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Us TOO INTERNATIONAL Prostate Cancer Education and Support Network

Prostate Cancer Screening Has No Effect on Overall Mortality

Routine PSA-based screening for prostate cancer remains controversial, as the debate continues over the balance between potential benefits and potential harm. A new systematic review and meta-analysis has found that, at best, prostate cancer screening using a PSA blood test leads to a small reduction in disease-specific mortality over 10 years, but it has no effect on overall mortality. The article was published online September 5th in the BMJ (British Medical Journal).

PSA screening was also associated with considerable biopsy-related and cancer treatment–related complications. Using modeling, the authors estimated that, for every 1,000 men screened, approximately one man would require hospitalization for sepsis, three men would require pads for urinary incontinence, and 25 men would experience erectile dysfunction.

So when men ask about prostate cancer screening, what should their physicians tell them? That question is addressed in an accompanying editorial by Martin Roland, BM, BCH, DM, FRCGP, FRCP, FMedSci, professor emeritus of health services research at the University of Cambridge, United Kingdom (UK), and colleagues.

The editorialists note that in the UK, there are more deaths from prostate cancer than from breast cancer, and

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Nuclear Pore Proteins May Be Effective Anticancer Targets for Prostate Cancer

Nuclear pore proteins may be effective anticancer targets for prostate cancer, according to researchers at Sidney Kimmel Cancer Center—Jefferson Health in Philadelphia. Their findings, published in the journal Cell, report that a particular gatekeeper—the nuclear pore protein called POM121—traffics molecules that increase tumor aggressiveness in prostate cancer.

First author Veronica Rodriguez-Bravo, PhD, assistant professor of cancer biology at Thomas Jefferson University in Philadelphia, said that blocking this gatekeeper prevents several molecules from reaching their targets in the nucleus, thus decreasing tumor growth. She and her colleagues showed that blocking POM121 transport helps restore chemotherapy efficacy in preclinical models of the disease.

“It was surprising to us to find such a striking nuclear pore composition change in advanced metastatic prostate cancer—specifically considering it was not known before and that these changes are related to mechanisms driving the disease,” Rodriguez-Bravo told Cancer Network.

Using computational biology techniques that integrate genetic information from prostate cancer patients and experimental models, the investigators dissected the functions of nuclear pore proteins across the course of the disease from early to late stages. They discovered that an abundance of the POM121 component of the

(Continued on page 4)

LDR Brachytherapy Beneficial in High-Risk PCa

Low-dose rate (LDR) brachytherapy (BT) for high-risk clinical stage T3 (cT3) prostate cancer is associated with excellent long-term biochemical control and survival, a new study finds.

LDR-BT, utilized primarily as a boost in conjunction with external beam radiation therapy (EBRT) and androgen deprivation therapy, is highly effective in treating cT3a and cT3b high-risk prostate cancer, investigators concluded.

Their study involving 99 men found that LDR-BT is associated with excellent biochemical control and survival, according to Manuj Agarwal, MD, of the University of Maryland School of Medicine in Baltimore, and colleagues. Median age was 69.4 years. They received either definitive LDR-BT or LDR-BT boost after EBRT. About 86% received androgen deprivation therapy (ADT). The median follow-up was seven years.

“The seven-year rate of freedom from biochemical failure (FFBF), prostate cancer-specific survival, and overall survival were 65.2%, 90.1%, and 77.9%, respectively,” Dr. Agarwal’s team reported in an article published ahead of print in the journal Brachytherapy. Patients who received LDR-BT boost achieved a seven-year FFBF rate of 73.5%. The authors reported no significant difference in outcomes between men with cT3a and cT3b disease and no significant associations between outcomes and Gleason score, initial PSA, and percent core positive rates.

“LDR-BT boost implantation of patients should be strongly considered for cT3 patients given the merits of trimodality care,” the authors concluded.

Renal & Urology News, 28 August 2018
Prostate-Specific Antigen Testing Initiation and Shared Decision-Making
Findings from the 2000 and 2015 National Health Interview Surveys
Li Jun, Ding H, Richards TB, Martin I, Kobrin S, Marcus PM
J Am Board Fam Med 31: 658-662, 2018

Purposes: Despite recommendations against prostate cancer screening with PSA tests, about one-fourth of men age ≥40 years received PSA tests in 2015. This study aimed to answer three questions for men who had a PSA test in the past year: (1) What percentage of these men received the test first suggested by physicians? (2) What factors were associated with physician-initiated PSA testing (PIPT) versus patient/someone else-initiated testing? (3) What percentage of patients ever had shared decision-making when tests were initiated by physicians?

