Prostate Heidelberg Cancer Support Group

Prostate Heidelberg

December 2022 Issue 224

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 13 December 10am – 12:30pm

At Uniting Church Hall *or*

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

https://us02web.zoom.us/j/84680683693?pwd=dnFCaGFOcjN1ZCs4M1ZWU0hZZll2Zz09

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MEMBERSHIP

CALENDAR YEAR PHCSG MEMBERSHIP (Jan – Dec) $20

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

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

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.

Member News

CO-CONVENOR AND SECRETARY/TREASURER
Standing down from December Meeting

As foreshadowed in the October Newsletter, we are standing down from our current positions at the December meeting. This is to enable us to focus on travelling overseas in 2023 to catch up with family and friends and see new places we haven't been able to visit courtesy of COVID.
We are very grateful to Max, other committee members and PHCSG for all the support and encouragement provided since we took up these roles.
We greatly value the friendships we've made and will remain in touch when we are in Melbourne.
Our thanks and best wishes to everyone for a Happy Christmas and a healthy and enjoyable New Year
Kind Regards
Mike Waller and Sue Lawes

Yonsa MPRED (abiraterone acetate + methylprednisolone) now available in Australia under prescription.

Yonsa MPRED is a fine particle formulation of abiraterone actetate at a dose of 500mg taken as 4 x 125mg tablets with concomitant steroid use of once or twice daily methylprednisolone (1 or 2 x 4mg tablets) dependent if for mHSPC or mCRPC respectively. Yonsa MPRED can be taken with or without food. Yonsa MPRED is available currently through the Yonsa FLEX access program, under which eligible patients will be able to access YONSA MPRED at a monthly cost of $1000. Yonsa FLEX has a safety net after 18 months of continued treatment (measured by 18 packs), after which patients will only be charged a fee of $200 per order to cover program administration costs. Patients enrolled with have Yonsa MPRED delivered directly to their home or other nominated address. (See https://www.tga.gov.au/resources/artg/346890)

Overhaul of prostate cancer test rules

On 24 November 2022, Prime Minister Anthony Albanese and Health Minister Mark Butler joined Prostate Cancer Foundation of Australia to announce an overhaul of Australia's Clinical Guidelines for PSA Testing to improve prostate cancer detection and survival rates. This will be implemented via PCFA led review of the 2016 Guidelines. Potential changes in store for the new guidelines include

- The recommendation against testing for men over the age of 70 is likely to be overturned based on new evidence revealing higher rates of newly diagnosed men in this age bracket having metastatic disease at point of diagnosis.
- The guidelines are likely to make a firm recommendation on testing for men with a strong family history of prostate cancer.
- The two-yearly intervals recommended for testing may be shortened for high-risk groups.
- The use of Multiparametric MRI prior to prostate biopsy in the diagnosis of prostate cancer is likely to be recommended, following listing of the scans in 2018, after the original guidelines were released.
- The immediate management and treatment of test-detected prostate cancers will be updated to reflect the latest standards of care, including the listing of PSMA PET/CT scans for men with suspected high-risk or recurrent disease.

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

Tongariro National Park New Zealand

Shortened Radiation Course OK for High-Risk Prostate Cancer

SOURCE:
3 November 2022
Astro 2022
https://www.practiceupdate.com/c/144312/32/1/?elsca1=emc_conf_ASTRO2022Post-2&elsca2=email&elsca3=practiceupdate_onc&elsca4=2022105_ASTRO2022Post-2&elsca5=conference&rid=NTMyMjc0MDc4NjM0S0&lid=39091850

Outcomes and side effects similar with five versus eight weeks of radiation for high-risk disease

A shortened course of radiation therapy is safe and effective for patients with high-risk prostate cancer, according to a study presented at the annual meeting of the American Society for Radiation Oncology, held from Oct. 23 to 26 in San Antonio.

Tamim M. Niazi, M.D., from McGill University in Montreal, and colleagues conducted a multicenter, phase 3 trial in which 329 patients were randomly assigned (1:1) to receive either conventionally fractionated radiation therapy (76 Gy in 2 Gy per fraction to the prostate and 46 Gy delivered to the pelvic lymph nodes in 38 daily sessions) or hypofractionated radiation treatment (concomitant dose escalation of 68 Gy in 2.72 Gy per fraction to the prostate and 45 Gy in 1.8 Gy per fraction to the pelvic lymph nodes in 25 daily sessions). All patients received neoadjuvant, concurrent, and adjuvant androgen suppression (median duration, 24 months).

