The annual Prostate Cancer Support Federation conference took place on Wednesday 13th April 2011 at the University of Manchester. The theme was “Clinical Trials – Hope for the Future” and covered:

- Treatment of hormone refractory disease,
- Developments in external beam radiotherapy,
- Developments in focal treatments of early stage disease, and,
- Risk based detection.

It was an information packed day well supported by approx 80 members from around the country.

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Continued from page 1

Prof Ken Muir kicked off the day with a risk-based alternative to population screening. He emphasised how the progress of the PCSF funded RISMAN trial has been good but ideally 60 GPs would be needed to run the trial for four years. This trial is more of a process and will evolve over time.

Genetics will play an important role in the future, as there is a predisposition of prostate cancer related to breast cancer, both hormone driven. The RISMAN table will be adjusted and improved upon with genetics being taken into account. Of course cost will be key, but some 78% of GPs asked were supportive of this trial. Exciting developments ahead but as usual prostate cancer awareness is so important.

The second speaker Miss Louise Dickinson from UCL talked about focal therapy.

HIFU (High intensity focused ultrasound) used to be used as “salvage” treatment after conventional treatment had failed to eradicate the disease. It is now sometimes being used as a first line treatment in patients who are deemed suitable although there is some resistance to this and is not a current standard therapy.

At present after PSA testing a patient may be offered a TRUS biopsy (if the PSA is high or other symptoms are present). This test is not 100% accurate. Approx one in three men are told they are cancer free when in fact they are not. This is because the 12-20 cores taken may indeed be normal, the cancer cells present may have just been missed. In HIFU patients a mapping biopsy is carried out under a general anaesthetic, image guided where some 40-50 cores are taken, making it unlikely to miss all the rogue cells present.

Other focal treatments include:

- Cryotherapy which uses freezing instead of heat.
- PDT – Photo Dynamic Therapy using light
- Brachytherapy – the implantation of radioactive seeds under general anaesthetic
- Radiofrequency Ablation
- Cyberknife – a new focal therapy
- Laser in its early stages of use is a potential future option.

To summarise the HIFU study:
- It encourages genito-urinary erectile function
- Is cancer control acceptable
- Can be repeated
- Is a day case treatment

In the future MRI may become a good method of follow up and imaging may possibly replace biopsy – encouraging!

We had a welcome lunch break which was delicious. Unexpectedly we were greatly entertained by the FOPS who were two friends from the support group, Friends Of Prostate Sufferers. They played and sang prostate related ditties which were very amusing! Light relief after information overload!

The afternoon session began with Prof Paul Symonds whose topic was ‘Developments of External Beam Radiotherapy’. He explained how radiotherapy is the art of using ionising radiation to destroy tumour tissue, although it is still poorly understood. It can be used radically with the hope to cure or as a palliative treatment to improve or suppress systems such as bone pain. Unfortunately in some cases there may be the risk of late damage (pelvic inflammatory disease) to the bladder, rectum, colon or small bowel.

A complication of radiotherapy is that it increases the risk of rectal / bladder cancer after ten years.

External beam radiotherapy versus Brachytherapy gives a similar survival rate in early stage disease. There is a good long term survival in higher risk local disease, with a low complication rate and it is useful for palliative bone metastases.

A trial in progress is monitoring radical surgery followed by radiotherapy. There is a 20 year survival rate though many of these patients would have had no recurrence anyway.

The last speaker of the day was Prof Nick James from the University of Birmingham. His talk was ‘Developments in Treatment of Hormone Resistant Prostate Cancer’.

- Systemic therapies used for node positive disease (advanced prostate cancer).
- The natural history of metastatic patients: Zoladex – Casodex - Chemotherapy - Death.
It takes two to three years to become hormone refractory with the average survival rate being one and a half to two years. However, treatments have now improved.

One hundred and fifty patients were found who had had three rises of PSA with noticing metastases, some are now surviving for ten years or so.

Consideration for 2011

Patients can be given chemotherapy early if life expectancy is thought to be five years plus.