Methods: We analyzed the 2000 and 2015 National Health Interview Survey data. We calculated age-standardized prevalence of PIPT for both years. For 2015, we used logistic regression to calculate adjusted prevalence ratios for PIPT. We also calculated the prevalence of ever discussing both advantages and disadvantages.

Results: Age-standardized prevalence of PIPT was significantly higher in 2015 (84.9%) than in 2000 (72.3%). In 2015, nearly 90% of PSA screenings for men aged ≥70 years were suggested by physicians. PIPT was positively associated with two or more comorbid conditions and number of patient visits to the doctor. Less than one-third of men reported they had ever participated in a discussion of advantages and disadvantages of PSA testing.

Conclusions: The majority of men who had PSA testing in the past year reported that their physicians were the first to suggest testing, including men aged ≥70 years. Our study also points to the challenges and needs in conducting shared decision-making before PSA testing in clinical practice.

Clinical Utility of Total Length Gleason Pattern 4 on Biopsy in Men with Grade Group 2 Prostate Cancer
Dean LW, Assel M, Sjoberg DD, et al.
J Urol, Article in Press

Purpose: The ideal methodology for quantifying secondary Gleason pattern 4 (GP4) in men with Grade group (GrdGrp) 2/Gleason score (GS) 3+4=7 on biopsy remains unknown. We compared various methods of GP4 quantification and evaluated their association with adverse pathology at radical prostatectomy (RP).

Materials and Methods: 457 men with GrdGrp 2 prostate cancer on biopsy who subsequently underwent RP at our institution. Only patients with ≥12 cores reviewed were included. Three methods for quantifying GP4 were evaluated: maximum %GP4 in any single core, overall %GP4 (mm of GP4/total mm of cancer) and total length GP4 (mm) across all cores. Adverse pathology at RP was defined as GS ≥4+3=7 (≥GrdGrp 3), any extraprostatic extension/semenal vesical invasion/lymph node metastasis. A training/test set approach and multivariable logistic regression were used to determine whether GP4 quantification methods could aid in predicting adverse pathology at RP.

Results: On multivariable analysis, all GP4 quantification methods were significantly associated with an increased risk of adverse pathology (p-values <0.0001) and increased AUC beyond the base model; largest increase was 0.044 with total length GP4 (AUC 0.728, 95% CI: 0.663-0.793). Decision curve analysis demonstrated increases in clinical net benefit with addition of GP4 quantification to the base model; total length GP4 clearly demonstrated the largest net benefit.

Conclusions: Our findings support inclusion of Gleason pattern 4 quantification in pathology reports and risk prediction models for patients with GrdGrp 2/GS 3+4=7 prostate cancer. Total length of GP4 across all cores provides the strongest benefit for prediction of adverse pathology.
Just when you thought it was safe to go to the local bar and have a drink, along comes one of the most comprehensive studies on the subject of alcohol and health benefits and detriments. A total of 694 data sources, and almost 600 studies later, and then the following conclusion: “We found the risk of all-cause mortality, and of cancers specifically, rises with increasing level of consumption, and the level of consumption that minimizes health loss is zero.”

Wait…what?! Did they just determine from one of the most comprehensive analyses ever done that there is simply no safe level of alcohol consumption?! This is more depressing than waking up Sunday realizing Michigan lost to Notre Dame! I love my occasional beer, but in my experience, I probably have to agree with this stupid conclusion. Alcohol is not only contributing more silent calories in an adult diet than any other type of commercial product (7 calories/gram), but the alcohol by volume (ABV) for drinks continues to increase, which means the calorific contribution continues to rise. Also, the average portion sizes are getting larger and larger, which means that again, the calorie content continues to increase.

Wait, there is more! Alcohol can cause a release of insulin that in some individuals can be far more excessive than what would be predicted, which means even more weight gain. Gee, I wonder why most fast diets have participants quit alcohol during the beginning phases of their diet plan to help them lose weight (sarcasm alert). Wait, there is more! Alcohol has become a form of self-medication for many people, which is why it is a drug of abuse and one of the most preventable contributors to cause of death on the planet. What also jumped out in this review was the potential striking increase in cancer risk with alcohol consumption, and I believe research has already preliminarily found that excessive alcohol consumption increases the risk of aggressive prostate cancer! What I think this also means is that it can increase the risk of prostate cancer recurrence after treatment. Wait Moyad! You are the doctor that first used the term “Heart Healthy = Prostate Healthy” in the medical literature, and alcohol is heart healthy so you were WRONG?!

