PROSTATE CANCER ACTION GROUP (S.A.) INC

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Australia

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NEWSLETTER

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OCTOBER 2006

Chairman's Report October 2006

National SAC Annual Conference & APCC Annual General Meeting 2006.

I was invited to attend the Annual Conference of the Support & Advocacy Committee of the PCFA and the AGM of the Australian Prostate Cancer Collaboration in Sydney from the 3rd – 5th October.
Both were very interesting and informative including a range of excellent speakers.
A very important part was "networking" with other participants. South Australian representatives on the SAC, Trevor Hunt and Gary Bowes attended. In accordance with PCFA requirements Trevor is now retiring from the committee and I will leave it to him to comment further on the meetings.
My thanks to the PCFA for the invitation to attend.

Awareness Evenings

As previously mentioned the forthcoming awareness evenings at Stirling and Mount Barker are being sponsored by the Freemasons of Stirling, Blackwood and Mount Barker and we are very grateful for their support.
The Freemasons throughout Australia and New Zealand have committed to raising the awareness of men's health during October and also November.
It is planned to hold 900 men's health seminars throughout Australia and New Zealand sponsored by the Freemasons, Beyond Blue and Andrology Australia with support from Smorgon Steel and the PCFA – what a fantastic effort.
For more details visit http://www.menshealth.org.au - a link is also on the PCFA website.

Stirling

The event will be held on Wednesday 11th October, at virtually the same time as this newsletter is distributed. The venue is the Stirling RSL Clubrooms, Apex Park Stirling with the presentation commencing at 7p.m. Key speakers will be urologist, Dr James Aspinall and Dr Graham Lyons from the University of Adelaide. We are hoping for a good attendance.

Mount Barker

The date of this presentation is 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.
Great support is being received from the Adelaide Hills Community Health Centre at Mount Barker.
All are welcome to attend this free evening and receive information and support in a relaxed, friendly environment.

Strathalbyn

This event is now likely to be held late in March 2007.

Speaking Engagements

In September and now in October our members have involvements with several speaking engagements.
Bill Toop spoke to the Freemasons at Port Adelaide on the 19th September.

Trevor Hunt will be speaking to a combined Freemasons, Lions and Rotary function at Kingscote, Kangaroo Island on the 17th October and I will be speaking at a Freemasons event at Balaklava on the previous evening.
Both Dean Wall and myself will have radio interviews in relation to the awareness evenings.
In addition our Group will be conducting the Stirling and Mount Barker awareness presentations.
We certainly are having some very busy months to wind up the year.

Mitcham Prostate Cancer Support Group
20 attended the September meeting including 2 new people. The guest speaker was Ken Cooney, a member of the Group, who spoke on his participation in a program by Ian Gawler. This included a brief meditation session. Ken is to be commended for his talk which members found very interesting.
At the next meeting members will view a DVD on the Men's Health Promotion Conference conducted by the PCFA in Melbourne on the 12th August.

The Freemasons Art Exhibition
The Exhibition held from the 16th & 17th & the 21st – 24th September was a successful event. I have not heard the final figures but understand the organisers are happy with the result which was substantially better than the inaugural event held last year.

Prostate SA
Prostate SA is involved with this year's Classic Adelaide Rally being held from 15th – 19th November. Brent Frewen of Prostate SA is looking for 10 – 15 volunteers to assist with jobs such as fund raising each day along the route using cash tins, helping the Lions Club run BBQ's and also assisting with various jobs at the closing event on Sunday 19th November.
If you think you can assist Prostate SA to raise urgent funds throughout this event, please give Brent a ring at The Cancer Council SA on 8291 4111 for further information.

Cancer Voices SA Steering Committee
The meeting held on the 27th September centred around the appointment of a Chairman and reaching agreement on the terms of reference and the questionnaire to be sent to various support groups.
Ashleigh Moore was appointed Chairman.

Jeff Roberts

MINISTER'S CANCER COMMENTS

It was reported in our September edition, on page 3, that Federal Minister for Health, Tony Abbott, had stated in a television interview that '*If you haven't got the symptoms, you probably don't need to get tested."* In that article, another government Minister, Mr. Jim Lloyd, quite rightly, took Mr. Abbott to task over his reported comments.

However, it was later reported that Mr. Lloyd received a phone call from Mr. Abbott, and Mr. Lloyd's office sought to recall his statement 20 minutes after it was issued.

Mr. Lloyd said he believed the ministerial confusion had come about over perceptions of the need for mass-screening, which he emphasised neither he nor the Prostate Cancer Foundation of Australia was advocating. Mr. Abbott's advice runs directly contrary to Foundation advertisements currently running on television.

Mr. Lloyd emphasised that "the correct message" on prostate cancer was that a PSA test was needed once men turned 40 if they had a family history of prostate cancer, and "all other men over 50 should talk to their doctors about having a PSA test even if they are healthy and have no symptoms." *(from Courier Mail, 2/9, p8, and others)*

(One would have to wonder what was said during that phone call. The original report did not suggest that Mr. Abbott said anything about mass screening during his TV interview, and the need for Mr. Lloyd to recall his statement is not obvious from that original comment. Moreover, the whole episode appears to suggest that Mr. Abbott, and his spokeswoman, do not have a very good knowledge of PCFA policy)

NATIONAL SUPPORT & ADVOCACY COMMITTEE ANNUAL CONFERENCE

TRANSITION AND CHANGE

The annual conference was held in Sydney on 3rd. October, and both Trevor and Jeff attended, together with Gary Bowes, as delegates and observer from South Australia. Delegates from all States and Territories attended the annual function, which was held in the conference room at the Best Western Motel, Pacific Highway, Artarmon.

The programme presented was of a very high standard, and proved to be most interesting. The morning session consisted of 4 guest speakers, each of whom provided us with both information and challenges.

