

Tackle AGM and Conference 2020 'Prostate Cancer Screening and Early Diagnosis'

The AGM and Conference took place on Tuesday 8 September via Zoom.

Tackle Chairman, Ken Mastris, welcomed everyone to the first virtual conference ever! He then paid tribute to all members who have passed away this year, including victims of the Covid pandemic, and especially to previous Chairman, Roger Wotton, and campaigner Keith Cass.

Ken welcomed two new Trustees, Julian Burgess and Roshani Perera.

He then quoted the latest statistics (from 2018) of 49,029 men diagnosed with prostate cancer in England – the highest ever annual increase at 19% more than in 2017. He hoped this was partly due to raised awareness and testing, due to the efforts of local Support Groups.

Having noted the result from the Lottery survey that 54% of men found their Support Group via medical staff, Ken suggested that this might be a good way to pursue the development of more Support Groups.

He then reported some of the work of Tackle officials:

- Working with stake holders in the UK and Europe, including attendance at the European Parliament to read the White Paper on Prostate Cancer.
- Getting involved in Pharma Patient Panels.
- Attending events to promote Tackle in other organisations, such as PCUK, Orchid, and the Prostate Cancer Research Centre.
- Working hard on PR – see the Tackle website.

Ken highlighted the good news for Tackle:

- Achieving Lottery funding over three years to support a new National Support Development Manager – Sarah Gray joins Tackle later in October, aiming in the first year to create five new Support Groups and build on existing ones.
- Continuing work on Evaluating Psychological Support Services by Roshani Perera.

Finally, Ken made a plea to all members to work with Sarah to help achieve the goals of the organisation and to use Tackle's social media sites to really be the 'voice of prostate cancer patients'.

Presentations

Patient Representative Report by Steve Allen

Steve Allen, who represents Tackle with various national bodies, gave an outline of what's been happening over the last year. His main tasks as representative concern:

- the review process for approval of new drugs for use in Prostate Cancer (PCa) by national bodies NICE and the Scottish Medicines Committee (SMC)
- The National Prostate Cancer Audit
- PSA screening
- being the interface between Tackle and pharma and other research projects.
- maintaining and increasing collaboration with PCUK.

Steve went through the current drug situations/problems with different types/stages of PCa, saying where new drugs were approved for use (or not) and what stage they were at in the NICE and SMC approval systems. He explained to Conference some of the complexities involved in getting approvals, based on statistics and evidence from pharma companies, and also, inevitably, cost considerations.

Surprisingly, Steve reported that Covid-19 had been of benefit to some men newly-diagnosed with PCa where chemotherapy was contra-indicated due to immunosuppression. For the duration of the pandemic, such men will be offered one of the newer drugs (Enzalutamide or Abiraterone) that are not normally approved for this group of PCa patients (and these individuals will continue on the treatment they have started when the pandemic is over).

Finally, Steve reported the good news that SpaceOAR™ has recently received extra funding for another 1400 men to receive the treatment. It will soon be fully funded for everybody to receive it. He asked if anyone at Conference who had received this treatment could contact him (see email below) as they would appreciate patient feedback.

A much more detailed report of Steve's activities is available from him upon request at: steve.allen@tackleprostate.org

The Prostagram – a fast MRI screening scan

Presented by Hashim Ahmed, Professor and Chair of Urology, Imperial College Healthcare NHS Trust; Chair, NCRI Prostate Research Group

Prof. Ahmed began by quoting the UK National Screening Committee: "PSA is a poor test for prostate cancer and a more specific and sensitive test is needed."

As a consequence, due to the 'unreliability' of the PSA test, in the past most men ended up having a TRUS biopsy (trans-rectal), which could miss important cancers or mis-diagnose unimportant ones, and had a relatively high incidence of serious post-operative infections.

Using MRI scans

It has been found that giving men MRI scans in hospitals allows cancers to be seen much more accurately and can be used to decide whether a biopsy is necessary. Using scans, a third of men can avoid biopsy and over treatment.

So far, around 4000 men have gone through this fast MRI scan pathway after being referred to hospital by their GP with an elevated PSA.

- 41% of them avoided immediate biopsy
- diagnosis was much quicker (9 days)
- post-operative infections were reduced to 0.1% using a trans-perineal biopsy.

The Prostagram Study

Prof. Ahmed's team's study was to see whether having a fast MRI (or ultrasound) in the community (not in a hospital) instead of, or in addition to, a PSA test would be a feasible way to find important PCa.

