We’re not castrated!

The Prostate Cancer Advisory Group has decided that the term Castration Resistant Prostate Cancer is indeed, as we have said for some time, insulting to men on hormone therapy. In a new document entitled "What does a high quality prostate cancer service look like?" to be published by the Department of Health, the term will not be used. The exact wording to be used to describe what used to be called Hormone Refractory disease (i.e. when conventional hormone treatment fails) has yet to be decided, but to quote Prof Mike Richards, the Cancer Tzar, "I do think we should find a new term if we can", and they will. Unfortunately this means that we don't get to make a record of our song sung at last year’s Autumn workshop, but it does represent an important victory for patient power, and that’s what your Federation’s all about.

Spring Conference and AGM

Leamington Spa

We were welcomed to a damp miserable Leamington Spa for the annual conference and AGM by Sandy Tyndale-Biscoe. He gave a brief review of the past three years and confirmed that the way forward in 2012 was the "Risk Based Approach".

Owen Sharpe (Chief Exec, The Prostate Cancer Charity) spoke about his charity and the Federation working closely together. He felt there was a real opportunity for change and that all men should have access to a good support group. New ways were needed to make these groups more readily available with better on line access to information and more telephone support. Prostate cancer has suffered from not getting true recognition for being the 4th biggest cancer in the UK. There was also the responsibility for having a more consistent voice which is what the Federation is about.

David Baxter-Smith with the backing of the Graham Fulford Charitable Trust performed some 21,000 PSA tests at venues around the country. He re-capped the PSA debate in 2009 where those in favour admitted the test wasn’t perfect but felt it was better than nothing, and those against worried about unnecessary biopsies with false negatives and false positives, leading to overtreatment. He commented that other screening tests for breast/cervical/bowel were also imperfect.

David thought that the attitude of GP’s in the community varied greatly, some not worrying until there were symptoms often too late, and others who were very in tune and interested in getting the correct tests and treatments started. There are no guidelines for urological training of GP’s and this poor exposure leads to poor GP care in lots of practices. He felt there was an overwhelming need for men to be aware of prostate health, family history and PSA awareness.

David Smith went on to talk on the Riskman Protocol and its development. The objectives were to save men having un-necessary biopsies while finding...
Continued from page 1

the earlier aggressive cancers. At present a GP pilot study is in progress with two GPs in the Midlands with links to Birmingham Medical School. It’s a randomised trial with one testing PSA only and the other testing Free to total PSA. Although it is a relatively inexpensive trial, Sanofi Avenis have donated £20,000, leaving £18,000 to find for phase 3.

Riskman needs the help of its Federation members to raise this money and several of the groups were happy to verbally donate with the rest to take the request back to their groups.

Prof. Ken Muir (Uni. of Warwick) brought his usual boundless enthusiasm to the floor. The future proofing of the Riskman Trial is to provide a better diagnostic test with robust and convincing evidence, and to adapt and incorporate forthcoming markers. Both screening and the PSA test have problems but other tests are on the horizon.

With the proposed risk based approach other markers have to be added which need to be cost effective. Although this has been approved, some evidence is needed that it will work, but doors are starting to open. Of the GP’s consulted 78% would be supportive and real data has proved favourable to Riskman. The start up work has been done and is ready to run, but funding is now needed.

An exciting development is genetic testing. There is an elevated risk if there is a family history of prostate cancer, but the exact things being passed on have to be identified. Every gene also known as a SNP adds a score of 5 points. These are all added in to the Sunnybrook calculator which is used in Riskman. PSA is being superseded and may not be necessary in the future. The risk calculator is already changing the whole debate. One third of all the genetic markers have been found. This can reduce by 30% the number of men needing to be screened. There is no more data left! Attitudes to using genetic markers are the way forward with targeted screening. Those younger men with a high genetic risk should go in to the screening programme.