Distress in Later Life

First speaker was Dr. Ian Webster AO, a consulting physician, at Liverpool Hospital, Shoalhaven area, and at the Matthew Talbot Hostel for the homeless, Woolloomooloo. He is also Emeritus Professor of Public Health and Community Medicine at the University of N.S.W., and Chief Patron of the Alcohol and other Drugs Council of Australia. If one also adds in his other commitments as Chairman of the National Advisory Council on Suicide Prevention, the Alcohol Education and Rehabilitation Foundation Ltd., and the N.S.W. Advisory group on Alcohol and Drugs, and President of the Governing Committee of the Ted Noffs Foundation, then you can see that this is a very busy and committed man. Not only that, but, from his address to us, it became evident that not only was he eminently qualified and committed, but also a very compassionate person.

"Distress later in life" was the title of his talk to us. More men than women take their own lives, although suicide attempts and self-harm are more common in women. Since records have been kept, older men have had the highest rates of suicide. But in the mid-70s, the rates of suicide moved down to peak in young men. The peak is now moving back again towards the older age groups. Suicide is a deliberate act.

In the 15-24 age group, suicides declined by 40%, after 1997, and other groups have also declined. But the rate has always been high in older men, who are more likely to die from an attempt – they think about it, and are more likely to be affected by disease and / or drugs. The main causes are known and preventable: (1) untreated depression –often masked by alcohol, and often missed in older people (2) untreated pain (chronic) – acute pain leads to chronic pain and is an enduring condition, mainly in bones and joints. There is also neuropathic pain, from parts missing. Persistent pain is distressing- people get frustrated – angry – and don't know what to do about it. It is also the third most expensive health matter.

Alcohol – 30% to 50% of completed suicides meet criteria for alcohol use disorder. When do they commit suicide? Mostly during a depressive episode, or during a binge episode.

The third factor is that ageing people are often socially isolated. We should keep in touch with them, as this will lessen suffering and isolation, and help prevent suicide.

In view of some unpleasant side-effects of some prostate cancer treatments, especially hormone therapy, I found this presentation to be quite relevant to our disease.

The Health of Boys and Men. – "If I have a party and people don't come, I shouldn't blame them"

Professor John J. Macdonald, Professor of Primary health Care at the University of Western Sydney, Co-Director of Men's health Information and Resource Centre, UWS, and president, Australasian Men's Health Forum.

One neglected area of health care and policy has been the health of boys and men. For historical reasons there has been a preoccupation with the health of women, and the fact that boys and men have, as a population, their specific experiences of health and health services.

The Men's Health Information and Resource Centre at UWS, of which he is a co-Director, has, since 1999, adopted a population health / social determinants of health approach to the health of boys and men (Macdonald J.J. 2005, Chapter 6). Such men's health policy as exists is often based on a "masculinities" view of men; a non-evidence based set of generally negative assumptions about men and their behaviour. The Resource Centre seeks to promote an evidence-based approach to men and boys health based on the social determinants, just as is done with any other sub-population.

Much of what passes as approaches to men's health, including their use of services, is based on negative stereotyping about men. "They don't get in touch with their feelings"; "they don't go to the doctors enough" etc.

In an animated and interesting presentation, Professor Macdonald held our attention, with his own style of informing and challenging us. With his "Billy Connolly" accent and constant movement, I doubt that any person

present was not kept "on the ball". If I was young enough to be going to university, I am sure that I would have found this man's style of presentation to be most appealing to learning. His way of imparting knowledge and opinions was very effective, and he certainly sent you away with challenges and thoughts to be considered.

I went to this meeting prepared to record some presentations, to be able to give a more accurate account of proceedings. It is with much regret that I have to confess that my lack of knowledge of technological gadgetry led to me not getting this presentation on tape (in fact, I missed the first 2 presentations). Therefore, my written notes of this presentation were rather skimpy.

Professor Macdonald queried whether we have a "health system" or a "disease system". The vocabulary in health care circles , in general, has largely to do with disease and other pathogenic concerns, e.g., at risk conditions. International men's health conferences inevitably see men as a "problem". He even quoted from a recent newspaper report about the proposed Men's Health Policy to be drawn up in S.A. (see PCAG Newsletter, September 2006). It may be his interpretation of these matters that struck such a cord with me, for I found much in his comments that was in accord with my thinking on this matter – if only we had such a man in S.A., with such clear thinking about men's health, and a workable policy.

He said that gender research and policy were often based on assumptions, not evidence. "Show me what you are doing to make your service more male friendly" (that is easy in S.A. there is nothing being done in this State). He gave us an example of this by quoting from a personal experience. His son is, apparently very supportive of feminism, and constantly praises efforts to support that cause. Then, our speaker had to accompany his son to the doctor, on one occasion. In the waiting room, they found that they were surrounded by posters, all aimed at promoting various aspects of women's health. Then they spotted the only poster that had any connection with men's health – a poster that urged women to take action over male violence. Yes, that is a common occurrence, and maintains the negative view of men's health in may places. Yet men still get blamed for not going to the doctor. "We need evidence-based research on men's health matters, but most are based on opinions".

His list of Social Determinants of Health included such items as social gradient, stress, early life experiences, work, unemployment, social exclusion, social support, addiction, food, transport, etc.

We have no funding to research men's health issues, and should formulate a National Men's Policy. Only N.S.W. has a Men's Health Policy.

This was a presentation that, alone, was well worth going to Sydney to hear.

'Him, His Prostate and His Pathologist'

Dr. Warick Delprado – Director of Histopathology, Douglass Hanly Moir Pathology.

Graduated from Sydney University, and did his pathology training at Westmead Hospital. He has a major interest in genitourinary pathology and cytology, and has published and co-authored many papers in the area. He served on the Australian Cancer Network's committee for localised prostate disease.

This is a difficult subject to report on, as Dr. Delprado took us through an explanation of the differentiation of human cells, leading to cancer, and how to recognise tumours, as compared to normal cells, and illustrations of margins. All of this was illustrated by numerous slides of tissue samples. This is not easy to demonstrate in a journal such as this, without the aid of coloured prints of his slides. He also illustrated the different types of tumours.

It was quite intriguing to learn how the various tumours are recognised, and how the Gleason score is assessed. We finished this presentation by participating in a practical exercise to see how well we could recognise cancer in a number of tissue sample slides, and assess the Gleason score. Surprisingly, many participants did quite well at this, but I am not sure that they could maintain the rate of accuracy for a full day in the laboratory.

