

# Prostate Matters

## Newsletter

ISSUE 4

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### Contents

- Page 2 Federation Conference and AGM 2009
- Page 3 PCRMP where we stand now
- Page 4 West Wales Group benefit from Federation grant.
- Page 5 West Wales continued
- Page 6 Clinical Trial Sarcosine
- Page 7 Arguments against Active Surveillance. Targetted PCa biopsy  
Dr Gleason dies
- Page 8 MRI in prostate cancer

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It is intended to publish this newsletter 4 times a year  
*Winter - Spring*  
*Summer - Autumn*

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Charity No. 1123373

Worried or concerned about prostate cancer?

**National Help Line**  
**0845 601 0766**

## The Federation moves forward

Sandy Tyndale-Biscoe – Hon Chairman

As you will see elsewhere in this edition, the Federation had a very successful Annual Conference in Stoke-on-Trent on 25<sup>th</sup> April, which, once again, was kindly sponsored by Prostate UK. As well as hearing an excellent set of presentations from some of the country's top researchers, we elected a strong committee of Trustees, and, equally important, we recruited people for some key posts. I am particularly pleased that Thomas Stuttford, GP, some-time MP, and journalist, has agreed to take on the role of political liaison. On a personal front, I was, in equal proportions, honoured, flattered and daunted to be elected Chairman.

In our first year the Federation has already achieved much. The successful *Promoting Patient Power* workshop in Leamington Spa in October, so kindly sponsored by the Graham Fulford, one of our 'Organisation Members', is an example of what we can do. This house magazine, *Prostate Matters*, is another, being a great success and widely read. Finally, with the launch of the "Real PCRMP", actively promoted by Prostate UK, we have shown that we can try to influence the thinking of the professionals who care for us.

We are always saying thank you to Prostate UK, and in particular we should acknowledge their small grants scheme which we manage for them. Last year we awarded a total of £2,500 to 12 of our member organisations. This year we have a total of £5,000 available, which can be awarded in amounts of up to £500.

That we have done so much in the first year is due to the efforts of our Trustees, and I particularly want to thank four of them who are standing down this year and who have overseen the past six or seven years of the Federation's gestation. These are: John Dwyer, who successfully led us into full official existence this time last year, Brian Atkins, Philip Barnard and Jim Stansfeld.

Where do we go from here? In the next few weeks the Trustees will be developing plans for the coming year. If you have ideas, please pass them to me, by post c/o this magazine, or by email to [chairman@prostatecancerfederation.org.uk](mailto:chairman@prostatecancerfederation.org.uk).

I feel optimistic at the start of the second year of the Federation's real existence. To paraphrase Wilfred Owen, in a letter written on New Years Eve 1917, "We are started. The tugs have left us; we feel the great swelling of the open sea taking our galleon."

# Federation Conference and AGM 2009

The conference was held on 25<sup>th</sup> April at Staffordshire University, Stoke-on-Trent campus. Approximately 60 members of support groups from across the country attended. John Dwyer, the Federation chairman, welcomed everyone to the conference and opened proceedings.

Morning Session

**The Role of the Media in Advocacy for Prostate Cancer - Dr Thomas Stuttaford** spoke first of a conference he attended with Major Ferguson, in Manchester, who when diagnosed with prostate cancer, was given little information, he was advised radiotherapy and decided to have that, but at the time this treatment was not curative. His death was listed as a heart attack, but like many others, his cancer would have had a great influence in causing his death. That awful phrase: "Most men die with it rather than of it" was so misleading as he felt the death rate from prostate cancer is greatly under-rated.

The GP is the first point of communication/information for anyone, but their knowledge varies. Consultants are very busy and can afford little time.

The press can provide a counterbalance to the spin coming from government, he felt it was important to have independent press because government is run by the treasury and they don't want to spend too much money on the NHS.

Women have enormous influence and provide valuable support to a man with prostate cancer, who bares the disease which ultimately affects the whole family.

He recounted various stories about his times of treating patients and felt there was now enough information available from all the various tests, to be able to distinguish between pussycats and tigers.

**Uncertainties about Treatment of Prostate Cancer - Emma Halls, Prostate Research Foundation & Lester Perkins, James Lind Alliance**

The Prostate Research Foundation has been around for fifteen years, every other year they organise a meeting of top clinicians/researchers, holding this event at different venues around the world, this usually attracts top clinicians who talk and share information about what they are doing and identify where research can help.

