Five years ago, we published an article in the Spring 2012 issue of Journey,(a “donors” publication from the Dattoli Cancer Foundation) entitled “New Options in Metastatic Prostate Cancer Treatment.” Provenge®, a form of immunotherapy, had just been FDA approved and was finding its way to patients who had exhausted both hormone therapy and chemotherapy. While the reported overall survival improvement from using the drug was only four months, this positive direction gave new hope to many who were facing failure. Research developing Provenge® also led to similar prostate immunotherapeutic agents including Prostvac® as well as many other exciting and novel immunotherapeutic agents, which hopefully will soon to be “fast tracked” by the FDA to the marketplace. \(^2\)

Also debuting around that time were Zytiga®, Xgeva® and Jevtana®, which are now among the agents regularly prescribed for recurrence of prostate cancer. Additionally, Xofigo® (Radium -223), an alpha particle radioisotope, can be delivered in a one minute infusion which attacks prostate cancer which has spread to bones. Not only does Xofigo® relieve bone pain, but it also improves overall survival. Xofigo® is now being combined with Zytiga®, Xtandi® and Provenge® and the combination appears to be synergistic.

Whereas Xofigo® only treats bone, other injectable isotopes called Actinium-225 (alpha emitter) and Lutetium-177 (beta emitter) attach to prostate-specific membrane antigen (PSMA). PSMA is found on the surface of most metastatic prostate cancer cells. Therefore, these newer isotopes treat not only bone, but can target metastases in any tissue or fluid, even undetectable systemic micro-metastases. Since they are alpha and beta emitters (very short range), there is far less toxicity to bone marrow or other nearby tissues. Lutetium-177 is currently being used investigationally while Actinium-225 is in the pipeline and we hope it will be released soon.\(^3\)

Xgeva® (denosumab) is a subcutaneous injection given monthly to treat and to deter further bone metastases by blocking the glycoprotein known as RANKL (receptor activator nuclear factor ligand) which plays an important role in prostate cancer proliferation in bone. This is used in prostate cancer patients having documented spread to one or more bone sites. In this setting, patients receive 12 consecutive months of Xgeva® and then enter a 3 month holiday. We are also currently using denosumab in patients without skeletal metastases in lower doses (Prolia®) given once, every 6 months to help strengthen the bones in prostate cancer patients who are on ADT with the added potential benefit of deterring metastatic bone spread. Meanwhile we are awaiting the outcome of trials delivering Xgeva® monthly in patients having organ confined, high-risk non-metastatic prostate cancer.\(^4\)

There is also a lot of interest in combining immune therapies with other agents, drugs and especially radiation. Combining radia-
tion with immunogenic drugs has great promise since the effects of the body’s immune response to cancer is enhanced. These immunogenic synergistic effects of radiation and immunogenic drugs (especially “check point” inhibitors and PARP inhibitors, to be discussed later, and even Zytiga® and Xtandi®) are thought to result from “autovaccination” by antigens released from dying cancer cells and fragmented, damaged DNA. Mechanistically, radiation (all types, even Xofigo®) has been shown to augment the afferent, as well as the efferent arms of cancer immunity. The induction of a positive T-cell response against cancer has been observed in numerous studies.

Looking back over those five years, in addition to new drugs, we have seen some interesting trends. One we believe is the unfortunate by product of a recommendation made by the U.S. Preventive Services Task Force (USPSTF) in 2012 that has discouraged men from getting routine PSA’s, and is predictably resulting in more men presenting with advanced cancer to lymph nodes and bone beyond the prostate gland than previously seen. Yet another alarming trend is the dramatic increase in numbers of men coming to us very shortly after having robotic surgery, reporting that their PSA never fell following surgery or if it did fall, it soon began to climb again and did so rapidly in many cases. These are men who believed that robotic surgery would resolve their prostate cancer threat with lesser side effects than conventional prostatectomy (“open retro-public”). These cases are not strictly “recurrence” but more correctly “persistence.” Their initial, original treatment did not remove all of their prostate cancer, and a secondary treatment (radiation or hormones or both) is required. If we see these men early enough following surgery (the lower the PSA, the better) we have had good success in defeating their cancers, once and for all, utilizing “Salvage” Dynamic Adaptive Radiation Therapy (DART) to maximally avoid unwanted toxicities to neighboring critical organs and structures. Perhaps if we had seen them first, our combination radiation assault coupled with brachytherapy, most likely would have totally eliminated their disease in the first place, and the patient could have been spared the side effects of surgery. Nonetheless, surgery remains an option in select patients following advanced diagnostic staging.