A most interesting presentation, with technology very well explained by a very good communicator.

Towards a national structured supportive care program for prostate cancer patients in accord with "good practice".

Astrid Przezdziecki, Clinical Psychologist, working in the Cancer Therapy Centre at Liverpool Hospital. She is a member of the Australian Psychological Society, Australian Association for Cognitive and Behaviour Therapy, Australian Pain Society, Australian Society of Sex Educators Researchers and Therapists, and the Clinical Oncological Society of Australia. She has worked in the areas of drug and alcohol, chronic pain, rehabilitation, dental psychology, sexual health and oncology.

It is widely recognised that support groups can provide benefits for those who attend. However, there are also difficulties that are being encountered. What are these difficulties? How can supportive programs attract wide referral and be attractive to a greater number of participants?

How do we best respond to a person's needs in these circumstances? There is evidence that support groups can help to increase well-being and help to reduce stress. In addition, they can assist in coping with the diagnosis, help reduce distress, improve self-esteem, reduce anxiety, better understand the cancer experience, increase confidence in dealing with health professionals, and help improve quality of life.

Reasons for attending support groups include obtaining information, developing a sense of belonging, to see how other people cope with their disease, and building a sense of empowerment and control. But only a minority of people diagnosed with cancer participate in a support group.

In a study conducted on support groups, some people not members of such a group were asked why they were not members. The reasons were (1) have enough support already (2) practical issues (3) not a "group" person (4) bad previous experience with a group (5) fearful of exposure / privacy invasion (6) wanting to "move on" from the cancer experience.

61% of group facilitators reported group problems – poor referrals, poor attendance, unsuitable venue, lack of appropriate resources, and limited access to guest speakers.

Facilitators from inactive groups reported that reasons for inactivity were poor attendance, difficulty in recruiting new members, support and information needs were satisfied for many members, lack of support from other organisations in the community, and practical issues.

A study of self-help issues among urology patients found the issues to be cost, accessibility, pertinence, and reliability. Challenges facing support groups included perception of public and clinicians, limited referrals from health professionals, influence from others, focus and content, and change in needs during cancer experience.

Men are less likely to participate in a support group than women, and many people feel that they don't need support. Men are reluctant to talk about needs, despite having a high level of distress. Many people are afraid of their emotions and fearful of distress and disclosure of personal details, and fear that support groups are much like AA groups.

Clinicians become a factor, also. Doctors and nurses report their concern about the potential for support groups to provide incorrect or inappropriate information, and cultivate false hope and unconventional therapies. Most clinicians do not refer patients to support groups. The main sources of people finding support groups are (1) word of mouth (2) public notices (3) notices in the media – most got their information from outside the clinical situation.

In a survey of urologists and radiation oncologists, 28% said they rarely or never referred patients to support groups, 28% said sometimes, 22% will refer, but are unsure, 22% often / always refer. Their main concerns were about misleading information, and the potential for bias from other members. They are obviously concerned about influence from others. (*Of course, it would be better if urologists, and other clinicians, would provide information more freely than appears to be the current practice*.)

Clinicians believe that support groups have the potential to increase anxiety, create a loss of trust and regret about decisions already made about treatment.

Anecdotes have important effects on men's decisions, and often, in adversity, men seek advice from others in similar situations. This can have a tremendous effect on men's decision making, and anecdotal advice may impact on men's decisions about treatment. Men are urged to be aware about this impact of anecdotal advice. As there may be some medico-legal consequences which could lead to legal action. They

must be careful, lest their anecdotal advice is interpreted as medical advice. There are a number of adverse effects, and clinicians are worried about advice on particular treatments, clinicians or facilities. Or even advice to avoid particular treatments.

Studies show that 80% of men advise their clinicians that they are members of a support group. Men considered that information needs are more important than support, and that most of their information needs are adequately met. The best time for information is considered to be at point of diagnosis, but this is not happening at this time. Men frequently return with questions such as "why wasn't I told this before?" or "I could have used this information earlier". The need is for cancer-specific information at diagnosis, such as disease treatment and management of side effects. An American study showed that the need is for clear information, mostly basic information about prostate cancer, treatment, management of side effects and sexuality.

Good practice calls for innovative programmes that appeal and address needs of participants. It must be accurate information coupled with timely intervention.

The speaker then outlined a project to be conducted in the S.W. Sydney area in 2007 to try to create a national supportive care programme for prostate cancer patients, in accordance with recommendations made from a CCNSW study, to prevent people from becoming "lost in the system", and focusing on newly diagnosed men and their partners.

A comprehensive, interesting and informative talk, delivered in a very clear manner.

2006 FREEMASONS ART EXHIBITION

The results of the recent Freemasons Art Exhibition appear to be quite good, and must be an encouragement to the organisers (try telling that to Ray and Jocelyn Nicholson who appeared to be exhausted by the time the exhibition closed, and they still had to sort out the distribution of sold pictures to the purchasers, and the return of unsold works to the respective artists).

Total art sales were $32,000, of which the promoters took $8,000 in commission, plus raffle proceeds of $3700. Exhibiting fees were $8.00 per entry, art catalogue sponsorship amounted to $1910, plus door entry fees. Expenses were $4,500 in prizes, hire of screens, production of catalogue, media advertising (at preferential rates), and carrier charges for transporting the art screens.

The net result is a very creditable net amount exceeding $10,000, some of which will be donated to the Cancer Care Centre, and the remainder going to the Masonic Foundation to support their men's health projects.

It takes a lot of courage and foresight to mount an art exhibition such as this, and the organiser are to be congratulated on their sterling efforts this is a just reward for their many long hours of hard work. We also acknowledge that they made a place for us to promote awareness of prostate cancer, at no cost to us, and we thank them sincerely for that.

We cannot place a figure on the value of any benefits that may flow from the goodwill and awareness that may flow both from the exhibition and our information stall. Our contacts may not have appeared to be very significant, but I am sure that we must have helped some people. Thanks, again, to the Freemasons.