In the pilot study, 400 men, mainly asymptomatic, were accepted onto the study. All of them had a PSA test, an ultrasound and a fast MRI scan. If any one of the tests was positive, the men went on to have a biopsy.

The PSA test was found to miss a lot of important cancers, which could be picked up by the MRI (the scan was 20% more accurate). If a scan score of 4 and above is used as the threshold for sending men for a biopsy, about the same number of men are biopsied as when using a PSA threshold of 3 and above.

Prof. Ahmed concluded by saying that a combination of a PSA test and a fast MRI scan would be the optimum: you find more important cancers but biopsy fewer men. In the future, the usual pathway could be that everyone gets an MRI. If the result is positive, men will go on to have a biopsy. Men will have an MRI every five years so there will be no need for a PSA test every two to three years, reducing the interval between screenings.

The next phase of the Prostagram study is the fundraising stage. They will need to recruit 20-30,000 patients, at a probable cost of £2-3 million (which is not expensive when compared to other current cancer studies).

Automation of Graham Fulford Charitable Trust's (GFCT) PSA results

Presented by Matthew Brine, MD Empresa

Last year, Empresa was introduced to GFCT and asked to help shape the way they organised and ran their PSA testing events, specifically to develop a bespoke electronic system to do exactly what GFCT required.

The service was launched in January 2020 using a new website called My PSA Tests. The website offers services both to groups wishing to hold PSA testing events and men wishing to attend them. Organisers register online, and can then set up and manage their event, with the help of Empresa's administration team.

Men wishing to find an event also register, and can then find locations, maps and the website for specific events. You can search for an event near you and, if payment is required, there is a facility to pay online too.

The results of all PSA tests are collected digitally and those tested are notified when to go online to find them. Empresa has imported the GFCT database of PSA test results since 2004, and all new results are automatically added. You can search the database and find all your test results from GFCT events since that year.

You can also now order PSA Home Testing kits on the website (read more on page 7).

The iCHROMA™ PSA method

Presented by John Bolodeoku, Director JB Consulting

John is an independent pharmaceutical physician and chemical pathologist with an interest in point-of-care testing devices. He has been working for about ten years with a company in Korea who have developed the iCHROMA™ method for PSA testing.

The test procedure is very simple: blood is taken and put into the device reader, with results ready in 15 minutes.

John presented three studies: original validation of the method; independent quality control assessment, and a live test of iCHROMA™ in the community in Worthing.

The first two studies found that iCHROMA™ results correlated very well against all other PSA tests in use in the UK (0.9 correlation), although it tended to a slight positive bias at higher PSA values.

In Worthing, 143 volunteers had blood tested by iCHROMA™ in the lab at JB Consulting and by the Abbott Architect method at Worthing hospital. 55 of the men also had a finger prick test, with results given at the event. Again, all sets of results correlated well (with a slight positive bias in the iCHROMA™ test, which can be improved with work on the reference range used).

iCHROMA™ therefore provides a reliable measurement of total PSA in both finger prick and venous blood tests.

The Conference concluded with a Q&A session.

You can download and view the full presentations and Q&A session from the Tackle website on:
www.tackleprostate.org/past-conferences.php#conference2020

Theranostics – what is it all about?

The word 'Theranostics' is not describing yet another alien life force in *Dr Who*!

It is, in fact, a hybrid of two words: Therapeutics and Diagnostics. It aims to describe the use of techniques that are normally employed in diagnosing a disease as part of the treatment for that disease. It invariably involves the use of nuclear imaging techniques using radio-isotopes, and is relatively new in the management of prostate cancer. However, the principle of Theranostics has been used in other areas for over 50 years.

Perhaps the best-known example is that of thyroid disease. Here, a very small dose of radioactive iodine (^{131}I) is given

to the patient, causing no harm. The ^{131}I is rapidly taken up by the thyroid, then the patient is scanned using a gamma camera. This identifies areas of the body with high concentrations of ^{131}I and thus areas of overactive thyroid tissue (or possibly thyroid cancer), which can be seen on the images produced. Treatment then involves giving the patient a stronger dose of the same radioactive ^{131}I which is taken up by the same areas and is now such that the cells are destroyed.

The same principle is being used in prostate cancer, but the agents used for diagnosis and then treatment are different from one another.

