

# Prostate Matters

## Newsletter

ISSUE 5 SUMMER 2009

### Contents

- Page 2 PSA Debate continued  
Real PCRMP
- Page 3 The Great Drag Race  
European Partnership  
Membership Fees  
Back issues of PM
- Page 4 Prostate Cancer  
Questionnaire
- Page 5 Questionnaire  
continued
- Page 6 Clinical Trial  
Green Tea and PCa
- Page 7 Unexpected success.  
New Drug.  
Duration of Androgen  
Suppression.
- Page 8 Information Booklet  
Infosheet

PM Editor: Roger Bacon  
email: [editor@prostatematters-uk.org](mailto:editor@prostatematters-uk.org)

It is intended to publish this  
newsletter 4 times a year

Winter - Spring

Summer - Autumn

Federation e mail address:  
[info@prostatecancerfederation.org.uk](mailto:info@prostatecancerfederation.org.uk)  
Charity No. 1123373

Worried or concerned  
about prostate cancer?

**National Help Line**  
**0845 601 0766**

## The Great PSA Debate 10<sup>th</sup> November – Leamington Spa

Readers will be aware of the controversy that surrounds PSA Testing of symptomless men – sometimes, and simplistically, referred to as “screening”. Put bluntly, with as little bias as we can manage, the PSA Test is a rotten test for prostate cancer; it produces far too many false positives, and it fails to detect a significant proportion of dangerous cancers. Of those cancers that are detected as a result of PSA testing, it is claimed that as many as 50% are irrelevant, and would never cause the man concerned any problems. Unfortunately weeding out such “pussycats” from the “tigers” seems to be beyond the capability of current medical practice.

BUT, early stage prostate cancer, the only stage at which it is generally agreed to be curable, normally produces no symptoms. In fact, there is only one indication, a suspicious PSA, and not always that. Now, those trying to reduce the death rate from this disease are understandably keen to detect as many cancers as possible at the stage where they can be cured, but they are also rightly anxious not to detect, and, worse still, treat, cancers that are irrelevant.

It's a huge controversy; clinicians are deeply divided about the issue, and by no means all urologists are in favour of testing. At a meeting of the British Prostate Group a couple of years ago, a majority of clinicians present (who we have to assume understand these things) went on record to say that they would *not* themselves have a PSA test. We, as patients, like to trust those who treat us as being people who understand the disease; that vote, it has to be said, puts a certain strain on that trust, since the same people happily test and treat us.

We are constantly told about the ‘risks’ of the PSA Test. Yet to most patients it stands to reason that knowing your PSA cannot do any harm. Used correctly such knowledge might save your life. Many clinicians think that that is a simplistic view born of a lack of understanding. To them the start of over-diagnosis is the initial suspicious result to a PSA Test, and from there on it is a slippery path to over-treatment.

Are there are deeper and darker issues at stake? As Tom Stuttford told us at the Federation's Annual Conference in April, there are those high up in the Department of Health who seem to fear an epidemic of prostate cancer, to the extent that, when he was an MP, severe pressure was put on him not to rock the boat by raising the issue of PSA Testing.

Are all these views irreconcilable? To test the case, and possibly advance the argument beyond its current rather puerile state, the Federation, once again collaborating with Prostate UK, as it has over the “Real PCRMP”, will this Autumn be holding “The Great PSA Debate”, at which eminent speakers, under the control of a celebrity chairman, will discuss the motion: “Every man at risk of Prostate Cancer (i.e. men over 50, or 40 for men with other risk factors) should be encouraged to monitor his PSA on an annual basis.” Note, no mention of screening; none of this, in any way, is about prostate cancer screening. It's about men getting the service from their GPs that has been promised by the Department of Health.

continued >>>

We have some excellent speakers lined up, including, broadly in favour of the motion, Prof Roger Kirby, of the Prostate Centre, the Federation's medical advisor, Mr David Baxter-Smith, who has enormous experience of running PSA Testing programmes sponsored by the Graham Fulford Charitable Trust, and Dr Tom Stuttford, former MP, GP, Times medical correspondent, and prostate cancer sufferer.

Broadly against the motion currently we have Dr Chris Parker, a highly respected oncologist from the Royal Marsden. John Neate of the Prostate Cancer Charity will be describing the Charity's policy of PSA testing and explaining why it does not advocate an awareness programme encouraging men to take the PSA Test.

