Prostate Heidelberg Cancer Support Group

Prostate Heidelberg

October 2022 Issue 223

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/84861550435?pwd=ZHNLMU1WWGs5QVJ6T0pTajk4QVpwUT09

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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

Tues 18 October 2022

Dr Jane Crowe – MBBS Hons, Masters GP Psychiatry.

Jane has been working for over 30 years as a GP in suburban Melbourne. In 2011 Jane started working part time as Prostate Cancer GP at the Epworth Hospital in Richmond and now at the Australian Prostate Centre in North Melbourne where she works as part of a multi-disciplinary survivorship clinic for men on androgen deprivation therapy. Jane uses her general practice skills and clinical prostate cancer knowledge in conjunction with other health professionals to help manage the many challenges a man with prostate cancer may encounter Jane's ultimate aim is to help optimise the quality life of men with prostate cancer by taking an individual and holistic approach in a meaningful way for her patients.

Member News

URGENT CALL FOR NOMINATIONS FOR CO-CONVENOR AND SECRETARY/TREASURER OF PHCSG

Mike Waller and Sue Lawes have plans for extensive overseas travel during 2023. Given this, and other work and family commitments, they will therefore be stepping down as Co-Convenor and Secretary/Treasurer of the Group effective from our December meeting (13 December). The Group is therefore looking for nominations as soon as possible from members to assume these roles, either wholly or on a shared basis. Anyone wishing to discuss what duties the roles entail etc should contact Max Shub, Mike Waller or Sue Lawes by email (prostateheidelberg@gmail.com) or by phone.

Max (0413 777 342); Mike (0438 616 240); Sue (0401 867 184).

Welcome to Prostate Pride Support Group in Melbourne

The Prostate Pride Support Group was formed in Melbourne in July 2022.

The group has been set up to provide support to the LGBTQI+ community who have been diagnosed with prostate cancer, to share common experiences and raise awareness of prostate cancer in a safe and confidential environment.

Partners and family members are welcome and encouraged to attend.

Please contact Jaco or Bryan for further information regarding meeting times and venue.

Jaco (Group Leader) 0412 106 441 prostatepride@gmail.com

Bryan (Secondary Contact) 0422 566 862 bryco009@hotmail.com

Prostate Heidelberg Cancer Guest Speakers

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.

Ashley has specialist knowledge in prescribing exercise programs for patients with cancer. To plan the program that is right for you, she takes into consideration your diagnosis, your treatment plan and any side effects you may be experiencing.

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

More Evidence For Benefits of Radiation Therapy in Metastatic Prostate Cancer

SOURCE:
31 August 2022
Becky Campbell
https://www.pcf.org/c/more-evidence-for-benefits-of-radiation-therapy-in-metastatic-prostate-cancer/?utm_source=NewsPulse&utm_medium=email&utm_campaign=SEPT22NP

In the U.S., between 2010-2019, nearly 7% of patients diagnosed with prostate cancer had metastatic disease at diagnosis. In 2022, this could translate into more than 18,000 people. Multiple treatment options exist, including combinations of standard androgen deprivation therapy (ADT), novel hormonal therapies, and docetaxel. Since 2019, radiation therapy (RT) to the prostate has been recommended as an option in addition to medication for patients with relatively fewer metastases.

This recommendation was based on initial results from the STAMPEDE clinical trial showing that among patients whose prostate cancer had spread less ("low-burden" disease), those who received RT to the prostate lived longer than those who did not receive RT. Burden of metastatic disease was defined by the number and location of metastases (see Box).

Now, a new publication of long-term results of STAMPEDE confirms the benefit of RT on survival and reports additional outcomes.

STAMPEDE is a very large multi-arm, multi-stage trial conducted in Europe that is comparing the efficacy of several different treatment regimens in men with newly-diagnosed metastatic prostate cancer who are starting long-term ADT. Within the overall trial, one "arm" looked specifically at the benefit of adding RT to ADT. There were two treatment groups (ADT, and ADT + RT), each with more than 1000 patients. 40% of patients had low-burden disease.

Patients were followed for a median of 5 years. In the *low-burden* disease group, patients treated with RT+ADT were 34% less likely to die than patients receiving ADT alone, and lived, on average, nearly 2 years longer (85.5 months vs 63.6 months). Consistent with the initial trial results, addition of RT to ADT was not linked to longer survival in patients with a *high burden* of disease.

Advanced prostate cancer can cause complications such as urinary or bowel obstruction. In the low-burden group, addition of RT was linked to lower rates of these complications and need for intervention (such as insertion of a urinary catheter).

There was no difference over the long term in quality of life between the two treatment groups.

It's also important to know about any side effects from adding RT. Differences were minor, and manageable: for example, at 4 years, 13% of patients in the RT+ ADT had reported a moderate-to-severe adverse event vs 9% in the ADT alone group. The authors noted that "the risk of toxicity from prostate RT, although low, could be further reduced by the use of more contemporary intensity modulated techniques."

These results add to the evidence showing that more intensive treatment for metastatic prostate cancer at diagnosis can help patients live longer, without increasing side effects. If you have been diagnosed with metastatic prostate cancer, talk to your doctor about what combination treatment options might be right for you.

New publication of long-term trial results confirms benefit of adding radiation therapy to the prostate in cancer that has not spread

Definitions:
Low vs High Burden of Metastases

High: Presence of visceral (such as liver or lung) metastasis OR 4 or more bone lesions with 1 or more of these beyond the vertebral bodies and pelvis

Low: Not meeting these criteria. Includes patients with only lymph node metastases, without bone or visceral disease, regardless of the number of nodal metastases.

