be related to multivitamin use and diagnosis of prostate cancer. Accounting for these factors did not change the conclusions.

The study has several strengths, including collection of multivitamin use data at multiple timepoints, extensive data on other relevant factors, and long follow-up time. One limitation is that because the study population consists of highly-trained health professionals (mostly white) who were expected to be already well-nourished, the results might not be generalizable to populations with different nutritional status or ethnic groups.

Prostate Cancer Prevention

So, if a multivitamin is not the answer, what CAN you do to prevent prostate cancer, or reduce the risk of recurrence if you've been diagnosed? Research suggests that certain dietary factors may help. To lower your risk of fatal prostate cancer, avoid whole milk, opt for healthy vegetable fats (like olive oil), choose fish over red and processed meat, and include cooked tomatoes and cruciferous vegetables (like broccoli) in your diet. If you smoke, ask your doctor for support to quit. And many studies have shown that exercise is a powerful tool to lower the risk of prostate cancer recurrence – by as much as 60%. For more, see our series of articles with Dr. Lorelei Mucci on lifestyle and prostate cancer.

Do You Need a Multi?

What about taking a multivitamin for general wellness? You may not need one if you follow a whole-foods diet with plenty of brightly-colored vegetables and whole grains, varied proteins (emphasizing plant-based), and minimal packaged "snack foods" and sugars. (A multivitamin is also not going to "make up" for a nutrient-poor diet: whole foods contain fiber and cancer-fighting antioxidants not found in a pill!) Everyone's health situation is different, so check with your doctor or a nutritionist about whether you are getting the right kind of nutrients in your diet. For example, if you are on hormone therapy for prostate cancer treatment, your doctor may recommend calcium and vitamin D supplements to maintain bone health. For more nutrition and lifestyle tips, download PCF's guide, *The Science of Living Well, Beyond Cancer*.

Cars lined up to drop tyre pressure for sand driving, Simpson Desert

ASCO 2022: ^{177}Lu-PSMA-617 Outperforms Cabazitaxel in Metastatic Prostate Cancer Despite Similar Overall Survival Rates

^{177}Lu-PSMA-617 offers greater activity and lower toxicity than cabazitaxel

Lutetium-177 prostate-specific membrane antigen-617 (^{177}Lu-PSMA-617) bests cabazitaxel in term of progression-free survival (PFS), tolerability, and patient reported outcomes, even though the two options provided a similar overall survival (OS) benefit among patients with metastatic castration-resistant prostate cancer, according to findings presented at the annual meeting of the American Society of Clinical Oncology, which took place here and online from June 3 to 7.

"^{177}Lu-PSMA-617 is a radiolabeled small molecule that binds to PSMA, enabling deliveries of high doses of β radiation to sites of tumor," said lead author Michael S. Hofman, MD, PhD, of the University of Melbourne in Australia, during his presentation of the data. "It has a 1 mm path length, so there is limited damage to normal tissues. The VISION trial, phase III, reported last year, demonstrated an improved OS and quality of life in men with metastatic castration-resistant prostate cancer with ^{177}Lu-PSMA-617 in combination with standard of care, versus standard of care alone. Standard of care was protocol-defined and included androgen receptor pathway inhibitors but did not [allow] systemic therapies, such as cabazitaxel. TheraP was the first randomized trial of ^{177}Lu-PSMA-617. We published our results in the *Lancet* last year, and the trial met its primary endpoint of prostate-specific antigen (PSA) 50% response rate." Also superior in the ^{177}Lu-PSMA-617 arm were PSA and objective response rate, with lower rates of toxicity, compared with cabazitaxel. At ASCO 2022, Dr. Hofman presented the first OS findings, following data cutoff on December 31, 2021.

For the TheraP trial, 200 patients with metastatic castration-resistant prostate cancer who had previously received docetaxel were randomized 1:1 at 11 sites in Australia to cabazitaxel 20 mg/m^{2}administered intravenously (IV) every 3 weeks for up to 10 cycles (n = 101) or to ^{177}Lu-PSMA-617 8.5 GBq IV every 6 weeks, with a reduction of 0.5 GBq for each cycle, for up to 6 cycles (n = 99). Patients in the ^{177}Lu-PSMA-617 arm underwent SPECT/CT at 24 hours, and treatment was suspended if there was minimal or no uptake.

