P.S.A. NEWSLETTER

Proudly affiliated with the PROSTATE CANCER FOUNDATION of AUSTRALIA	***PROSTATE(CANCER) SUPPORT AWARENESS ADELAIDE GROUP*** www.psaadelaide.org over 4,435 since Nov 03 A Member of the Association of Prostate Cancer Support Groups (SA) Inc.	Mailing Address:- PSA Prostate Cancer Support Group 39 Greenfield Rd Seaview Downs, SA 5049 Reg at (08) 8298-8040 **NEWSLETTER NO. 74**

November '06 Newsletter including a report on the November Meeting held at the Burnside Hospital on 20.11.06

Thank you to our sponsors:
The Burnside War Memorial Hospital, the Federal Government's Cancer Support Groups Grant Program and the State Funded Volunteer's Support Fund. Members Please Note:- Our next meeting will be our Annual General Meeting and this will be held from 7.00 pm on Monday 19th February, 2007, at the **Fullarton Park Centre, 411 Fullarton Road, Fullarton**, and **not** at the Burnside Hospital. (See the mud map by Amy (page 12). After the Annual General Meeting there will be a general discussion amongst members. Roll Up!

SEASONS GREETINGS

BEST WISHES FOR A MERRY CHRISTMAS AND A HAPPY NEW YEAR.

FROM:- YOUR PRESIDENT, BARRY OAKLEY. VICE PRESIDENT AND RESEARCH LIBRARIAN JOHN MAYES. 2ND VICE PRESIDENT JEFF ROBERTS. SECRETARY/TREASURER/NEWSLETTER EDITOR REG MAYES. WEBMASTER/ASSISTANT NEWSLETTER EDITOR/PHOTOGRAPHER IAN FISK. NAME-TAG MANAGER/PROOF READER PAM FISK. NEWSLETTER TEAM MEMBERS, JEFF ROBERTS AND PAUL FERRETT AND SUPPER CO-ORDINATOR MARGARET OAKLEY.

Chair: Barry Oakley Members present 50.

Apologies: Gary, Les and Joy, Donald, Brian, and Richard and Valerie.

New Members: John, Neville, Phillip and Robyn, Garry and Alison, Trevor and Julie, Max, and Barry and Kathleen. **A big welcome to all**!

Gary Bowes is still on our sick list having spent 10 days in the St. Andrews Hospital due to radiotherapy treatment. Gary has now returned home and says he is much improved but still suffers a bit of pain in his neck. Gary would like to thank all the members who sent him "get well" cards and who have telephoned him or visited him whilst in hospital. He says this cheered him up no end. **Get well Gary!**

IMPORTANT NOTICE

New Ball Game for Next Year! New meeting venue

Yes we are in for some big changes for our PSA Adelaide Group for 2007, but we think we are strong enough to be able to manage them. The Management of the Burnside Memorial Hospital has advised us that they are unable to accommodate our group meetings from now on as they require the lecture room for other purposes. Your committee has been scouting around for some time and have come up with a new meeting venue at the **Fullarton Park Centre, 411 Fullarton Road, Fullarton**. We have booked their Park View room for our Annual General Meeting on 19th February '07, commencing at 7pm. Please see the mud map (Page 12) drawn by Amy as to how to get there and parking arrangements etc. There is room to park about 50 cars. There are tea and coffee making facilities, a small kitchen, a white board and TV/DVD and plenty of chairs. After parking your car in the free off- street car parking facility, go into the nearby old homestead next to the car park and our room is about half way down a passage past the reception area and on the left hand side. We booked this room for the third Monday of each month from February to November inclusive. Meetings will be held from 7.00pm to 9.30pm as usual. There is a sign on Fullarton Road which reads "Fullarton Park Centre, 411. Hughes Gallery". (see photo). Keep a sharp look-out for this sign as you can easily miss it. If travelling south, turn right at the sign to go straight into the car park. If the car park is full, you can park in nearby Fisher Street.

Election of Officers for our new 2007 Committee

At our Annual General Meeting on 19th Feb. all positions will be declared vacant. The positions are President, two Vice Presidents, Secretary/Newsletter Editor, Treasurer, Membership Secretary, Research Librarian, Assistant Librarian, Webmaster/Assistant Newsletter Editor/Photographer, Name Tag Secretary and Supper Co-ordinator. We are also looking for two members to assist with the folding and mailing of our 320 Newsletters each month. Nominations for all of the above positions will be accepted by mail from now up until 12th February '07. Further nominations will be accepted from members attending the Annual General Meeting. Just post your nomination to Reg Mayes, Sec/Treasurer, PSA Adelaide Group, 39 Greenfield Rd., Seaview Downs, SA.5049, but make sure that the person you nominate also signs your letter stating that he/she accepts the nomination, otherwise it will be invalid. We will definitely need a new President, one new Vice President, a Secretary/Newsletter Editor, a Treasurer, an Assistant Librarian (a new position), a Membership Secretary (to handle the printing of 320 address labels each month and to keep an accurate record of our member's names and addresses) and a Supper Co-ordinator. The present holders of these positions have indicated that they will not be re-nominating for '07. Reg has said that he will continue to record our guest speaker's lectures and submit these and other information to the new Secretary/Newsletter Editor. This would ease the work load on the Secretary. All the positions are open to both males and females. Another innovation is that the position of President and the two vice Presidents will be rotated after 12 months. i.,e. One Vice President would become the President for the next twelve months. So put your thinking caps on and nominate for one of these positions and post it onto the Secretary as soon as possible. The future of the PSA (Adelaide Group) depends on the election of a strong committee. We know you can do it!

Our Information Brochures

These brochures are now out-of-date due to the change of our meeting venue for next year and the forthcoming change of the President's and Secretary's names and phone numbers etc. There will also be a change in the Mitcham group's contact number. So don't distribute any more of these brochures, and in fact, if you notice any of the old ones around, you can retrieve these and destroy them. We don't want people turning up for meetings in February at the Burnside Hospital when the meetings are being held at the Fullarton Park Centre. New brochures will be printed next year. (an updated version is on our website, but will have to be updated again after our Feb 19th AGM)

Stop Press! Stop Press! Movember

We have just heard that the latest figures for the Fund Raising "Movember" Event come in at a whopping $2,000,000. This money will go to the PCFA towards prostate cancer research. A fantastic Achievement! This shows what growing a moustache can do!

