Prostate Heidelberg Cancer Support Group

Prostate Heidelberg

September 2022 Issue 222

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 PHCSG Meeting

Tuesday 20 September 10am – 12:30pm

At Uniting Church Hall

or

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

https://us02web.zoom.us/j/82860016346?pwd=d3BiT3FGWlVzcVlxTnZPdWx0Y2Y0UT09

MEMBERSHIP

HALF CALENDAR YEAR PHCSG MEMBERSHIP (July – Dec) $10

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

EFT Payments to:

Prostate Heidelberg CSG
BSB 083 256
Acct 583244292

Contents

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 Heidelberg Cancer Guest Speakers

Tues 18 October 2022 TBA

Tues 13 December 2022

Ashley Bigaran – Exercise Physiologist Austin

Ashley presently holds a position with the Baker Heart and Diabetes Institute Sports Cardiology team as their AEP and research assistant. Ashley is currently pursuing her PhD and will be exploring the factors contributing to exercise intolerance in cancer patients.

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

Can I get travel insurance if I have cancer?

SOURCE:
https://fastcover.com.au/travel-insurance/can-you-get-travel-insurance-if-you-have-cancer

https://www.insurancebusinessmag.com/au/news/breaking-news/revealed--what-the-best-travel-insurance-providers-in-australia-cover-419231.aspx

Hopefully, with Covid lockdowns a distant memory, some of you may be thinking about travelling again.

Travel insurance is not only essential because of the ongoing pandemic but with or without COVID-19, there are some things that may go wrong while travelling, including theft, catching other illnesses, or even natural and man-made disasters. Travel insurance can help cover these as well.

Finding travel insurance after a cancer diagnosis can be difficult, but doesn't mean you have to stop travelling. Many policies will provide cover for a range of pre-existing medical conditions such as diabetes or asthma. However, cancer is usually not covered automatically.

Cancer is considered a pre-existing medical condition. A pre-existing medical condition is any condition that has been diagnosed, is being treated, or that you exhibit symptoms of at the time of purchasing your travel insurance policy.

Travel insurers may fall into one of three categories:

1) Medical cover for cancer is included (often for the cost of an additional premium).

In some cases, you may have to pay an extra premium to receive cover for cancer on your travel insurance policy. In these cases, you can choose to pay the extra premium and you'll receive cover for potential emergencies related to cancer while travelling.

2) Medical cover for unrelated emergency expenses is provided, but cover for any expenses related to cancer is excluded.

You're still covered for unrelated overseas medical emergencies, such as if you had a fall and broke a bone, but there is no cover for any claims arising from or related to your pre-existing condition.

3) No cover is available due to the cancer.

Some insurers may ask you to contact them directly, others may refuse to provide you with any cover if you are undergoing treatment.

If a policy does provide you with medical cover but excludes expenses related to the cancer, you may still receive the majority of the policy's benefits.

Some of the other benefits you can find in a policy may include:

- Cover for emergency medical expenses unrelated to your pre-existing medical condition, for example, food poisoning or breaking a bone from a bad fall.
- Cancellation cover where the cause of cancellation is unrelated to your pre-existing medical condition. For example, if you were involved in a car accident before your trip and become injured, or because your parents or children become severely unwell.
- Cover for the loss or damage of your belongings, including mobile phone, camera, travel bag and travel documents.
- Travel delay expenses cover.
- Rental vehicle insurance excess cover.

Some travel insurers will offer cover for cancer, provided you meet a few conditions.

These conditions can include:

- A medical assessment, so the insurer knows that you're fit to travel.
- Whether or not you are in remission and how long you've been in remission.
- Whether you are currently receiving treatment. Cover is often excluded if you're currently undergoing treatment for cancer.

(If you are non metastatic you may be able to get coverage for an extra premium, but it's very unlikely if you have mets.)

Conditions and exclusions may differ depending on your travel insurance provider and policy type. Always read the Product Disclosure Statement (PDS) or ask if you're not sure before purchasing a policy.

It's important to disclose any pre-existing medical conditions on the online medical assessment when purchasing a policy to ensure you'll be covered if you have any health complications overseas.

Non-disclosure does not mean you'll be provided with cover. The travel insurer is likely find out about your medical history when assessing any travel insurance claims that may invalidate your entire policy.

Tips for a safe journey:

- Check travelling requirements and regulations in the destination.
- Consider limiting travel to one or a few places in one country at a time rather than travelling to multiple nations in one go.
- Read the terms and conditions before booking travel. Make sure refunds are allowed.
- Book flexible tickets for flights. Some airlines currently allow rebooking of cancelled flights but be aware of the expiry dates.
- Make sure the hotel booking can be cancelled, or at least changed.
- Stock up on prescription medication and carry information about your condition.

Risk of Skeletal-Related Events After Treatment With Abiraterone or Enzalutamide in Patients With mCRPC

SOURCE:
5 September 2022
Advanced Prostate Cancer
https://www.practiceupdate.com/journalscan/97502/67/11?elsca1=emc_enews_weekinreview&elsca2=email&elsca3=practiceupdate_advancedprostatecancer&elsca4=advancedprostatecancer&elsca5=newsletter&rid=NTMyMjc0MDc4NjM0S0&lid=2084959

TAKE HOME MESSAGE

The authors utilized the SEER–Medicare linked database to compare the risk of skeletal-related events (SREs) among men with metastatic castration-resistant prostate cancer (mCRPC) receiving abiraterone acetate (AA) or enzalutamide (ENZ). Overall, 5856 patients were included; of whom, 4207 received AA and 1649 received ENZ. The authors noted that 1112 patients recently received chemotherapy whereas 2730 recently received zoledronic acid or denosumab. Notably, 837 patients had at least one SRE after the index date. Multivariable analyses showed that there was no significant difference in the risk of SREs between patients receiving AA and those receiving ENZ (P = .890). Denosumab use was associated with a lower risk of SREs (P = .001).