We know that patients feel strongly about this matter. This is an excellent opportunity, both to learn more about the complex issues that surround screening for prostate cancer, and to make your voice heard. The results of the debate will be presented to the National Screening Committee, who are scheduled to update their recommendation on prostate cancer screening during coming year.

As with our successful *Promoting Patient Power* workshop last Autumn, the debate will be held in Leamington Spa, a location suitably central for our members to get to from most parts of the country. We are still finalising details of the venue, which will be announced on the Federation Website shortly, where full details will be posted.

Attendance will be free to accredited members of Member Organisations of the Prostate Cancer Support Federation. Places in the debate are bound to be at a premium, so get your initial registration in right away, by emailing < [greatPSAdebate@prostatecancerfederation.org.uk](mailto:greatPSAdebate@prostatecancerfederation.org.uk) >, or, if you have no email, writing to The Great PSA Debate, Prostate Cancer Support Federation, Mansion House Chambers, 22 High Street, Stockport, Cheshire SK1 1EG, quoting the name of the support group of which you are a member.

*Sandy Tyndale-Biscoe, Chairman PCSF*

## The Great PSA Debate

addressing the motion: "Every man at risk of Prostate Cancer (i.e. men over 50, or 40 for men with other risk factors) should be encouraged to monitor his PSA on an annual basis."

will take place on

**10<sup>th</sup> November 2009**

at

**Leamington Spa**

Venue to be finalised

10.30 to 4.30pm

Confirmed Speakers include:

**Prof. Roger Kirby**, president of Prostate UK;

**David Baxter-Smith**, medical advisor to the Federation;

**Tom Stuttford**, political advisor to the Federation;

**Dr Chris Parker**, Onchologist, Royal Marsden;

**John Neate**, Chief Exec. of the Prostate Cancer Charity;

To Book Your Place:

Email: [greatPSAdebate@prostatecancerfederation.org.uk](mailto:greatPSAdebate@prostatecancerfederation.org.uk)

or write to:

**The Great PSA Debate, Prostate Cancer Support Federation,  
Mansion House Chambers, 22 High Street, Stockport SK1 1EG**

## 'Real PCRMP' gets plaudits and wide-spread distribution

The 'Real Prostate Cancer Management Programme' leaflets, produced by the Federation in collaboration with Prostate UK, have come in for considerable praise and have been circulated widely, so much so that we have distributed the bulk of the 30,000 copies we had made and are now preparing for a re-print.

As a reminder, these leaflets were prepared because we believed that it was unacceptable that GPs were having to rely on biased, out of date guidance from the Department of Health, published in 2002, about what to say to symptomless men who ask for a PSA Test. We believed that this question could be answered in simple terms which recognise the advantages of having a PSA Test, whilst acknowledging its weaknesses as a test for prostate cancer. We accordingly produced our leaflet which says all that needs to be said on a single sheet of A5 paper, rather than the 30-odd page document the Department had been preparing. In March this year a report was published which showed good evidence of the benefits of screening, and work on the PCRMP was suspended.

The situation has moved on, and the revised PCRMP has just been published. Although the bias of the original 2002 document has thankfully been removed, it shows signs of hurried production and still suffers from a number of drawbacks, chief amongst them being: it is bulky and unlikely to be read by most GPs, it does not reflect current clinical best practice where other factors, particularly PSA history, play an important part in deciding whether or not to proceed to biopsy, and is quite wrong about the current status of National Screening Committee recommendations.

The case for GPs having a simple leaflet stating the key facts remains, and we encourage our readers, if they have not already done so, to distribute the Real PCRMP leaflets to their GPs. To obtain copies, please write to:

The Real PCRMP, Cedarcroft,  
Sunnyway, Bosham, Chichester PO18  
8HQ, or email: [realpcrmp@pcrmp.org.uk](mailto:realpcrmp@pcrmp.org.uk).



Montambanco Productions is looking for men who have been affected by prostate cancer to take part in an important new film and a new national awareness-raising event –

**The Great Drag Race.**

Prostate cancer kills a man every hour in the UK. In fact, 1 in 11 men will be diagnosed with the disease in their lifetime. Yet, whilst breast cancer receives huge public support, 70% of adults in the UK don't even know what the prostate does.

But we want that to change. **The Great Drag Race** is a film that will follow eleven men who have been affected by prostate cancer and who are at different stages of managing the disease as they embark on an extraordinary journey. Through their personal stories we will learn about the disease and how it affects men's lives.

