PROSTATE CANCER ACTION GROUP (S.A.) INC

Affiliated with
Prostate Cancer Foundation of
Australia

ABN 26 499 349 142

NEWSLETTER

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MOVEMBER 2006

Why Movember? This is not a spelling error. **Movember** (formerly November) is a charity event held during the 11th month of each year. At the beginning of November guys register with a clean shaven face. The Movember participants, known as Mo Bros. then have the remainder of the month to grow their moustache, and along the way, **raise as much money and awareness about male health issues as possible**.

Movember culminates at the end of the month, at gala parties. These glamorous and groomed events will see Tom Selleck and David Boon look-alikes battle it out on the catwalk for their chance to take home the prestigious **Man of Movember** title.

Why Men's Health? Whichever way you look at it, men are far less healthy than women. The average life expectancy for men is 6 years less than females. Men have a much greater incidence of conditions such as cancer, suicide, cardiovascular disease, accidental death, obesity and smoking-related diseases, which are killing men at a rate two to four times that of women.

The Obvious Question Is - Why? Part of the answer is a lack of awareness about the very real health issues faced by males, the good old "she'll be right" attitude and a reluctance to seeing a doctor about an illness, or for regular medical checks. The aim of **Movember** is to change this attitude, make male health more fun by putting the mo back on the face of Australia and, in the process, raise some serious funds.

In 2006, the key male health issues **Movember** is supporting include (1) prostate cancer because every year in Australia 2,700 men die of this disease – more than the number of women who die from breast cancer, and (2) Male Depression because 1 in 6 men are affected by depression, and most don't seek help. Untreated depression is a leading risk factor for suicide. Rates of suicide are more than double the national road toll. *(Refer to the **Movember** website www.movember.com.au)*

Chairman's Report November 2006

Awareness Evenings

Stirling

This proved to be a successful event with a satisfactory attendance of 70. Dr James Aspinall gave an excellent presentation as did Dr Graham Lyons. The members of our Group who spoke were Ray Power, Ian Fisk and Coralie Hunt and they were well received by the audience. The Stirling RSL proved an excellent venue.

Mount Barker

As previously reported this presentation will be held on Wednesday 15th November at the Mount Barker Bowling Club commencing at 7p.m. The visiting urologist to the area, Dr Christopher Switajewski will be speaking as will Dr Graham Lyons on Diet and Prostate Cancer. Members of our Group will also speak.
All are welcome to attend this free evening.

On the above events we received sponsorship from the Freemasons of Mount Barker, Hahndorf, Stirling and Blackwood with support from the Stirling Community Hospital Inc. and the Adelaide Hills Community Health Service which was greatly appreciated.

Strathalbyn
The date of this presentation is the 20th March 2007.
Our contact at Strathalbyn is David Merry and he has already arranged for urologist Dr John Bolt to speak.

Speaking Engagements
Our members were involved in 2 speaking engagements in October.
Trevor Hunt spoke to a combined Freemasons, Lions and Rotary function at Kingscote, Kangaroo Island on the 17th October where approximately 50 attended.
I spoke at a Freemasons/Lions event at Balaklava on the previous evening with 60 people attending.
Dean Wall had a radio interview with 101.5 FM on the 31st October whilst I spoke on 5AA prior to the Stirling presentation.

Mitcham Prostate Cancer Support Group
18 attended the October meeting and viewed 2 segments of a DVD on the PCFA Men's Health Promotion Conference held in Melbourne on the 12th August.
The DVD covers men's general health issues and was well received by members.
The speaker for the next meeting, to be held on Thursday 23rd November, will be Ms Jan Rowe from the Repatriation General Hospital.
All are welcome to attend.

Classic Adelaide Car Rally
Prostate SA is still looking for volunteers to assist at the Classic Adelaide Rally to be held from the 15th – 19th November.
If you can assist Prostate SA to raise urgent funds throughout this event, please give Brent Frewen a ring at The Cancer Council SA on 8291 4111 for further information.

A brief review of 2006
As normal, our November meeting will be the Group's final meeting for the year.
I believe 2006 has been a successful year for the promotion of prostate cancer awareness. Whilst there is still much to be done to raise the level of awareness a great deal of favourable publicity took place.
In South Australia it commenced with the SA Launch of the National Awareness Campaign, Be-a-Man on the 17th February.
During the year our Group's activities have been widespread.
Our members attended the National Prostate Cancer Call-In plus events such as a prostate cancer promotion at a city café, Man-a Live at Semaphore, the 2 day Karoonda Farm Fair and the Freemasons Art Exhibition for the purpose of spreading awareness and distributing pamphlets.
This month some members will be supporting Prostate SA at the Classic Adelaide Car Rally.
This year to date our Group has been involved in 3 public awareness evenings with another to be conducted at Mt Barker on the 15th this month. The 3 meetings have produced a total attendance of 290 – a very pleasing result.
Our members have been involved in 9 speaking engagements to various community groups and several radio interviews.
The recent awareness evening at Stirling and the one about to take place at Mt Barker have been sponsored by the Freemasons in those areas and we are very pleased to have this involvement. We hope the relationship continues in the coming years.
All this has been achieved with a severe lack of numbers in the Group and new members are desperately needed. We intend to widen our search for new members in 2007.

The compliments of the Season to everyone.

Jeff Roberts

Brief Notes from the National Support & Advocacy Committee Conference Tuesday 3rd October 2006, held at the Twin Towers Inn, Artarmon.

Attendees: David Sandoe (Co-Chair), Don Baumber (Co-Chair), Con Casey (Secretary); Graham Nicholls, Chris Bateup, (NSW/ACT); Keith Williams (NT/Qld); Gary Bowes, Jeff Roberts & Trevor Hunt (SA); Max Shub & Peter Gebert (Vic); Karen Rendell & Nick Waldon (WA); Daryl Hyland, Lionel Foote & Roger Large (Qld). Judy Lee (Tasmania); John Ramsay & Andrew Giles.

Observers: Colin Bartlett, Mark Tweeddale, (NSW/ACT); Barry Young, Prostate Cancer Foundation of New Zealand.

Apologies: Peter Gluth (Vic) due to illness.