Notably, 15 men assigned to cabazitaxel withdrew their consent for the trial, and many went on to seek treatment with ^{177}Lu-PSMA-617 outside of the study protocol. In addition, following the protocol, 32% of patients in the ^{177}Lu-PSMA-617 arm and 21% in the cabazitaxel received treatment with cabazitaxel. Another 5% and 20%, respectively received treatment with ^{177}LuPSMA-617.

All patients underwent PET imaging, and they were only enrolled in the trial if ^{68}Ga-PSMA-11 showed high PSMA expression (at least one site with SUVmax > 20) and ^{18}F-FDG PET/CT demonstrated no FDG-positive/PSMA-negative sites of disease . Patients were stratified by disease burden, prior enzalutamide or abiraterone treatment, and study site.

After a median follow-up of 36 months, death rates were 69.3% in the cabazitaxel group and 78% in the ^{177}Lu-PSMA-617 group. PFS was greater with ^{177}Lu-PSMA-617 treatment, for a hazard ratio of 0.62 (95% confidence interval 0.45–0.85, P = .0028). The OS, on the other hand, was similar for both groups, with a hazard ratio of 0.97 (95% confidence interval 0.70–1.40, P = .099).

No additional safety signals were identified with longer follow-up.

Among 61 men excluded by imaging with PFSA/FDG-PET before randomization, restricted mean survival time to 36 months was 11.0 months (95% confidence interval 9.0–13.1). These patients' off-protocol treatments included cabazitaxel in 48% and ^{177}Lu-PSMA-617 in 5%. Median OS was 18.8 months among randomized patients, compared with 11.0 months among patients who failed the screening for the trial.

A biomarker analysis revealed that PSMA is a predictive biomarker for response to ^{177}Lu-PSMA-617, with higher expression related to greater response.

"The post-protocol treatments limit our ability to see any OS difference," said Dr. Hofman. "Therapy was never powered for OS, and this is also significant with regards to withdrawals in the cabazitaxel arm, in patients seeking to have ^{177}Lu-PSMA-617 therapy, which did not occur in the ^{177}Lu-PSMA-617 arm. The clinical implications are that ^{177}Lu-PSMA-617 has similar OS to cabazitaxel, a proven life-prolonging therapy, but with fewer adverse events and better patient reported outcomes, but we should be clear that ^{177}LuPSMA-617 shows greater activity. That is not just confined to PSA rates. We see it with radiographic PFS."

This study was conducted in collaboration with Endocyte.

SOURCE:
15 June 2022
Michael S Hoffman MD PhD
https://www.practiceupdate.com/c/137407/67/11/?elsca1=emc_enews_weekinreview&elsca2=email&elsca3=practiceupdate_advancedprostatecancer&elsca4=advancedprostatecancer&elsca5=newsletter&rid=NTMyMjc0MDc4NjM0S0&lid=20849595

Finishing Line – The Barossa Valley

Commonwealth Seniors Health Card Eligibility is Changing. Find out if you Qualify

Source https://thenewdaily.com.au/finance/superannuation/2022/06/29/seniors-health-card/

Commonwealth Seniors Health Card eligibility

	Current income caps	July 1 income caps	Current effective assets cap	July 1 effective assets cap
Singles	$57,761	$90,000	$2.3 million	$4 million
Couples	$92,416	$144,000	$4 million	$6.5 million

If you are 67 or over and haven't qualified for a Commonwealth Seniors Health Card (CSHC) yet, you may be eligible from July 1.

That's because during the election campaign both parties promised to dramatically increase the income threshold above which access to the card cuts off.

The table below describes the new situation: The government believes an extra 50,000 people will now be eligible for the card.

"That is a substantial increase and it means a lot of people who have just been missing out will be eligible," said John Goldie, a director of Paramount Financial Solutions.

Currently, singles and couples cannot get a card if they earn more than $57,761 and $92,416, respectively.

The new limits will be $90,000 and $144,000, respectively.

Getting the card entitles you to bulk billing at many medical clinics and means you can obtain many prescriptions listed on the Pharmaceutical Benefits Scheme from as little as $6.60 per script.

There is no asset test on the CSHC, but your superannuation will have a deemed income attached, which will contribute to the income test.

The deeming rate will be frozen for the next two years at 0.25 per cent for the first $53,600 in assets for a single and for the first $89,000 for a couple.