Our brave cast want to put the issue of prostate cancer firmly in the minds of the public, so these ordinary men of all ages, shapes and sizes will join forces and undergo training to become drag queens for one spectacular show at a London club. By physically transforming themselves into women, they will hope to draw attention to their plight – and change the country's attitude to 'male issues' for good.

The film will follow our chaps as they each work with a choreographer, a stylist, and a professional drag queen to perfect a simple routine to be performed to a rapturous reception in a cabaret club. But that's only half the story. These men will all be helping to raise awareness on a national scale. The big aim is to set a new world record and persuade 10,000 ordinary blokes to don dresses and join them in a 26 mile march through London on 20th June 2010.

So, if you happen to be - or know

- a fearless fellow who has been affected by prostate cancer and want to help to raise awareness of this disease, then we'd love to hear from you. Even if you don't feel ready to talk on camera about your experiences then you can still get involved in **The Great Drag Race National March** a brilliant way of raising publicity and of driving the message home about men, prostate cancer and the inequalities. So please do get in touch.

Event organisers are: Caroline Coombs, Nic Bathurst or Rosie Saunders at:

Montambanco Productions Email: [nicbathurst@montambanco.com](mailto:nicbathurst@montambanco.com) or [caroline-coombs@montambanco.com](mailto:caroline-coombs@montambanco.com)  
Telephone: 07956-386-530 or 07765-225-108

**Group Membership fees to the Federation are now due**

At our AGM in April this year a vote was carried which levied a membership fee for each 'group' to join the Federation based on £1 for each of 'their' members up to a maximum payment of £100.

**Further copies of Prostate Matters Issues 3 and 4**

are available should your group require them.

Contact by email: [editor@prostatematters-uk.org](mailto:editor@prostatematters-uk.org) or phone 01903 775602 to enquire/order

**FIGHTING CANCER  
A European Partnership is Born**

The European Commission has launched the European Cancer Partnership to step up and invigorate Europe's long-standing commitment to fight cancer. Thus the European Cancer Patient Coalition's (ECPC) joint drive with MEPs against Cancer (MAC) and the sterling work undertaken by the Slovenian EU Presidency to make the fight against cancer once again a priority, have borne fruit.

Cancer patients can take heart that this new European Partnership has the potential to make a real difference for them, their family, carers and indeed EU citizens across the 27 EU Member States.

With one in three people being diagnosed with cancer during their lifetime, the Commission initiative is very timely. The Partnership will identify existing gaps in cancer prevention, treatment, care and research across the EU where there are startling and - for cancer patients - unacceptable differences in outcomes. By mobilising the political commitment of Member States and all relevant stakeholders to put their collective knowledge and energy behind the Action against Cancer, Europe has an opportunity to reduce the cancer burden for the benefit of patients, citizens and society.

ECPC is delighted that the European Action against Cancer embraces patient groups in its Partnership; and we will continue to work tirelessly to ensure that the patient perspective is kept at the centre of the Partnership.

The European Partnership for Action against Cancer will be launched officially in Brussels in the autumn of 2009, and the Commission hopes that all Member States and stakeholders committed to the European fight against cancer will join this sustainable action to curb the European burden of cancer, by working together - in partnership.

# Prostate Cancer Questionnaire

Earlier this year PCaSO decided to ask its members to complete a questionnaire that had been produced by Ian Graham-Jones, the charity's secretary. The questions were quite varied and covered such things as symptoms, GP visit, consultant and diagnosis, treatment, side effects of hormone therapy and quality of life after treatment.

The whole questionnaire was 8 pages long and there were some reservations among the committee of PCaSO as to whether members would actually want to spare the time to complete this and post it back. However it was decided to go ahead and 630 questionnaires were circulated with a remarkable response of 230 returns (35%) which is way above what normally comes back from such projects. This shows the level of feeling out there and the fact men do want to be heard.

The following is a summary of the findings, the full report is 6 pages long.

## Symptoms

We found that 38% of men that were subsequently diagnosed to have prostate cancer had no noticeable symptoms, 41% of those had locally advanced, rather than early stage disease. This is a significant proportion, and points to the need for awareness and early diagnosis. The most common symptoms that prompted a GP visit were night-time visits (nocturia) and slow stream.

