



SYDNEY  
ADVENTIST  
HOSPITAL

# PROSTATE CANCER SUPPORT GROUP

Cancer Support Centre, Jacaranda Lodge  
185 Fox Valley Road, Wahroonga NSW 2076

Proudly affiliated with



Prostate Cancer  
Foundation  
of Australia

## MARCH 2010 NEWSLETTER

### 2010 PROGRAMME

<b>March</b>	8 22	Support Discussion Meeting <b>Pathology Results—determining factors</b> Dr Bevan Hokin, Director of Pathology Department.
<b>April</b>	12	Support Group Discussion Meeting No evening meeting due to Anzac Day Public Holiday
<b>May</b>	10 24	Support Group Discussion Meeting <b>Consumer/Carers Forum</b>
<b>June</b>	14 28	No afternoon meeting—long weekend <b>Sexual Rehabilitation after prostate cancer treatment</b> Dr Phillip Katelaris, Urologist
<b>July</b>	12 26	Support Group Discussion Meeting <b>Topic TBC</b> Assoc. Prof. Henry Woo, Urologist
<b>August</b>	9 23	Support Group Discussion Meeting <b>Clinical Trials</b> Dr Gavin Marx, Medical Oncologist
<b>September</b>	13 27	Support Group Discussion Meeting <b>Topic TBC</b> Dr Kris Rasiah, Urologist
<b>October</b>	11 25	Support Group Discussion Meeting <b>Radiation Proctitis</b> Prof. Pierre Chapuis, Colorectal Surgeon
<b>November</b>	8 22	Support Group Discussion Meeting <b>Palliative Care</b> Dr Yvonne McMaster, Palliative Care specialist (retd).
<b>December</b>	13	Christmas Celebration

Meetings commence at 2.30pm for 3pm for Support Group Discussions on the second Monday of the month whilst the evenings meetings (on the fourth Monday night) with the Medical Professionals commence at 7pm. Partners & families welcome.

**Disclaimer:** The information in this newsletter is not intended to be a substitute for professional medical advice, diagnosis or treatment. Always seek the advice of your qualified medical professional.

## Vale - Dr John Conroy OAM

The funeral to celebrate the life of John was held on Wednesday 3rd March at St. Michael's Anglican Church, Newport.

Our dear friend and colleague passed away on Sunday 28th February. John was an active and passionate member of both the Northern Beaches Prostate Cancer Support Group and the Northern Beaches Palliative Care Centre. John regularly attended the SAH PCSG before establishing the Northern Beaches group and then became a very active member of various committees of PCFA. He was a tireless worker.

Many in our circle of prostate cancer consumers and wives/partners will remember John as a gentle man who gave himself to the cause of helping families in their different journeys of life. He was an active member of the community of his church, St. Michael's Anglican.

John will be sadly missed by many friends, his wife Una, son Crispin, daughter-in-law Esperanza and granddaughters, Zoe, Ty and Ara.

## Early Management of prostate cancer— Dr Michael Izard

*Extract from Australian Family Physician Vol. 39 No 1/2 January/February 2010*

*Prostate cancer is now the commonest cancer diagnosed in Australia. In 2005 there were 5913 men diagnosed with prostate cancer in New South Wales alone (31% of male cancers, 17% of all cancers). However, that year there were only 980 deaths from prostate cancer in NSW, and so prostate cancer dropped to be the fourth commonest cause of cancer death, ahead of breast cancer with 877 deaths. This discrepancy is a major cause of the angst experienced in the detection and management of prostate cancer. What is needed is a way to separate the significant prostate cancers from the insignificant ones, and accept that identifying them is a very different issue to managing them aggressively.*

### Screening

There is a divergence in professional organization recommendations about prostate cancer screening. Some organizations recommend screening such as the Urological Society of Australia and New Zealand. Other organizations, such as the royal Australian College of General Practitioners, suggest that there is insufficient evidence to recommend routine screening for prostate cancer.

Recent literature has added further confusion, providing ammunition for both camps on whether or not to screen. In 2009, two large studies published their interim results. The American Prostate, Lung, Colorectal and Ovarian Cancer Study trial was criticized as heavily flawed in its selection of men already screened by prostate specific antigen (PSA) (and thus removing many of the already present malignancies). In this study 82% of the 'screened' arm were actually screened, while 52% of the 'control' arm also chose to have their PSA measured. Unsurprisingly, little difference in outcome was shown. The European Randomised study for Screening in Prostate Cancer (ERSPC) showed an advantage in survival to men who were screened, with a relative reduction in death from prostate cancer by 20%. This translates into an overall reduction of seven per 10,000. Neither trial is ideal.