Above those figures, income will be deemed to earn 2.25 per cent a year.

The table above shows how much in assets outside your home you will be able to hold and still be eligible for the CSHC.

How do you get it?

Although legislation hasn't yet been passed to deliver the more generous income limits, the Services Australia website notes they are coming.

There are two ways you can apply. The simplest is probably to visit Centrelink and make an application directly.

But for many people that's not an attractive option, as it could mean waiting in a long queue and perhaps being exposed to COVID-19 or flu while you are in the office. The other option is to go online and either fill in forms directly or print them out and send them in via post.

Filling in the forms

Like lots of official forms, those linked to the CSHC can be intimidating, but if you follow the directions you will find

(continued page 13)

your way through it.

One potential stumbling block with the form, however, is how you report your income.

The form asks for your estimated taxable income, but for many retired people their only income will be a super pension, which is not taxable.

So, you don't need to report super pensions here.

However, if you have a part-time job you should report your income at this point.

And if you have an investment property or other investments that pay income, then you must also report that in this part of the form.

Deemed income

The form will direct you to yet another form – SA 330 – if you answer that you have superannuation income.

So fill in that one if you have a super pension or annuity. Centrelink will work out a deemed income from that amount and use that to establish your eligibility.

The deeming provisions for the CSHC apply only to superannuation pensions and annuities. If you have other assets these will be measured only according to the income they produce.

If you have an investment property that is unoccupied or shares that don't pay dividends, these will not restrict your eligibility as no deemed income will be placed against them.

"You can have enormous wealth and still qualify for the CSHC, which does raise social equity issues in my view," said Paul Versteege, policy manager at the Combined Pensioners and Superannuants Association.

Annuities can be an advantage when it comes to claiming the CSHC.

That is because only 60 per cent of their value, for annuities over particular time frames, or none of the value, for lifetime annuities, will be subject to deeming.

Extra benefits

There are many sweeteners added to the CSHC depending on where you live. State and territory governments give card holders a number of additional benefits.

These range from energy and transport rebates, to a whopping $1660.60 in sweeteners from the Western Australian government. For many people, there is a strong emotional value in getting the card, too.

"The seniors card has almost become a symbol for some people," Mr Versteege said.

"They say, 'I mightn't get the pension, but I'm getting something from the government'."

Research Study

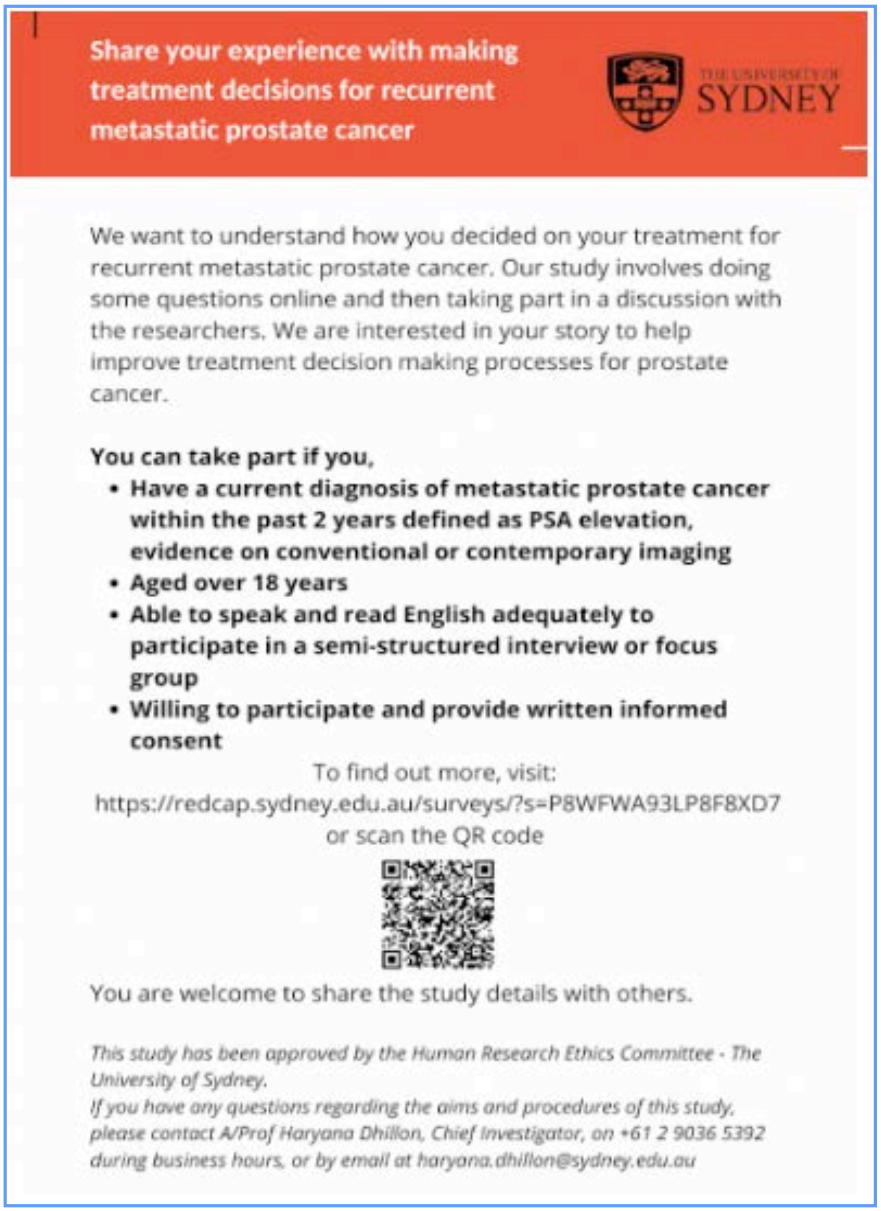
This study is the initiative of one of our members, Colin O'Brien. Colin is also a member of ANZUP's Consumer Advisory Panel (CAP). ANZUP encourages members to consider new ideas that can be developed to ultimately support patients or improve current practice.