I apologize for being so depressing because I do love my occasional beer, but after 33 years in the business of lifestyle medicine it is hard to argue with this study and what I have personally witnessed out there in the real world. Although, I cannot lie that every time we lose to Ohio State, which has been a lot lately (insert my favorite curse word here), the beer that I have after we lose “the game” has acted as my temporary therapist. Oh well, if they lose this year, then it is probably time to pay for a real therapist anyway since the previous one is not looking very good after this latest study.

References:

Men’s Eating and Living (MEAL) Study (CALGB 70807 [Alliance]): Recruitment Feasibility and Baseline Demographics of a Randomized Trial of Diet in Men on Active Surveillance for Prostate Cancer
BJU Int 121: 534-539, 2018

Objective: To assess the feasibility of performing national randomized trials of dietary interventions for localized prostate cancer.

Methods: The Men’s Eating and Living (MEAL) study (CALGB 70807 [Alliance]) is a phase III clinical trial testing the efficacy of a high-vegetable diet to prevent progression in patients with prostate cancer on active surveillance (AS). Participants were randomized to a validated diet counselling intervention or to a control condition. Chi-squared and Kruskal-Wallis analyses were used to assess between-group differences at baseline.

Results: Between 2011 and 2015, 478 (103%) of a targeted 464 patients were randomized at 91 study sites. At baseline, the mean (SD) age was 64 (6) years and mean (SD) PSA concentration was 4.9 (2.1) ng/mL. Fifty-six (12%) participants were African-American, 17 (4%) were Hispanic/Latino, and 16 (3%) were Asian-American. There were no significant between-group differences for age (P=0.98), race/ethnicity (P=0.52), geographic region (P=0.60), time since prostate cancer diagnosis (P=0.85), PSA concentration (P=0.96), clinical stage (T1c or T2a; P=0.27), or Gleason sum (Gleason 6 or 3+4=7; P=0.76).

In a pre-planned analysis, the baseline prostate biopsy samples of the first 50 participants underwent central pathology review to confirm eligibility, with an expectation that <10% would become ineligible. One of 50 participants (2%) became ineligible.

Conclusion: The MEAL study shows the feasibility of implementing national, multi-institutional phase III clinical trials of diet for prostate cancer and of testing interventions to prevent disease progression in AS.
Nuclear Pore Proteins
(Continued from page 1)
	nuclear pore was associated with aggressive tumors that continue to grow despite standard therapy. The researchers also showed that blocking POM121 could block molecules such as MYC, E2F1, and the androgen receptor from reaching the nucleus to activate tumor growth. These three molecules are known to drive aggressive prostate cancer.

Study coauthor Josep Domingo-Domenech, MD, PhD, associate professor of medical oncology at Sidney Kimmel Medical College at Jefferson, said this study shows that blocking the import machinery may be an effective strategy to target the un-druggable. “MYC is an oncogenic transcription factor in which successful direct blockage does not exist,” he said.

“The clinical implication of our study is the description of a paradigm-shifting treatment option for advanced prostate cancer patients. We believe analyzing the status of the nuclear pore will allow identification and stratification of patients in levels of aggressiveness of the tumors. Furthermore, this information will hopefully allow nuclear import inhibitors to be considered as a therapeutically option for such patients,” Domingo-Domenech told Cancer Network.

The researchers are now hoping to identify specific chemical compounds against POM121 and determine their efficacy and toxicity for use in human clinical trials. Soroush Rais-Bahrami, MD, assistant professor of urology and radiology and co-director of the University of Alabama at Birmingham Program for Personalized Prostate Cancer (Continued on page 8)

Screening Has No Effect on Overall Mortality (Continued from page 1)

men will continue to ask their general practitioners (GPs) about testing. “How GPs respond varies greatly,” they write. “Some GPs will offer the test with little or no discussion, whereas others will decline to order PSA testing and advise their patients that the test has little or no value.

“The problem is that the PSA test, the only test currently available, has a high incidence of false positive and false negative results, and many cancers detected through PSA are indolent and would never cause the patient any harm,” the editorialists write. When patients request a PSA test, conversations “should explore their reasons for requesting a test and include evidence-based discussions about possible harms and benefits of PSA testing,” Roland and colleagues comment.