This study suggests that there is no difference in the risk of SREs between patients with mCRPC receiving AA and those receiving ENZ and that denosumab has evidence of benefit with respect to preventing SREs in this real-world population.

Kamal Sahu MD

Abstract

BACKGROUND

Skeletal-related events (SREs) from bone metastases disease carry significant morbidity in men with metastatic castration resistant prostate cancer (mCRPC). The differential risk of SREs among patients receiving abiraterone acetate (AA) or enzalutamide (ENZ) is unknown.

METHODS

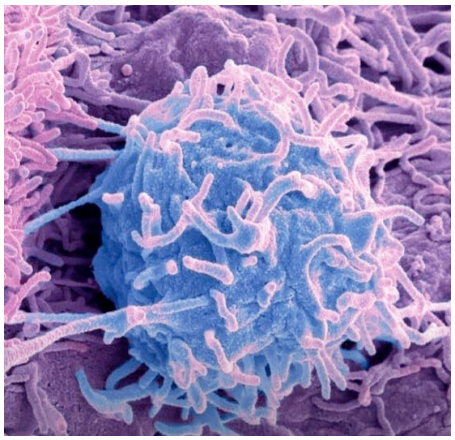
To compare the risk of SREs among men with mCRPC receiving AA or ENZ, a retrospective cohort study using the SEER-Medicare Linked Database was conducted. Men with prostate cancer aged ≥65 years at first AA or ENZ prescription (index date) from 2011 to 2015 were identified. Patients were followed until the earliest occurrence of SRE, death, Medicare disenrollment, or December 31, 2016. The primary outcome was a composite endpoint of SRE (pathologic fracture, spinal cord compression, or surgery or radiation to bone) after the index date. Multivariable logistic regressions including key demographic and clinical covariates with death as a competing risk were conducted.

RESULTS

Overall, 5,856 patients were identified (4,207 received AA and 1,649 received ENZ). Median age was 76.5 years (IQR 71.4-82.3), 4,557 (77.8%) were White, 1,112 (19.2%) had recent chemotherapy, and 2,730 (46.6%) had recent zoledronic acid or denosumab. Eight-hundred and thirty-seven (14.3%) patients had ≥1 SRE after index date. In multivariable analyses, there was no difference in SRE risk based on AA and ENZ (HR=0.99 for ENZ, 95%CI 0.84-1.16, P=0.890). Denosumab was associated with lower SRE risk (HR=0.75, 95%CI 0.64-0.88, P=0.001).

CONCLUSIONS

In this large cohort of men with mCRPC, there was no difference in risk of SRE between AA and ENZ. Decision-making should be informed by prior therapies, comorbidities, toxicity profiles, and patient preferences. Denosumab has evidence of benefit in preventing SREs in this real-world population.



Research Suggests Commonly Used Prostate Cancer Treatment Rewires Engine of Prostate Tumors

SOURCE:
Oncology & Cancer news

https://www.sciencedaily.com/releases/2022/09/220915104739.htm

Drugs like enzalutamide that inhibit male hormones from activating the androgen receptor have been used to treat advanced prostate cancer for more than a decade. While successful in most cases, these drugs can eventually stop working, but there is a limited understanding about how this change occurs.

A new study from the University of Michigan Rogel Cancer Center suggests androgen receptor inhibitors can fundamentally rewire and reshape how prostate tumors function, and in certain cases even make them more aggressive. These findings [were] published in *Nature Communications* on Sept. 15.

Male hormones function as fuel, turning on the androgen receptor that acts as the engine of prostate cancer cells. For the past 80 years, treatment for patients with advanced prostate cancer has focused on interfering with these hormone levels—now typically done through hormone lowering shots and drugs like enzalutamide. Eventually, nearly all tumors develop workarounds and escape treatment, and in most cases, tumors remain dependent on male hormones to power their growth. Other examples of treatment resistance remain poorly understood.

"The greatest unmet need in the clinic right now is understanding the workarounds in a tumor that becomes resistant to androgen receptor targeting drugs so we can determine how best to treat the patient whose tumor has begun to grow," said Joshi Alumkal, M.D., Wicha Family Professor of Oncology and Professor of Internal Medicine, whose team led this research in collaboration with the Zheng Xia laboratory at the Oregon Health & Sciences University Knight Cancer Institute. Thomas Westbrook, M.D., hematology-oncology fellow, was the study's co-first author along with post-doctoral fellow Xiangnan Guan, Ph.D. "Once enzalutamide stops working, there are limited options. We don't know how or why most tumors become resistant."

Alumkal wanted to understand what was present in these tumors to begin with and what happened after tumors started to grow on enzalutamide treatment.

He and colleagues recruited patients to a longitudinal study to obtain metastatic biopsies before enzalutamide treatment and at the time the tumor became resistant to treatment. His team collected serial biopsies from 21 patients, enabling them to understand the workarounds in the tumor from each patient.

Alumkal says this is the largest collection of matched metastatic biopsies before and after enzalutamide. "To understand resistance to drugs, researchers often collect samples from some patients before treatment and from a different group of patients whose tumors are treatment resistant. However, that approach is much less precise because there could be other significant differences between those patients. You can't pinpoint if the differences have anything to do with drug exposure or have more to do with the tumors just being different to begin with."

Alumkal's sequential sampling method provided a much clearer picture of how enzalutamide resistance might emerge.

When they compared the baseline sample to the progression sample from the same patient, most tumors showed no significant gene expression changes. "That the gene expression program of a tumor prior to treatment looked very similar at progression while on enzalutamide is quite remarkable," Alumkal says. "It speaks to how well most of the tumors were able to adapt and keep the androgen receptor engine on despite enzalutamide treatment."