Public Awareness Evening at Mount Barker

This event attracted over **80 people** and was organized by the Freemasons of Mt. Barker, Hahndorf, Stirling and Blackwood with the assistance of the Prostate Cancer Action Group (SA) Inc., the Cancer Council, SA, and the Adelaide Hills Community Health Service. The main speakers were **Dr. Christopher Switajewsk**i (Urologist) and **Dr. Graham Lyons** (Scientist), one of our members. A number of prostate cancer survivors and a carer also spoke.

Barry Oakley also reported that he spoke to about 40 workers at the West Torrens Council recently about prostate cancer matters. Barry said that his talk was well received and he was able to hand out quite a few of our brochures.

Our Annual Xmas BBQ at Chapel Hill

This was a great success with **23 of our members rolling up** and enjoying themselves. The weather was perfect. We had three free raffles, Xmas Cake and rides on Graham Lyons' utility and quad bike. Many thanks Graham! Also many thanks to Pam Fisk who organized a quiz contest and to Ian for taking plenty of photos for our Newsletter. By the way, the yabbies Graham provided for us were delicious! We all can't wait for next year to come around again!

Raffle winners Kornelia Mayes, Theban Roberts and Geoff Murch and grand daughter

Classic Adelaide Rally

The association of ProstateSA with Classic Adelaide 2006 was a resounding success. ProstateSA would like to thank **Silverstone Events** for nominating them as the benefiting charity for the event. A classic 1969 Marcos GT 3000 was branded with the ProstateSA message which attracted much attention and positive remarks. **The 5 day event helped raise awareness of prostate cancer in South Australia and much needed funds in the fight against prostate cancer.** The event which finished on Sunday 19th November was a very successful alliance for **ProstateSA**. Funds raised during the event went to ProstateSA for funding research, public education, and support programs related to prostate cancer in South Australia. Our members **Ian Fisk, Jeff Roberts, and Barry Ferris** from the Mitcham P/C Group took part in the fund raising activities at Macclesfield and the cooking of sausages at a BBQ. Thanks chaps! Other participants in the fund raising activities were various groups including **members of the Lions Club and Willunga High School**

students. Brent Frewen from ProstateSA said that he was pleased with the fund raising which totalled **in excess of $27,000 and would like to thank all volunteers who gave of their time and energy to assist.** The money generated included support through various sponsors. **An excellent result!** ProstateSA was the only charitable body allowed to raise funds throughout the event. **So well done guys and gals!**

Wives and Watchful Waiting

Notice to husbands! If you are on "watchful waiting" the wife of an interstate P/C Group member would like to hear from your wife in order to discuss issues etc. If your wife is interested, please ask her to e-mail IreneG@hume.vic.gov.au for a bit of a chat. Irene would like to hear from someone whose husband has decided not to have surgery or radiotherapy, but stay on "watchful Waiting" for the time being.

The Treasurer's Report

Since our last meeting we have received the following donations:- Frank ($25), Keith of Streaky Bay ($30), Rev. Donald ($20), Keith and Joy ($20), Austin Noblett ($20), Barry and Margaret, ($20), and Joan Egel's Tea Party ($85). – **Total $220.00.** Many thanks all!

Joan Egel's Afternoon Tea

One of our members, **Joan Egel**, organized an afternoon tea for her girl friends and took up a collection for the PSA Adelaide Group. **This raised $85.00 which was donated to us**. **Many thanks Joan!** With $70 of the money we bought two more copies of the book **"Foods that Fight Cancer".** We now have three copies of this excellent book in our library. See John Mayes if you would like to borrow a copy. Incidentally, books and videos borrowed at our last meeting do not have to be returned until our Annual General Meeting on 19th Feb. '07.

Senator Jeannie Ferris, M.P.

As mentioned in our last Newsletter, Reg has written to Senator Ferris **to try and find out how much Federal money has been spent on prostate cancer groups over the last 10 years as compared with breast cancer groups**. The Senator suffers from Ovarian Cancer and is concerned that not enough money is being spent on this and other women's cancers when compared with breast cancer. We feel the same when it comes to prostate cancer and would like to know where we stand in the pecking order when it comes to Federal or State Government funding. *(My guess is that men run well and truly last - Reg.)*

The Ambassador's Training Course

Ian Fisk has just returned from a two-day "Ambassador's" Training Course held in Melbourne and organized by the Protate Cancer Foundation of Australia (PCFA) to train selected volunteers throughout Australia to carry out public speaking engagements about prostate cancer. Ian had Brachytherapy treatment a few years ago and has developed an excellent PowerPoint presentation of this procedure. We are quite sure that Ian will be a valued member of the "Ambassador's Public Speaking Group" and wish him well with any future speaking engagements.

Note Dean Wall from the Action Group also attended the training. Also attending were people from Western Australia, Northern Territory, Queensland, NSW Victoria and Tasmania ie the whole of Australia was represented. Included were two ladies, one a nurse from Queensland who's husband has been treated for prostate cancer and the other the Western Australia PCFA State Manager.

The drug "Flomaxtra" and the PBS Scheme

We have received a reply from **Chris Pyne, M.P**. and Secretary to the Minister for Health, **the Hon. Tony Abbott** MP., to the effect that it is up to the **CSL Ltd** to apply to have this drug listed under the PBS. The company hasn't yet done so. Your Committee is looking at this and will refer the matter to the PCFA, Sydney, requesting them to approach CSL Ltd. **The drug "Flomaxtra" is widely prescribed for men to assist them with their peeing problems,** particularly after having had a prostatectomy, radiotherapy or brachytherapy. Although it is a prescription drug, there are no discounts available for pensioners or anyone else. The cost from my local Pharmacy is **$59.80 for 30 tablets**. One of our members has to take at least 2 tablets and sometimes 3 tablets per day to make him piddle, which costs him $1,408 or more per year. We will keep you posted on developments!