These discussions should also be “informed by the patient’s ethnicity and family history” and include information about recent advances in multiparametric MRI before biopsy and active surveillance. “Multiparametric MRI is improving diagnosis and may reduce the number of men needing biopsy. Both of these interventions can reduce the harms of testing,” the editorialists note.

Little Impact on Mortality

The new meta-analysis was conducted by Dragan Ilic, PhD, School of Public Health and Preventive Medicine, Monash University, Victoria, Australia, and colleagues from around the world. It included five randomized controlled trials with a total cohort of 721,718 men. Included were the Cluster Randomised Trial of PSA Testing for Prostate Cancer (CAP) study, conducted in the UK; the Prostate, Lung, Colorectal and Ovarian (PLCO) Cancer Screening Trial, conducted in the United States; trials conducted in Canada and Sweden; and the European Randomized Study of Screening for Prostate Cancer (ERSPC), a multicenter study across eight European countries.

Four studies reported on all-cause mortality, and PSA screening did not appear to have any effect (incidence rate ratio [IRR], 0.99; 95% confidence interval [CI], 0.98-1.01; moderate-quality evidence). This extrapolated to one fewer death from any cause per 1,000 participants screened.

In addition, the results from the five trials indicate that PSA screening had little or no effect on prostate cancer-specific mortality (IRR, 0.96; 95% CI, 0.85-1.08; low-quality evidence). This corresponded to zero fewer deaths from prostate cancer per 1,000 participants screened.

The authors note that a sensitivity analysis of studies at lower risk for bias (n=1) demonstrated that screening seems to have no effect on all-cause mortality (IRR, 1.0; 95% CI, 0.98-1.02; moderate certainty) but may have a small effect on prostate-specific mortality (IRR, 0.79; 95% CI, 0.69-0.91; moderate certainty). This corresponds to one fewer deaths from prostate cancer per 1,000 men screened over 10 years. Screening did, however, increase the detection of prostate cancer of any stage (IRR, 1.23; 95% CI, 1.03-1.48; low-quality evidence). This finding corresponded to seven more diagnoses of prostate cancer per 1,000 men screened.

“This systematic review provides important information for an individual man’s decision making about prostate cancer screening,” note the authors. Their analysis indicates that, at best, screening yields “only a small benefit in prostate cancer specific mortality, but does not reduce overall mortality.

“This small benefit should be weighed against the potential short-term complications (biopsy related, false positive and false negative findings) and long-term downstream effects (treatment related side effects, in particular related to urinary and sexual function),” they add.

Medscape Medical News
11 September 2018

Resources Address Anxiety, Depression and Prostate Cancer

Many men who are diagnosed with prostate cancer, or are managing the disease, experience some level of anxiety and/or depression. Caregivers may also be affected. The psychosocial challenges surrounding treatment choices and side effect management can have a negative impact on the prostate cancer journey. Anxiety and depression aren’t always effectively treated, in part because the symptoms may not be recognized.

We encourage you to visit the Us TOO web page for important information on recognizing and managing anxiety, depression and prostate cancer.

www.ustoo.org/anxiety-and-depression
Long-Term Outcomes After Deferred Radical Prostatectomy in Men Initially Treated with Active Surveillance

Godman RA, Schafferer M, Pihl C-G, Stranne J, Hugosson J
J Urol 200: 779-785, 2018

**Purpose:** We sought to determine long-term outcomes after deferred radical prostatectomy (RP).

**Materials & Methods:** The study population consisted of all 132 men with screening detected prostate cancer who underwent deferred RP from January 1, 1995 to December 31, 2014 after active surveillance in the Göteborg Randomized, Population-based Prostate Cancer Screening Trial. The last date of followup was May 15, 2017. Followup during active surveillance was performed with PSA tests every three to six months and repeat biopsies every two to four years. Triggers for RP were disease progression based on PSA, grade and/or stage, or patient request. Outcomes included adverse pathology findings at RP, defined as Gleason score greater than 3+4, extraprostatic extension, positive margins, seminal vesicle invasion and/or N+ (positive lymph nodes), if the index tumor at RP was identified at biopsy and PSA-free survival. Kaplan-Meier analysis was performed.

**Results:** Median time from diagnosis to surgery was 1.9 years (IQR 1.2-4.2) and median postoperative follow-up was 10.9 years [interquartile range] 7.5-14.5). A total of 52 men (39%) experienced at least one unfavorable pathology feature at RP. The 10-year PSA relapse-free survival was 79.5%. The index tumor was not identified in the diagnostic biopsy in 38 of the 132 men (29%) or at the last repeat biopsy that preceded RP 22 of 105 (21%).