One encouraging observation of these patients with persistent disease is that the word is finally getting through to urologists and oncologists that as soon as the PSA starts to rise, the patient should be evaluated for further treatment. In the recent past, these men (the patients and their physicians) often waited until the PSA was up around 2.0 or higher before any action was taken. Today we know that if the PSA inches up to even 0.2, or two consecutive rises after surgery (even if less than 0.2), one should start considering further treatment (radiation +/- hormones). Recognize that prostate recurrence following surgery may be comprised of high grade, mutated, undifferentiated cancers which bear little resemblance to the “parent prostate cell.” In view of this, they often flourish and yet produce minimal amounts of PSA.

So what is in store for the man whose rising PSA following surgery signals the recurrence or persistence of his prostate cancer? The first thing is to verify the presence of disease, and whether it is local (in the “prostate bed” – tissue left behind) or beyond the prostate or both. Newer, more sophisticated diagnostic technologies can determine the location (s) of recurrent/persistent malignancy. Is it still in the prostate bed and/or has it traveled to the lymph nodes or bone?

WHAT IS THE “PSA BOUNCE”

PSA Bounce or “flare” is a phenomenon experienced by about 30-40% of patients who have undergone prostate brachytherapy (seed implants) and 10-20% of patients receiving temporary High Dose Rate prostate brachytherapy. While the most thoroughly analyzed patients are those having permanent seed implants, it has also been reported to occur in patients having undergone prostate irradiation alone to high dose level and we are even seeing this phenomenon occur in patients undergoing nodal radiation. It is a temporary rise in PSA occurring about 18-24 (range 6 – 36) months following implant, possibly caused by radiation induced prostatitis (inflammation of the prostate which may be clinical and associated with prostate symptoms, or subclinical – that is, asymptomatic) triggering a release of PSA.

Interestingly, in approximately one third of these cases, there is no prostate in-
flammmation. This is not recurrence. The “bounce” seems to occur more often in younger men (55 years or younger), and in men of all ages having larger prostate glands. The PSA bounce may subside with a course of antibiotics or alpha-blockers or anti-inflammatory medications, supplements or it just diminishes naturally over time.9

I believe that I may hold the world record for the highest "benign PSA bounces." I performed brachytherapy on a 45 year old male from Ireland approximately 15 years ago and later his PSA increased to as high as 28.6! Urologists hovered over him wanting to remove his prostate. They didn’t (this took a lot of convincing) and now, 15 years later, his PSA is undetectable.

After a thorough review of the recurrent patient’s history and current lab and imaging reports, ruling out “local” extension of the disease (meaning the immediate area outside the prostate gland), we may recommend an advanced lymph node screening exam as well as screening for metastatic disease spread to bone and visceral organs. Prior to 2009, these men were sent to The Netherlands for a Combidx scan, which used nanoparticle technology to detect distant prostate cancer spread. For more than 5 years, we have been sending men with suspected “distant” metastatic disease for another nanoparticle test called “Feramoyxtol” (Feraheme) which has high predictive accuracy to pick up on lymph node disease. This is most commonly coupled with an ¹¹⁸F PET/CT scan, a very exacting test detecting disease spread to bone. These nanoparticle tests are known as USPIO scans (ultra-small super paramagnetic iron oxide) or Feraheme, referring to the reagent used in imaging. The method of action is the same. The patient is injected with the reagent one day, and the scan is performed the next day.10

The reagent used will “light up” the lymph chain and clearly indicates which nodes are harboring active prostate cancer cells. With this information, we can design precision DART treatments to address those specific lymph nodes and treat them at a high dose level. Since the test is based on advanced CT and MRI imaging, visceral metastasis to liver and lung can also be detected.