Please complete the study if you are eligible. Your knowledge may help the 30% - 40% of men, who find they have a biochemical recurrence after their initial treatment to eliminate the disease, by improving the decision making process.

The Australian and New Zealand Urogenital and Prostate Cancer Trials Group

ANZUP is the leading cancer cooperative trials group that brings together all of the professional disciplines and groups involved in researching and treating below the belt (penile, bladder, kidney, prostate and testicular) cancers and conduct high quality clinical research.

ANZUP identifies gaps in evidence and areas of clinical need, collaborates with the leading clinicians and researchers in below the belt cancers, and communicate frequently and effectively with the broader community along the way.



Flinders Ranges

Olaparib in BRCA-mutated Metastatic Castration-Resistant PCa: Product Review

BRCA mutation testing is now Medicare Benefits Scheme reimbursed for mCRPC.BRCA mutation status should be determined by an experienced laboratory using a validated test method. Tumour tissue specimens can be obtained as either fresh tissue following primary tumour debulking surgery or from formalin-fixed paraffin-embedded tissue block (which can be stored for many months or years). In the PROfound trial, tumor testing was conducted centrally with the use of archival or recent biopsy tissue from primary or metastatic disease.

Locations of laboratories offering tumour BRCA1/2 testing can be found across Australia. Laboratories that are NATA (National Australian of Testing Authorities) accredited include:

- NSW Health Pathology
- Peter MacCallum Cancer Centre
- Monash Health Pathology
- Genomics for Life
- PathWest
- If the patient tests positive for BRCA1 or BRAC2 mutation on a tumour test, they should be referred to genetic services for genetic counselling and for germline testing. For information about genetic services across Australia, please refer to: https://www.genetics.edu.au/SitePages/Genetic-Services.%20aspx.

Germline testing in men with mCRPC can potentially benefit other family members. If a germline mutation is identified, testing for the same mutation in family members (cascade testing) may be performed. Identifying family members with BRCA1 or BRCA2 mutations could inform potentially lifesaving risk-reducing interventions.

