Next month we celebrate MOvember. MOvember is a fund-raising initiative and an awareness campaign for men’s health which has become a worldwide phenomenon. Since its humble start in 2003 in Melbourne, MOvember has grown to become a global men’s health movement inspiring millions of people to participate in this worthy cause. It is well recognised that a diagnosis of prostate cancer affects not only the person concerned, but also the close family members and the extended circle of friends who may also exhibit signs of depression and anxiety. Around one million Australian adults live with depression, and two million suffer from anxiety disorders. Not uncommonly anxiety and depression coexist. Beyondblue is a national independent organisation whose mandate is to address the needs relating to anxiety and depression often experienced by those affected with prostate cancer and, as a result, MOvember’s men’s health partner Beyondblue is supportive of this financial initiative.

The MOvember Foundation along with Beyondblue has committed $6.25 million to improving the lives of men with prostate cancer. The Australian Survivorship Action Partnership (ASAP) has been announced as of 23 March 2012. The initiative is innovative model of partnering that will build on the strengths that already exist across Australia.

The current initiative is recognition of the key unmet needs relating to anxiety and depression often experienced by those affected with prostate cancer and, as a result, MOvember’s men’s health partner Beyondblue is supportive of this financial initiative.

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The MOvember Foundation Campaign funds programs both directly and indirectly through men’s health partners. In Australia, MOvember’s men’s health partners are the Prostate Cancer Foundation and Beyondblue, the national depression and anxiety initiative. The MOvember Foundation is a not-for-profit organisation.

The MOvember Foundation along with Beyondblue has committed $6.25 million to improving the lives of men with prostate cancer. The Australian Survivorship Action Partnership (ASAP) has been announced as of 23 March 2012. The initiative is committed to the creation of a collaborative network of organisations focusing on improving the lives of men with prostate cancer as well as their partners, families and carers. This action results from the recognised physical and mental health issues that need to be addressed as a priority for men from the time of diagnosis of prostate cancer.

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Prostate Cancer Support Groups in the Queensland Chapter

There are 28 PCSGs in the Chapter with a total membership of approximately 3,500 men.

<table>
<thead>
<tr>
<th>Peer Support Group</th>
<th>Contact</th>
<th>Phone</th>
<th>Peer Support Group</th>
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<tr>
<td>Advanced (all areas)</td>
<td>Jim Marshall</td>
<td>07 3878 4567</td>
<td>Hervey Bay (Ipswich)</td>
<td>Ros Male</td>
<td>07 4197 7244</td>
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<tr>
<td>Beenleigh</td>
<td>Peter Keech</td>
<td>0407 070 194</td>
<td>Maryborough</td>
<td>Terry Carter</td>
<td>07 3281 2894</td>
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<td>Brisbane</td>
<td>Peter Dornan</td>
<td>07 3371 9155</td>
<td>North Burnett</td>
<td>John Clinton</td>
<td>0418 194 262</td>
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<td>Bundaberg</td>
<td>Rob McCulloch</td>
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<td>Sunshine Coast</td>
<td>Russell Tyler</td>
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<td>Capricorn Coast (Yeppoon)</td>
<td>Jack Dallachy</td>
<td>07 4933 6466</td>
<td>North Queensland (Townsville)</td>
<td>Clarke Berglin</td>
<td>07 4773 3303</td>
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<tr>
<td>Central Queensland (Rockhampton)</td>
<td>Lloyd Younger</td>
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<td>Far North Queensland (Cairns)</td>
<td>Jim Hope</td>
<td>07 4039 0335</td>
<td>North Queensland (Equine)</td>
<td>Craig Thurgate</td>
<td>0412 661 924</td>
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<td>Far North Queensland Partners</td>
<td>Margaret Rolfe</td>
<td>07 4045 1031</td>
<td>North Queensland (Day)</td>
<td>David Hughes</td>
<td>02 6687 0008</td>
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<td>Gladstone</td>
<td>Geoff Lester</td>
<td>07 4979 2725</td>
<td>Northern Rivers (Day)</td>
<td>Peter Martin</td>
<td>07 4096 6315</td>
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<tr>
<td>Glass House Country</td>
<td>Bob McLean</td>
<td>07 5496 9601</td>
<td>North West Qld (Mt Isa)</td>
<td>Yvonne McCoy</td>
<td>07 4743 2054</td>
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<tr>
<td>Gold Coast Central</td>
<td>Peter Jamieson</td>
<td>07 5570 1903</td>
<td>Sunshine Coast</td>
<td>Rob Tonge</td>
<td>07 5446 1318</td>
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<td>Gold Coast North</td>
<td>John Caldwell</td>
<td>07 5594 7317</td>
<td>Toowoomba</td>
<td>David Abrahams</td>
<td>07 4613 6974</td>
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<tr>
<td>Gold Coast Partners</td>
<td>Maggie Angus</td>
<td>07 5577 5507</td>
<td>Twin Towns and Tweed Coast</td>
<td>Ross Davis</td>
<td>07 5599 7576</td>
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<td>Gympie</td>
<td>Robert Griffin</td>
<td>07 5482 4659</td>
<td>Whitsunday</td>
<td>Dave Roberts</td>
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**Associated Support Groups**