This quality of life after treatment is being reviewed in the European study, but by the time the data emerges it is possible that both surgical and radiation treatment techniques will have advanced and we will have difficulty extrapolating from this 'old' information to these newer techniques. Radiation oncology now uses conformal radiotherapy and intensity modulated radiation therapy (IMRT) techniques, and with the introduction of tomotherapy (or "RapidArc"), there is steadily reducing radiotherapy morbidity. Surgical techniques with laparoscopic and robotic options may reduce their side effect rates. Yet other techniques exist that are still experimental (eg, cryotherapy or high intensity focused ultrasound (HIFU)).

At times there is an assumption that active management by either surgery or radiotherapy can be avoided with the judicious use of hormonal manipulation once the man is symptomatic, with progressing disease. This overlooks that hormonal therapy carries its own set of side effects, both physical and psychological. It forgets that what might hold true for an infirm octogenarian does not hold true for a man in his 50s or 60s when hormonal manipulation as a primary treatment may rob him not only of quality of life but of one (possibly two) decades of life as well.

### PSA, PSA doubling time, PSA velocity and free to total ratio

Given the limitations of PSA screening, other options are being actively investigated. Studies, such as the Baltimore Longitudinal Study of Aging, have shown that men over 75 years of age with a PSA of <3 are unlikely to die of prostate cancer. It is also clear that cancers start with a low volume, hence a low PSA does not mean that there is no cancer in younger men. As such, a PSA of <4 in the younger man is not 'safe'. Approximately 25% of men with a PSA of 3—4 already have prostate cancer, although the significance of that malignancy is the crux of the issue (the ERSPC used an upper limit of normal as three, and identified more cancer as a result). The doubling time of a PSA rise may depend on whether the disease is confined within the gland or if it has metastasised, and this applies both before and after radical treatment.

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There is controversy, but it is generally agreed that a PSA doubling time (PSA-DT) of 1 year or more is indicative of a tumour confined to the prostate, while a PSA-DT of 6—120 months or less is suggestive of metastatic disease.

When the PSA is <10, it may be helpful to use three broad groupings based on its rate of rise, ie PSA velocity (PSA-V). If the PSA-V is <0.3ng/mL/yr then there is probably little cause for concern that significant prostate cancer present. Conversely, if the PSA-V is rising at a rate of >0.75ng/mL/yr then there should be concern that malignancy might be present and further investigation considered. Biopsy has been recommended if the rate of rise is >1.0ng/mL/yr. The PSA-V impacts with PSA-DT, as a rise in PSA of >1.0ng/mL/yr implies a volume of disease that is becoming clinically relevant.

The free to total PSA ratio (FTTR) has been clearly shown to be a useful aide in discriminating between a high PSA due to malignancy against a high PSA due to other causes. If the FTTR is .25%, then malignancy is either unlikely or unlikely to be of clinical significance. Catalona's trial showed 'that the 25% cutoff detected 98% of cancers for subjects aged 50—59 years, 94% for subjects aged 60—69 years, and 90% for subjects aged 70-75 years'.

From this it can be seen that serial PSA values, including the FTTR, can provide useful information; far more than a PSA reading in isolation. By monitoring the value, the velocity and DT, and perhaps the decline in the FTTR, men can be identified to pass to the next step of prostatic biopsy and identification of malignancy. Ideally, we should dissociate this step from a societal assumption that identification of such a malignancy automatically progresses the man to treatment.

### Understanding choices

The consultation that delivers the diagnosis is often where treatment options are proffered. As such, it is not reasonable to assume that everything has been fully comprehended. Having the patient return (or see another clinician) to repeat treatment options allows a better understanding, and consequently more control over the process. A second opinion could be provided by the surgeon, but perhaps a radiation oncologist might provide another perspective. Obviously this puts burdens on the health system and patient, but it should at least be considered and used where possible. Support groups such as the Prostate Cancer Foundation of Australia and Lions Australia can also be of assistance. All choices should be proffered: active surveillance, cancer chemoprevention with finasteride, hormonal manipulation, radical prostatectomy, external beam radiotherapy (EBRT) (in one of its guises) or brachytherapy. It is here, at this point, that the dissociation of diagnosis from treatment is required, and it is here that input from a second opinion to re-emphasise this and answer questions may be invaluable.