There is a unique opportunity to design a proper screening programme and get it right! A baby could be genetically screened at birth which would cost around £1,200 about the same as for personalised screening. This may be a difficult concept for the NHS and it is probably 10yrs off happening.

As usual we were well looked after and had a very enjoyable lunch, followed by the AGM.

The afternoon session started with Prof Norman Maitland (Uni of York) on “Moving beyond PSA - Future prospects for Diagnosis and Screening”.

The natural history of prostate cancer is not well understood. Tests on a whole prostate gland can show a number of different cancers within that one organ. With sometimes multiple tumours present, the difficulty is finding the ones which will be fatal. Ideal markers for diagnostic screening are that they must be cancer specific, accessible, stable and stand up to rigorous blind testing.

Better sensitivity and specificity tests must be developed. All markers for diagnosis and prognosis will work better in combination. A glimpse into the future: The detection of circulating cancer cells which can be fluorescented and then tracked and cell tracking in patients with viruses. The cancerous stem cells have to be knocked out. The dark side of chemotherapy is that the stem cells are not killed off but radiotherapy can kill them.

The workload of a GP is immense, dealing with surgeries, paperwork, visits, prescriptions, reports and medicals. He or she may have 2,000 patients, work extended hours and be running a small business coping with staffing, IT, finances etc. But their role is very important in the detection of aggressive prostate cancer. Emma Malcolm from Prostate Action is taking roadshows around the country to educate GP’s and make them more aware of this disease.

Overall a great deal of progress is being made on the understanding of prostate cancer and the best ways to treat it.

Emma Runs the London Marathon 2012

Hearty congratulations to Emma Malcome, CEO of Prostate Action, who raised over £5000 by completing the London Marathon. Yes, all 26.5 Miles!! VERY WELL DONE INDEED.
Having been told as a schoolboy that as a result of deteriorating eye-sight and the need for spectacles I would not be able to fulfil by childhood ambition to become a train-driver I turned my aspirations to the next best career choice of becoming a surgeon for whom I was assured perfect vision (without glasses) was not a requisite. It was, however, a necessary condition for admission to medical school to pass G.C.E. examinations in Mathematics and Latin (as well as a few other non-obligatory subjects). I managed with some facility to convince the examiners of my numeracy skills but classical endeavours proved more taxing although eventually satisfactory such that I was admitted to Trinity College, Dublin.

I pondered for a long time the necessity for the fluency in Latin. It was in the fourth year of medical school that all was revealed and we were told about the “per rectum” examination. With a well-lubricated and gloved index finger we could locate any anal, lower-rectal or prostatic pathology and without such an examination we might be considered by the General Medical Council to be negligent. The professor of surgery clearly told us that from a diagnostic point of view “if you don’t put your finger in it you might put your foot in it”!!

It is, therefore, after forty years of carrying out this clinical examination and having done an estimated 40,000 (including five members of the House of Lords whose prostates are much the same as commoners) that I now question the value of this test.

Even with a size 8 1/2 glove an acromegalic* or arachnodactylic** (that’s why I needed a classical education) doctor can only palpate about a third of the circumference of the posterior surface of the prostate and not appreciate any denser abnormalities within the prostate gland. A T3 or T4 tumour within the gland may be appreciated by the discerning finger but these tumours, if aggressive, are nearly always but curative treatment. A T2 tumour may be found with a sensitive pulp applied to it but potentially aggressive and yet equally potentially curable T1 tumours will, by definition, not be felt. The owners of these prostates may then be given bad advice and told that “all is well” even if a blood test for P.S.A. is elevated.

In a recent survey [1] of 610 questionnaires returned by final year medical students only 42% had had a compulsory clinical attachment in Urology lasting on average one week. 46% had had compulsory attachments partially based in Urology but mainly with other surgical specialties. Lectures and anatomy sessions were the main teaching methods. It was noted that 24% of these students had received their urological training from G.P.s. and 21.2% of the students had already expressed General Practice as their career intention although it is estimated that approximately 50% of all medical students will become G.P.s. (Between 5% and 10% of a G.P.’s consultations are for a urological condition [2]). There are currently no national guidelines for urological undergraduate education in the U.K.