WOAD - WHY IT'S GOOD FOR YOU

WOAD, the war paint of ancient Britons and Celts, could join the armoury in the fight against breast cancer. New research has found the plant *Isatis tinctoria*, a member of the cabbage family, has 20 times the concentration of an anti-cancer chemical than its cousin broccoli, already the subject of research. The chemical glucobrassicin (one of a group of compounds called glucosinolates) acts against oestrogen in the human body, which can promote the growth of breast cancer. One problem has been the difficulty of extracting enough glucobrassicin from broccoli for research studies. So woad may be a better alternative, scientists say. *(SMH 31/8, p6) This story brought back boyhood memories to this writer, of a song which we used to sing with great gusto. If you want to hear a rendition, ask Dean Wall.*

SHOULD I BE TESTED?

Cancer screening tests can find cancer early, but are they always a good idea?

Cancer is a very scary thing. All of us have known someone whose life has been affected by cancer. Particularly in the past, cancer was a terrifying and life-threatening diagnosis.

Then along came screening tests and the notion that cancer could be found early and treated more effectively. Pap smears were introduced to prevent cervical cancer, and large-scale trials showed screening for breast and bowel cancer could reduce the chances of dying of these cancers.

Since then, there's been no looking back. Screening for these and many other cancers - lung, prostate, ovarian, and skin cancer for example - has been proposed and tried.

Now our cancer tests are so good we can find very small, very early cancers - and maybe finding them is doing more harm than good!
As our medical tests get better and better and we can 'see' into our bodies in ever increasing detail, we can pick up more and more 'abnormalities' - or perhaps it's better to call them 'variations' - than anyone ever realised existed.

For example, if we look hard for it, we can find prostate cancer in well over half of older men - but for most of these men their prostate cancer will never bother them. About a third of adults have thyroid cancer, and up to 40 per cent of middle-aged women have low-grade breast 'cancer' (ductal carcinoma in situ) if you look hard enough for it.

But not all of these cancers matter. Some of them grow so slowly they never cause any problems, or we die of something else first anyway, or some of them may even go away (dealt with by genetic repair mechanisms or our immune systems).

Better safe than sorry - or maybe not

So what's the problem with finding cancer early? The main problem is we can't tell the bad cancers apart from the innocuous cancers and so we have to treat everyone. Thus cancer screening brings with it real risks of over-diagnosis and over-treatment.

Having a cancer diagnosis is a very serious psychological burden for anyone. And of course it doesn't stop there: cancer therapies (surgery, radiation and chemotherapy) have important risks and side effects. So while you would want cancer therapy if you had a cancer that was going to get worse without treatment, you /wouldn't/ want it if all you had was an indolent cancer that was never going to make you sick. In fact if you had one of those cancers, it won't make you sick, but the treatment will.

There are other harms of cancer screening too. Sometimes the tests are wrong. So you can get an abnormal test result even though you don't have cancer. While doctors sort this out, you may have to go through a whole series of increasingly invasive tests. This can be a very stressful time - some people describe it as the scariest time of their lives.

Or the follow-up tests themselves might hurt you. For example, if you get an abnormal result on your faecal occult blood test for bowel cancer, you will be referred for a colonoscopy exam of your bowel. Apart from not being fun, US data from good clinical centres shows this exam can cause major complications, even death. The risks are not well documented for colonoscopy as part of an FOBT screening program, but data suggest the major complications (such as bleeding and bowel tears) may occur in 1 to 3 people per 1,000 having a colonoscopy, and may kill around 4 or 5 per 100,000 people having a colonoscopy (see Screening for colorectal cancer <http://www.ahcpr.gov/clinic/uspstf/uspscolo.htm>, Systematic evidence review, US Preventive Services Task Force).

In the case of bowel cancer screening, at least we know it works - it reduces the chances of getting, and of dying of bowel cancer in the future. So you might be willing to trade the risk of harm now against the chance of future benefit. But with other types of cancer screening, for example screening for prostate, lung or ovarian cancer, there isn't yet any good evidence of benefit.

Should I be tested?

Cancer screening is a close call. There is no single right answer to the question 'Should I be tested for cancer?' Some people will say, 'No thank-you. I want no part of this. I want to focus on being healthy now and not worry about getting tests unless I become sick'. Others will say, 'Yes I want to be screened, I realise there are downsides but there are benefits too and I want a chance to be one of the few people who will benefit'. Either choice is rational. If you choose to be screened, the chance that you will benefit is small, and the chance that you will be badly harmed is small. Most people will neither benefit nor lose from screening because all cancers are rare in well people who have no symptoms. (By the way, that's what cancer screening is - having tests for cancer when you're well. If you have symptoms, such as a breast lump, a breast change, or abnormal bleeding from the bowel or vagina you should see a doctor. All doctors agree that finding and treating cancer that is already causing symptoms is important.)

And people may choose differently for different cancers - men may choose, for example, to screen for bowel cancer but not for prostate, or vice versa, or both or neither. We need to resist pressure to push people to get tested because 'that's the responsible thing to do' and give them balanced information so they can choose what they want.

**Note:* This article is based on Associate Professor Alex Barratt's three-part series on Radio National's Health Report </rn/healthreport/> from 22 August to 5 September 2005, winner of the 2006 Pfizer Australia Eureka Prize for Health and Medical Research Journalism.*

As described on the Health Report, the Screening and Test Evaluation Program at the School of Public Health, University of Sydney is running an online trial of its decision aid for women aged 40 years who are considering whether to begin screening mammography. If you are a woman aged around 40 we invite you to participate in this study. Go to the Australian Screening Mammography Decision Aid Trial<http://www.mammogram.med.usyd.edu.au/> for more information.

CAPITAL TAKES UP CANCER FIGHT

A new specialist agency, Cancer Australia, would be established t in Canberra to coordinate Australia's battle against cancer, the Federal Government announced yesterday.

Cancer Australia's first priority would be auditing the national cancer effort, Health Minister Tony Abbott said. The agency will guide improvements in prevention and care, provide support to the public and health professionals and make recommendations to the Government.