1. GOVERNANCE

Retiring Committee Members

- **Queensland/NT – Don Baumber & Keith Williams**
- **NSW/ACT – Con Casey & Graham Nicholls**
- **Vic – Not applicable – Peter Gluth due to ill health**
- **South Australia – Trevor Hunt**
- **Western Australia – not applicable**
- **Tasmania – John Dowsett**

New Committee

- **Qld/NT - Bill McHugh plus two** – to be advised following Chapter election process.
- **NSW/ACT – David Sandoe, Steve Callister & Chris Bateup**
- **Vic. - Max Shub & Peter Gebert**
- **South Australia – Gary Bowes & Jeff Roberts**
- **Western Australia – Karen Rendell, Nick Waldon**
- **Tasmania – Judy Lee plus one** to be advised following Chapter election process.

SAC Executive

Nominations for the three positions need to be submitted prior to next teleconference for the voting process to be completed for that meeting.

Action: John Ramsay/ALL

2. UPDATE ON WHAT WAS AGREED LAST YEAR;

- **Relationship with PCFA & SAC**

Don Baumber raised the issue as to the mission statement "helping to reduce the impact of Prostate Cancer on families" as to why basic research outcomes similarly can't be brought to reduce the impact on Australian families?

The PCFA mission statement as re-articulated in the Rules of Affiliation is more encompassing than just the family and includes a whole-of-community approach. Much social research and policy aims to do just that – reduce societal impact.

Andrew Giles suggested that the National Support and Advocacy Committee - as the voice of all the affiliated support groups in Australia – could recommend to the National Board that they'd like to see a percentage of money spent on translational research. He suggested that a future teleconference of SAC could focus on such issues and that the terminology needs to be defined in plain English.

It was asked that Don Baumber provide to SAC, information on his involvement and progress to date with the QUM (Quality Use of Medicines) through CHF.

Don Baumber suggested the incoming SAC committee should add this to their list of objectives; that is – from bench to clinical practise such as trials of hormone ablation with other drugs or RT as to outcomes. There is a need to have in place a terms of reference.

It should be noted that PCFA is currently involved in the development of clinical and consumer guidelines for the RAVES study with Urological Society of Australia and New Zealand (USANZ), Medical Oncology Group of Australia (MOGA) and Trans-Tasman Radiation Oncology Group (TROG).

- **Relationship with Rural & Remote Communities**

Funds from the Commonwealth Bank go to rural supportive care and awareness. In NSW this covered awareness evenings in Bathurst, Dubbo and Tamworth. In Victoria this included five rural/regional areas with the recent Road Show, whilst similarly in WA it could include such towns as Kalgoorlie, Broome and other regional centres - to be negotiated.

Graham Nicholls outlined activities to date between PCFA National office, Lions and NSWCC in initiating new groups in the Greater South Eastern Region, including the Eden/Monaro, Far South Coast and Riverlands. This requires follow up and further action.

Action: John Ramsay/ Graham Nicholls et al.

Similarly a question was raised about the Echuca/Moama visit by Max Shub and others who recently attended and found only three couples and three men attended plus convenor. It was stated by the convenor that there had been a failure by the local press to give the location of the meeting.

Andrew Giles pointed out that the growth and development of individual groups was the primary role of the various State Chapters and if it was agreed (for example) by the Victorian Chapter that there was a need for greater involvement in a particular area then this should be undertaken. John Ramsay stated that there is an absolute need for there to be clear messages as to whom is facilitating this initiative – that is PCFA not PAA.

Action: Victorian Chapter/ Chapter Executive /John Ramsay

It was asked of the convenors what emphasis had been placed on the establishment of new support groups in rural/remote Victoria during the Road Show. Andrew Giles responded that major aim was general awareness as a precursor to identifying the need for and viability of establishing a local support structure.

Keith Williams asked what, therefore, is to happen in the Northern Territory? John Ramsay indicated that this was a good question and sought clarification as to what Keith's impressions where given his long association with the Territory and how this could inform development. John indicated that NT Health, CCNT and John Curtin School of Public Health are willing partners.

Action: SAC National and PCFA National office

- **Insurance**

This subject has been the focus of considerable discussion over the past twelve months. It was indicated that if anyone individual or group requires clarification that they consult with Andrew Giles or David Sandoe. Don Baumber indicated that the QCC still had issues with the constitution of PCFA .

Action: *The Board has received recommendations to be presented and approved at the AGM.*

Con Casey further indicated that the provision of medical advice by groups /group members is not indemnified. Andrew Giles confirmed that the giving of medical advice is *not* covered nor would it be covered by PCFA insurances and directed the Committee member back to the latest Rules of Affiliation for clarification.

- **Governance/Structure**

Retiring National SAC Committee members shall receive appropriate recognition from PCFA at a later date – formally acknowledging their involvement and contribution. In NSW/ACT we welcome Steve Callister and Chris Bateup joining David Sandoe. In Queensland/NT Bill McHugh will be joined by two new members yet to be elected by that Chapter. In Victoria we now have Max Shub and Peter Gebert and in South Australia Gary Bowes may be joined by Jeff Roberts (who will defer his final decision of acceptance until the end of October). In WA, we have Karen Rendell and Nick Waldon whilst Judy Lee joins us from Tasmania. We hope to recruit another member to join Judy with the recent announcement that John Dowsett has retired.

The SAC National Executive had consisted of Con Casey (Secretary), Don Baumber and David Sandoe, (Co-Chairs). The new committee will elect the new chair and two others as the SAC Executive with John Ramsay and Andrew Giles as ex-officio members. The National SAC Executive role is deemed necessary to make urgent and timely decisions on behalf of National SAC committee which it represents.

It was noted that between this meeting and the next SAC National Teleconference, (now in December), Qld/NT and Tasmania need to fill their vacancies.
Nominations and voting will take place for the three vacating National Executive roles to be completed by the next teleconference. A decision will then be made as to whether there is a requirement for Co-Chairs, and the maintenance of the Honorary Secretary position considering that the National office substantively fulfils this function.

Constitutionally, one place is available on the National Board from the SAC National Committee.

Max Shub asked what role the National SAC actually plays or fulfils? Andrew Giles responded that the SAC acts as the voice of support groups across Australia and it was – through the Chairman of the SAC – the mechanism by which the National Board was informed of support groups activities and initiatives and also the way the support groups – again through the Chairman of the SAC - were kept informed on National Board activities.

