Once again the Prostate Cancer Support Federation is holding an Autumn Workshop, this year focussing on lifestyle issues and how they affect men suffering from (and surviving) prostate cancer. We have a line-up of speakers covering all the ways our lifestyles can affect our chances of surviving prostate cancer, and how the disease and its treatment’s effects on our lifestyles can be ameliorated.

Speakers (to be confirmed) will include:

- **Margaret Rayman**, Professor of Nutritional Medicine at Surrey University and author of *The Prostate Care Cookbook*
- **Professor Robert Thomas** of Cranfield University, author of *Lifestyle After Cancer – the facts*
- **Sarah Stewart-Brown**, Professor of Public Health at the University of Warwick, whose specialisation is the impact of mental health and well-being on cancer survival.
- **Dr Jasmin Hussein**, Chief Medical Officer, Oncology Division, Sanofi Avenis
- **Mr Timothy R. Terry** BSc, FRCS, LRCP, MS Consultant Urological Surgeon, Andrology and Life Style
- **Darren Breen** of iMedicare, whose talk will be entitled “SOMAtherapy ED: Penile Fitness in your hands”

Attendance (including lunch) will be free to accredited members of Federation Member Organisations. Full details of the programme and the venue will be available in late August, at which time formal booking will commence. For more details, and to book a place, go to: 
This is the first of a series of reviews of books related to prostate cancer that occasionally come our way. If you have a favourite (or even hated!) book that you would like to see reviewed, or of which you would like to offer a review, please get in touch with the editor editor@prostatematters-uk.org.

We start the series with two books aimed primarily at patients, *Coping Successfully with Prostate Cancer* by Dr Tom Smith, and *Prostate Cancer – the Facts* by Malcolm Mason & Leslie Moffat.

**Coping Successfully with Prostate Cancer by Dr Tom Smith**

This book, which is an ‘updated’ version of a book published 10 years ago, is a strange mixture of the apparently quite good and the quite definitely not very good. I believe that I learnt something from it about areas of prostate cancer where my knowledge is sketchy, in particular details of advanced prostate cancer and its treatment, but there are so many errors in the material that I do know very well, e.g. diagnosis and treatment of early stage prostate cancer, that I cannot be sure that what I think I’ve learnt isn’t false. It is factually wrong in a number of places. In particular, there are many examples of where the original text of ten years ago has not been properly updated to take account of the 2010 scene. This is particularly the case with the section on brachytherapy, and that on chemotherapy, both of which are wildly out of date.

There are some quite glaring omissions. For example:

- There is no mention of Active Surveillance, a potent new approach to resolving the over-treatment problem arising from prostate cancer screening. It would appear that Dr Smith has no understanding of the important distinction between this and Watchful Waiting, which, for obscure reasons, he chooses not to refer to by its universally known name, but calls “wait and see”.

- There is no mention of laparoscopic surgery (not robotic) which has been around for some 10 years, and, in the hands of a skilled surgeon is yielding significantly better outcomes than traditional, open surgery.

- Brachytherapy is now a standard treatment, of equivalent stature to RP and EBRT, for early stage disease, yet it is discussed only as an “other” treatment, along the same lines as cryo-therapy and HIFU, with some extremely old statistics based on very small samples.

- The chapter on choice of treatment for early stage disease is quite inadequate, particularly in view of the fact that it’s one of the most important choices a man will make.

- The section on chemotherapy makes no mention at all of the increasing success of treatments for late stage disease, e.g. abiraterone and docetaxel. This news has been around for two years. Where has Dr Smith been?

There is nothing at all about diet. There is a large body of evidence that suggests that risk of prostate cancer is diet related, and this is something that prostate cancer patients are more interested in than any other group of patients. The absence of any mention at all, even with caveats, of this topic renders this book pretty much useless to someone who has no other resources.

No references are given. This, combined with the fact that the book is not endorsed by any specialist in the disease, immediately casts doubt on the reliability of the information provided.

Some examples of other errors are:

- He states that “sexual feeling”, which is a term he earlier uses to denote libido, but may mean orgasm, is lost after prostatectomy (RP); this is nonsense. RP has no effect whatsoever on libido, and orgasm capability is retained, indeed some find it strengthened.

- He implies that only some men lose ejaculatory function after RP; in fact it is invariably the case that this function is lost after RP (it’s what the prostate does, after all), and generally with any of the other radical treatments.