There were no significant differences in survival between the two radiation groups for any outcomes at seven years, including overall mortality (81.7 versus 82 percent; hazard ratio [HR], 0.92; 95 percent confidence interval [CI], 0.56 to 1.53; P = 0.76), prostate cancer-specific mortality (94.9 versus 96.4 percent; HR, 1.31; 95 percent CI, 0.46 to 3.78; P = 0.61), biochemical recurrence (87.4 versus 85.1 percent; HR, 0.89; 95 percent CI, 0.49 to 1.60; P = 0.69), distant metastatic recurrence (91.5 versus 91.8 percent; HR, 0.89; 95 percent CI, 0.41 to 1.90; P = 0.76), or disease-free survival (86.5 versus 83.4 percent; HR, 0.82; 95 percent CI, 0.47 to 1.46; P = 0.50).

Further, there were no significant differences in grade 3 or higher acute or delayed genitourinary and gastrointestinal toxicities at two years, and no new toxicities emerged. Neither arm had grade 4 toxicities.

"The long-term results confirm that high-risk prostate cancer patients can safely and effectively be treated with moderate hypofractionated radiation therapy," Niazi told Elsevier's *PracticeUpdate*. "Given that our study has seven years of follow-up, and we used the contemporary radiation fields and long-term androgen deprivation therapy, I don't think there is a need for validating these results. I believe our results should establish 68 Gy in 25 fractions as a new standard approach."

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

A Few Comments on the Surgical Option for ADT

The original form of androgen deprivation therapy, which won Charles Huggins, MD, the Nobel prize, was surgical castration. Although that may seem like excessive treatment compared to the injectable LHRH agonist and antagonist drugs now used for ADT, it remains as effective for PCa control and less expensive in the long term. In poverty-stricken parts of the world, surgical castration is still offered to patients who cannot afford the more expensive LHRH agonist and antagonist drugs.

But what about in a country like Turkey?

In a new study, researchers asked 217 urologists and 170 medical oncologists in Turkey, if they offered surgical castration as an ADT option to their advanced PCa patients. Only 7.5% offered this option. Surgeons were statistically more likely to offer it than medical oncologist, but that is hardly surprising since surgical castration is a surgical procedure performed by surgeons.

We have two comments on this study.

In the discussion of their findings, the authors take it as a given that patients consider surgical castration detrimental to their body image. This may be true, but the literature documenting this is very limited. There is remarkably little data on patient preference for different forms of ADT, where the patients were confirmed to be fully informed of the costs and benefits of all the treatment options. One would suppose that patient choice would be influenced by their knowledge about the effectiveness of the treatment against the side effects that might occur.

A common argument against surgical compared to pharmacological castration is that surgery is not reversable. However, this argument is not particularly relevant for older, patients with advanced disease and do not desire to father children. Patients in that class, who start on ADT, are likely to stay on treatment for the rest of their life.

A couple of studies have found that PCa patients, who elected surgical castration for ADT, were significantly less anxious overall than patients on injectable depot LHRH medications. Now, with so many different ways to suppress testosterone's influence on PCa cells, it might be worth exploring how much patient comfort or discomfort—with any form of treatment—is influenced by their knowledge of treatment options.

If less than 10% of physicians present all the options to their patients, it would not be surprising that patients may not be making well-informed decisions about their treatments. Are few advanced PCa patients in Turkey (or elsewhere) considering surgical castration for ADT because they feel it will negatively impact their self-image or because they are not being told about that option by their physicians?

This is more than an academic discussion. There are increasing data showing that the effectiveness in cancer control for patients on the standard ADT drugs can be enhanced with the newer androgen receptor targeting agents (ARTAs). But ARTAs are not cheap drugs. When patient's financial status is limited, ADT via surgical castration remains a credible option. It certainly should remain an option offered to patients, who might benefit from both standard ADT plus an ARTA, but can't afford both.

To read the full paper, see: https://www.turkishjournalofurology.com/Content/files/sayilar/206/287-293.pdf

SOURCE:
25 October 2022
https://www.lifeonadt.com/life-on-adt-blog

Our thanks to Richard J. Wassersug, PhD and project assistant, Carly Sears, for their review and summary.

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

Darolutamide Plus ADT and Docetaxel Improves Quality of Life Vs Placebo in mHSPC

SOURCE:
1 November 2022
Leah Lawrence
https://www.oncologynurseadvisor.com/home/cancer-types/prostate-cancer/prostate-cancer-metastatic-castration-resistant-continued-enzalutamide-delay-progression-resistance/?utm_medium=email&utm_source=rasa_io&utm_campaign=

Quality of life data from the phase 3 ARASENS study highlighted how early treatment intensification with darolutamide plus standard androgen deprivation therapy and docetaxel improved patient-relevant end points compared with placebo in the management of metastatic hormone-sensitive prostate cancer.