Technetium bone scanning

This is now a standard investigation in the diagnosis of prostate cancer where spread to the bones may have occurred. Bone scanning with radioactive technetium ($^{99\text{m}}\text{Tc}$) was introduced in the early 1970s. Earlier isotopes of calcium, strontium and phosphorus had been researched before that. $^{99\text{m}}\text{Tc}$ is taken up by active bone cells, including cancer cells, and these areas of increased activity can be seen on a gamma camera scan. A single photon emission computed tomography (SPECT) scan combines this with a CT scan for increased sensitivity and can identify smaller metastases than the gamma camera alone.

Treatment with Radium-223: ^{223}R is much more radioactive than the technetium used for diagnosis but is taken up by bone cells in exactly the same way. The highly concentrated, localised radiation destroys very active cancer cells within the bone. It is used for patients who have bone secondaries – those in soft tissues or lymph nodes are not affected by ^{223}R . The patient may need up to six sessions of treatment with injections of ^{223}R given by intravenous infusion.

PSMA Scanning with Gallium-68

^{68}Ga is a radioactive substance that attaches to the cell wall of prostate cells, and not to any other cells – hence the term Prostate Specific Membrane Antigen (PSMA) scan. A PET scan is then used to identify the ^{68}Ga , and therefore prostate cells. Abnormal areas showing the presence of prostate cells can be identified as areas of metastatic prostate cancer. PET scans using other chemicals, e.g. choline, can be used to scan for prostate cells but the ^{68}Ga scan is arguably more sensitive and specific. It is also easier to produce as a radioactive substance. The images produced by the scan can be enhanced by combination with a standard CT scan to enable identification

of very small metastases – around 5mm in size. ^{68}Ga is taken up by bone, soft tissues and lymph nodes and can locate secondary spread throughout the whole body.

Treatment with Lutetium-177: In simple terms ^{177}Lu can be regarded as the highly radioactive equivalent of ^{68}Ga . It is given by intravenous infusion and will be taken up by exactly the same metastases as identified by the ^{68}Ga PSMA scan. The highly concentrated radiation then damages and destroys those cancer cells. A number of sessions will be needed. Progress of treatment is monitored using PSA levels and repeated ^{68}Ga scans. This is a relatively new treatment and has yet to be adopted onto the NICE pathway for treatment of advanced prostate cancer. As yet, it is not widely available on the NHS except for patients undergoing a research trial, but we await results of randomised studies for ^{177}Lu , and initial results are promising for its use in the future.

Undoubtedly, the use of Theranostics will be developed further. More mildly radioactive molecules will be identified that will attach very specifically to certain cells and can be identified by suitable scanning techniques – so-called 'radioactive ligands'. The next step will be to identify a highly radioactive molecule that will similarly attach to that specific cell to provide a therapeutic response. As our knowledge of prostate cancer increases, we may be able to distinguish between different types of cancer cell. By having a highly refined technique – possibly being able to selectively target certain types of cancer cell – the side-effects may be minimised further.

Steve Allen, Tackle Patient Representative

Experimental blood test can confirm prostate cancer – and its clinical significance

The study

'Identifying prostate cancer and its clinical risk in asymptomatic men using machine learning of high dimensional peripheral blood flow cytometric natural killer cell subset phenotyping data'

Simon P Hood, Georgina Cosma, Gemma A Foulds, Catherine Johnson, Stephen Reeder, Stéphanie E McArdle, Masood A Khan, A Graham Pockley

Scientists at Nottingham Trent University and Loughborough University, and Professor Masood Khan at University Hospitals Leicester NHS Trust have been developing a new test for prostate cancer which can also identify its potential risk level in order to avoid mis-diagnosis and over treatment.

The current approach

Currently, the most common approach for detecting prostate cancer measures the blood level of a protein called the prostate-specific antigen (PSA). Heightened amounts of PSA may mean that the patient has cancer, but 15% of individuals with prostate cancer have normal levels of the protein, and many healthy people can have high amounts of PSA.

Furthermore, moderately elevated levels of PSA might indicate the presence of prostate cancer, but the cancer might not be clinically significant and so no more than 'watch and wait' is required. The PSA test is therefore not widely accepted as a reliable diagnostic tool.

Although other methods to detect prostate cancer exist, their success is limited. A biopsy of the prostate can be taken, but results from this invasive procedure are often incorrect because the cancer is not present in the whole prostate and therefore may not be detected in the sample. Scans can help to spot a tumour, but they are not accurate enough to be conclusive on their own. New tests that avoid mis-diagnosis are urgently needed.