"Laucke Wafer Grains" biscuits containing selenium"

These products are now becoming more plentiful in Supermarkets and Health Food Shops. They are a round wafer type biscuit containing wheat, maize, rye, triticate, linseed and Bio-fort Selenium. They are sold in boxes containing 300 grams of biscuits. There is a list of serving suggestions on the box. If you want a small daily dose of selenium, then these are the things to buy. They are also rich in dietary fibre. If you are making your own bread, then try out the **Laucke Golden Wholemeal Mixes**. **Bio-max bread containing selenium** is also available at some outlets. Check out their web site on http://www.laucke.com.au for further information.

Presentations

Our President, Barry Oakley, called on members of the hard working Committee to come forward and presented them with **small gifts of appreciation for their year's efforts.** He said that the success of the PSA Adelaide Group largely depended on the Committee's determination and selection of **excellent lecturers** during the year and in the production of **an informative monthly Newsletter and the running of an excellent up-to-date library.** He would like to thank the four Urologists, 3 Health Workers, a Scientist and a Lawyer who gave up their time to come along to our meetings and lecture to us. Donations by members and also the Federal Governments Grant for Cancer Support Groups had enabled us to **post out about 320 Newsletters** each month to members in every State in Australia. **The Cancer Council SA** also assists us with the Newsletter production and we would like to thank **Chris Nolan** for her efforts. Barry then took the opportunity to wish all members a **Very Merry Christmas and a Happy New Year**. He hoped to see everyone roll up at our new venue at the Fullarton Park Centre on February 19th '07.

"Your food stamps will be stopped effective March 1992 because we received notice that you passed away. May God bless you. You may reapply if there is a change in your circumstances."—Department of Social Services, Greenville, South Carolina

Second instalment of article 'The Problem with Dairy Products.' Remember the question, why all the fuss over something that is 'natural' to human beings ?

Why the absorption of Insulin like Growth Hormone Type 1 from Dairy Products into the blood serum is not good news.

The question ending the last paragraph perhaps can be answered by considering the over-all pattern and trend in research findings regarding IGF-1.

In one of the books in our library 'The Prostate Miracle-', the author Stoff, [an immunologist] quotes on P36 a study in the Journal 'Science' January 1998, where it was reported that a study of 15,000 men found that those whose blood levels of IGF-1 were high were four times more likely to develop Prostate Cancer than those whose blood levels were low. Stoff points out that IGF-1 is a powerful stimulant to growth in cancerous tissues as well as normal tissues. He points out that IGF-1 levels are usually significantly elevated seven years in advance of PSA scores and that high IGF-1 levels are markers for any cancer, not just Prostate Cancer. Dunn et al., 1997:4667 in British Journal of Cancer Research. Reported on research with mice on calorie restricted diets (20% lower calories than normal diet) had far fewer tumours than mice on a normal diet (these mice had been dosed with a known bladder carcinogen); the calorie restriction appeared to protect them from tumours. If the calorie restricted mice were given a tiny quantity of IGF-1 to restore the IGF-1 levels to what they were on a full calorie diet, the protective effect disappeared, which implicated the IGF-1 as the agent that promoted the tumours. [Remember from an earlier paragraph the point that changes in calorie intake affect IGF-1 secretion.]

Another interesting piece for the puzzle is that it is known that women who have had multiple pregnancies have reduced rates of breast and colon cancer. It is also known that these women have up to 15% lower levels of serum IGF-1 and it is hypothesised that this is connected to the reduced cancer rates. In 2002 a research study pointed out that IGF-1 Receptors are up-regulated in primary prostate cancer and the up-regulation commonly persists in metastatic disease. In other words CaP cells are easier to stimulate for growth by IGF-1molecules than normal cells which have fewer appropriate receptors.

Another book we have in our library, Professor Jane Plant's book 'Prostate Cancer-' throws more light on the question.

A quick survey of material on Pages 82-83 of the book will give a clear idea that those who would want to argue that there is no clear connection between IGF-1 and CaP are on a 'hiding to nothing'. At a meeting of the Royal Society of Medicine in London in October 2003, entitled 'Biology of IGF-1: its interaction with insulin in health and malignant states', eight papers were devoted to the topic of IGF-1 and Cancer. In one paper Grimberg, a distinguished endocrinologist from Philadelphia USA," illustrated how IGF-1 signalling may contribute to each stage of cancer progression including enhancing the survival and proliferation of cancer cells. She also presented evidence that IGF-1 may promote cancer indirectly by interaction with other hormones, especially testosterone and oestrogen, the sex steroids long implicated in prostate and breast cancer." Other authors have also suggested that there is a direct effect of IGF-1 on cancer incidence because it is critical for maintaining cell survival, particularly in transformed cells.' Later Plant writes," The IGFs, IGF-1 and IGF-11, have a similar structure to that of insulin, but their concentrations in the blood are much higher because they are bound by specific binding proteins (e.g. IGFBP-1 to -6). These binding proteins prevent IGFs from docking with their receptors and stimulating cancer cells. The main carrier IGFBP-3, is particularly important in determining the extent to which IGF-1 is free to dock with its receptors on prostate-cancer cells. Most (90 per cent) of the circulating IGF-1 is bound to IGFBP-3, and associations of IGFs with prostate cancer are generally strongest where the ratio of IGF-1 to IGFBP-3 is highest - in other words, where there is more free IGF-1 to lock onto receptors on the prostate. Recent evidence indicates that IGFBP-3 also promotes suicide of prostate-cancer cells." Later Plant quotes evidence that suggests that IGF-1 is the most potent survival factor to over-ride the apoptosis or suicide signals within damaged or defective cells. Page 85 reveals "nutritional status is critical to circulating levels of IGFs and that studies of normal adults demonstrate that, as protein levels in the diet increase, so do those of circulating IGF-1. A 50 % reduction in calorie intake or a 30 % reduction in protein intake significantly reduced levels of circulating IGF-1." On page 83 Oliver and others are cited in Cancer Epidemiol Biomarkers Prev, 13, 163-165. 2004. where they "examined the relationship between serum IGF-1 and PSA in 367 healthy men with no evidence of prostate cancer and found a positive association between the two chemicals. In other words those with high IGF-1 levels have correspondingly high PSA levels and those with low IGF-1 levels have low IGF-1 levels. They observed that the association between IGF-1 and PSA was stronger for older men, which they suggest reflects the induction of cell proliferation in the prostate gland; the association was clear, even at very low PSA levels."