The agency's first chief executive officer is Professor David Currow, a former president of the Clinical Oncological Society of Australia *(and formerly CEO at Daw Park Hospice in Adelaide). (Canberra Times 26/8, p2, & other papers)*

LOCAL TEAM FIND WAY TO STALL TUMOURS

A Brisbane research team has identified a gene that could stop solid tumours developing by strangling their blood supply. Peter Koopman of the University of Queensland Institute of Bioscience said that in mice a mutant form of the gene SOX18 blocked blood supply to tumours and stopped the tumours growing. The discovery has implications for aggressive and lethal cancers, including breast, colon, pancreatic and lung cancer.

SOX18, unlike many other drugs and genes, is known to do just two things – one is to build new blood vessels, and the other is to contribute to the development of new hair follicles. Professor Koopman said one of the advantages of SOX18 was that it targeted the tumour's growth, leaving the rest of the body alone, unlike many conventional treatments such as chemotherapy. *(Courier Mail, 3/8, p21*)

OBESITY RAISES RISK OF PROSTATE CANCER RECURRENCE

Risk found to be present after radiotherapy and not just surgery

Obese men have an increased risk of cancer recurrence after undergoing treatment with radiotherapy for localized prostate cancer, new research shows.

The findings "suggest a link to the biologic basis of tumor progression that can be therapeutically exploited," lead author Dr. Sara S. Strom, from the M. D. Anderson Cancer Center in Houston, and colleagues note.

Previous reports have linked obesity with an increased risk of biochemical failure -- treatment failure determined by laboratory tests-- after prostate surgery. However, it was unclear if the same held true for men treated with radiotherapy.

The study, reported in the current online issue of the journal /Cancer/, involved 873 men who underwent radiation treatment as their only treatment for localized prostate cancer between 1988 and 2001.

Obesity was determined by an elevated body mass index (BMI), a ratio of height to weight commonly used to determine if a person is overweight or underweight. The researchers found that 18 percent of the men were mildly obese and 5 percent were moderately to severely obese.

Obese patients were more likely to be a younger age at diagnosis, to have a more recent diagnosis, and to be African-American.

After an average follow-up period of 96 months, 295 men experienced biochemical failure and 127 had full disease recurrence with symptoms.

Additional analysis revealed that obesity was a statistically significant independent predictor of both biochemical failure and disease recurrence. Moreover, as the severity of obesity worsened, the risk of these negative outcomes increased.

For example, mildly obese men had a 55-percent higher risk of biochemical failure and moderately-to-severely obese men had a99-percent higher risk compared with normal-weight men. Similarly, the corresponding increases for prostate cancer recurrence were 65 percent and 66 percent.

The researchers say the findings underscore the importance of obesity in prostate cancer progression. Understanding the mechanism involved, they hope, "will lead to rationally designed preventive strategies."

SOURCE: /Cancer/, June 26, 2006. Copyright © 2006 Reuters Limited.
<http://www.prostatecancerfoundation.org/>

HELP FOR SIDE EFFECT OF PROSTATE CANCER

Queensland Cancer Fund nurse co-ordinator, Sylvia Milner, has put together Australia's first *Sex After Treatment* guide for prostate cancer patients.

"It's very challenging for men and most men don't talk a lot about the impact loss of sexual function has on them and their partners," Mrs. Milner said. "So many men I talk to say this, prostate cancer. Is the first health challenge they have."

Former fire fighter, Jock Honeyman, a 62-year-old who was diagnosed with aggressive prostate cancer in February 2002, said the guide, which was officially launched yesterday, would have been a valuable resource when he was first told he had prostate cancer.

For more information about *Sex After Treatment*, phone the Queensland Cancer Fund helpline (13 11 20), or download a copy from http://www.qldcancer.com.au *(Courier Mail, 5/9 p14)*

PROSTATE RESEARCHER RECOGNISED AMONG ELITE

A Brisbane scientist's work on prostate cancer has been chosen as one of the top 10 medical breakthroughs in Australia in recent years. Queensland University of Technology researcher Judith Clements was the only Queenslander selected for a *10 of the best* booklet announced yesterday by Federal Health Minister Tony Abbott. The booklet lauded the most important medical breakthroughs funded in the past few years by the National Health and Medical Research Council. (*Courier Mail, 2/9/ p8)*

1. What are your fees?

Your doctor will talk to you about his or her fees for any proposed treatment, and, if they can, about any out of pocket costs that you might have to pay when you go to hospital.

2. Are there fees for any other doctors?

Ask your doctor about fees for other doctors, such as the anaesthetist and
assistant surgeon. If they can, your doctor will explain the fees of other doctors involved in your care or they will provide you with their contact details so that you can find out about their fees, and about any out-of-pocket costs that you might have to pay.

3. Will I have any out-of-pocket costs?

If you have to go into hospital for surgical or medical care, there may be an out-of-pocket cost or medical gap that is not covered by Medicare or your private health fund. A medical gap is the difference between the combined amount paid by Medicare and your private health fund for a medical service, and your doctor's fee.

4. Is your fee an estimate only?

Remember, your doctor can only estimate the cost of your in-hospital or day surgery elective procedure in advance.

5. Can I have an estimate of your fees in writing?

Yes. Either your doctor or the doctor's office staff will provide you with an estimate in writing of the likely cost of your proposed treatment, and, if they can, any out-of-pocket costs that you might have to pay.

6. If the cost changes, when will you let me know?

In an emergency or if something unplanned happens during your procedure, there may be additional costs to you that could not be estimated in advance. This information will be provided to you as soon as possible after treatment occurs.

7. What if I need a prosthesis?

Prostheses include pacemakers, defibrillators, cardiac stents, joint replacements, intraocular lenses and other devices that are surgically implanted during a stay in hospital. Before surgery, your doctor will tell you if one is required, why you need it and whether it will cost you anything. Most prostheses available won't cost you anything, but if you have an out-of-pocket cost to pay, your doctor will explain why this prosthesis is the best one for you.

8. Should I contact my health fund?

Yes. Check with your private health fund whether your treatment will result in any to find out what you are covered for and out-of-pocket costs.

"let's talk about fees..." http://www.ama.com.au

NO ALCOHOL, PROSTATE CANCER RISK: STUDY

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 tumours and the pattern and type of alcohol consumed," Dr Graham Giles and colleagues from the University of Melbourne, Australia, write.