The challenge

The clinical challenge in prostate cancer diagnosis resides in distinguishing men with low- or small-volume intermediate-risk cancer which is unlikely to progress and requires only 'active surveillance', from men with intermediate disease which is likely to progress, or high-risk disease, both of which require treatment.



Scientist Simon Hood in the lab

It is essential that men with low-risk prostate abnormalities are not diagnosed as having prostate cancer, as those with low-risk disease do not require active treatment.

Unnecessarily labelling men as having prostate cancer can assign these men to life-long surveillance, and have significant psychological, quality-of-life, financial and societal consequences.

Men with PSA levels lower than 20 ng/ml (normal levels are typically less than 5 ng/ml) pose a major problem. Although only 30–40% of these men will have prostate cancer, all of them currently undergo potentially unnecessary, invasive prostate biopsies to determine who has the disease. It is this group of men for whom the development of new and more accurate approaches for the early detection of cancer is a clearly unmet clinical need, and for whom the benefits of a new approach will be most significant.

A new way

The scientific teams at Nottingham Trent and Loughborough Universities, and Professor Masood Khan at University Hospitals Leicester NHS Trust have found that prostate cancer can be identified by changes in the immune system in the blood, specifically in the white cells which protect the body against infection and disease.

Building on earlier work, they have devised a simple blood test which, combined with computer tools, can confirm the presence or absence of prostate cancer and also the stage of the disease – low, intermediate or high risk. It is expected that this new approach could reduce invasive biopsies by about 70% and help identify patients needing urgent treatment or closer monitoring. The test is also more accurate than current methods and can confirm the stage of the disease with 99% accuracy.

"Due to the reduction in unnecessary biopsies, [the test] would also result in significant savings for the NHS."

Professor Graham Pockley

The new test would be used following a PSA test and would benefit men who are showing no symptoms but have a slightly elevated PSA level by enabling clinicians to put appropriate strategies in place.

The future of the test

The test is still at the experimental stage. The team now needs to validate the approach in a prospective Clinical Trial in a larger number of men, to demonstrate its effectiveness and get approval for it to be used to make important clinical decisions. The team is currently trying to obtain the funding which is needed to undertake such a trial.

Professor Graham Pockley, Professor of Immunobiology Director, John van Geest Cancer Research Centre, Nottingham Trent University

The study has been published in the international scientific journal *eLife*: <https://elifesciences.org/articles/50936>.

Article originally commissioned by Rob Banner (Trustee, Tackle) for PROSTaid newsletter.

Message from Sarah Gray, Tackle's National Support and Development Manager

After Tackle's successful bid for Lottery funding, we were delighted to recruit Sarah Gray as Tackle's new National Support and Development Manager. She started work in September, and this is her report of her initial few weeks.



What was also interesting was that not everyone was from Reading, which got me thinking about some of the opportunities for Zoom meetings and how they can break down geographic barriers.

Sarah says...

As the saying goes, 'time really flies when you are having fun', and the four weeks since I came into post have gone by in a flash. I have spent much of this time listening and asking questions, finding out as much as I can about Tackle's Support Groups. I have read the Lottery funding papers thoroughly and learnt how the Lottery project will mean that Tackle Prostate Cancer can work with you in your Support Groups to ensure that in the future many more men can be empowered with the knowledge, skills and confidence to navigate their way through a prostate cancer diagnosis.

Coping with Covid

Throughout my career I have worked with many types of support groups, all of them – of course – in pre-Covid days when people were able to meet face to face, so I did wonder how people were managing whilst being unable to meet in the regular way.

What I have found is that our federation is full of amazing volunteers who run groups, and they have adapted and learnt new skills such as hosting Zoom meetings.

Zoom in action

These skills were in evidence when at the end of my third week I was invited to sit in on a Zoom meeting with the Reading group. Around 35 men and a couple of wives were in the meeting. It was a great experience, with an inspiring clinician who gave an informative talk on brachytherapy. There was lots of time to ask questions, and time for men to share experiences and ask questions of each other and the nurse who was in attendance. They also discussed club news about various things, including a forthcoming walk. Everyone was welcoming, relaxed and friendly.

Tackle's network to grow. It is about us all working together to build a collective community to ensure all men living with and beyond a diagnosis of prostate cancer are able to access locally based peer support if they want to. I also need to ensure men have a voice which we can harness to use in partnership with other charities to campaign for better services, treatments, care and support.