Patients with metastatic hormone-sensitive prostate cancer (mHSPC) who received early treatment intensification with darolutamide (Nubeqa) plus standard androgen deprivation therapy (ADT) and docetaxel (Taxotere) experienced an improvement in patient-relevant end points compared with placebo in combination with ADT and docetaxel, according to a quality of life analysis from the phase 3 ARASENS study (NCT02799602).

At baseline, most patients had high quality of life scores in terms of the Brief Pain Inventory–Short Form (BPI-SF) scale, with 40.8% of patients reporting no pain and 39.8% reported mild pain in the overall population of 1305 patients. Moreover, in the total treatment population, 9.5% of patients experienced moderate pain and 6.9% had severe pain.

Investigators reported that the times to worsening of disease-related physical symptoms and pain interference were maintained following darolutamide treatment in the overall treatment population. The median time to worsening of National Comprehensive Cancer Network–Functional Assessment of Cancer Therapy Prostate Cancer Symptom Index 17-item questionnaire (NCCN-FACT-FPSI17) physical symptoms was 19.3 months (95% CI, 13.8-24.8) for the darolutamide arm and 19.4 months (95% CI, 15.4-27.6) for the placebo arm (HR, 1.04; 95% CI, 0.89-1.22). In a planned exploratory analysis, the median time to worsening of BPI-SF pain interference was not estimable (NE) in the darolutamide arm and the placebo arm (HR, 0.86; 95% CI, 0.64-1.15).

The randomized, double-blind, placebo-controlled phase 3 ARASENS study enrolled a total of 1306 patients across 286 treatment centers in 23 countries. Patients were randomly assigned 1:1 to either receive 600 mg of darolutamide or matched placebo twice a day plus ADT and 6 cycles of docetaxel.

The primary end point of the study was overall survival (OS). Secondary end points included time to castration-resistant prostate cancer, time to pain progression, symptomatic skeletal events (SSEs), time to first SSE, time to initiation of subsequent systemic antineoplastic therapies, time to worsening of disease-related physical symptoms, and safety.

Patients were eligible to enroll on the study with histologically or cytologically confirmed prostate adenocarcinoma and metastatic disease. Additional requirements for patients included being candidates for ADT and docetaxel, having an ECOG performance status of 0 or 1, and having adequate bone, liver, and marrow function. The study also stratified patients based on extend of disease and alkaline phosphatase level.

Among patients with moderate or severe baseline pain, a post hoc exploratory analysis highlighted a trend towards a delay in time to worsening of disease-related physical symptoms and pain interference in the darolutamide cohort vs the placebo cohort. The median time to worsening of physical symptoms for patients with moderate or severe baseline pain was 41.4 months (95% CI, 36.1-NE) for the placebo arm and not estimable for the darolutamide arm (95% CI, NE-NE; HR, 0.63; 95% CI, 0.39-1.04). The median time to worsening of BPI-SF pain interference among patients with moderate or severe baseline pain was not estimable for either treatment arm (HR, 0.60; 95% CI, 0.29-1.24).

The cumulative incidence of adverse effects was comparable and generally low across both arms. For patients in the darolutamide and placebo arms, respectively, the estimated cumulative incidence of time to fall was 6.6% vs 4.6% (HR, 1.05; 95% CI, 0.65-1.69), time to fatigue incidence was 33.1% and 32.9% (HR, 0.95; 95% CI, 0.79-1.15), and the time to fracture incidence was 7.5% and 5.1% (HR, 1.09; 95% CI, 0.70-1.70). Moreover, the estimated cumulative incidence of time to mental impairment disorder was 3.5% and 2.3% (HR, 1.16; 95% CI, 0.60-2.25), the incidence of time to rash was 16.6% and 13.5% (HR, 1.15; 95% CI, 0.87-1.53), the incidence of time to cardiac disorder was 10.9% and 11.7% (HR, 0.76; 95% CI, 0.54-1.05), and the incidence of time to hypertension was 13.7% and 9.2% (HR, 1.20; 95% CI, 0.86-1.67) across both respective arms.

Based on a safety analysis set, investigators indicated that darolutamide lowered the risk of death by 32.5% compared with placebo. Moreover, fewer prostate cancer-related deaths were observed in the darolutamide arm vs the placebo arm, further confirming the regimen's survival benefit. The 48-month survival probability in terms of prostate-cancer-related deaths was 70.8% for the darolutamide arm vs 58.3% for the placebo arm (HR, 0.65; 95% CI, 0.53-0.79). In terms of overall survival (OS), the 48-month rate was 62.7% for the darolutamide arm and 50.4% for the placebo arm (HR, 0.68; 95% CI, 0.57-0.80; *P* <.0001).