David Sandoe reinforced this view by indicating that at Board Meetings the National SAC represents and articulates the position(s) of its constituent State Chapters ; the National SAC is an integral part of the PCFA and contributes to the national focus and governance of 83 groups and ensures the maintenance of a consistent and uniform position on policy as articulated by its membership of health consumers; such as through the Public Awareness & Education Committee [PA & E Committee] - an example being the development of the recent PSA Statement. This was instigated by the National SAC and facilitated by Gary Bowes, Bill McHugh and PA & E Committee member & NSW Board Member, Bryan Lowe.

The operation of the State Chapters are more localised and look after the individual needs of their constituent groups This will be further enhanced by the training of identified members and others for the national Ambassador program.

An emphasis is placed on the need for group leaders to be over their own diagnoses (at least two years post treatment) and to be running a successful group. They also need the confidence and respect of clinicians and treatment/care teams. There is a National/State requirement to attain this profile.

SAC also has a responsibility to mentor new groups and their leadership teams; and monitor and provide maintenance to existing groups.

Don Baumber added that SAC has a role to initiate working parties for specific tasks from time-to-time; including the development of position statements based on evidence based criteria in relation to prostate cancer and associated issues.

Refer role document in conference handbook.

- **Speaker's & Leader's Kits**

Accolades received from Colin Bartlett on the Speaker's Kit being a dynamic document with Roger Large, Karen Rendell and Graham Nicholls acknowledging it as a valuable tool.

A new DVD is to be made available in the near future (there is a need to re-jig some current content.) Folders and CD/DVD currently out of stock

Action: John Ramsay/ Andrew Giles

Con Casey indicated that a "Question and Answer" section has been initiated. Con awaiting Bill McHugh's copy being returned to him in order to continue development (Con has had a computer malfunction).

Action: Con Casey

- **Badging and publicity**

Protocols and a style manual are being set up with regard to use of the logo and livery.

Lionel Foote amplified the need for a 'logo' style guide for support groups; emphasising what works best in particular scenarios. A set of standards is required.

Publicity is available, please don't reinvent the wheel. Contact PCFA with your request. Templates will be made available in the revised Leader's Kit.

Action: John Ramsay/Lionel Foote/Andrew Giles

- **Fundraising**

David Sandoe indicated that it is a State and National Board responsibility to fund raise. For further policy information please contact Andrew Giles or John Ramsay

Groups may fund raise for the purposes of local need but, all activities must be appraised to the National office; with all major and nationally significant activities requiring endorsement and approval by the National office – including use of logo and tax exempt status, official receipts etc – there are clear and mandatory criteria which must be complied with – don't assume anything or you could find yourself exposed to legal penalty.

Andrew Giles stated that the PCFA had developed two key documents to assist the general public with running fundraising events. These are the "Ten Point Plan" for the successful fundraising event as well as the "Proposal to Run a Fundraising Event" form. Both are available from the National Office as well as shortly on the website.

He stressed that all funds raised must be lodged with the National office for audit and tax purposes. It is contrary to policy that groups accrue large amounts of funds in local accounts (these are not audited and outside mandated accountability requirements). Lionel Foote asked who audits the individual accounts of each support group? Andrew Giles responded that as there is only one national PCFA bank account – into which all support groups are requested to deposit their income – the auditing is done centrally. If a support group does have it own bank accounts then this is outside the nature of the PCFA and those groups will need to undertake there own auditing and management.

Ideally support groups should restrict themselves to more appropriate actions, such as supporting national campaigns etc.

With regard to normal expenses, each Chapter was now requested to submit a budget and statement of expenditure to John Ramsay for review. Payments will then be made in accordance with that budget (once approved) and receipt of supporting documentation.

Action: John Ramsay to include appropriate reference in Leader's Kit.

- **Website**

The PCFA is in process of

- streamlining information for consumers and clinicians
- Jan Morley to take over updates and maintenance.
- will include linkages to support groups and other allied sites.

- **National Support & Advocacy Manager (NS & A Manager)**

Con Casey asked: If the NS & A Manager is serving on any committees?

John Ramsay stated that he sits on a number of work related committees in a professional / clinical capacity under the delegation of the CEO. He stated that these accord with both his formal qualifications and almost twenty –five years of primary health experience both in Australia and overseas in developing and managing HIV/AIDS; tuberculosis, Hepatitis C and behavioural/environmental cancer services.

An example is his current position on the NSW Cancer Institute – Oncology Group – Urology as a clinician and consumer health advocate; where he co-chairs with Professor Pam Russell the Research and Clinical Trials working group. He has also been involved in the NSW Cancer Plan Review – focusing specifically on supportive care and the development of multidisciplinary care teams for the 2007 – 2010 Cancer Plan.

It was agreed that there should have a comprehensive list of SAC National Committee members participation in the various prostate cancer related committees.

Action: John Ramsay/ Andrew Giles

- **Budget**

Covered in CEO's presentation.

There is approximately $10,000 allocated per Chapter and this is administered/ controlled by the National office and includes all state/territory expenditure including national activities. Each Chapter is requested to submit a budget for the expenditure and use of this allocation.

- **PSA Statement**

Now accepted as PCFA policy.

- **National Audit of CaP Research**

Covered in CEO's presentation.

3. *GENERAL ITEMS FOR DISCUSSION:*

- **Fundraising/Distribution of Funds/Projects**

Covered in CEO's presentation.

- **Andrology Australia.**

Check website: www.andrologyaustralia.org.au ~focus is on Men's Sexual Health.

- **Communications between PCFA / SAC /groups**

Covered by early discussions.

- **Retired SAC Members**

Retired SAC Members are welcome to offer to contribute from time-to-time in a number of areas including projects and other committees that match their skill, experience and demonstrated commitment.

- **Role of SAC/Value Add/Role of Executive & Composition of Executives**
- **Maximising Effort & Expertise**

Covered in CEO's report.

- **The Freemason Initiative**

Over the coming months Freemason's will be holding Men's Health Forums at various locations around the country. Details are now on the PCFA website.

- **Depression**
- **Advanced Cancer**

Agreed these two subjects need our focus in the next 12 months.

Action: Working parties to be set up.

- **Other organisations – eg. Cancer Council's**
- **Helpline**
- **Men's Health**

General discussion took place on these items.

- **Marketing material**

Polo shirt & Cap will be promoted on website and supplied to Support Groups. Henry Buck's have produced a PCFA tie soon to be available.