## The GP visit

55% of men were unaware of the PSA test before the GP visit, and 45% knew about it to ask for the test. Only 32 men reported any unwillingness on the part of their GP to give them the test, but significantly in very many cases (55%) the GP appeared not to explain the weaknesses of the test as a diagnosis for prostate cancer, or to point out the 'pros and cons' of the test, as proposed by government guidelines. These, we feel, are significant figures, but in spite of this, many rated their GP highly in their care and concern over their problems. The comments we received on this aspect of the

prostate cancer journey do reflect a wide range of concerns. A selection of these is given below; further information, including age at diagnosis where relevant, is given in brackets.

*"The inadequate response by my first GP will possibly cost me my life". The consultant said: "If caught earlier, a cure might have been possible" [age 51].*

*"GP just gave me a urine test and said "No blood, you're OK". Only on my insistence that there was a problem did he give me a blood test with a PSA reading of 44".*

*"My GP was very thorough – he told me he gives PSA with other tests to every man approaching 50".*

*"He did not consider that I needed a test, as no symptoms present" [age 62, PSA 12, later Gleason 6].*

*"Very glad my GP referred me, as it turned out that the cancer affected most of my prostate despite my having NO symptoms".*

As expected, the majority of PSA readings taken at the GP visit were below 10, but a significant number were high – two of which were over 1000.

## Consultant referral and diagnosis

Turning to the consultant visit and the diagnosis, a remarkable number of patients had private treatment – 27% as opposed to 73% receiving NHS treatment. Despite this, there was very little difference between the waiting times for referral. As expected, most men were in the 65 to 69 age range at diagnosis. Nevertheless, a significant number had been diagnosed in their early 50's.

16 men contracted some form of infection following biopsy – a surprising number, considering the now normal practice of giving antibiotics. However, only 38 (18%) found the experience painful, while 42% described it as 'uncomfortable' and 40% as 'not too bad'.

It is clear that most men understood, or had explained to them the Gleason system, and knew their

Gleason grade, though the stage of the cancer was sometimes neither given nor fully explained.

An encouraging number (over two thirds) sensibly had a wife/partner/friend present, and about 14% felt they could not understand the consultant's explanations, or felt unable to ask questions. However, 67 (28%) were not given any literature to take away with them, which seems a disturbing number, although we have not analysed how recently these patients received their diagnosis.

## Nurse Specialists

Only 54% were seen by a nurse specialist, though we know that few private patients have the opportunity for a CNS consultation, nor do we know how many men were diagnosed before specialist nurses became established in hospitals. Of those that saw a nurse specialist, their rating was very high.

## Consultant rating

The man's experience with his consultant was the next area of concern, judging by the unsolicited comments we received, a selection of which is appended below:

*"The junior doctor advising me of the biopsy result said "You have had cancer for some years. Normally you would have 15 years to live, but your expectancy could be 8 years".*

*"Consultant's assistant said: "I've got some shitty news for you".*

*"The consultant was blunt and insensitive".*

*"The junior said: "If the treatment doesn't work [i.e. radiotherapy] you can have an orchidectomy". When this was explained it was rather shocking" [age 54].*

## Treatment

Of the 251 responses to this section, two thirds of the men felt they were given no choice of treatment. However, in nearly all cases men felt that they were satisfied that they had made the right choice. There were, of course, a few exceptions: 77% felt that the treatment was fully successful, 19% partially so, and only 5 felt that their choice had not been a success.

The skills of the surgical and oncology teams were all very highly rated,

although the nursing care was more variable. One member, after robotic surgery, gave 5 (excellent) to the surgeons and 0 for the ward nurses. Of radiotherapy, a member described it as:

*“a bit of a sausage factory but very pleasant and considerate”.*

In deciding on their option, one third of the responses in this section felt that their options were not fully explored. 42% felt on their own in making a decision, and it was the internet that most turned to for help. Two themes came through from comments made. Firstly, the concern over the patient having to make the treatment decision: *“I was surprised to be asked to decide what treatment I would like when one has no idea of the problem”.* *“I was told to look on the internet for information!”.*

Secondly, the lack of information on alternative treatments:

*“No information given or offered on HIFU, LRP or robotic RP – no encouragement to explore other avenues”.* *“I was told what treatment was necessary, and I was given no choice. The consultant was blunt and insensitive”.*

One man, aged 76, was given open surgery, and was not advised of any alternative treatment.

#### Quality of Life

About half of those with early stage prostate cancer have made changes to diet and lifestyle, and for those with locally advanced or advanced cancer, the percentage was much higher, 68% making more radical dietary changes.