Patting the Hormone Therapy Shark with Tim

SOURCE: https://www.youtube.com/watch?v=4zLrKZyhKfM

This episode of GU Cast is essential listening for anyone who has anything to do with androgen deprivation therapy (ADT), or "hormone therapy", for men with advanced prostate cancer. Whether you are a prescriber (especially if you are a prescriber), nurse or allied health professional, patient, loved one, industry representative, or researcher - this is one not to miss. Tim Baker is an award-winning author, journalist and storyteller specialising in surfing history and culture. At the age of 50, he was diagnosed with metastatic prostate cancer (PSA 120 and bone metastases), and has been on intermittent ADT for the past seven years. Thankfully his cancer is well controlled, but the story of his experience is a sobering insight into the devastating impact of ADT, especially in a younger man. But his self-directed strategy of MEDS (Meditation; Exercise; Diet; Sleep), is an inspiring insight into under-utilised mechanisms to make life on ADT more tolerable. Although he is a believer in medical science and is grateful for the expertise of the specialists who have looked after him., Tim's description of his initial diagnosis and management is uncomfortable listening for those who prescribe a lot of ADT. We all need to do more to support patients in these situations, and Tim's story certainly gives plenty of food for thought. Meditation? Surf classes? Psychedelic-assisted therapy? It's all in here! Declan and Renu loved this book. It's a great gift for anyone involved in the hormone therapy arena - why don't you pick up a copy or give it as a present for Christmas?! Available in all the usual places. GU Cast is also available on Apple Podcasts/Spotify etc https://www.buzzsprout.com/904063/117...

Getting the Best Out of Your Interactions with Your Doctor

- Keep a detailed record of your diagnosis, tests, treatments, medicines.
- Collect and write down questions that may involve complex issues and answers for appointments with your consultant. Note down the answers/key points. Take someone with you, if possible. You will always think of something you should have asked!
- If you want to discuss a study you're interested in, email it ahead of your visit indicating you'd like to discuss the study. Only seek discussions on peer-reviewed articles in professional journals.
- If there are a lot of subjects you want to discuss, send an agenda before the meeting. The doctor may want to put aside more time for the meeting. Keep agenda points clear and short and any discussion focused
- If you have serious concerns or uncertainties about the diagnosis or proposed course of treatment, seek a second opinion.

LuPSMA: The Specifics

A 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.

SOURCE:
15 September 2022
Janet Farrar Worthington
https://www.pcf.org/c/lupsma-the-specifics-part-2/

Prostate Cancer Foundation
Curing Together.

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."

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 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."

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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."

EXTEND Trial: Metastasis-Directed Radiation Therapy Plus Hormone Therapy May Improve Progression-Free Survival in Patients With Advanced Prostate Cancer

Source:
26 October 2022
https://ascopost.com/news/october-2022/metastasis-directed-radiation-therapy-plus-hormone-therapy-may-improve-progression-free-survival-in-patients-with-advanced-prostate-cancer/?utm_medium=email&utm_source=rasa_io&utm_campaign=newsletter

Researchers from The University of Texas MD Anderson Cancer Center demonstrated that adding metastasis-directed radiation therapy to intermittent hormone therapy improved progression-free survival in patients with oligometastatic prostate cancer. Findings from the multicenter EXTEND trial were presented by Tang et al at the 2022 American Society for Radiation Oncology (ASTRO) Annual Meeting (Abstract LBA05).

At a median follow-up of 22.1 months, the median progression-free survival had not yet been reached in patients who received the combination therapy, suggesting a significant improvement over the median progression-free survival of 15.8 months in those who received only hormone therapy. The combination was well-tolerated and lengthened the period patients could maintain a break from hormone therapy without disease progression, suggesting this approach could improve quality of life for patients with advanced prostate cancer.

"We know that radiation technology has evolved to directly target metastases, to reduce side effects, and to better treat [patients] with prostate cancer," said principal investigator **Chad Tang, MD**, Associate Professor of Radiation Oncology at MD Anderson. "This study provides much-needed data on the benefits of combining these newer radiation techniques with hormone therapy to improve outcomes."

Metastasis-directed therapy involves direct local treatment of metastatic lesions through surgery or radiation, with the goal of killing all cancer cells in that location. Metastatic prostate cancer generally is treated with systemic therapies, the most common of which is continuous hormone therapy. Using metastasis-directed therapy to treat patients with oligometastatic disease has increased in recent years.

Oligometastatic cancer, which is defined as five or fewer metastases seen on imaging, represents a transitional state between localized and widespread metastatic disease. The first study showing benefit with definitive local therapy was conducted at MD Anderson and published in 2016. Since then, there has been substantial research in this area.

However, despite data supporting the benefits of upfront hormone therapy and its synergy with radiation treatment, there have been no randomized trials testing this combination for patients with oligometastatic prostate cancer.