### Radiotherapy options

There is an increasing lexicon of radiotherapy choices, perhaps best explained by a radiation oncologist. External beam radiotherapy (EBRT) has progressed significantly with better computers and better imaging, such that doses of 70—80 Gy (compared to the 60—66 Gy of 10 years ago) can now be given with much reduced toxicity. This need for a higher dose has been shown in a recent meta-analysis to be of benefit using techniques such as IMRT and RapidArc tomotherapy or image guided radiotherapy. Brachytherapy techniques also aim to deliver these higher doses, with ~90 Gy equivalent doses from either permanent implants (low dose rate seed implantation) or temporary implants (high dose rate implants which are usually given with EBRT). Brachytherapy has an advantage over external techniques of being able to finesse the dose away from the rectum to reduce or avoid the rectal morbidities seen with techniques used 10 years ago. These options have been shown to have very good long term control, but all have positives and negatives, which are best discussed in a tailored and individual basis.



Author: Michael Izard MBS, FRANZCR MMedHum, is Clinical Senior Lecturer, Sydney Medical School And Radiation Oncology Associates, Mater Hospital, Sydney NSW.

## Raising awareness at Turramurra Seniors Day



Our team of Graham and Adele Staggs, Kathie and Tony Wright were visited by David Sandoe whilst they manned the exhibit and information stand at the Turramurra Uniting Church Seniors Day on Saturday 27th February.

The group had a successful morning in raising awareness about prostate cancer and of course, informing the public of our support group at the Cancer Support Centre, Sydney Adventist Hospital.



## Special guest at book launch

General Peter Cosgrove AC MC (retd.) joined Associate Professor Prem Rashid at the Hilton Hotel Sydney for the launch of Prem's book, *Prostate Cancer—Your Guide to the Disease, Treatment Options and Outcomes, Third Edition 2010*.

See Page 5 for more information.

## The Message Goes to Air

Dr Ross Walker, in his "Healthy Living" program on radio 2UE at 6.00pm on Saturday 30th January, helped spread the message about early detection of Prostate Cancer.

He interviewed one of our Support Group's Men's Health ambassadors, Allan Lawson. In a lengthy interview, he and Allan discussed the aims and activities of the volunteer Ambassadors, the management of the program by PCFA and the support and funding by the Commonwealth Department of Health and Ageing.

The success of the Speaker's program was indicated by the fact that the initial annual target of talking about men's health to 19,000 people was reached in three months and the target has now been reset to 50,000 people.

Across Australia, 100 Ambassadors are promoting awareness of prostate cancer and the availability of help with incontinence. Invitations to present on Prostate Health and Continence Health to community groups such as Rotary and Probus clubs, sports clubs, organizations and corporations are readily accepted.

Allan Lawson,  
Ambassador

## Changes in Sexuality and Intimacy after the diagnosis and treatment of Cancer: The Experience of Partners in a Sexual Relationship with a person with cancer

*Extract from Cancer Nursing: July/August 2009—Volume 32 Issue 4 pp 271-280*

### Abstract:

Changes in sexuality and intimacy after cancer were examined using open-ended questionnaire responses with 156 informal carers who were partners of a person with cancer. Interviews were conducted with 20 participants to examine changes in depth. Seventy-six percent of partners of a person with "nonreproductive" cancer types and 84% of partners caring for a person with cancer involving "reproductive" sites reported an impact on their sexual relationship. Cessation or decreased frequency of sex and intimacy was reported by 59% of the women and 79% of the men. Renegotiation of sexuality and intimacy after cancer was reported by only 19% of the women and 14% of the men.

Reason for changes to sexuality after cancer were the impact of cancer treatments, exhaustion due to caring, and repositioning of the person with cancer as a patient, not a sexual partner. Changes to sexuality were associated with reports of self-blame, rejection, sadness, anger, and lack of sexual fulfillment.

Positive consequences of changes included accepting the changed sexual relationship and having increased closeness and intimacy.

These findings reinforce the need to acknowledge the sexual needs of partners as well as people with cancer, by healthcare professionals working in cancer and palliative care.