**Conclusions:** A large proportion of men had unfavorable pathology findings at deferred RP and the index tumor was frequently not identified. There is a clear need for better risk classification and protocols to determine disease progression during active surveillance.

Impact of Family History of Cancer on Risk and Mortality of Second Cancers in Patients with Prostate Cancer

Prostate Cancer Prostatic Dis 5 September 2018; Epub

**Background:** Survival rates are increasing in men with prostate cancer (PCa) and second primary cancers (SPCs) are becoming more common in these patients. However, the etiology and clinical consequences of SPCs are not well-known. We define the impact of family history on PCa and causes of mortality in these patients.

**Patients & Methods:** A nationwide cohort study based on the Swedish Family-Cancer Database covering 4.4 million men and 80,449 prostate cancers diagnosed between 1990 and 2015. Relative risks (RRs) and cumulative incidence for SPCs and for familial SPC were calculated for PCa patients.

**Results:** SPC was diagnosed in 6,396 men and more than a third had a first-degree family history of any cancer; the familial risk was 1.37 (95% Confidence Interval [CI]: 1.27-1.40), compared to 1.10 (1.08-1.16), without a family history. Cumulative incidence by the age of 83 years reached 21% for PCa alone, 28% in those with SPC, and 35% in men with SPC and family history. Family history was associated with the risk of seven specific SPCs, including: colorectal, lung, kidney, bladder and skin (both melanoma and squamous cell) cancers, and leukemia. Colorectal and lung cancers were common SPCs, and family history doubled the risk of these SPCs. In men with SPC, half of all causes of death were due to SPC and only 12.77% were due to PCa. Most SPC deaths were caused by lung and colorectal cancers.

**Conclusions:** SPCs were an important cause of death in patients with PCa and family history was an important risk factor for SPCs. Prevention of SPC should be essential when PCa survival rates are being improved and this could start by conducting a thorough assessment of family history at the time of PCa diagnosis.

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And Much More at www.ustoo.org/Pathways-Seattle-Webcast
Experts Find Flaw in Prostate Cancer PET Imaging Technique

Researchers have discovered potential for misdiagnosis when relying solely on prostate-specific membrane antigen (PSMA) PET imaging in prostate cancer staging. Lead author Christoph Rischpler, MD, and colleagues studied the PSMA-ligand uptake in cervical, coeliac and sacral ganglia in 401 men. Compared to adjacent lymph node metastases, they found the uptake was above background levels in 401 men – more than 98%. The findings confirmed prior studies that determined benign tissue may also show increased PSMA expression – potentially causing confusion with lymph node metastases and unnecessary therapy changes.

“It is important that nuclear medicine physicians be aware of this pitfall, as the interpretation of PSMA PET scans may have a substantial impact on therapy guidance,” said Rischpler, with the department of nuclear medicine at the Technical University of Munich in Germany, in a news release.

Rischpler and colleagues urged nuclear medicine specialists to heed their warning, but not to completely disregard PSMA PET imaging. Instead, they suggested analyzing PSMA-ligand uptake together with exact localization and configuration of appropriate lesion to identify PSMA levels from ganglia and lymph node metastases, according to the release.

“We hope that an increased awareness among nuclear medicine physicians of this important pitfall helps to increase diagnostic accuracy and improve therapy guidance, preventing unnecessary procedures for prostate cancer patients,” Rischpler concluded.

Health Imaging
10 September 2018

Obese Prostate Cancer Patients Do Worse After Radical Prostatectomy

Study of Korean radical prostatectomy (RP) patients showed that those who were obese had significant increased odds of biochemical recurrence and cancer-specific mortality. Obese patients with prostate cancer are more likely to experience worse outcomes after RP, a new study suggests. Investigators at Seoul National University Bundang Hospital in Seongnam, Korea, studied 2,997 prostate cancer patients who underwent RP from 2006 to 2017. They stratified patients into three body mass index (BMI) groups according to World Health Organization (WHO) recommendations for Asian men: normal weight (less than 23 kg/m^2), overweight (at least 23 but less than 27 kg/m^2), and obese (27.5 kg/m^2 or higher).

In multivariate analysis, obese men had significant 1.27-fold increased odds of biochemical recurrence and 2.3-fold increased odds of cancer-specific mortality compared with normal weight men after adjusting for PSA level, diabetes mellitus, pathologic Gleason score and other clinicopathologic factors, Young Dong Yu, MD, and colleagues reported in Scientific Reports (Vol. 8, p. 11962, 2018).