This study shows that the combination of metastasis-directed radiation and intermittent hormone therapy significantly improved progression free-survival, with manageable toxicities, for patients with oligometastatic disease.

— Chad Tang, MD

Improving Erectile Function, Part 2: What You Can Do After Surgery

SOURCE:
9 September 2022
Becky Campbell
https://www.pcf.org/c/improving-erectile-function-part-2-what-you-can-do-after-surgery/

Men undergoing surgery for prostate cancer often fear its side effects, including losing the ability to have erections. PCF-funded investigator Dr. Ashutosh Tewari, chairman of urology at the Icahn School of Medicine at Mount Sinai Hospital, and team have reviewed the latest research on strategies to improve erectile function that can be considered before, during, and after prostatectomy. In Part 2 of this series based on the publication, we summarize post-operative approaches.

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. Note: if you don't have success at first with injections, make sure to get tips from a urologist or sexual medicine specialist on how to inject.

- 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. Be aware of drawbacks to VED use, including unnatural pivoting of the penis, a bluish color, and less warm erections.

- 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. Read a patient's story here.

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"

(continued page 10)

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

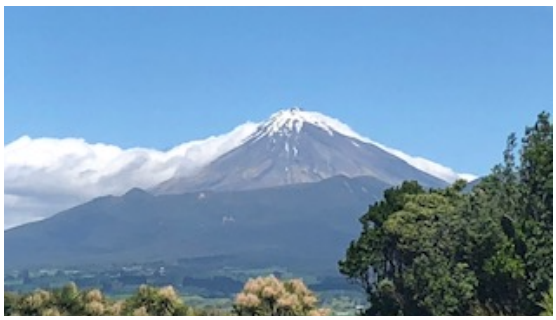
An adequate level of testosterone is needed to have erections. Testosterone falls with age, so older men (the population at risk for prostate cancer) may already have this as a contributing factor to poor erectile function. After prostate cancer, patients (and their doctors) may be concerned about using 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.

Investigational therapies

There are multiple therapies at various stages of investigation, from animal models to clinical trials in patients. These include: hyperbaric oxygen therapy, low-intensity extracorporeal shockwave therapy, use of stem cells, and nerve grafting. Be wary of online advertisements for ED treatments that are unproven: they may range from an ineffective waste of money, all the way to risky. If you are considering an investigational therapy, it is recommended that you do so only as part of a clinical trial. Speak with your doctor about whether a clinical trial might be right for you.

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



When a surgeon says he "got it all," it doesn't mean he did

SOURCE:
Washington Post
https://healthunlocked.com/prostate-cancer-community/posts/148850901/when-a-surgeon-says-he-got-it-all-it-doesn-t-mean-he-di

"It's a common scene: A patient recovering from cancer surgery speaks with their surgeon, who reassures them the procedure went well and that doctors "got it all."

But those three words can sow serious misunderstandings and even medical mistrust, suggest the authors of a recent viewpoint article in JAMA Oncology. jamanetwork.com/journals/ja...

The problem lies in a disconnect between surgeons' "got it all" phrasing and their patients' expectations, a group of bioethicists and surgeons write, because patients may think that, if all visible tumor tissue has been removed, they are cancer free — and that might not be the reality.

Although cancers can be completely removed through surgery, cancer cells can also spread to lymph nodes and other parts of the body despite tumor removal, and follow-up chemotherapy might be necessary. Even when a tumor is removed, only pathology can confirm that there is no cancer in the lymph nodes.

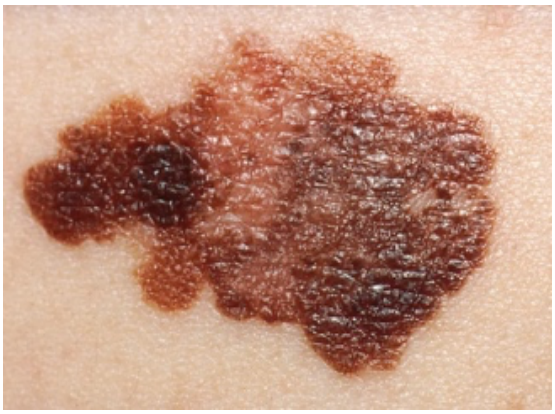
Because of its plain-English simplicity, "got it all" is unlikely to be questioned by patients, the researchers suggest. The writers of the paper worry the phrase could prompt patients to refuse chemotherapy when they receive a later confirmation that there is cancer in their lymph nodes.

