PROSTATE CANCER ACTION GROUP (S.A.) INC

Affiliated with
Prostate Cancer Foundation of
Australia

ABN 26 499 349 142

NEWSLETTER

WEBSITE www.pcagsa.org.au

N O V E M B E R 2 0 0 5

Chairman's Report November 2005

Awareness Evenings

Blackwood

I am pleased to report our Group has been successful in obtaining a further Community Grant from the City of Mitcham, on this occasion to conduct an Evening at Blackwood by Mid 2006. Dr Peter Sutherland consults at the Blackwood Hospital and has indicated he would again be willing to speak for us, subject to availability.

Clare

At this stage I have not been able to make further contact with the Men's Health Worker at Clare regarding the possibility of a presentation at Clare early in 2006. However I will continue to follow up in this regard.

Grant Applications

As mentioned our further Grant application to the City of Mitcham was successful and to quote the acceptance letter "The Community Development Grants Sub-Committee is appreciative of the time and effort you and your organisation have devoted to your funding application". Well done Rob.
I also spoke briefly to the Sub-Committee and provided some additional information eg. possible speaker and venue.

BE-A-Man Launch

I am quoting information supplied by Reg Mayes, Adelaide Support Group.

"Health In Men (HIM) and Prostate Cancer Foundation of Australia join forces
A men's health screening and referral program, known as Pit Stop, has become an annual component of Health In Men (HIM), Royal Adelaide Hospital men's health initiative. This year Pit Stop will be conducted in conjunction with the SA launch of PCFA's BE-A MAN campaign. The launch will be held in the main foyer of the RAH on 29th November, 2005 – with the exact launch time yet to be advised. The main purpose of the campaign is to encourage men to talk to their doctor about their health, including prostate issues, with a focus on prevention rather than cure. The health screening program conducted by the RAH will complement the preventive health messages conveyed through the "BE-A MAN" campaign. RAH Health Promotion will distribute PCFA's "Pee Balls" to all men who pass through the Pit Stop program. It is anticipated that a range of men's health experts and well known personalities will be involved throughout this media launch."

The Latest News from Prostate SA

(Also courtesy of Reg Mayes)
"Prostate SA is hosting their first multi-disciplinary meeting for Urologists, Oncologists and radiation Oncologists on the 10th November. Dr Mark Rosenthal, who is an Oncologist, will be the key speaker.
This is planned to be a series of meetings over the next 12 months.
Prostate SA is planning to be involved with the PCFA for the launch of the BE-A MAN campaign on the 29th November.

Progress is being made with the Cancer Council and we now have a number of options proposed by the consultant Mr Ray Blight and we hope that a final decision will be made by the end of November."
(From Prof.Villis Marshall)

Mitcham Prostate Cancer Support Group
There was an attendance of 19 at the October Meeting.
The guest speaker was Lloyd Evans who has been a GP for approximately 50 years. Although officially retired he has continued locum duties throughout the State.
Lloyd spoke of his involvement with the Royal Flying Doctor Service where he is a Board member. He gave a very interesting presentation that was greatly appreciated by members and again emphasized how vital the RFDS is to this Country.
The next Meeting will be held at 7.15p.m. on Thursday 24th November at the Colonel Light Gardens RSL Club. The guest speaker will be Gordon Frith who is a nurse in the urology section at the Royal Adelaide Hospital and a member of the Prostate Cancer Action Group.
For more information phone Jeff Roberts on 8277 3424 or check our website on www.pcagsa.org.au

New members urgently required
The Action Group is desperately in need of new members.
There is a great deal of satisfaction to be gained in spreading the word on prostate cancer awareness. A large commitment is not required and our Group would welcome anyone who wishes to join.
No membership fees are required – we operate mainly on grant monies.
Our meetings are held on the second Tuesday of each month other than January and December.
If anyone is interested please phone myself on 8277 3424 or contact other members of the Group
You can find further information by visiting our website on:
www.pcagsa.org.au
We look forward to hearing from you.

A brief review of 2005
As usual our November Meeting will be our Group's final meeting for the year.
At the close of 2004 I commented on the recent lack of publicity on prostate cancer issues and expressed the hope 2005 would show a substantial improvement. In many ways this did occur and I believe there has been greater interest amongst the community. Unfortunately, there were the usual negative comments from some sources with the much maligned PSA test receiving its normal adverse publicity.
As one who was probably saved from advanced prostate cancer by a vigilant GP and the DRE, I was annoyed by comments of how adverse men are to this test and the fact GP's often seem reluctant to conduct the test.
I was pleased to hear Dr Peter Sutherland in an interview at the time of the National Prostate Cancer Call-In state that both the PSA and DRE were essential tests.
Our Group conducted 3 public awareness evenings in 2005 with a total attendance of 432 – an excellent result. In addition, 2 of our members spoke at a presentation at Port Augusta sponsored by Abbott Australasia and supported by the Corporation of the City of Port Augusta. Apart from the awareness evenings several of our members also spoke to various community groups.
The Mitcham Support Group started as a result of our awareness evening in February and is progressing satisfactorily.
Our Group also attended events such as Man Alive 2005, the Mount Compass Field Day and The Vietnam Veteran's Men's Health Expo with the purpose of spreading prostate cancer awareness and distributing pamphlets.
It has been a busy year and as mentioned above our Group desperately new members. I hope this occurs in 2006 as our activities are currently restricted by lack of numbers.

The compliments of the Season to everyone.

Jeff Roberts

Do you know any person who would be interested in spreading awareness of prostate cancer – perhaps someone who would gain satisfaction from ensuring that other men do not have to endure the outcomes that some of us have had to endure. Then tell us about them- they could gain immense satisfaction from helping other men, and their families.

MINUTES

Prostate Cancer Foundation of Australia National Support and Advocacy Committee Teleconference

Thursday 20th.October,2005

Commenced: 2:58pm Concluded:4:40pm

Chair: David Sandoe (NSW/ACT)
Minutes: John Ramsay
Participants: David Sandoe, Pam Sandoe, Con Casey, Bob Wilson, Ean McArthur, Don Baumber, Trevor Hunt, GaryBowes, Karen Rendell,
Cheryl Mellor, Bill McHugh, John Ramsay
Apologies: Keith Williams, Graham Nicholls, John Dowsett, Andrew Giles

Order of Business:

(i) Introduction:(David Sandoe) (i.i) Welcome to National Support &Advocacy Manager; (i.ii) Request that in future agenda items be submitted in a succinct and timely manner, that is, no last minute 'bombardments' (i.iii) Change of telephone contact details for Bill McHugh 07.3203.3565; Trevor Hunt 08.8381.9791; (i.iv) NSAC Minutes to be in bullet points.