A further recent survey [3] of final year medical students at Manchester University reported low levels of confidence to manage common urological conditions and it has also been shown that poor exposure to urology as an undergraduate results in poorer patient care in the community [4]. A survey of foundation year doctors at 28 different medical schools showed that 90.7% felt that their undergraduate teaching in urology was suboptimal [5]. The same survey showed that the majority (61.5%) felt unable to distinguish an abnormal feeling prostate from a normal feeling prostate.

So where does that bring us to in the twenty-first century? No longer do we have a “per rectum” examination but we now have a Digital Rectal Examination (D.R.E.) - everything has gone digital and we have digital cameras, digital radios, digital television and even the rectal examination has gone digital!! It is clearly shown that undergraduate training is deficient in preparing our present General Practitioners who are then required to make potentially life and death decisions relating to possible life-threatening conditions within a man’s prostate.

“Don’t worry about your raised P.S.A. You haven’t got any bothersome symptoms and your prostate feels quite normal so come back if you get trouble” is the story I have heard on numerous occasions. That is tantamount to saying “Don’t bother me now that you may have an early and yet potentially aggressive but curable prostate tumour (T1) come back later (when it has become a T4X0M1) and it is incurable.”

I do not, therefore, believe that G.P.s with an inadequate urological training should be making such decisions. Any man with a P.S.A. above the normal threshold should be investigated by an experienced consultant urological surgeon and not even a junior doctor and certainly not a nurse.

That would be one way of identifying and treating (where appropriate) early potentially aggressive and curable prostate cancer.

*acromegalic - someone who has a disorder of the pituitary gland causing among other things long fingers

** arachnodactylic - long spidery fingers associated with a genetic disorder.
MDV3100 acts as a very potent antagonist of androgen receptors, and binds to the receptor very tightly. It is more potent and more specific than older antiandrogens, some of which had agonist and antagonist activity; this has led to MDV3100 being called a “super antiandrogen.”

It is also unique in that it inhibits androgen-receptor signaling, which is a key driver of prostate cancer growth. It has several sites of action: it inhibits the binding of androgens to the androgen receptor, it inhibits nuclear translocation of the androgen receptor, and it inhibits the association of the androgen receptor and DNA inside the cell nucleus.

It was specifically designed to block the androgen receptor and the androgen-receptor signaling that is considered to be a driver of this disease.

**Affirm and Prevail MDV3100 Trials**

**Affirm**

The phase 3 study, known as AFFIRM was conducted in men with metastatic hormone-resistant prostate cancer (HRPC) who had progressed after treatment with docetaxel-based chemotherapy.

Results from a large phase 3 study of the agent MDV3100 in advanced prostate cancer has exceeded expectations and after interim analysis has been stopped after it showed a 37% reduction in the risk of death over the placebo. The 18.4-month median survival against 13.6 for the placebo compares starkly with the equivalents in Abiraterone and Cabazitaxel.

The results from AFFIRM are part of the approval application that the manufacturer, Medivation, has already filed with the US Food and Drug Administration (FDA). The FDA has granted fast-track designation for this postchemotherapy indication.

This is a niche that has been filled with new agents over the past year or so. In addition to MDV3100 for use in post docetaxel HRPC, the radiopharmaceutical radium-223 chloride (Alpharadin, Medivation) — will soon be submitted for FDA approval for use in HRPC patients with bone metastases. In addition, 3 other products have recently been approved for use in this patient population — Abiraterone (Zytiga, Janssen), Cabazitaxel (Jevtana, Sanofi), and the vaccine sipuleucel-T (Provenge, Dendreon).