Other advanced imaging tests include PET/CT C-11 Choline and PET/CT Carbon Acetate C-11 scans. Aside from nanoparticle imaging, other functional and molecular imaging is being carried out. For example, Gallium-68 PSMA (Ga-68) is being investigated and has great promise. It attaches to PSMA which is on the surface of metastatic prostate cancer cells and can therefore detect bone, lymph node and visceral metastases with high predictive accuracy, even with low PSA’s. Because Ga-68 is much more stable than C-11 Choline (which is short lived and has to be made one dose at a time at select imaging centers), Ga-68 PSMA test could be used at medical centers around the nation.

Meanwhile, 3D color Flow Power Doppler Ultrasoundography (used at our Center and a few select centers worldwide) can pick up intra-prostatic cancer recurrence. I have personally reseeded up to 1,000 patients with intact prostates, with great success and limited morbidity. This is referred to as “salvage” prostate treatment (either partial prostate or entire prostate). Other potential options include, but are not limited to, cryoaulation (freezing), HIFU (heating), biothermny (freezing and heating), Nanoknife (irreversible electroporation) and focal MRI guided interstitial ablation. Each has its own benefit and side-effect profile.

Any of the above can treat the entire prostate gland or a portion of the gland (i.e. partial treatment). Partial treatment should never ever be recommended as initial treatment and should only be considered as salvage therapy. Similar to breast cancer, prostate cancer is also a “field effect” disease. That is, what has happened at one or several locations, will occur elsewhere in the gland since all cells have been subject to the same environmental cues and genetic predilections. This will lead to multiple future focal treatments and greatly increased morbidity. Additionally, more traditional and effective salvage therapies will be compromised in patients having initial partial treatments.

Most patients who recur in the prostate gland will be identified have spread to other sites following careful re-staging. Even if the re-staging proves negative, I most often combine salvage re-seeding along with DART to relevant nodal chains, as the possibility that lymph nodes harbor microscopic cancer. To date, even the most sophisticated, advanced diagnostic tests cannot pick up microscopic disease.11-12

We have been collecting

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data on these cases, namely men having lymph node and boney disease spread, and we are in the process of preparing an article to report our success in utilizing Feraheme and other functional and molecular imaging tests to denote lymph node spread as well as in treating patient subsets in an upcoming medical journal. We are working with the University of Washington in Seattle and the preliminary results look extremely favorable. We are also partnered with Harvard University using yet another advanced imaging test, $^{18}$F – Fluorocitovine, more commonly known as an “Axumin-Enhanced PET Scan,” with impressive early results picking up residual/recurrent disease within the prostate/prostate bed, lymph nodes, bones and visceral metastasis.

Beyond this direct approach with radiation and 2nd-line hormonal therapies there are new immunotherapy agents in the testing process, which ramp up both B-cells and especially T-cells to attack prostate cancer cells. These are broadly known as “check point inhibitors” and encompass a class of drugs including anti-PD-1/PDL-1 inhibitors (e.g. Opdivo® also known as nivolumab, etc.) as well as anti-CTLA-4 (Yervoy®). These immune checkpoint inhibitors are currently being used in other cancers and have been FDA-approved for melanoma, lung and kidney cancer.

Genetic testing, (especially BRCA1/BRCA2 in prostate cancer) is becoming increasingly important, as is molecular profiling, to select the right drugs for the specific tumor. A recent survey from Memorial Sloan-Kettering Cancer Center suggests that immunotherapy agents for prostate cancer show enhanced benefits when utilized in combination with various biologic agents, chemotherapies, and radiation. For example, patients having BRCA2 mutations most commonly respond to yet another group of novel drugs called PARP inhibitors (poly ADP-ribose polymerase) to help determine if patients will respond to the immune drug Lynparza®. We anxiously await the release of the PARP inhibitor drug Lynparza® for patients who are initially resistant to Zytiga® or Xtandi®, or who become resistant over time. Meanwhile a test analyzing serum called “droplet digital PCR assay” can help determine patients who will best respond to Zytiga® and Xtandi®. The biomarker Androgen Receptor Splice Variant-7 (AR-V7) expression in tissue, and more recently in blood, could predict resistance to Zytiga® and Xtandi®, although it could help personalize checkpoint inhibitors, or possibly even chemotherapies more specifically designed for the tumor.