Item:**1.1** Confirmation of Minutes of 18th.August,2005 **moved:** Con Casey **seconded:** Gary Bowes
Matters Arising: nil

1.2 Confirmation of Conference Minutes of 19th September,2005 **moved:** Karen Rendell **seconded:** Bill McHugh

2. Business Arising:

2.2.1 SAC Support Group Coordinator (14October,2005);appointment of NS&A Manager.

2.2.2 PSA Position Statement (v. Item 7)

2.2.3 Kits: Leaders and Trainers (distribution underway)

2.2.4 Request that the next SAC Conference include a Q&A with a urologist, medical oncologist, radiation oncologist and pathologist.(Bill McHugh)

(side item) Concert for Max at the National Gallery of Victoria (Federation Sq.) a resounding success (David Sandoe) : some discourse that Victorian chapter were unaware of final arrangements

Suspension of standing orders : change of agenda order (foreshadow Item 6)

3.CEO Update : report to be forwarded separately.

4. State Chapters : NSW minutes to be circulated, and it was requested that other state and territory chapters do likewise.

4.1 Query as to visitation schedule of NS&A Manager re: Q'ld.

4.2 Victoria Chapter: number of issues arising; generally in relation to communications (intra and inter); uniformity and consistency of promotions and information.Press releases and educational materials for dissemination to be vetted and approved by National office Sydney.Including use of PCFA logo. Suggestion by Bob Wilson that Ean rewrite documents; PCFA vet/approve and send with covering letter to CCVIC and Victorian Minister for Health

4.3 S.A Chapter: Royal Adelaide Hospital / Be A Man launch :29.11.05; Movember contacts and web site (Gary Bowes). SA Chapter has achieved much in the space of 4 years in relation to rural and metropolitan awareness (Trevor Hunt). Gary suggested standard brochure/flyer from PCFA personalised by each Chapter/PCSG for awareness programs.

4.4 Tasmania: nil ; contact Jennifer Lyall for next Meeting.

4.5 W.A Chapter:(Karen Rendell and Cheryl Mellor): a number of issues arising in relation to geographic spread, access ; communications; shared responsibilities; and quality of relations

(including policy differences) with the WA Cancer Council. Follow up on budget proposal for equipment to Board in November.

5. Brief Updates: Q'ld (Bill McHugh):consumer program 15 Nov; Clinical Oncological Annual Conference.; SA (Gary Bowes)RAH; Patient Care; Consumer Health Forum; Vic (Bob Wilson) health awareness and support groups for men; urologists and oncologists; NSW:
(David Sandoe) see NSW SAC report; also Victorian Chapter forthcoming meetings 9th and 10th November with Executive and PCSG leaders.

6.SAC : Election Guidance (Con Casey spoke to this item which had been previously circulated; highlighted 'terminating/finite' duration of elected positions; who will replace whom); (Don Baumber spoke briefly to Q'ld Council and SAC scenario). Agenda Item March/April meetings.

7. PSA Statement (Bill McHugh) : >35yr males PSA screen to establish benchmark for future antigen tests; free to total (explanation of relevance / importance); would reduce number of TRUS biopsy; who is the audience /target group; feedback required to circulated document by end of November.

8. Next NSAC Teleconference 3:00pm - 4:30pm Thursday 8th.December,2005

9.Other Matters: (i) Meeting with Roche to include Andrew Giles, David Sandoe & Don Baumber; (ii) Approach Dr. Paul Cozzi re HIFU article for Prostate News; (iii) copy of P.Stricker's "Powerpoint" slides as presented at European conference; (iv) Complimentary Therapies seminar at the Garvan on 29/10 NSWCC

10. I x day SAC Conference for late April,2006

(Members should note that I have been misquoted in this record of the meeting, and that my telephone number is also recorded incorrectly. Appropriate corrections have been notified to John Ramsay)

MEN WITH METASTATIC PROSTATE CANCER REQUIRED FOR TRIAL

Professor Villis Marshall is conducting a trial at the Royal Adelaide Hospital which is aimed at investigating the value of a drug called Zometa which has been shown to be effective in improving quality of life and bone events such as fractures in men with metastatic prostate cancer which is no longer fully controlled by androgen deprivation. The new study is to determine if similar benefits can be achieved in men who have metastatic disease, but where the disease is still controlled by androgen deprivation therapy. In essence, it is repeating the earlier studies, but at a time when the disease is still amenable to androgen deprivation. Men will be randomised to either a treatment arm where they will receive Zometa intravenously, or no treatment until the disease becomes hormone-resistant. All participants will be followed up for 3 years to monitor the progress of the disease to determine whether the Zometa is having further beneficial effects. There may be men known to PCAG members who would be interested in joining this trial. The requirements are that they have known spread of the prostate cancer to their bones, but their PSA levels are stable on androgen deprivation therapy. Before entering the men into the trial, we would need to inform their treating doctors to ensure that there would be no disruption to their normal care if they entered the trial.

For further information please contact the Research Coordinators, Paula Vanderzon and Catherine Easterbrook on (08) 8222 4438 or alternatively, Professor V.R. Marshall on (08) 8222 5680.

NEW BLOOD TEST FOR PROSTATE CANCER

A new blood test for prostate cancer reported in the *New England Journal of Medicine* this week is more accurate than the current prostate-specific antigen (PSA) test and could prevent unnecessary prostate biopsies.

Researchers at the University of Michigan Comprehensive Cancer centre have discovered a panel of 22 biomarkers that can accurately identify a patient with prostate cancer. Blood samples were taken from 331 prostate cancer patients prior to surgery and 159 healthy men, and tested for the 22 compounds. Samples that were not cancerous were correctly identified 88% of the time, and samples that were cancerous tested positive 81.6% of the time. (*New Engl. Journal of Med. 2005; 353: 1224-35)*

This is much more reliable than the single PSA biomarker which produces a wrong diagnosis of cancer in 80% of cases. (One wonders whose estimate is that?) *(W/E Australian, 24/9, Health Section p31*

MAN ALIVE **2006**

Imagine yourself at Semaphore Foreshore...surrounded by a diversity of sights and sounds that will stimulate your senses. Be amazed by Giant Puppets; hear high quality musical talent from around the globe, be transported to the plains of Africa with the sounds of beating drums...smell the aromas of the exotic foods.

Now don't just imagine it... Be part of it !!

Man Alive! 2006
Men's Health & Well-being Festival
Sunday March 19th - 10 am - 4 pm

Building on the success of 2004 and 2005, the Semaphore Foreshore will once again be transformed from a blank canvas to a living, vibrant 'village' of colourful marquees, music, fun and activities.