James Lind Alliance has been working with the Research Foundation and helps promote involvement of patients

in medical research.

**Developments in Translational Research in Prostate Cancer - Professor Noel Clarke, Cancer Research UK / Manchester University**

Started by talking about basic science in research - early trials - further trials, phase 2 & 3 - outcome studies - education of doctors. It is difficult to take tissue samples and store them - legislation issues causes problems. It is costly and timely to create a tissue bank - regulation/consent. Showed charts relating to translational research used to determine a dose to give patients, in phase 1 trials.

Use of Spectroscopy - showed slides giving information on how this works. Fats in diet increase bone marrow fats which tumours feed on, this in some way explains why people in Japan & China who have a very low intake of fat in their diet, do not suffer from prostate cancer in anything like the numbers we have in the west.

After lunch the afternoon session started with the business part of the day. **Chairman's Report** - John Dwyer outlined what the Federation had achieved in the last year, NICE, PCRMP, Website development, Helpline, Europa Uomo, he thanked those individuals involved in making things happen, particularly Prostate UK, who have continued to support us and agreed to sponsor this conference and Graham Fulford who had provided further funding.

**Treasurers Report** - Hugh Gunn presented the accounts for the last year, his closing remarks were that the Federation doesn't run without money, and the whole question of membership fees to the Federation was then thrown open for discussion. This resulted in a proposal from the floor that the membership fees for each 'group' to join the Federation is based on £1 for each of 'their' members up to a maximum payment of £100. This was proposed, seconded and carried.

**Election of Officers and Trustees** - John Dwyer, the existing chair, informed the meeting that he intended to stand down as chairman, the current secretary Sandy Tyndale-Biscoe was prepared to stand as chairman and in the absence of no other candidate, was duly elected. The full list of elected officers and trustees along with those volunteer-

ing to fill specific roles for the Federation are listed below:

**Chairman:** Sandy Tyndale-Biscoe

**Treasurer:** Hugh Gunn

**Secretary:** Mike Lockett

**Trustees:** > David Smith - PCaSO

Keith Hobby -PCS > John Dwyer -PCS

> Roger Bacon - PCaSO

> Graham Fulford - GFCT

> Rob Banner - Prostaidd

**Roles and Functions:**

European Rep: - Mike Lockett

Medical Advisor: - David Baxter-Smith

Newsletter Editor: - Roger Bacon

Grants Sec: - Sandy Tyndale-Biscoe

Publicity/PR: - VACANT

Fund Raising/Sponsorship: - Rob

Banner

Website: - Sandy Tyndale-Biscoe

Helpline coordinator: - John Coleman

Development/Recruitment - Graham Fulford

Membership secretary - Alan Ashmore

Representatives on National groups:

NCRI; PCAG; PCCA; NICE -

David Smith / John Dwyer

Political Liaison - Dr Tom Stuttaford

Education/Research: - John Dwyer

**Amendments to Constitution:** the new chairman outlined and explained the changes proposed in the constitution and those present voted to accept all the proposed amendments.

**AOB:** Mike Lockett spoke about MAC the European Government group formed by Euro MPs and called Members Against Cancer.

**Developments in Therapy for Prostate Cancer - Professor Nick James, Cancer Research UK / University of Birmingham**

He first talked about the problem of overtreatment ...Surgery v Watch & Wait for low risk. Surgery representing the extreme end of treatment and ww being no treatment.

Study figures showed that after 10 years, 16% on ww died and 12% died who had surgery.

Early disease - huge overtreatment, many options...do they need treating? Sun exposure verses cancer risk...this can affect all cancers not just melanoma. Talked about PC Spec and estrogenic activity.

Conclusions - survival times improving with more use of current agents > many new therapies on trials > treatment likely to change in the next few years.

*A fuller report on the conference can be found on our website:*

[www.prostatecancerfederation.org.uk](http://www.prostatecancerfederation.org.uk)

# PCRMP where we stand now

In our last edition, under the headline “Prostate Cancer Risk Management Programme – men are betrayed again”, we described how the Trustees of the Federation had decided, because of the continued absence of up-to-date unbiased guidance to GPs on what to say to a symptomless man who asks about the PSA Test, to publish its own set of leaflet on the matter. This would have been in direct head-to-head competition with the proposed publication by the Department of Health of a revised, but still unbalanced and obsolete, version of its Prostate Cancer Risk Management Programme. Well, events moved fast in March, and our leaflet is now published, although it is not quite what we originally had in mind. What we have published is both less controversial, and more urgently needed.