The association between IGF-1 and PSA raises for me another interesting question: to what extent does PSA that has escaped into the blood serum, actually 'drive prostate cancer'? I have seen a few oblique references to the possibility however nothing in terms of research. Now with the importance of IGFBP-3 clear as an important factor that can render IGF-1 inactive, the possible role of PSA as a protease in the blood serum which can break up or cleave IGFBP-3, and thus release IGF-1 to go on its 'merry way' stimulating CaP cells, becomes obvious. This is perhaps how PSA helps 'drive CaP'. Even as early as 1992, an article in the Journal of Clinical Endocrinology and Metabolism, Vol 75, 1046-1053, was saying this -"Cleavage of IGFBP-3 by PSA resulted in a marked reduction in the binding affinity

of the fragments to IGF-1, but not to IGF-11. We speculate that PSA may serve to modulate IGF function within the reproductive system or in prostate cancer by altering IGF - IGFBP-3 interactions." It is important to realise here that IGFBP-3 is formed naturally within the body and does not come from any possible exogenous source such as milk etc.

So far I have just focussed on the way consumption of milk products can increase the levels of Insulin Like Growth Factor -1, an important growth factor in your blood serum. I have not looked at many other important growth and stimulatory factors in dairy products. Clearly there is a problem for prostate cancer patients. What can you do? The above discussion has provided plenty of hints: (1) Drop the level of protein in your diet so that meets your metabolic needs but is not in excess. (2) Dramatically cut down or eliminate dairy products from your diet but also ensure that you get calcium from other sources. 'Don't throw the baby out with the bathwater' and end up exacerbating any problems with osteoporosis by dropping your calcium intake to inadequate levels. (3) Ideally cut your calorie intake significantly. There are ways in which you can achieve this without constant hunger or mal-nourishment. (4) Eat lots of fruit to keep your dietary fructose levels fairly high through out the day. This does not mean short changing yourself on vegetables- particularly those of the cruciferous family. (5) Finally, drink as much green tea as you can manage. This is particularly important when one understands the role of IGF-1 and IGFBP-3 in the progression of CaP. Please note the following :-

'Cancer Research' , Dec. 1, 2004; vol 64 : pp 8715-8722 Report that a team of researchers from the University of Wisconsin and Case Western University have documented the role of **green tea polyphenols** (**GTP**) in modulating the insulin-like **growth factor-1 (IGF-1**) driven molecular pathway in **prostate tumour cells** in a mouse model for human prostate cancer.

"Consumption of **GTP** led to reduced levels of **IGF-1**," said Hasan Mukhtar, Ph.D., Department of Dermatology at the University of Wisconsin, the senior author of the paper. "GTP also led to increased level of one of the **binding proteins for IGF-1**, the **insulin-like growth factor binding protein-3**. These observations bear significance in the light of studies that indicate increased levels of **IGF-1** are associated with increased risk of several cancers, such as prostate, breast, lung and colon."

GTP modulation of cell growth via the **IGF-1** axis coincides with the limited production or phosphorylation of key survival proteins, including **P13K, Akt** and **Erk1/2**, the research indicated. The **P13K** molecular pathway in cells, which includes **Akt** and **Erk1/2**, works to promote cell survival, rather than programmed cell death, also known as **apoptosis**. A Paper 'Green Tea Polyphenols Thwart Prostate Cancer at Multiple Levels." Outlining the above, was given by **Dr. Mukhtar and others**, at The 96th annual meeting of the American Association for Cancer Research at Arnheim California April 16-20 , 2005.

Lecture by Professor Villis Marshall, Clinical Director of Surgical Specialities, Royal Adelaide Hospital. Notes made by Reg Mayes.

Note:- Villis has not yet had the opportunity to confirm the accuracy of these notes, any corrections will be in our next newsletter.

In his opening remarks Professor Marshall said that there have been remarkable changes in the investigation and treatment of prostate cancer over the last 10 years. The medical profession has moved on quite a lot in understanding this disease.

Recently he attended a large conference held on **Fraser Island, Qld.** for discussions with other Urologists from around the world **into what course future research and treatment for prostate cancer was likely to take.** Other similar conferences have been held at Palm Springs USA and Victor Harbor in SA. The conference on Fraser Island gave Australian Urologists the opportunity **to forge links with other Urologists from around the world**, and in particular from Los Angeles and San Francisco in the USA. It also allowed for the exchange of workers from these centres which will result in a valuable exchange of ideas.

Quite a bit of time was taken up with **discussions on breast cancer as well as prostate cancer**. This might surprise some people but both breast cancer and prostate cancer are hormonal related diseases. Advance in the research of breast cancer and its causes could be beneficial in the treatment of prostate cancer and should not be overlooked. Vice versa is also the case.

Prior to the use of the **Prostate Specific Androgen blood test (the PSA test)** we didn't know how far the cancer was progressing. Now days we know and appropriate action can be taken in regards to treatment. In the age group of 55yrs to 74 yrs, men with a low PSA reading have very little risk of dying from prostate cancer. **If the Gleason score is 7**, a high majority of men will die of prostate cancer within 15 years of being diagnosed. A Gleason score of 8 and above are the lethal numbers. There is still a high degree of uncertainty between pathologists about what is the actual difference between a Gleason score of 7 and 8.

Villis said that a friend of his, a Professor, died of a brain tumour at the early age of 57. This was within 6 months of him being diagnosed. If he had been diagnosed earlier, perhaps something could have been done to save him. **He emphasized the importance of having medical check ups**

and if you know you have prostate cancer, then don't ignore other symptoms which may be related to a different disease altogether. If these other symptoms are ignored, and put down to prostate cancer, it could have very serious consequences. One has to focus on one's overall general health.