- He suggests that fertility can be maintained after RP through stimulus of the “remaining prostate gland tissue”. This seems to completely misunderstand the nature of an RP. There is no remaining prostate gland tissue, or, for that matter, seminal vesicles. The only practical means of retaining fertility after treatment, is prior sperm donation.

- HIFU (which he calls “hyperthermia”) uses sonic energy not microwaves.

- He says that TURP and laser treatments are for prostate cancer; they are not.

The style, a mixture of patronising medical ‘down talk’ and sometimes dramatic ‘journalese’ is inappropriate for a book that is supposed to provide reliable information, and this is eventually irritating. There are some very strange (and unsupported) excursions into exaggeration (e.g. “constant stream of good news” in the Preface – try telling that to the 10,000 men who die of it each year) and occasionally wild.

*Continued page 3*
Continued from page 2

fantasy. A particularly glaring example of the latter is a totally dreamt-up suggestion that there might be a connection between the apparently reducing age at which boys first have sex and the incidence of prostate cancer. For a start there is as much evidence that frequent ejaculation reduces the risk of cancer as there is that it raises it; secondly, the age at which boys first experience sex has little relationship to frequency of ejaculation – Dr Smith seems to be have forgotten what teen-age boys get up to in the privacy of their bedrooms!

Was there anything I liked about the book? Well, The good doctor is on the side of the angels about screening; it’s unfortunate he spends so much time undermining the case. The explanation of the way hormone therapy works is well done, and so far as I can tell accurate, and it certainly helped me understand it properly for the first time. But is it accurate (bearing in mind the inaccuracies in other areas)?

In conclusion, the main problem with the book is that, although it claims to be updated from 2000, the updating is patchy and incomplete. If Dr Smith wants to sell his book twice then he should make sure he’s done the updating work.

In many ways this book sums up the ‘GP Problem With Prostate Cancer’. Ten years ago, Dr Smith took the trouble to become considerably more knowledgeable about our disease than the vast majority of his colleagues, and we should be grateful for that. But a little knowledge is always a dangerous thing, particularly when it gets out of date, and the worrying thing about this book is the thought that other GPs, seeing that it is written by one of their number, might use it to do what we all want, get up to speed with prostate cancer. I hope that instead they read the book that follows.

Coping Successfully with Prostate Cancer is published by Sheldon Press (01235 465579), price £7.99

Prostate Cancer – the Facts
by Malcolm Mason & Leslie Moffat

In contrast to Coping Successfully with Prostate Cancer, this book is written by two gentlemen who clearly know their stuff (a fact that will come as no surprise to those of our members who heard Prof Mason speak at our 2009 Annual Conference). It is another updated version of a book published some years ago (in 2003) but in this case the authors (a leading oncologist and a leading surgeon) are specialists practicing in the forefront of the latest research. The update is genuine and timely, albeit with some surprising gaps (see below). That said, already the circus has moved on: there is only a very cautious mention, for instance, of abiraterone, which, since publication of this book, has shown itself to be remarkably effective treatment for hormone resistant disease (I refuse to use the now fashionable term “castrate refractory”).

But it is obviously impossible for a printed publication to remain fully up to date, and the sections on radio therapy, including high dose brachytherapy, and chemo therapy are full and informative. The discussion on side effects is comprehensive, without being alarmist.

By contrast, surgery is treated quite briefly, and, surprisingly, there is no mention of the more modern forms, laparoscopy and robot assisted surgery. Nor is there any mention of other surgeon performed treatments, such as HIFU or cryotherapy.

The screening argument is presented in detail, and provides a useful (if erroneous) insight into something that is a mystery to most patients: “Why do so many otherwise intelligent clinicians decry the PSA test, and even suggest that there might be some harm in knowing your PSA?” Mason and Moffat rely on the well rehearsed argument that trials show that, to save 1 life you have to treat 48 men, 47 of whom, by inference, did not need treatment. This is a simplistic and philosophically flawed argument and only considers mortality, ignoring the improvements in quality of life of those treated who never, as a result, get to advanced disease. It is also out of date; the figure indicated by the most recent trials is more like 1 in 12, slightly better than for breast cancer.

There is an informative and balanced discussion about clinical trials, but, regrettably, no list of current trials, or pointers to how one might find out whether there is a current trial that might be suitable for an individual condition. (In case you want to know, go to Cancer Research UK website: www.cancerhelp.cancerresearchuk.org/trials"
The chapter on sex and prostate cancer would be a disappointment, were I not so used to being disappointed in this area. It confines itself to a (perfectly accurate) discussion of the various treatments for erectile dysfunction, and ignores the much wider sexual implications of prostate disease and its treatment.