Proudly supported by MIX 102.3, this festival is a great opportunity to showcase your organisation as relevant, accessible and appropriate to men's needs. Join us in celebrating the diversity and positive contributions of men within our families and communities.

Participating agencies are strongly encouraged to present their service in an interactive / fun way

Also included this year is an application form for the Man Alive! Award.

Man Alive! 2006 Award

Help us celebrate these men!

Man Alive! 2006 is a festival celebrating the positive contribution by men in our community, and promoting men's health and well-being. The event will take place on Sunday 19th March 2006 (Semaphore Foreshore Reserve) and we would like to hear about men who have made a significant impact in the lives of others without seeking recognition.

If you know a man who has made the community a better place to live in by their positive actions, or a man who has been important in your life, send this story to us together with a photo. These will be displayed at the event to have their story told at Man Alive! 2006, acknowledging the positive contribution and difference they have made! Finalists will be chosen for a special award on the day and the chance to WIN a Great Prize!

"A great man in my life is -.....- Great Stories to be seen. heard and told!"

The Man Alive! 2006 Planning Committee will be responsible for establishing a panel to select a sample of stories from the community.

We are encouraging agencies to invite people in their communities to submit stories of men who have been a positive influence in their lives -and/or contribute positively through their action to the community. It could be about a brother, uncle, father, partner, coach, teacher, volunteer, friend - any male person who has helped through inspiration, encouragement, support, commitment and application to improving the quality of life for others. A photo of the nominated person should also be submitted for a display we are planning to develop at the event. If you do not have a photo of the man, a photo of an image that symbolizes a special quality about him can be submitted.

- .Stories and photos submitted will be copied for display/presentation purposes. To have documents returned (if not sent electronically by email) entries must include a stamped and self-addressed envelope.

- .Stories (and photos) would need to be submitted by 5.00 pm 31st January 2006 and authors should have the consent of the person they are writing about. The author should also be willing to attend the Man Alive! 2006 Festival to accompany their nominated person if their story is chosen for presentation.

- .Each nominee must be a living (at the time of nomination) resident of South Australia, and the information provided by the author (nominator) must be accurate (to the best of the author's knowledge).

- .High profile Australian's cannot be nominated.

- .Each story must be no more than 250 words and have additional contact details for both the writer and nominee (names and phone numbers).

- .The organizers will not be responsible for nominations/stories and photo's that are late, lost, damaged, misdirected by mail, have postage due or illegible.

- The panel's decisions are final and no correspondence will be entered into.

.Award story recipients will be notified by phone and award ceremony will be held at Man Alive! 2006.

All supporting material (story/photo) becomes the property of the organizers. It is possible that some of the stories submitted may be published as part of the Man Alive! 2006 Report, and in other men's health promotion initiatives. The consent of the person being written about needs to be submitted indicating their understanding/agreement that their story/photo may be presented at the Man Alive! 2006 event and in post event publications and report. Acknowledgement will be given to contributors in any future publications.

The stories should be sent to Enfield Community Health Service, and marked 'attention Man Alive! 2006 Planning Committee'. The address is PO Box 508 Prospect East SA 5082. If you require any assistance please contact Pip on 8342 8600. Email applications can be sent to:pip.messent@health.sa.9ov.au

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NEW WEAPON IN PROSTATE CANCER FIGHT

A treatment combining hormone therapy and drugs to combat prostate cancer may soon be trialled in Adelaide. Researchers believe traditional hormone therapy, which cuts a man's production of testosterone, combined with drugs which target a protein in the tumour, could be the next development in preventing relapse.

Professor Wayne Tilley, the Dame Roma Mitchell Chair in cancer research at Adelaide University and the Hanson Institute, said surgery or radiation treatments could cure the disease if it was confined to the prostate. In many cases, however, the cancer will spread to the bone and other tissues. Hormone therapy eliminates the testosterone that feeds the tumour, but the tumour inevitably regrows. Professor Tilley's research shows the protein that governs the effect of testosterone on the tumour cell plays a critical role in this regrowth. *(Adelaide Advertiser, 28/9, p24)*

APPROVAL FOR S.A. CANCER FIGHTER

Shares in Adelaide-based biotechnology company Bionomics rose yesterday after the company announced patent approval in New Zealand for an anti-cancer treatment.

"New Zealand is a small market for pharmaceuticals but it's an important first test to patent validity," managing director Deborah Rathjen said.

"If you can get your claims granted there, it's a point to Europe and the U.S. We're anticipating selecting an Australian clinical candidate early next year." The patent is for a series of compounds called "vascular targeting agents", used in treating solid tumours. They act by starving tumours of the blood flow they need to grow, the company said. *(Adelaide Advertiser, 2/11, p51)*

PCFA C.E.O. UPDATE – SEPTEMBER 2005

A quick update on our very successful - if hectic - activities during one week in September, the international prostate cancer awareness month.

Meeting of the PCFA Support and Advocacy Committee (SAC)

SAC *met* to review activities and plan for 2006 and beyond. Representatives from every State and Territory attended. The meeting was a great success and may prove to be a watershed in the development of our support groups.

Research Committee

Rob Baxter facilitated a meeting with some the leading prostate cancer researchers in Australia as we move towards the formation of the PCFA Research Committee - one of the major new initiatives to come from our national restructure.
Also in attendance were:
Professor Judith Clements - Queensland University of Technology
Professor Villis Marshall - Dame Roma Mitchell (and chair of APCC)
Associate Professor Gail Risbridger Monash Institute
Professor Pam Russell- POW/UNSW
Professor Rob Sutherland - Garvin
Wayne Tilley, Dame Roma Mitchell laboratories, Hanson Institute and University of Adelaide
With Professor Gillian Duchesne (Peter McCallum) as the only apology

The meeting was very positive with a great willingness to support the PCFA's move towards consolidating its position as the peak body for prostate cancer. Everyone who attended accepted the offer to join the new PCFA Research Committee and Rob and I will work together to fill out some of the areas of expertise that the current group does not have.

The establishment of our own Research Committee - especially one that has such top people on it - is, I believe, a major step for the PCFA.

SHHHH! - Secret Men's Business

With the Prince of Wales Oncology Research Centre, we held a very enjoyable and good fund raising luncheon at Dockside Cockle Bay. The highlight was a panel discussion involving Wayne Swan, Music legend Marty Rhone and Urologist Stuart Ehsman that was moderated by journalist Sheryl Taylor. As well as awareness, the function raised just over $23,000.