But that wasn't the only surprise.

In three of the 21 cases, Alumkal and his team saw a profound shift in the wiring—or gene expression program—of the tumors.

"We knew that sometimes tumors become fuel-independent and no longer rely on the androgen receptor. These tumors instead turn on a gene expression program more common in nerve cells, rather than prostate cells, and shift to an aggressive form called neuroendocrine prostate cancer."

But Alumkal found that in 15 percent of cases, the tumors also became fuel-independent for another reason. "These tumors were wired in a unique way and were most consistent with a subtype of prostate cancer called double-negative prostate cancer, meaning the tumors no longer had the androgen receptor as an engine. But they also did not become neuroendocrine prostate cancer."

Alumkal uses vehicles to describe this change.

"Initially, nearly all prostate tumors are gas guzzlers: very fuel dependent and powered by the androgen receptor as the engine. When treated with hormonal treatments, most tumors remain fuel-dependent but become more fuel efficient, able to go farther with less gasoline.

"Our work showed that the majority of the tumors—even after receiving enzalutamide—remain very fuel-dependent, which suggests that continuing to target the androgen receptor could make an enormous difference in these tumors," Alumkal continued.

Alumkal found that three tumors converted to become double negative prostate cancer—akin to an electric vehicle. "The gasoline engine was replaced by a

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completely distinct set of machinery that allowed tumors to grow and survive," Alumkal explained. The DNA mutations found in the baseline and progression biopsies from these converter tumors were the same, which strongly suggests that enzalutamide completely rewired the engine of the original fuel-dependent tumor to become fuel-independent at disease progression. "It's a dramatic shift to wrap your head around."

Although the baseline tumors appeared similar under the microscope, Alumkal's team identified specific genes that were highly expressed in those that eventually became double negative prostate cancer. This result suggests that certain tumors exist in a hybrid state, initially dependent on fuel but at risk for becoming a fuel-independent double negative prostate cancer during enzalutamide treatment.

Alumkal says results from the sequential sampling method suggest that enzalutamide is causing tumors to adapt, in some cases dramatically.

Alumkal notes that the gene signature he identified is preliminary, and the team has more work to do. "Still, the fact that the DNA looks similar in the converters strongly indicates that enzalutamide is reprogramming tumors. We have more work to do, but it may be possible up-front to identify patients at greatest risk of having their tumor become fuel-independent after treatment with drugs like enzalutamide," he said.

Source: https://www.gathermycrew.org.au

Gather My Crew was founded in 2017 by Dr Susan Palmer, a psychologist with many years' experience supporting families going through crisis. But it was not until her friend needed help that the idea for Gather My Crew was first born.

Her friend Rachel required back surgery and her recovery would involve six weeks of bed rest. Susan wanted to help keep life as normal as possible for Rachel and her family – and had a group of 30 wonderful people able to lend a hand. But it wasn't long before the text messages, ring-arounds, spreadsheets and late-night phone calls became too time consuming and difficult to manage.

It was a 'lightbulb' moment and the beginning of Gather My Crew...

After talking with colleagues looking for an easy, 'online help roster' that would make coordinating all of this help a breeze, Susan was shocked to discover that nothing like it existed.

Twelve months later, Gather My Crew was launched.

Created based on the expertise of people who had 'been there, done that', as well as the clinicians who supported them, Gather My Crew exists to make sure people going through a crisis get the right help, at the right time from their friends and family – without all of the stress that usually comes with coordinating help via traditional means.

New mobile apps

We have launched a new app with increased functionality to help your patients or clients get the right help at the right time.

https://www.gathermycrew.org.au/getting-started/

New support service

We have a new website and referral partner resource pack for you to use as part of your service. Contact us to receive yours - it's all FREE!

https://www.gathermycrew.org.au/support-us/

LuPSMA: The Specifics

SOURCE:
September 15, 2022
JANET FARRAR WORTHINGTON
https://www.pcf.org/c/lupsma-the-specifics-part-2/

A whole new form of treatment for metastatic castrate-resistant prostate cancer (mCRPC) is here: PSMA-targeting therapy. The first PSMA-targeting therapy approved in the U.S. – with more being tested now in clinical trials – is LuPSMA (^{177}Lu-PSMA-617; Pluvicto®), previously discussed here.

We asked medical oncologist and PCF-funded scientist Michael J. Morris, M.D., of Memorial Sloan Kettering Cancer Center, for a guide to the specifics of getting LuPSMA:

Who's eligible for this treatment? To qualify, men must have metastatic CRPC that has progressed despite androgen deprivation therapy (ADT), an androgen receptor (AR)-blocking drug such as abiraterone, enzalutamide, apalutamide, or darolutamide *and* prior treatment with chemotherapy, in addition to having a positive PSMA-PET scan.

What are the benefits? "If you look at the overall study results," says Morris, "about half the patients had major responses to LuPSMA, and 10 percent of those men had complete responses" – meaning they had no evidence of disease by standard imaging. In the men who had major responses, PSA levels plummeted, spots of metastasis shrank or disappeared, the men felt better, had less pain, more energy, and an improvement in quality of life.

There are some side effects, including a risk of anemia, and "during the period of infusion, about 40 percent have some upset stomach," which was helped by anti-nausea medication. "Overall, it's a pretty manageable therapy." For many men, LuPSMA is better tolerated than chemotherapy, and produces a better response. "This population of patients has very advanced disease and few treatment options," says Morris. "This is a really promising and helpful therapy to help these men not just live longer, but better, as well."

A new theranostic medicine that targets PSMA, a molecule made by prostate cancer cells, can help some men with metastatic prostate cancer. In the future, it may be used in new ways to help even more men, at even earlier stages of cancer.

Prostate Cancer Foundation
Curing Together.