Final pathologic findings showed that obese men had increased PSMA expression. “It is important that nuclear medicine physicians be aware of this pitfall, as the interpretation of PSMA PET scans may have a substantial impact on therapy guidance,” said Rischpler, with the department of nuclear medicine at the Technical University of Munich in Germany, in a news release.

Rischpler and colleagues urged nuclear medicine specialists to heed their warning, but not to completely disregard PSMA PET imaging. Instead, they suggested analyzing PSMA-ligand uptake together with exact localization and configuration of appropriate lesion to identify PSMA levels from ganglia and lymph node metastases, according to the release.

“We hope that an increased awareness among nuclear medicine physicians of this important pitfall helps to increase diagnostic accuracy and improve therapy guidance, preventing unnecessary procedures for prostate cancer patients,” Rischpler concluded.

Health Imaging
10 September 2018

SBRT Appears Effective for Oligometastatic Prostate Cancer

Stereotactic body radiation therapy (SBRT) appears to be effective for oligometastatic disease in men with recurrent prostate cancer (PCa), a new study suggests.

Ciro Franzese, MD of Humanitas Clinical and Research Hospital, Milan-Rozzano, Italy, and colleagues analyzed findings from 64 patients who underwent SBRT for 90 metastases. Fifty men (78.1%) received SBRT for lymph node metastases, two patients (3.1%) were treated simultaneously for lymph node and bone metastases, and 10 (15.7%) were treated for bone metastases only. Two patients received SBRT for lung metastases. Of the 64 patients, 27 were treated with androgen deprivation therapy (ADT) when they underwent SBRT and 37 were not.

The median follow-up was 15.2 months. Rates of local control at 6, 12, and 18 months were 94%, 88%, and 84%, respectively, the investigators reported online ahead of print in the journal Cancer Medicine. Men with castration-resistant disease had a significant two-fold increased risk of disease progression than those with castration-sensitive disease.

(Continued on page 8)
Preliminary Data from Study Demonstrates 94% Accuracy in Detecting Aggressive Prostate Cancer

VolitionRx Ltd. announced preliminary data from a prospective, multi-centered Proof of Concept Study of 84 men into the utility of Volition’s Nu.Q™ assays to diagnose men with high-grade prostate cancer (PCa).

At 88% specificity, the Volition panel of five assays (including PSA) identified 94% of high-grade PCAs that require treatment (as defined by Gleason Score). This compares with just 33% identified by PSA alone.

“This is a very exciting outcome for us as we continue the development of our assays beyond colorectal cancer. The preliminary data from this study showed that Volition’s panel of assays identified men with potentially lethal high-grade PCa with much greater accuracy than PSA alone. Based on this data, we believe that this test could assist clinicians in more accurate patient selection for prostate biopsy and treatment and substantially reduce the amount of unnecessary procedures in men with low-grade tumors or no tumor. The next step is to confirm these statistically significant findings in independent larger clinical trials,” said Dr. Jake Micallef, Chief Scientific Officer at Volition.

In the Proof of Concept Study, a blood sample was taken prospectively from men referred for prostate biopsy in three Belgian hospitals. Men were grouped by biopsy findings as having no cancer (most of whom had elevated PSA levels), low-grade cancer or high-grade cancer.

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Doctor Chodak’s Bottom Line

Gerald Chodak, MD, Author, Winning the Battle Against Prostate Cancer, Second Edition
http://www.prostatevideos.com/

Editor’s Note: Us TOO has invited certain physicians and others to provide information and commentary for the Hot SHEET to enrich its content to empower the reader. This column contains the opinions and thoughts of its author and are not necessarily those of Us TOO International.

P1, “Prostate Cancer…”
Screening for prostate cancer is again making news. A large meta-analysis involving over 700,000 men, who included both the European and American studies found that overall survival was not affected and the impact on prostate cancer survival was extremely small amounting to one life saved per 1,000 men screened. It will be interesting to see how this study is discussed but it does mean that it is a critical piece of information that all men should receive before a PSA is performed.

The Bottom Line: A large meta-analysis has found that screening may save only one man per 1000 screened while causing significantly more harm.