We are hopeful that these checkpoint inhibitors and other novel therapies are “fast tracked” by the FDA, similar to the experience with Zytiga® and Xtandi®.

BE VIGILANT, ACT PROMPTLY

In conclusion, the message here is that all men who have had a prostate cancer diagnosis and have been treated with any method should be very vigilant in watching their PSA. The moment it starts to rise, extra concern should be given to the rise, and finding out why it is rising. While drugs like Proscar® and Avodart® are known to reduce the PSA, many men take vitamins/supplements and change their diets and lifestyles following a prostate cancer diagnosis and treatment. This is a very good thing, with the objective being to slow the rate of the PSA rise, velocity and doubling time, and to improve general health. There is, however, the scenario, especially with “Active Surveillance” whereby the PSA declines (without Avodart® or Proscar®) which may lull patients into a false sense of security. As previously described in patients following surgery, this is the case since some cancers may mutate, become more aggressive, no longer resemble the parent prostate cell and are no longer obliged to even make PSA! This is a great cause for concern. This phenomenon is even missed by some of the most astute urologists, oncologists, and even some prostate oncologists.

Final note: Like early diagnosis, the best time to treat a recurrence is as soon as it is evident.

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Source: Dr. Michael Dattoli, Dattoli Cancer Center, 2803 Frutieville Road, Sarasota, (941) 957-1221

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Our thanks to those who help us continue our outreach.

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In Memory of Peter Randlev
Walt & Diane Sutkowski

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Merry Christmas
In Memoriam

We are sad to report the passing to two of our long time members who contributed much to our group over the years, Peter Randlev and Robert Lee (Bob) Smith.

Peter Randlev was born on August 14, 1928 in Evanston Illinois and died October 4. Those dates impart nothing of the caliber of the man, his generosity and accomplishments. Peter passed away while visiting his home town which included a visit to his old high school where he was feted and thanked for his donation to his alma mater. He was buried next to his parents in line with his wishes. He is survived by his wife, Yvonne, whom he married 45 years ago and many cousins and friends all over the country.

Peter graduated from Northwestern University with a degree in electrical engineering and was even a member of the marching band. It was the continuation of his lifelong interest in music and the arts. We can remember his attending many West Point band concerts over the years that he and Yvonne lived in Rhinebeck.

Peter served with the US Army in Korea, surviving the battle of the Korean Winter. His service encompassed many posts in the US and he was even one of the “Atomic Soldiers” who witnessed the nuclear tests in our southwestern deserts.

Peter, as so many of our group, worked for IBM where he retired as a Senior Engineer. He was the holder of many patents and creator of several inventions. In 2008 he won the X12 Gilbert Award which recognizes outstanding long term actions, activities and professional accomplishments related to development and implementation for X12 standards. The X12 is the standard for Electronic Data Interchange.

Bob Smith, as he was known to us all, fought a valiant battle for the past 15 years with prostate cancer. He was born in April, 1940 and passed away September 2. He leaves his wife, Joy O’Connor, two daughters Jessica and Jacklyn and several grandchildren.

Bob was always willing to help those newly diagnosed and never forgot to mention that his particular case was not the norm, so that others would not be disheartened. A rare attribute in a person and another reason that we admired him so very much.

Bob was born in Raleigh NC, and raised in Omaha. He received his Bachelors in Linguistics from Harvard and a Master’s in Social work at Columbia. He was a social worker in the New Paltz Schools for many years touching many lives with his compassion and knowledge. His second career was as a French/German translator in New York. He was yet another man who had a great intellect and many accomplishments.
The European Medicines Agency’s (EMA) Committee for Medicinal Products for Human Use (CHMP) recommended that the prostate cancer combo therapy Zytiga (abiraterone acetate) plus prednisone/prednisolone in combination with androgen deprivation therapy (ADT) be approved in the European Union for the treatment of early stage prostate cancer, Janssen announced.