Is LuPSMA Right for Me? Can I Get it? Good news: After some initial production delays, LuPSMA is available internationally. The best way to know whether you are a good candidate for this therapy is to ask your medical oncologist. For now, LuPSMA is more readily available at large medical centers. "More than most therapies," says Morris, LuPSMA requires collaboration among doctors from several different specialties. "True interdisciplinary care between medical oncologists, nuclear medicine physicians, urologists, and medical oncologists is key to optimal treatment with radioligand therapy." But as radioligand therapy becomes more common, Morris expects more centers to be able to offer this multidisciplinary treatment.

LuPSMA is not a cure. But these are early days yet, and LuPSMA promises to open other treatment possibilities. "Perhaps if we move the treatment up earlier in the disease, the benefits for patients will be even more amplified. We have seen this with several drugs in prostate cancer: if you give it when the disease is less advanced, the more benefit you see." This idea is being explored in other trials, including the PSMAfore trial, which has just completed patient recruitment. "This is an international study testing LuPSMA in men who have not received chemotherapy who have metastatic castrate-resistant prostate cancer (CRPC), and who have progressed through one AR pathway inhibitor, so it's one step earlier" than what the FDA currently approves."

A second trial, one step earlier still, is called PSMAddition. "This is for men who do not yet have CRPC, who still respond to hormonal therapy." Participants in this

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

trial are randomly assigned to receive either ADT plus an AR inhibitor and LuPSMA, or just the hormonal therapy alone.

Still other trials under way are investigating radioligand therapy using many different tactics. Generally, Morris continues, "in advanced disease, if you put someone on a drug that inhibits AR signaling, PSMA expression goes *up*. When PSMA goes up, the effectiveness of radioligand therapy likely goes up: the more drug that adheres to the prostate cancer cells because there are more PSMA molecules, the more radiation you're able to get to the tumor." In laboratory studies, scientists are also working on laying the groundwork for success: exploring ways to turn up PSMA expression to maximize the radioligand's effectiveness – like preparing a field before the crop is planted.

Another mechanism that might make LuPSMA and other radioligands more effective is to double down on the mechanism of action. "When you deliver radiation to prostate cancer cells, you're damaging the DNA," Morris says. "We have agents that inhibit DNA repair in the form of PARP inhibitors (such as olaparib), already approved for prostate cancer patients with DNA repair defects (who have tumor mutations in genes such as BRCA 1/2). We could potentially give a PARP inhibitor with a DNA-damaging agent like LuPSMA, and get a more durable response that way." Or, it may be that patients with a mutated DNA damage repair gene turn out to be "particularly sensitive to radioligand therapy. There are many different strategies we're looking at to enhance the effect of LuPSMA, or have radioligand therapy enhance other drugs. All these questions are wide open."

Yet another way to go might be to use radioligand therapy in combination with immunotherapy. "DNA damage also increases the immune response," says Morris. "A lot of new immune therapies are being tested right now. Perhaps radioligand therapy can improve the immune response to prostate cancer, and immunotherapy can also improve the response to the radioligand."

Then there's the LuPSMA treatment regimen itself. Can it be improved? "Currently, we give it in four cycles, one every six weeks, with the option of two additional cycles if it looks like the person has tolerated treatment well," says Morris, "so a total of six cycles every six weeks." There is anecdotal experience from countries that have been using radioligand therapy longer than the U.S., of giving more cycles. "I think we need to do those studies in a formal way, to generate the data as to how many cycles is safe and tolerable, when do you stop, and when do you keep going. There's nothing magic about six cycles. There's also nothing to say that's the optimal way of giving it; perhaps some patients would benefit from fewer treatments, with more prolonged breaks in between if they have a good response. Maybe we could stretch it out.

"There are so many questions about optimization," he continues. "Certainly, the VISION trial answered some questions: does it prolong life? Yes. Can we identify patients who will benefit from it? Yes. But different sets of questions have now opened up: Which patients will benefit the most? Which patients are less likely to be helped, and should instead try a different treatment?"

Although "we usually give it a cycle or two before we assess whether a patient is responding or not, some patients do really have significant and quick responses" to LuPSMA. "There are some extraordinary responders, and then some patients who don't respond at all. We really want to understand how to distinguish between the two."

As a field, radioligand therapy is still very new. "This is that first entrée into it for prostate cancer. The first step of a long road." And yet, because the results have been so promising, Morris is seeing patients who want to undergo radioligand therapy very early on – "instead of up-front ADT or even before surgery or radiation! We don't have the data to say we should be using it outside of a clinical trial."

But LuPSMA has already done something very important in the field of prostate cancer: It has offered new hope, Morris says. "It's good for everybody." For patients and their families, it brings results that improve quality of life: "PSA drops, metastatic lesions shrink, patients feel better, have more energy and feel more like their old selves." It makes doctors feel happy and encouraged, too: "Doctors lose sleep over our patients. We worry about them. We get very attached to them. We want them to live, and live well, and live the best lives they can. Having a therapy that allows them to do well is important to them, and to us."

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.

BINS4Blokes: a campaign to champion men's health

The Continence Foundation of Australia's advocacy push will boost wellbeing and inclusivity in Australian communities.

In Australia, 1.34 million men and boys live with incontinence. A national health campaign is set to improve their social and economic participation and quality of life – but it needs support.

BINS4Blokes is an Australia-wide awareness campaign advocating for the installation of incontinence bins in male public toilet facilities. The campaign is an initiative of the not-for-profit Continence Foundation of Australia, https://www.continence.org.au/

Australia's peak body in promoting bladder and bowel health.

The current situation

Right now, most people using male public toilet facilities do not have a way to dispose of incontinence products. This can result in unhygienic disposal and incontinence products ending up in landfill, parks, gardens and oceans.

A lack of incontinence disposal bins also has huge impacts for community and social participation, with men more likely to stay home and not take part in everyday activities.