Australian Prostate Cancer Collaboration (APCC) Scientific Meeting

There were at least four positive outcomes from this conference for the PCFA:

- I gave a presentation on the success of the "Be a Man" campaign in which I presented both the original ANOP data that underpinned the campaign, as well as the further data we have collected.
- David Sandoe and I met with Villis Marshall and the other members of the APCC executive to discuss the possibility of a merger. At this stage a merger seem unlikely but we will try and increase our collaborative activities so there is less duplication of activities. A small steering committee has been set up to work on closer collaboration.
- Importantly by having the meeting of SAC just prior to APCC this meant that the SAC members could also attend the APCC meeting.
- At the AGM of the APCC there was much appreciation for the PCFA in its support of their the key initiatives - such as the Tissue Bank and guidelines for advanced prostate cancer.

Commonwealth Bank Sponsorship

On 24 September, we launched our new sponsorship with the Commonwealth bank at Bathurst. The CBA is supporting the extension of our support group network - especially in regional and rural areas over the next three years (starting in NSW and Vic). Thanks to our Bathurst Support Group team who arranged almost 200 people to attend an information session given by Phillip Stricker who took questions from the floor for almost 45 minutes. We had some excellent media, and the local CBA representative spoke enthusiastically about the importance to the Bank of its relationship with PCFA.

The next information sessions are planned for Dubbo (NSW), Tamworth (NSW), Shepparton (Vic) and Mornington Peninsula (Vie).

Support Groups Media

To further generate some metropolitan and regional media I wrote a very generic media release that I offered to all 63 support groups to promote their local group. Many took up the opportunity and we have received some excellent coverage.

Andrew Giles

YEARLY PSA SCREENING APPEARS TO LOWER MORTALITY RISK AFTER PROSTATE CANCER SURGERY.

By Ed Susman DENVER, CO -- October 20, 2005 –

Annual screening of prostate specific antigen (PSA) levels in men who undergo radical prostatectomy appears to be associated with a 3-fold reduction in 10-year mortality. Researchers reported the findings here at the 47th annual meeting of the American Society for Therapeutic Radiology and Oncology (ASTRO).

Men who do not have the yearly tests have 3 times the mortality from prostate cancer after 10 years than those who are tested yearly, indicated Jason Efstathiou, MD, Clinical Fellow in Radiation Oncology, Harvard medical School, Boston, Massachusetts, United States.

In an oral presentation on October 19th, Dr. Efstathiou said that **over a 10-year period, 11.3% of men who don't have annual PSA screening tests die from the disease, compared with 3.6% of those who do have yearly tests**.

That difference reached statistical significance at the P = .0002 level, he said.

However, doctors said the findings are unlikely to end an ongoing debate over the utility and value of recommending annual examinations. The American Cancer Society and the American Urological Association have both backed annual PSA screening of men over 50. The U.S. Preventive Services Task Force has not.

To solve the dilemma, Dr. Efstathiou and colleagues reviewed the results of three ongoing large randomized trials in the U.S. and Europe. Those results will not be reported until at least 2008.

"Our findings do give us clues into what I expect the large trials will show," he said. ***"If those studies confirm the results of this trial, annual PSA testing will become standard."***

The analysis involved 1492 men who underwent radical prostatectomy but experience biochemical failure, defined as a PSA level higher than 0.4 ng/mL.

The men were recruited between 1988 and 2002.

Of the total, 841 men had yearly annual PSA screens before their diagnosis. The rest were community referrals who may or may not have had PSA screens, Dr. Efstathiou said. The median follow-up after biochemical failure was 4.5 years for screened men and 4.1 years for the community referrals.

The screened men fared better on almost every score, he said. For example their PSA level at the time of diagnosis was 5.1 ng/mL versus 9.5 ng/mL in the community referrals, a difference that was statistically significant at the P < .0001 level.

In addition, the results show that 25.1% of men who were screened annually had aggressive cancers compared to 42.1% of the community referrals (P < .0001).

PSA levels doubled in the 3 months after prostate cancer surgery in 4.6% of screened men and 12.1% of the community referrals (P < .0001). PSA doubling in the 3 months after surgery is a surrogate endpoint for prostate cancer death, Dr. Efstathiou explained.

The 10-year cumulative incidence of prostate cancer-specific mortality estimates following biochemical failure were significantly lower in the screened cohort than in the community referral cohort, he added.

"This simple yearly blood test would appear to discover prostate cancers at an earlier, less aggressive stage and may lower the risk of dying from prostate cancer," Dr. Efstathiou concluded.

[Presentation title: Evidence to Support that Serial Screening Decreases Prostate Cancer-

Specific Mortality: Abstract 185]

DOCTOR PATIENT RELATIONSHIP IMPORTANT IN DECIDING ON PROSTATE CANCER SCREENING

By Crystal Phend SAN FRANCISCO, CA -- October 18, 2005 –

Prostate cancer screening and treatment has led to increased survival rates, but their role remains controversial.

A long-term relationship with the patient is essential for family physicians to help patients decide on screening and treatment options, according to a presentation here at the annual meeting of the American Academy of Family Physicians (AAFP). *"As family physicians, the best option remains to establish and maintain a longitudinal relationship with our patients that allows us to individualize their risk and maximize their benefit,"* said Warren A. Jones, MD, past president of the AAFP and Professor of Health Policy, University of Mississippi Medical Center, Jackson, Mississippi, United States.

Several organizations have screening guidelines, but there are significant differences among them about when and who to screen. The American Cancer Society and American Urological Association, for example, recommend yearly prostate cancer screening beginning at age 50. The AAFP guidelines follow those of the U.S. Preventative Services Task Force and leave the choice to individual men and their doctors.

"If you do decide on screening, begin at age 50 for men at low risk and age 40 to 45 if high risk," Dr. Jones said.

Other risk factors for prostate cancer that impact on screening decisions are black race and family history of the disease. Dr. Jones recommended that screening include both the digital rectal exam and prostate specific antigen (PSA) testing. "PSA without the digital rectal exam is like driving with only two wheels," he said. "You can get where you're going but it's going to be a hell of a ride."

If the first PSA test result comes back high, allow 6 to 10 weeks to see if it comes back down, then retest and discuss what the options are with the patient, Dr. Jones said.

After a positive digital rectal exam or PSA result, the next step is a transrectal ultrasound followed by biopsy.

Physicians and patients should consider age, general health and clinical staging as factors in the decision whether to treat and should look at the total impact of treatment on the patient, not just physical impact, Dr. Jones said. *"The evidence is not a substitute for knowing our patient,"* he added.

