

prostate matters

Newsletter of the Prostate Cancer Support Federation  Issue 10 Autumn 2010

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Worried or concerned about prostate cancer?

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Prostate Cancer Support Federation Workshop “Prostate Cancer Research – Patients Lead”



The Prostate Cancer Support Federation presents a cheque for £27,100 to Prof. Ken Muir, for the commencement of the Riskman Free to Total Trial.

The Prostate Cancer Support Federation held its third autumn workshop at the University of Warwick on 10th November. The event, chaired by **Sandy Tyndale-Biscoe**, was kindly sponsored by Prostate Action. It was well attended by 50 people representing 19 member organisations.

The theme of the day was prostate cancer research, with the emphasis on how patients' organisations, such as the Federation, can influence the direction of research and indeed initiate it. In this context the main topic, and indeed the whole of the morning session was devoted to the RISKMAN risk-based screening trial that is being run by Prof Kenneth Muir of the University of

Warwick, and for which members of the Federation have provided the initial funding.

The day was opened by the Federation's medical advisor, **Mr David Baxter-Smith**,

consultant urologist, and the leading light behind the nation-wide PSA testing sessions organised by the Graham Fulford Charitable Trust. In an amusing and informative talk he compared the early diagnosis situation for prostate cancer with that of other cancers. He went on to introduce the nomogram-based approach of RISKMAN, and reviewed some of the new tests for indications of prostate cancer. In a toe curling description of the process of a



Sandy Tyndale-Biscoe

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PCSF's AGM and Annual Conference - April 13th 2011, at The University of Manchester. Conference Theme: Getting future treatment now - clinical trials for prostate cancer

NEWS LETTER SPONSORED BY
Treatments for Prostate Cancer through Cryosurgery





Mr. David Baxter-Smith

prostate biopsy, he provided a graphic illustration of the key objective of the trial, which is to show that as many or more dangerous, early-stage, prostate cancers can be found whilst subjecting many less men to unnecessary biopsy.

Prof Muir introduced the RISKMAN trial summarising the epidemiological background. He rehearsed the over-treatment objection against conventional population screening and explained the advantages and costs of risk-based approach in making the decision to proceed to biopsy. The efficacy of this approach is already scientifically proven. What is not known is whether it will work in a population screening context. The trial will answer this by recruiting a number of GP practices to invite their eligible patients to be screened with a PSA Test. Practices will be randomised to use either a risk-based approach to handling the results or the standard approach (as recommended by Dept of Health). He then outlined the factors that would be weighed up to establish a man's risk of having dangerous disease, using the Sunnybrook prostate cancer calculator. A key question that has to be resolved is what is the level of risk that



Professor Ken Muir

should lead to biopsy? In a straw poll in the room, a figure of between 5% and 10% seemed most popular. Warwick University are conducting a public poll to establish an acceptable figure.

Prof Muir went on to review the current status of the trial, which is that, thanks to the seed-corn funding provided by Federation members (a total of over £27,000 has been raised) the basic protocols are being developed, the trial has been accepted in principle by the NCRI, and a number of their reservations and questions have been resolved. GP Practice recruitment will commence early in 2011 and is expected to be complete by 2013. A crucial issue is: how enthusiastic to participate will GPs' practices be?

To help answer this question, next up was **Dr Nigel Cole** a GP from Litchfield. He explained that he is the only male doctor in his practice and therefore has a particular interest in men's health. It is his experience that most men only see their GPs as a result of pressure from their wives, after get-

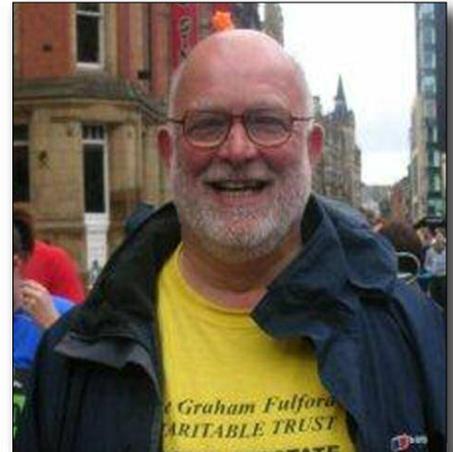


Doctor Nigel Cole

ting muddled information from magazines, internet etc. Attendance at well men clinics is patchy and, historically they do not address prostate issues. Furthermore, prostate cancer represents a particular problem because of variations in clinical practice, patient preferences etc. He compared the situation with other regular checks, for example cholesterol, where risk assessment factors lead to GPs being better placed to advise on results. A further example of where the approach would be useful is in advising patients who come back after referral to discuss what the consultant has said.