## Dr Charles "Snuffy" Myers—visits Sydney, Melbourne and Brisbane

PCFA, in partnership with St. Vincent's Private Cancer Centre, was honoured to be able to bring US expert Dr Charles "Snuffy" Myers to Australia to provide new insight on treatment for advanced prostate cancer.

An exponent of the Mediterranean Diet, cholesterol goals, exercise, blood pressure and blood sugar goals and trouble-shooting of side-effects, he also espouses that patients need to play their part to minimize the damage and to improve general health when undergoing hormonal treatments.

Dr Myers is the Founder of the American Institute for Diseases of the Prostate and the Foundation for Cancer Research and Education. He is based in Earlsville, Virginia. He draws on his experience as Chief of Clinical Pharmacology at the National Cancer Institute at the National Institutes of Health and Director of the Cancer Centre at the University of Virginia.

## PCFA National Conference to be held 6 to 8 August 2010

The next conference is to be convened on the Gold Coast from Friday 6th to Sunday 8th August 2010.

The Conference will bring together leading Australian and international speakers and showcase the latest developments in prostate cancer research, management, health promotion, treatment and support.

The conference will have designated streams for scientific research, clinical developments, support group instruction and healthcare professional training. Key international speakers so far confirmed include:

- Dr John Mullhall, a microsurgeon and specialist in sexual and reproductive medicine from Memorial Sloan-Kettering Cancer Centre. Dr. Mullhall is the author of the recently released book "Saving your Sex Life: A guide for men with Prostate Cancer"
- Dr Peter Scardino, a surgeon who is head of the Prostate Cancer Programme at the Memorial Sloan-Kettering Cancer Centre, who along with other colleagues has pioneered the use of statistical models to predict the natural progression of prostate cancer and how it will respond to treatment
- Mr Virgil Simmons, founder of prostate Net in the USA whose innovative approaches to health promotion (using barbers and other networks to convey health messages) have been used as models in numerous countries around the world—including Australia.

In 2010 we will be using the meeting as an opportunity to map a way forward to dealing better with prostate cancer in Australia.

Extract from a report by Andrew Giles, CEO, PCFA.



### Registrations closing soon

Registrations for the Pirtek Fishing Challenge close on 28 March 2010. So **go online** at PCFA's website, [www.prostate.org.au](http://www.prostate.org.au) for more information, or [www.pirtekfishingchallenge.com.au](http://www.pirtekfishingchallenge.com.au) to sign up.

Enjoy the experience and raise funds for PCFA whilst you relax and enjoy the challenge!

### Congratulations to three notable recipients of the Australia Day Awards

Companion (AC) in the General Division to **Donald R. Argus AO**, of Caulfield East, Vic. For leadership in mining & finance, conservation, health, charities, sports groups.

Member (AM) in the General Division to **Professor Robert Alexander (Frank) Gardiner**, of Wellington Point, Queensland for service to medical research in urology; and

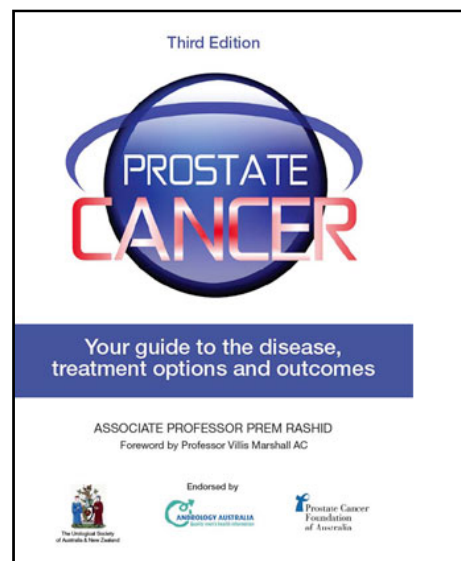
Medal (OAM) in the General Division to **Anthony (Tony) Sonneveld**, Seven Hills, NSW for service to non-destructive testing industry and to the community.

### Valuable new resource launched

## PROSTATE CANCER: Your Guide to the Disease, Treatment Options and Outcomes, Third Edition 2010

General Peter Cosgrove, AC, MC, (retd), pictured below third from left, helped launch this very informative guide to Prostate Cancer at Sydney's Hilton Hotel on Friday 26th February 2010.

Also attending (*left to right*) were David Sandoe OAM, Deputy National Chair PCFA; Dr David Malouf, Chair of USANZ; author Associate Professor Prem Rashid, and Graeme Johnson, National Chairman PCFA. The launch was also attended by the members of the medical fraternity, consumers, friends of PCFA and the media.