P1, “LBR Brachytherapy…”
Does the addition of low dose rate brachytherapy improve the outcomes of men with T3 disease treated with external radiation? Some information is provided in a study by Agarwal, et al. who treated 99 men with cT3 disease. ADT was also given to 86% of the patients. They report excellent biochemical control and overall survival and recommend that LDR-BT boost be used for men with T3 disease. Unfortunately, this study does not make it possible to truly assess the value of the brachytherapy. There is no control group, most of the men also received ADT and we know that ADT plus external radiation improves survival, but the added value of brachytherapy has not been established in a well done study. Without randomized data there is no way to determine the added value of brachytherapy.

The Bottom Line: Adding a brachytherapy boost to men with T3 disease treated with external radiation may help, but a better study is needed to make that determination.

P2, Clinical Utility of…”
Gleason scoring has been a great benefit to counseling men and evaluating therapies for prostate cancer. It now appears that Gleason Grade 3 carries very low risk but the presence of Grade 4 increases the risk. Unfortunately, the Gleason scoring system does not take into consideration small amounts of Gleason Grade 4. The study by Dean, et al. looks at different ways to measure Gleason 4 so that it can improve our understanding of what to expect from the disease. The total amount of Gleason 4 in the biopsies had the best increase in the area under the curve for predicting adverse pathology. Unfortunately, that increase was only 0.044 so whether it is good enough to become a standard remains uncertain and more data are needed.

The Bottom Line: Measuring the amount of Gleason Grade 4 in a biopsy may help to improve counseling for men with prostate cancer, but more support is needed.

P6, “Obese Prostate…”
The Korean study of men undergoing radical prostatectomy reveals some interesting information about body weight and radical prostatectomy. A retrospective analysis of almost 3,000 men found that body weight was a risk factor for positive surgical margins, extra-prostatic invasion, pathologic score greater than 7 and lymph node invasion. Worse outcomes occurred with greater weight. Assuming this might also be true for Caucasian men, what should be done with this information? It is unlikely that having men lose weight before treatment would help. Should these men not be treated surgically? That is one possible conclusion, although we would need to see similar data for men treated with external radiation to determine if the outcomes would be better.

The Bottom Line: Higher weight appears to be associated with worse outcomes after radical prostatectomy, at least for Korean men.

PROSTATE CANCER HELPLINE: 1-800-808-7866 WWW.USTOO.ORG

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Oligometastatic PCa
(Continued from page 6)

Oligoprogressive patients were less likely than oligorecurrent patients to achieve local control. According to National Comprehensive Cancer Network criteria, 3.1%, 54.7% and 42.2% men had low-, intermediate-, and high-risk disease, respectively.

The study population, which had a median age of 71.8 years, included men treated initially with surgery (20.3%), surgery plus adjuvant or salvage RT (54.7%), RT alone (7.8%), ADT (7.8%), and high intensity focused ultrasound (9.4%). The median time to biochemical relapse was 32.8 months.

Median RT dose was 42 Gy (range 18-60) in two-eight fractions. The median dose per fraction was 7.5 Gy. Of the 64 patients, 19 (29.7%) had castration-resistant disease when undergoing SBRT.

Prostate Cancer Advisor
10 August 2018

Preliminary Data
(Continued from page 7)

cancer. The samples were tested with a panel of five assays (PSA, two Nu.Q™ assays and two inflammatory biomarkers).

Assay results correlated with the Gleason Score, which is one of the main predictors for aggressive PCa determined on biopsy. This suggests the assays may provide better risk stratification than that available using PSA tests for men with actual or suspected PCa, leading to better patient management and fewer unnecessary biopsies.

Commenting on the results, Principal Investigator, Professor Thierry Roumeguere, Head of Urological Services, Erasme Hospital, Brussels, Belgium said “A non-invasive test to help in the risk stratification of men with suspected or actual PCa will be a major step forward in the management of this disease. Correlation of panel results with Gleason Score shows great promise in this regard.”

PR Newswire
13 August 2018

Nuclear Pore Proteins
(Continued from page 4)

Care in Birmingham, Alabama said, “this study shows a promising finding which may change the paradigm of how patients are treated in the future. “We may be able to sensitize patients with advanced metastatic prostate cancer to various treatments they may otherwise be resistant to. It does need further validation in preclinical studies and clinical trials prior to altering the treatment workflow for these patients with incurable forms of prostate cancer. However, it may provide a path for more successful treatments,” Rais-Bahrami told Cancer Network.

CancerNetwork
11 September 2018

Obese Men
(Continued from page 6)

significantly higher rates of positive surgical margins than overweight and normal weight men (13.9% vs. 2.6% vs. 1.4%, respectively), extraprostatic invasion (19.9% vs. 15.6% vs. 11.1%), pathologic Gleason score of 8 or higher (50.8% vs. 38.5% vs. 30%), and lymph node invasion (14.5% vs. 14.3% vs. 10.6%) compared with overweight and normal weight patients.