For top flight clinicians, Mason and Moffatt, possibly aware of the popularity of these approaches amongst their patients (and their wives), take a fairly relaxed stance on complementary and alternative issues. The praise may be faint, but it is not damning.

So, on balance, this is a good and useful book, but not without its flaws. A ‘Curate’s Egg’, in fact.

Prostate Cancer - the Facts is published by Oxford University Press (01865 242913), price £9.99

Future reviews
As stated earlier, this is the first of a series of reviews. In the pipeline for future review are:

The Cancer Survivor’s Companion by Frances Goodheart & Lucy Atkins

Natural Approaches to Prostate Cancer by Christopher Garner

A Finger up your … by Doug Gray

Page 3
It’s hard to believe it’s nearly a year since Prostate Action was founded. So much has happened since the merger of Prostate UK and Prostate Cancer Research Foundation (PCRF) in October last year, it feels like my feet haven’t touched the ground. Despite the hectic pace of change, it feels like it has gone incredibly smoothly. That is down, in no small part, to the fantastic team in the office ensuring that everything has been done with dedication and professionalism – from the big things like joining two databases, getting our fundraising events up and running and building a new website to the smaller things like organising the new office layout and remembering how everyone takes their tea. It is no mean feat to merge two charities but, to my mind, it will help us make life much better and easier for patients and that is really what it’s all about.

So what are doing that we weren’t before? The answer is not that much. If anything, the merger has served to clarify the principle aims of both of the former organisations into one mission: funding research and education to beat prostate disease.

We are carrying on the long established good work of Prostate UK and PCRF with the aim of improving them through the efficiency of one focused charity with a larger supporter base to draw from. We are still training approx 600 GPs about all prostate diseases every year across the country (we know from speaking to patients that this is really important), we also train newly qualified urologists and we are still funding research and promoting collaboration via our open grant round and the world renowned Forum.

We have combined our supporter events, so June and July have seen us racing around the country dressed either in fancy decorated pants at Pants in the Park or dressed as women for The Great Drag Race. These events are vital for not only raising much needed funds, but also to get the prostate message to as many people as possible.

We are also committed to enabling the Federation to continue as the voice for patients and their families. We will continue to provide funding for the conferences and workshops the Federation runs, and the small grants scheme, and have committed to a grant cover the costs of employing a Development Director for the next five years, so that the Federation can be self-sustaining and independent.

For me though, the most important thing for us to do now is to make some noise and raise more money. We, as charities, and you, as patients, need to make our voice heard. The status quo is not good enough. GPs need to understand the prostate better and provide the most appropriate treatment; urologists need to offer unbiased advice and communicate better with GPs. We need new developments in treatment to come to the market much quicker and patients need to be involved in the decisions around this. And, more than anything, prostate research needs much more funding. We have just received 69 applications for research into all three prostate diseases, worth a total of £6.1 million. Unfortunately we can’t fund all of them this year and if this research isn’t being funded elsewhere the chances of new advances appearing quickly are reduced.

But we feel we are moving in the right direction. The merger is our first step towards achieving our goal of beating prostate disease and improving the lives of all men now and in the future. We are living in an interesting time of change for healthcare in Britain and it remains to be seen how the NHS will look in a year’s, two year’s, five year’s time. With our first year nearly over and everything in place we believe we are in a great position to have an impact and help change things for the better. In the coming year, with your help, Prostate Action will go from strength to strength and I can’t wait to be rushed off my feet again.

Please Check Your Details

Please would all affiliated members check on the PCSF website, that their details are correct on both the map:

http://tinyurl.com/429ee7f

and the contact web page:

www.prostatecancerfederation.org.uk/membershipList.htm

If there are any alterations, please contact:
Sandy Tyndale-Biscoe
Email  webmaster@prostatecancerfederation.org.uk
We have had “The Great P.S.A. Debate” and now I think it is time to turn the coin over and look at diagnosis for prostate cancer in a different and possibly controversial/provocative way.

Most of our readers will be familiar with the advice put out by N.I.C.E., The Department of Health, P.C.T.s, The Media, Urologists and General Practitioners. “The blood test to measure P.S.A. levels is a lousy test, it has poor sensitivity and poor specificity and is prone to false positive as well as false negative results.” It very rarely acts as a diagnosis of Prostate Cancer and, at the best, can only act as an indicator of prostate disease. This leads to many men with a P.S.A. level above a certain threshold being subjected to an unpleasant series of prostate biopsies which can occasionally lead to significant complications. Only a minority of these men will be found to have Prostate Cancer and some of these will receive unnecessary treatment. The majority of men who have had biopsies will be told that they have no tumour and could then be lost to follow up. So clearly there is little to recommend men to have this test.