Why do men get prostate cancer? This is a really big question and we are all looking for an answer. One suggestion is to identify certain genes that are important in the development and control of prostate cancer. **Androgen Receptors** - how are these things controlled? They are a bit like a rheostat in a control panel. We are now having a very close look at how these work as they could slow down the advance of prostate cancer. Mutations in the Androgen Receptor gene can lead to neoplastic transformation. **It is interesting that in lung cancer we can predict which genes will or won't respond to chemotherapy treatment**. Certain genes produce substances that suppress cancer cells. For example the gene FRP4 reduces prostate cancer growth. The question is to know how to switch a gene on or off.

It has been suggested by some researchers that **stress or emotional factors** may affect genes. We are looking at this, and also looking at muscle cells and what part they play in the scheme of things.

In Australia, we have one of the **lowest male participation rates for clinical drug trials** involving prostate cancer in the whole world. How to redress this situation seems to be a problem. If anyone has any ideas on this, he would like to know.

Natural Complementary Medicines: We are now investigating the value of natural complementary medicines and in particular to see if they are effective **when combined with traditional medications used in chemotherapy**. The theory is that if they are effective, then the chemotherapy dose may be able to be reduced. There are side effects with chemotherapy treatment as some agents used are quite toxic. Any reduction in the use of these more toxic agents would be a big plus. Villis mentioned B1-calutamide and 17-AAG as being two of the agents.

Green tea is now going through clinical trials. This product has been widely used in the Asia/Pacific area for a long time. **Grapes used in the making of red wine** are seen to be beneficial. **Grape seed extract was tested but did not appear to be of much benefit**. One problem in using Chinese or Asian herbs, plants and seeds etc., is **a lack of quantity control** which can adversely affect results. More scientific studies are needed using these products that are not contaminated. **This all takes time and money.**

One interesting fact is that **breast cancer therapy researchers are looking at using certain natural products** as some agents in these products make receptors more vulnerable to chemotherapy treatment.

Professor Marshall then went on to say that no two prostate cancers are exactly the same. It's a bit like forests being basically the same but on closer examination the forests are different. **In future, we may have to tailor the treatments given to suit different types of prostate cancers.**

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In answer to some questions raised by members, Villis said that **high dose Oestrogen therapy** was used for men with prostate cancer about **20 years ago**, but was abandoned when **cardio-vascular problems and deep vein thrombosis** showed up in men having this treatment. The present methods for treating prostate cancer are much safer, so Oestrogen is not used in the mainstream for treating prostate cancer. He doubts if any Urologists would recommend it.

Another member asked if **exposure to asbestos or other outside contaminates** affected the prostate, and caused prostate cancer later in life? Villis said it was not known if these influences affected the androgen receptor genes and eventually caused prostate cancer, **but he couldn't rule it out**. A member asked the question that everyone wanted to know and that is **if one is on maximum androgen hormone blockage and the PSA level starts rising**, what future treatment can be given to halt the slow spread of prostate cancer? Villis said that two or three things can be done in this situation. One is to **monitor the PSA doubling time** and if it is only a slow climb, then it is reasonable to just monitor it and continue with the hormone treatment. The PSA usually has to **rise to about 100** or greater before any symptoms start to develop.

Another option is to **withdraw one of the androgens** making up the hormonal dose for a while and this should see the PSA level slow down. **Another androgen could be withdrawn later**. **Chemotherapy can then be used in very advanced cases of prostate cancer**. More studies are now being carried out on this subject and there might be an answer in a few years time. **Radiotherapy can be used to zap any "hot spots" that may occur in the body from time to time.**

All treatments have some sort of side effects. Radiotherapy doesn't always destroy all the prostate cancer cells and some of these are likely to grow again. **With radiotherapy**, quite a few men will suffer from minor burns to parts of the rectum and **these cause diarrhoea**, **more frequent bowel actions and sometimes bleeding from the rectum for a few weeks** or months. *(Yes Villis, tell me about it! I have had diarrhoea for over 12 months caused through "radiation proctitis." I know of one chap who has been suffering with it for 5 years after having had radiotherapy. I think he must have had the old external broad - beam radiotherapy. – Reg.)*

Erectile dysfunction and impotence is another nasty side effect from the three major treatments, i.e. **radiotherapy, brachytherapy** (radioactive seed implantation) and **prostatectomy.** With brachytherapy the damage to erectile nerves is less. Another problem is **incontinence with restricted urine control** for sometimes up to 6 months. Lots of men will have to wear pads for a while. **In some cases a slow dribble of urine may last for some years and may even require surgical intervention**. Most men will have to wear a catheter for a week or two after having had a prostatectomy

or brachytherapy. The saying goes that if you can't pee well before having brachytherapy, you won't pee well afterwards. *(You can't win can you? – Reg.)* **However, Villis emphasized that research is going on all over the world into the cause and the best treatments for prostate cancer sufferers. We are now starting to see the light at the end of the tunnel. We need more skilled Urologists, Oncologists, Researchers and money in order to accelerate the speed of this research.** ***(I hope some Government Departments and Politicians are reading this report – Reg.)***

Villis used his specially prepared **PowerPoint presentation** to help explain some of the more complicated parts of his lecture**. Barry thanked him on behalf of members for his very informative and "up-to-date" lecture** and handed him a **"Be-a-Man" T shirt**, a Prostate Support Group lapel badge and some of Wolf Blass' very best Red Label Shiraz. Barry thought it would be a good idea for Villis to wear the T shirt when operating on a bloke and when the bloke woke up and saw Villis standing there with the words "BE- A- MAN" emblazoned on the front of the shirt, it would frighten the daylights out of him. *(Yeah! I suppose that would be one way of getting the bloke out of the intensive care ward in a hurry – Reg).*

Get well Joy

Our member Joy Belton has been laid up with a knee re-construction job for a couple of weeks. She spent nine days in two hospitals. Joy is now home again and feels much better, we all wish her well. She's mad that she missed our Xmas BBQ.