Building a community

My role is very much to support

The more men who are able to access peer support through Groups present and future, the greater the collective sound of that voice will be and the more it will be heard by the people who have the power to drive change and improvements.

I need your help

None of this can happen without you. I have learnt about the great work of many of the Groups during my first month, but I need your help to find out more.

I plan to send out two surveys over the forthcoming months. Firstly, one to Group leads, so I can understand more about how we can work together and,

secondly, one to the individual members of the Groups. My project is funded by the National Lottery and they need us to collect information about the sorts of people who will be benefitting from this project. As anyone who has ever evaluated any sort of project knows, you need some baseline information to show where you have come from, so you can evidence how you have got where you are going!

If you would like to invite me to your Group to talk about the Lottery project or want to ask me any questions, or suggest ideas, please get in touch.

My email is sarah.gray@tackleprostate.org or you can call me on **07725 083533**.



Welcome to Tackle

the errol
mckellar
foundation

Tackle is delighted to welcome The Errol McKellar Foundation as a new partner member. They say: "We encourage men to seek a PSA test and to talk about their experience before, during and after diagnosis and aftercare. We encourage women to talk about their journey as partner/carer and offer support wherever possible."

<http://www.theerrolmckellarfoundation.com/>

A warm welcome also to new Support Group **The Walnut Club**, based at Broomfield Hospital in Chelmsford.

We look forward to hearing more about what you get up to in the future.

<https://www.thewalnut.club>

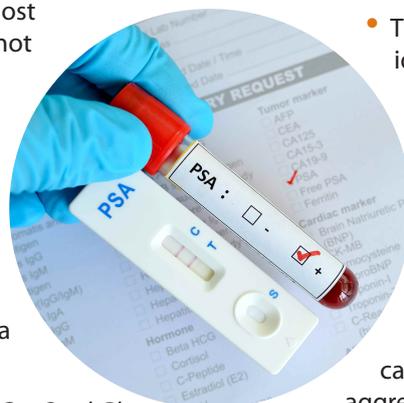


Tackle's Appeal to the National Screening Committee (NSC)

In June this year, the NSC published their draft recommendation that there should not be "PSA-based screening for prostate cancer in asymptomatic men ... in the UK", the same as their recommendation in 2015.

Tackle, along with CHAPS and Orchid Male Cancer and many members of Tackle, presented an appeal to the NSC in September, coordinated by Chris Booth, a member of Tackle's Clinical Advisory Board. Prostate Cancer (PCa) screening using the Prostate Specific Antigen (PSA) blood test aims to detect PCa at an early, curable stage.

Although fully entitled to ask for a test, most men in the UK do not do so, and GPs are not encouraged to offer the test on the grounds that the 'harms' of screening outweigh the benefits of cure for a small number of men with aggressive PCa. However, over 12,000 men die from PCa every year in the UK, and the UK's mortality rate is higher than most of our western European neighbours'. The UK has not experienced the fall in PCa mortality that has been seen in countries which use PSA testing extensively; indeed, the UK death rate is rising.



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Harms and benefits

The claim that the 'harms' of screening outweighed the benefits was arguably true during the first 20 years of PSA testing, due to PSA not being a specific marker for PCa and the test being unable to differentiate between aggressive, lethal PCa and non-aggressive, insignificant PCa. Neither was there an accurate, non-invasive second-line test to provide the answers. As a result, thousands of men diagnosed with cancers which would now be considered harmless underwent radical over-treatment with its significant risk of serious complications: impotence, incontinence and bowel damage.

Consequently, in 2015 the National Screening Committee (NSC) recommended against developing a national PCa screening policy. This has been endorsed by the latest NSC report. In summary, this report draws principally on three randomised, controlled trials (RCTs) of PSA-based screening to draw its conclusion. Unfortunately, two of these trials – PLCO and CAP – are entirely inadequate to allow this conclusion to be drawn. Regarding the third trial – ERSPC, – the report has emphasized its flaws, but has failed to acknowledge an overall reduction of PCa mortality of 30%, or to highlight individual trial centres within ERSPC reporting 50% reductions in PCa mortality.

Advances in diagnosis and management

Medicine does not advance on the basis of RCTs alone, and the report's biggest omission is its failure to connect with actual clinical practice in western Europe and specifically the UK.