Take-home messages

- BRCA1 or BRCA2 mutations are present in about 6–12% of men with mCRPC
- Men should have a tumour BRCA test at diagnosis of mCRPC to detect germline and/or somatic mutations
- Olaparib is a PARP inhibitor that targets tumours with BRCA mutations
- The PROfound trial included men with BRCA-mutated mCRPC who had progressed following treatment with a NHA (with or without taxane therapy):

o rPFS was longer in this group of men who were treated with olaparib (9.8 months) compared with NHA (3 months) (p-value not stated)

o The risk of disease progression was reduced by 78% with olaparib compared with the NHA

o Median OS was longer in those treated with olaparib (20.1 months) compared with NHA (14.4 months) (p-value not reported)

o Olaparib showed a survival benefit compared with NHA in patients who had previously received taxane therapy, as well as in patients who had not received prior taxane therapy

The adverse event profile of olaparib has been well characterised, with anaemia, nausea, and fatigue or asthenia being the most common adverse events

SOURCE:
Research Review PRODUCT REVIEW
Assoc Prof Ben Tran
https://www.researchreview.com.au/

Expert overall conclusions

The PROfound trial is a real game-changer. It provides evidence for the benefit of olaparib in mCRPC patients harbouring BRCA mutations. Not only is this benefit for PFS, but also for OS. Additionally, this benefit is seen in both those who have received and those who have yet to receive docetaxel chemotherapy. As an oral treatment, our patients will find it much more acceptable than chemotherapy. While the control arm of PROfound might be criticised, there is no doubt that in patients with BRCA mutations, olaparib is a useful treatment that can provide benefit. However, it is now on us, as clinicians to ensure we give our patients the best opportunity to have this treatment, and that starts with making genetic testing a routine in our practices.

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.

Co-Driver Joel in the Barossa Valley

Partners of Many Prostate Cancer Sufferers Made Ill or Feel Undermined by the Disease

Source
19 March 2018
European Association of Urology
https://www.sciencedaily.com/relea

22 June 2022
By Tim Baker

- Choose your times to discuss your health. Don't let cancer conversations leak into every part of your daily lives. It's difficult for your partner to be going about their day and suddenly find themselves in the midst of a grim conversation about your test results, treatment options, fears and distress. Agree on a time for a weekly catch up, or ask if it's okay before launching into such topics.
- Don't let cancer dominate your worlds. Still do the things you've always enjoyed together as much as possible, whether that's swing dancing, eating out, bush walking, travel. The fatigue of hormone therapy can sabotage a lot of good intentions, but it can be worth pushing through tiredness to open yourself up to new experiences or maintain your favourite pastimes.
- Even when libido and sexual function are impacted, physical closeness and intimacy matter. Become a good hugger. Be affectionate. Addressing erectile dysfunction is a whole topic of its own we'll re-visit in a future blog post, but it is worth consulting a men's sexual health specialist early on to see what can be done to maintain sexual function.
- Learn your partner's "love language" – that is, how do they like you to show your love for them. Verbal expressions of love, physical touch, small acts of service like doing chores, gifts? We all have our own love language and learning your partner's can help ensure they feel loved and appreciated.
- Don't lean exclusively on your partner, no matter how well they seem to be holding up. Spread the load. Call on close friends and extended family and a psychologist, if necessary.

Even so, and despite both parties' best efforts, many relationships come apart under the strain of a cancer diagnosis and this shouldn't be seen as a failure or an abandonment or betrayal. A prostate cancer diagnosis changes us and is likely to change your relationship in ways that are difficult to foresee. Many men struggle with a sense of loss, of not being the stoic protector or provider we've been raised to see as a man's role. Sharing these fears and insecurities can help build a new closeness and a new kind of relationship.

https://pcfa.org.au/news-media/news/weekly-blog-navigating-relationships-after-a-diagnosis/

Summary: Many wives of advanced prostate cancer sufferers feel that their lives are being undermined by their husband's illness, with nearly half reporting that their own health suffered. In addition a focus subgroup has revealed that many feel isolated and fearful, and worry about the role change in their lives as their husband's cancer advances. This study, developed with the wives of men with metastatic prostate cancer who were being treated with hormone therapy, is amongst the first carried out on how prostate cancer affects the partners of sufferers.

On top of the Big Red, Simpson Desert

ADT, Disease Transition Are Risk Factors for Depression, Anxiety in Prostate Cancer

SOURCE:
28 June 2022
Jessica Nye PhD
https://www.renalandurologynews.com/home/news/urology/prostate-cancer/adt-prostate-cancer-disease-transition-risk-factors-depression/?utm_medium=email&utm_source=rasa_io

Patients with prostate cancer were more likely to develop psychological symptoms during disease/treatment transitions or when starting ADT. Longitudinal screening for depression and anxiety in men with prostate cancer identified additional patients who initially did not present with symptoms, according to results of a study presented at the 2022 ASCO Annual Meeting.