To investigate, the researchers analysed 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 one to 19 grams 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 per cent).

Prostate cancer mortality was also reduced in this group (44 per cent).

If it can be confirmed that moderate alcohol consumption protects against aggressive and fatal prostate cancer, it would have a "major impact," Dr Giles and colleagues point out, because "there are no established modifiable risk factors for this common type of cancer". *(The Australian, 3/10/06)*

HEALTH REVOLUTION ON THE HORIZON

AUSTRALIA is on the verge of a health revolution offering cancer cures, replacement body parts and hope that paraplegics will walk again.

That's the view of the nation's top scientists, who have nominated seven medical advances they believe will transform our lives -with stem-cell science, gene technology and bionic innovation at the forefront of the coming breakthroughs.

Ten eminent medical scientists combined their expertise to look into the future for the Research Australia project.

The report, Then, Now Imagine, is released today to coincide with national Thank You Day, when researchers thank those who fund their work.

It says new drugs and vaccines will soon emerge to tackle a range of cancers, while stem cells will help cure diseases such as diabetes, Parkinson's and multiple sclerosis.

Miniature technology and smart materials are predicted to help repair damaged nerves and possibly broken spinal cords.

Surgery techniques will allow specialists to operate on babies in utero and heal brain injuries.

Some advances, such as gene profiling to detect disease risk, may be available in a decade. *(Copyright 2006 News Limited. The Advertiser 9/10, p5)*

MAN ALIVE! 2007

Feel the energy, you don't want to miss this!

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 II

Man Alive! 2007
Men's Health & Well-being Festival
Sunday March 18th
10 am - 4 pan

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

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 (please see attached information). Please promote within your networks to help us generate a great collection *of* stories about men who contribute to the lives of others.

Genetic map identifies cancer genes

By Maggie Fox in Washington 08sepO6

THE first genetic map of colon and breast cancer shows that nearly 200 mutated genes - most of them previously unknown - help tumours start, grow and spread, US researchers reported.

The findings could lead to new treatments for cancer, better ways to diagnose it, and certainly will provide insights into the second-leading cause of death in the developed world, the researchers said.

Dr Kenneth Kinzler of Johns Hopkins University in Baltimore, who helped lead the study, said it showed that cancer was more complex than even experts in the genetics of the disease had believed. "There are a lot of mutated genes," Dr Kinzler said.

"A lot of things seem to have gone wrong." "We expected to find a handful of genes, not 200," added Tobias Sjoblom, the principal author of the study.

The researchers said they had identified 189 genes, with an average of 11 per tumour, that were clearly mutated in breast and colon tumours.

"The vast majority of these genes were not known to be genetically altered in tumours and are predicted to affect a wide range of cellular functions, including transcription, adhesion, and invasion," they wrote in their report published in the journal *Science.*
The team, including researchers at the University of South Carolina and Case Western Reserve University in Cleveland, looked at 11 samples each from breast and colon tumours surgically removed from patients. *(The Australian, 8/6)*

Gene clues in prostate treatment

A GENE which gives men with prostate cancer a life-saving clue about whether their disease will spread has been uncovered by Australian scientists.

One in five men who have their prostate removed because of cancer will develop the disease in another part of their body in the following decade. But doctors have no clues at the time of surgery whether the disease is aggressive and likely to spread.

Researchers at Sydney's Garvan Institute have now discovered that a gene called AZGP1 gives strong clues about the future dangers. Men with insufficient levels of the gene in their prostate at the time of surgery have a greatly increased risk of developing cancer in their bones or elsewhere later on.

At present the best judge of disease development is through regular monitoring of prostate-specific antigen (PSA) levels for about ten years after surgery.

Professor Sue Henshall, leader of the study of 228 prostate cancer patients, said the discovery could lead to tailored treatment for individual prostate cancer sufferers. "This means we'll be able to identify the men that can benefit from more aggressive treatment very early on when they still have potentially curable cancer," Prof Henshall said.

"And the other patients that have a lower risk of developing metastatic disease could have the option of deferring their radiotherapy or chemotherapy."

The researchers have developed a simple, automated tissue test to indicate levels of the gene pre-surgery but say it will be 5-10 years before it can be used.

"The test is ready now but we really need to make a case for the clear relationship globally and take it to patients around the world before we can go ahead," Prof Henshall said.

"The good news though is that (when it is in place) it will allow doctors and patients to make much more informed decisions at the time of prostate cancer surgery."

This study, funded by the Cancer Institute NSW, was published today in the US *Journal* of the *National Cancer Institute* *(The Australian, 4/10/06)*

PROSTATE CANCER CALL-IN RESULTS

The prostate Cancer Call-in conducted on t7th September attracted a positive response from the general public. During the evening (between 6pm. and 9pm,) the Cancer Helpline received 143 calls, with a further 45 prostate cancer calls during the week in response to the event.

For the month 14/8/06 to 8/9/06 the Helpline had 695 calls – usually approx. 600 – with 24% male callers.

On the night of the call-in, 68 packages of information were sent out to callers. From my recollection, most of the prostate cancer volunteers came from our Group, none of whom were called to respond to any of the callers.

ANTIOXIDANT SUPPLEMENTS "NO BENEFIT"

By Samantha Baden

EXPENSIVE high-dose antioxidant supplements have no benefits but can increase blood pressure in some people, a pharmacology expert says.

Professor Kevin Croft of the University of Western Australia School of Medicine and Pharmacology, said recent research showed there were no benefits from popular high-dose vitamin C and E supplements and a healthy diet would be more beneficial.

Antioxidants such as vitamin C and E act to protect cells against the effects of free radicals, which are potentially damaging byproducts of energy metabolism.

Free radicals are said to damage cells and contribute to cardiovascular disease and cancer.

Prof Croft will tell the Congress of the International Society for the Study of Fatty Acids and Lipids (ISSFAL) in Cairns on Monday that large population studies over many years appeared to create a link between antioxidants in the diet with reduced risk of heart disease.

As a result, the use of vitamin C and E supplements was widespread and the industry worth billions of dollars.