Chemo drugs being Cabazitaxel (a potential new drug) and Docetaxel. Two trials are ongoing at present:

- French trial
- STAMPEDE trial

The STAMPEDE trial is the ‘systemic therapy in advancing metastatic prostate cancer evaluation of drug efficacy’. This is a six arm trial of some 2000 men. Unfortunately, two arms of the trial have been discontinued as they have were not proving beneficial. There is the possibility of new drugs such as Cabazitaxel and Danusabib being introduced.

Abiraterone Acetate has been getting good press and encouraging outcomes are being monitored. Having completed it’s third stage trial, it is expected that it will receive it’s license, for men who have had chemotherapy, in the Autumn of this year. See article on page 6

In conclusion a very worthwhile and enjoyable conference that I would recommend to anyone.

Either Called "Chemobrain" or "Chemofog," the Long-Term Chemotherapy-Induced Cognitive Decline in Cancer Survivors Is Real


AA Argyriou, K Assimakopoulos, G Iconomou, F Giannakopoulou, HP Kalofonos

Abstract

Context: In recent years, there is growing evidence in the medical literature to support an association between administration of commonly used chemotherapeutic agents and an increased risk for cognitive impairment.

Objectives: We herein critically summarize data relating to the pathophysiological mechanisms by which chemotherapy may induce cognitive impairment in patients surviving from solid tumors. The clinical and epidemiological characteristics and the proposed management strategies to counter chemotherapy-induced cognitive impairment (CICI) also are presented.

Methods: References for this review were identified by searches of PubMed from 1995 until December 2009 with related terms.

Results: Both the pathogenetic mechanisms and the overall clinical nature of CICI remain vaguely defined. Findings indicate that CICI is a relatively common event that, in most of the cases, remains underdiagnosed, thereby adversely affecting the quality of life of patients with cancer. Effective pharmacological interventions toward the symptomatic or prophylactic management of CICI also are lacking.

Conclusion: Either called “chemobrain” or “chemofog,” the long-term CICI in cancer survivors is real. The need for multidisciplinary care interventions toward a timely diagnosis and management of CICI is clearly warranted.

The editor would like it noted that he is definitely not suffering from this condition.
Setting Research Priorities
Sandy Tyndale-Biscoe

The James Lind Alliance (JLA) is an independent organisation funded by the National Institute of Health Research and Medical Research Council, UK, whose role is to facilitate an independent and integrative approach to determining both patients’ and clinicians’ views on setting the research agenda, by a process known as “priority setting”. Some two years ago, at the request of the Federation and the Prostate Cancer Research Foundation (now Prostate Action), they set up a Priority Setting Partnership which had the ultimate objective of identifying the Top Ten unanswered questions about prostate cancer, as assessed by patients and clinicians. The faith is that research funders will take these priorities into account when awarding funding to researchers. The programme completed last October and we are the first to publish the results.

What we did

There were six steps in the process, which in all took about 2 years to complete. In Step 1, a call was put out to attend an initial meeting at which stakeholders (both clinicians and patients) were invited to participate in the programme by submitting items of uncertainty. Over 30 individuals and organisations were represented at this meeting. Step 2 was the “harvesting” of putative uncertainties. Stakeholders consulted their own constituencies (e.g. clinical organisations, or patient support groups) and then submitted details of their key concerns about prostate cancer. About 250 such raw uncertainties were submitted by stakeholders.

As might be expected, there were many duplications in this harvesting process, not all the submitted items met the criteria of uncertainty (unknown but knowable), and not all of them were expressed in the form of a question that a research programme could be designed to answer. Step 3 was a consolidation process that resulted in a final list of 134 validated uncertainties, which, in Step 4, was sent to all stakeholders, with an invitation to choose their ten most important items (the “initial vote”). Responses were received from over 40 organisations and individuals.

In Step 5, the results of the initial vote were consolidated to reduce the list of uncertainties to one (the “Top Thirty”) that would be manageable in Step 6, the Final Stakeholder Meeting. Some amalgamation of items was carried out in order to overcome uneven “clumping”, where some topics had a number of uncertainties proposed, all sufficiently different to justify keeping them separate, whilst others, sometimes believed to be equally important to responders, had only one or two. This was skewing the results in favour of those topics with fewer items.