Men with incontinence are already a vulnerable population, with research showing a clear link between incontinence and depression. A survey of Australian men with urinary incontinence found that half (50 per cent) avoided situations where they could not access a toilet easily. Shockingly, some men's routines included staying home as a precautionary measure (27 per cent).

A positive change for men's health

Adding incontinence bins in male public toilet facilities is essential to help people live and work to their full potential. Every bin installation will help with the stigma around incontinence, and be meaningful to men who are battling health issues related to their bladders and bowels.

Councils taking the lead

BINS4Blokes is rapidly picking up pace around Australia. Early supporters, including Camden Council in New South Wales, see the campaign as another step towards supporting men's health issues.

Mayor of Camden Cr Theresa Fedeli says: "The BINS4Blokes initiative provides an opportunity for us to participate in a project that facilitates and further enhances social inclusion within the community."

The Continence Foundation of Australia has the resources needed to implement BINS4Blokes in your community. Get involved and head to https://bins4blokes.org.au/resources/

for posters and information for toilet providers and councils.

If you are having incontinence issues, call the National Continence Helpline on

1800 33 00 66

BINS 4 Blokes

This is a GREAT initiative. Something every country should follow. Have you ever tried to plot the toilets in a foreign city on google maps? Hopefully all male visitors to Melbourne, and Australia, will benefit.

Please spread the word and ensure your local council gets on board.

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.

For help with the cost of products visit:

CONTINENCE AIDS PAYMENT SCHEME

https://www.servicesaustralia.gov.au/who-can-get-continence-aids-payment-scheme?context=21826

MFS Benefit Derived From Long-Course Therapy With ADT Plus Radiotherapy After Surgery in Prostate Cancer

SOURCE:
13 September 2022
Kristie L Kahl
https://www.cancernetwork.com/view/mfs-benefit-derived-from-long-course-therapy-with-adt-plus-radiotherapy-after-surgery-in-prostate-cancer

First results from the RADICALS-HD trial demonstrated improved metastasis-free survival with 2 years of androgen-deprivation therapy (ADT) plus radiotherapy in men with prostate cancer.

First results from the RADICALS-HD trial (ISRCTN40814031) showed improved metastasis-free survival (MFS) and time to salvage therapy with the addition of 2 years of androgen deprivation therapy (ADT) to radiotherapy following radical prostatectomy in men with prostate cancer. These data were recently presented at the 2022 European Society for Medical Oncology Congress (ESMO).

"Up until now, doctors and patients have had to depend on opinion really to choose whether or not to have hormones with their postoperative radiotherapy, and so these results will now help doctors and patients in the future to have an evidence-based choice," Chris Parker, MD, consultant clinical oncologist, The Royal Marsden NHS Foundation Trust, and professor, Prostate Oncology, The Institute of Cancer Research in London, said in a press briefing at the congress.

When evaluating the duration of the added therapy, 24 months of ADT improved MFS, compared with just 6 months of ADT (HR, 0.77; 95% CI, 0.61-0.97; *P* = .03), with 10-year MFS rates of 78% and 72%, respectively. Moreover, according to the abstract, the time to salvage therapy was delayed (HR, 0.73; 95% CI, 0.59-0.91); however, overall survival (OS) was not improved (HR 0.88; 95% CI, 0.66-1.17) with long- vs short-course therapy.

When evaluating the efficacy of ADT with radiotherapy, vs no hormone therapy, 6-month ADT failed to improve MFS (HR, 0.89; 95% CI, 0.69-1.14), with 10-year MFS rates of 79% and 80%, respectively. Similar to the long-course therapy comparison, time to salvage ADT was delayed with 6 months of ADT (HR, 0.54; 95% CI, 0.42-0.70); however, OS was not improved (HR, 0.88; 95% CI, 0.65-1.19).

"When men are getting radiotherapy for prostate cancer as their initial treatment, we know that the addition of hormone therapy improves the efficacy and survival. We also know that longer courses of hormone therapy are more effective than shorter courses of therapy," Parker said. "However, when men are getting radiotherapy after surgery, we don't know about the role of hormone therapy."

Therefore, in the randomized, controlled trial, investigators aimed to evaluate the use and duration of ADT with postoperative radiation therapy by randomizing patients to receive either no ADT, 6 months of ADT (short course), or 24 months (long course) of ADT.

"So, the objectives of the trial were to test the efficacy of adding hormone therapy to postoperative radiotherapy and also to compare the efficacy of short-course and long-course hormone therapy," Parker explained.

In 2 separate comparisons, investigators compared radiation alone vs short-course ADT (n = 1480), and also short-course ADT vs long-course ADT (n = 1523).

The trial was conducted in the UK, Canada, Denmark, and Ireland.

Key eligibility criteria were comprised of indication for radiation therapy after previous radical prostatectomy and no previous postoperative ADT.

MFS served as the primary end point. Secondary end points included time to salvage ADT and OS.

The median age of patients was 66 years. Overall, 23% of patients reported with pT3b/T4, 20% with Gleason scores 8 to 10, and a median pre-radiotherapy PSA of 0.22 ng/ml. Risk factors were more favorable in in the none-vs-short–course therapy arm, compared with the short-vs-long –course therapy arm, according to the abstract.

Median follow-up was 9 years.

"The new information from this important study will ensure clinicians can better tailor treatment for prostate cancer patients following surgery and help facilitate important discussions," Parker said in a press release. "This will mean some receive a more effective treatment while sparing others unnecessary intervention. We already knew prostate cancer patients initially treated with radiotherapy benefitted from hormone therapy. However, we did not know whether hormone therapy would also benefit those receiving radiotherapy after prostate surgery."