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<tr>
<td>Brisbane Partners</td>
<td>Wendy Marshall</td>
<td>07 3878 4567</td>
<td>Innisfail</td>
<td>Desleigh Barrow</td>
<td>07 4061 9177</td>
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<tr>
<td>Kingaroy</td>
<td>Robert Horn</td>
<td>07 4690 5800</td>
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CONTRIBUTING GUEST EDITOR:
Dr Phillip Stricker

Advances in imaging and diagnostic testing - How will that affect prostate cancer management in the future?

One of the big issues in prostate cancer management is the lack of accuracy of imaging tests making accurate diagnosis and management more difficult. Recent developments in magnetic resonance imaging (MRI) have begun to address this issue. Recent studies have shown there will be an increasing role of imaging using MRI in the areas of tumour detection, staging of prostate cancer and management decisions. Furthermore, changes in biopsy techniques including MRI-guided biopsies or transperineal grid-directed biopsies may also have an impact on diagnosis and management.

What’s changed in MRI imaging?

Traditionally MRI uses a magnet of different strengths to assess tissues and create an image. Depending on which tissues one asks the imaging to look at, they have different shades of grey. These images are called T1 and T2-weighted images. In the diagnosis of cancer, these traditional imaging techniques do not differentiate benign from malignant tissue. More recently MRI is now able, through sophisticated software, to look at how tightly cells are packed (diffusion-weighted imaging) and also looking how blood flows in tissues (dynamic contrast-enhanced MRI) and also looking at the chemical make-up of tissue (spectroscopy). With the use of all these techniques, we now have what is called a multiparametric MRI and experienced radiologists and urologists are now able to interpret these images and more accurately separate cancerous tissue from benign tissue. At this stage, these techniques are still being standardised and perfected and their exact role is unsure but the following are some of the emerging possible roles for this type of multiparametric MRI (mMRI):

1. Early detection in diagnosis of prostate cancer.

Whilst PSA, digital rectal examination and ultrasound-guided biopsy remain the gold standard for early detection of prostate cancer, all these suffer with missing some aggressive cancers and over-detection of relatively harmless (insignificant) cancers. MRI offers the potential of reducing the number of unnecessary biopsies in patients with equivocal PSA readings and also of detecting aggressive cancers in high-risk individuals such as those with family histories. Studies now suggest that multiparametric MRI can minimise the number of unnecessary biopsies whilst improving the accuracy of early-detection of aggressive tumours in high-risk individuals.

2. Improving the accuracy of biopsy.

The current technique of biopsy uses a relatively blind ultrasound-guided technique. MRI offers the hope of more accurately helping target tumours in the prostate. To date, there is evidence that MR-guided biopsy techniques or the use of MR imaging to help guide ultrasound-guided biopsies may improve the targeting of cancers and furthermore may avoid biopsying small, nondangerous tumours of the prostate and therefore minimise over-detection. I am personally trialling both of these techniques. Furthermore, MRI tends to detect only higher grade tumours as the appearance of high-grade tumours is different on multiparametric MRI to low-grade tumours. By not seeing the small low grade lesions MRI may help minimise over-detection but the jury is still out. One of the weaknesses of MRI is that there are certain areas of the prostate where cancers are very difficult to detect (the transition zone). Fortunately, this is the least common site for prostate cancers.

3. Transperineal Template Biopsy.

There has been an increasing use of transperineal biopsy which has several advantages over transrectal biopsy in that,

A. It minimises the risk of infection.
B. It samples the front of the prostate more accurately, a site where traditional transrectal biopsies often miss tumours.

Transperineal biopsies are generally used when previous traditional biopsies have been clear and some urologists including myself use it as the primary initial biopsy technique.

4. Planning surgery and radiotherapy.

MRI has the potential to improve the accuracy of assessing the extent of cancer in the prostate by telling us where it is, whether it has broken through the capsule, whether it has eaten into the seminal vesicles or whether it has spread to the lymph glands. These have implications in terms of which treatment is chosen and also how this treatment is executed (ie surgery or radiotherapy). It also helps decide as to whether to spare or remove erectile nerves in surgery for complete cancer clearance.

5. Helping monitor patients on active surveillance.

An increasing number of patients are found to have low-risk cancers, probably never destined to cause any problems. Currently these patients require regular biopsies to ensure the cancer has not progressed. Saturation transperineal or transrectal biopsy is currently used to ensure no high-grade cancers are missed. MRI may have an increasing role of ensuring there is no high-grade
A blood test for prostate cancer billed by its manufacturer as “an answer to the current PSA [prostate-specific antigen] testing controversy” has won FDA approval, the company said.

It was said that the agency had okayed its premarket approval application for the so-called Prostate Health Index test, which incorporates measurement of a PSA precursor protein called pro-PSA along with total and free PSA.