In 2002 the Government decided that every man over 50, **having been fully informed of the implications**, should be entitled to an annual PSA test, set up by his GP. However, the guidance under this programme was heavily biased towards the so-called “risks” of having the test. As a result there were many cases where a man was denied the test until symptoms developed, when curative treatment was all too often no longer feasible. Two years ago, after considerable lobbying by ourselves, a revision of the guidance was announced, which was due for publication early this year. In the event, this never happened, because, towards the end of March everything changed when the *New England Journal of*

*Medicine* published interim results from two major studies into PSA-based screening; one of these showed significant reduction in mortality; the other showed no benefit. This completely opened up the arguments both for and against screening, but above all it rendered the draft of the revised Guidance Pack obsolete. The Department therefore announced that it would not now be published, and GPs are being referred back to the original version published in 2002.

This changed things completely, and we decided to take a less confrontational approach. As a result we gained increasing support from the profession for what we were doing, and got the full backing of Prostate UK, the UK’s largest charity that specialises in all prostate diseases, with the active participation of their Chairman of Trustees, Prof Roger Kirby, one of the top urologists in the country. The result is a simple leaflet (which may indeed be enclosed with this newsletter, depending on the arrangements set up by the patient support group that distributed this copy) that summarises what a GP should say to a symptomless man who asks for the test.

Although we had great reservations about the draft of the Government’s revised guidance, without its publication the situation is even worse than it would have been had it been published, because GPs are once again being told to follow the heavily biased and out of date 2002 guidance. This, obviously, takes

no account of the enormous progress made over the past few years, both in understanding early stage prostate cancer and in clinical practice. In particular enormous advances have been made in the top prostate cancer centres in dealing with PSA results and also relating them to numerous other factors which concern the significance or otherwise of a cancer once it has been diagnosed.

This is not, as some have commented, an obscure medical difference of opinion. There is a tendency, amongst a small but significant number of GPs, to discourage men from having the PSA test, and we have to stop this. We know of too many cases where a man has been effectively denied the test and has subsequently been diagnosed with advanced, incurable disease. We are asking you to help by placing as many of these leaflets as possible in your GP’s surgery. You should explain that this is a balanced summary of the PSA argument, endorsed by eminent clinicians and the major charity in the UK looking after prostate disease.

To obtain copies please email [realpcrmp@pcrmp.org.uk](mailto:realpcrmp@pcrmp.org.uk), or write to: The Real PCRMP, Cedarcroft, Sunnyway, Bosham, Chichester, West Sussex, PO18 8HQ.

For more details about the Real PCRMP, including the opportunity to join the PSA Debate, visit the website: [www.PCRMP.org.uk](http://www.PCRMP.org.uk)

Sandy Tyndale-Biscoe

**Leighton Hospital Prostate Cancer Support Group**  
I read with interest the article in the Federations Prostate Matters Newsletter regarding their desire to compile our own Prostate Cancer Risk Management Programme and felt this is one way forward to enhance our promotion of awareness and the probability to have more GP's providing PSA tests for those men at risk due to Family History and age. At the Crewe meeting last Saturday (7<sup>th</sup> March) I put it to the members that we should donate some money to the Federation to help financially with this venture and it was agreed unanimously to direct some funds to that cause.

**The Federation would like to thank the Leighton Hospital Prostate Cancer Support Group for donating £3500 towards the costs of producing the “Real PCRMP” leaflet, which has now been printed and is currently being distributed across the country to as many GPs as possible.**

## West Wales Group benefit from Federation Grant by Philip Burr

In early September 2007, aged 62, I had radical surgery for prostate cancer. Since then I have talked to many prostate cancer patients. Some wish only to put their experience behind them, giving it as little thought as possible. This I can understand. Others wish only to help others as they tread their way through the shock of prostate cancer diagnosis and treatment. Like many readers, I belong to this group.

For me, the six months between my first PSA test and diagnosis was calm enough. My first biopsy found nothing and because I had no symptoms I approached a second biopsy with equal composure. I am now very critical of well-meaning advice which encourages men with symptoms to visit their GP. This infers that asymptomatic men will not have cancer.