RADICAL PROSTATECTOMY - IT'S NOT AS BAD AS YOU THINK!

Max Murray — Sunshine Coast Support Group

Eighteen months ago I underwent a radical prostatectomy after having been on "watchful waiting" for over fifteen years. In those fifteen years I agonised over the possible consequences of an operation; the embarrassment and inconvenience of incontinence, loss of libido, erectile dysfunction, shortened penis, and all these in addition to the operation itself.

Then I attended a couple of local Support Group Meetings which gave me cause to rethink. There were all these blokes there who'd been through it and seemed healthy and happy and without all my imagined problems. I came to my senses. Back I went to my GP and in turn the urologist. PSA 8 and Gleason Score 3+4. The cancer was still confined to the prostate capsule. Time for the op.

What an anti-climax! The operation and the few days in hospital was almost a holiday. After four days I was walking around town, took in a movie and had lunch with my wife and daughter all without my daughter even knowing that I'd been in hospital and was wearing a catheter and bag.

The incontinence was a nuisance to begin with but it quickly diminished and within two weeks all I needed was a pad in my underdaks. Eight months later I was totally dry and pad-less, even at night.

Impotence was a hassle. My libido hadn't decreased but the stirring in the loins didn't translate to action at the front. I needed to get things back into working order ASAP.

Pills? Pumps? Injections? Implants? Injections didn't hold much appeal and at this stage I wasn't desperate enough to consider an implant.

After trying and rejecting "Viagra" because of the adverse side-effects I found the best way to achieve this was with a vacuum pump. These are available from the local "adult shop" and come in an amazing array of shapes, sizes, colours, flashing lights, bells and whistles; the mind boggled, I kid you not! Regular use of the pump improved my "penile health", getting the blood flowing again and stretching the urethra back to its original length and of course allowing me to enjoy a sex life again.

In fact there are some advantages in matters sexual. There's no ejaculate so no arguments about who's going to sleep on the wet patch, the intensity of the orgasm is just as great and as the penis doesn't deflate after climaxing, more than one orgasm per sitting, so to speak, is achievable.

Why on earth did I wait? The worry that dogged me every day for the fifteen years of "watchful waiting" is gone and my waterworks operate like a teenager's. Life is great and I appreciate every day.

I make a plea to all those who are hesitating; DON'T! A radical prostatectomy is not nearly as bad as you think!

Comment. We are grateful to Max for telling his story and giving us plenty to think about. And of course, we are delighted that the outcome for Max looks so positive - a urologist's dream. But we know that the RP is reserved for T1 or T2 patients who are suitable for surgery, and that the biochemical relapse rate (a subsequent rising PSA) can be 15% or more. For patients who are eligible for the RP, even though the RP is the "gold standard", there are competing treatment options. Since each patient's circumstances are unique, the choice of treatment, including RP and 'watchful waiting', should be a decision shared with one's medical practitioner and significant others.

From the Nov 2006 issue of the Queensland Prostate Cancer News

A married couple in their early 60s was out celebrating their 35th wedding anniversary in a quiet, romantic little restaurant. Suddenly, a tiny yet beautiful fairy appeared on their table and said, "For being such an exemplary married couple and for being faithful to each other for all this time, I will grant you each a wish."

cont'd next page

One dead, 13 injured in X-ray blunder at French hospital

AFP via Yahoo! News - 12-Oct-06

Agence France-Presse reported that one person died and 13 others fell sick after they were exposed to excessive doses of X-rays as they were being scanned for prostate cancer at Epinal Hospital near Strasbourg in eastern France.

The accidents occurred between May-04 and May-05, where staff misused a new software programme that had been installed in the X-ray unit. The Lorraine Regional Hospital Agency said that 23 patients received excessive doses of radiation, and the 13 who fell ill suffered from rectal inflammation and needed surgery to fit an artificial anus.

The French health ministry has ordered an independent inquiry into the affair.

Our Joke for the Month: "Irish Whiskey" with thanks to John Shields of the Onkaparinga P/C Support Group.

Paddy staggered home very late after another evening with his drinking mate, Mick. He took off his shoes to avoid waking his wife, Brigid. He tip-toed as quietly as he could toward the stairs leading to their upstairs bedroom, but misjudged the bottom step. As he caught himself by grabbing the banister, his body swung around and he landed heavily on his rump. A whiskey bottle in each back pocket broke and made his landing especially painful. Managing not to yell, Paddy sprung up, pulled down his pants and looked in the hall mirror to see that his butt cheeks were all cut and bleeding. He managed to quietly find a box full of band-aids and began putting a band-aid, as best he could, on each place where he saw blood. He then hid the now almost empty band-aid box and stumbled his way to bed. In the morning, Paddy woke up with searing pain in both his head and butt with Brigid staring at him from across the room.

She said, "You were drunk again last night weren't you Paddy?"

Paddy replied, "Why would you say such a mean thing?"

"Well" said Brigid, "it could be the open front door, it could be the broken glass at the bottom of the stairs, it could be the drops of blood trailing through the house, it could be your bloodshot eyes**, but mostly ……. it's all those band-aids stuck over the hall mirror."**

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.

Oh, I want to travel around the world with my darling husband" said the wife. The fairy waved her magic wand and - poof! - two tickets for the Queen Mary II luxury liner appeared in her hands.

Then it was the husband's turn.

He thought for a moment and said: "Well, this is all very romantic, but an opportunity like this will never come again. I'm sorry my love, but my wish is to have a wife 30 years younger than me."

The wife and the fairy were deeply disappointed, but a wish is a wish... So the fairy waved her magic wand and - poof!

The husband became 92years old.

The moral of the story: Men who are ungrateful bastards should remember.....

Fairies are female.

Presentation by Prof. Pierre Chapuis, Colorectal Surgeon on "Management of Radiation Proctitis" on Monday 24th July, 2006 at 7 pm.

From the Sept/Oct Sydney Adventist Hospital Prostate Cancer Support Group

Radiotherapy is frequently used in the treatment of cancer in combination with other treatments. In men the two most prevalent cancers requiring radiotherapy are cancer of the bladder and prostate. "*As after radical surgery where complications may occur radiotherapy is not without problems*".