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ESMO 2022: Radiotherapy Alone After Surgery Effective for Some Patients With Prostate Cancer

SOURCE:
19 September 2022
https://www.practiceupdate.com/c/142161/32/1/?elsca1=emc_conf_ESMO2022Post-1&elsca2=email&elsca3=practiceupdate_onc&elsca4=202282_ESMO2022Post-1&elsca5=conference&rid=NTMyMjc0MDc4NjM0S0&lid=39091850

Patients with prostate cancer who struggle with the side effects of hormone therapy may benefit from radiotherapy alone, while two years of androgen deprivation therapy (ADT) appears to be more effective than six months of treatment for patients at high risk for recurrence of prostate cancer, according to a study presented at the annual meeting of the European Society of Medical Oncology, held Sept. 9 to 13 in Paris.

Chris Parker, M.D., from the Royal Marsden NHS Foundation Trust and the Institute of Cancer Research in London, and colleagues evaluated the outcomes of patients who received no ADT ("none"), six months of ADT ("short"), or 24 months of ADT ("long") along with postoperative radiotherapy for prostate cancer. The study, part of the RADICALS protocol, encouraged three-way randomization and two-way randomization between none-versus-short or short-versus-long. The primary outcome measure was metastasis-free survival (MFS), while secondary outcomes included time to salvage ADT and overall survival (OS).

Researchers evaluated 2,839 patients, including 492 in the three-way randomization, 1,480 patients entering the none-versus-short comparison, and 1,523 patients entering the short-versus-long comparison. In a median follow-up of nine years for the none-versus-short group, based on 268 MFS events, six months of ADT did not improve MFS (hazard ratio [HR], 0.89; 95 percent confidence interval [CI], 0.69 to 1.14), and the time to salvage ADT was delayed (HR, 0.54; 95 percent CI, 0.42 to 0.70); however, OS was not improved (HR, 0.88; 95 percent CI, 0.65 to 1.19).

In the short-versus-long group, based on 313 MFS events, 24 months of ADT improved MFS (HR, 0.77; 95 percent CI, 0.61 to 0.97), while time to salvage ADT was delayed (HR, 0.73; 95 percent CI, 0.59 to 0.91). Similar to the none-versus-short group, OS was not improved in the short-versus-long group (HR, 0.88; 95 percent CI, 0.66 to 1.17).

The study authors concluded that in patients having postoperative RT after radical prostatectomy, 24 months of ADT versus six months of ADT improved both time to salvage ADT and MFS; while six months of ADT versus no ADT improved time to salvage ADT but did not improve MFS.

"The new information from this important study will ensure clinicians

Study also shows two years of hormone therapy more effective than six months of treatment

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."

With regard to the potential benefits for patients, Parker said, "The risk of metastases is reduced in patients undergoing radiotherapy and androgen deprivation therapy following radical prostatectomy. The trial showed encouraging results for radiotherapy without hormone therapy so some patients, concerned with upsetting side effects of hormone therapy, can be reassured this treatment alone is a good option."

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

Can Physical Exercise Prevent Chemotherapy-Induced Peripheral Neuropathy in Patients With Cancer?

SOURCE:
7 March 2022
https://pubmed.ncbi.nlm.nih.gov/35271844/

A Systematic Review and Meta-analysis

Abstract

Objective: This systematic review analyzed the effects of physical exercise programs in patients with cancer undergoing chemotherapy on chemotherapy-induced peripheral neuropathy (CIPN) prevention.

Data sources: PubMed, Web of Science, Scopus, and Cochrane Library were searched for relevant studies published before December 2020. Additional references were identified by manual screening of the reference lists.

Study selection: Based on the Population, Intervention, Comparator, Outcomes, and Study Designs strategy, randomized controlled trials in which physical exercise was applied before or during chemotherapy to prevent or ameliorate CIPN were included.

Data extraction: Two reviewers blinded and independent screened the articles, scored methodologic quality, and extracted data for analysis. The review was conducted and reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses statement. Sensitivity and precision analysis databases was included. Risk of bias assessment and meta-analysis were conducted using the Cochrane tools.

Data synthesis: Of 229 potentially relevant studies, 8 randomized controlled trials were included and scored. They comprise a total of 618 patients with cancer. MEDLINE and Scopus databases recorded the highest sensitivity. None of the studies achieved a "low" overall risk of bias. Four studies were included in meta-analysis for quality of life, and a significance standardized mean difference was found between groups from baseline of 14.62; 95% CI, 6.03-3.20, with a large effect size g=0.83; 95% CI, 0.48-1.18) in favor of physical exercise program compared with usual care.

Conclusions: Physical exercise at the onset of chemotherapy has shown promising effects on the prevention of CIPN, specially improving quality of life.

EX-MED cancer

Why should people with cancer exercise?

If the effects of exercise could be encapsulated in a pill it would be prescribed to every person with cancer. Even if this pill had just a fraction of the positive health benefits

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

- Is a safe & effective program specifically designed for people with cancer
- Counteracts the adverse effects of cancer and its treatment
- Involves an individualised exercise medicine program delivered by experienced exercise physiologists in local fitness centres
- Enhances physical and mental wellbeing and delivers profound improvements to the lives of people with cancer
- Is based on the latest scientific research
- Is an Australian Charities and Not-for-profit Commission (ACNC) registered not-for-profit organization
- Is designed and administered by international leaders in the field of exercise and cancer research and practice

- Years of scientific research has established exercise as an invaluable medicine in the management of cancer. Evidence based guidelines recommend all people with cancer exercise regularly to help tolerate and recover from cancer treatments.
- Research shows that people with cancer who exercise regularly have a lower relative risk of dying from cancer, a lower relative risk of cancer recurrence and they experience fewer and/or less severe treatment-related adverse effects.