My investigation and diagnosis had been undertaken at a small local hospital. When diagnosed, I asked what support was available. I was told none, nor was I referred to a named nurse then or later (Roger Bacon's report in PM2 suggests this is not unusual). I was given no literature to take home. The four months from diagnosis to treatment were anxious times, made more problematic by poor communication between the hospital and me, the patient. At the end of that period, and feeling poorly served by the NHS at a local level, I was transferred to another, larger hospital for surgery. By contrast the Urology Department at this hospital was very good, my confidence returned and my treatment was excellent once home, I recall writing a number of letters of thanks. I was particularly grateful to the theatre and ward staff and of course, my new consultant.

By October, I had begun to list the concerns I had about my diagnosis and early treatment, at my local hospital. I intended to

raise these issues with them for the benefit of future prostate cancer patients. For example, I collected literature from national and local organisations to whom patients could turn for support, and put together a pack which I suggested to the hospital could be given to patients at the point of diagnosis. When I approached the hospital, I did not make a formal complaint and the matters I raised dragged on much longer than anticipated. I can only hope that better practice will now ensure that all prostate cancer patients will get the best possible attention.

By November, I had also written an account of my prostate cancer journey. I did this at the suggestion of my consultant on the basis that it might be useful to other men faced with similar problems. As a side effect, I found the experience quite therapeutic.

Most of my pre-treatment information had been sourced from the Prostate Cancer Charity. I had also talked to the trained nurses who man their helpline. It was natural for me to want to repay this charity and I approached Claire Carlin, Community Fund-raising Manager and offered to fund-raise for them. I have been doing so ever since.

By early 2008, I had made a considerable number of contacts from within the world of prostate cancer. I had been given a copy of the Macmillan Directory of Cancer Support Groups and realised that prostate cancer support groups were already widely established in other parts of the United Kingdom. I made contact with each of the four existing groups in Wales. All were keen to offer advice and share their expertise. I knew then that I had to set up a similar group for men and their families in West Wales. I wanted to put in place a support group which offered men the opportunity to talk to other

men who had been through the same experience, something which had not been available to me.

A letter to a local newspaper seeking likeminded individuals brought just enough response to move forward and by the end of March 2008, The West Wales Prostate Cancer Support Group came into being. Our 'catchment area' covers three counties, Ceredigion, Carmarthenshire, Pembrokeshire plus Swansea, Neath-Port Talbot, and Bridgend. Patients from rural areas travel many miles to attend 'local' clinics and even further for radiotherapy or surgery. There are several, mainly small, hospitals seeing patients in West and South West Wales and 150 GP practices. In this respect I believe we are very different from most other prostate cancer support groups.

We cannot yet contemplate holding the hospital based meetings with guest speakers which are a feature of some other groups. Members would face the same difficulties attending such meetings that they do attending out-patient clinics. However we do hope soon to establish small social events at a local level and will reconsider other meeting as our membership grows.

However much has already been achieved by our small committee in a very short space of time, and though it has not always been straightforward we have learnt by experience along the way. When we heard of the plan to establish a *Federation of support groups*, it was natural for us to want to learn more. I'm sure the new Federation will actively encourage and advise new groups. We hope they will see this as a priority. We know that setting up a new group can be quite daunting.

Our prime aims have been to support men and their families through the processes of investigation, diagnosis, treatment and

then coming to terms with their cancer. We quickly established our own local helpline and we refer men to other local and national sources of support as well.

In addition to fundraising for the Prostate Cancer Charity we must now raise funds for our own work. One of our main sources of income has been the supermarket collection. This was initially a one-man exercise, but we now endeavour to have at least two collectors on each occasion since members of the public often want to talk.

These events then become an opportunity to raise prostate cancer awareness with other events, awareness becomes the main focus and fundraising becomes of secondary importance. We have been fortunate to have been welcomed at a number of events at one of our county show grounds where we make available a range of literature provided by Cancerbackup, the Prostate Cancer Charity and Prostate UK. When engaged in fund-raising or awareness we follow a strict code of conduct, we want to promote a professional appearance and be invited back!

Next year we plan to start a rolling programme of awareness events across the region which are exclusively for that purpose. To this end we made preparations for a 'trial run' event to take place in September 2008 and put in a bid for a Prostate UK small grant of £250 promoted by the Federation. We hoped this would pay for this event and a second event early next year.