Action: Andrew Giles/John Ramsey

- **Public Awareness and Advocacy Committee**

This committee now has wider national membership. David Sandoe, Chair.

- **Victoria & NSW Board Patron's**

Both Board's now have their State Governors as Patron.**Prostate Cancer Foundation of New Zealand**

Barry Young, indicated his pleasure in being invited to attend our conference, he confirmed that we all have similar challenges and appreciates the close liaison which he hopes will continue into the future.

- **Affiliation procedure**

Keith Williams raised the question as to whether the 'affiliation' procedure should be looked at again.
David Sandoe responded by advising that appropriate consideration had been given to this exercise and the papers were being completed (with the occasional amendment to suit local requirements) and were rolling in from around the country.

John Ramsay & Pam Sandoe 23/10/06

ON GETTING OLDER

I've sure gotten old! I've had two bypass surgeries, a hip replacement, new knees and fought prostate cancer and diabetes. I'm half blind, can't hear anything quieter than a jet engine, take 40 different medications that make me dizzy, winded, and subject to blackouts. Have bouts with dementia. Have poor circulation; hardly feel my hands and feet anymore. Can't remember if I'm 85 or 92, Have lost all my friends. But, thank God, I still have my driver's licence.

Reporters interviewing a 104-year-old woman: "And what do you think is the best thing about being 104?" the reporter asked. She simply replied, "No peer pressure."

ANDROGEN DEPRIVATION THERAPY MAY INCREASE RISK OF DIABETES AND CARDIOVASCULAR DISEASE

Use of hormone therapy for the treatment of non-metastatic prostate cancer may increase the risk of diabetes and cardiovascular disease

According to the results of a study published in the Journal of Clinical Oncology, use of a gonadotropin-releasing hormone (GnRH) agonist for the treatment of non-metastatic prostate cancer may increase the risk of diabetes and cardiovascular disease. Because androgen deprivation may increase fat mass and insulin resistance, it's possible that it could increase the risk of diabetes and cardiovascular disease.

Androgen deprivation can be achieved through the use of medications such as gonadotropin-releasing hormone agonists, or by surgically removing the testicles (bilateral orchiectomy).

Men with early-stage prostate cancer generally have a favorable prognosis, and understanding the frequency of serious treatment-related side effects is an important part of treatment planning. Because androgen deprivation may increase fat mass and insulin resistance, it's possible that it could increase the risk of diabetes and cardiovascular disease.

To explore the risks of diabetes and cardiovascular disease in men with localized or regional prostate cancer (cancer that has not spread to distant sites in the body), researchers conducted a study among more than 70,000 Medicare enrollees with prostate cancer. Information about medication use and health outcomes was collected from medical claims data. Overall, 36% of the men had received a GnRH agonist and 7% underwent surgical removal of the testicles.

During four-and-a-half years of follow-up, 5.4% of study participants had a heart attack and 4.5% experienced sudden cardiac death. Among the men who were initially free of diabetes, 10.9% developed diabetes. Among the men who were initially free of coronary heart disease, 25.3% developed coronary heart disease.

- Compared to men who did not receive androgen deprivation therapy, men who were treated with a GnRH agonist were 44% more likely to develop diabetes, 16% more likely to develop coronary heart disease, 11% more likely to have a heart attack, and 16% more likely to experience sudden cardiac death.
- Compared to men who did not receive androgen deprivation therapy, men who underwent surgical removal of their testicles were more 34% more likely to develop diabetes. Risks of coronary heart disease, heart attack, or sudden cardiac death were not increased.
    - The researchers note that it's unclear why the risks of bilateral orchiectomy would differ from the risks of GnRH agonists. It's possible that the relatively small number of men who underwent orchiectomy may have produced some uncertainty in these results, but the researchers note that additional studies are needed to clarify this question.

The researchers conclude that use of GnRH agonists in the treatment of localized or regional prostate cancer may increase the risk of diabetes and cardiovascular disease. The researchers note that "Decisions about GnRH agonist treatment for locoregional prostate cancer should weigh improvements in cancer-specific outcomes against potential increased risks of diabetes and cardiovascular disease."

Reference: Keating NL, O?Malley J, Smith MR. Diabetes and Cardiovascular Disease during Androgen Deprivation Therapy for Prostate Cancer. /Journal of Clinical Oncology/. 2006;24:4448-4456. -- produced by CancerConsultants.com <http://www.cancerconsultants.com/>

GOOD LONG-TERM RESULTS WITH INTENSITY MODULATED RADIATION THERAPY FOR PROSTATE CANCER

Study provides additional evidence that IMRT is a safe and effective treatment for men with localized prostate cancer

According to the results of a study published in The Journal of Urology, use of high-dose intensity modulated radiation therapy for localized prostate cancer results in good long-term cancer control.

Intensity modulated radiation therapy (IMRT) is a newer approach to radiation therapy that allows for the more precise delivery of radiation to cancer cells, while sparing healthy surrounding tissue. This allows for the use of higher doses of radiation therapy.

To describe long-term outcomes after use of high-dose IMRT for the treatment of localized prostate cancer, researchers at Memorial Sloan-Kettering Cancer Center in New York evaluated 561 men who had been treated with IMRT between 1996 and 2000. Study participants were classified into prognostic groups (favorable, intermediate, or unfavorable) on the basis of tumor size, Gleason score, and pretreatment level of prostate-specific antigen (PSA).

* Eight-year survival without a PSA increase was 85% for men with favorable prognostic factors, 76% for men with intermediate prognostic factors, and 72% for men with unfavorable prognostic factors.
* Death due to prostate cancer occurred in none of the men with favorable prognostic factors, 4% of men with intermediate prognostic factors, and 16% of men with unfavorable prognostic factors.
* The probability of grade 2 or grade 3 rectal bleeding during the eight-year period was 1.6%. Urethral strictures that required dilation developed in 3% of patients.
* Erectile dysfunction developed in roughly half the men who had initially been potent.

This study provides additional evidence that high-dose intensity modulated radiation therapy is a generally safe and effective treatment for men with localized prostate cancer.

Reference: Zelefsky MJ, Chan H, Hunt M, Yamada Y, Shippy AM, Amols H. Long-term Outcome of High Dose Intensity Modulated Radiation Therapy for Patients with Clinically Localized Prostate Cancer. The Journal of Urology. 2006;176:1415-1419. produced by CancerConsultants.com <http://www.cancerconsultants.com/> Copyright ©2006 CancerConsultants.com<http://www.cancerconsultants.com/>.