Patients should be encouraged to keep copies of health records with them regarding dates of diagnosis and treatment, types of cancer, and such *"since patients are highly mobile and 'Katrina-like' disasters can occur,"* he said.
[Presentation title: Prostate Cancer Controversies. Session 008]

GOOD NEWS ON CANCER

Hormone treatment improves the chances of surviving prostate cancer by more than one-third, the Early Prostate Cancer study shows.

The drug Casodex delays progression of the cancer for up to three years, and reduces the risk of it spreading to the bones by one-third, the study shows. When combined with radiotherapy. Patients have 35% better chance of survival. *(Adelaide Advertiser, 2/11, p8)*

What's **happening** Nationally?

Update on the Cancer Consumer Network Project

The Cancer Consumer Networks Project is progressing well with a consumer sub-committee now established to oversee the project to completion. Our project coordinator, Lisa Herron, has completed consultations with cancer support and consumer groups Australia wide and is now engaged in collating all the information to form the final report to the Cancer Services section of the Commonwealth Department of Health and Ageing.

Throughout the consultation process there has emerged a strong impetus from cancer consumers to develop a network or group that would represent and voice the common interests and concerns of people affected by cancer. There is mounting evidence and relevance towards developing a new national cancer consumer group that would be sustainable, representative and effective and accountable to consumers.

The Cancer Council Australia (TCCA) has agreed to help facilitate the development of a national cancer consumers group. TCCA will host and fund a face to face meeting of approximately 15-18 key consumer representatives in mid-October, which is currently in the planning process. With the assistance of a facilitator this group will advise on the rationale for and role of a national cancer consumer organisation or network and develop recommendations for its objectives, structure and membership, governance and funding.

The Cancer Council Australia has also agreed to continue funding the project coordinator's role until December 2005. This is welcomed and appreciated by all who are currently involved in this project.

Our next newsletter should see both the release of the support and consumer groups scoping report and hopefully affirm the establishment of a national cancer consumer organisation.

Jane Cruickshank
Chair, Cancer Consumer Networks Project

Cancer Voices across Australia

This CVN initiative continues to gather momentum. There is now a contact in each state who is ready to act as their state's representative when the states and territories speak together to help form a national cancer consumer organisation. This as an important step forward. Sally Crossing visited staff at the Queensland Cancer Fund in August and she and Jane Cruickshank took part in a teleconference with keen Queensland consumers. Sally also met with Jean Dalgleish of the Cancer Council Tasmania, and was invited to speak to the Victorian public meeting in Melbourne (25 June).

Cancer Voices NSW has offered to help new state groups as they begin. We can offer our name, objectives, structure, issues and experience over the last five years. As health is delivered at state level, and differently in each state, the operating world for cancer consumer advocates is never the same. We see our role as simply to help, if we can and if requested. SC)

Cancer Australia

Cancer Australia was announced in the Government's election policies in October 2004. Its establishment as a coordinating body at national level was strongly supported by Cancer Voices NSW. WE recommended that the very successful model of the National Breast Cancer Centre (which incorporates Ovarian) be used and built onto, so that a Cancer Australia could be commissioned quickly and efficiently.
Sally Crossing and John Stubbs have separately discussed consumer expectations and recommendations of and about Cancer Australia, in Canberra with the Cancer Adviser to the Hon Tony Abbott MF Minister for Health.

Cancer Support Grants Programme

The Department of Health & Ageing announced on July that it had allocated $830,000 to 15 "cancer support groups". Forty applications were considered No allocations were received by generic groups and Cancer Voices NSW itself missed out. Only one NS\ applicant received funding - Can Revive, to expand services for Chinese speaking people with cancer in NSW. Funds mainly went to Foundations (prostate, lung, leukemia) and to regional health services to assist their support services.

TUMOUR MARKERS – WHAT ARE THEY?

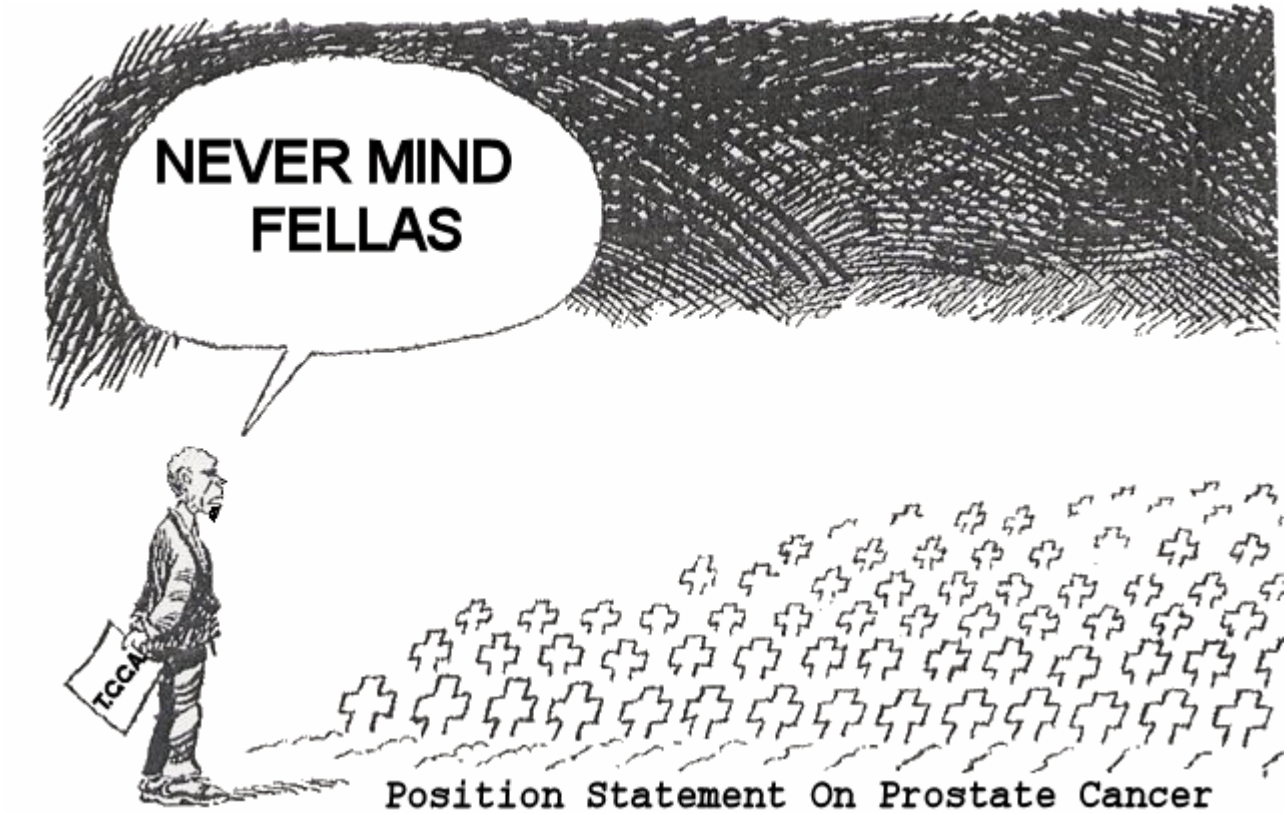
Tumor markers are substances, usually proteins that are produced by the body in response to cancer growth or by the cancer tissue itself.