Untreated depression or anxiety has been associated with poorer outcomes. Patients with prostate cancer often experience many phases of disease or treatment spanning years, and androgen deprivation therapy (ADT) has been associated with mood changes and depression.

For this study, 201 men who had a prostate cancer-related clinic visit in the last 6 months were sent the 9-item Patient Health Questionnaire (PHQ-9) and General Anxiety Disorder-7 (GAD-7) screening tools every 60 days via email. Risk factors for developing symptoms of depression or anxiety were evaluated (score of 10 or higher on PHQ-9 or GAD-7, respectively).

- *Patients had localized (50.7%), metastatic (30.3%), and biochemically recurrent (18.9%) prostate cancer, and 40.8% were receiving ADT. The patients reported a history of depression (22.9%), anxiety (19.9%), and other (9.0%); 19.9% were on antidepressants, 8.5% on anxiolytics, and 2.0% antipsychotic.*
- *Most patients responded to at least 2 screening emails.*
- *At a mean follow-up of 6.5 months, 15.4% screened positive for depression and 4.5% for anxiety. Half of those with positive screening results had negative screening results at the initial evaluation.*
- *The development of symptoms occurred more frequently during a period of disease or treatment transition (P =.003) and when starting or continuing ADT (P =.002).*
- *Screening positive was associated with a history of psychiatric disorder (odds ratio [OR], 6.3; P =.001), ADT (OR, 3.8; P =.005), and lower income (OR, 1.7; P =.002).*
- *These data reinforced current recommendations that symptoms of depression and anxiety should be longitudinally screened, as half of patients with prostate cancer developed depression or anxiety during their disease course.*

Reference

Wong RL, Cheng HH, Fann JR, et al. Longitudinal screening for depression and anxiety in prostate cancer (PC) and association with disease and treatment factors. *J Clin Oncol.* 2022;40(suppl 16; abstr 5023).

This article originally appeared on Oncology Nurse Advisor

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.

MRI Scans can Detect Prostate Cancer More Accurately than New Imaging Technique

Dorper Sheep

A team of researchers in Australia and New Zealand has found that MRI scans can detect prostate cancer more accurately than the newer, prostate-specific -PSMA PET/CT scanning technique.

The findings are being presented today at the European Association of Urology's annual congress (EAU22), in Amsterdam.

Prostate-specific membrane antigen (PSMA) PET/CT scans, approved by the US FDA in 2020, use a radioactive dye to 'light up' areas of PSMA, which is found on the surface of prostate cancer cells. They are presently used to manage prostate cancer, as they can accurately measure the progression or recurrence of the disease. So, in this trial the researchers set out to find if they could be used to diagnose prostate cancer as well.

The PEDAL trial recruited 240 patients across five hospital groups who were at risk of prostate cancer. Every patient was given both an MRI scan and a PSMA PET/CT scan. If imaging suggested the presence of prostate cancer, a biopsy was performed by the patient's urologist.

The MRI scans picked up abnormalities in 141 patients, while the PSMA PET/CT scans picked up abnormalities in 198 patients. A total of 181 patients (75%) underwent a prostate biopsy, and subsequently 82 of those patients were found to have clinically significant prostate cancer.

Since each patient had both type of scans, the researchers could assess which type had more accurately detected those patients who had prostate cancer. The researchers found that MRI scans were significantly more accurate at detecting any grade of prostate cancer than the PSMA PET scans (0.75% for MRI vs 0.62% for PSMA PET).

Associate Professor Lih-Ming Wong, Consultant Uro-oncologist at St Vincent's Hospital in Melbourne, Australia, headed the research team. He said: "Our analysis found that MRI scans were better than PSMA-PET for detecting any grade of prostate cancer. When we looked only at clinically significant prostate cancers, there was no difference in accuracy. As this study is one of the first to explore using PSMA-PET to diagnose cancer within the prostate, we are still learning and adjusting how to improve using PSMA-PET in this setting.

Although detection thresholds will be fine-tuned as diagnostic use develops, Professor Wong believes the trial has important lessons for clinicians.

This study confirms that the existing 'gold standard' of pre-biopsy detection - the MRI - is indeed a high benchmark. Even with fine-tuning, we suspect PSMA PET/CT won't replace the MRI as the main method of prostate cancer detection. But it will likely have application in the future as an adjunct to the MRI, or for people for whom an MRI is unsuitable, or as a single combined "diagnostic and staging" scan for appropriately selected patients."