Rectal bleeding is a known treatment complication of prostate cancer. Three different terms are used to describe this condition. They are:

- Actinic proctitis
- Radiation proctitis
- Chronic radiation-induced rectal bleeding (CRRB).

Rectal bleeding may complicate treatment in 5 to 10 per cent of patients.

Rectal bleeding caused by radiation thickening of the walls of small arteries supplying the rectum, and so by narrowing them restrict the blood flow to the rectal wall. To compensate for this, new thread-like capillaries grow in profusion very close to the internal surface of the rectum. It is the fragility of these capillaries that causes the bleeding. As this does not involve true inflammation, "proctitis" is an inappropriate term, and Prof Chapuis prefers the third description (CRRB).

The rectal bleeding may not start until some 12 months to three years after treatment. Because bleeding is a known side effect of radiation therapy for prostate cancer, and rarely may be life threatening patients should be informed of this risk and consent to such treatment.

Rectal symptoms can fall into two broad categories which are partly dose related:

a) *Acute:* Symptoms include tenesmus (pain on passing stools); diarrhoea; urgency of defaecation; bleeding;
b) *Chronic:* Symptoms include stricture (narrowing or restriction); fistula (abnormal passage); CRRB; varying degrees of incontinence; loss of compliance & storage capacity of the rectum.

Clinical features of CRRB include:

- It is classed as Grade III on a scale of seriousness from I to IV, i.e. quite serious. Around 50% of cases are late onset (i.e. starting later than one year after treatment).
- From a situation with the patient not experiencing any problems it may become chronic with progressively increasing bleeding resulting in iron deficiency anaemia which may require daily dosage of iron tablets.
- Fifteen to 20 years ago it quite often led to transfusion-dependent anaemia, necessitating frequent blood transfusions, but this is now very unusual as a result of much improved radiotherapy techniques.

It is important for prostate cancer patients to recognise that some degree of "collateral" damage will inevitably occur to the rectum due to the radiation treatment. Late development of bleeding will be experienced by a small proportion of these patients, but this is nowhere near as common or severe a problem as in the past. A critical decision is whether the benefit of the radiation treatment of the cancer outweighs the risks of rectal bleeding or other complications as a result of that treatment

The factors which affect the risk include:

- the total dose of the radiation;
- the fractionation of the dose, i.e. how it is delivered;
- the build of patient, as obese people are more susceptible;
- diabetes;
- hypertension;
- previous abdominal or pelvic surgery (adhesions);
- chronic diverticular disease of the proximal bowel;
- Bleeding may be exacerbated if taking drugs such as asprin, Warfarin or Plavix.

Possibly because of their genetic makeup, some men are inherently more sensitive to radiation.

Quality of life issues that may influence the decision whether to opt for/out of radiotherapy include:

- the alarm caused by unexpected bleeds;
- the late onset (leading to several years of anxiety about whether bleeding will occur);
- the absence of identifiable risk factors in many cases, preventing prediction of whether any particular patient will be affected;
- whether the patient has other conditions, such as diabetes or hypertension.

Additional issues include:

- the unpredictable nature of the bleeding which is socially inconvenient and acutely embarrassing;
- the resulting anaemia is debilitating;
- poor response to treatment;
- simple treatments often prescribed (e.g. steroid suppositories or enemas) are usually of little benefit
- the condition can last for a long time;
- there is a (small) possibility of it progressing to Transfusion Dependent Anaemia

Patients with CRRB should be thoroughly assessed, including their history and a physical examination, a blood test including a full blood count, iron studies and coagulation profile. Then a safe and thorough examination by colonoscopy of the large bowel enables the severity of the condition to be determined and identification of

Dr. Chapuis says:

"It is fundamentally important that the prospective radiotherapy patient be informed about the possibility of CRRB, so that he can make an informed decision whether to go ahead."

other sources of bleeding. A cystoscopy and/or special small bowel x-ray are sometimes appropriate. Sometimes anorectal manometry is needed to test the strength of the sphincter muscle prior to treatment. The patient may be asked to keep a record of bleeds by marking a calendar as treatment progresses.

There are several options for treatment, which will be influenced by the location of the source of bleeding and the extent of the condition.

Minimally invasive therapy includes:

- electrocautery;
- Argon plasma coagulation therapy (APC);
- endoscopic laser;
- formalin (formaldehyde) dressings applied under a general anaesthetic;
- hyperbaric oxygenation with multiply treatment episodes required.

In the case of APC or endoscopic laser, each potential bleeding point needs to be separately treated. The procedure may require several visits, spaced a few weeks apart, to allow the lining of the rectum to recover. The procedure may be undertaken under conscious sedation or general anaesthesia.

The use of formalin began in the 1960's. It was found that the formalin destroyed the superficial lining (which then separated off) thus causing the bleeding to stop and allowing the new lining to re-grow without blood vessels. However, the appropriate concentration for the formalin was uncertain, and the approach was abandoned until more recently, when a particular low concentration has been found to be both effective and safe. A blood count is taken before and after treatment. The patient undergoes a general anaesthetic and is prepared by applying plastic skin dressings applied to the skin surrounding the anal passage. A speculum is inserted and dressings containing formalin are packed into the rectum through it and left for five to ten minutes before being removed. This is repeated until bleeding ceases.

Up to 20 per cent of patients treated with the formalin method experience complications such as:

- mucus incontinence either from treatment or from the initial Radiotherapy;
- some patients may need to wear a pad;
- acute prostatitis (very rare);
- narrowing of the rectum (very rare);
- ischaemic ulcer – prevented by taking care to cover exterior of anus with a plastic skin during treatment.

Use of either the laser or the formalin method, or both together, results in 75 – 80% success. However, treatment and follow-up may be necessary for up to 12 months

For otherwise intractable cases, several surgical options exist.

Our sincere thanks to Prof. Chapuis for his carefully structured presentation and clear explanations, and for fielding wide-ranging questions.

Mark Tweeddale & Pam Sandoe

SAH PCSG

27th July, 2006

Edited and approved by Dr. Chapuis.