NEW BIOMARKER PREDICTS SPREAD OF PROSTATE CANCER

Low levels of a protein called AZGP1 indicate that the cancer is likely to spread

Low levels of a protein called AZGP1 (for zinc-alpha2-glycoprotein) in prostate cancer specimens indicate that the cancer is likely to spread to other sites in the body after removal of the prostate, researchers report in the Journal of the National Cancer Institute.

AZGP1 levels, Dr. Susan M. Henshall pointed out to Reuters Health, could allow for more targeted treatment.

"Men with low levels of the marker could benefit from more aggressive treatment, such as radiotherapy or chemotherapy, around the time of surgery when they still have potentially curable cancer," she explained. "On the other hand," Henshall added, "men with a low risk would have the option of deferring treatments that have a negative impact on quality of life."

Previous studies have found that decreased AZGP1 levels in malignant prostate samples correlated with disease recurrence. To see if AZGP1 levels also predict metastasis, or spread to other sites, Henshall of the Garvan Institute of Medical Research, Darlinghurst, Australia and associates analyzed AZGP1 expression in prostate specimens removed from228 prostate cancer patients.

Compared with high levels of expression of AZGP1, absent or weak expression was associated with a five-fold higher likelihood of localized recurrence, metastasis or death from prostate cancer.

The team suggests that if a simple, automated assay for detecting AZGP1 were developed, it "could eventually be used in the clinic to improve the prediction of metastatic spread of prostate cancer."

Also, because AZGP1 can be measured in surgical specimens long before a rising PSA level can be detected -- indicating disease recurrence -- it would provide timely information to guide additional treatment.
SOURCE: /Journal of the National Cancer Institute/, October 4, 200

A L C O H O L D O E S N O T A F F E C T P R O S T A T E C A N C E R R I S K

Drinking does not appear to be associated with the overall incidence of prostate cancer, but men who drink alcohol may have a lower risk of developing aggressive prostate cancer and of dying from the disease

Drinking does not appear to be associated with the overall incidence of prostate cancer, according to findings published in the /International Journal of Cancer/. However, men who drink alcohol may have a lower risk of having an aggressive prostate cancer and dying from this cancer.

"Although there is little evidence to support an association between alcohol consumption and prostate cancer risk, questions remain concerning the effect on aggressive and non-aggressive tumors and the pattern and type of alcohol consumed," Dr. Graham G. Giles and colleagues from the University of Melbourne, Australia, write.

To investigate, the researchers analyzed data on 16,872 men followed from 1994 to 2003. The participants ranged in age from 27 to 70 years at the beginning of the study, when questionnaires were used to obtain detailed information on alcohol consumption.

A total of 732 cases of prostate cancer occurred, including 132 aggressive cases and 53 prostate cancer-related deaths.

Overall, no association was observed between alcohol intake and the development of prostate cancer. Also, the pattern of drinking and type of alcohol were not significantly associated with prostate cancer risk.

Compared with abstainers, men who consumed 1 to 19 gram per day of alcohol, (no more than about one and a half drinks per day), had a slightly reduced risk of aggressive prostate cancers (34 percent). Prostate cancer mortality was also reduced in this group (44 percent).

According to the U. S. Department of Agriculture's Dietary Guidelines, 12 ounces of beer equals 12.9 grams of alcohol, 5 ounces of wine equals13.5 grams, and 1.5 ounces of distilled spirits (80 proof) equals 14.0 grams of alcohol.

If it can be confirmed that moderate alcohol consumption protects against aggressive and fatal prostate cancer, it would have a "major impact," Giles and colleagues point out, because "there are no established modifiable risk factors for this common type of cancer."
SOURCE: /International Journal of Cancer/, September 2006.

The nice thing about being senile is that you can hide your own Easter eggs.

DEATH FROM CANCER TO DISAPPEAR WITHIN 20 YEARS

DEATH from cancer - and possibly heart disease - will be a thing of the past within 20 years because of advances in genetic technology, an expert said today.

John Shine, director of the Garvan Institute for Medical Research in Sydney, today said he believed while people would still get cancer in 20 years time, they would not die from it.

Scientists now knew it was possible to develop "smart" drugs which targeted particular disease-causing or susceptible genes and it was only a matter of time before there were drugs which could target cancer, he said.

"I think there's no doubt death from cancer will be confined to the annals of history," Professor Shine said after addressing a genetics conference in Perth today.

"And I think a very similar thing will apply to heart disease," he said.

Such targeted drugs would not damage healthy cells and would therefore have fewer side effects than current treatments, he said.

Professor Shine said he believed there was strong support for such advances, despite reservations in some sections of the community to genetic technology.

"I think when you are dealing with human health, especially devastating diseases like cancer, I think the community really does drive political opinion," he said.

The only hurdles to developing such drugs are therefore technical, he said.

"And people will figure out a way around that stuff," he said.

Professor Shine pioneered gene research in the 1970s when he identified the genes for insulin and the human growth hormone and has been called the "father of cloning". (© *The Australian 24oct06)*

Prostate cancer being overtreated, study shows

By Robert Bazell *Chief science and health correspondent NBC News 15th Auguust 2006*

Many prostate cancer patients - and their doctors - may be overreacting to the word "cancer;" according to a study out today. Of the 234,000 American men expected to be diagnosed with prostate cancer this year, most will get surgery or radiation. But in many of those cases, the men might fare better without the aggressive treatment.

The study out today offers strong evidence for what many doctors have been saying surgery or radiation for prostate cancer is often unnecessary.

Many doctors agree that surgery, radiation is often unnecessary

"We're seeing lots of men and some of them have small tumors and are getting too much treatment," says Dr. Peter Carroll of the University of California, San Francisco.

In one of the largest studies to examine this issue, researchers at the University of Michigan collected records of more than 64,000 men with early prostate cancer. Almost 25,000 had very low risk tumors, yet more than of half of those still got surgery or radiation.

Studies have shown that "watchful waiting" - closely monitoring the cancer- is a valid option for many such men with early-stage prostate cancer. They might even do better if they waited until treatment was really necessary.

Why? Experts say patients and doctors sometimes overreact to the word "cancer."