The test is indicated for men with regular PSA test results in the range of 4ng/mL to 10ng/mL, just above the upper limit of normal.

According to the co-discoverer of pro-PSA, Kevin Slawin MD of Memorial Hermann-Texas Medical Center in Houston, the marker is more closely associated with prostate cancer than total and free PSA. Combining the three markers makes the Prostate Health Index more specific than conventional PSA testing.

A pivotal, multicenter study sponsored by Beckman Coulter found that the number of negative biopsies in patients with positive blood-test results was reduced by 31% with the Prostate Health Index versus conventional PSA screening, the company said.

Editor’s note
This test (Prostate Health Index) is currently available in Queensland. Out of pocket expense is $90 ie no Medicare refund.
REAL LIFE STORY FROM A QPCN READER

Editor’s note: My thanks go to Stephen Jackson for his response to QPCN request for local stories about prostate cancer. He demonstrates the importance of early detection and intervention of prostate cancer and he endorses the significance of local Support Groups. He is happy to share his experiences here with readers. What a great ambassador with a wonderful sense of humour.

Dear Editor,

Several issues ago in QPCN, there was a little box asking for prostate war stories from the members. I’ve just got to the stage where there is something definite about my journey through prostate-land, so I put these words together for you. The newsletter is very informative, even if some of the statistics challenge my poor brain.

I should confess to being tardy, procrastinating and probably more than a little bit stupid. I had heard about prostate cancer, read (and kept!) newspaper articles, followed the surgical options, and yet never had a PSA test. And as for a DRE...well a GP gave me a slip for a PSA test, and failed to read me the riot act, so I procrastinated. Finally had it done, and it read 4. My regular GP said wait and retest in 12 months. Well I did that when I should have, and it read 6.4. She was rather firm about my seeing a Urologist. The DRE was done, and ‘something was there’. I was told to have another PSA test, this time avoiding exercise, sex AND bicycle riding. So, it plummeted to 6.3. He then suggested I have the Prostate Health Index test, where a reading of 45+ would indicate a high probability of cancer. And I scored 97 point something. I then had a biopsy, which came up with scores indicating the cancer scored 8 on Gleason’s table.

After all that I couldn’t very well question anything, could I? We agreed that removal of the prostate was the best option, considering the scores I had achieved, and opted for open surgery rather than robotic. About 10 days later I was having a sleep-over in hospital, with tubes all over the place. I recovered from the surgery quite well and was home in 3 days, developing skills with the catheter bag. Bloody awkward, but you didn’t have to get up through the night to go to the toilet!

And blind luck, with a dose of good fortune, came in with the pathology indicating the cancer had not escaped the prostate capsule, and the lymph things showed no sign of cancer. The catheter came out after 25 days and I resumed pelvic floor exercises, and discovered the joys of regaining continence.

Now I have a good understanding of what my wife has been through! Eleven weeks later the next PSA test came back at <0.01, and that was very nice to see. So another PSA test in 3 months, then presumably several over the next 5 years, before a ‘clean bill of health’ can be given. So you can see that I was tardy, procrastinating and stupid. That I’ve come out so well is blind luck. Nothing else. It could have been so different.

I joined a Support Group in mid-March; in April I had the sleep-over in hospital for the operation. May was coping with continence and pads, and June was a long planned trip in north Queensland I was NOT going to miss. But because of the speed of removal after diagnosis; the very nice PSA number of <0.01; and my present rude health (some incontinence and total impotence excepted), I don’t feel like a cancer survivor. When I look at what others have gone through, are going through, I feel more like a fraud.

As a post script, I asked my doctor if he had sent me for the Prostate Health Index just to convince me, and yes he had. But I don’t mind that. He did a good job and answered all my questions. Upfront. Clearly. And now I bore my friends with discussion on the prostate. Nothing worse than a reformed sinner!

Stephen Jackson, Ph 0438 943 813.

TOOLS FOR MENTAL WELLNESS: FEEL HAPPIER, HEALTHIER AND MENTALLY STRONGER

REFERENCE. Karen Tyrell, Brisbane author of Me and Her: a Memoir of Madness, and Top 30 Tools for Mental Wellness, 2012

Dealing with prostate cancer is very stressful for everyone in the family. We often lose sleep and become over-stressed, anxious and depressed facing life’s challenges.

Karen Tyrell shares her journey back from trauma and severe anxiety to holistic health in an amazing story of recovery. Karen opens her heart to readers through her most intimate moments of despair. She has generously given QPCN subscribers the opportunity to enjoy Top 30 Tools for Mental Wellness.

“Hello, my name’s Karen. Once I was severely stressed, barely able to sleep. Tormented by anxiety and night terrors. When I empowered myself with a tool-box of techniques to cope with stress and learn resilience, my overall feeling of health and wellness returned.