The recommendation is for newly diagnosed, high-risk, metastatic hormone-sensitive prostate cancer (mHSPC) patients. The European Commission, which has the authority to approve or deny this new indication, will review the CHMP’s recommendation.

The recommendation is for newly diagnosed, high-risk, metastatic hormone-sensitive prostate cancer (mHSPC) patients. The European Commission, which has the authority to approve or deny this new indication, will review the CHMP’s recommendation.

The European Commission has already approved the combination of Zytiga plus prednisone / prednisolone as treatment for adult men with mCRPC who have no or mild symptoms and failed to respond to ADT, and for whom chemotherapy...

Life gives us brief moments with another... but sometimes in those brief moments we get memories that last a lifetime...
py is not indicated.

The therapy is also approved for adults whose disease has progressed or who received a Taxotere (docetaxel)-based chemotherapy regimen.

“We are very pleased with the CHMP’s decision, which recommends abiraterone acetate plus prednisone / prednisolone in combination with ADT for use in adult patients with newly diagnosed high-risk metastatic hormone-sensitive prostate cancer,” said Dr. Ivo Winiger-Candolfi, Oncology Solid Tumor Therapy Area Lead at Janssen Europe, Middle East and Africa.

“Janssen Oncology has played a significant role in transforming the way prostate cancer is treated so far and aims to continue this progress,” he added.


Here’s Why Cancer Survivorship Becomes Lonely

There’s a well-kept secret you’ll discover on your own about living as a cancer survivor. Most of us learn this painful lesson after many unsuccessful attempts to receive understanding and support from our healthy friends and family.

A cancer survivor asked this question in a cancer support group: “Does anyone ever feel like they’re alone in life?”

One person answered: “Every day.”

Another answered: “All the time.”

At some point in the journey as a cancer survivor, I believe everyone feels some degree of isolation or loneliness. I remember the first (and last) time I shared how much I hated living in diapers. I thought sharing my experience with a group of women in my church would increase the odds of someone understanding my struggles.

The first unhelpful remark minimized what I was going through. A woman said: “Living in diapers isn’t so bad.” For me, losing urinary control and living in diapers was the most awful, life-changing event in my lifetime. Her remark was miles apart from how I felt.

Another woman said: “What’s the big deal? It’s temporary.”

Prior to surgery, my urologist warned me that I could be in diapers for the rest of my life due to my pre-existing urological issues. I had no reason to think or believe that living in diapers was a temporary condition, and neither did she. I was annoyed with her attempt to help me put things in perspective when she had no idea of the facts.

The third woman informed me that I should feel “grateful to be alive.” At that point in my journey, I was feeling sorry I survived prostate surgery. Once again, the gap between what I was told to feel, compared to how I actually was feeling, was immeasurable.

After numerous unsuccessful bids to get support from healthy folks, I realized there was an insurmountable “expectation gap.” The expectation gap is the difference between what people think is going on versus what’s really going on. I wrote a chapter about my experiences with the expectation gap in my book, “I Left My Prostate in San Francisco — Where’s Yours?”

I found the expectation gap was too wide to cross when I was relating to healthy friends, family, and colleagues. I believe healthy folks have no framework, or basis for understanding. They are unable, or too frightened, to hear about the realities of cancer survivorship.
It doesn’t matter how close you were, how long you’ve known one another, or whether you’re flesh and blood. It’s unlikely you’ll receive the understanding, support, or caring you hoped you’d receive from most of your healthy friends and family. Most folks who never lived with cancer cannot understand the side effects of treatment, the quality-of-life changes, the changes in your level of energy, or the changes in how you feel about your body and your self-image.