But recent studies of higher dose supplementation showed no benefits but pointed to potential adverse effects, he said.

Perth researchers who looked at people with risk factors for cardiovascular disease said some patients taking high doses of vitamin E had higher blood pressure.

Prof Croft said while vitamins C and E were essential for good health, people did not need them in any higher doses than could be gained from a balanced diet.

"I would say to people seeking to prevent the risk of cardiovascular disease, or patients who have had a heart attack, not to bother with high-dose antioxidant supplements," Prof Croft said.

"Instead, make sure you have a good, healthy diet rich in a variety of fresh fruit and vegetables, cereals and moderate intake of beef, poultry and fish."
(FROM The Australian,

CUPPA A DAY BEATS STONES

DRINKING tea reduces the risk of bile stones and cancer, especially among women, new data suggests.

Bile stones, often seen in women and which have been linked to obesity, occur in the ducts that transfer bile from the liver to the small intestine. If the stones block the opening of the gallbladder, they can cause discomfort and pain, typically just below the rib cage on the right side of the abdomen.

By contrast, biliary tract cancers are "rare but highly fatal", according to a new study in the International Journal of Cancer by Ann Hsing and colleagues at the US National Cancer Institute. "Apart from gallstones, (causative) factors for biliary tract cancer are not clearly defined," they note. Several studies "have suggested that consumption of tea, especially green tea, is protective against a variety of cancers".

In the new study, conducted in China, the researchers examined the effects of tea consumption on the risk of biliary tract cancers and biliary stones. Studied were 627 patients with biliary tract cancer, 1037 with biliary stones, and 959 comparison subjects.

The team obtained data on demographics, medical and dietary factors, and tea consumption. Drinkers were defined as those who drank at least one cup per day for at least six months. Of the 959 control subjects, 394 (41 per cent) were always tea drinkers.

In women, drinking at least one cup per day for at least six months seemed to cut the risks of bile stones by 27 per cent, gallbladder cancer by 44 per cent, and bile duct cancer by 35 per cent. In men, tea had a similar effect, but not of the magnitude seen in women.

Certain chemicals in tea may prevent cells from growing abnormally and may have anti-inflammatory effects that reduce the risk of these bile tract diseases, Hsing's team explains. Further studies are needed to see if these findings can be duplicated. *(FROM The Australian, 22/7)*

SUPPORT SITE TARGETS MEN WITH BREAST CANCER

*Men with breast cancer can become easily isolated in a society that sees their condition as a woman's disease. *Kellie Bisset *reports*

THERE was no shock or anger when John Johnson was diagnosed with breast cancer two years ago. No paralysing fear or wild bursts of emotion, not even that sick feeling of dread people describe when they suddenly realise their life has been up-ended.

Just an awful numbness.

As he sat facing his doctor in the utilitarian surrounds of the surgery, there were ordinary things: a desk, a couch, a cold July day outside. The doctor asked if he had any questions.

"There were no thoughts in my head, no panic," he says. "I was overcome by numbness and not even knowing what sort of questions to ask." Johnson was diagnosed with early stage breast cancer.

It was early morning and when he left the surgery he headed not for somewhere quiet to think, but for the office: "They were expecting me. I did not know what else to do."

His journey began after he injured his chest with a car door. Concerned that while the bruising had subsided, a lump behind his left nipple hadn't, Johnson visited his GP.

A clinical examination and an ultrasound raised the suspicions of doctors and he was sent for a biopsy. Less than two weeks later he had undergone mastectomy ? removal of all of his left breast tissue, including his nipple, down to the muscle. The result was a sunken chest, a long scar, considerable pain, and significant anxiety about whether the medical team had "got it all".

The numbness that had initially gripped him gave way to anger and a few panic attacks. But in the weeks that followed, there were also the attitudes of others to deal with.

"A male friend of mine said 'can we call it something else other than breast cancer?'," Johnson, 58, says.

When he told a female friend he hadn't seen in a while about his condition, she told him his joke wasn't funny. "She did not believe that men could get it - it was a bit of an eye-opener. When I told my boys they went to school and told their friends and they did not believe it either."

Johnson found this a challenge. "It was like a denial of my illness." Such attitudes are common. A poll of 600 men conducted last week by the National Breast Cancer Centre found one in three did not know men could get the disease.

Johnson says while there was plenty of information about breast cancer, most of it was geared towards women with little or no mention of men - and how they might get gender-specific help. There was also no male support network, and while they were understanding women, Johnson says it just wasn't the same talking through issues with an all-female discussion group.

This abundance of pink has also been worrying the National Breast Cancer Centre.

Breast cancer in men is rare - only about 100 Australian males a year are diagnosed, compared with 11,800 women. But that's one man diagnosed nearly every three days, says the centre's director, Helen Zorbas. And currently, those 100 men don't have access to the same support as women.

"It's a small number but it's obviously an area of unmet need," Zorbas says.

The centre hopes that's about to change with the launch of Australia's first comprehensive website for men with the disease, or concerned about a change in their breast.

The site, launched yesterday, is an attempt to help men access information - and there's not a shade of pink to be seen. It's also part of a push to increase community awareness about male breast cancer to at least alleviate some of the pressure these men face.

Zorbas has experienced first-hand the discomfort of male patients in a system geared towards women. "They feel isolated and foolish when sent off for a mammogram," she says. "There is an added layer of stigma. Men I have seen with breast cancer have a pragmatic approach . . . the typical male says 'let's get it fixed now'. The fact that this is not an instant fix is another area where men need additional support."

UK researchers also acknowledged these issues recently in an article published in /The Lancet/ (2006;367:595-604). The authors said male breast cancer was a neglected disease, and described current support systems as "rudimentary".

In women a breast cancer diagnosis could lead to depression and anxiety, but no structured psychosocial studies had been reported in male breast cancer.

"There is evident need for national protocols for both information and support for men diagnosed with breast cancer," they said.

Breast cancer in men most commonly affects those over 50.

According to the Australian Institute of Health and Welfare's report/Cancer in Australia 2001/, there were two cases of breast cancer in men under 40 that year. Six men were in their 40s and the remaining 87 were aged 50 or older.