Unsurprisingly, as the prostate is a sexual organ, erectile dysfunction and lack of libido were recurring features in members' responses. Some commented on the fact they were not told of the side effects:

*“No information or advice on sexual implications of hormone treatment given”.*

*“With hormone therapy - mood swings, depression and ED badly affect quality of life and thence my wife's QOL. (Suicide sometimes contemplated)”.*

*“Loss of sexual function and the relationship between my wife and me is not the same”.*

This shows the need for partners to talk about the effect that some prostate treatments can have on life, and for partners to be understanding of each other – counselling can play an important part in this aspect, which appears to not often been offered or taken up.

Others have taken a positive approach to life after (or with) prostate treatment and some members gave some useful tips:

*“I have recently completed 10,000 miles of long-distance walking ... to counter the weakening effects of Zoladex on bone and muscle”.*

*“I have put myself on a vegan diet with supplements and PSA has halved to 3.5”.*

*“I tried Vitamin B17 (apricot kernels) and was on this treatment both before and when my Zoladex treatment stopped for 6 months. The fact that my PSA rose ... convinced me that the full B17 treatment was useless”.*

*“I was given acupuncture for hot flushes – it helped”.*

#### Hormone Therapy

Some may be aware of the Prostate Cancer Charity's report on a recent survey they conducted on men having hormone therapy treatments called *Hampered by Hormones?* (June 2009). It is available on their website [www.prostate-cancer.org.uk](http://www.prostate-cancer.org.uk), or a copy can be obtained direct from the PCC. Only 322 men throughout the UK responded to their survey, but in general our findings were broadly similar to those of the charity. Of our 230 responses, 68 were having hormone – or in very few cases chemotherapy – treatment, so our figures are based on this smaller number.

About two-thirds (63%) were being treated for locally advanced, while for the remainder (37%) the cancer had reached the advanced stage. For most (75%) this was their first diagnosis, the remaining 25% the cancer had recurred after initial primary treatment.

We asked whether members had been offered counselling for their hormone treatment and only 24 men and their partners (of the 82 responses to this question) had been offered this. This is a major point that the PCC survey makes: there was too

little information given on the side effects of hormone therapies, and too many men were not told about these before starting treatment.

We also asked about bone health, and 67% were given bone scans before starting their treatment but in only 20% of cases was the bone density monitored.

#### Side effects of hormone therapy

We found, unlike the PCC survey, that in all 68 cases men suffered hot flushes, erectile dysfunction and loss of libido (sexual desire) during the treatment – i.e. 100% each, while breast swelling occurred in 85% of cases. This confirms that these often debilitating side effects should be expected with the treatment.

We asked our members to give a subjective rating 1 – 5 of the degree of distress from each side effect (1 being minimal, 5 being unbearable), in general men felt more able to cope with hot flushes, breast problems and mood changes, and least able to manage the sexual aspects. This agrees with the PCC's findings.

Some comments we received on treatment side-effects were:

*“If I'd believed the first consultant/Macmillan nurse I'd be down and out. The second consultant was far different, so I live as normal a life as possible without thinking too much about my condition”.*

*“I have some depression and frustration, irritable moods and anxiety”.*

*“I have a positive attitude and an understanding wife and family”.*

*“Sex and desire have gone. With a less understanding spouse it could have been destructive to our relationship”.*

And from a 56 year old diagnosed with a PSA of 235: *“Am unable to work because of fatigue – social life is limited”.*

These results are interesting for a relatively small number, however, and it may be that a national survey based on PCaSO's questionnaire could be undertaken in the future, possibly by the Prostate Cancer Support Federation.

The full questionnaire report will shortly be available from PCaSO at PO Box 66, Emsworth PO10 7ZP.

# Clinical Trial

## ALSYMPCA trial

### Phase III trial of Alpharadin for men with Hormone Refractory Prostate Cancer and bone metastases

Alpharadin (radium 223) is very similar to calcium, so that when it is injected into the blood, the body takes it up in the bones, and especially in bone secondaries. Because radium-223 is radioactive, it then delivers radiotherapy to the bone metastases. The radiotherapy is delivered over a very short range indeed, less than a millimetre, so the effect is targeted on the bone metastases while sparing other tissues.

So far, Alpharadin has been compared with placebo in a trial of 64 men with advanced prostate cancer who were all receiving standard treatment in addition. The drug was extremely well tolerated. In fact there were more side-effects in the placebo group than there were in the Alpharadin group! Encouragingly, men who received Alpharadin lived significantly longer than those getting standard treatment plus placebo. After two years, twice as many men were alive in the Alpharadin group as in the placebo group.