Other research has found that cancer patients tend to be optimistic about surgery as a potential cure for their cancer. One 2015 study of 3,954 patients who had cancer surgery found that about 80 percent of those with lung cancer and 87.5 percent of those with colorectal cancer thought surgery would cure them, despite differing prognoses for people with those diseases. That perception even applied to the majority of respondents with Stage 4 cancers that had spread to the lymph nodes.

Ultimately, though, cancer surgery usually serves two purposes: therapy and diagnosis.

"Because patients primarily hear about surgery as being therapeutic, they are primed not to consider the diagnostic function of surgery," according to the article. The writers say surgeons should watch their words — or risk disappointing or misleading patients."

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.



Melanoma Diagnosis Linked to Increased Risk of Prostate Cancer

2 December 2022
https://www.renalandurology news.com/home/news/urology/prostate-cancer/melanoma-diagnosis-linked-to-increased-risk-of-prostate-cancer/?utm_medium=email&utm_source=rasa_io&utm_campaign=newsletter

More than twofold increased risk of prostate cancer seen for men with first melanoma diagnosed 10 to 15 years before study recruitment. (*Source: Getty Images)*

(HealthDay News) — Melanoma diagnosis is associated with increased risk of subsequent prostate cancer, according to a study published online in the *British Journal of Cancer*.

Sam Egger, from the University of Sydney, and colleagues recruited men from 2006 to 2009 to examine the association between cutaneous melanoma and subsequent risk of prostate cancer. Data were included from 96,548 eligible men, of whom 1,899 were diagnosed with melanoma during the melanoma diagnosis period. During follow-up, 3,677 incident prostate cancers were diagnosed.

The researchers found that the risk of a subsequent prostate cancer diagnosis was increased for men with a melanoma diagnosis versus those with no melanoma (fully adjusted hazard ratio, 1.32; 95 percent confidence interval, 1.09 to 1.60). Weak evidence was seen for higher risks of a subsequent prostate cancer diagnosis for men diagnosed with more than one versus one melanoma. The association was also seen if first melanoma diagnosis was 10 to 15 years before study recruitment (fully adjusted hazard ratio, 2.05; 95 percent confidence interval, 1.35 to 3.12).

"Our study is the first to show that the positive association between melanoma and the subsequent risk of prostate cancer diagnosis is unlikely to be due to confounding from increased medical surveillance after a melanoma diagnosis," the authors write. "The positive association remained significant even after the over-adjustment for rate of prostate-specific antigen monitoring tests."

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

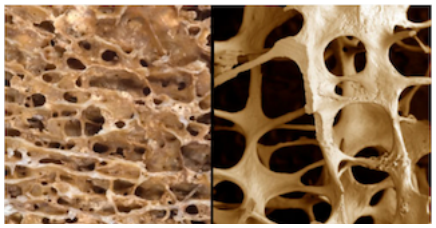
https://www.sciencedaily.com/releases/2022/09/220915104739.htm?utm_medium=email&utm_source=rasa_io&utm_campaign=newsletter

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

1800 33 00 66

Osteoporosis

SOURCE:
https://my.clevelandclinic.org/patients/information/access



What is osteoporosis?

The word 'osteoporosis' means 'porous bone.' It is a disease that weakens bones, and if you have it, you are at a greater risk for sudden and unexpected bone fractures. Osteoporosis means that you have less bone mass and strength. The disease often develops without any symptoms or pain, and it is usually not discovered until the weakened bones cause painful fractures. Most of these are fractures of the hip, wrist and spine.

After age 50, one in two women and one in four men will have an osteoporosis-related fracture in their lifetimes. Another 30% have low bone density that puts them at risk of developing osteoporosis. This condition is called osteopenia.

What causes osteoporosis?

Researchers understand how osteoporosis develops even without knowing the exact cause of why it develops. Your bones are made of living, growing tissue. The inside of healthy bone looks like a sponge. This area is called *trabecular bone*. An outer shell of dense bone wraps around the spongy bone. This hard shell is called *cortical bone*.

When osteoporosis occurs, the "holes" in the "sponge" grow larger and more numerous, which weakens the inside of the bone. Bones support the body and protect vital organs. Bones also store calcium and other minerals. When the body needs calcium, it breaks down and rebuilds bone. This process, called bone remodeling, supplies the body with needed calcium while keeping the bones strong.

Up until about age 30, you normally build more bone than you lose. After age 35, bone breakdown occurs faster than bone buildup, which causes a gradual loss of bone mass. If you have osteoporosis, you lose bone mass at a greater rate. After menopause, the rate of bone breakdown occurs even more quickly.

SYMPTOMS AND CAUSES

What are the symptoms of osteoporosis?

Usually, there are no symptoms of osteoporosis. That is why it is sometimes called a silent disease. However, you should watch out for the following things:

- Loss of height (getting shorter by an inch or more).
- Change in posture (stooping or bending forward).
- Shortness of breath (smaller lung capacity due to compressed disks).
- Bone fractures.
- Pain in the lower back.