Some tumor markers are specific for one type of cancer, while others are seen in several cancer types. Many of the well-known markers are seen in non-cancerous conditions as well as cancer. Consequently, these tumor markers are not diagnostic for cancer.

There are only a handful of well-established tumor markers that are being routinely used by physicians. Many other potential markers are still being researched. Some marker tests cause great excitement when they are first discovered but, upon further investigation, prove to be no more useful than markers already in use.

The goal is to be able to screen for and diagnose cancer early, when it is the most treatable and before it has had a chance to grow and spread. So far, the only tumor marker to gain wide acceptance as a general screen is the Prostate Specific Antigen (PSA) for men. Other markers are either not specific enough (too many false positives leading to expensive and unnecessary follow-up testing) or they are not elevated early enough in the disease process.

Some people are at a higher risk for particular cancers because they have inherited a genetic mutation. While not considered tumor makers there are tests that look for these mutations in order to estimate the risk of developing a particular type of cancer. BRCA1 and BRCA2 are examples of gene mutations related to an inherited risk of breast cancer and ovarian cancer For more information, see our overview on genetic testing.



HEY DOC, DO I STILL NEED THIS CATHETER?

Kara Gavin | University of Michigan Health System | 07.29.2005

Millions of hospital patients could be spared the humiliation and infection risk that come with a urine-collecting catheter, a new study finds, if hospitals used a simple reminder system to prompt doctors to remove the devices after two days.

About 25 percent of hospital patients at any given time have urinary catheters -- and a substantial proportion of patients have them much longer than they really need them, experts say. This greatly raises their risk of getting a painful urinary tract infection or even a blood infection.

But a new University of Michigan Health System study, funded by a patient safety grant from the Blue Cross Blue Shield of Michigan Foundation, shows that simply having nurses flag patients' records with a written reminder can jog the memory of busy doctors, prompt them to consider removing the catheter, and lead to a much shorter time with a catheter for many patients. The study is published in the August issue of the Joint Commission Journal on Quality and Patient Safety.

The written-reminder system isn't expensive, and in fact the study finds that its cost equals or is less than the savings that a hospital could achieve by reducing infections among patients. An estimated 40 percent of infections developed by patients during their hospital stay are urinary tract infections, and most of these infections are due to urinary catheters. The cost of treating each infection that causes symptoms is estimated to be at least $500.

"Doctors are responsible for ordering the removal of catheters, but research has shown that many of them forget which patients have catheters and how long they have them," says lead author Sanjay Saint, M.D., M.P.H., a hospitalist at the VA Ann Arbor Healthcare System and an associate professor of internal medicine at the U-M Medical School. "Our reminder system helps doctors do the right thing," he adds.

"Catheter reminders may become automatic as hospitals implement computerized doctors-orders systems. But since about 90 percent of American hospitals still don't have such systems, our study suggests that written reminders should be used in their place," says Saint, the director of the UMHS/VA Patient Safety Enhancement Program, which researches ways to prevent patient injuries and adverse events during hospital care. He is also a member of the Patient Safety Committee that oversees clinical patient safety improvement efforts at UMHS.

Ira Strumwasser, Ph.D., president and CEO of BCBSM Foundation, says, "This is a terrific example of how a simple change in a process can make a real difference in lessening the risk of infection for thousands of patients, as well as reduce costs associated with treating infections."

The controlled trial, carried out for 16 months in four wards of the U-M's University Hospital, involved patients who had been admitted for surgery or with general ailments including kidney and lung problems. Two of the wards used the reminder system and two did not, but a nurse checked the records of every patient each day.

The first eight months of the study gathered baseline data on catheter use. Then, for the next eight months on the two wards where reminders were used, the nurse attached a pre-written order and a sign-here sticker to each patient's chart every day after the catheter had been in place for 48 hours. After about four months, she began paging doctors who didn't fill out the order to either continue the catheter or remove it. The medical director of the Infection Control & Epidemiology division, Carol Chenoweth, M.D., began e-mailing doctors as they started their one-month rotations on the wards.

The data were then analyzed and adjusted for the differences in age, sex and length of hospital stay among the patients on the different wards.

In all, the proportion of each patient's hospital stay that involved a catheter went down by 7.6 percent on the reminder wards compared with baseline, and went up by 15.1 percent in the no-reminder wards. The researchers measured this proportion as a

percentage of each patient's total days in the hospital -- if a catheter was used for three of six days, that was a 50 percent proportion.

About two-thirds of the doctors on the reminder wards routinely filled out the daily order after the paging reminders began. When the researchers excluded the one-third of doctors who ignored the reminders, the numbers got even better: The percentage of patient days spent on a catheter went down by 25.7 percent in the reminder group.

The cost of the reminder system, including the nurse's time and the printing of reminders, would be about $53,200 per year, the researchers estimated. The savings, based on conservative estimates of the number of catheterized days, the proportion of doctors who would comply, the risk of urinary tract infection (5 percent for each day on a catheter) and the cost of treating symptomatic infection, would be about $53,449. That means the system would pay for itself with $249 left over.

If all doctors in a hospital complied fully, the savings could be in the tens of thousands, Saint says.

The nurse who checked the records for the entire study period, Maureen Thompson, R.N., M.S.N., notes that catheter reminders are now a routine part of patient care in UMHS intensive care units. "Through our involvement with the Keystone statewide initiative to improve patient safety within ICUs, we have made the daily consideration of invasive line discontinuation a key element of our daily patient safety review," she says.

Saint says that his team has applied for funding to extend the program into more non-ICU wards until the U-M Health System begins using a computerized physician order-entry system in 2006.

In the meantime, he says, hospitals everywhere may be able to institute their own reminder system of written reminders and pages, and thereby reduce the number of days patients are catheterized. "A major way for health care facilities to reduce hospital-acquired infections is to get rid of unnecessary devices, including catheters," he says. "Rather than just relying on the memories of over-worked doctors who are focusing on a patient's medical condition and not their catheter status, we may be able to reduce both the morbidity and mortality associated with urinary tract infections. It's a systems-based solution, and could even be used for other applications."