During the last ten years good research evidence and clinical practice in the UK have entirely changed the diagnosis and management of early PCa. The key advances have been:

- The risk factors for PCa have been clearly identified.
- International screening guidelines have achieved a high degree of consensus, and there is comprehensive UK guidance available for the optimum use of PSA.
- mp-MRI has been confirmed as an accurate, non-invasive second-line test capable of differentiating between aggressive and non-aggressive PCa.
- Over-treatment of non-aggressive PCa in the UK has been virtually eliminated, with active surveillance proven as a safe 'treatment' option.
- Screening studies that have been running for up to 20 years are demonstrating up to 50% falls in PCa mortality.
- Screening and early intervention is a superior clinical option providing better quality of life, at less cost, than lengthy treatment and eventual death from PCa.

In summary, this clinical evidence supports an urgent, clinically driven, re-appraisal of the options now open for PSA-based screening in the UK. We recommend a fundamental change in approach moving to a risk-based, case-finding 'Smart Screening' strategy. Anything less would be highly discriminatory.

This summary was prepared by Chris Booth, who is on Tackle's Clinical Advisory Board and is Clinical Director of CHAPS, on behalf of Tackle, CHAPS and Orchid and we are very grateful to him. Thanks to all our members who supported it. We expect to hear the result of the appeal in December.

Support Groups 'Zoom' into the technological age

Patients and family can be very anxious during initial referral and diagnosis for prostate cancer. They are unlikely to know much about the cancer, so they don't know what to expect. Human nature is to try to be in control of your life, but while undergoing tests, waiting for diagnosis, and not knowing what follows, this is difficult and can give rise to great anxiety.

There are over 100 local Prostate Cancer Support Groups (PCSGs) across the UK. Patients find them invaluable to learn about the disease and make new friends who fully

understand their situation. At local PCSGs you will meet many men and their partners who have been through similar experiences and can give you their tips for coping. After diagnosis, when considering treatments offered, men who have undergone them can share their experiences.

The Covid effect

Covid-19 caused a huge reduction in access to clinicians and changed many patients' medical procedures, leaving them feeling confused and lost. The virus also stopped





local PCSG meetings. Lack of access to help made life difficult and confusing for patients and their families.

Zooming in on the problem

In this perfect storm, many PCSGs wondered what they could do. The North Hants PCSG immediately switched their April meeting to Zoom, a new word to most people then. The Peer Support Team of Prostate Cancer UK started bi-weekly Zoom meetings for group leaders, to work on keeping PCSGs going and continue providing support. Prostate Cancer UK provided Zoom licences and ran training sessions. By May, many PCSGs were coming on to Zoom.

Zoom doesn't suit everyone. Some PCSGs don't have the knowledge and technology needed to connect. I have set up Zoom meetings for groups needing help, and provided one-to-one help for members connecting up. The Reading group uses its helpline number for members having problems connecting. Tackle, using a generous donation from Janssen, has provided some technology to help connect on Zoom.

What do we actually do on Zoom?

Presentations and Q&A sessions work well on Zoom. The small groups of informal chats at meetings don't unless your group is small. Zoom meetings can be split into 'rooms'. Finding presenters was difficult. Many

clinicians were no longer available to present due to Covid-19 work. Prostate Cancer UK built up a list of available presenters, which has been invaluable.

With remote Zooms, 'local' is no longer a constraint, so members can easily attend a PCSG that is miles away. The FOPS based at Chorleywood has invited different groups to each of its Zoom meetings, doing a virtual tour of the country. Many other groups are now doing the same. Some members previously unable to attend meetings in person joined via Zoom for the first time in years.

Some of the other events run by PCSGs have moved to Zoom too. Reading PCSG has a gym class which now attracts members from as far away as Illinois, USA!

It's still important for members and potential members to know how to contact PCSGs for one-to-one support, and PCSGs must not forget members who can't use Zoom.

While all PCSGs look forward to meeting in person again, Zoom meetings will surely continue for remote members and remote presenters. Covid-19 has accelerated adoption of this new technology. Support is available from Tackle and Prostate Cancer UK for groups yet to take this step.

Andrew Gabriel is a prostate cancer patient who helps run three PCSGs, provides one-to-one support for members, presents to many PCSGs, and mans the Tackle national helpline – andrew.gabriel@tackleprostate.org

Graham Fulford Charitable Trust (GFCT) introduces a PSA Home Testing kit



About us

We launched GFCT in 2005 after a close friend and a close relative were diagnosed with prostate cancer (PCa). As is often the case they were diagnosed far too late and sadly both died within a few years.