Lih-Ming Wong, Associate Professor, Consultant Uro-oncologist at St Vincent's Hospital in Melbourne, Australia

SOURCE:
3 July 2022
Reviewed by Emily Henderson
https://www.news-medical.net/news/20220703/MRI-scans-can-detect-prostate-cancer-more-accurately-than-new-imaging-technique.aspx?utm_medium=email&utm_source=rasa_io

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.

Olivia Newton-John
Cancer Wellness & Research Centre

Call the Plumber – "Exercising your Muscles"

Exercise plays an important role in minimising treatment-related side effects including fatigue, physical function as well as improving quality of life.
You are invited to an information session to better understand how to 'exercise your muscles' during and following prostate cancer treatment.

Thursday 21st July 2022
4.00pm – 5.30pm
Online via Microsoft Teams

Presented by
Carla D'Amico - Prostate Cancer Specialist Nurse
Ashley Bigaran - Exercise Physiologist
Santha Tisseverasinghe - Continence Physiotherapist

To register for this session, scan the QR code or click on the link in the attachment, in the email

For queries, please contact 9496 3799 or email wellness@austin.org.au

Prostate Cancer Foundation of Australia

Cancer Council Victoria

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.

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 Committee

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

PHCSG Meetings 2022 10am – 12:30pm

Tues 15 Feb
Tues 15 March
Tues 19 April
Tues 16 May
Tues 21 June
Tues 19 July
Tues 16 August
Tues 20 September
Tues 18 October
Tues 15 November
Tues 13 December (the second Tues to avoid the week prior to Xmas. Includes Xmas lunch – subject to COVID restrictions)

2022 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 2022
- Links between Gut Microbiome & Aggressive PCa
- Radpid PCa Screening Kits
- How Much Should You Eat?
- Abiraterone/DT Combo Associated with High Metastasis-Free Survival Rate
- Terbiom-161 Clinical Study Collaboration
- Electrical Pudendal Nerve Stimulation vs Pelvic Floor Muscle Training
- Identifying PSA Patterns in mHSPC Treated with Abiraterone & Prednisone
- Viagara Linked to Lower Risk of Alzheimer's
- Ductal Adencarcinoma
- BAT vs Enzalutamide in MCRPC
- Systemic Therapy Patterns in MCRPC
- Exercise May Stop Disease in its Tracks
- AI Accurately diagnoses PCa
- New Insights into Molecular Drivers of Treatment Resistance in PCa
- Decreased Fracture Rate by Manadating Bone Protecting Agents

February 2022
- Why Aren't More Men Electing to Have an Orchiectomy?
- Could More Testosterone be the Key to Fighting PCa? Part one
- Inflammation from ADT may Cause Fatigue
- Optimal Duration of ADT Depends on the Type of Radiation
- How does ADT Affect the Brain?
- Pomegranate may Help Reduce Certain Cancers – Study
- The Perils & Pitfalls of PSA in Advanced PCa
- One Man's Mission to Make PCa Fix Open for All
- Physical exercise can Improve Quality of Life
- Gather My Crew
- Does One Recover Testosterone Faster when Stopping LHRH Antagonist or Agonist?
- Clinical Trials & Studies

March 2022
- Will PSA Testing be Replaced? Novel Screening Approches
- How Bipolar Androgen Therapy Works
- Bipolar Androgen Therapy and the Immune System
- The Role of SBRT
- On Metabolic Syndome, Statin Drugs & PCa Progression
- Yoga Improves QoL in Men Newly Diagnoses with PCa
- The Trials & Tribulations of Managing Men with mHSPCa
- How Enzalutamide Impacts QoL in Metastatic Cancer
- Low-meat and Meat-free Diets associated with lower overall cancer risk
- Transdermal Oestradiol for Androgen Suppression
- PCa Test Cuts False Positives
- Trial to Evaluate Men Starting ADT
- Who goes on ADT with RT to Treat Intermediate Risk PCa
- Darolutamide & Surival in mHSPC
- Effect of High Dose Vitamin D on Bone Density & Strength
- How Important is Bone Mineral Density for Men on ADT
- Bipolar Androgen Therapy – A Patient's Guide
- The D-Health Trial – Effect of Vitamin D on Mortality
- Does Estradiol Improve Cognitive Function for men on ADT?
- SBRT or Convemntional RT for Macroscopic Prostate Bed Recurrence
- To continue ADT – or Not?
- Biochemical Definition of Cure with Brachytherapy of PCa
- New Radiotracer increases Accuracy
- Less Meat, Less PCa?
- PCa's Sweet Tooth
- RP vs RT in Ductal Carcinoma of Prostate
- Survival after RP vs RT in Nodai Positive PCa