"Prostate cancer is different in several ways," says Dr. Mark Scholz with Prostate Oncology Specialists. "It grows much more slowly, it doesn't spread nearly as easily."

When Larry Cano learned he had prostate cancer, the side effects of surgery and radiation were much on his mind, especially incontinence and sexual problems. "Some of us at a certain age may be willing to forego our sexual lives," Cano says. I haven't met anybody that's willing to do that!"

Cano, a karate instructor and film producer, met doctors who told him he had to have surgery - others said radiation was the only answer. But he took some time, explored his options and decided to take a course of hormone therapy and monitor the cancer. "I think I did the best thing for me, knock on wood!" Cano says. "It was a very successful outcome."

Experts emphasize that prostate cancer can be life threatening and require surgery or radiation. But they say patients and doctors need to be educated to understand that is often not the only choice.

(From @ 2006 MSNBC Interactive)

Too many options with prostate cancer

WASHINGTON - It took eight agonizing months for Charles Linzey to decide how to treat his early-stage prostate cancer. His wife, in contrast, had her early-stage breast cancer surgically removed just a month after diagnosis.

It's not that the Baltimore businessman was less decisive. Instead, Linzey ran into a distressing reality: Unlike with breast cancer and many other malignancies, doctors simply couldn't tell him which therapy was a better bet for the leading male cancer.

There is little good research directly comparing prostate treatment options to help the newly diagnosed choose between surgery, two types of radiation, or watching a small tumor to see if it needs treating at all.

"I never felt comfortable, even when I made my choice, with my choice. Because no one would say, 'That's a good choice, says Linzey, 59, who ultimately went with implanted radioactive "seeds" and is faring well.

Two new studies suggest the advice gap has consequences: overtreating early-stage tumors, and therapy choices driven by fear and misperceptions.

"When we give people choices, it's sometimes more difficult," acknowledges Dr. John B. Fiveash, a radiation oncologist at the University of Alabama, Birmingham, who is at the forefront of a fledgling trend to try to change that - through specialized prostate clinics.

Key for patients to know: "Not all prostate cancer is the same," stresses Dr. John T. Wei, a University of Michigan urologist who recently reported that about 55 percent of men with low-risk tumors are overtreated, unnecessarily exposing them to such side effects as impotence and incontinence.

Certainly aggressive prostate cancer can kill. But often, prostate cancer is so slow-growing, and discovered when it's so small, that men will die of something else before it ever causes symptoms, much less becomes life-threatening.

One man in every six will get prostate cancer, but only one in' 34 will die of it, the American Cancer Society says. That sounds reassuring until you're the man wondering if you'll be in the lucky majority or not. Unfortunately, doctors have no easy way to tell.

Adding to the confusion: Studies are contradictory about whether aggressive treatment really improves a low-risk man's long-term chances of survival - or if a better option might be to closely monitor the tumor and treat it only if it starts to grow, so that he doesn't endure side effects until he really has to.

Types of treatment – and the option of ignoring it – confuse patients

And while some older studies do suggest that radiation and surgery recipients fare equally well for up to 10 years. Fiveash laments that there are no direct comparisons of more modern surgical and radiation techniques, including more precisely targeted, potentially safer ways to deliver radiation.

So doctors typically just present all the options and let men choose.

Michigan's Wei. and colleagues tracked more than 64,000 men deemed so low-risk that they were good candidates for what's dubbed "active waiting" instead of immediate treatment. Those over 70 were most likely to be unnecessarily treated, he reports this month in the Journal of the National Cancer Institute.

How do men choose? University of Colorado researchers interviewed 20 newly diagnosed patients just after a doctor explained their options. More than half wanted treatment as fast as possible; they were too frightened to wait even for a second opinion, the researchers recently reported in the journal Cancer.

More troubling were the myths. Some called removing a cancerous prostate a guarantee for a cure - it's not - while others opted for radiation because they wrongly thought only surgery could cause impotence. In *fact,* men were more likely to follow a friend's recommendation than to compare the limited scientific data on treatment side effects and benefits.

To help men make more educated choices, UAB and Michigan head a small but growing number of cancer centers that offer "multidisciplinary prostate cancer clinics." Modeled on the one-stop consultations long available to breast cancer patients, men can see, in one visit, urologists, radiation oncologists and other specialists, to compare their options with proponents of each.

And Wei and the Michigan Cancer Consortium developed a, Web site - www.prostatecancerdecision.org - that presents what scientific data is available for each therapy at a 6th-grade reading level, for a side-by-side comparison.

Linzey, the Baltimore man, recalls his frustration as specialists quickly laid out the top option for his wife's breast cancer at the same time he was searching out doctors to debate the pros and cons of prostate treatment.

"It's a shame there is no right answer," says Linzey, whose tests suggest his cancer is gone three years after he settled on seed implants. He gets regular checks, so even if it returns, "the chances of it killing me are pretty slim."

ARE YOU INTERESTED IN HELPING OTHER MEN AND THEIR FAMILIES?

The Prostate Cancer Action Group (S.A.) Inc. is a not for profit Group of volunteers who are dedicated to spreading the public awareness of prostate cancer – a disease that is the silent killer of 2,700 Australian men each year. If you, or any of your friends, and colleagues would like to join our group, we would make you, or them, welcome to our ranks. We need more people to assist us with awareness campaigns, and the consistent demand from other organizations for speakers about the disease.

"WHAT IS IT WITH MEN'S HEALTH?"

MEN, THEIR HEALTH AND THE SYSTEM: A PERSONAL PERSPECTIVE

Gregory O Malcher (MJA 2006; 185 (8): 459-460)

With united, sustained action, general practice organisations and practitioners can help stop our men dying or "diseasing" too early.

What is it with men's health? Ten years ago, men's health nights in pubs were all the go. Now we don't even have those. There's the occasional event or TV item, but always a one-off. Women's health researchers, practitioners and advocates get lots of resources and publicity, and good on 'em. But men are still dying too early from stuff that can be prevented. (Anonymous man, Daylesford, Victoria, 2006)

As National Convenor of GPs4Men, the Australian General Practitioners' Network for Men's Health, I hear occasional comments like this from patients I see in my full-time rural general practice. Recently, I have run into colleagues who, noting the absence of men's "health bites" in the media, ask if I'm still involved. My answer is "yes, but differently".