After looking into the disease, we quickly realised that early diagnosis was the key. We were fortunate to meet urologist David Baxter Smith, who was giving PCa awareness talks including offering PSA tests. He explained the test was far from perfect but that "until something better comes along it's all we have". We felt we had to help and that's when we formed GFCT.

Fantastic growth

From carrying out just over 300 tests in 2005, and working with lots of Prostate Cancer Support Groups, Masonic Lodges, Lions Clubs and others, we were directly or indirectly involved in carrying out around 30,000 tests in 2019.

In 2014 we realised that with around 40,000 test results to date we needed to computerise so we could help track the movement in men's scores. Susan Hart came on board in 2019 and soon

identified that we needed "... a fully integrated online system where men can access all their results at any time." (They could still receive postal results if preferred).

Going online

Matt Brine and his team from Empresa proved to be the people to help us put this into practice. They developed an online system featuring all the parameters we required.

The new system gives men direct access to all their previous results from tests with us, and allows them to find and book online any testing event. The positive response from users was brilliant and we were flying in March until Covid forced us to suspend our events. Even so, by then we'd hit over 148,000 tests on over 100,000 men and found just under 1,900 cancers.

Home testing kit

And the good news is that, despite the pandemic, we are still able to offer men PSA tests. There can't have been many 'silver linings' to the storm clouds created by Covid-19 but a small chink of light for us is the time it's given us to finalise and launch a home testing kit option to complement our PSA testing events.

In June, we carried out a successful pilot with around 100 men and the new system is now fully operational.

The system is safe, robust and well tested: we use the same laboratory



as before (The Doctors Laboratory), and the clinical overview of results and detailed follow-up letters are in the same format as before. The only difference is that, rather than a nurse taking a blood sample, men take a finger prick sample themselves.

The huge advantage it has over traditional testing events is that men can order a test online literally 24/7, 365 days a year from the comfort and safety of their own home.

If you want a Home Testing kit or to find out more, please visit www.mypsatestests.org.uk, call Susan Hart on 01926 419959 or email us at info@psatestests.org.uk.

Graham Fulford, Founder and Trustee GFCT

tackle

prostate cancer

www.tackleprostate.org

The National Federation of Prostate Cancer Support Groups

Tackle Prostate Cancer is the campaign name of
The National Federation of Prostate Cancer Support
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Registered Office: Kemp House, 152 City Road,
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Ambassadors

David Gower OBE
Damian Hopley
Lord Rose

Supporter

Jason Leonard OBE

Honorary President

Sandy Tyndale-Biscoe

Our volunteers

Trustees:

Ken Mastris, Chairman
Alphonso Archer
Rob Banner
Julian Burgess
Professor Frank Chinegwundoh MBE,
Clinical Advisor
John Coleman, Secretary
Erik Friis-Scheel, Finance
Jackie Manthorpe
Roshani Perera

Helpline coordinator: John Coleman

Information officer: Alan Ashmole

Tackle Patient Representative: Steve
Allen

Regional coordinators:

John Coleman	North West
John Burton	London
Brian Jones	Wales
Robin Millman	North East
Sandy Tyndale-Biscoe	Western Counties
Allan Higgin	South East

Our support

Group Liaison	Simon Lanyon
Lottery Project Mgr	Sarah Gray
PR & Marketing	Siobhán Connor

Editor's note

Many of our articles contain links to
information on the internet. The best way
to access these is to go to our website:
www.tackleprostate.org where you will
find the web edition of this and past
issues of Prostate Matters with live links.

Prostate Matters delivery

Your individual copy of
Prostate Matters is delivered to
you from your local prostate
cancer support group. If you
have a change of address or
any other notifications, please
would you contact your local
support group.

Check your details

Unless otherwise requested, your
details will appear on the list of groups
on our website.

We ask all affiliated groups to check their details
on the Tackle website. The information has been
updated to include meeting times and places.

See the map at: <http://tinyurl.com/omp6y5e>

If you require any corrections, please contact
Simon Lanyon: simon.lanyon@tackleprostate.org.

PSA testing events

If your group is holding a PSA testing event, we'll add it to the list on
the Tackle website. Email info@tackleprostate.org with the date, time,
town, postcode, contact name and phone number.

Helpline

0800 035 5302

Our telephone helpline
is manned
by prostate cancer patients,
for patients and their
families

365 days per year

9:00am to 9:00pm



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