Our first choice venue, The Guildhall in Cardigan was ruled out, since it was about to be closed for the winter for refurbishment. I promised our committee that I would look at St Peter's Civic Hall in nearby Carmarthen and in a moment of enthusiasm verging on recklessness I made a provisional booking for this venue for 10th September 2008.

Reckless, because the venue, though ideally situated, was larger

than we needed and proportionately more expensive. However I was fortunate to have the support of our committee who, like me could see the additional opportunities this venue could provide. We agreed that we would make this an 'All Cancer Awareness Event' hosted and organised by The West Wales Prostate Cancer Support Group. We contacted one or two cancer support groups in the area and word spread very quickly. Other cancer support groups took up the challenge and within a short time we had a good balance of support groups, local and national cancer charities and NHS representatives, 22 organisations in total, all wanting to take part. In addition we invited film-maker Richard Urbanski who showed visitors a recently launched DVD "From Home to Hospital" featuring the stories of six cancer patients.

Helen Dorman from South West Wales Cancer Network, an enthusiastic supporter of our group attended early planning meetings and her organisation helped fund the event. This meant that the cost to our own group, apart from the hard work and many anxious moments, was no greater than for a smaller 'prostate cancer only' event. Our own costs went on administration, invitations and publicity. Approximately half of the Federation grant funded these costs leaving the balance in hand for our First Prostate Cancer Awareness Event of 2009.

The organisation of the event had

several 'never again' moments, but went very smoothly on the day, thanks in part to our team of volunteers who took on a number of different roles during the day and enticed members of the public into the venue. The event was well received by visitors and participants alike. Feedback from participants was very positive, many hoped for a similar event next year. Anne Mart, Development Coordinator for Macmillan Cancer Support in Wales wrote recently, "I have been singing the praises of the event and its organisation to many people." As well as generating cancer awareness, the different organisations taking part had the opportunity to talk to others working in the same field. The event has certainly opened doors for our own organisation and put us on the map. Although we used part of our grant to help organise an *All Cancer Awareness Event* I hope the Federation and Prostate UK will acknowledge that this was money well spent.

As a new support group we have learned that awareness is an issue where we can be effective immediately with few resources other than hard work, enthusiasm and a desire to spread the word. Knowing that we have the support of the Federation in our work is very encouraging. We would like to thank them and *Prostate UK* for supporting our awareness events and urge other groups wishing to embark on a project to contact the Federation with a view to applying for a small grant.

Prostate UK have generously made available the sum of £5,000 for small grants to be paid to patient support groups in 2009. Groups must be members of the Federation. These grants can be used for running their organisation, equipment purchase, raising awareness, advertising or providing support to their members.

The grants, which will be up to a maximum of £500 each, are managed by the Federation.

This report is an excellent example of what can be done.

To apply for a grant, either download an application form from the Federation website or contact Sandy Tyndale-Biscoe on 01243 572990

# Clinical Trial

## HOT II

### A trial looking at hyperbaric oxygen (HBO) treatment for people who have long term side effects following radiotherapy for a pelvic cancer

A multi-centre research collaboration led from The Royal Marsden Hospital

#### Background

Most patients having radiotherapy to the abdomen or pelvis notice one or more side effects, but these usually clear up once treatment is finished. Once the symptoms have settled, there are, broadly speaking, four long-term outcomes for patients in terms of their bowels: between 10 and 20 of every 100 patients have no long-term symptoms; between 30 and 40 are able to cope with changes in bowel habit that have little impact on daily life, but about 30 patients develop change in bowel function that interfere to some degree with daily activities and long-term quality of life. Finally, a few develop serious problems that can be very difficult to control. Fortunately, there are signs of progress in treating bowel symptoms caused by radiotherapy. A recent clinical trial of high pressure oxygen therapy (HBO - the kind used in divers who get the 'bends' and elite footballers after injury), provides evidence that radiotherapy side effects can be improved.

We aim to repeat this work in a randomised trial comparing high pressure oxygen treatment with sham treatment. We are looking for volunteers to join us in this ambitious research programme.

#### Aim

The aim is to test the efficacy of hyperbaric (high pressure) oxygen (HBO) therapy in reducing intestinal symptoms caused by pelvic radiotherapy at least 12 months earlier and which persist despite optimal standard measures.