Improving Erectile Function

SOURCE:
9 September 2022
Becky Campbell
https://www.pcf.org/c/improving-erectile-function-part-1-what-you-can-do-before-surgery/?utm_source=NewsPulse&utm_medium=email&utm_campaign=SEPT22NP

Part 1: What You Can Do Before Surgery

If you've been diagnosed with localized prostate cancer and are considering having surgery (radical prostatectomy), you may be concerned about potential side effects, including loss of erectile function.

About 40% of men lose some erectile function after surgery. This can have a major impact on quality of life for both the patient and his partner. However, there are ways to improve erectile function, especially if multiple strategies are combined and are personalized to the patient. A team led by PCF-funded investigator Dr. Ashutosh Tewari, a urologist and chairman of urology at the Icahn School of Medicine at Mount Sinai Hospital, reviewed the latest research on strategies used before, during, and after prostatectomy.

Planning Before Surgery

The area around the prostate has delicate nerves and blood vessels needed for erections. It's important for your surgeon to have as much information as possible before surgery about your anatomy and the extent of the cancer. Your doctor may use MRI combined with other information (such as PSA, grade group, number of positive cores on biopsy). This can help to guide a custom-tailored approach during surgery.

It's also important to know about your baseline erectile function: one questionnaire is called the International Index of Erectile Function (IIEF). Your erections after surgery can only be as good as they were before surgery. Men may have some degree of erectile dysfunction (ED) before surgery due to other factors such as age, diabetes, or cardiovascular disease. Research is underway to develop better methods of predicting a patient's risk of ED after surgery.

What You Can Do Before Surgery

You've probably heard of *rehabilitation*: care and activities to help get back to baseline after illness or treatment. *"Prehabilitation"* means optimizing your health before treatment to potentially improve your outcomes. Some studies suggest that using multiple approaches, both before and after surgery, may support recovery. More research is needed to better define effective prehabilitation in prostatectomy.

- Adopt a Healthy Lifestyle: What's good (or bad) for your heart is good (or bad) for your penis. As noted above, factors such as cardiovascular disease, diabetes, obesity, smoking, and high cholesterol can affect erectile function. They can also affect recovery of erectile function after surgery. If you smoke, get support from your doctor to quit.
- "Kegels"/Pelvic Floor Muscle Training: Kegel exercises involve squeezing your pelvic floor muscles for a few seconds, then relaxing. They are an important part of treatment for incontinence. Doing Kegels before radical prostatectomy may be helpful in recovery of erectile function, although the effects seen in studies are small.
- Medication and a Multi-Pronged Approach: Medications called PDE5 inhibitors (e.g., Viagra, Cialis) are commonly used for ED, and are also used after prostatectomy. In one study, men received tadalafil (plus the supplement L-citrulline) daily for 2 weeks prior to nerve-sparing robot-assisted surgery, and continued this after surgery. They were instructed to use other erectile aids (vacuum erection device daily and penile injections as needed), and received advice on a healthy diet, exercise, and sleep. More men in this group reported return of erectile function after 1 year compared to men who did not participate in the pre-operative program (56% vs. 24%).

It Takes Two: The Partner's Role

For men with a partner, it's important to consider his partner's sexual function, aspects of the relationship, and expectations about returning to sexual activity. For example, the partner's expectations about sexual relations, and their willingness to participate in penile rehabilitation, may affect the patient's sexual desire and motivation after surgery. Thus, Tewari and colleagues encourage a complete assessment of the partner's sexual function as part of prehabilitation.

What this means for patients: Before you have surgery, ask your doctor if there are any other tests you should have that would help plan for the procedure. Talk to your care team about what you can do before surgery to help maximize your ability to have erections after surgery. Make a pro-active plan for your post-surgical rehabilitation. Research suggests that starting interventions earlier can lead to better recovery.

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(continued page 7)

Part 1: What You Can Do After Surgery

Men undergoing surgery for prostate cancer often fear its side effects, including losing the ability to have erections.

Sexual and erectile function is a complex process, often involving a partner as well as the patient. Thus, it may be unrealistic to expect that post-operative sexual problems can be fixed with a single "magic bullet" (such as a dose of Viagra).

Tewari and team cite four main categories of interventions:

- Medicines and devices
- Psychosocial
- Hormonal assessment
- Investigational/emerging

Maintaining a healthy lifestyle through nutrition, exercise, and stress management is advised to maximize results. Open communication about your needs, priorities, and challenges with your healthcare team and your partner, if applicable, is essential.

Medicines and devices

In general, research suggests that starting these interventions early may lead to better recovery of erectile function.