If it's diagnosed at the same stage, breast cancer prognosis is similar in men and women. But according to the US National Cancer Institute, breast cancer in men is often diagnosed at a later stage, meaning the chances of cure are smaller.

Zorbas says there is no Australian data to support the contention that men are being diagnosed later in their disease, but she does stress the importance of early awareness.

"The stage of diagnosis really impacts on survival," she says. "We don't want to create unnecessary hype in men but there is less breast tissue, so a lump is easy to find. It is about not ignoring symptoms."

Adelaide breast surgeon Melissa Bochner says that for many men, the issue of work is central to their ability to deal with the disease.

"Breast cancer treatment can take a long time - up to a year. There are concerns about being able to work effectively during treatment, and that may be an issue if the man is the main breadwinner in the family.

"There are a lot of unspoken issues for men in terms of sexuality." Hormonal treatments such as tamoxifen can impair sexual performance and cause hot flushes ? something women are almost resigned to, but an alien concept to men.

Bochner, who works at Royal Adelaide Hospital, says men with a strong family history of breast cancer need to be particularly vigilant. And those who know their families actually carry the BRCA1 and 2 gene mutations - known to be associated with elevated breast cancer risk - should also have a risk management protocol in place.

Zorbas says regular mammographic screening in asymptomatic men with a family history of breast cancer is not backed up by evidence, but men do need to get a handle on their risk and their best course of action is a clinical examination.

For those who do need a mammogram though, she says it's surprising how experienced technicians can manage to get a good sample of breast tissue from a man.

John Johnson considers himself lucky his disease didn't spread to the lymph nodes or anywhere else in his body. He hasn't needed chemotherapy or radiotherapy, but his daily course of tamoxifen means he may have to endure hot flushes for his remaining three years of treatment.

In the early stages of his disease he made plans "to move on". "I thought I only had two years to go for a long while. I started cleaning up and throwing things away."

But life is slowly returning to normal, and while he's more emotional than in the past, there's plenty of scope to plan for the future.

One thing he does think about is the need more information for men like him. Since his diagnosis, work colleagues have had friends in their circle pick up breast lumps simply from discussing his experience.

In the early stages he found it important to talk to his GP and benefited from lectures run by Sydney's Liverpool Hospital, which helped him deal with his anger and allayed some fears. But he really could have done with some male bonding, and says there needs to be a way of getting men together on this issue.

"There are only 100 a year they have got to be around somewhere. Talking to someone else who has been through it is important and I did not have anybody like that. A group of men really would have helped me." (*The Australian, 22/7)*

http://www.nbcc.org.au/men http://www.nbcc.org.au/men © The Australian

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FDA OKs CLINICAL TRIAL FOR HIGH-INTENSITY ULTRASOUND

by Amanda Willis | U.S. HIFU LLC

Enrollment Begins in Phase I Study of High Intensity Focused Ultrasound in Patients with Locally Recurrent Prostate Cancer

CHARLOTTE, NC, HIFU, LLC along with trial sponsor, Focus Surgery, Inc., announced today that the U.S. Food and Drug Administration (FDA) has granted approval to initiate a clinical trial for locally recurrent prostate cancer utilizing High Intensity
Focused Ultrasound (HIFU) with the Sonablate® 500. Recurrent prostate cancer is cancer that returns after the patient has received initial treatment for cancer.

The study will be conducted at Indiana University School of Medicine by principal investigators Dr. Michael Koch and Dr. Tom Gardner. A second trial site will be announced soon.

Patients who have had cancer return after receiving external beam radiation therapy (EBRT) or brachytherapy for prostate cancer are potential candidates for study enrollment. For more information about enrollment as a study subject contact U.S. HIFU at 1-888-874-4384.

HIFU with the Sonablate® 500 uses sound waves to destroy the tissue of the prostate gland by rapidly heating the targeted area in a matter of seconds. The procedure delivers HIFU energy with a transrectal ultrasound probe and is usually preformed on an out-patient basis with an epidural anesthetic.

Although still in clinical trials in the U.S., the Sonablate® 500 is already approved in many countries including Europe and Canada for the treatment of localized prostate cancer and benign prostate hyperplasia (BPH).

Prostate cancer is the most common type of non-skin cancer in American men and the second leading cause of death in men. The American Cancer Society estimates that there were about 230,900 new cases of prostate cancer in the U.S. in 2004 and that 30,000 men die from the disease each year.

by Steve Mitchell | United Press International | 07.12.2006

THE ARMY SAVED MY LIFE

A Mandatory 40th Birthday Physical Save My Life

I'm a 44 yr old black male. As a 39 yr old Army Major (extremely fit6'1" 175 lbs, great diet, exercise, never smoked, never drinked, and have no family history of Prostate Cancer) I underwent my routine birthday audit (prior to my 40th birthday) and was informed my PSA count was elevated. Therefore, I was scheduled to be examined by the Urologist.

I asked the Urologist what was the best method for detecting Prostate Cancer? I was told a Biopsy; therefore, I requested one. The Biopsy results (August 2003) indicated my Gleason score was 6; therefore, I requested to have surgery immediately.

I was given a surgery date of October 9, 2003 (I was 40 yrs old). Because I was the youngest Prostate patient to ever come through Walter Reed Army Medical Center (Washington, DC) the Army took semen samples and stored in a local bank in case I wanted to have more children. The surgery was a success, both nerves were spared.

I walked 3-4 miles a day while wearing the catheter. The day the catheter was removed I had an erection that night (without use of Viagra). Although I was medically retired from the Army, I am still 6'1", 175 lbs. I still exercise daily at 4:00 AM and have not lost any muscle tone or strength. I still have erections (use 1/2 of a Viagra sometimes).

The moral to my story is Prostate Cancer doesn't discriminate (age, race, physical condition, or family history); therefore, please get checked at an early age (I recommend 40).

MORE TO COME

Owing to a shortage of time, I have not been able to write reports on other matters from the two conferences in Sydney. Hopefully, I will be able to publish some material in the November edition.

There was some interesting material from the APCC meeting, and plenty of information from Andrew Giles, CEO of the P.C.F.A.

Newsletter compiled by

Trevor Hunt