#### Trial design

The study is called a double-blind randomised controlled trial. It compares volunteers given 100% oxygen under pressure (the test group) with volunteers given 21% oxygen (air) under pressure (the control group). The allocation of volunteers to test group or control group is decided randomly by a computer in our trials office, not by the patients or their doctors.

#### What does the trial involve?

Hospital Visits - Before you can start the study, you will see a bowel specialist. They will ask you about the long term side effects of radiotherapy and how it affects your daily life. They may suggest other ways to improve your symptoms, which you must try before taking part in this trial. If this treatment or advice helps, then you will no longer be able to take part.

#### Hyperbaric units

Everyone will go to one of the specialist centres taking part in this study to have hyperbaric oxygen therapy (HBO). You go every day, 5 days a week, (Monday to Friday) for 8 weeks. Each treatment takes about an hour and a half.

To have HBO treatment, you will have to travel to one of the following specialist centres in > Gosport > Hull > London > Cardiff > Plymouth

Other centres are coming on line in the Wirral and Great Yarmouth.

#### Who can enter this trial?

You can enter this trial if you

- ⇒ Had cancer in the past that had not spread outside the pelvis (this includes rectal cancer, prostate cancer, testicular cancer, bladder cancer, cervical cancer, womb cancer and ovarian cancer)
- ⇒ Had radiotherapy at least 12 months ago
- ⇒ Have no signs of cancer now
- ⇒ Have bowel problems caused by your radiotherapy and they have not improved with medication or changes in lifestyle
- ⇒ Are well enough for hyperbaric oxygen therapy
- ⇒ Are at least 18 years old

#### Referral to the study

If you think you may be eligible and are interested in finding out further details about what is involved in the trial, please contact: Sue Martin, Trial Coordinator to Dr Jervoise Andreyev, Consultant Gastroenterologist in Pelvic Radiation Disease and Professor John Yarnold, Consultant Clinical Oncologist.

Tel: 020 8661 3273 <> Fax: 020 8661 3107 <> Email: sue.martin@icr.ac.uk

## Sarcosine may distinguish slow-growing prostate cancers from those likely to become lethal

Dr. Beecher, a colleague of lead author Dr. Arun Sreekumar, from the University of Michigan gave a lecture on this possible breakthrough that can supposedly discriminate between aggressive and non-aggressive prostate cancers.

The research of team looked at more than 1,000 metabolites, or small molecules, in tissues associated with prostate cancer. These findings suggest that not only is sarcosine a marker of cancer aggressiveness, it also has a role in endowing a cancer with malignant properties.

Thus, sarcosine may distinguish slow-growing prostate cancers from those likely to spread and become lethal. On the other hand benign prostate cells take on cancerous characteristics in lab dishes when exposed to sarcosine.

According to Dr. Beecher, sarcosine has been validated and re-validated several times. The results are promising: "Sarcosine continues to predict the aggressiveness of the tumours." The metabolomic analysis yielded the observation that sarcosine was highly associated with tumour development. The scientific data support a correlation and provides biological insights.

Conveniently, sarcosine can be identified in urine, a less invasive test than the blood analysis needed for the standard prostate specific antigen, or PSA test.

Prostate cancer diagnosis, according to William Isaacs, a molecular biologist at the Johns Hopkins University School of Medicine in Baltimore, is an "imprecise science." Quite often men have PSA scores that fall into a gray area. Therefore, invasive biopsy is needed to clarify a diagnosis. Possibly sarcosine can help to clarify the PCa diagnosis.

Friday, 20 March 2009  
Franz Gunter

## Arguments against active surveillance in early prostate cancer

Dr. Eric Klein argues against active surveillance in PCa treatment at the 6th ESOU Meeting

*Tuesday, 3 February 2009-* In his arguments regarding the limits of active surveillance in early stage prostate cancer (PCa), Dr. Eric Klein (Cleveland, USA) said the lack of better tools in identifying indolent prostate disease disqualifies active surveillance as a standard management approach in PCa.

"Until better tools for indentifying indolent disease and true biologic progression are available, active surveillance should not be a standard management approach," Klein said in defence of his position in not favouring active surveillance. Arguing against, Prof. Freddie Hamdy maintained that delaying immediate intervention in a large number of screen-detected prostate cancer patients is "entirely reasonable and ethical" Klein said there are still no nomograms that can sufficiently predict disease progression.