Currently, there are no clear guidelines about which agent should be used when, but there is plenty of discussion. However it is expected that the benefit/risk profile of MDV3100 will likely position MDV3100 as the front-line agent for post docetaxel HRPC.

**Details of Results**

The AFFIRM study was conducted in 1199 men with progressive HRPC who had failed on docetaxel; they were randomized in a 2:1 ratio to receive oral MDL3100 160 mg once daily or placebo.

The survival benefit that led to the early termination of the trial was supported by favorable changes in several secondary end points, A significantly higher proportion of patients on MDV3100 showed tumor shrinkage on computed tomography or magnetic resonance imaging and had a decline of 50% or more in prostate-specific antigen (PSA).

Time to disease progression, assessed by either imaging or PSA decline, was 5 months longer, on average, in the MDV3100 than in the placebo group.

MDV3100 is “extremely well tolerated.” The data on adverse events showed slightly fewer events, numerically, in patients in the MV3100 group than in the placebo group, but individual adverse events were not specified. It was reported that 5 patients in the MV3100 group and 0 in the placebo had seizures, but this could be because these were patients who were very sick and were taking other medications. Overall, the frequency of the adverse events reported with MV3100 was less than with placebo.

**Prevail**

Is a second phase 3 trial and is being conducted in patients with metastatic HRPC who are chemotherapy naive.

Recruitment for this trial is still ongoing in countries except the USA and no results have yet been published. One of the UK trial sites is the Royal Marsden Hospital and informally the results are showing great promise. Potentially this a drug that could replace Bicalutamide (Casodex) as a primary treatment for metastatic cancer and have a long life as a treatment that also suppresses the transcriptional activity of the mutant receptors. However a third trial going head to head with Bicalutamide might be needed to confirm the efficacy of the drug at this part of the pathway.

**Glossary**

**Agonist** - is a chemical that binds to a receptor of a cell and triggers a response by that cell

**Antagonist** - Whereas an agonist causes an action, an antagonist blocks the action of the agonist
Providing a positive experience of care for patients, service users and carers is one of the five domains in the NHS Outcomes Framework, reflecting the importance we are placing on patient experience. The Framework sets out that it is now standard practice in healthcare systems worldwide to ask people to provide direct feedback on the quality of their experience, treatment and care. When analysed alongside a range of additional information sources (including complaints and operational data), this information provides local clinicians and managers with intelligence on the quality of local services from the patients’ and service users’ point of view, which means that patient feedback has an important role to play in driving improvements in the quality of service design and delivery. Making information publicly available on patients’ experiences of care in different hospitals should also drive up quality and should promote informed choice for patients.

The first large scale survey of cancer patients’ experience of care in England was undertaken in 2000 by the Department of Health. This involved patients with six cancer types (lung, breast, bowel, prostate, ovary and Hodgkin’s Lymphoma). At that time patients with prostate cancer in general reported a poorer experience of care than those with the other three most common cancers. Comparisons with the experience of care of women with breast cancer were particularly unfavourable.

In 2004 the National Audit Office undertook a comparable survey, but on a smaller scale. This showed that prostate cancer patients continued to report a worse experience of care than those with breast, bowel and lung cancer.

The 2010 cancer patient experience survey included all cancer types, and patients from all 158 eligible Trusts participated in the survey. Over 100,000 adult patients who had received cancer treatment as either an inpatient or a day case between January and March 2010 were invited to participate and nearly 70,000 people did so, a high return rate for surveys such as this. Key findings include:

- the experience of patients with forms of cancer where comparable data are available (lung, breast, bowel and prostate cancer) has generally improved since 2000
- patients with rarer forms of cancer generally report a significantly worse experience of their treatment and care than patients with the four most common forms of cancer
- the care provided by clinical nurse specialists (CNSs) is valued highly by patients, with those who had access to a CNS (84%) reported a significantly more positive experience than those who did not
- the experience of men with prostate cancer, has significantly improved and prostate cancer is no longer an outlier

I think the main reason for men reporting a more positive experience of care in 2010 was the implementation of the NICE Improving Outcomes Guidance in Urological Cancers in the mid-2000s. This guidance came out later than guidance for the other more common cancers, and the quality improvements we have seen over the last few years would not have been experienced by patients in 2000 and 2004. Indeed on some questions prostate cancer reported more positively than those with the other common cancers. They were most likely to be given written information, a choice of treatments, and to be involved in decisions about their treatment.