In the Final Meeting (on 4th October last year) approximately 30 individuals, representing clinicians and patients (mostly the latter but clinicians were well represented) sat down together to reach consensus on the ranking of the Top Thirty, and agreed a list of the Top Ten items. Two separate teams (selected at random and re-shuffled half way through) achieved a remarkable consensus over the day, separately nominating exactly the same top seven items. In the subsequent discussions, a very quick agreement was achieved on the ranking of all the Top Thirty items.

The final list

The final “Top Ten” list (actually eleven, as four items tied in 8th place) are:

1. How can over-treatment for prostate cancer be prevented by identifying and excluding the treatment of harmless tumours? This item was only 10th in the initial vote (Step 4, above), which raises the question of whether the possibly more informed members of the final workshop “undemocratically” skewed the result. And if so, would that be a bad thing? The fact that this item emerged as the most important issue that faced prostate cancer patients and clinicians is, though, deeply significant; it represents an awareness amongst both patients and clinicians that it is the single issue that stands in the way of widespread early detection through some form of screening, and the desire by both groups to end the appalling death rate that seems to stem from the absence of such a programme. The importance of this issue is emphasised by the fact that another item (8c) with similar intent, but different emphasis1 also made the Top Ten.

2. Is there a genetic marker for prostate cancer that would be both more sensitive and more specific than PSA serum level? This item was also ranked 2nd in the initial vote, and its ranking suggests a consensus, again, that testing for early stage disease is the key to reducing mortality. The high ranking of these top two items reflects an awareness that what has to be done to fix the prostate cancer problem is to increase early detection. It is poignant to think that for all the patients involved in this priority setting exercise, developments in these areas will be too late to benefit them.

3. What can be done to delay or prevent the onset of hormone independent prostate cancer? This ranked 6th in the initial vote. Its position high on the list reflects the fact that, after improving early detection, the best chance of reducing the death rate is to delay, or make less lethal, the final stages of the disease.

4. Are there any dietary measures that can prevent prostate cancer or slow its progression? In the initial vote, this was the top item by a large margin, achieving a 20% higher score, and nearly 50% more votes than the nearest item (Item 2 above). It is, of course, known to be a favourite area for patients. The issue’s demotion to 4th by the final workshop is possibly a recognition that research in this area is notoriously difficult to get funded and even more difficult to do in a way that will satisfy the EBM2 police.

5. Does serial PSA measurement in patients with prostate cancer accurately monitor disease progression? This was 3rd in the initial vote. It is not

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1 I cannot see a real difference. Perhaps these should have been merged.
2 EBM: Evidence Based Medicine
about screening, but refers to the use of PSA as a follow up in Active Surveillance and Watchful Waiting, and as a monitor for disease recurrence after curative treatment. Its appearance so high in the list came as somewhat of a surprise, and clearly reflects uneasiness amongst patients and clinicians that disease progression or recurrence is not always being spotted through PSA monitoring.

6. Would prostate cancer screening targeted at high risk groups, i.e. those with positive family history, and ethnic minorities with higher rates, improve the outcomes of treatment in these groups? This item ranked 7th in the initial vote. It is the only screening related issue that made the Top Ten, which, bearing in mind the well documented enthusiasm for population-based screening amongst patients, is perhaps surprising, but it probably represents a recognition that Hell is going to freeze over before the Department of Health agrees to full screening. This item’s presence in the Top Ten is good news for the Federation, as prime sponsors for the RISKMAN Trial, as it directly addresses this question.

7. Does active surveillance work for treatment of prostate cancer? This item is one of the few surprises that emerged from the Final Workshop, as it ranked only 24th in the initial vote. Without a transcript of the proceedings at the workshop it is not possible (and beyond your reporter’s powers of memory) to establish what caused such a spectacular (but unconscious – the rankings from the initial vote were hidden) promotion, but it is likely to be due to a recognition of the fact that Active Surveillance, if it works, could reduce over-treatment, and so weaken the anti-screening argument. But the protocols of Active Surveillance are not well established or standardised, and until they are, there must be doubt about its efficacy.