"While very exciting, neither nomogram approaches nor new biological markers have sufficient predictive power to accurately choose patients for surveillance," said Klein. "And results from the largest published series suggest a substantial risk of having non-curable disease at time of radical prostatectomy in those who choose surveillance."

He, however, conceded that there is little question that most early stage prostate cancer is "...not threatening to the health of the patient and that a substantial amount of this disease is over treated."

"Active surveillance is an attractive option, but in the absence of validated markers for tumour progression, is essentially a finesse of clinical judgment and patient psychological tolerance for uncertainty," noted Klein.

He said the major questions that need to be answered in support of an active surveillance approach are: can biologically indolent tumours be accurately identified at diagnosis?; can robust clinical tools

that reliably signal the need for intervention be developed and applied while the tumour is still curable?; and, what is the psychological burden of surveillance?

After the debate by Hamdy and Klein, the audience voted on the issue with a majority of the audience voting **for** active surveillance at 52.9% , 37.5% voted for radical prostatectomy and the remaining 9.6% selecting radiation therapy as their preferred therapy.

*Article by Joel Vega*

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## Targeted Prostate Cancer Biopsy And Cancer Treatment Earns Acceptance From Top Prostate Specialists

To date, more than 3,500 prostate biopsies and subsequent cancer treatment procedures have been conducted using the proprietary TargetScan(R) technology, adopted by prostate specialists in search of more effective cancer treatments with fewer side effects. The TargetScan technology has been shown to accurately map the prostate, delivering precise, repeatable biopsies that record results from specific locations within the gland. The ability to target specific locations may deliver optimal cancer treatments while reducing negative side effects, such as erectile dysfunction and incontinence that result from more aggressive cancer therapies.

TargetScan collects 3-D images using a proprietary stationary ultrasound probe; leads physicians in systematically mapping prostate locations; and guides biopsy sampling and/or cancer therapies through needle placement within the defined template map. The original technology was introduced in 2005 and is now used at the nation's top urologic centres, including Washington University, Duke University, Emory University, New York University and the University of Michigan - and is being adopted in private practice by urologists interested in bringing state-of-the-art care to their offices.

"TargetScan is an excellent tool

that reliably defines where cancer exists in the prostate and maps the prostate in a reproducible manner so I may accurately follow a patient's progress and cancer status over time," explains James K. Bennett, M.D., a leading urologist in private practice in Atlanta. "This is the future of prostate cancer diagnosis and treatment for men who seek alternatives to extreme surgical treatments and negative side effects."

Gerald L. Andriole, Jr., M.D., Professor and Chief of Urologic Surgery at Washington University School of Medicine in St. Louis is a member of a multi-centre team that conducted an evaluation of TargetScan. Their study was published in the *British Journal of Urology* and showed that TargetScan template guided biopsy technology potentially produces a higher cancer detection rate for first time biopsies and a more accurate assessment of grade. "More accurate biopsies and targeted cancer treatments may help patients achieve better results with fewer negative side effects," says Dr. Andriole.

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## Dr Gleason dies at 88

Dr. Gleason, the Minnesota pathologist who developed the Gleason score that is now used almost universally to predict the likely outcome of prostate cancer, died Dec. 28 of a heart attack at his home in Edina, Minn. He was 88. His method of predicting the course of a patient's prostate cancer has not been improved upon in 40 years.

Gleason was an unknown, junior-grade pathologist at the Minneapolis VA Medical Centre in 1962 when he was approached by the hospital's chief of urology, Dr. George Mellinger, who asked Gleason to develop a standardized rating system for tumours to ease communication between hospitals.

At the time, there was no uniform system for determining the grade of prostate tumours - a measure of how far they had progressed and of their likely course. Each pathologist pretty much used his own system, which made comparing research results among different groups nearly impossible. Now the 'Gleason' grading system is used everywhere.