Here’s a couple of my tips…

1. Be determined to live your healthiest, happiest life. That’s your driving force.

2. Develop your own individual wellness plan, incorporating pro-active resilience techniques so you can tackle life’s challenges and bounce “back”.

http://www.karentyrrell.com/free-ebook-30-tools-mental-wellness/
History & Operation
The Prostate Cancer Support Group of North Queensland (Townsville) was established in 1994 by a Community Health worker and a small group of men and their wives and partners who were confronted with the problems caused by prostate cancer.

Purpose
• to support men who have been diagnosed with prostate cancer or who are experiencing prostate cancer symptoms or prostate problems, and also their wives and partners and
• to promote prostate cancer awareness within the community.

The members of our current committee are:
Convener: Clarke Berglin
Treasurer: Merv Albion
Secretary: Sharyn Albion
Librarian: Gloria Cody
Newsletter Editors: John & Jean Evans
Meet & Greet: Ron Saunders
Group Founder: Les Payne

As one of the Group’s original founders Les Payne continues to be involved on the committee in an advisory capacity. Les is now in his 80s and his commitment and dedication is an inspiration to us all.

Our Group holds monthly meetings on the 3rd Tuesday of the month at the Townsville RSL, Charters Towers Rd, Hermit Park, Townsville at 10am. Meeting attendance averages around 20 people including men and their partners and families. Guest speaker topics include men’s health and prostate cancer, incontinence, general health and wellbeing, community services and other areas of interest.

There are currently approximately 80 people on our mailing list with 90% living in the Townsville area (including Magnetic Island) and the other 10% scattered throughout North Queensland.

Cancer Council Queensland, “Seniors Picnic in the Park” organised by the Townsville City Council and Prostate Cancer Foundation of Australia (PCFA) events such as Bunnings’ barbeques.

We owe special thanks to the Townsville RSL for providing us with a meeting room, which is greatly appreciated, and we would also like to acknowledge the assistance that we receive from Cancer Council Queensland in helping with our mailouts and providing services like counselling and courses for cancer sufferers.

On 6 September 2011 we lost long-term committee member Fred Thompson to prostate cancer. Fred, a former union organiser, was a great asset to the committee. No one organised our tent at “Relay for Life” like Fred did. It was organised superbly down to the last detail. He was a true gentleman and a great friend, and his presence is sadly missed. Fred was 92 and is survived by his wife Loma. We greatly appreciate the contribution that Fred and Loma made to our Group over many years.

Recent Group Highlights
• July 2011 - sponsored three local nurses to undertake a Prostate Nursing Care course conducted by La Trobe University;
• March 2012 - adopted a Constitution to formally recognise the Group as a not-for-profit Community Service Organisation for Australian Tax Office purposes;
• June 2012 - purchased two special beds for the Palliative Care Unit at the Townsville Hospital. These beds were presented to the Palliative Care Unit at a morning tea handover on 28 June 2012.
• 2012 – the Townsville Hospital was chosen as one of the sites for the PCFA Prostate Cancer Specialist Nurse program. The successful candidate for the position was Trish Husband. Trish is well known to our Group through her involvement as a former PCFA Speaker Ambassador and local incontinence health support worker.

Our Group was able to sponsor the nurse course at La Trobe University and purchase beds for the Palliative Care Unit thanks to funds received from local benefactors who directed that their donations be used to benefit the local community.
Local Highlights
Early this year Townsville received its first PET scanner which is located at Queensland X-Ray at Mater Hyde Park Centre. It is a great benefit as patients receiving cancer treatment now don’t need to travel all the way to Brisbane for a PET scan. A second PET scanner is to be installed at the Townsville Hospital later this year. Both these machines incorporate a CAT scanner and are similar to the machine at the Mater Hospital in Brisbane.

The Cancer Centre at the Townsville Hospital is being expanded and work has already started on construction of the building extension to the oncology area. This will add extra chemotherapy day treatment chairs as well as other improvements. The Townsville Hospital is a major regional hospital and patients from all over North Queensland are referred there for specialist treatments, including cancer treatment.

Townsville is a growing city and is one of the many centres in regional Queensland which is benefiting from the mining boom. It is fast establishing itself as the ‘Sporting Capital’ of North Queensland due to events like the V8 Supercars (held in July) and is home to two popular national sporting teams - the North Queensland Cowboys NRL rugby team and the Townsville Crocs NBL basketball team.

The award is presented to others in acknowledgement of the work they have carried out, like Max, spreading the awareness message, promoting research and supporting men and their families affected by prostate cancer.

In August the Queensland Chapter of PCFA presented Max Gardner Awards to two members of the Chapter whose efforts and dedication over many years have substantially contributed to assisting men and their families deal with prostate cancer and increased community awareness of this disease.

The award recipients were Daryl Hyland and John Stead.

Daryl Hyland was diagnosed with prostate cancer in 2000. He underwent a radical prostatectomy but positive surgical margins meant a continuing regime of hormone ablation plus a course of salvage external beam radiation therapy. This has given Daryl a wider personal experience than most of the havoc prostate cancer can inflict.