However, there are still areas for improvement. Compared to the other three more common cancers, prostate cancer patients were less likely to be given the name of a CNS (81% prostate, 91% other common cancers) and less likely to report hospital staff providing information on finance and benefits (35% prostate, 54% other common cancers).

Although the 2000 and 2004 surveys were important in helping us understand services nationally, feedback suggested they had little impact in driving improvements in the quality of services locally. In order to address this, for the 2010 survey we developed a series of actions to make the survey more relevant and important locally. Following the publication of the national report in December 2010, we published 158 bespoke Trust level reports, which included comparisons of teams within hospitals where there was sufficient data. The survey provider Quality Health has visited the 10% worst performing Trusts to explain their results and offer practical help on actions to improve the experience of their patients.

Another key part of disseminating the 2010 results has been benchmarking, as shown in the figure below, with Trusts in the top 20% on a specific survey question shaded green and those in the bottom 20% shaded red. The difference is
striking. The challenge now is for the “red” Trusts to improve their performance. Each row represents one of the 67 items in the questionnaire and each column represents a different NHS Trust. As a result of this action, the survey is clearly having an impact locally this time around. For example, the London cancer networks have produced an action plan to improve experience in London hospitals, and every Trust in London has produced their own action plan. The survey data has also been made freely available to allow a series of analyses to be undertaken on such a rich data source and to enable commissioners and providers to focus on the areas for quality improvement locally.

To keep up the momentum, we are already repeating the survey. The 2011/12 survey will cover inpatient and day case patients over the period 1st September 2011 to 30th November 2011. Nearly 115,000 patients have been sent a questionnaire, and we expect the national and Trust level reports to be published in June 2012. These will contain comparisons with the 2010 survey, and I would urge all PCSF members to look at their local hospital results. In line with the new Health and Social Care Act, the NHS Commissioning Board will be responsible for quality improvements in the NHS in the future. Two of the Board’s stated principles are a clear sense of purpose focused on improving quality and outcomes, and putting patients, clinicians and carers at the heart of decision-making. Groups like the PCSF will be very important in helping the Board achieve this, especially in identifying opportunities for improvement from data sources such as the cancer patient experience survey.

The national and Trusts level reports can be found at the following link:
http://www.quality-health.co.uk/cancer-survey-materials

---

Peripheral Neuropathy

Peripheral Neuropathy is a burning or itching itching of feet and hands, which can spread up the ankles or wrists which is particularly annoying at night.

Often associated with loss of feeling in the feet or hands and deterioration of balance. There are over 70 causes of PN. It can lead to extreme and continuous pain. The obvious known causes are chemotherapy treatments for cancers, diabetes, lack of certain vitamins, particularly B12, or previous exposure to radiation or toxic minerals, e.g. lead. There has been new research showing that intake of gluten can aggravate it in certain instances (even though that person has no celiac symptoms). There is no known cure, though a gluten free diet can mostly cure it, if stuck to for long enough – IF that is the cause! (This is very new research, and not accepted or known about by many neurologists).

It has been reported by members that it ust might be an after effect of a prostatectomy. If anyone has these symptoms, please would you get in touch with Ian Graham-Jones at ian@grahamjones.plus.com

---

A Bioscanner in every Pharmacy

Chorleywood Hertfordshire, so the papers say, is one of the best places to live. We Friends of Prostate Sufferers (FOPS) hosted a Prostate Roadshow there last June with a tripartite Consultants Forum of David Baxter Smith, Alvan Pope and Julian Shah who first explained the prostate and then answered questions for over an hour which encouraged 150 men to give blood for PSA testing.