## MRI in Prostate Cancer

Jelle Barentsz, M.D., Ph.D  
Professor of Radiology  
University Medical Centre - St. Radboud  
Nijmegen, The Netherlands  
Edited from PCRI *Insights* November,  
2008 v 11.4

*Confirming the diagnosis of prostate cancer is not always easy. A patient with complaints and an elevated PSA does not necessarily have prostate cancer. Developments in MR imaging are rapid. This paper describes how the use of MR imaging can be of great value for patients with prostate cancer.*

Current medical imaging techniques, such as trans-rectal ultrasound (TRUS) and conventional MRI, can visualize prostate disease but are barely able to distinguish between cancer and non-malignant disease. Ultrasound-guided biopsy and subsequent histological examination often give a definitive diagnosis of prostate cancer. But since biopsies are taken randomly, there is a risk that the tumour is missed or that the most aggressive part of the tumor is not biopsied. In the Gosselaar study<sup>1</sup>, prostate cancer was detected in 29% of the men in the first TRUS-guided biopsy. After the second biopsy, it was detected in 19%, and after the third biopsy, again in 19%. Sampling of additional 'low signal' areas on TRUS results in a positive tumour in only 3.5 % of men.

Functional multi-modality MR imaging includes high resolution MR imaging (1a), dynamic contrast-enhanced (DCE) MRI (1b), MR-spectroscopy (MRS) (1c), and diffusion weighted MR imaging (DWI) (1d). With functional multi-modality MR imaging, it is possible to detect and exactly localize the tumour in the prostate with more than 90% accuracy. DCE-MRI gives more information regarding the

perfusion of the prostate and the tumour. In prostate cancer, there are more blood vessels (and above all more leaky blood vessels) by which the tumour receives more blood and therefore shows more and earlier contrast enhancement. MRS provides quantitative information about choline (elevated in tumour) and citrate concentration (often depressed in tumour) in the prostate. DWI-MRI allows visualization of the amount of free-moving water molecules in tissue; in a tumour, this movement is diminished.

### Local Staging

Although a large number of men above age 50 will develop prostate cancer, only in a small proportion of patients will their tumour become aggressive. For the majority of men with non-aggressive tumours, one can delay invasive treatment until the tumour becomes aggressive (watchful waiting). It is essential to precisely characterize the tumour. This can be achieved with multi-modality MRI.

With nomograms based on the serum PSA-value, the tumour's aggression (expressed in Gleason grade), and the outcome of a digital rectal examination, an attempt is made to predict (1) the aggression and local extension of the tumour, and (2) the presence of lymph node metastasis. Based on these nomograms, the further treatment strategy is determined. Unfortunately, these nomograms are only moderately reliable, so that it is not always possible to make the right treatment decision. By means of functional (multi-modality) MR imaging, information can be acquired regarding the aggression of the tumour. Furthermore, an MR-examination, performed at high field strength (3 Tesla) with use of an endo-rectal coil (ERC), allows a very accurate determination of minimal (sub-millimeter) extraprostatic

spread. The sensitivity and specificity of 3T ERC MR imaging for determination of extra-prostatic disease are respectively 87% and 96%<sup>3</sup>. If it is decided to surgically remove the prostate, it is important to know where the tumour is located and whether it shows extra-prostatic growth. If the tumour is distant from the neurovascular bundles, these bundles can be spared. This decreases the chance of post-operative impotence. If the MRI shows obvious extra-prostatic extension, it can be concluded that surgery is less useful so the best choice is hormonal therapy with or without radiotherapy.

Nowadays, prostate cancer is increasingly treated with directed, local radiotherapy. If the precise location of the tumour is known, it is possible to give a local boost to this location in the prostate. This has the advantage that less radiation is given to the surrounding tissue, with fewer side-effects. An MRI can supply this information.

### PSA Recurrence

If there is a PSA rise in a treated patient, the most important question is: is this the result of a local recurrence, or is it caused by lymph nodes or bone marrow metastases? MRI also has a role in this situation:

⇒ First, bone metastasis can be excluded by means of a 'whole-body' MRI.

⇒ If this is negative, then Combindex MRL should be used to exclude node metastasis.

In post-treated patients, we found no correlation between PSA value or PSA doubling time and positive nodes. There was, however, a positive correlation between PSA velocity and positive nodes on MRL. Thus, even in patients with a low PSA, but high PSA velocity, a MRL is of use to exclude metastases.

Finally, multi-modality MRI can be performed to determine if there is a local recurrence.

**General Disclaimer** This newsletter is providing news, information, personal memoir and opinion about prostate cancer. It also reports, quotes and cites published medical views and research findings about prostate problems. Anyone who wishes to embark on any dietary, drug, exercise or other lifestyle change intended to prevent or treat a specific disease or condition should first consult with and seek clearance from a qualified health care professional.