Short-term Androgen Annihilation in Non-metastatic Recurrent Men Delays Progression

SOURCE:
11 September 2022
https://www.prostatecancer.news/2022/09/short-term-androgen-annihilation-in-non.html

A difficult question for patients who still having rising PSA after prostatectomy and salvage radiation is: Is there any advantage to starting advanced hormone therapy before metastases are visible?

Rahul Aggarwal presented the early results of the PRESTO trial. Patients (n=504) were chosen who had the following characteristics:

- Failed prostatectomy and salvage radiation (85%). Half of those who had salvage radiation, had adjuvant ADT at the time
- PSA>0.5 ng/ml
- PSA doubling time (PSADT) ≤ 9 month
- no metastases on conventional imaging (bone scan/CT/MRI)

Patients were randomly assigned to one year of any of the following treatments:

A. ADT only

B. ADT+apalutamide

C. ADT+abiraterone+apalutamide

With follow-up of 21 months, biochemical progression-free survival (bPFS, PSA stayed under 0.2 ng/ml) was:

- 20 mos. in Group A
- 25 mos. in Group B (48% improvement vs Group A)
- 26 mos. in Group C (52% improvement vs Group A)
- No significant differences attributable to PSADT
- Group C wasn't significantly different from Group B (Zytiga added little)

Other findings:

- Testosterone recovered in 4-5 months in all groups
- More hypertension with abiraterone

Other trials have looked at adding a limited term of 2nd line hormonal medicines when there is rapid PSADT but before metastases have been discovered on conventional imaging.

- Spetsieris et al. added abiraterone for 8 months. Afterwards, bPFS was 27 mos vs 20 mos. for ADT-only.
- Madan et al. reported substantial PSA control with intermittent use (two 3-month cycles) of enzalutamide alone without ADT. PSA didn't rise for 6-7 months after the first and second cycles.

With detection of metastases with PSMA PET scans, the advantage of early intervention will become clearer. There is also a clearer advantage for men with a higher Decipher score. It is likely that even intermittent use will be advantageous. Men with rapid PSADT after salvage radiation should consider a short-term intervention with one of the advanced hormonals.

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.

The Addition of Androgen Deprivation Therapy and Pelvic Lymph Node Treatment to Prostate Bed Salvage Radiotherapy

(NRG Oncology/RTOG 0534 SPPORT): an international, multicentre, randomised phase 3 trial

SOURCE:
14 May 2022
https://www.sciencedirect.com/science/article/abs/pii/S0140673621017906

Background

In men with a detectable prostate-specific antigen (PSA) level after prostatectomy for prostate cancer, salvage prostate bed radiotherapy (PBRT) results in about 70% of patients being free of progression at 5 years. A three-group randomised trial was designed to determine whether incremental gains in patient outcomes can be achieved by adding either 4–6 months of short-term androgen deprivation therapy (ADT) to PBRT, or both short-term ADT and pelvic lymph node radiotherapy (PLNRT) to PBRT.

Methods

The international, multicentre, randomised, controlled SPPORT trial was done at 283 radiation oncology cancer treatment centres in the USA, Canada, and Israel. Eligible patients (aged ≥18 years) were those who after prostatectomy for adenocarcinoma of the prostate had a persistently detectable or an initially undetectable and rising PSA of between 0·1 and 2·0 ng/mL. Patients with and without lymphadenectomy (N0/Nx) were eligible if there was no clinical or pathological evidence of lymph node involvement. Other eligibility criteria included pT2 or pT3 disease, prostatectomy Gleason score of 9 or less, and a Zubrod performance status of 0–1. Eligible patients were randomly assigned to receive PBRT alone at a dose of 64·8–70·2 Gy at 1·8 Gy per fraction daily (group 1), PBRT plus short-term ADT (group 2), or PLNRT (45 Gy at 1·8 Gy per fraction, and then a volume reduction made to the planning target volume for the remaining 19·8–25·2 Gy) plus PBRT plus short-term ADT (group 3). The primary endpoint was freedom from progression, in which progression was defined as biochemical failure according to the Phoenix definition (PSA ≥2 ng/mL over the nadir PSA), clinical failure (local, regional, or distant), or death from any cause. A planned interim analysis of 1191 patents with minimum potential follow-up time of 5 years applied a Haybittle-Peto boundary of p<0·001 (one sided) for comparison of 5-year freedom from progression rates between the treatment groups. This trial is registered with ClinicalTrials.gov, NCT00567580. The primary objectives of the trial have been completed, although long-term follow-up is continuing.

Findings

Between March 31, 2008, and March 30, 2015, 1792 eligible patients were enrolled and randomly assigned to the three treatment groups (592 to group 1 [PBRT alone], 602 to group 2 [PBRT plus short-term ADT], and 598 to group 3 [PLNRT plus PBRT plus short-term ADT]). 76 patients subsequently found to be ineligible were excluded from the analyses; thus, the evaluable patient population comprised 1716 patients. At the interim analysis (n=1191 patients; data cutoff May 23, 2018), the Haybittle-Peto boundary for 5-year freedom from progression was exceeded when group 1 was compared with group 3 (difference 17·9%, SE 2·9%; p<0·0001). The difference between groups 2 and 3 did not exceed the boundary (p=0·0063). With additional follow-up beyond the interim analysis (the final planned analysis; data cutoff May 26, 2021), at a median follow-up among survivors of 8·2 years (IQR 6·6–9·4), the 5-year freedom from progression rates in all 1716 eligible patients were 70·9% (95% CI 67·0–74·9) in group 1, 81·3% (78·0–84·6) in group 2, and 87·4% (84·7–90·2) in group 3. Per protocol criteria, freedom from progression in group 3 was superior to groups 1 and 2. Acute (≤3 months after radiotherapy) grade 2 or worse adverse events were significantly more common in group 3 (246 [44%] of 563 patients) than in group 2 (201 [36%] of 563; p=0·0034), which, in turn, were more common than in group 1 (98 [18%] of 547; p<0·0001). Similar findings were observed for grade 3 or worse adverse events. However, late toxicity (>3 months after radiotherapy) did not differ significantly between the groups, apart from more late grade 2 or worse blood or bone marrow events in group 3 versus group 2 (one-sided p=0·0060) attributable to the addition of PLNRT in this group.