- PDE5 inhibitors (e.g., sildenafil [Viagra], tadalafil [Cialis]). These medicines increase blood flow in the penis. Starting them earlier is linked to greater likelihood of recovery. For example, in one trial patients took sildenafil twice weekly after nerve-sparing prostatectomy, beginning immediately after catheter removal OR with delayed initiation. Patients who started early treatment were 3 times more likely to achieve complete recovery of erectile function. Regular use (i.e., daily) appears to be more effective than on-demand use.
- Penile injections. Again, starting early after surgery is linked to higher rates of recovering spontaneous erections. Think of the penis like your muscles – just as you need to get up and walking after surgery, even with a walker or cane, you've got to start using your penis, with whatever assistance is required. "Trimix," which combines 3 medications, may be associated with less pain.
- MUSE (Medicated Urethral System for Erection). Alprostadil, one of the components of Trimix, can be inserted into the urethra. This approach has been in use for over 2 decades. In one study, MUSE combined with oral medications resulted in better penile rigidity and sexual satisfaction.
- Vacuum erection device (VED). This is another way to get your penis moving. Penile shortening can be a problem after surgery; early use of a VED can preserve penile length. VED combined with oral medication may have added benefit over medication alone.
- Pelvic floor muscle therapy (Kegel exercises). Do them after surgery to help regain urinary continence. Evidence also suggests a benefit to recovering erectile function. Even among patients with persistent erectile dysfunction (ED) after surgery, starting Kegels 12 months after surgery (vs. 15 months) was linked to better erectile function and less climacturia (leaking urine during ejaculation).
- Penile prosthesis. If you're struggling after trying other interventions, you still have options. Although use of a prosthesis after prostatectomy is not common (about 2%), satisfaction rates are high.

Psychosocial interventions

Diagnosis and treatment of prostate cancer can lead to depression, stress, and anxiety, which can compound sexual problems. Therefore, understanding a patient's psychological health and addressing those concerns is key to successful recovery of sexual function. For example, patients who participated in cognitive behavioral therapy had better self-esteem, satisfaction with orgasms, and increased sexual confidence.

Penile rehabilitation and recovery take time, patience, and persistence. Patients may "give up" on the process, which can lead to further anxiety, frustration, and a "cycle of avoidance" of both intercourse and the rehabilitation program. In this situation, one approach may be a type of therapy called Acceptance and Commitment Therapy (ACT). In one trial, participation in ACT led to increased use of penile injections and ability to better cope with ED. Partners should be involved in psychosocial interventions as well.

The role of hormones

An adequate level of testosterone is needed to have erections. Testosterone falls with age, so older men (the population at risk for prostate cancer) may already have this as a contributing factor to poor erectile function. After prostate cancer, patients (and their doctors) may be concerned about using testosterone supplements. However, more recent evidence shows that testosterone replacement is safe in patients treated for prostate cancer with no evidence of remaining disease. Ask your doctor about testing your hormone levels.

What this means for patients: Know that there are many options available to help regain erectile function after prostatectomy. Don't suffer in silence: be as open as you can about any challenges so that your health care team can support you. Remember that sexual function is in the head and "heart" as well as the penis. Speaking with an individual therapist, couples therapist, or participating in group sessions may help with recovery. If you are in a relationship, involve your partner in your treatment plans both before and after surgery.

This article has been edited for brevity. To read the full version https://www.pcf.org/c/improving-erectile-function-part-1-what-you-can-do-before-surgery/?utm_source=NewsPulse&utm_medium=email&utm_campaign=SEPT22NP

Fatigue, Health-related Quality-of-Life and Metabolic Changes

SOURCE:
Ternov KK et al.
Prostate Cancer Research Review
Issue 58-2022

Fatigue, health-related quality-of-life and metabolic changes in men treated with enzalutamide or abiraterone acetate plus prednisone for metastatic castration-resistant prostate cancer: A randomised clinical trial (HEAT)

Summary: This single-centre, open-label, phase IV trial compared fatigue, health-related quality-of-life (HRQoL) and metabolic changes in 170 men with mCRPC treated with enzalutamide or abiraterone acetate plus prednisone (AAP). The primary outcome, change in Functional Assessment of Chronic Illness Therapy-Fatigue questionnaire, showed a clinically meaningful difference in fatigue favouring AAP (3.4 points; 95% CI 1.2-5.6, p = 0.003). Glycated haemoglobin (HbA1c) increased more among AAP versus enzalutamide recipients (3.4 mmol/mol, 95% CI 2.1-4.8; p = 0.001); 8 patients developed type 2 diabetes in the AAP group. No serious TRAEs were observed.

Comment: Given that patients with metastatic prostate cancer can expect to be on novel androgen receptor signalling inhibitors for an extended period of time, long-term tolerability and potential complications are important. This open label study randomised patients with mCRPC to either abiraterone or enzalutamide as first-line treatment, with various assessments at baseline and at 3 months. As expected, enzalutamide caused more fatigue, but this was offset by an increase in measures of glucose intolerance and diagnosis with type 2 diabetes. Changes in HRQoL also favoured abiraterone; however, the level of change was not considered clinically significant. As the two agents are probably equivalent from a cancer control point of view, drug selection should be

Defining the impact of family history on detection of high-grade prostate cancer

SOURCE:
Clements MB et al.
Eur Urol. 2022;82(2):163-169
David Utz

Summary: This multinational study sought to estimate the risk of finding high-grade prostate cancer on prostate biopsy based on family history (first-degree prostate cancer 15,799 men; more detailed family history for 4617 men). High-grade prostate cancer was more likely in patients with first-degree (aOR 1.77; 95% CI 1.57-2.00; p < 0.001; RR 1.40), or second-degree, (aOR 1.38 (95% CI 1.07-1.77, p = 0.011, RR = 1.22) prostate cancer in families with a history of first-degree breast cancer (aOR 1.30; 95% CI 1.01-1.67; p = 0.040; RR = 1.18). The effect of a family history did not differ based on PSA but differed based on age.