"Spare" time previously spent on activities with GPs4Men, particularly liaison with members, has been leached away by work on the Royal Australian College of General Practitioners' (RACGP) position statement on men's health (to match the 1997 position statement on women's health), now endorsed and available on online,1 <#0_i1091797> and the ongoing RACGP men's health curriculum review.

GPs4Men was founded in 2003 in response to the lack of policy and funding for men's health on a national level. Australia still has no national men's health policy, despite the existence of a women's health policy since 1989. It would be naïve to suggest that simply developing a policy would be sufficient to deal with all the challenges of men's health policy without adequately funded programs = "piffle". Yet, for those of us involved in men's health, there remains an overwhelming desire to see a formal acknowledgement by the federal government (whether a policy, position statement or other document) of the broad and unique issues of men's health, and a preparedness to fund a national program to address these issues.

I wonder whether the government's problem might be that the problem seems "too big". A multiplicity of interest groups, including sociologists, "masculinists", "men's shed" workers, community nurses, endocrinologists, GPs, urologists, social workers and educators - all hold valid points of view. But has this very diversity led to an apparent government standstill due to "overload"? Whatever the reason, GPs simply must do something about Australian men's health. The recent RACGP health inequalities study clearly demonstrated the appallingly high mortality rates for men compared with women across the socioeconomic spectrum.2 <#0_i1091799> Notably, it showed that:

- the mortality rate for 25-64-year-old men in the most socially advantaged group of the population was higher than that for 25?64-year-old women in the most socially disadvantaged group; and

* men in the most socially disadvantaged group had a mortality rate nearly double that of the most socially disadvantaged women.

Further, there can be no argument that groups of men - Indigenous men, war and service veterans,3 <#0_i1091802> and men affected by poverty - are at high risk of health problems and have specific medical needs.

At present, the federal government's response seems to be to restrict funding largely to men's sexual health programs based, presumably, on the unassailable assertion that testes and prostates are unequivocally male. The problem with this approach is that it ignores key issues; not only the stark statistics, but also the differences between how men and women view their bodies (especially in dysfunction), and in how they use the health care system. The major recipient of federal funding in men's health ($4 million over 4 years) = the male reproductive health centre, Andrology Australia - runs excellent community and

medical education programs. However, it is beyond this organisation's terms of reference to tackle the crucial issue of men's underuse of the health care system.

It would again be simplistic to suggest that simply finding ways of bringing men into more effective contact with GPs would solve the problems of men dying or "diseasing" too early. Many other issues also demand attention, from men's involvement in pregnancy and postnatal depression, to masculinity issues in schools and the workforce, to addictions, to social isolation and relationship problems. Nevertheless, bridging the chasm between GPs and their potential male patients is crucial, as GPs are the key providers of primary health care.

Marketing health to men needs to be viewed as a crucial and do-able component of any worthwhile campaign to improve men's health. Such marketing is too important to just be left in the hands of a group of enthusiastic health professionals. Men's health needs the sort of marketing expertise used by those who are intent on persuading teenagers to smoke. It should be sustained, professional, well funded and be driven by clear goals. Men's health is also desperate for high-profile sustained support. The Prime Minister's newly appointed obesity ambassadors, Harry Kewell and Kieren Perkins, should have their portfolios enlarged to encompass the broader issues of men and their health. We need the support of influential figures like the Prime Minister and the Minister for Health to achieve this. Their early morning walks and bike riding, respectively, serve as excellent examples for Australia's men.

The membership of GPs4Men (of about 70 individual GPs and almost a third of the 118 Australian Divisions of General Practice [ADGP]) believes that it is the responsibility of the GP Reference Group organisations - the RACGP, the ADGP, the Australian Medical Association (AMA) and the Rural Doctors Association of Australia (RDAA) - to make a joint submission to our federal government for a federally funded men's health program that puts into action a men's health policy. It is up to those who fund health care to find ways of taking Australia's overworked GPs to where men are more comfortable using their services, especially the workplace. It is up to those who deliver health care to identify the best way forward.

Not only united but also sustained effort will be required from general practice organisations. The AMA produced a position statement on men's health in 2004,4 <#0_i1091805> but has since seemed to move on to other priorities. The RACGP has had a Women's Health Taskforce since 1997; surely it is time for the college to have an active Men's Health Taskforce. The ADGP is moving slowly towards greater activity in men's health, with a session dedicated to men's health at its upcoming national forum on the Gold Coast in November this year. Many GPs and Divisions would respond to local needs for men's health programs, but cannot because of lack of funding. The RDAA has also expressed its broad support for men's health; understandably so in the light of the dire state of rural men's health.

In the absence of any structural or funded initiatives, there is still much being done and that can be done in general practice. All GPs (and possibly all medical practitioners) should consider how they can increase the uptake of their services by the "unreachable" group -30-60-year-old men. I believe that general practice has some way to go before we can feel satisfied with how we market health to our male population. "Man-friendly" appointment systems and consulting times with after-work times and more on-the-day appointments, waiting rooms, and reception staff are key parts of a "whole-of-practice" approach, as are outreach services to workplaces and other venues. Similarly, a "whole-of-consultation" approach involves offering options to the men we do see which take into account the fact that many men prefer a more physically-based approach to lifestyle prescription, and may require specific direction about follow-up. Community resources which meet men's exercise needs are often lacking. For many men, a trusting relationship with a personal physician or practice is built over a series of consultations.

Australia's men, our women's and men's groups and our GPs believe that Men's health is much more than sexual health - this is not the case in much of the developed world. We therefore have a great opportunity to lead the world, or at least to share the lead in the important area of men's health.

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SIDE EFFECTS OF PROSTATE CANCER TREATMENT

You have the right to *information*, *treatment* and *support* when fighting the side effects of prostate cancer treatment.

Side Effects Overview

New and better treatments are saving more lives every day. However, *treatments have side effects *and you should know the facts.

Side effects of prostate cancer treatment may include:

Incontinence - the inability to control urine flow when coughing, laughing, sneezing, or exercising.