A large trial, involving hundreds of men, is now needed to confirm these exciting results. All men will receive best standard treatment for prostate cancer. In addition, they will either get Alpharadin or placebo, given as a monthly injection for 6 months. Two patients will be allocated to Alpharadin for every one allocated to placebo.

The trial is now open in more than 20 centres throughout the UK, as well as other centres across the world, and is expected to complete recruitment in early 2010.

#### Eligibility

To be eligible men must have hormone refractory disease and:

- > a rising PSA level
- > bone metastases
- > either be using painkillers or have had recent radiotherapy for bone pain
- > no intention to have chemotherapy within the next 6 months

#### For more information

Details of the trial can be found at: [www.algeta.com](http://www.algeta.com)

The Chief Investigator in the UK is Dr Chris Parker  
e-mail: [chris.parker@icr.ac.uk](mailto:chris.parker@icr.ac.uk)

If you want further information or are interested in taking part in this trial, in the first instant you should speak to your doctor / consultant or person responsible for your treatment.

For those living in the south, the CMO of Algeta will talk about ASYMPCA Trial at the next meeting of the PCaSO Fareham Group on 15th October - see [www.pcaso.com](http://www.pcaso.com) for details.

## Green Tea and Prostate Cancer Progression

Green tea is the second most popular drink in the world, and some epidemiological studies have shown health benefits with green tea, including a reduced incidence of prostate cancer, according to Cardelli. However, some human trials have found contradictory results. The few trials conducted to date have evaluated the clinical efficacy of green tea consumption and few studies have evaluated the change in biomarkers, which might predict disease progression.

Cardelli and colleagues conducted this open-label, single-arm, phase II clinical trial to determine the effects of short-term supplementation with green tea's active compounds on serum biomarkers in patients with prostate cancer. The biomarkers include hepatocyte growth factor (HGF), vascular endothelial growth factor (VEGF) and prostate specific antigen (PSA). HGF and VEGF are good prognostic indicators of metastatic disease.

The study included 26 men, aged 41 to 72 years, diagnosed with prostate cancer and scheduled for radical prostatectomy. Patients consumed four capsules containing Polyphenon E until the day before surgery – four capsules are equivalent to about 12 cups of normally brewed concentrated green tea, according to Cardelli.

Findings showed a significant reduction in serum levels of HGF, VEGF and PSA after treatment, with some patients demonstrating reductions in levels of greater than 30%, according to the researchers.

Cardelli and colleagues found that other biomarkers were also positively affected.

"Unfortunately, this trial was not a randomised trial, which would have been needed to be more sure that the observed changes were truly attributable to the green tea components and not to some other lifestyle change (better diet, taking vitamins, etc.) men undertook in preparation for surgery," added Nelson, who is also a senior editor for Cancer Prevention Research. However, "this trial is provocative enough to consider a more substantial randomised trial."

## Unexpected success of experimental treatment

Early last month there were reports on TV and in many newspapers of a new "wonder" drug called **Ipilimumab** which had been developed in the Mayo clinic, Rochester, America.

After androgen ablation (hormone therapy) which blocked the body's production of testosterone, this drug tricked the immune response into "burning" long enough to overpower the cancer cells. Within weeks of treatment the tumours of two patients could not be seen on MRIs. Before treatment each of them had aggressive tumours that had grown well beyond the prostate gland into abdominal areas. Both patients saw their prostate specific antigen (PSA) levels drop to the point where they became eligible for surgery. There are 20 other patients who are showing improvements and who are being monitored by the surgeons. Dr Kwon said: "This is one of the holy grails of prostate cancer research. We've been looking for this for years."

The Mayo Clinic team in the US said the "startling" results in the study of 108 men has prompted a phase III trial sponsored by Bristol-Myers Squibb which is currently recruiting worldwide.

Until large scale studies are carried out it is unclear whether this response can be repeated in other patients or is an anomaly.

For details about the trial go to:

[http://www.clinicaltrial.gov/ct2/show/study/NCT00861614?term=ipilimumab&rank=31&show\\_locs=Y#locn](http://www.clinicaltrial.gov/ct2/show/study/NCT00861614?term=ipilimumab&rank=31&show_locs=Y#locn)

## New Drug showing promise

producing highly promising results in preliminary drug trials, **Olaparib** was given to 19 patients with inherited forms of advanced breast, ovarian and prostate cancers caused by mutations of the BRCA1 and BRCA2 genes.