He noted that the risk-based approach depended on an assessment of a digital rectal examination; here experience is important. In his view, nurses are more likely than GPs to follow guidelines strictly, and would be better. Patients would probably be happy with that.

In general, Dr Cole was all for the trial, and believed that knowledgeable GPs would wish to participate. However, this is not the case for all GPs, and patients groups will need to push their practices to participate.



Graham Fulford

As the final speaker in the morning session, **Graham Fulford** gave a short review of the funding situation for the trial. Thanks to the very generous response to his appeal to Federation member organisations, the costs of the start up work (about £30,000) are secured, and this should keep things going until next spring, at which point the first GP practices will be recruited. For next year, a further £100k will be needed. Subsequently, the bill will rise to about £2M, and we will need to approach the major funders. There is good confidence that this can be raised, particularly as "matched funding" is an important principle to funding organisations, and, by factoring in the notional cost of work already done by Mr. David Baxter-Smith (at no actual charge), the Trial team can exploit the "investment" already made.

Federation members are invited to lobby the trustees of major charities, for example the Prostate Cancer Charity, for funding.

Finally Prof Muir emphasised the importance of risk-based screening being evaluated in the context of a ran-

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domised control trial; he asked that Federation members contain their impatience to get things moving outside the trial as too many practices taking up the idea of risk-based screening would muddy the waters, and not move us anywhere towards changing clinical practice.



Emma Halls

At the start of the afternoon session, **Emma Halls** introduced herself as the Chief Executive of Prostate Action, the new charity resulting from the merger of Prostate UK and the Prostate Cancer Research Foundation. Both these organisations have historically concentrated on prostate research and this led to the initiation, 2 years ago, of a research priority setting programme for prostate cancer, run by the James Lind Alliance, in which patients and clinicians came together to identify the key priorities for research about the disease. The programme is now complete, and a list of 31 “uncertainties”, that is things about the disease that are known to be unknown, but knowable, has been identified, and prioritised. At a meeting attended by a representative group of patients and clinicians, the top 11 such uncertainties were agreed and ranked, and these were presented, in random order, to the Workshop. As the plan is to publish this work in a major international medical journal, details cannot yet be published, but it was noteworthy that the audience agreed that the list covered all the ‘burning questions’. It was noted though, that the emphasis was very much on the early stages of the disease.

The Federation hope to publish the results in full in the Spring edition of *Prostate Matters*.

Turning to on-going research, and the latest results, **Dr Clare Allen**, a radiologist

from University College London, gave a fascinating review of the latest

developments in MR imaging of prostate cancer, making the point that, compared with other conditions, prostate cancer is very much the poor relation. Huge amounts of imaging time and expertise are spent on sore knees, but it is quite rare for a prostate tumour to be examined. Instead there is a rush to the crude, invasive and often inaccurate process of biopsy. In her words, the “biopsy cart comes before the imaging horse”. Indeed this is spectacularly the case where a biopsy performed within the past few weeks can completely destroy the utility of an MRI scan.

With the aid of some convincing images Dr Allen showed how more aggressive cancers are often more easily detected by MRI than by biopsy, and predicted a time when biopsy would only be performed after an MRI scan has detected and located a potentially dangerous cancer. As a monitoring tool as part of an active surveillance programme, a regular MRI scan would be both cheaper, and very much more acceptable to the patient.



Doctor Clair Allen

There are some obstacles to this. Apart from overcoming the prejudice against MRI as a prostate cancer diagnostic, there is a need for specialist analysts. At present it is more a case of someone who’s done all the knees for the day and now does the last one, a prostate.