If you’re fortunate enough to look reasonably healthy, folks with little or no understanding of cancer will assume you feel as good as you look. They don’t understand that how you look physically does not reflect how you feel physically or emotionally. As a result of the “expectation gap,” it’s natural to allow your hurt or disappointment to interfere with your close relationships. When you do, you’ll find yourself kicking friends, family, or colleagues out of your life.

I understand your disappointment and hurt. I also know the value of keeping friends, family, and colleagues in your life. In order to accomplish this, you’ll need to adjust your expectations. I won’t discuss issues related to surviving prostate cancer with healthy folks unless I’m invited. The people I’ll rely on for support and understanding are on the same journey as I am with prostate cancer.

In the age of Facebook and the internet, it is easy to find support groups online. If you prefer person-to-person support, you can find out if that’s available in your community with a few Google searches.

Following is a list of my do’s and don’ts:

**Do’s**
- Forgive anyone who disappoints you.
- Form a team of friends, family, fellow cancer survivors, healthcare professionals, a support group, your spiritual community, and your partner to share your life with you, as they are able, while you live with cancer.
- Keep as many familiar people in your life as possible, even if they don’t understand what you’re going through.
- Find outlets to share your journey with others.

**Don’ts**
- Don’t kick anyone out of your life for the sole reason that they didn’t give you the understanding or support you needed.
- Don’t expect anyone who hasn’t lived with cancer to understand your experiences.
- Coping with cancer can challenge you for years or decades. Don’t expect folks to stay on your team through the entire journey.
- Don’t give up seeking support, understanding, and encouragement.

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Note: Prostate Cancer News Today is strictly a news and information website about the disease. It does not provide medical advice, diagnosis, or treatment. This content is not intended to be a substitute for professional medical advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health provider with any questions you may have regarding a medical condition. Never disregard professional medical advice or delay in seeking it because of something you have read on this website. The opinions expressed in this column are not those of Prostate Cancer News Today, or its parent company, BioNews Services, and are intended to spark discussion about issues pertaining to prostate cancer.

Rick Redner

Rick Redner received his master’s degree in social work from Michigan State University. He has spent many years working as a medical and psychiatric social worker. He is the author of the award-winning book I Left My Prostate in San Francisco—Where’s Yours? His second book Everything You Never Wanted to Know About Erectile Dysfunction and Penile Implants won the Beverly Hills International Book Awards in Men’s Health in 2016. Additionally, the book was a winner in the 2017 IAN Book of the Year Awards.

While preserving sexual function was one of the most important factors for many men undergoing prostate cancer (PC) treatment, this preference was not reflected in the treatments chosen by men with low-risk PC, a new research study found.

The study detailing this finding, “Prostate Cancer Patient Characteristics Associated With a Strong Preference to Preserve Sexual Function and Receipt of Active Surveillance,” was published in the Journal of the National Cancer Institute.

Men with early-stage prostate cancer have multiple options with similar benefit, but that vary in terms of how it affects their quality of life. While active surveillance is the best option for preserving sexual function, it is not clear if a patient’s preference is affecting treatment selection. To address this matter, researchers at the University of North Carolina Lineberger Comprehensive Cancer Center conducted a survey of nearly 1,200 prostate cancer patients in North Carolina.

The team found that more than half (52.6 percent) indicated that preserving sexual function was “very important.” However, this preference was not reflected in the treatment choices made by men with low-risk PC. Researchers reported, which could indicate that patients might have been insufficiently informed about their options.

Of the 568 men identified in the survey as having low-risk PC, 43.4 percent received active surveillance. The approach consists on regular monitoring, ensuring that a patient receives treatment if the disease becomes more aggressive. However, the researchers found that men who had a strong preference for preserving sexual function did not choose active surveillance more frequently than those who weren’t as concerned about preserving sexual function.

“Unfortunately, we found that men who had low-risk prostate cancer and wanted to preserve sexual function did not necessarily choose active surveillance more frequently than those who weren’t as concerned about preserving sexual function,” Ronald C. Chen, MD, MPH, and associate professor in the UNC School of Medicine Department of Radiation Oncology, said in a press release. “This indicates that many patients may not have known about active surveillance as an option.”