Saint emphasizes that a successful reminder system, like the one implemented in the study, needs to be interdisciplinary, involving infection control professionals, nurses, and physicians. In addition to Saint, Chenoweth and Thompson, the new paper's authors are research associate Samuel Kaufman, M.A., and research assistant professor of internal medicine Mary A.M. Rogers, Ph.D., M.S. The study was sponsored by a patient safety grant from the Blue Cross Blue Shield of Michigan Foundation.

SCREENING AWARENES – A PATIENT'S VIEW

***Summary ***
Public awareness of prostate cancer (PC) is increasing. As a result, men are increasingly approaching the health services to find out about their PC situation. This can lead to screening and early detection.

Patients can, however, find themselves in an extremely controversial situation, since medical experts in many countries have strongly opposing positions with respect to the need for and the value of screening. Dependent on the methods used, screening can give false positive or negative results. This can lead to over treatment which may be associated with a significant risk of chronic illness e.g. in relation to sexual and urinary function.

But early detection seems to be the only method to save lives, especially in relatively younger men.

*What can empowered patient groups e.g. PROnet recommend to their fellow men?

*Men and potential patients should be fully informed and aware of:

* All appropriate diagnosis options and prognosis - All patients should have an extensive and thorough diagnosis.
* With slow growing PC, no rush is necessary in most cases.
  All therapy options, including the inevitable and potential side effects.

Every patient should develop a partnership with his physician, in order to fully understand the risks and benefits of screening and potential treatments.

We all know that each and every therapy decision has a "Las Vegas factor" - a lottery factor, where you never know if the best decision has been chosen and what the outcome will be. However, with the most efficient diagnosis you take all the chances for a possible win in the battle against prostate cancer.

PROnet should therefore continue to advocate early detection but should also advocate awareness of the unwanted and unnecessary consequences of mass screening. It should also advocate training for patients to insist on appropriate diagnosis.

***To screen or not to screen?**
*Let’s have a look what other professional organisations have to say

***a) Not to screen** - The U.S. Preventive Services Task Force* in it’s prostate cancer screening guidelines [1] <#1>, is one example which strongly recommends against screening:

"Routine screening for prostate cancer with digital rectal examinations, serum tumor markers (e.g., prostate-specific antigen), or transrectal ultrasound is not recommended" and "The lack of evidence regarding the benefits of prostate screening and the considerable risks of adverse effects make it important for clinicians to inform patients who express an interest in screening about the consequences of testing before they consent to screening."

***b) To Screen** - the American Cancer Society*, in its recently updated prostate cancer screening guidelines [2] <#2>, is one example, which takes an opposing outlook. After a careful review of the scientific evidence and issues surrounding prostate cancer screening, it updated its prostate cancer screening guidelines stating that:

"Both prostate specific antigen (PSA) and digital rectal examination(DRE) should be offered annually, beginning at age 50 years, to men who have at least a 10-year life expectancy, and to younger men who are at high risk.

Screening for prostate cancer in asymptomatic men can detect tumors at a more favourable stage (anatomic extent of disease). There has been a reduction in mortality from prostate cancer, but it has not been established that this is a direct result of screening."

Unnecessary aggressive treatments, which may result from finding that PSA is a little higher than normal, can do a lot of damage and reduce quality of life in a high number of patients for the rest of their lives.

PROnet believes that early detection measures are necessary and is advocating early detection, via mass screening.

However, we also believe that radical prostatectomy, radiation or other invasive therapies are not necessary in many cases, since clinically non-relevant PCs are common. In many cases, we believe that active surveillance is all that is necessary for many years.

What do other urological professionals say regarding the treatment problem?

*Treatment
*An article from the Journal of the National Cancer Institute in 2001[3] <#3>discussed clinically localised prostate cancer therapy i.e. treatment of early disease. The authors reported that there are no randomised clinical trials comparing the efficacy of aggressive therapies with more conservative therapies. The study looked at four management options:
- radical prostatectomy
- radiation therapy
- watchful waiting
- hormonal therapy

They studied more than 3,000 men who were diagnosed with prostate cancer. The article states

“The choice of initial treatment for clinically localised prostate cancer is difficult for both the physician and patient given the scientific uncertainties about the relative efficacy of each therapeutic strategy. Do all men with clinically localised prostate cancer have access to all treatment options? Are they informed of the potential risks and benefits? Are clinicians providing information about all options to their patients?”

The paper concludes
“There is a lack of consensus for care of this disease, probably attributable to the lack of definitive evidence of the efficacy of one approach versus another. Until such evidence can be obtained, we urge that men diagnosed with prostate cancer be informed of the potential risks and the potential benefits of all four main treatment options so that they might make an informed decision”,

Similarly, the *American College of Physicians* [4] <#4>, discuss the pros and cons of aggressive treatment of early disease as follows:

> "The ratio of cumulative incidence, which is increasing because of early detection efforts, to mortality rate, which is relatively stable, suggests methods are not fatal. Moreover, aggressive treatment of prostate cancer confers substantial risk for illness and a small but finite risk for death, which must be borne immediately in return for a putative benefit that may be realised only in the distant future."
>
> "No published controlled trials have proven that radical prostatectomy or radiotherapy reduces rates of death from clinically localised prostate cancer."
>
> “The disparity between the approximate 30% prevalence of histologic prostate cancer in men older than 50 years of age and the 3% lifetime risk for death from this disease shows the difficulty in distinguishing cancer that is destined to cause illness and death from cancer that is not. This uncertainty is central to the debate about whether early detection efforts are appropriate."

The U.S. *Preventive Services Task Force* [1] <#1> also offers its view of the efficacy of surgery and radiation treatment with intent to cure:

> "Current evidence from observational studies suggests that surgery and radiation therapy in patients with localised disease may offer no additional survival benefits over more conservative therapy (observation and delayed hormone therapy)."

What are the empowered patients (PROnet) to recommend to their fellow men?
We as PROnet patients:

a) Should raise awareness of prostate cancer, its risk factors, screening (adding careful diagnosis and prognosis) and appropriate treatment options.

b) Believe that routine PSA measurement without a frank discussion of the issues involved is inappropriate.

c) Recommend strongly that patients have an extensive and thorough diagnosis, since with slow growing PC no rush is necessary in most cases.

d) Highlight that problems arise, not from over diagnosis but over-treatment:

e) Inform and train men and potential patients about all appropriate diagnosis options, prognosis and therapy options including the inevitable and potential side effects.

f) Encourage the patient to develop a partnership with his physician. A patient should be aware of his full diagnosis and treatment options.

g) Stand fully behind the need to provide an unbiased summary of the potential benefits and harms that can result from screening, as identified in the position paper (4) of the *AMERICAN COLLEGE of PHYSICIANS,

"All men who are considering having digital rectal examination and PSA measurement should understand the potential risks and benefits of screening and participate with their physicians in deciding whether to be tested. Before any testing occurs, patients should be fully informed about the following:

1. Prostate cancer is an important health problem.
2. The benefits of one-time or repeated screening and aggressive treatment of prostate cancer have not yet been proven. Digital rectal examination and PSA measurement can both have false-positive and false-negative results.
3. The probability that further invasive evaluation will be required as a result of testing is relatively high.
4. Aggressive therapy is necessary to realise any benefit from the discovery of a tumour.
5. A small but finite risk for early death and a significant risk for chronic illness, particularly with regard to sexual and urinary function, are associated with these treatments.
6. Early detection may save lives.
7. Early detection and treatment may avert future cancer-related illness.