Since then we have been advertising the new Bioscanners, supplied by the Graham Fulford Trust, which are now installed in both local Pharmacies and doing a great job of testing men who walk in and, after having the seven golden rules explained to them, walk out with a PSA test result twenty or so minutes later.

As you can see from the advert below men who have received a normal PSA result are so grateful that it must become another of our missions to install Bioscanners into Pharmacies throughout the land so we can thwart more Tigers.

Bob Arthy
Surgeon experience – key to successful outcome for prostatectomy

By Sandy Tyndale-Biscoe

Recent research, published last year in the BJUI, shows something that we all expect, that the more experience of carrying out radical prostatectomy (RP) a surgeon has, and the more of such procedures he or she does per year, the better the outcomes and, in particular, the lower the likelihood of positive surgical margins (PSM) and biochemical recurrence (BCR, i.e. rising PSA).

Alarmingly, the research shows that less than half the surgeons in the UK carrying out RPs do more than 10 procedures per year, and only 6% of them can be regarded as experts in the field (doing more than 30 procedures per year).

The authors undertook a detailed analysis of the British Association of Urological Surgeons (BAUS) Section of Oncology Complex Operations Database to report UK outcomes of RPs with operative variables, including the surgical approach, lymphadenectomy status, blood loss, hospital length of stay and individual surgeon case volume.

The postoperative variables assessed included surgical specimen Gleason score and pathological tumour stage, prostate weight and the presence of PSM, as well as evidence of BCR.

A total of 8032 RP cases were entered on the database and follow-up data was available on 4206 of them. Mean patient age was 61.8 years and the mean presenting PSA was 8.3ng/mL. Open RP procedures were performed on 5429 patients and laparoscopic RP on 2219. The PSM rate for the entire series was 38%. Multivariate analysis of variables which might affect PSM revealed pre-operative clinical stage, surgeon case volume, RP specimen Gleason score and pathological stage were significant parameters.

Analysis of annual surgeon caseload revealed that 54% of surgeons performed an average of less than 10 procedures per annum and only 6% of surgeons performed an average of 30 or more procedures per annum. When individual outcome variables were examined against surgeon case activity it was demonstrated that outcomes are clearly improved beyond 20 cases and there is a trend to continued improvement up to the series maximum of 40 cases per annum.

The relationship between surgeon case volume and improved outcomes has been extensively examined across surgical specialties in recent years. A well established link has been described for a number of high-risk surgical procedures associated with higher mortality rates. An increasing body of evidence has suggested improved outcomes amongst higher volume RP surgeons with respect to mortality, early and long-term complications, length of stay, and PSM and BCR rates.

In the UK, the first steps towards provision of high volume surgeons was made through the 2002 Improving Outcomes Guidance (IOG). A threshold of 50 urological pelvic oncology cases (RP or cystectomy) was set for the hospital. However, an annual minimum case volume of only 5 such procedures was set for an individual surgeon.

RP has an almost negligible peri-operative mortality rate and therefore mortality alone is not a good proxy measure of outcome. Analysis of more procedure specific and oncological outcome measures was required. Using such variables, the authors have shown increasingly better BCR outcomes when surgical RP caseloads exceeded a threshold of between 15 and 20 cases per annum, and beyond these threshold figures, the improvements in outcomes trend continues. This level of surgeon activity is significantly higher than that currently recommended in UK guidelines.

This is not news. Studies published in 2008 and 2010 showed that the learning curve for cancer control after RP is steep and does not start to plateau until the surgeon has performed about 250 operations. Treatment by surgeons who have performed 10, rather than 250, previous open radical prostatectomies is associated with a significantly higher relative BCR risk. Based on current IOG guidelines and on the current UK annual surgeon median RP caseload activity of just five cases per annum, it will take the average UK urologist 50 years to reach the peak of this learning curve plateau. This amounts to twice the career working lifetime of a NHS urological surgeon.