I am going to suggest we look at this in another way. P.S.A. is produced by cells within the prostate gland and some of this escapes into the blood stream. Extremely sensitive and very modern laboratory analysers are able to measure very accurately the very tiny amount present in blood and when over an accepted threshold malignant cells (potentially aggressive or non-aggressive) are responsible. The patient then goes on to have prostate biopsies. Thirty years ago we would have done one or perhaps two biopsies into an area of digitally suspicious gland. With the help of trans-rectal ultrasound this was increased to six biopsies and in recent years increased again to ten or twelve biopsies. Occasionally saturation biopsies are performed with at least thirty cores being taken. With most organs of the body (e.g. bowel, stomach, bladder, lung) the tumour is seen with an appropriate optical instrument and then a biopsy (of the tumour) is taken. However, in the case of the prostate gland, an early curable tumour, cannot be seen with an optical instrument, can only rarely be felt and occasionally identified with imaging. Most prostate biopsies are, therefore, taken not from the tumour but from the organ itself and in a relatively random fashion - I would say using blunderbuss techniques. Is it any wonder that in two thirds of the men subjected to this the tumour (and thereby the P.S.A. secreting cells) is missed and men are being discharged with the inappropriate advice that they have no growth.

Clearly the blood test for P.S.A. is a very accurate means of indicating Prostate Cancer and the subsequent series of Trans-Rectal Ultrasonically guided biopsies is a lousy means of finding the growth, with poor sensitivity and specificity and prone to a majority of false negative results. Although in some instances of false negatives the growth that has been missed by the technique of taking the biopsies it will not prove to be clinically significant because the tumour is of low aggressiveness and not life threatening but in other instances the tumour missed will eventually become clinically apparent and potentially life-threatening and beyond the stage when cure can be considered. Such men may have been given the inappropriate and dangerous advice that they have no tumour and will be lost to follow-up and subsequent monitoring.

In summary let’s look at this another way. The blood test for P.S.A. is an excellent means of diagnosing Prostate Cancer but is let down by generally poor biopsy techniques. Let’s not blame a very scientific blood test for the poor results achieved by prostate biopsies.

Medical Advisor

Federation Name Change (not)

As some of you will know, it has been suggested that the name of the Prostate Cancer Support Federation should be changed to try to reflect its patient bias.

Having listened to the views of our members and after due consideration, it has been decided to leave the name unchanged, but add the following strap line:

‘The Voice of Prostate Cancer Patients and their Families’

It is hoped that this will meet with the approval of all of our members!
The wake-Up Call

Leonardo da Vinci  April 15, 1452 – May 2, 1519
Peter Sandison  February 13, 1941 – Present day

Leonardo da Vinci is revered for his many Masterpieces from his painting of the Last Supper to the lady with the enigmatic smile, the Mona Lisa.

Yet art genius as he was, his other passions included Botany, Cartography, Engineering and a somewhat macabre interest in the dissection of the human body.

He attended autopsies, which were frowned upon in the sixteenth century, and were often carried out in secrecy. The detailed drawings he made of the human body were said to be unlike anything anyone had ever seen before. In fact his drawings were so accurate they were only improved upon with discovery of the use of X-ray by Wilhelm Rontgen in 1895.

Da Vinci wanted to crack the code of the human body by observing, cutting and investigating it. He hoped in doing so, he would find whatever it is that makes people truly alive- the soul.

Leonardo da Vinci never found the Soul nor did he ever find the Prostate! The prostate was first described by Venetian anatomist Niccolò Massa in 1536, and illustrated by Flemish anatomist Andreas Vesalius in 1538.

Prostate cancer was not identified until 1853.

One of da Vinci’s inventions, through his interest in engineering, was the robot.

It is rather apt that a recent development in the treatment of Prostate Cancer is the use of the Da Vinci Robot to perform the Prostatectomy. Hence my introduction!

In February 2008 I was diagnosed with prostate cancer.

I described my symptoms to my GP who said that a PSA test should rule in or out the possibility that I had prostate cancer.

My PSA level was high enough to cause concern and I was referred to a Consultant Urologist at Ealing Hospital.