Interpretation

The results of this randomised trial establish the benefit of adding short-term ADT to PBRT to prevent progression in prostate cancer. To our knowledge, these are the first such findings to show that extending salvage radiotherapy to treat the pelvic lymph nodes when combined with short-term ADT results in meaningful reductions in progression after prostatectomy in patients with prostate cancer.

Funding

National Cancer Institute.

Association Between Duration of Gonadotropin-Releasing Hormone Agonist Use and Cardiovascular Risks

SOURCE:
6 September 2022
https://www.practiceupdate.com/journalscan/97558/67/11?elsca1=emc_enews_weekinreview&elsca2=email&elsca3=practiceupdate_advancedprostatecancer&elsca4=advancedprostatecancer&elsca5=newsletter&rid=NTMyMjc0MDc4NjM0S0&lid=20849595

Abstract

BACKGROUND

Although androgen deprivation therapy has known cardiovascular risks, it is unclear if its duration is related to cardiovascular risks. This study thus aimed to investigate the associations between gonadotrophin-releasing hormone (GnRH) agonist use duration and cardiovascular risks.

METHODS

This retrospective cohort study included adult patients with prostate cancer receiving GnRH agonists in Hong Kong during 1999-2021. Patients who switched to GnRH antagonists, underwent bilateral orchidectomy, had <6 months of GnRH agonist, prior myocardial infarction (MI), or prior stroke was excluded. All patients were followed up until September 2021 for a composite endpoint of MI and stroke. Multivariable competing-risk regression using the Fine-Gray subdistribution model was used, with mortality from any cause as the competing event.

RESULTS

In total, 4038 patients were analyzed (median age 74.9 years old, interquartile range (IQR) 68.7-80.8 years old). Over a median follow-up of 4.1 years (IQR 2.1-7.5 years), longer GnRH agonists use was associated with higher risk of the endpoint (sub-hazard ratio per year 1.04 [1.01-1.06], p = 0.001), with those using GnRH agonists for ≥2 years having an estimated 23% increase in the sub-hazard of the endpoint (sub-hazard ratio 1.23 [1.04-1.46], p = 0.017).

CONCLUSION

Longer GnRH agonist use may be associated with greater cardiovascular risks.

TAKE-HOME MESSAGE

In this retrospective study, the authors aimed to investigate the association between the duration of gonadotrophin-releasing hormone (GnRH) agonist use and cardiovascular risks. Of the 4038 patients who were included, the endpoints (myocardial infarction, stroke, or both) occurred in 735 patients over a median follow-up period of 4.1 years. Multivariate analysis showed that patients receiving GnRH agonists for ≥2 years had a 23% increase in the risk of cardiovascular events.

Extended use of GnRH agonists is associated with increased cardiovascular risk, especially if administered for ≥2 years. Physicians should intensify cardiovascular monitoring in patients receiving GnRH agonists for a long period.

–
Vinay Mathew Thomas, MD

Long-Term Outcomes and Genetic Predictors of Response to Metastasis-Directed Therapy vs Observation in Oligometastatic Prostate

SOURCE:
5 September 2022
Advanced Prostate CancerJournal of Clinical Oncology

Metastasis-directed therapy for oligometastatic castration-sensitive prostate cancer is increasingly being utilized. In this article, the authors report the long-term outcomes of pooled-data analysis from two prospective trials, STOMP and ORIA. Both of these trials used PET-directed radiotherapy for metastasis-directed therapy, and the combined data, unequivocally, show that progression-free survival is improved relative to the control group. This type of data is driving the increasing use of stereotactic body radiotherapy for PSMA PET–detected oligometastatic disease. Importantly, there is clear evidence that other systemic therapies, such as hormonal therapy, can be safely delayed in these patients.

An interesting analysis presented for the first time in this paper from the Journal of Clinical Oncology is that high-risk pathogenic mutations are particularly important for the disease prognosis of those receiving metastasis-directed therapy. Herein, mutations within ATM, BRCA1, BRCA2, RB1, or TP53 were characterized as high-risk. For those without a high-risk mutation, the progression-free survival (PFS) was 13.4 months for those receiving metastasis-directed therapy; whereas, the PFS was only 7.5 months for those who had a high-risk mutation. These data are important in terms of guiding physician choices for those with oligometastatic disease. We look forward to larger trials addressing this issue, but these preliminary data and long-term follow-up outcomes clearly suggest that metastasis-directed therapy is appropriate for men with oligometastatic disease detected by PET imagining.

Abstract

Clinical trials frequently include multiple end points that mature at different times. The initial report, typically based on the primary end point, may be published when key planned co-primary or secondary analyses are not yet available. Clinical Trial Updates provide an opportunity to disseminate additional results from studies, published in JCO *or elsewhere, for which the primary end point has already been reported.*

The initial STOMP and ORIOLE trial reports suggested that metastasis-directed therapy (MDT) in oligometastatic castration-sensitive prostate cancer (omCSPC) was associated with improved treatment outcomes. Here, we present long-term outcomes of MDT in omCSPC by pooling STOMP and ORIOLE and assess the ability of a high-risk mutational signature to risk stratify outcomes after MDT. The primary end point was progression-free survival (PFS) calculated using the Kaplan-Meier method. High-risk mutations were defined as pathogenic somatic mutations within *ATM*, *BRCA1/2*, *Rb1*, or *TP53*. The median follow-up for the whole group was 52.5 months. Median PFS was prolonged with MDT compared with observation (pooled hazard ratio [HR], 0.44; 95% CI, 0.29 to 0.66; *P* value < .001), with the largest benefit of MDT in patients with a high-risk mutation (HR high-risk: 0.05; HR no high-risk: 0.42; *P* value for interaction: .12). Within the MDT cohort, the PFS was 13.4 months in those without a high-risk mutation, compared with 7.5 months in those with a high-risk mutation (HR, 0.53; 95% CI, 0.25 to 1.11; *P* = .09). Long-term outcomes from the only two randomized trials in omCSPC suggest a sustained clinical benefit to MDT over observation. A high-risk mutational signature may help risk stratify treatment outcomes after MDT.