The final presentation of the afternoon was given by **Gunter Kuhnle** from the Department of Food and Nutritional Sciences at the University of Reading, in which he reviewed the hard evidence



Gunter Kuhnle

for the impact of diet and nutrition on the risk of contracting, and ability to recover from, prostate cancer. In particular recent research is comparing cancer outcomes with actual measured levels of the ingredients concerned (lycopene, etc), rather than a man’s reported consumption of the relevant food. As ever, the evidence is equivocal, and many of our favourites turn out not to display any measurable benefit across large populations. He summarised the situation with the following result from the World Cancer Research Fund’s 2007 report on Food, Nutrition, Physical Activity and the Prevention of Cancer:

FOOD, NUTRITION, PHYSICAL ACTIVITY, AND CANCER OF THE PROSTATE		
In the judgement of the Panel, the factors listed below modify the risk of cancer of the prostate. Judgements are graded according to the strength of the evidence.		
	DECREASES RISK	INCREASES RISK
Convincing		
Probable	Foods containing lycopene ^{1,2} Foods containing selenium ¹ Selenium ³	Diets high in calcium ^{4,5}
Limited — suggestive	Pulses (legumes) ⁶ Foods containing vitamin E ¹ Alpha-tocopherol ⁷	Processed meat ⁸ Milk and dairy products ⁵
Limited — no conclusion	Cereals (grains) and their products; dietary fibre; potatoes; non-starchy vegetables; fruits; meat; poultry; fish; eggs; total fat; plant oils; sugar (sucrose); sugary foods and drinks; coffee; tea; alcohol; carbohydrate; protein; vitamin A; retinol; thiamin; riboflavin; niacin; vitamin C; vitamin D; gamma-tocopherol; vitamin supplements; multivitamins; iron; phosphorus; zinc; other carotenoids; physical activity; energy expenditure; vegetarian diets; Seventh-day Adventist diets; body fatness; abdominal fatness; birth weight; energy intake	
Substantial effect on risk unlikely	Beta-carotene ⁹	

NORFOLK AND WAVENEY PCSG SPREADS THE WORD!

by David Haines - President

Two years ago we decided to step up our Awareness and Information campaign across Norfolk, after having had several worrying instances brought to our attention.

Many comments were made from men who had been refused a test by their G.P. In several cases this had occurred, even when there was a family history of Prostate or Breast Cancer, or both. The feed-back included such comments as "I wish we had known about the PSA test earlier", this from bereaved wives and partners, and the fact that over 50% of our audiences had no knowledge at all about Prostate Cancer, nor indeed where the gland was located and what its function was.

We referred these comments to our local PCTs, Urology Departments, local M.P.s and the then Health Minister, where they were treated with some scepticism, disdain, and polite comment. As a result our Chairman, Ray Cossey, and the Committee agreed that a more practical, hands-on campaign was called for.

We set out to arrange a programme of public meetings, offering free PSA tests. After contacting Kidderminster PCSG, for more information, we were referred to the Graham Fulford Charitable Trust, and to David Baxter-Smith. As our aims were similar, we decided to join forces adding a voice from the East of England, but using our own funds and organisational skills. We arranged a series of meetings in the Centre, East, and North West of Norfolk, where the largest population centres are located. We had raised sufficient funding to allow us to undertake 250 tests at each meeting.

We were able to solicit the voluntary help of a team of eight phlebotomist-nurses, and the co-operation of the Pathology Department of the Norfolk & Norwich University Hospital. David Baxter-Smith gave us his unstinting support and attended each meeting to explain to our audiences, in his inimitable way, the pros and cons and necessity of PSA testing and early diagnosis, together with his valuable oversight of the medical aspects of Prostate Cancer. Our latest meeting in Fakenham, last month, was our most successful to date, when donations from those present exceeded £2,000, which greatly helped to defray our costs.

There was an overwhelming response to each meeting, with over 700 applications for our first event: both of the other events were also greatly over-subscribed. Those men we could not absorb were sent information leaflets and advised to consult their G.P. for a PSA test. We explained that under DoH guidelines, every man over 50 should be given a PSA test, if he requests one from his G.P. They were asked to advise us if they met with refusal.