Comment: A positive family history is recognised to be one of the strongest risk factors for prostate cancer development. This large multicentre study including close to 16,000 men gives more precise estimates of risk for clinically significant cancer (ISUP grade group >2). A family history of the disease in a first-degree relative conferred a 1.77-fold increase in relative risk even after adjusting for other factors such as PSA, whereas for a second-degree relative this dropped to 1.38-fold. The RR was also greater (although to a lesser degree) in patients with a first-degree family history of breast cancer. Yet again it proves the importance of choosing your parents wisely.

Bipolar Androgen Therapy (BAT):

SOURCE:
January 2022
Edward Weber
https://grandroundsinurology.com/pca-commentary-volume-161-january-2022/

A Treatment Option for Metastatic Castration-Resistant Prostate Cancer (mCRPC).

The BAT regimen was introduced in January 2015 in a report by Schweizer and his Johns Hopkins colleagues: "Effect of Bipolar Androgen Therapy for Asymptomatic Men with Castration-Resistant Prostate Cancer" (*Sci Transl Med*). In their study, 16 men with low to moderate metastatic burden received monthly cyclic intramuscular testosterone (T) injections, which elevated the ADT-suppressed T from castrate to supraphysiologic levels greater than 1500 ng/dl. The T levels fell back to baseline by 28 days. During treatment, androgen suppression was maintained.

Results: A 50% drop in PSA (PSA50) as well as a radiographic response were seen in half the patients. Of special importance (and a continuing theme in future research and in this Commentary): "All patients (10 of 10) demonstrated PSA reductions upon receiving [subsequent] androgen-ablative therapies [i.e., Xtandi or Zytiga], suggesting that BAT may also restore sensitivity to ADT."

Proposed mechanism for BAT suppression of prostate cancer growth: This issue was extensively investigated by Chatterjee, Schweizer, Nelson and colleagues (*J Clin Investig*, Sept 2019), with their conclusion that supraphysiologic androgen (SPA) suppresses cancer growth by inducing DNA damage. They noted that androgen receptor signaling was markedly increased as an adaptive response to castrate levels of testosterone. In response to castrate T levels, the androgen receptor increases copy numbers by 30 – 90-fold and accumulates resistance mutations such AR-V7, against which BAT has been found effective.

The study found that SPA:

1. Induces double stranded DNA breaks and simultaneously suppresses DNA repair

2. Arrests the cycle of cellular proliferation

3. Promotes a 45% increase in cell death (apoptosis)

This lethal result was especially prominent in the presence of deleterious mutations in the BRCA family of DNA repair genes. This observation suggested that "…these findings support clinical trials of SPA in combination with PARP inhibitors" such as olaparib and rucaparib (the combination BAT/olaparib is already under protocol study).

Two examples of BAT restoring sensitivity to hormone therapy after resistance develops to a prior androgen receptor targeted agent such as Zytiga.

Example 1: (*J Clin Oncol*. Feb 2021)

The 'TRANSFORMER' trial compared responses (evaluated by CT and bone scans) in men who had progressed on prior abiraterone (Zytiga). The BAT regimen was administered to 94 men while 101 received standard enzalutamide (Xtandi) along with ADT. The radiographic progression-free survival for both BAT and enzalutamide (ENZ) was 5.7 months.

Of significance, however: When progression was noted in each arm, a crossover to the alternate arm was allowed. A PSA50 was seen in 77.8% of patients crossing to BAT from ENZ, compared to 23.3% in crossing from ENZ to BAT, confirming the hypothesis that BAT sensitizes cancer to subsequent ENZ therapy. The overall survival in the BAT to ENZ schema was 32.9 months vs. 30.2 months for the reverse.

Their key observation: "However, the most important finding is that post-abiraterone BAT can markedly improve the magnitude and duration of response to enzalutamide when used as an intervening [i.e., subsequent] therapy."

Example 2: (Sena et al. *Eur J Cancer*. 2021)

The 'RESTORE' trial of 29 patients found a modest 14% PSA50 response to BAT when used after progression on ADT. But when Zytiga or Xtandi were used following BAT, the responses were impressive: 85% of men showed PSA90 response (15 of 18). "Twelve of 15 patients … with metastatic CRPC remain on abiraterone or enzalutamide with a median duration of follow-up of 11.2 months."

Their key observation: The adaptive upregulation of the androgen receptor responding to castrate T levels "generates a therapeutic vulnerability to high-dose T treatment."

Adverse effects *AND* beneficial effects of BAT:
Adverse effects: In the TRANSFORMER trial, the adverse effects of BAT were compared to those of enzalutamide.

Findings – BAT vs. enzalutamide: Fatigue, 31% vs. 48%; generalized pain, 31% vs. 16%; limb edema, 17% vs. 11%; back pain, 20% vs. 24%; diarrhea, 11% vs. 24%; nausea, 13% vs. 22%; appetite loss, 12% vs. 28%; depression, 1% vs. 13%; anxiety, 2% vs. 9%; hot flashes, 8% vs. 10%; and hemoglobin gain, 3.4% vs. 0%.

Beneficial effects: Changes in physical parameters seen after three months of BAT in men with mCRPC were reported by Marshall et al. (*BJUI,* March 2021). "The 60 included patients had a mean decrease of 8.2% of subcutaneous fat and 18.2% of visceral fat and gained 6.7% in muscle mass." Substantial improvement was seen in lipid levels: LDL, HDL and triglycerides were all down 12.4%, 9.1%, and 26.9% respectively, and quality of life was generally improved.

Their conclusion: "This is the only therapy to date for the treatment of advanced prostate cancer that is associated with these improvements and has promising implications for the long-term health of men with mCRPC."