PSA bounce after radiation for prostate cancer does not predict clinical failure

Will Boggs, MD
Reuters Health
Posting Date: November 1, 2006
Last Updated: 2006-11-01 15:11:22 -0400 (Reuters Health)

NEW YORK (Reuters Health) - Transient increases in prostate-specific antigen level (PSA bounce) after radiation therapy for prostate cancer are associated with a higher risk for biochemical failure, but not for clinical failure, according to a report in the October 1st issue of Cancer.

"Do not react quickly if a patient's PSA rises and conclude that their cancer has returned," Dr. Eric M. Horwitz from Fox Chase Cancer Center, Philadelphia, Pennsylvania told Reuters Health. "The PSA bounce is common for all patients treated with radiation and it does not represent treatment failure."

Dr. Horwitz and colleagues sought to determine the biochemical and clinical significance of the PSA bounce in a pooled analysis of 4839 patients with prostate cancer treated by external beam radiation therapy (EBRT) alone. A post treatment PSA bounce was noted in 978 (20%) patients.

At 10 years after treatment, 58% of patients with PSA bounce had no biochemical evidence of disease, the results indicate, compared with 72% of patients without PSA bounce.

This difference in biochemical failure did not, however, translate into differences in rates of distant failure, cause-specific survival, or overall survival, the researchers note.

"Immediate salvage treatment (specifically hormones) is not necessary until a recurrence has been definitively diagnosed," Dr. Horwitz concluded.

Cancer 2006;107:1496-1502.

ProstateSA Update

ProstateSA have published their first newsletter. It has been emailed to some, and is on their website:- (http://www.prostatesa.org.au).

The first item of news is below:-

"Mr Gordon Pickard AM has formally accepted the role of **Patron** and his associate, **Mr Ron Wall,** has also accepted an invitation to join the ProstateSA board and we would like to extend a warm welcome to both.
Mr Pickard AM is well-known in South Australia and internationally regarded as a highly acclaimed real-estate developer and philanthropist.

Since 1967, Mr Pickard AM has been forming companies which now make up South Australia's largest retirement and land development group.

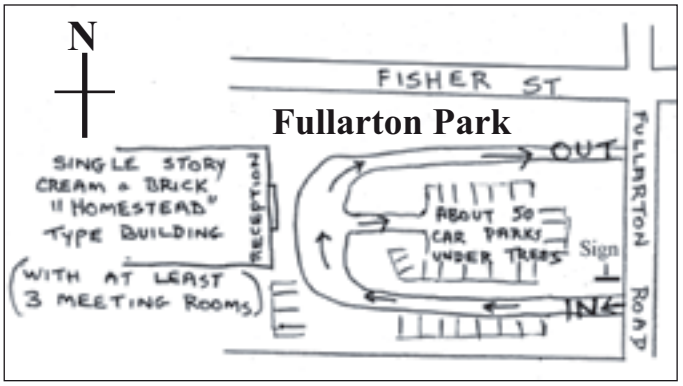
Mr Pickard AM was awarded recognition in the 2002 Australia Day Honours by receiving the Member of the Order of Australia for service to the South Australian Community, a benefactor to a broad range of charitable and youth sporting organisations and to the building industry. "Having personally experienced prostate cancer myself, I know the importance of early detection to increase the opportunities for greater survival. Every male over 50 should talk to their doctor whether they experience symptoms or not," said Mr Pickard AM. **Mr Rod Buchecker** has been formally accepted on TCCSA board – congratulations Rod! Mr Buchecker will add this role to his existing position with the ProstateSA board**"**

Mr Gordon Pickard of course was responsible for the installation of the DaVinci Robot at the Royal Adelaide Hospital!

Other topics include:- Blue Tie Cocktail Party, Key Position statement, Major Blue Robbon Events, Community Blue Ribbon Events (including Loose Change day, Cycling Event, Charity House, Crows Day and "a Boys will be Boys Night", Classic Adelaide 2006, ProstateSA Partnerships (with Support Groups, EJ Whitten and PCFA etc).

Dates for Meetings during 2007 and Map

Our meetings will be held on the third Monday of each month from Feb. to Nov. inclusive commencing at 7.00pm and finishing at 9.30pm. However the meeting on 20.8.07 will start at 7.30pm. They will all be held at the Fullarton Park Centre, 411 Fullarton Rd, Fullarton. (South West corner of Fullarton Road and Fisher Street) The dates are:- 19.2.07 (Annual General Meeting and Election of Officers and a General Discussion), 19.3.07, 16.4.07, 21.5.07, 18.6.07, 16.7.07, 20.8.07, 17.9.07, 15.10.07 and 19.11.07. Details of the proposed lectures etc., will be published in our February PSA Newsletter.



We are still on the **look-out** for cartoons, and interesting news items about prostate cancer which might be suitable for publication in future PSA Newsletters**. Even a story about yourself and your P/C experience could be OK.** Just drop Reg a line at 39 Greenfield Rd., Seaview Downs, SA .5049 if you have anything of interest.

We are still looking for more members who are on the Internet and wish to have "**The Newsletter**" delivered via the internet, instead of a hard copy via post. If you would like to save us postage and printing, **please e-mail your email address** to our Webmaster, Ian Fisk, at info@psaadelaide.org

This Newsletter was compiled and typed by Reg Mayes. Ian Fisk, Jeff Roberts, Pam Fisk, Reg and Amy folded and posted the Newsletter. After re-arranging news items on his computer and supplying the photographs, Ian printed the master copy. 320 copies were distributed. Pam Fisk proof read the Newsletter. We would like to thank the Cancer Council South Australia for providing their support and particularly to Chris Nolan for her contribution. The views expressed in this Newsletter do not necessarily represent the views of the Cancer Council SA. Disclaimer – The PSA (Adelaide Group) is not responsible for advice given by guest speakers, or use of products mentioned in this Newsletter. Nor are we responsible for information contained on websites, books, magazines, pamphlets or extracts from articles mentioned in this Newsletter, nor for video, DVD's or tapes distributed to members. Medical Advice should be obtained from your Doctor.