Based in Mackay at the time of diagnosis and treatment, Daryl was a Queensland representative at the inaugural National Support Groups’ Meeting in 2001. With this experience behind him plus a desire to promote prostate cancer awareness in the local area, Daryl was the driving force behind the establishment of the Mackay & District Prostate Cancer Support Group in 2005 and became the Group’s first Convener.

With many of the members of the Mackay Group living further afield there was a need for another Group to the North around the Whitsundays. Daryl, accompanied by other members of the Mackay Group, held an awareness evening at Proserpine and from that meeting

Continued...
MAX GARDNER AWARDS Continued...

the Whitsunday Prostate Awareness and Support Group was formed. Their first meeting, chaired by Daryl, was held in November 2005.

In 2006 Daryl and wife Judy moved to the Gold Coast for family reasons.

He immediately became involved in the Gold Coast Support Group and in 2007 joined the Queensland Chapter Council (QCC) as one of three Queensland PCFA Support & Advocacy Committee members. He continued in this and other Council roles with a year off in 2011 following mandatory resignation after serving for four years, but rejoined in 2012.

In the year preceding Daryl’s “year off” he was diagnosed with non-Hodgkin’s lymphoma. In spite of the problems and rigours associated with subsequent chemotherapy Daryl continued to attend and participate in meetings relating to Chapter and Support Group business and during 2011 continued to operate as Queensland’s Support Group Co-ordinator, involving many hours of work and travel, liaising with the current Groups and looking for opportunities for the establishment of additional Groups where local demographics indicated a need.

During this time he was directly responsible for the establishment of a new Gold Coast evening Support Group to cater for working men who couldn’t attend daytime meetings and also for the establishment of a Group for men with advanced prostate cancer. This latter Group meets via a monthly teleconference and accepts men from all over Queensland and interstate.

Since moving South Daryl has played a major role in setting up and running the annual State Conveners’ Conferences and Workshops and Chairs the Conveners’ teleconferences. His commitment to the Groups and Queensland Chapter is invaluable.

In an interview with the “Gympie Times” in August last year Ray said that helping others was a focus that helped him deal with his own prostate cancer which was then terminal. He continued, “I’ve got terminal cancer. They don’t know how long. When someone tells you you’re terminally ill it takes some sinking in. But at the end of the day I’m okay with it. I don’t know what’s ahead of me because no-one talks about it. You’ve got no idea. Even now I know where I’ve been, but I don’t know where I’m going.”

Rather than spend his last months moping around Ray agreed to “star” in a movie where he could act naturally and follow his journey through to the final scene which was to be his death, hopefully in his own bed. The movie aims to show the positives of the inevitable end that awaits us all and Ray’s wish was that it would help others deal with this situation.

Our deepest sympathy is extended to Ray’s wife Klara and their family following their sad loss.

ORBITUARY VALE RAYMOND ARTHUR CHEASLEY

We’re sad to report that Ray Cheasley passed away on 14 August. Ray was 73 years of age and was a past Convener and member of the Gympie & District Prostate Cancer Support Group since the Group’s inaugural meeting in July 2006. Together with his wife Klara, he was hands-on Group member occupying the Treasurer’s position for four years and then Convener for a year prior to resigning because of ill health.

In an interview with the “Gympie Times” in August last year Ray told you you’re terminally ill it takes some sinking in. But at the end that awaits us all and Ray’s wish was that it would help others deal with this situation.

Our deepest sympathy is extended to Ray’s wife Klara and their family following their sad loss.
Dr Troy Gianduzzo is a prostate cancer specialist operating from The Wesley and The Royal Brisbane & Women's Hospitals. He specialises in Robotic Prostatectomy and Prostate Brachytherapy.

In July Dr Gianduzzo gave a presentation covering brachytherapy’s current status as a treatment for prostate cancer and where it sits in relation to other prostate cancer treatments, particularly external beam radiotherapy and surgery, both open and robot assisted.

The position of the prostate gland makes it difficult to access. It sits in the pelvic cavity directly below the bladder, immediately in front of the rectum and behind the pubic bone.

A prostate cancer diagnosis, perhaps suspected following prostate-specific antigen (PSA) testing and a digital rectal examination (DRE), is generally confirmed via a biopsy where a number of core samples of prostate tissue are taken, either through the rectal wall or through the perineum.

The biopsy samples are examined by a pathologist who will examine the prostate cells for signs of cancerous tissue and, if cancer is present, will assign the biopsy samples a Gleason grade which will range from 1 to 5 (1 the lowest) depending on the amount of cancerous tissue present. The two most common grades in the biopsy samples are added together and this becomes the Gleason score. In terms of aggressiveness scores of up to 6 are considered to be low to moderate risk cancers, 7 are intermediate risk and 8-10 are high risk. When adding the grades the most common grade is noted first, thus a Gleason score 7 could be either a 4+3 or a 3+4 with the 4+3 being the more aggressive of the two.