Who is at risk for developing osteoporosis?

- Everyone's risk for osteoporosis fractures increases with age.
- Your risk of developing osteoporosis is also linked to ethnicity.
- Another factor is bone structure and body weight.
- Family history also plays a part in osteoporosis risk.
- Finally, some medical conditions and medications increase your risk

These include steroids and treatments for prostate cancer.

You do have control over some of the risk factors for osteoporosis.

- **Eating habits:** You are more likely to develop osteoporosis if your body doesn't have enough calcium and vitamin D.
- **Lifestyle:** People who lead sedentary (inactive) lifestyles have a higher risk of osteoporosis.
- **Tobacco use:** Smoking increases the risk of fractures.
- **Alcohol use:** Having two drinks a day (or more) increases the risk of osteoporosis.

DIAGNOSIS AND TESTS

How is osteoporosis diagnosed?

Your healthcare provider can order a test to give you information about your bone health before problems begin. Bone mineral density (BMD) tests are also known as dual-energy X-ray absorptiometry (DEXA or DXA) scans. These X-rays use very small amounts of radiation to determine how solid the bones of the spine, hip or wrist are. Regular X-rays will only show osteoporosis when the disease is very far along.

MANAGEMENT AND TREATMENT

How is osteoporosis treated?

Treatments for established osteoporosis may include exercise, vitamin and mineral supplements, and medications. Exercise and supplementation are often suggested to help you prevent osteoporosis. Weight-bearing, resistance and balance exercises are all important.

What medications are used to treat osteoporosis?

There are several classes of medications used to treat osteoporosis. Your healthcare provider will work with you to find the best fit.

Bisphosphonates

Bisphosphonate osteoporosis treatments are considered antiresorptive drugs. They stop the body from re-absorbing bone tissue. There are several formulations with various dosing schemes (monthly, daily, weekly and even yearly) and different brands:

Biologics

Denosumab (Prolia®) is product that is available as an injection given every six months to women and men.

Anabolic agents

These products build bone in people who have osteoporosis.

Supplements

It's important to remember that dietary supplements, although available everywhere over-the-counter and online, aren't regulated in the same way that prescription medications are. Also, even though something is 'natural,' that doesn't mean that it is safe for everyone at all times.

(continued page 13)

You might be told by your healthcare provider to get adequate amounts of calcium and vitamin D. This is important if you have osteoporosis or if you are trying to prevent it. It's best if you can meet those needs with a food plan, but you might not be able to do that. There are plant-based calcium supplements, some of which are based on algae.

The recommended amount of daily calcium intake is 1,000 mg to 1,200 mg daily via diet and/or supplements. Taking more than this amount of calcium has not been shown to provide additional bone strength but may be associated with an increased risk of kidney stones, calcium buildup in the blood vessels and constipation.

There are different ideas about the necessary levels of vitamin D, but it's true that many people do not have adequate levels and might need to take supplements. Your healthcare provider might test your blood levels and then make recommendations based on these results.

You and your healthcare provider will always need to discuss whether the benefits of taking something, whether is a prescription drug or a supplement, outweigh the risks.

For those who need supplements, remember that the body can only absorb 500 mg of calcium at a time. You should take your calcium supplements in divided doses, since anything more than 500 mg will not be absorbed.

Lifestyle

Maintaining a healthy lifestyle can reduce the degree of bone loss. Begin a regular exercise program. Exercises that make your muscles work against gravity (such as walking, jogging, aerobics, and weightlifting) are best for strengthening bones.

Do not drink too much alcohol. Do not have excessive amounts of caffeine. Don't use tobacco at all.

LIVING WITH

What can you do if you are living with osteoporosis?

If you have osteoporosis, you should continue with the lifestyle measures mentioned earlier in terms of eating well, getting enough exercise, avoiding excessive caffeine and alcohol consumption, and not smoking. Make sure that you follow the suggestions of your healthcare provider. You should do all that you can to prevent falls inside and outside of your home. You might want to start with a medical evaluation, which could lead to your healthcare provider providing assistive devices.

Prevent falls inside your home

- Keep your floors free of clutter, including throw rugs and loose wires and cords. Use only non-skid items if you have mats, carpets or area rugs.
- Make sure your lighting is bright enough so that you can see well.
- Do not use cleaners that leave your floors slippery.
- Clean up any spills that happen immediately.
- Use grab bars in the bathroom and railings on stairways.

Prevent falls outside your home

- Make sure lighting is adequate in all areas outside your home.
- Use a backpack or other type of bag that leaves your hands free.
- Keep areas outside in good repair and free of clutter.
- Wear sensible shoes with non-slip bottoms.