From daily discussions with PC patients I believe with currently available diagnostic measures much more can be done in daily urological practice to save the patient’s integrity and prevent over treatment and harm post-screening.

1. In cases where the PSA is found a little higher than the commonly accepted cut-off value of 4 ng/ml too often an automated process leads to an instant biopsy.

2. In cases of small prostate cancer and low aggressiveness (Gleason Score 6 and lower) found by the biopsy, then radical local therapy is often to be recommended. Radical prostatectomy is considered to be the "Golden Standard" by Urologists.

Below are examples of common patient questions that should be discussed with the physician for the biopsy decision:

To what extent does a benignly enlarged prostate or a prostatitis contribute to the higher PSA-value?

What is the rate of doubling of PSA (PSA doubling time) or the rate of increase in PSA (PSA velocity)? Is it abnormal so that PC is more likely present than not?

What is the ratio of the free PSA? Does it suggest malignancy?

I recommend that PSA should be tested several times before a biopsy. A decision should never be based on one PSA-Value alone.

Latest imaging (3 dimensional coloured ultrasound, endo-rectal MRI, PET etc.) will help find the location of a suspected area in the prostate to prevent several biopsies without any finding.

"Active PSA-Surveillance" can prevent any surprises. Prostate cancer is regularly a very slow growing cancer. There is almost no risk in this event.

Some other hints for a careful diagnosis include:

Gleason Score (the grade of differentiation of prostate cells due to the cancer) allows an assessment of PC aggressiveness, and is one of the most important diagnostic tools.
Gleason grade 4 and/or 5 disease is an important negative prognostic factor that usually relates to more extensive disease and to a more aggressive situation.
Clinical and pathological staging is important information for continued discussion about therapy.
The Partin Tables and the Kattan – Nomogram provide a solid tool for assessing the overall situation. Each and every patient should discuss these data with his physician.
In cases of a more aggressive disease, many more diagnostic factors and diagnostic measures should be evaluated, including:
ProstaScint Scan, a staging tool (not available in Germany)
Bone Scan and Computer Tomography (6 to 8 mm Metastases minimum)
MRI, endorectal MRT, PET scan (much higher resolution of imaging)
DNA ploidy provides additional information on the aggressiveness of PC and its responsiveness to androgen deprivation therapy.
Prostatic Acid Phosphatase (PAP) should be part of baseline PC evaluation
Chromogranin A (CGA) is used to help identify patients with an aggressive from of PC
More biochemical markers like NSE and CEA may contribute to a thorough prognosis
Transforming Growth Factor Beta 1 (TGF β1) is believed to be one of the most important regulators of prostate growth acting under normal circumstances to inhibit proliferation of cells by inducing programmed cell death (apoptosis) of the prostatic epithelial cell.

We all know that each and every therapy decision has a "Las Vegas factor" - a lottery factor, where you never know if the best decision has been chosen and what the outcome will be. With the most efficient diagnosis you take all the chances for a possible win in the battle against prostate cancer.

PROnet should therefore continue to advocate early detection but should also advocate awareness of the unwanted and unnecessary consequences of mass screening and advocate training for patients.

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MICROWAVE CANCER TREATMENT WARNING

Health Minister Tony Abbott has warned cancer patients against the use of microwave therapy, after a review found it could be less effective than conventional therapies.

The $250,000 review by a special committee of the National Health and Medical Research Council found the microwave treatment touted by Perth doctor John Holt as a cancer cure was not superior to conventional therapy.

The committee found there was no proof to support the use of microwaves in fighting cancer, either alone or when combined with radiotherapy.

Releasing the findings of the year-long review in Melbourne, Mr Abbott said he was disappointed the treatment was not the magical cure that many had hoped it would be.

"I have to say I am a little disappointed at this result," Mr Abbott said. "But the fact is, we have to be objective. Now, I have to say that the conclusions of the study were that there is no evidence that Dr Holt's treatment is superior to conventional, orthodox cancer treatment.

"And there is considerable evidence that in at least some areas, Dr Holt's treatment is inferior to conventional, orthodox cancer treatment ... and my very strong recommendation to people suffering cancer would be, use orthodox treatment, don't use this treatment."

But he stopped short of saying Dr Holt, who has since retired, had placed patients' lives in danger.

"I think it would be fairer to say that their cancer has not been improved by Dr Holt's treatment in ways that couldn't more readily have been achieved by more conventional treatment," Mr Abbott said.

Australian Medical Association president Mukesh Haikerwal went further, saying the findings showed the treatment could in fact be "more dangerous" than conventional methods.

"It's very important when there are novel treatments out there people do not lose sight of the fact that conventional therapies are actually there to help them, can make them better and shouldn't be discarded for something that's not true and not trusted," Dr Haikerwal said.

The committee examined Dr Holt's patient records along with scientific evidence on the therapy, which has gained wide publicity amid positive accounts from cancer sufferers.

The review found microwave cancer therapy in combination with radiotherapy was inferior - compared to conventional radiotherapy alone - in the treatment of breast cancer, lung cancer, lymphoma or prostate cancer. It also found radiotherapy resulted in improved symptom control rates in bladder cancer patients, than when used in combination with microwave treatment.

The committee recommended a review of the eligibility for Medicare funding of Dr Holt's treatment and also called for the Therapeutic Goods Administration to examine the safety of the microwave machines he used.

Mr Abbott rejected suggestions Dr Holt had been irresponsible, describing him as a very dedicated doctor.

A spokesperson for Dr Holt declined to comment on the review's findings. http://news.ninemsn.com.au/article.aspx?id=65153

Newsletter compiled by Trevor Hunt

LATE MESSAGE: (Received this morning 8/11/05) It now appears that the S.A. launch of the “Be A Man” campaign is likely to be delayed until “early in 2006”, at the request of the sponsors, APIA.