If cancer is confirmed the tumour or tumours (prostate cancer can be multi-focal) will be given a stage which will be one of 4 groups, T1 to T4 (there are sub-groupings within these groups), where in general terms T1 means that the tumour is small and cannot be detected by finger examination, in T2 the tumour can be felt but is still confined to the prostate, T3 is where the tumour has spread into the tissue around the prostate or perhaps into the seminal vesicles and T4 means the cancer has reached adjacent organs such as the bladder, rectum or pelvis.

Once the above details have been confirmed, treatment options can be discussed and a tailored approach can be worked out depending on the patient’s individual needs.

Regular readers of this publication will be familiar with these treatment options but, briefly, active surveillance is a non-interventional approach where a patient with low risk or early...
non-aggressive prostate cancer is regularly monitored via PSA testing and DREs plus a biopsy if and when it may be indicated. Many prostate tumours fall into this category meaning a man may eventually die with prostate cancer rather than because of it. However by regularly checking on the progress of the cancer further treatment can be carried out if indicated.

A radical prostatectomy is the surgical removal of the prostate gland and can be carried out using open surgery or a laparoscopic or robot-assisted laparoscopic procedure.

External beam radiotherapy (EBRT) uses a high-intensity radiation beam generated from an external source called a linear accelerator. The beam is aimed at the prostate and will kill tumour cells whilst causing minimum damage to healthy cells.

Brachytherapy is another form of radiotherapy where the radiation is delivered from an internal, rather than an external, source. There are two types of brachytherapy.

High-Dose Rate (HDR) brachytherapy delivers radiation through hollow needles or catheters which are temporarily placed inside the prostate. Whilst it can be used as a monotherapy it is generally used in conjunction with EBRT to increase the radiation dose without affecting surrounding organs.

Low-Dose Rate (LDR) brachytherapy is the permanent implantation of radioactive “seeds” within the prostate so that the radiation dose is slowly delivered over the ensuing months.

HIFU (High-Intensity Focused Ultrasound) and Cryotherapy are not widely used treatments for prostate cancer. With HIFU, as the name suggests, a high-intensity ultrasound beam is progressively focused on all sections of the tumour destroying the cancer cells. The procedure for cryotherapy is similar to that of HDR brachytherapy. Hollow needles are placed in the prostate but instead of delivering radiation through the needles, argon gas is used to freeze and kill the tumour cells, a similar principle to the doctor using liquid nitrogen to freeze minor skin cancers, naevi and sun spots.

The traditional radical prostatectomy required a large incision to allow the surgeon access to the prostate and surrounding tissue, organs and nerves. It required up to 5 days in hospital and many weeks to fully recover and the large incision increased the chances problems caused by blood loss and post-operative complications. In the late 1990s laparoscopic prostatectomies were being undertaken and from 2000 onwards robotic-assisted laparoscopic surgery was being used.

From the surgeon’s point of view laparoscopic surgery was difficult to master but the advent of the “robot!” solved this problem. The advantage robotic has over open surgery is that it is less invasive meaning shorter hospitalisation and faster recovery times. In the hands of experienced operators there appears to be no difference between open and robotic surgery in long-term outcomes.

For those with localised prostate tumours surgery offers excellent local control, salvage radiotherapy may be used if cancer recurs, continence and potency can improve with time, it allows for accurate staging and is a better option for younger men. As with all surgery, not just prostate, there can be complications but these are rare with experienced surgeons. Erectile function and incontinence are two areas of concern to most men contemplating surgery.

Incontinence is generally short-term with around 30% of men pad-free a week after catheter removal, that figure rises to 60% at 3 months and 90-95% at 12 months. The remainder may require further surgical intervention if there’s no improvement 1-2 years post-op. It is critical that men begin pelvic floor exercises prior to surgery and keep them going afterwards.

Improvement in erectile function will continue over 1-2 years following surgery, with 70-80% regaining erections at 12 months if both nerves are spared during the procedure and the man had good erections prior to surgery.
LDR brachytherapy is an alternative to surgery for low-to-intermediate risk prostate cancers. The procedure, which takes around 2 hours, generally requires an overnight stay in hospital and the patient can go home with a short course of antibiotics and perhaps alpha blockers to assist voiding. LDR brachytherapy is minimally invasive and avoids some surgical issues which may be an advantage in older men. Once the “seeds” are implanted the radiation is delivered directly to the prostate, there are few problems with incontinence and impotence rates are small for men who have good potency prior to the operation. 80-90% are potent at 12 months and 50% at 5 years.

However LDR brachytherapy is not suitable for everyone. The lack of data about the long-term effects of the radiation means it may not be suitable for younger men (<55), there may be limited salvage options if biochemical recurrence occurs and there is a risk of urine retention which could require intermittent catheterisation for up to 6-12 months.

For LDR brachytherapy to be covered by Medicare the tumour must be staged at T1c/T2 with a maximum Gleason Score of 7 and PSA less than 10. From a medical point of view the prostate volume should be less than 50cc and the man must not have undergone a TURP (trans urethral resection procedure or “re-bore”).