TAKE-HOME MESSAGE

This pooled analysis of the STOMP and ORIOLE trials reported long-term outcomes of metastasis-directed therapy (MDT) and evaluated genomic predictors of treatment outcomes following MDT in patients with oligometastatic castration–sensitive prostate cancer (omCSPC). At a median follow-up of 52.5 months, median progression-free survival (PFS) was longer with MDT than with observation in patients with and without a high-risk mutation. The PFS benefit associated with MDT was higher in patients with a high-risk mutation than in those without a high-risk mutation (13.4 vs 7.5 months).

Long-term outcomes indicate a sustained clinical benefit of MDT over observation in patients with omCSPC, suggesting that this therapy should be considered in this patient population. A high-risk mutational status may predict treatment response following MDT, and future studies should explore biomarkers to optimize patient selection.

Oliver Sartor MD

Best Approaches and Updates for PCa Biochemical Recurrence

SOURCE: https://ascopubs.org/doi/full/10.1200/EDBK_351033

Biochemical recurrence develops in almost one-third of men with prostate cancer after treatment with local therapy. There are numerous options for management, including surveillance, salvage radiation, androgen deprivation therapy (ADT), and clinical trials. This article reviews the current approaches to radiation therapy, ADT, and molecular imaging in men with biochemically recurrent prostate cancer. First, radiation therapy, including selection of field, dose, and use of concurrent antiandrogen therapy, is reviewed. Next, molecular imaging is addressed, including prostate-specific membrane antigen PET imaging and its increased sensitivity in identifying sites of disease. Finally, the factors associated with starting ADT are explored, and the data supporting intermittent over continuous ADT are reviewed. Lastly, the use of prostate-specific membrane antigen PET imaging and its potential role influencing therapy are discussed.

PRACTICAL APPLICATIONS

- Salvage radiation to the prostate bed and pelvic lymph nodes is the standard approach to treating biochemical recurrence.
- The concurrent use of antiandrogen therapy with radiation therapy has also demonstrated improved overall survival.
- Prostate-specific membrane antigen PET scans have the ability to detect recurrent disease at lower prostate-specific antigen levels and improve progression-free survival when these lesions are covered in the radiation treatment plan.
- The decision to initiate androgen deprivation factors depends on multiple factors, including Gleason score, initial prostate-specific antigen, prostate-specific antigen doubling time, and patient preference.
- If androgen deprivation therapy is initiated, intermittent therapy is preferable to continuous therapy.

Despite undergoing definitive local therapy with radical prostatectomy (RP) or radiation for prostate cancer, many men will go on to develop prostate-specific antigen (PSA) recurrence with no evidence of disease on conventional imaging. This disease state is called biochemical recurrence (BCR). Estimates for the risk of developing BCR range from 20% to 40%.[1,2] The Phoenix criteria[3] are used to define BCR postradiation therapy, which requires an increase in PSA of at least 2 ng/mL above the postradiation PSA nadir, whereas BCR post-RP is defined as at least two PSA values that are 0.2 ng/mL or higher.[4] Therapeutic options include salvage radiation therapy (SRT) for patients with post-RP PSA recurrence. For those men with postradiation recurrence, the best approach is controversial. Current options include surveillance, androgen deprivation therapy (ADT), and clinical trials. This article reviews the current diagnostic and therapeutic approaches for patients with BCR and discusses the increasing use of prostate-specific membrane antigen (PSMA) PET imaging in this disease state.

To Read the entire article go to:
https://ascopubs.org/doi/full/10.1200/EDBK_351033

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 now 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"

August 2022
- Prostate Cancer Cases Risk Being Diagnosed Too Late
- Does Testosterone Cause Prostate Cancer?
- Treatment Intensification Patterns and Utilization
- Home Based Exercise Programs Show Promise
- Novel Liquid-based Biopsy Launched in US
- Healthy Lifestyle Cuts PCa Mortality Among High Risk Men
- Active Surveillance Plus Enzalutaimde Monotherapy Vs Active Surveillance
- Treatment of Metastatic Hormone Sensitive Prostate Cancer
- Strategies to Help Get Your Life Back
- Study May Help Define Role of PSMA PET Scan in Recurrent PCa
- Cancer Loves Sugar & Sugar *REALLY* Loves Cancer
- Matters of Survivorship – Sexual Health

September 2022
- My Cancer Care Record
- Can I get Travel Insurance if I Have Cancer?
- Risk of Skeletal Related Events with Abiraterone or Enzalutamide
- Research Suggests Commonly used PCa Treatment Rewires Tumours
- Gather My Crew
- LuPSMA Specifics
- Bins 4Bloke
- MFS Benefits Derived from Long Term ADT + Radiotherapy After RP
- Short-term androgen annihilation in non-metastatic recurrent men delays progression
- The addition of ADT & Pelvic Lymph Node Treatment to Prostate Bed Salvage Radiotherapy
- Association Between Duration of Gonadotropin-Releasing Hormone Agonist Use and Cardiovascular Risks
- Long-Term Outocmes & Genetic Predictors of Response to MDT cs Observation in Oligometastatic Prostate Cancer
- 1Best Approaches & Updates for Prostate Cancer Biochemical Recurrence

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