Surgery, radiation therapy, and active surveillance are all treatment or monitoring options for patients with low-risk PC. But surgery and radiation therapy are more aggressive treatments that have side effects like sexual dysfunction, or decreased urinary function.

However, active surveillance is a strategy that allows men to undergo regular testing until the disease develops rather than undergo immediate treatment. Studies have shown that during the 10 years after diagnosis, most men (50-66 percent) on active surveillance don’t require treatment, allowing them to avoid the troublesome side effects experienced with other treatments.

This approach is widely recognized as the best strategy to preserve sexual function for this subset of patients. “Active surveillance is widely recognized to be an excellent option for patients diagnosed with low-risk prostate cancer, because it is the best option to preserve the patient’s quality of life including sexual function,” Chen said. “Some patients with prostate cancer may initially want aggressive treatment, and it is important for the physician (urologist and radiation oncologist) to fully counsel patients about the slow-growing nature of low-risk prostate cancer and that active surveillance is a safe option,” he said.
These results seem to suggest there is a disconnect between patients’ preferences and treatment options available to them, Chen argued. “The takeaway for prostate cancer patients is that they should always ask two important questions,” Chen added. “One, how aggressive is my cancer? Two, what are my options? After understanding this, it is important they communicate with their doctor what their priorities are in making a decision among the available options.”

Physicians also need to counsel their patients, helping them choose a treatment that better reflects their preferences.

Carolina holds a BSc in Anthropology and a MSc in Urban Studies, and brings her interdisciplinary skills to her writing on a range of different topics in science, research and advocacy news. Source: https://prostatecancernews.today/2017/10/31/sexual-function-concerns-not-always-reflectedin-prostate-cancer-treatment-choices/?utm_source=Prostate+Cancer&utm_campaign=b9af384f59-RSS_MONDAY_EMAIL_CAMPAIGN&utm_medium=email&utm_term=0_a6d9c27ca8-b9af384f59-71812337

Adding Xtandi (enzalutamide) to hormone therapy reduces the risk of cancer spreading in patients with non-metastatic castration-resistant prostate cancer (CRPC), new Phase 3 trial data shows.

Additional results announced by Pfizer and Astellas Pharma, the drug developers, also show that the safety profile of Xtandi in this population is consistent with previous clinical trials. “Many prostate cancer patients who initiate androgen deprivation therapy will experience disease progression illustrated by a rising PSA level, and currently, there are no FDA-approved treatment options for patients with non-metastatic CRPC until they develop confirmed radiographic metastatic disease,” Dr. Neal Shore, MD, director, Carolina Urologic Research Center, said in a press release.

Pfizer and Astellas initiated the multinational PROSPER trial (NCT02003924) to determine the effects of Xtandi in men with non-metastatic CRPC. The trial enrolled approximately 1,400 patients with prostate cancer that had progressed, based on rising PSA levels, despite androgen deprivation therapy (ADT) but with no symptoms or other evidence of metastasis.

Participants were randomly assigned Xtandi plus hormone therapy or a placebo plus hormone therapy. The study’s primary endpoint was metastasis-free survival, which is the amount of time passed until the cancer spread. “We are delighted with the significant results seen in the PROSPER study, showing that Xtandi plus ADT delayed clinically detectable metastases compared to ADT alone in patients with non-metastatic CRPC whose only sign of underlying disease was a rapidly rising prostate-specific antigen (PSA) level,” said Mace Rothenberg, MD, chief development officer, Oncology, at Pfizer Global Product Development. “We look forward to further analyzing the detailed efficacy and safety results from PROSPER, and submitting them for presentation at an upcoming major medical meeting,” Benner added.

Additional studies on Xtandi are ongoing, including the ARCHES trial (NCT02677896) in metastatic hormone-sensitive prostate cancer, and the EM-BARK trial (NCT02319837) in non-metastatic hormone-sensitive prostate cancer.


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If you have moved, have a new email or phone or no longer wish to receive the newsletter, please let us know.

It’s up to you to keep us informed so we can keep you informed.

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