The results from the over 700 men now tested, so far indicate a higher than average incidence of Prostate disease in this area, and more tellingly, the local hospital Urology Departments have told us of an increase in referrals over the same period in excess of 20%! This has, of course, increased the workload on local Pathology and Radiology Departments, and to help alleviate this situation, we have funded an additional state-of-the-art Bladder Scanner, at a cost of £8,000 and also contributed a further £5,000 towards the cost of diagnostic equipment for Prostate Cancer.



A job well done, the Norfolk phlebotomist-nurses team take a breather with David Baxter-Smith, and Ray Cossey (Chairman), after a hectic PSA Test session in Fakenham"

As a result of this activity, the benefits of PSA testing are now seen, by some of our former critics, to far outweigh its shortcomings. The attitude of local health professionals is, slowly but surely, beginning to change; one Norfolk-based PCT asking for details and costs of our programme, hopefully with a view to implementing something along similar lines. Some ten G.P. practices have expressed both moral and financial support, with one Norwich G.P. personally donating £1500 towards our costs.

We have had enquiries from other East Anglian PCSGs, in particular our friends in Ipswich PCSG, who will, we are given to understand, shortly be running their own test programme. Our next step will be to co-ordinate our regional results, and hold further meetings with Norfolk PCTs to present to them our findings and to highlight what we perceive to be the shortcomings presently existing, concerning the early diagnosis of Prostate Cancer.

The coalition Government's view on screening has taken a dramatic leap forward with the £160m Bowel Cancer Screening programme, and the time seems ripe to press home the case for Prostate Cancer screening, in some form, at an early date. The cost of early diagnosis and treatment is far less than is incurred by late diagnosis. One drawback is the lack of co-ordinated data on these costs by the Anglia Cancer Network.

We can detect some light emerging at the end of a very long tunnel, and with similar activity by our associated Groups within the PCS Federation, we are more optimistic that the culture will change faster than we have seen during the past seven years.

With the number of new PCa cases in Norfolk now exceeding 450 annually, and likely to increase, we have built up our volunteer support contact network across the county, and now have 29 volunteer PCa patients, able and willing to offer help and advice, under the guidance of our Welfare Officer, David Wiseman, who has been trained by Macmillan Cancer Care. With a county as large and as rural as Norfolk, the aim is to have someone nearby who can offer an informed sympathetic ear to all who have a need.

EUROPA UOMO – KRAKOW MASTERCLASS

Attended by Mike Lockett

Back in November 2009, I reported a “Call to Action” initiative by Europa Uomo to work towards ensuring that all men in all European countries have access to the best possible information and treatment on prostate cancer. One of the actions resulting from this initiative was the creation of a Masterclass which was to be held for countries and areas where patient support and advocacy is thin.

The first of these was held in Krakow from 19-22 September 2010.

Europa Uomo, in conjunction with the European School of Oncology (ESO) and the European Association of Urology (EAU), held the Masterclass for patient advocates and the title of the class was “From Fear to Hope”.

Many Eastern European countries are only at an early stage of establishing self help patient support groups for prostate cancer and some have no groups at all. Therefore one of the aims of the Masterclass was to help these countries to learn what is happening in other parts of Europe and to relate this to the needs of men with prostate cancer and the needs of their families. Reflecting the location and the focus on Eastern Europe a number of the medical speakers were from Poland and for part of the Masterclass an emphasis was placed on Health and Cancer in Eastern Europe. The establishment of support groups, the importance of “quality of life” and the art of living with prostate cancer were all considered and were facilitated by patient representatives.

Although there was a focus on Eastern Europe, to save time and money it was decided that the Masterclass should also replace the scientific section of the annual Europa Uomo General Assembly and therefore most of the Europa Uomo membership was also present.