8a. Is there a vaccine that can prevent prostate cancer? (8th equal) This item, which ranked 15th in the initial vote, nearly never made it to the list at all. The strict ground rules for the process were that items had to be treatment uncertainties. Because of the particular difficulties surrounding prostate cancer, this was expanded to allow any issue that is an intervention, and on the grounds that refusal of a PSA test to a symptomless man is the denial of an intervention, and is generally attributable to the ignorance or bias of GPs, this item was admitted to the original list of 134 uncertainties. The fact that it made even the Top Thirty is a reflection of how strongly both patients and specialist clinicians feel that GP education is a top priority. Indeed it was a conclusion of the Great PSA Debate.

8b. Do variations in GP awareness of prostate cancer affect outcomes? (8th equal) This item, which ranked 15th in the initial vote, nearly never made it to the list at all. The strict ground rules for the process were that items had to be treatment uncertainties. Because of the particular difficulties surrounding prostate cancer, this was expanded to allow any issue that is an intervention, and on the grounds that refusal of a PSA test to a symptomless man is the denial of an intervention, and is generally attributable to the ignorance or bias of GPs, this item was admitted to the original list of 134 uncertainties. The fact that it made even the Top Thirty is a reflection of how strongly both patients and specialist clinicians feel that GP education is a top priority. Indeed it was a conclusion of the Great PSA Debate.

8c. Are there any non-intrusive diagnostic tests that will identify aggressive prostate cancers whilst not identifying harmless cancers? (8th equal) This item was also “picked out from the ruck” in the initial vote, where it ranked down at 17th. As explained above, it is only subtly different from Item 1, and perhaps if the Final Workshop had had more time, it would have not been in the list.

8d. What is the effectiveness of new treatments for prostate cancer such as High Intensity Focused Ultrasound and Cryotherapy? (8th equal) Apart from Item 3 above, this is the highest ranked item that directly addresses treatment, and it is the only one that concerns primary treatment. Perhaps this reflects a belief amongst both patients and clinicians that, although there is undoubted potential for improvements in the standard treatments, in terms of both outcome and side-effects, such improvements will be marginal at best, and the main area of hope for such improvements lies in these new areas.

Things left out

Obviously, the eleven (ten, really) items listed above do not cover the entire range of important questions about prostate cancer, and every reader will react with his own “but what about …?”. Significantly, screening (except in the risk-based form) is not there, and nor, to this reporter’s intense disappointment, is there anything about sex, or, indeed anything about reducing the other side-effects of treatment. A significant item that was discussed at length, but which finally didn’t make the Top Ten was “Can needle biopsy of the prostate cause cancer to spread?”. Indeed. An intriguing issue that often crops up and made it to the Top Thirty, but not the Top Ten was “Does having had a vasectomy increase my risk of prostate cancer?”.

The challenge - get the results used

The results of the priority setting programme will be published shortly in appropriate medical and research journals, and sent directly to research funders, in the hope that they will be taken into account in their funding decisions. But we need to do more, and the Federation will be active over the next year, asking difficult questions of the various funding bodies who have not already signed up (in a sense) to this exercise. Some encouragement can be taken from the following quotes:

Emma Malcolm of Prostate Action, says: “Now that we have a top 11 treatment uncertainties our next priority will be to get the list to as many prostate research funders as possible, so we can start to influence the research agenda, in addition to looking at how we can use the list to influence our own research. This may not be a quick process, but we must ensure that these questions are answered.”

Helen Rippon of The Prostate Cancer Charity (who was on the Steering Group for the work) says: “The Prostate Cancer Charity is delighted to have participated in this important project; we believe strongly that research should be led by the needs of men affected by prostate cancer and that research funders have an obligation to identify and understand these needs. We will use this list to inform our own investment in medical research and hope that other funders can be persuaded to do so too.”
We believe that education is crucial to beating prostate disease and the damage it can cause to people's lives. That's why we run free one day Masterclasses for all primary healthcare professionals.

We select the top speakers from around the country and local to the venues. The full day's programme provides delegates with six hours free CPD for attending. Delegates are encouraged to engage in debate with the speakers and their local peers and colleagues by submitting questions and common issues before the Masterclass and raising further ones during the day.

The programme has recently been reworked to give an even greater emphasis to the practical issues of dealing with patients and their families in primary care. Our close ties to the research community (which we fund and develop through our grants programme) mean we have access to the latest discoveries and techniques relating to treatment. We combine this with the practical knowledge gained from talking to GPs and patients all over the country to provide a complete overview of prostate disease.