Prior to robotic assisted surgery, LDR brachytherapy was a genuine option for men contemplating an open prostatectomy because of the short hospital stay and minimum pelvic invasion. Robotic surgery now equals the time in hospital. The chart below compares the two procedures.

External beam radiotherapy (EBRT) does not have the same restrictions as LDR brachytherapy (previous TURP, prostate volume) and, being non-invasive, avoids the risks associated with surgery. It can be used to treat high-grade tumours and treat a broader area plus there’s the option of an HDR brachytherapy boost for high-risk tumours.

Offsetting these advantages, there are only limited salvage options following EBRT, there’s a chance of either or both rectal and bladder toxicity, erectile dysfunction can be a problem and the treatment needs about 7-8 weeks (5 days per week) of daily hospital visits. These days EBRT is often accompanied by a course of hormone therapy which will bring its own short-term side effects (reduced libido, hot flushes, inertia etc).

Over the past decade there have been enormous improvements in the delivery of EBRT which have reduced the problems of unwanted side effects following treatment. Image guided radiotherapy (IGRT) and intensity modulated radiotherapy (IMRT) are now commonplace and greatly reduce or eliminate damage to the bowel, bladder and urinary tract and surrounding tissue. Damage to these areas was a previously common side effect, often short-term but in some cases long-term.

Boosting EBRT with HDR brachytherapy reduces treatment time and allows for an increase in the amount of radiation delivered to the prostate (dose escalation) without giving excess radiation to the tissue and other organs surrounding the gland.

Whether a man opts for surgery (robotic or open) or radiotherapy (LDR Brachytherapy, EBRT or EBRT + HDR brachytherapy) the possibility of side effects following treatment should be discussed. The main issues concern the bladder and urinary function, bowel problems and the possibility of impotence.

These problems will generally diminish over time or are treatable, assuming there was normal function prior to therapy, however they are matters that need to be weighed up prior to deciding on a treatment regime.

More information on all of the above procedures can be obtained by visiting Dr Gianduzzo’s website www.troygianduzzo.com.au
NEW HEALTH TECHNOLOGIES AND CLINICAL TRIALS

REFERENCE. S Holland1, T Hope, J Med Ethics 2012;38:366-371 doi:10.1136/medethics-2011-100294. Research ethics. 1Departments of Philosophy and Health Sciences, University of York, York, UK stephen.holland@york.ac.uk. 2The Ethox Centre, Department of Public Health, University of Oxford, Oxford, UK

The ethics of attaching research conditions to patients access to new health technologies is controversial, because of the scarcity of healthcare resources, the competing demands of payers, providers and patients and the uncertainty of the evidence base. Given this, additional information about new health technologies is often considered valuable. One response is to make access to a new health technology conditional on further research.

Access can be restricted to patients who participate in a research study, such as a randomised controlled trial. Alternatively a new treatment can be made generally available, but only on condition that further evidence is collected (eg on long-term outcomes and adverse events, in patient registries).

NEW HEALTH TECHNOLOGIES AND CLINICAL TRIALS

REFERENCE. Anna Azvolinsky PhD, Cancernetwork, The Lancet and the Lancet Oncology, 21 March 2012

Three papers published in the Lancet and the Lancet Oncology show that aspirin (drug information on aspirin), taken daily, may prevent cancer and could even treat certain cancers. All three publications were from the same research group. People that took daily aspirin had a 38% overall reduction of colorectal cancer and other gastrointestinal cancers compared to those who did not take aspirin.

Additionally, death rates from cancer in aspirin-takers were 15% lower, and rates of metastasis were about 35% lower. Daily aspirin takers among 34 trials and over 69,000 participants had reduced cancer deaths especially after at least five years of taking aspirin. Among six trials focused on daily low-dose aspirin, the over-the-counter pill reduced cancer rates. These trials looked at primary vascular event prevention and found that the participants also had reduced risk of major vascular events, but an initial increased risk in major bleeding. The authors conclude that the pooled analysis “adds to the case for daily aspirin in prevention of cancer.”

Another study found that aspirin reduced the risk of metastases among participants in five UK trials that aimed to assess the rate of cardiovascular events for aspirin vs placebo. Participants that took regular aspirin had lower rates of distant metastasis or spread to regional lymph nodes, another finding consistent with previous randomised trials. The metastasis observation could also “explain the apparent early reduction in cancer incidence on aspirin” seen in the six primary prevention trials analysed, according to the authors.

The authors suggest that because platelets play a role in metastasis to distant tissues, aspirin’s effect may be to change platelet dynamics. They propose that other antiplatelet drugs may also have a similar effect on metastasis. Three research studies stated that the research is an “impressive collection of data that moves us another step closer to broadening recommendations for aspirin use.” They also postulate that any future utilisation of aspirin to prevent vascular diseases must now also take into consideration the effect on cancer prevention.