This is in no way a complete list of things that you can do to help prevent falls, but this is a starting point. Also remember to take your time. You might be less careful if you are in a hurry.

When should you call the doctor about osteoporosis?

If you have risk factors and are concerned about osteoporosis, ask your healthcare provider about being screened, even if you are not as old as 65 (for women) or 70 (for men). Osteoporosis can be serious. Fractures can alter or threaten your life. A significant number of people have osteoporosis and have hip fractures die within one year of the fracture. Always call your healthcare provider if you fall, if you are worried about bone breaks, or if you have back pain that is severe that comes on suddenly.

Remember that you are able to lead an active and fulfilling life even if you do have osteoporosis. You and your healthcare provider can work together to make this happen.

Treatment Without ADT Delays Initiation of Systemic Therapy in Prostate Cancer

SOURCE:
28 November 2022
https://www.oncologynurseadvisor.com/home/cancer-types/prostate-cancer/treatment-without-adt-delays-initiation-of-systemic-therapy-in-prostate-cancer/?utm_medium=email&utm_source=rasa_io&utm_campaign=newsletter

(HealthDay News) — For prostate cancer patients with a solitary oligometastatic lesion, metastasis-directed therapy without androgen deprivation therapy (ADT) can delay initiation of systemic therapy, according to a study published in the December issue of *The Journal of Urology*.

Jack R. Andrews, M.D., from Mayo Clinic Arizona in Phoenix, and colleagues characterized outcomes among 124 patients with prostate cancer from 2008 to 2018 with a solitary oligo-recurrent metastatic lesion on positron emission tomography imaging who were treated with metastasis-directed therapy without ADT. Patients were treated with stereotactic body radiation therapy (57 patients; median follow-up, 53 months) or surgical excision (67 patients; median follow-up, 54 months).

The researchers found that 80.5 percent of the patients treated with surgery had >50 percent decline in prostate-specific antigen at the first follow-up, with 29 percent three-year radiographic progression-free survival. In this cohort, the median time to initiation of systemic therapy was 18.5 months. Overall, 40.3 percent of patients treated with stereotactic body radiation had >50 percent decline in prostate-specific antigen at first follow-up, with 17 percent three-year progression-free survival. The median time to initiation of systemic therapy was 17.8 months.

CLINICAL TRIALS

AlphaBet

Combination of Radium-223 and Lutetium-177 PSMA-I&T in Men with Metastatic Castration-Resistant Prostate Cancer

Brief Summary:

This clinical trial will evaluate the safety of Radium-223 in combination with 177Lu-PSMA-I&T in metastatic castration-resistant prostate cancer: Phase I/II study

Sponsor:

Peter MacCallum Cancer Centre, Australia

Information provided by (Responsible Party):

Peter MacCallum Cancer Centre, Australia

Detailed Description:

This prospective, single-centre, single-arm, open label, phase I/II trial will assess and establish the maximum tolerated dose (MTD), dose-limiting toxicities (DLTs), and recommended phase 2 dose (RP2D) of Radium-223 in combination with 177Lu-PSMA-I&T in patients with mCRPC.

36 men with mCRPC who have progressed on second-generation AR antagonist will be enrolled in this trial in two stages: dose escalation and a dose expansion phase over a period of 24 months.

Actual Start Date: 13 Sept 2022

Estimated Primary Completion: June 2026

Estimated Study Completion Date: 1 Dec 2026

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 2023 10am – 12:30pm

Tues 21 Feb
Tues 21 March
Tues 18 April
Tues 16 May
Tues 20 June
Tues 18 July
Tues 15 August
Tues 19 September
Tues 17 October
Tues 21 November
Tues 12 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
- Ex Med & Hospital exercise programs
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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

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

December 2022
- Developing Therapies for Treatment Resistant PCa
- Shortened Radiation Course for High Risk PCa
- Comments on the Surgical Option for ADT
- Darolutamide Plus ADT & Docetaxel Improves QoL Vs Placebo in mHSPC
- Continued Enzalutamide Can Delay Progression in mCRPC Despite Resistance
- What PCa Patients Treated With ADT Recall
- Patting the Hormone Shark
- 10-11 LUPSMA – The Specifics
- Extend Trial
- Improving Erectile Function
- When a surgeon says he 'Got It All' It Doesn't mean he did.
- Melanoma Diagnosis Linked to Increased Risk of PCa
- Osteoporosis
- Treatment without ADT Delays Systemic Treatment
- Clinical Trials

Disclaimer: *Information in this newsletter is not intended to take the place of medical advice. Please ask your doctor to clarify any details that may be related to your treatment. PHCSG have no liability whatsoever to you in connection with this newsletter.*

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