Upcoming Masterclasses

Plymouth, The Plymouth Holiday Inn, 20 May 2011
Oxford, St Hilda's College, 22 July 2011
Brighton, The Metropole Hotel, 16 September 2011
London, The Institute of Physics, 18 November 2011
Ipswich, The Ipswich Conference Centre, 27 January 2012
Belfast, The Hilton Templepatrick, 23 March 2012

Ideally, we would like to have two representatives from the local support group at each event

How to register
Bookings for Masterclasses are managed by Expotel.
You can book via their website:  
http://tinyurl.com/6k9ppar

or by getting in touch with them by post:

Expotel Events
St James House
192 Wellington Road North
STOCKPORT
SK4 2RZ

Telephone booking line: 0845 054 8422

Abiraterone Works In Most Prostate Cancer Subgroups

The investigational drug Abiraterone Acetate significantly improved outcomes in metastatic castrate-resistant prostate cancer in virtually every study-defined patient subgroup. Of 16 patient subgroups, a survival benefit with abiraterone was observed in 15. Only in patients who had an Eastern Cooperative Oncology Group (ECOG) performance status of 2 did treatment with abiraterone fail to show a significant difference, Howard I. Scher, MD, chief of the genitourinary oncology service at Memorial Sloan-Kettering Cancer Center, in New York City, said at the 2011 ASCO Genitourinary Cancers Symposium. Overall survival the primary endpoint of the study had been previously presented at the European Society for Medical Oncology in Milan last October.

The detailed subgroup analysis showed:

- 15.4 month overall survival among patients on abiraterone who had taken one previous line of chemotherapy, compared with 11.5 months for those on placebo, a 37% relative risk reduction (95% CI 0.51 to 0.78)
- 14.0-month overall survival among patients on abiraterone who had taken two previous lines of chemotherapy, compared with 10.3 months for those on placebo, a 26% relative risk reduction (95% CI 0.55 to 0.99)
- 15.3 month overall survival among patients on abiraterone with ECOG performance status of 0-1, compared with 11.7 months for those on placebo, a 36% relative risk reduction (95% CI 0.53 to 0.78)
- 7.3 month overall survival among patients on abiraterone who had an ECOG performance status of 2, compared with 7.0 months for those on placebo, a 19% relative risk reduction (95% CI 0.53 to 1.24).

Dr. Scher also reported significant differences in time to pain breakthrough, time to PSA progression, time to radiographic progression, and in PSA response.

While most of the data was presented in Europe, Oliver Sartor, MD, medical director of the Tulane Cancer Center in New Orleans and co-moderator of Scher's session stated that the new information on subgroups was encouraging.

Breaking News!
On July 29th, the US FDA approved the use of Abiraterone for Castration-Resistant Prostate Cancer. NICE is expected to follow suit!
We have decided to invite the companies who supply treatments for Prostate Cancer put their point of view as to why their treatments are beneficial. Over the next 4 issues we hope to have a series of articles for different treatments and this is the first, from our sponsor Galil Medical. We emphasise that the Federation does not endorse or promote the suitability of any particular treatment for a patient. However, we firmly believe that any decision regarding treatment has to be made by the patient, informed by knowledge and material given through the information booklet Knowledge Empowers and articles produced in Prostate Matters, and working with his consultant, who will be able to advise on the suitability of that type of treatment for that particular patient.

A clinically proven, minimally invasive, radiation-free cancer treatment that protects your quality of life.

Cryotherapy is a minimally invasive treatment (no incisions) that uses extremely cold temperatures to kill cancer tumors. Cryotherapy is widely used around the world and has over ten years’ clinical experience to support its safety and effectiveness. It is recognized by the American Urological Association and the European Association of Urology as a treatment for prostate cancer.

Since prostate cancer treatments have similar survival rates, side effects and quality of life are important considerations when choosing your treatment.

What can I expect from this treatment?

A prostate cryotherapy procedure usually takes between 90 minutes and 120 minutes. Prostate cryotherapy can be performed on an outpatient basis. This may mean that you do not need to stay in hospital for more than one nights stay or maybe even only a few hours after your treatment and (dependant on independent cases).

You will have a drainage catheter left in place for a few days until you are able to urinate. You will be shown how to manage the catheter before you return home.