In the report, the authors suggest concentrating RP surgery into the hands of surgeons performing no less than 20, and ideally 35–40 or more RP cases per annum. By this means, surgeons may at least reach the peak of their learning curve considerably sooner and well before the middle, rather than at the end of their urological careers. We strongly support this approach.

What can the individual patient do in the face of the likelihood that he will be offered a serious surgical procedure by someone who is, to put the best slant on it, not at the top of his or her game? First and foremost, he can ask what his surgeon's total case volume is, how many of these resulted in PSM or BCR, and how many procedures he or she does every year. These are figures everyone is entitled to know, and if the surgeon is reluctant to provide them, it says something about his or her attitude to the job. If your surgeon's total experience is low, say between 50 and 100 procedures in total, ask whether the procedure will be supervised by someone more experienced. If you are left with doubts, or the surgeon is really low on the learning curve, you can always ask to go elsewhere. Unfortunately, with the IOGs setting the currently ludicrously low level of case volume of 5 per year, you may not win the argument to be treated at a higher volume centre.

However, there is always one other route out of the dilemma. The implications of this study are profound for the decision about whether to go for surgery or radio-therapy (RT), a very difficult choice faced by almost all men diagnosed with early stage disease. If, as was the case when I went through this agony, you are spending hours looking at all the factors that indicate the probability of local spread, and the likelihood of successful surgery, you have a new factor to take into account that trumps all those ones about prostate volume and whether the tumour is T2a, b or c. If your surgeon hasn't done at least 100 RPs and isn't doing at least 20 a year, you can forget all that. Ask to see an oncologist and then go for RT or brachytherapy. The outcomes are very much the same, and operator experience doesn't seem to count so much.
Prostate Matters is published four times a year, providing news, information, personal memoir and opinion about prostate cancer. It also reports, quotes and cites published medical views and research findings about prostate problems.

The Federation does not promote any treatments or dietary, drug, exercise or lifestyle change intended to prevent or treat a specific disease or condition. Anyone who wishes to embark on any such treatments should first consult with and seek clearance from a qualified health care professional on any treatment or lifestyle changes.

Gloria Hunniford
Our New Patron

Gloria Hunniford is a well-known TV and radio personality; her career spanning 30 years. Born in Ireland in 1940, Gloria started her career as a singer and went on to be the first woman to have her own daily radio show on Radio 2, which she presented for 13 years. For many years she hosted a very successful television chat show, Sunday Sunday.

Gloria currently presents Cash in the Attic for BBC1 and Cash in the Celebrity Attic for BBC2 as well as Rip-Off Britain for BBC1 and Angels for Sky Real Lives. Gloria has also co-hosted The One Show, is a regular on The Alan Titchmarsh Show for ITV1 and was the co-host of Castle in the Country for BBC2. Gloria has won many awards including TV Personality of the Year, Radio Personality of the Year and, in 2001, a Lifetime Achievement Award.

Gloria has a deep understanding of how a family is affected by a diagnosis of cancer. In April 2004 Gloria’s daughter, Caron Keating, also a television presenter, died of breast cancer at the age of 41, leaving two young boys. The year after Caron died Gloria wrote a book called Next to You, subtitled “Caron’s Courage Remembered by Her Mother”. In Gloria’s ‘Letter to Caron’ on she writes:

Watching you bravely battle with cancer has taught me so much about positivity, tenacity, dignity, spiritual growth and integrity.

We are extremely grateful to Gloria for agreeing to be our Patron.

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

We are delighted to announce that Gloria Hunniford has joined Dr Thomas Stuttaford as a Patron of the Prostate Cancer Support Federation.