Renal & Urology News
August 17, 2018

Join us in person or via online webcast with live audio and video. To register, contact Terri at 877-978-7866 or terril@ustoo.org.
QUESTION FROM PROSTATE CANCER SURVIVOR:
After my nerve-sparing prostate surgery this past year, I seem to get more partial spontaneous erections in the morning. However, I’m not able to achieve an erection from stimulation by my partner. I’m very frustrated. Why is this happening?

RESPONSE FROM DR. JEFFREY ALBAUGH:
Thank you for your great question. First, it is always good to have any erection response (spontaneous or with stimulation). In the early stages after prostate removal, you are looking for any signs of response from your penis with filling, thickening, heaviness, stretching or expanding. These are partial responses, even in the absence of any hardness. The nerves for erections must be dissected (pulled free) from the prostate during prostate removal. Even though they were sparred, they were never meant to be touched or manipulated in any way. The nerves are traumatized and inflamed. They do not function properly because of this trauma and nerves can take a long time to recover. It can take an average of two years (and may continue to recover for up to five years) for nerve recovery. Erection recovery could happen quicker. Everyone is different in terms of erectile function recovery and not everyone will recover their function, unfortunately. Most men notice a slow, steady progression towards more fullness/thickness/filling in the penis, moving towards hardness over that two-year period. What you are experiencing is not unusual and it is a good sign of erectile recovery.

Many factors come into play when you are trying to have sex with your partner. You may be anxious or worried about erections or pleasing your partner. This anxiety causes a physical response from your body with increased adrenaline and this will often lead to losing your erection. When you are having sex, it is most helpful to stay focused and mindful so you and your partner can enjoy feeling connected and have pleasure (it is supposed to be fun). You and your partner don’t need a hard penis to reach orgasm as men and women both can orgasm/climax without intercourse through oral stimulation, manual stimulation, rubbing genitals, and/or vibration on the genitals. It can be very helpful to talk with your partner about your fears and concerns about sex. Reaffirm that you want to please your partner and work together towards the goals of connectedness, pleasure and orgasms regardless of erections.

It is important to keep working with your healthcare team to regain sexual function through penile rehabilitation (promoting blood flow to the penis through regular stimulation and the use of various erectile dysfunction treatments such as pills, a vacuum device or penile injections, if needed). You can learn more about erections after prostate cancer treatment and penile rehabilitation at the upcoming Chicago Prostate Cancer Pathways for Patients and Caregivers event and webcast with live online audio and video on November 3, where I will be giving a presentation on the subject. To register, contact Terri Likowski at 877-978-7866 or terril@ustoo.org. You can access the new edition of my book or download a free copy of my original book at www.drjeffalbaugh.com.

Do you have a question about sexual health or intimacy? If so, we invite you to send it to Us TOO. We’ll select questions to feature in future Between the Sheets columns.

Please email your question to: uestooBTS@ustoo.org

Or mail your letter to:
Us TOO International
Between the Sheets
2720 S. River Road, Suite 112
Des Plaines, IL 0018
Us TOO Presents:
Prostate Cancer Pathways for Patients & Caregivers

Free Educational Event and Webcast Series

Saturday, November 3
Chicago, IL
Location TBD
10:00 am - 3:30 pm

Schedule to be Announced

Let Us Help You Plan Your Path Through Every Step of Your Journey...

Prostate Cancer Pathways for Patients and Caregivers is a new educational event and webcast series from Us TOO International. The Englewood, NJ, Pathways event is the second of three regional events planned for 2018.

Each Pathways event provides valuable content including:
- An educational overview of prostate health and prostate cancer awareness
- Presentations with relevant content for newly diagnosed, recurring, and advanced patients
- Content to help Us TOO support group leaders maximize their impact on the local prostate cancer community

This Event will Feature a Special Presentation on Erectile Dysfunction and Incontinence After Prostate Cancer Treatment

Presenters for the Chicago Event:
- Dr. Jeffrey Albaugh, Board Certified Advanced Practice Urology Clinical Nurse Specialist, Board Certified Sexuality Counselor, Director of Sexual Health at NorthShore University HealthSystem and at Jesse Brown VA Medical Center, and member of the Us TOO Board of Directors.
- Others to be announced.

All sessions will be webcast live and videotaped.

Presenting Sponsor:

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