In addition to a number of speakers from Poland, medical experts from across Europe (including Belgium, Ireland, Germany, France, Holland and Italy) presented the latest information and views on treatments relating to many stages of prostate cancer. These included the mainstream treatments of surgery, radiotherapy and hormone treatments as well as more recent developments and the discussion of treatments for more advanced cancer. Of particular interest to me was the current attention being paid (across Europe) to the expected introduction of Abiraterone for castration resistant prostate cancer and a session on Bone health issues in prostate cancer. Also of interest was a presentation by Alberto Bossi, a Radiation Oncologist from France, who was presenting on Radiotherapy in prostate cancer. During his presentation a discussion on Surgery versus Radiotherapy ensued and it was the first time that I had heard a Radiologist state that he would take into account any bladder and bowel problems that a man had when giving advice on this decision. The inference was that he would see this group of patients to be at a higher risk of later problems resulting from radiotherapy.



On reflection the Masterclass was a great success, although one of the measures will be the results from the Eastern European countries. On speaking to the Bulgarian representative, who has vast experience of working in the voluntary sector with the Red Cross for many years, the task of changing a culture from one where the state provided everything to one of self help is enormous.

There was some criticism of the schedule – the days started at 8.30am for delegates (7.30am for Steering Board members) and went on to 7.30 pm each day, obviously with normal breaks. Nevertheless I felt that the event was probably the most effective and in depth that I have attended since I have been representing the Federation at Europa Uomo. There were some twenty three formal presentations over three days as well as many informal opportunities to explore and discuss issues with other delegates. The reputation of Europa Uomo is now at a level that organisations such as ESO and EAU are very keen to work with and support our organisation. I felt that we even gave some of the medical experts from different disciplines and countries an opportunity to exchange views and experiences with each other.

Finally, as an adjunct to the Masterclass, Virgil Simons, President of The Prostate Net (<http://theprostatenet.org>), came over from New York to talk about their organisation and the work that they do in the USA. I believe that our Federation has achieved a great deal since we were established in 2008, but a look at Prostate Net could help us to identify the level to which we might choose to aspire.

It was agreed with the speakers that the slides would be made available for publication by Europa Uomo. Obviously slides only provide headlines, but for anyone wishing to view them, they will be made available soon at the website: <http://www.europa-uomo.org> .

Please Check Your Details

Please would all affiliated members check on the PCSF website, that their details are correct on both the map and the contact web page.

If there are any alterations, please contact:

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Abiraterone Raises Bar in Metastatic Prostate Cancer Treatment

Elsevier Global Medical News. 2010 Oct 11, S Freeman

MILAN (EGMN) - The novel androgen-blocking agent abiraterone acetate significantly improved overall survival in men with metastatic castration-resistant prostate cancer; the eagerly awaited results of the phase III COU-AA-301 trial have shown. Treatment with abiraterone acetate resulted in a median overall survival of 14.8 months, compared with 10.9 months for the placebo-treated control arm, with a hazard ratio of 0.646 (P less than .0001), representing a 35% reduction in the risk of death.

"These are clearly the most impressive results that I've seen in a long time in this population of patients who have failed one or two lines of chemotherapy," said Dr. Cora N. Sternberg, chairman of the department of medical oncology at the San Camillo and Forlanini Hospitals, Rome.

Dr. Johann de Bono, who presented the late-breaking findings at the 35th Congress of the European Society for Medical Oncology, said, at an advance press briefing: "An improvement of 3.9 months might not seem like much, but you have to understand that in this late stage of prostate cancer there are only four drugs that have ever shown a survival benefit. We now hope, for our patients' sake, that we can make [abiraterone] widely available."

Dr. de Bono, of the Royal Marsden Foundation Trust and the U.K. Institute of Cancer Research, both in London, reported that the study was unblinded following the recommendation of the trial's Independent Data Monitoring Committee in August 2010.

The multinational, multicenter COU-AA-301 trial involved 147 sites in 13 countries throughout Europe, the United States, Canada, and Australia. A total of 1,195 men (mean age 69 years, about 90% Caucasian) with metastatic castration-resistant prostate cancer who had failed up to two chemotherapy regimens, one of which contained docetaxel, were randomized to one of two treatment arms. In one, oral abiraterone acetate was given at a daily dose of 1,000 mg plus 5 mg of twice-daily prednisone to 797 men, while in the other arm 398 men received placebo plus the steroid.