The results confirmed that I had Prostate Cancer which required urgent treatment.

The treatment through the NHS was excellent and involved Ealing, Hammersmith, and Charing Cross Hospitals. I was also assigned a very helpful MacMillan Nurse.

I feel fortunate and blessed that my encounter with cancer has had a positive outcome. So now I urge all men over 45 to ask their GP for a PSA test.

Your life may depend on it.

In summary:-

1) The PSA test is a blood test that can be an indicator of prostate cancer.
2) Every year in the UK alone 10,000 men die from prostate cancer. With early diagnosis many of these lives could be saved.

Tonight whilst writing this article I received an email about a friend who has been taken into hospital a few days ago and has been told that he has incurable prostate cancer. He is 58 years old and is in considerable pain.

Tuesday, 5th April 2011

Alpharadin trial so successful it has been stopped

Alpharadin, or radium-223 chloride, is a new formulation that specifically targets cancer that has spread to the bone. It is being developed by Algeta and Bayer Schering Pharma AG, and has been studied in a 922-patient randomized study called ALSYMPCA. A planned interim safety check found that the study had achieved its goal of showing an improvement in overall survival, and the study was therefore halted so that patients who were assigned to the placebo arm could be switched over to the treatment.

The analysis showed median survival was 14 months for those on Alpharadin, compared with 11.2 months for those on placebo. Both groups also were given standard therapy (including chemotherapy where appropriate). The full trial results will be presented at the European Cancer Conference in September this year.

What followed was a ‘roller coaster ride’ of tests, biopsy, scans and then the wait for results.

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Tuesday, 5th April 2011
Alpha radiation is a potent form of radiation that travels short distances and in particular targets cancer at bone sites. The study supports the idea that a survival benefit can be achieved by attacking cancer that has spread to the bone. These bone metastases are the main cause of painful symptoms and death among patients with advanced prostate cancer whose disease has progressed despite standard hormonal treatments.

Dr Chris Parker, from the Royal Marsden Hospital, and Principal Investigator of ALSYMPCA, said: “Around 90% of men with advanced prostate cancer have bone metastases, which are the main cause of disability and death in this disease. Advanced prostate cancer has a poor prognosis, and treatment options are limited. Based on the observed survival benefit and its safety profile, Alpharadin may become an important treatment for patients with bone metastases from advanced prostate cancer”

Andrew Kay, Algeta’s President and CEO, said: “The positive outcome of the ALSYMPCA interim analysis is a tremendous result ..., most importantly for the patients with CRPC (castrate resistant prostate cancer) who have bone metastases, which is an area of high medical need where there are few treatment options. Alpharadin, potentially the first alpha-pharmaceutical, demonstrated a survival benefit in this trial for patients with bone metastases and this is an exciting time for the company. We would like to thank all the investigators and patients who contributed to this clinical trial.”

Alpharadin is an investigational agent and is not yet approved for marketing by the European Medicines Agency (EMA), the U.S. Food and Drug Administration (FDA), or any other health authorities. However, Dr Parker tells us that if this treatment follows the same path as Abiraterone, which had similar trials results as these about a year ago, we can expect it to be submitted for NICE approval within the next year.

Beating the Tiger

Bob Arthy and his friends hold a support group for local men who need advice on prostate issues.

Here, Bob gives his honest and touching perspective on suffering with prostate cancer.

“I suppose it all started at the ‘Rose and Crown,’ a popular little pub that me and my friend Jimmy Spence like to frequent from time to time.

We’d both had a high risk and potentially aggressive prostate cancer, or “Tiger” cancer as we like to call it - but we’d survived the treatments, and weren’t expected to be one of the 12,000 men that die from prostate cancer each year. .. well not just yet anyway!

After diagnosis, Jimmy had radiotherapy sessions and I chose surgery.

Neither of us knew much about the prostate gland, buried deep in the body surrounding the neck of the bladder, or its propensity to harbour a deadly killer from middle age onwards.

It’s a big shock when the Tiger strikes, and leaving it unchecked can result in premature death.

So Jimmy and I got chatting about an awareness campaign. We went away and wrote a couple of songs about prostate cancer and got others involved. So, on one beautiful spring morning in 2009, we all hit the streets in Chorleywood singing the songs and chatting, in the main street, in the shops and in the pubs. We collected for Prostate UK and The Prostate Cancer Charity, but much more importantly we were making men and their partners aware that your body needs monitoring and if necessary, checking out down there; especially as middle age approaches. If you have any concerns about your prostate, you should see your GP in the first instance.