April 2022
- Apalutamide no on the PBS
- The Benefit of Exercise
- Ex Med and Hospital exercise programs for patients wit PCa
- Gut Environment changes due to ADT
- Effect of Statins on Advanced PCa or abiraterone/enzalutamide
- Researchers identify five types of bacteria in men with aggressive PCa
- Curative treatments didn't work – what should I do?
- Molecular Mechanisms of Coffee on PCa
- ADT use & duration with RT for Localised PCa
- Association of Muscle Mass after RP
- Is ADT Necessary when you take Abiraterone?
- Obesity Linked to Improved Survival in Advanced PCa
- A Novel Oral Cytoskeleton Disruptor – experimental drug Sabizabulin
- Survival Benefit to Debulking with radiation
- QoL in mHSPC men taking Enzlautamide
- Cleveland Clinic Study Links Microbiome to Aggressive PCa
- Portable Method for PSA Screening
- Clinical Trials

May 2022
- Apalutamide no on the PBS
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- Survival Benefit to Debulking with radiation
- QoL in mHSPC men taking Enzlautamide
- Cleveland Clinic Study Links Microbiome to Aggressive PCa
- Portable Method for PSA Screening

June 2022
- My Cancer Care Record
- Common Blood Test Results Explained
- Don't Allow Statistics to Dictate Your Treatment
- Getting Second Doctor's Opinion
- Primary Care Use of FRAX / Quality of Life in in the Stampede Trial
- Penile Traction Therapy
- SPPORT Trial
- Persistent Testosterone Suppression after Cessation of ADT for localised PCa
- MSK SScientists Identify New Subtype of PCa
- Clinical Efficacy of Bipolar Androgen Therapy with MCRPCa
- Three steps Further
- Treatment Intensification in mHSPCa
- On The Radar /
- Mediterranean Style Dietary with High Interval Training
- Clinical Trials

July 2022
- My Cancer Care Record
- Prostate Cancer Australia's most common cancer
- My Cancer Care Record/ 4 Doxetacel vs Nonsteroidal Antiandrogen with ADT for High Volume mHSPCa
- Treatment Intensification in mHSPCa
- Clinically localised PCa: AUA/ASTRO
- ASCO 2022: Enzamet Update: Benefit Adding Enzalutamide
- Role of Radiotherapy in Oligometastatic HSPCa/
- 8 Review of a plant based diet
- Recent Advances in Management of mPCa
- Multivitamin Use not linked to PCa Risk
- Lu-PSMA-617 Outperforms Cabazitaxel in mPCa
- Commomwealth Seniors Health Card – changing
- Olaparib in BCRA mutated mCRPCa
- Partners of PCa sufferers made ill
- ADT Risk Factors for Depression & Anxiety
- MRI scans detect more accurately than new imaging techniques
- Information Session 'Call the Plumber"

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
- 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

November 2021
- New PCa drug helping men live lomger
- What predicts who goes on continuous vs intermittent ADT
- Gut Bugs can drive PCA growth & resistance
- Exception to early salvage radiation
- PCa Urine Test
- New Strategy against Treatment resistant PCa
- Blood Test may help treat PCa

Prostate Cancer Studies
- Caregiver Health Literacy/Supportive Care Program/access to Nutrition Info
- Optimal Dietary & Exercise

December 2021
- PCa Thwarted by Gut Microbiota
- Exercise is Medicine
- Giving Cancer a "Brown-Out"
- Wake Up! It's Time to Address Sleep Issues
- The Complex Natural Biochemistry of a Healthy Diet
- ADT: What You Really Need to Know
- Andropause and the Treatment Nobody Talks About
- Unlocking the Secrets of Sleeping Cancer Cells
- Treatment-Related Regret
- New PCa Treatment Coul d Improve Outcomes for Advanced Patients
- PCa Trials – Recruiting
- Promising Treatments & New Methods