In 12 of the patients - none of whom had responded to other therapies - tumours shrank or stabilised.

The study, led by the Institute of Cancer Research, features in the New England Journal of Medicine.

Julian Lewis, 62, was treated with olaparib after being diagnosed with advanced prostate cancer.

Within a month or two levels of a key chemical marker of cancer went down to a low level, and have now stayed low for more than two years.

Olaparib - a member of a new class of drug called PARP inhibitors - targets cancer cells, but leaves healthy cells relatively unscathed.

The researchers, working with the pharmaceutical company Astra-Zeneca, found that patients experienced very few side-effects,

and some reported the treatment was "much easier than chemotherapy".

Researcher Dr Johann de Bono said the drug should now be tested in larger trials.

He said: "This drug showed very impressive results in shrinking patients' tumours. It's giving patients who have already tried many conventional treatments long periods of remission, free from the symptoms of cancer or major side-effects."

Cancer cells with the BRCA1 or BRCA2 mutations are the first to be shown to be sensitive to PARP inhibitors.

Men with a BRCA mutation have a risk of up to 15% of prostate cancer.

Dr Peter Sneddon, of the charity Cancer Research UK, said: "It is very encouraging to see the development of 'personalised treatment', tailored to the requirements of the individual patient, becoming a reality as it offers the opportunity to design new drugs that are truly selective".

"Although development of this drug is in its early stages, it is very exciting to see that it has the potential to work when other treatment options have failed."

## Duration of Androgen Suppression in the Treatment of Prostate Cancer

**Background:** The combination of radiotherapy plus long-term medical suppression of androgens ( $\geq 2$  years) improves overall survival in patients with locally advanced prostate cancer. We compared the use of radiotherapy plus short-term androgen suppression with the use of radiotherapy plus long-term androgen suppression in the treatment of locally advanced prostate cancer.

**Methods:** We randomly assigned patients with locally advanced prostate cancer who had received external-beam radiotherapy plus 6 months of androgen suppression to two groups, one to receive no further treatment (short-term suppression) and the other to receive 2.5 years of further treatment with a luteinizing hormone-releasing hormone agonist (long-term suppression).

**Results:** A total of 1113 men were registered, of whom 970 were randomly assigned, 483 to short-term suppression and 487 to long-term suppression. After a median follow-up of 6.4 years, 132 patients in the short-term group and 98 in the long-term group had died; the number of deaths due to prostate cancer was 47 in the short-term group and 29 in the long-term group. The 5-year overall mortality for short-term and long-term suppression was 19.0% and 15.2%, respectively. Adverse events in both groups included fatigue, diminished sexual function, and hot flushes.

**Conclusions:** The combination of radiotherapy plus 6 months of androgen suppression provides inferior survival as compared with radiotherapy plus 3 years of androgen suppression in the treatment of locally advanced prostate cancer.

N Eng. J Med. 2009 Jun 11; 360(24):2516-2527, M Bolla, TM de Reijke, G Van Tienhoven, ACM Van den Bergh, J Oddens, PMP Poortmans, E Gez, P Kil, A Akdas, G Soete, O Kariakine, EM van der Steen-Banasik, E Musat, M Piérart, ME Mauer, L Collette

# Prostate Cancer Support Federation

Mansion House Chambers  
22 High Street, Stockport  
Cheshire SK1 1EG  
Tel: 0161 474 8222

Charity No. 1123373

## Federation Trustees

Officers:

Chairman: Sandy Tyndale-Biscoe

Secretary: Mike Lockett

Treasurer: Hugh Gunn

Trustees: Graham Fulford,  
John Dwyer, Roger Bacon, Keith  
Hobby, David Smith, Rob Banner,

## Volunteers for Roles and Functions

European Representative:

Mike Lockett

Medical Advisor:

David Baxter-Smith

Newsletter Editor:

Roger Bacon

Grants Secretary:

Sandy Tyndale-Biscoe

Fund Raising/Sponsorship:

Rob Banner

Website Maintenance:

Sandy Tyndale-Biscoe

Helpline Coordinator:

John Coleman

Development/Recruitment:

Graham Fulford

Membership Secretary:

Alan Ashmole

Publicity/PR: - VACANT

## Representatives on National groups

NCRI; PCAG; PCCA; NICE -

David Smith / John Dwyer

## Political Liaison

Dr Tom Stuttford

## Education/Research Coordinator

John Dwyer

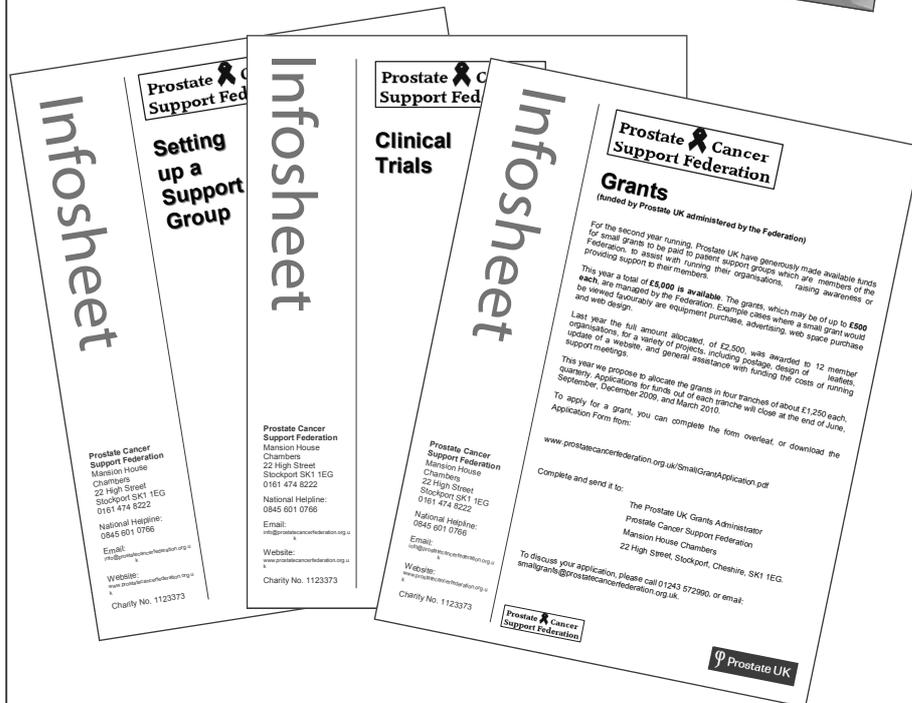
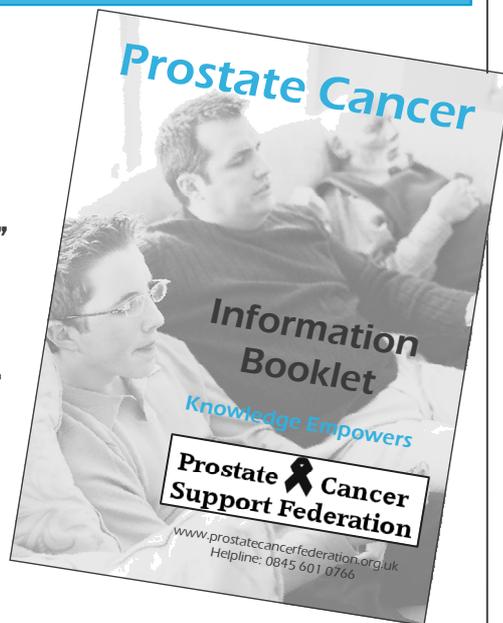
*Prostate Matters* is published four times a year. It provides news, information, personal memoir and opinion about prostate cancer. It also reports, quotes and cites published medical views and research findings about prostate problems. Anyone who wishes to embark on any dietary, drug, exercise or other lifestyle change intended to prevent or treat a specific disease or condition should first consult with and seek clearance from a qualified health care professional.

[www.prostatecancerfederation.org.uk](http://www.prostatecancerfederation.org.uk)

e mail: [info@prostatecancerfederation.org.uk](mailto:info@prostatecancerfederation.org.uk)

At our AGM in April the Federation launched a 48 page Information Booklet titled "Knowledge Empowers" These are now being offered to all member groups FREE of charge.

Contact us at Mansion House Chambers address phone 0161 474 8222 to order your copies.



The Federation have launched a series of "Infosheets" at the moment there are six more are planned -

**Grants <> Clinical Trials <> Manifesto**  
**Setting up a Support Group**  
**Cancer Waiting Times <> Role of CNS**

if you would like copies sent to your group, contact Mansion House Chambers address or Phone 0161 474 8222 or download them from our website [www.prostatecancerfederation.org.uk](http://www.prostatecancerfederation.org.uk)