BOTTOM LINE:
BAT has been found equivalent in radiographic-free survival to enzalutamide when used after progression on ADT in mCRPC, but significantly improves the response and duration of a follow-up second generation AR targeted therapy following BAT. This suggests a place for BAT early in the sequence of therapy of men with mCRPC, a regimen which has to be further validated.

Longer Course of ADT with Postop Radiotherapy Improves Metastasis-Free Survival in PCa

SOURCE:
14 September 2022
Andrea S Blevins Primeau PhD MBA
http://com/home/topics/covid19/tixagevimab-cilgavimab-therapy-for-patients-hospitalized-with-covid-19/

A 2-year course of ADT improved MFS when compared with 6 months of ADT, but 6 months of ADT did not improve MFS when compared with no ADT.

Adding a longer course of androgen deprivation therapy (ADT) to postoperative radiotherapy can prolong metastasis-free survival (MFS) in patients with prostate cancer, according to data presented at ESMO Congress 2022.

In the phase 3 RADICALS-HD trial, a 2-year course of ADT improved MFS when compared with 6 months of ADT. However, 6 months of ADT did not improve MFS when compared with no ADT.

Researchers decided to test the efficacy of adding ADT to postoperative radiotherapy because the role of ADT in this setting "is uncertain, and current guidelines are largely silent on the matter," said study presenter Chris Parker, MD, of the Royal Marsden Hospital NHS Foundation Trust in London, UK.

The RADICALS-HD trial included 2839 patients with prostate cancer who underwent radiotherapy after radical prostatectomy. Patients were randomly assigned to receive a short course of ADT (6 months), a long course of ADT (24 months), or no ADT.

For the comparison between long-course ADT and short-course ADT, 1523 patients were randomly assigned to short-course ADT (n=761) or long-course ADT (n=762).

For the comparison between no ADT and short-course ADT, 1480 patients were randomly assigned to short-course ADT (n=747) or no ADT (n=737).

Dr Parker noted that adverse clinical factors were more common in the long-short ADT comparison than in the short-none comparison.

Short vs None

At a median follow-up of 9 years, short-course ADT did not prolong MFS compared with no ADT (hazard ratio [HR], 0.89; 95% CI, 0.69-1.14; *P* =.35). The 10-year MFS rate was 79% in the no-ADT arm and 80% in the short-course ADT arm.

Likewise, there was no significant difference in freedom from distant metastases between the short-course and no-ADT groups (HR, 0.82; 95% CI, 0.58-1.15; *P* =.24). However, short-course ADT significantly delayed the time to salvage hormone therapy (HR, 0.54; 95% CI, 0.42-0.70; *P* <.0001).

Overall survival (OS) was similar between the short-course and no-ADT groups (HR, 0.88; 95% CI, 0.65-1.19; *P* =.42). The 10-years OS rate was 86% in the no-ADT arm and 85% in the short-course ADT arm.

Long vs Short

Long-course ADT significantly improved MFS compared with the shorter course (HR, 0.77; 95% CI, 0.61-0.97; *P* =.03). The 10-year MFS rate was 78% with long-course ADT and 72% with short-course ADT.

A long course of ADT also improved freedom from distant metastases (HR, 0.63; 95% CI, 0.47-0.85; *P*=.002) and time to salvage hormone therapy (HR, 0.73; 95% CI, 0.59-0.91; *P* =.005).

However, OS was similar between the short-course and long-course ADT groups (HR, 0.88; 95% CI, 0.66-1.17; *P* =.38). The 10-year OS rate was 82% in the short-course group and 85% in the long-course group.

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

Research suggests commonly used prostate cancer treatment rewires engine of prostate tumors

SOURCE:
15 September 2022
University of Michigan
https://www.sciencedaily.com/releases/2022/09/220915104739.htm?utm_medium=email&utm_source=rasa_io&utm_campaign=newsletter

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 will be 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

(continued page 12)

A new study suggests androgen receptor inhibitors can fundamentally rewire and reshape how prostate tumors function, and in certain cases even make them more aggressive.

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.

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 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

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.sciencedaily.com/releases/2022/09/220915104739.htm?utm_medium=email&utm_source=rasa_io&utm_campaign=newsletter

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

1800 33 00 66

Adjuvant versus early salvage radiation therapy after RP for pN1 PCa

SOURCE:
Practice Review Issue & 2022
J Clin Oncol. 2022;40(20):2186-92 J Clin Oncol. 2022;40(20):2179-82

Men with lymph node-positive prostate cancer have better outcomes if they receive up-front adjuvant RT after prostatectomy rather than waiting for salvage RT, conclude researchers who performed a review of 1614 such patients treated in Germany from 1995 to 2017.

A median of 12 lymph nodes was sampled among all men. In both the adjuvant and salvage RT groups, 45 Gy was delivered to pelvic nodes, and a median dose of 68.4 Gy was delivered to the prostatic bed. Adjuvant RT was administered at a median of 3.4 months after prostatectomy, and salvage RT was delivered at a median of 21.4 months. Men who received adjuvant RT were more likely to have worse disease, with PSA levels >20 ng/mL; tumours of stage pT3b or higher; positive surgical margins; and adjuvant ADT use. The investigators used propensity scoring and other methods to adjust for differences in patient and disease characteristics and treatment selection.