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Friends of Prostate Sufferers

Since then we have started Friends of Prostate Sufferers (FOPS) with our President being a local urologist. There are now 10 men in our action group, the majority having been treated for prostate cancer. We hold a Council meeting once a month to push forward our main aims of raising awareness and helping prostate cancer victims deal with the psychological troubles that treatments for this cancer all too often bring in their wake. Our website is www.thefops.org.uk. Make contact, we have travelled down the lonely road ourselves and are now here to help you beat the Tiger.”

Thank you for reading, Bob Arthy

Federation moves up a gear

The Prostate Cancer Support Federation in the four years since its founding, has undoubtedly achieved great things, but maintenance of this pace is threatened by the fact that the charity is currently run on an entirely voluntary basis by the Committee of Trustees who are mostly prostate cancer patients. The burden of the work falls largely on the shoulders of a few men who receive no financial recompense and who all have other things to do with their lives. The Trustees have therefore decided, with financial support underwritten by Prostate Action (see Emma Malcolm’s article on p4), to engage (and pay) a Consultant to act as Development Director, and take over a significant proportion of the work currently done by volunteers, implementing the strategic goals of the Federation, managing day to day activities, providing sound financial management and, in particular, developing and implementing a fundraising strategy.

The person recruited for this post will have the following key objectives:

• To establish the Charity as the primary voice of prostate cancer patients and their partners throughout the UK.
• Within five years, to develop the Charity, and in particular its financial position, to the point at which it is self-sustaining, whilst maintaining and indeed enhancing all its services to member organisations.

The post, which will command a salary of £25,000 for working 3 days a week, will be advertised widely in August. If you, or someone you know, is interested in the position, please contact our recruiting consultant, Anne Ballar (annechantal@btinternet.com), who will provide full details.
Denosumab shows promise over Zoledronic Acid for treatment of bone metastases in men with HRPC – but experts disagree on its value

A recent well publicised phase 3 study compared Denosumab (D’mab, marketed as ‘Xgeva’ by Amgen) with Zoledronic Acid (ZA, the standard treatment) for prevention of skeletal-related events in men with bone metastases from hormone-resistant prostate cancer (HRPC).

In the study, 1,904 men with HRPC were enrolled from 342 centres in 39 countries, and were randomised evenly to receive either 120mg subcutaneous D’mab plus intravenous placebo, or 4mg intravenous ZA plus subcutaneous placebo, every 4 weeks for a year. The primary endpoint was time to first on-study skeletal-related event (SRE), (e.g. pathological fracture, radiation therapy, surgery to bone, or spinal cord compression).

The median time to first on-study SRE was 20.7 months for D’mab compared with 17.1 months for ZA, which is a significant improvement. Adverse events (e.g. bone pain, respiratory infections) were recorded pretty much equally (and distressingly often, about 95%) in both arms, and serious adverse events (e.g. cellulitis) were recorded for 63% of those on D’mab and 60% of those on ZA.

The crude interpretation of these results is that D’mab is better than ZA for prevention of skeletal-related events, and potentially represents a novel treatment option in men with bone metastases from HRPC. As a result, regulators in the European Union have granted marketing authorisation for Xgeva for the prevention of skeletal-related events in adults with bone metastases from solid tumours.

Of course, things are never as clear-cut as this, and, in a study reported to the American Society of Clinical Oncology in June, it was claimed that the added cost of the drug far outweighed the apparent benefits. “What we found is that there were very little gains in quality-adjusted life-years with the use of D’mab - very, very minuscule, about five per thousandths of a year,” senior author Marc Botteman said in an interview. Readers will not be surprised to learn that Mr Botteman’s work was sponsored by Novartis, maker of ZA.

But, in Amgen’s view, these calculations do not take account of the real benefits of D’mab, in particular, the fact that it can be given as a quick injection rather than an intravenous infusion. NICE will be assessing Xgeva in the near future, and we are very keen to feed into this process input from patients who have experience of the distressing effects of bone pain from metastatic cancer. If you’d like to help, contact Sandy Tyndale-Biscoe, on: 01243 572223.

Resources available from the PCSF,
please fill in the number required in the boxes, cut out the form and send to:
Prostate Support Federation, Mansion House Chambers, 22 High Street, Stockport, SK1 1EG
Postage and Packaging will be charged

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<td>It’s A Man Thing, Awareness Card</td>
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