Baseline characteristics were well matched between the two treatment arms, with radiographic progression evident in 69.6%, significant pain present in 44.2%, two prior chemotherapies used by 28.3%, and bone, node, or visceral metastases in about 90%, 41%-45%, and 29% of patients, respectively, showing that this patient population had a particularly poor prognosis.

Not only was the primary end point of overall survival significantly improved, said Dr. de Bono, but it also was improved in all the subgroups of patients studied; these included performance status, number of prior chemotherapy regimens, type of progression, and baseline PSA above the median. Secondary end points of time to 0 PSA progression, radiographic progression-free survival, and PSA response rate were also significantly improved in the abiraterone arm vs. the placebo arm.

"Abiraterone in my experience is very well tolerated, without the toxicity of chemotherapy," Dr. de Bono said. Similar rates of all-grade (98.9% vs. 99.0%) and grade 3/4 (54.5% vs. 58.4%) treatment-emergent events occurred in the abiraterone and placebo groups, respectively. Grade 3/4 adverse events of special interest that occurred in the abiraterone and placebo groups were fluid retention (2.3% vs. 1.0%), hypokalemia (3.8% vs. 0.8%), liver function test abnormalities (3.5% vs. 3.0%), hypertension (1.3% vs. 0.3%), and cardiac disorders (4.1% vs. 2.3%).

"A 35% reduction in the risk of death is an important end point," Dr. Sternberg said, but highlighted that, as these are only interim results at a median follow-up of 12.8 months, the final overall survival data would be important.

"Abiraterone sets a new standard of therapy in the hormonal treatment of metastatic castration-resistant prostate cancer post docetaxel. We have raised the bar" Dr. Sternberg suggested. "Prostate cancer is not yet a chronic disease, but we are making progress."

The study was financially supported by Ortho Biotech Oncology

Research & Development, a unit of Cougar Biotechnology, affiliated with the Janssen Pharmaceutical Companies of Johnson and Johnson. Dr. de Bono is employed by the U.K. Institute of Cancer Research, London, which has a commercial interest in the development of abiraterone acetate and has served as a paid consultant of Johnson & Johnson. Coauthors of the study are employed by Ortho Biotech Oncology. Dr. Sternberg has acted as an advisor for Johnson & Johnson, Astellas, Sanofi-Aventis, Novartis, Amgen, and Dendron, and has received research funding and participated as an investigator in abiraterone clinical trials.

Dr. Chris Parker: Abiraterone

Separately from the above event

Dr. Chris Parker, who is well known to members of the Federation, was interviewed by L Scott Zoeller of OncologySTAT. Dr. Chris Parker is Honorary Consultant in Clinical Oncology at the Royal Marsden Hospital and Senior Lecturer in Prostate Cancer Translational Research at the Institute of Cancer Research, Sutton. The following comments have been selected by us from that interview. The whole interview can be viewed at:



www.oncologystat.com

OncologySTAT: How will the results of this study affect standard care in this patient population?

Dr. Parker: In this particular patient population, in the postchemotherapy setting, abiraterone will be a standard of care, no doubt. Then, if you compare abiraterone with docetaxel, which is standard first-line chemotherapy in prostate cancer, abiraterone appears to be more active and less toxic. So in my view, it is inevitable that abiraterone will become the standard of care in the prechemotherapy setting as well as the postchemotherapy setting.

OncologySTAT: How does abiraterone work?

Dr. Parker: The mainstay of treatment in advanced prostate cancer for the past 70 years has been castration. We have known for that long that lowering testosterone levels is an effective treatment for prostate cancer. Abiraterone is the first drug to lower testosterone levels by a further order of magnitude. The drug inhibits testosterone synthesis in the adrenal glands and also in the prostate tumors themselves. This appears to be a highly effective mechanism for treating advanced prostate cancer. This agent is truly the first of its kind.

OncologySTAT: What remaining questions need to be addressed in future trials?