This book is available online at the PCFA website: [www.prostate.org.au](http://www.prostate.org.au)



## Prostate Cancer Support Group Details - Cancer Support Centre Jacaranda Lodge

Group Leaders: David Sandoe OAM  
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Graham & Adele Staggs gstaggs@accsoft.com.au

Cancer Support Centre:  
Annette Polizois support@sah.org.au  
Cancer Support Centre phone number: 02 9487 9061

Useful websites: www.prostate.org.au www.pcfa.org.au  
www.prostatehealth.org.au www.prostatecancer.com.au  
www.cancercouncil.com.au www.andrologyaustralia.org  
www.beyondblue.com.au www.apccbioresource.org.au

Useful websites USA: www.ustoo.org www.prostatenet.org www.pcri.org

You can find us at: [www.sah.org.au](http://www.sah.org.au) to view previous newsletters by following:  
"Our Services" click on Health & Wellness; then click Cancer Support Centre;  
'Resources & Information'; Monthly Newsletter or here (which is underlined)

### A consumer's story:

Pat & John Troller, from Bathurst, came to the hospital recently and wrote this of their experiences:

#### John

We had attended the pre-admission clinic twice so we knew the place pretty well. The experience there gave us the confidence and trust we felt all the way through. But look you took two units of my blood before the op in case I needed it during the surgery. You have just taken heaps so I need it now!

Pat and I arrived at the SAH to stay in Jacaranda Lodge on the tenth of January so that John could be admitted very early the next morning for a radical prostatectomy and gland clearance by Dr Phillip Katelaris. The journey down from Bathurst, via the Bells Line of Road was easy surprising us by taking only 2 hours 40 minutes. What a relief it was to find that there was absolutely no hassle about parking in the hospital grounds. Another welcome surprise was to find it was so inexpensive during the whole time John was in hospital.

Jacaranda Lodge had everything one would desire –it was clean, tidy, and spacious with facilities including several large lounge rooms to choose from, well equipped kitchens even books and games to help one relax and pass the time. This Lodge is a showplace. You should run regular tours for health service managers and tourists! Another blessing is the low cost for so much.

The appointed day came. This was it. Tense with a fixed smile I ventured into the admissions part of the hospital to find what I wonder? What I did find helped to ease some of the anxiety as the staff were smiling, welcoming and the organisation was smooth. Nothing better to put one at relative ease. There is a calmness and peace about this place. It must be awful when that does not happen. So many similar questions with everyone double checking me and the surgery. I certainly was not going to have the wrong bit removed! Then the anaesthetist broke the spell by sticking needles into me. Not to worry as before I could recite two verses of Psalm 121 I was away with the fairies.

Bang ...I woke up with Pat and our son Julian grinning at my dopey behaviour. Tubes all over the place as expected but then I found that they were all in me! Keeping still was the best analgesic. The physiotherapist broke another spell the first morning. I pleaded "But nobody in their right mind would cough now". But I did as she smiled so sweetly and was so kind.

Pam and David Sandoe and Graham Postlethwaite were generous enough to visit me in hospital. That was most encouraging. Unfortunately, I had left just before John Goodall (RNSH) arrived to say hello but all have stayed in touch over the last few weeks. This prostate cancer support group network works well in help and encouragement. Sadly, Pat and I did not see the group in action in Jacaranda Lodge but I know that the facilities there and the group are models for others to follow.

The staff became friends, willing helpers so welcome during those long nights. I could not ask for more care and attention. Nevertheless I took the opportunity to leave the fourth morning which must be a reflection on the skill of the surgeon and staff. With a smile and quiet authority Dr Katelaris said you can go home - I went. Again smooth organisation let me out quickly and efficiently. Would I come again –yes, of course but do you mind if I put it off for a while? Nothing personal of course.

#### Pat

Our journey through prostate cancer surgery was made so much easier by choosing Dr Katelaris as our surgeon and our experience at the Adventist Hospital. We were reassured at every step. Always careful attention to detail and a friendly helpful smile. When we looked a little bewildered there was always someone to point us in the right direction. Thank you to all the staff and volunteers in the hospital and for the exceptional facility Jacaranda Lodge. Our fear and anxiety was turned into confidence and calmness – an experience we will share with others who find themselves in the same situation.

February 2010