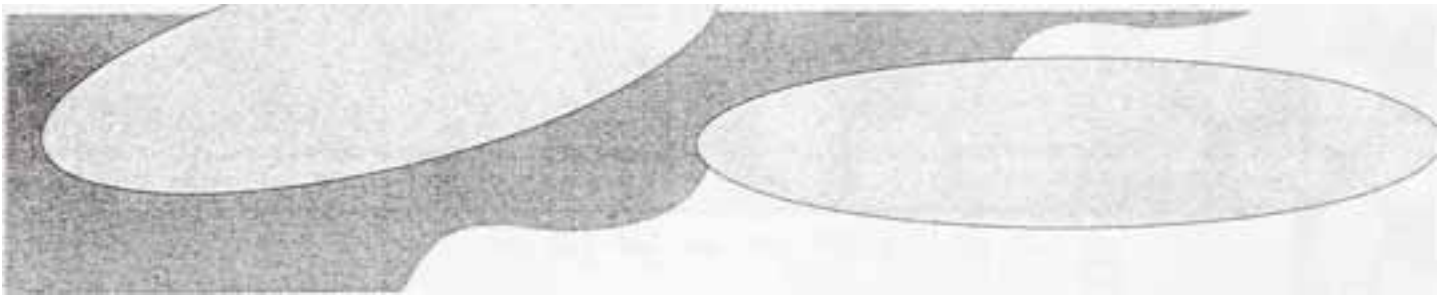
Erectile dysfunction - also known as *impotence*, is the inability to get an erection.

Fatigue - a daily lack of energy associated with excessive whole-body tiredness and not relieved by sleep.

Pain - not usually a major effect of treating local prostate cancer. However, advanced prostate cancer can cause pain, particularly when metastisized to the bone. Chemotherapy can also cause pain, anemia and nausea.

*Bone Pain or Weakness - *weakness and increased porousness in bone, can be caused by hormone therapy. Cancer that has metastasized to the bone can also cause pain.

Depression - Occasional feelings of sadness, anger and anxiety are normal for people going through a major challenge like cancer, but sometimes, these feelings just won’t go away. Feelings that persist may be a sign of a serious condition, and should be discussed with your doctor.



A TO Z OF STRESS MANAGEMENT

Always take time for yourself, at least 30 minutes per day

Be aware of your own stress meter: know when to step back and cool down

Concentrate on controlling your own situation, without controlling everybody else

Daily exercise will bum off the stress chemicals

Eat lots of fresh fruit, vegies, bread and water, give your body the best to perform at its best

Forgive others, don't hold grudges and be tolerant-not everyone is as capable as you

Gain perspective on things, how important is the issue?

Hugs and kisses and laugher, have fun and don't be afraid to share your feelings with others

Identify stressors and plan to deal with them better next time

Judge your own performance realistically, don't set goals out of your own reach

Keep a positive attitude, your outlook will influence outcomes and the way others treat you

Limit alcohol, drugs and others stimulants, they affect your perception and behaviour

Manage money well, seek advice and save at least 10% of what you earn

No is a word you need to learn to use without feeling guilty

Outdoor activities by yourself, or with friends and family can be a great way to relax

Play your favourite music rather than watching TV

Quit smoking, it is stressing your body daily, not to mention killing you too

Relationships, nurture and enjoy them, learn to listen more and talk less

Sleep well, with a firm mattress and supportive pillow, don't overheat yourself and allow plenty of ventilation

Treat yourself once a week with a massage, dinner out, the movies, moderation is the key

Understand things from the other person's point of view

Verify information from the source before exploding

Worry less, it really does not get things completed better or quicker

Xanadu, regularly retreat to your favourite space , make holidays part of your yearly plan and budget

Yearly goal setting, plan what you want to achieve based on your priorities in your career, relationships etc

Zest for life, each day is a gift, smile and be thankful that you are part of the bigger picture

You will never look at a cup of coffee the same way again... .

A young woman went to her mother and told her about her life and how things were so hard for her. She did not know how she was going to make it and wanted to give up. She was tired of fighting and struggling. It seemed as one problem was solved, a new one arose.

Her mother took her to the kitchen. She filled three. pots with water and placed each on a high fire. Soon the pots came to boil. In the first she placed carrots, in the second she placed eggs, and in the last she placed ground coffee beans. She let them sit and boil, without saying a word. In about twenty minutes she turned off the burners. She fished the carrots out and placed them in a bowl. She pulled the eggs out and placed them in a bowl. Then she ladled the coffee out and placed it in a bowl. Turning to her daughter, she asked, "Tell me what you see."

"Carrots, eggs, and coffee," she replied.
Her mother brought her closer and asked her to feel the carrots. She did and noted that they were soft. The mother then asked the daughter to take an egg and break it. After pulling off the shell, she observed the hard-boiled egg. Finally, the mother asked the daughter to sip the coffee. The daughter smiled as she tasted its rich aroma. The daughter then asked, 'What does it mean, mother?" Her mother explained that each of these objects had faced the same adversity - boiling water. Each reacted differently. The carrot went in strong, hard, and. unrelenting. However, after being subjected to the boiling water, it softened and became weak. The egg had been fragile. Its thin outer shell had protected its liquid interior, but after sitting through the boiling water, its inside became hardened. The ground coffee beans were unique, however. After they were in the boiling water, they had changed the water." Which are you?" she asked her daughter. 'When adversity knocks on your door, how do you respond? Are you a carrot, an egg or a coffee bean?"

Think of this: Which am I? Am I the carrot that seems strong, but with pain and adversity do I wilt and become soft and lose my strength?

Am I the egg that starts with a malleable heart, but changes with the heat? Did I have a fluid spirit, but after a death, a breakup, a financial hardship, or some other trial, have I become hardened and stiff? Does my shell look the same, but on the inside am I bitter and tough with a stiff spirit and hardened heart? Or am I like the coffee bean? The bean actually changes the hot water, the very circumstance that brings the pain. When the water gets hot, it releases the fragrance and flavor. If you are like the bean, when things are at their worst, you get better and change the situation around you.

When the hour is the darkest and trials are their greatest, do you elevate yourself to another level? How do you handle adversity? Are you a carrot, an egg or a coffee bean?

May you have enough happiness to make you sweet, enough trials to make you strong, enough sorrow to keep you human and enough hope to make you happy. The happiest of people don't necessarily have the best of everything; they just make the most of everything that comes along their way. The brightest future will always be based on a forgotten past; you can't go forward in life until you let go of your past failures and heartaches.

May we all be COFFEE!

To all our members and readers we sincerely wish you an enjoyable Christmas with your loved ones, and a healthy, peaceful and prosperous year in 2007

Newsletter compiled by Trevor Hunt