Dr. Parker: There is an ongoing trial of abiraterone versus placebo in the prechemotherapy setting. That trial is fully recruited and we are waiting for the results. There will now be huge interest in those results, which I expect we will get either in 2011 or 2012. There is a huge sense of expectancy that the prechemotherapy trial will also be positive, leading to abiraterone as a new standard of care in that setting. One unanswered question is 'when should you stop abiraterone?' In the trials that have been done, and those currently underway, abiraterone was stopped at the point of disease progression. I think an important question to ask is whether, in fact, abiraterone should be continued even beyond disease progression, in the hope that it would slow down the rate of subsequent progression.

Given that abiraterone is so well-tolerated, it would lend itself to combination therapy with any number of other agents. No doubt there will now be a plethora of abiraterone combination trials.

SHOULD WE BE USING HORMONE DEPRIVATION AS FIRST-LINE THERAPY IN PROSTATE CANCER PATIENTS?

Professor Damian Greene

Consultant Urological Surgeon, Head of the Department of Urology, Sunderland Royal Hospital

The place of hormone deprivation in prostate cancer has been established for over 60 years. Traditionally, hormone deprivation was used in patients with advanced and metastatic prostate cancer only although the timing and correct role for hormone deprivation, apart from patients with symptomatic metastases, is still not standardised. We are now aware that the side-effects associated with long-term hormone deprivation are much more profound than previously understood and a wide variety of serious problems including metabolic syndrome, cognitive impairment, cardiac problems and osteoporosis are but a few of the serious problems encountered. In the case of patients with symptomatic metastases, the benefits of hormone deprivation outweigh these disadvantages. Hormone deprivation is a good last line of defence.

In recent years, hormone deprivation has been used routinely in combination with external beam radiotherapy (EBRT). In high risk cases, up to three years of hormone deprivation is undertaken. In many cases, patients can expect many years of life after the initial treatment but the true impact of hormone deprivation on these patients may be over-looked in favour of the benefit in follow-up PSA profile achieved by hormone deprivation. In addition, many of the high-risk patients will have had a full course of hormone deprivation and when the PSA begins to rise after treatment, this may represent hormone – escaped prostate cancer rather than local recurrence. In other words, the last line of defence has been used in the first line of attack and may not be available to deal with treatment failures in the future.

In recent years, alternative treatment options using ablative therapies such as Cryotherapy have emerged as an alternative to therapies that utilise hormone deprivation as a first line of attack on prostate cancer. Long term follow-up data showing excellent outcomes and acceptable morbidities are now available. These treatments allow avoidance of hormone deprivation as a first line treatment and retain the possibility of using hormone deprivation in the future should the need arise.

Difficulties have arisen in the UK following the publication of NICE guidelines on prostate cancer which looked on treatments such as cryotherapy as “experimental” although none of the treatments for prostate cancer has level 1 (high level) evidence of effectiveness. This has caused problems of access to alternative ablative therapies such as cryotherapy in the UK.

Another area of concern in prostate cancer treatment is the use of adjuvant therapies when the primary treatment has failed to control the disease. This is often evident on PSA

follow-up and the role of adjuvant radiotherapy in patients with biochemical failure after radical prostatectomy is an example of changing clinical practice in this area which is being investigated in the RADICALS clinical trial.

In patients who have undergone EBRT where the primary treatment has failed, the problem of salvage treatments points up more of the difficulty of using hormone deprivation as a first line strategy. While some of these patients will have developed local prostate cancer recurrence, some will have developed micro-metastatic disease which may already be hormone-resistant and incurable. Salvage cryotherapy is a well established treatment for patients with radiation-failed prostate cancer and the long term survival rates are of the order of about 40%. While a positive prostate biopsy and a negative MRI and bone scan are pre-requisites for treatment, a considerable number of these patients already have micro-metastatic disease which does not show

on the scans. Unfortunately, we do not have any imaging at present to reliably detect micro-metastatic disease, a rapid PSA doubling time following treatment failure is often suggestive of this problem. The alternative to salvage cryotherapy in radiation-failed prostate cancer is salvage radical prostatectomy, however while success on maintaining satisfactory follow-up PSA levels between salvage surgery and salvage Cryotherapy is similar, rates of incontinence and other complications are significantly higher in salvage surgery.