After adjusting for the time-dependent use and duration of ADT, all-cause mortality was decreased at a median follow-up of 7 years among men with at least four positive pelvic nodes on pathology. All-cause mortality was 23.4% among 115 early salvage RT patients compared to 7.7% in 86 men who received adjuvant RT. For each additional positive node, there was an 8% reduction in all-cause mortality risk with adjuvant RT. The results were not statistically significant for the 1323 men with one to three positive nodes, but it may be that a larger cohort is needed for the results to reach significance, the authors note.

The authors suggest that the degree of the possible modest reduction in men with one to three positive lymph nodes should be personalised by considering life expectancy and weighed against the potential toxicities of pelvic RT.

Men with four or more positive nodes would likely benefit, and this should be considered when deciding on whether to recommend adjuvant RT. Treatment at progression to castrate-resistant or metastatic prostate cancer followed European guidelines and was comparable whether men received adjuvant or salvage RT. The investigators note that while standards of care evolved over the study period, it is very unlikely that differences in subsequent treatment between the groups accounted for the study findings.

Editorial

The findings suggest that in this particular patient population, salvage RT may not be early enough, comment radiation oncologists in a related editorial. At a time where early salvage RT is being widely incorporated over adjuvant RT despite a lack of randomised data for certain high-risk groups, such as pN1 patients, the findings from this study are "provocative," they say. Previous studies regarding RT timing after radical prostatectomy support salvage RT at PSA progression, but they included very few patients who had positive nodes after surgery, and in some cases the studies did not adjust for ADT use. By foregoing adjuvant RT in favour of early salvage RT there's a possibility that pN1 patients may be harmed. The editorialists conclude that all patients with pN1 prostate cancer - and particularly those with increasing node positivity - should be advised on the potential survival benefits of upfront adjuvant RT demonstrated in this study and the risk that early salvage RT may not be early enough, they add. The editorialists point out a limitation of the study was that PSA at the start of salvage RT was a median of 0.3 ng/mL, not the usual level of 0.1–0.2 ng/mL, so it's possible salvage therapy was delivered later than it would in clinical practice.

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

Whole-pelvic radiation therapy for high-risk patients

SOURCE:
16 August 2021
https://www.prostatecancer.news/2021/08/whole-pelvic-radiation-therapy-for-high.html

The decision about whether or not to treat the entire pelvic lymph node area along with the prostate (called whole pelvic radiation therapy (WPRT)) or to treat just the prostate with a margin around it (called prostate-only radiation therapy (PORT)) has long been a matter of judgment. Now we have proof of its benefit in most high-risk patients.

Murthy et al. reported the results of "POP-RT," a randomized clinical trial conducted among 224 high-risk and very high-risk patients treated at the Tata Memorial Hospital in Mumbai, India between 2011 to 2017. What sets this trial apart from previous trials that had equivocal results (like RTOG 9413 and GETUG-01) are the rigorous patient selection criteria and the now-proven treatments they received.

80% of patients were screened using PSMA PET/CT to rule out those with already-detectable lymph node or distant metastases. The rest were staged using bone scan/CT. Local staging (T1-4) was done with CT, MRI, and physical examination. Patients had to have a probability of microscopic lymph node metastases of greater than 20% using the Roach formula:

Probability of cancer in pelvic lymph nodes = (⅔ x PSA) + (10 x (Gleason score - 6))

This meant that high-risk patients had to have the following risk characteristics:

- If Gleason Score 8-10: Any PSA, T1-T3a N0 M0
- If Gleason Score 7: PSA > 15, T1-T3a N0 M0
- If Gleason Score 6: PSA > 30, T1-T3a N0 M0
- Also, any other "Very High Risk" including T3b-T4 N0 M0, with any Gleason Score, any PSA, if their Roach probability was > 20%
- In this group of patients, the median Roach probability was about 40% and the median PSA was 28 ng/ml.

Treatment consisted of dose-escalated IMRT and 2 years of adjuvant androgen deprivation therapy (ADT):

- Prostate dose= 68 Gy in 25 fractions or treatments (equivalent to about 81 Gy in 40 treatments)
- Pelvic lymph node dose = 50 Gy in 25 treatments (note: this is somewhat higher than the 45 Gy in 25 treatments that is usually given)
- Pelvic lymph nodes up to the aortic bifurcation were treated, which conforms to current RTOG specs.
- ADT was started 2 months before IMRT and continued for a total of 2 years
- Note: this trial began before ASCENDE-RT proved the superiority of brachy boost therapy, but used a higher IMRT dose and longer ADT. This high-dose IMRT/long-term ADT treatment was proven effective by the DART 01/03 GICOR trial.

After median follow-up of 68 months, the oncological results were:

- 5-year biochemical failure-free survival was 95% for the WPRT group vs. 81% for the PORT group.
- 5-year disease-free survival, which means they had no PSA progression *and* no radiographic progression, was 90% for WPRT (15 recurrences) vs 77% for PORT (36 recurrences).
- 5-year metastasis-free survival, which is a good surrogate endpoint for overall survival, was 95% for WPRT vs 88% for PORT
- Younger patients (< 66) derived more benefit from WPRT
- Among those with recurrences, most (52%) of the recurrences in the PORT arm were in pelvic lymph nodes, whereas few (12.5%) were nodal recurrences in the WPRT arm.

Murthy et al. also reported on toxicity and patient-reported quality of life outcomes comparing the two treatments.