Will life return to normal?

Cryotherapy does not involve invasive surgery, therefore most patients are able to return to work and an active lifestyle once they no longer need their catheter- typically within one week or less. You can resume sports and activities usually between a week or two after your procedure.

Will this treatment impact on my sex life?

Your doctor may have explained that ALL curative treatments for prostate cancer can affect a man’s ability to obtain or maintain an erection. This risk may seem daunting, but it is important to remember that there have been significant advances in medication and other aids to help men whose natural ability to obtain an erection is lost or reduced.

What other factor affect my quality of life?

A recent study looked at how different prostate cancer therapies affect their patients’ health-related quality of life (QOL). They identified urinary symptoms as one of the factors which have an impact on patients’ quality of life. Frequent visits to the toilet during the day are inconvenient and can be embarrassing, while at night, they lead to disturbed sleep patterns for patient and spouse.

This study showed that cryotherapy patients experienced urinary problems immediately after the procedure, but patients recovered quickly reaching 97% of their pre-treatment/baseline QOL score within 12 months of their treatment. These patients went on to exceed their baseline score at 36 months.

In other words, their urinary symptoms improved after cryotherapy.

For more information on prostate cryotherapy treatment including focal and salvage treatments--please contact Lizzie Bennett at Galil Medical on: 
01293 459848 or lizzie.bennett@galilmédical.com

Prostate cancer is the most commonly diagnosed cancer and the second most common cause of cancer death in men. The widespread use of PSA testing has contributed to a dramatic increase in the number of men undergoing transrectal ultrasound (TRUS) guided prostate biopsies. Data from the US suggests that more than 1.2 million needle prostate biopsies are performed each year.

TRUS was introduced in 1968 as an imaging tool to assist in the diagnosis of prostate cancer. TRUS allows biopsies to be accurately guided towards the peripheral zone where cancers predominate therefore achieving reasonable sampling of the prostate. It has a sensitivity of 39-52% and specificity of 82%. Additionally it carries low morbidity and can be performed in the office setting. Hence, systematic TRUS-guided prostate biopsies remains the gold standard for detecting prostate cancer. However, a limitation of this technique is that men with an initial negative biopsy are often found to have subsequent prostate cancer. Almost a quarter of prostate cancers are identified after an initial negative biopsy. Furthermore, the cancer detection rate decreases with increasing number of biopsy sessions, with yields of 10–20% for the second biopsy and below 10% for subsequent biopsies. Repeated TRUS-guided biopsy results in sampling of the same prostate areas and other potential tumour sites can be missed. Whether to pursue further repeat TRUS-guided biopsy for patients with a rising PSA level following an initial negative biopsy is a common clinical dilemma and remains a diagnostic challenge. Therefore, to address this important dilemma, transperineal template prostate biopsy (TPTPB) technique has recently been developed.

TPTPB is a specialist technique which utilises many of the steps that are undertaken in performing brachytherapy. It is a general anaesthetic day-case procedure which takes approximately 30 minutes to perform. In order to visualise the prostate a cryoprobe is placed trans-rectally. It is essential to keep the probe stable in position, hence, the need for a stepper which is attached to the theatre table. This allows the taking of biopsies systematically from the anterior, mid and posterior aspect of the prostate from the apex to the base both on the right and left. Recent developments in MRI, such as diffusion weighted, has demonstrated that patients with rising PSA despite previous negative TRUS guided prostate biopsies may harbour prostate cancer in the anterior apical area of the prostate. This is an area that can not be reached by TRUS biopsies but is easily accessible by TPTPB.

We have now performed more than 80 such procedures in Leicester. In our experience; 70% of patients have been diagnosed with prostate cancer. Furthermore the procedure is well tolerated and associated with minimal morbidity. The procedure has enabled us to diagnose prostate cancer at an earlier stage in a difficult group of patients, the majority of whom would previously have been diagnosed with advanced disease where treatment with curative intervention would not have been possible.

TPTPB requires specialist equipment such as the stepper and cryoprobe which are not inexpensive. Hence; we are, therefore, grateful to our local prostate support group, PROSTaId for their generosity in purchasing the necessary equipment without which it would not have been possible to perform TPTPB.