In response to the NICE guidelines and in an attempt to further evaluate management of radiation failed prostate cancer, a new UK study of salvage cryotherapy versus hormone deprivation is now being planned. The CROP study will be a multi-centre UK trial which should improve access for radiation failed prostate cancer patients to salvage cryotherapy and allow high quality randomised outcome data to dictate future management of this challenging patient group.

In the meantime, we need to ask serious questions about the rationale of using hormone deprivation as part of first line therapy in prostate cancer patients in the absence of metastatic disease. There are now other options including ablative therapies and surgery whose role in localised and locally-advanced prostate cancer has expanded in the last decade. We need to understand more completely the significant morbidities associated with long-term hormone deprivation and to answer the question that is foremost in this area of prostate cancer treatment. “Why are we using our last line of defence as our first line of attack when we have so many alternatives?”



Professor Damian Greene

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John Dwyer

Prostate Matters is published four times a year, 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.

PCSF does not promote any treatments, or dietary, drug, exercise or other lifestyle change intended to prevent or treat a specific disease or condition. Anyone who wishes to embark on any such treatments should first consult with and seek clearance from a qualified health care professional on any treatment or life style changes.

**PRESS RELEASE, 27 OCTOBER 2010
EU Cancer Patients Concerns Heard: Cancer Patient Mobility
Moves Closer to a Reality**

A 'yes' vote in the European Parliament's public health committee today has paved the way for cancer patients to get medical treatment anywhere in European Union. The draft directive aims at clarifying and strengthening the rights of patients who have to seek treatment in another Member State.

Tom Hudson, ECPC President stated 'We very much welcome today's vote which sends a strong signal to all Member States of a future system that would put cancer patient's needs at the center and allow them to access treatment abroad when necessary. ECPC will support the proposal which ensures our key concerns are highlighted when the vote takes place in January, 2011.'

There were 227 amendments to the plan, and six consolidated amendments, but handshakes were made over the following three points:

- Patients can seek medical care in another country without prior authorization. However, for hospital stays and specialized care, patients could need pre-authorization from their national health system.
- A country could only refuse to authorize cross-border care in a very limited number of circumstances. Prior authorisation systems should rely on clear and transparent criteria so as not to hamper the steps taken by patients who need to resort to health care treatments in another Member state
- Europeans rare cancer patients would be covered under the proposed law.

One of the key points of the ECPC's position, reflected in today's vote, was to ensure an adequate codification of the existing ECJ case law in order to avoid any new legal uncertainty or loopholes for cancer patients, while maintaining the financial and organizational sustainability of national healthcare systems that treat cancer patients in their own Member States. While cancer patients don't like to be cared for far from home in another member state,

should they want or need to, they should be entitled to the same rights for information, treatment and reimbursement. It was also important to include mechanisms preventing, as much as possible, patients from having to pay in advance for the costs of cross-border healthcare. Information is also a key point when each Member State will be obliged to maintain national contact points to inform patients about the availability of healthcare.

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Peter Loader

Sadly, we have to report that Peter Loader, founder member of the Somerset Prostate Support Group lost his battle with prostate cancer on Monday 18th October.



In June 2000 Peter was diagnosed with prostate cancer at the young age of 53. Not only a young age but it had spread to ten sites on his skeleton and he was given a 3 year prognosis. He finished working in 2001 although he hated giving up the job he loved.

In his retirement he started researching prostate cancer treatments worldwide with the view that knowledge might help increase survival.

Peter was truly inspirational and demonstrated remarkable courage and fortitude in coping with his disease and helping others to cope with theirs. He was one of the founders of SPSA and has driven this group from the start. It would not be where it is today without his input. He was a positive active force and he brought help and comfort to countless people; not just the men with prostate cancer, but the wives and partners as well. Through his research he became a fount of knowledge which was invaluable. His contacts were worldwide and his influence as a prostate cancer campaigner will be sorely missed.