- Acute grade 2 or greater GI toxicity was 33% for WPRT vs 25% for PORT (not statistically different)
- Acute grade 2 or greater GU toxicity was 33% for WPRT vs 24% for PORT (not statistically different)
- Late-term grade 2 or greater GI toxicity was 8.2% for WPRT vs 4.5% for PORT (not statistically different)
- Late-term grade 2 or greater GU toxicity was 20.0% for WPRT vs 8.9% for PORT (statistically different)
- Very few patients in either arm suffered serious (grade 3) toxicity. There was no grade 4 toxicity.
- While higher rectal radiation doses were *not* associated with higher bowel toxicity, higher bladder doses were associated with higher urinary toxicity.
- Patient-reported outcomes were not significantly different for urinary, bowel or sexual adverse effects.

It is worth noting that cancer in the Indian population is generally more progressed than in the US population at the time of diagnosis. Those with Stage T3b/T4 (seminal vesicle invasion and invasion into surrounding organs) accounted for 47% of this group, whereas it's a rare finding in the US because of more prevalent earlier PSA testing. Another difference is that 27% of patients had a previous TURP, which is high compared to the US. It is possible that the high TURP rate may have contributed to extra urinary toxicity seen in men getting WPRT.

Given the relatively mild side effect profile with no clinically significant difference to patients, WPRT should be the standard of care for high-risk patients at high risk of pelvic lymph node involvement. In 2027, we will have the results of a much larger, multi-institutional randomized trial (RTOG 0924) of WPRT vs PORT. Also, there was no increase in second malignancies due to the expanded coverage in this study.

CLINICAL TRIALS

LIBERATE

Clinical registry of focal low dose rate brachytherapy in men with biopsy confirmed low-intermediate risk prostate cancer

Trial summary: This study aims to establish a clinical registry, encompassing patient data from men with prostate cancer undergoing focal LDR brachytherapy.

Principal Investigators:
Icon Cancer Centre Radiation Oncologist Dr Andrew See and Epworth Healthcare Urologic Surgeon A/Prof Jeremy Grummet

Locations
Epworth Richmond
Epworth Freemasons
Geelong

Investigators
Dr Andrew See

Principal Investigator focal brachytherapy for prostate cancer

What is focal brachytherapy for prostate cancer?

Brachytherapy has been used to treat prostate cancer for many years and involves the insertion of small radioactive seeds into the prostate, which deliver radiation over a period of time.

Focal brachytherapy uses the same technique, however offers even greater precision by placing the radioactive source into the tumour itself rather than the whole prostate, preserving the rest of the prostate gland.

Focal brachytherapy treatment has been made possible thanks to advances in imaging technologies, which allows doctors to visualise and treat only the diseased area of the prostate. It is delivered by a multidisciplinary care team, including a urologic surgeon, radiation oncologist, radiologist and pathologist.

In the past there have been many examples where precision treatments have revolutionised cancer care, such as lumpectomy for early breast cancer compared to radical mastectomy (removal of the entire breast).

Focal brachytherapy offers the same precision for men with prostate cancer, sparing the remaining prostate gland and avoiding the difficult side effects that are common with traditional treatment options such erectile dysfunction, urinary incontinence and bowel urgency. Through this minimally invasive procedure men with prostate cancer can return to normal life quickly, while their treatment continues to actively fight cancer cells for up to 100 days post-surgery.

AMG 509

A Phase 1 Study Evaluating the Safety, Tolerability, Pharmacokinetics, and Efficacy of AMG 509 in Subjects With Metastatic Castration-Resistant Prostate Cancer

This phase I trial is trying to understand how much is safe and effective for the treatment of castration-resistant prostate cancer that has spread to other parts of the body.

This trial is treating patients with castration resistant prostate cancer.

This is a systemic therapy trial.

You may be able to join this trial if:

- You have had treatment but your cancer has gotten worse or has not responded to the treatment you have been given.
- Your cancer has spread to other parts of the body.

You may be excluded from this trial if:

- You have a certain disease or psychological condition.
- You have been diagnosed with a prior or secondary type of cancer.
- You have had certain treatments, surgical procedures or drugs.
- You have previously been treated (or are currently being treated) on a clinical trial.

Clinical trials have complex eligibility criteria - talk to your doctor about your interest in this trial.

Monash Health, Medical Oncology
Clayton
Genitourinary Research Study Coordinator
gu.oncresearch@monashhealth.org
0436387664

Use the hyperlinks, where available to access additional clinical trial information.

- NCT04221542
- 20180146

Commercial Sponsor

AMGEN

Summary

This is a dose exploration and expansion study. In the dose exploration phase, eligible patients will receive a short term intravenous (IV) infusion of AMG 509 to determine the recommended phase 2 dose (RP2D) or a maximum tolerate dose. In the dose expansion phase of the study, eligible patients will receive the RP2D of AMG 509, administered as a short term IV infusion. Dexamethasone will be administered in both the dose exploration and expansion phase, prior to cycle 1 dosing.

https://trials.cancervic.org.au/details.aspx?ID=vctl_nct04221542

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
- The Benefit of Exercise
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- 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

September 2022
- More Evidence for Benefits of RT
- 4 Radiotherapy Alone After Surgery Effective with Some Patients
- 5 Can Physical Exercise prevent Chemo-Induced Peripheral Neuropathy
- 5 Defining the Impact of Family History on detection of High Grade PCa
- 6-7 Improving Erectile Function
- 8 Fatigue, Health Related QOL / Impact of Family History on Detection of PCa
- 9 Bipolar Androgen Therapy (BAT)
- 10 Longer Course of ADT post RP
- 11-12 Treatment Rewires Engine of Prostate Tumours
- 13 Adjuvant vs Early Salvage RT after RP for pN1 PCa
- 14 Whole Pelvic RT for High Risk Patients
- 15 Clinical Trials

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