However, the studies did not include two of the largest clinical studies that evaluated the effect of aspirin on cancer risk. However, data on the mechanism of aspirin and the role of inflammation in preventing cancer is still lacking. Whether the current evidence is enough for the medical community to consider changing guidelines and to recommend aspirin as a preventive measure against cancer is yet to be seen.

MORE DATA SHOWING ASPIRIN CAN HELP PREVENT CANCER

REFERENCE. Anna Azvolinsky PhD, Cancernetwork, The Lancet and the Lancet Oncology, 21 March 2012

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Nurse Practitioner Intervention Affects Cancer Patient QOL, 30 May 2012 - A consultative visit with a nurse practitioner improves the quality of life of patients with metastatic cancer, according to a small study published online 4 May in the Journal of Palliative Medicine. Patients who received this intervention showed significant improvements in their emotional and mental well-being. On the emotional domain of the Functional Assessment of Cancer Therapy-General (FACT-G) scale, an assessment tool that has been widely used and prospectively validated as a measure of quality-of-life end points, there was a statistically significant improvement in the intervention group, compared with the control group (P = .0106).

Cellular Particles Fuse With Organs Establishing An Environment Ripe For The Spread Of Cancer, 6 Jun 2012 - The fact that different types of tumours only spread to specific, preferred organs has been known to scientists for longer than a century. However, so far, research has not been able to shed light on the mechanisms of organ specific metastasis ie the 1889 ‘soil and seed’ theory. A study recently published online by Nature Medicine could now help explain this hypothesis by proposing a new mechanism to control cancer metastasis, offering a novel diagnostic and treatment potential.

Beta-Carotene Safe During Prostate Cancer Treatment, HealthDay News, 7 June 2012 - The use of the antioxidant beta-carotene during radiation therapy treatment for prostate cancer is not associated with an increase in prostate cancer deaths or metastases, Danielle N Margalit MD MPH of the Harvard Radiation Oncology Program in Boston, and colleagues, conducted a prospective randomised study (as part of the larger Physicians’ Health Study) involving 383 men receiving radiation therapy for prostate cancer. Participants were randomly allocated to receive beta-carotene (50 mg on alternate days) or placebo and were followed for a median of 10.5 years. The research was published in the May issue of the International Journal of Radiation Oncology*Biology*Physics.

Dental Plaque Linked to Cancer Risk, 12 June 2012 - Poor oral hygiene may be associated with increased risk of cancer and premature death, researchers found. Among healthy adults in Sweden plaque build-up increased the relative risk of premature death 79% (OR 1.79 95% CI 1.01 to 3.19, P=0.048), Birgitta Söder PhD of the Karolinska Institutet in Huddinge Sweden, and colleagues, reported in BMJ Open. The finding, the authors wrote, suggests that increased plaque and associated toxins and enzymes may be released from the built-up biofilm and enter the bloodstream through the gingival crevice, thus increasing the risk of malignancies.

Weight Loss Linked to Reduced Cancer Incidence, Mortality, HealthDay News, 15 June 2012 - Weight loss, particularly intentional weight loss, is associated with a reduced incidence of cancer and mortality, especially for women and for obesity-related cancers. Sarah Birks of Monash University in Melbourne, and colleagues, conducted a systematic review of the literature and identified 34 studies that investigated the impact of weight loss on cancer incidence and mortality. A review was published online 4 June in Obesity Reviews.

Testosterone Therapy Does Not Up Prostate Cancer Incidence, HealthDay News, 15 June 2012 - Testosterone replacement therapy (TRT) appears to be safe and does not increase the incidence of prostate cancer, Mark R Feneley MD from University College Hospital, and Malcolm Carruthers MD from the Centre for Men’s Health (both in London) conducted an updated audit to analyse the long-term incidence of prostate cancer for men receiving TRT. Data was reviewed from 1,365 men (mean age 55 years) with symptomatic androgen deficiency receiving TRT (pellet implants, Restandol, mesterolone, and Testogel) and monitored for up to 20 years. The study was published online 6 June in The Journal of Sexual Medicine.

Above Information Sourced from Cancer Daily News

THE GOOD NEWS ABOUT COFFEE

In one study, Chinese researchers reviewed 41 studies published between 1990 and 2011 and concluded that regularly eating fresh fish reduces the risk of colon cancer by 4% and rectal cancer by 21%. Colon cancer is the third leading cause of cancer death in the Western world. Previous research has found that people who live in countries with high levels of fish consumption are less likely to develop colon or rectal cancer.
CONTINUOUS HORMONAL THERAPY

Most Prostate Cancer Patients Fare Better With Continuous Hormonal Therapy

REFERENCE. Rachel Warren, Editorial Director, Oncology, 6 June 2012

At this year’s annual meeting of the American Society of Clinical Oncology, a group from the University of Michigan led by Maha Hussain MD reported results of an international phase III trial showing that intermittent hormonal therapy is less effective than continuous therapy in patients with metastatic prostate cancer who have minimal disease.

On average, patients with minimal disease spread who received continuous therapy lived for nearly two years longer than those receiving intermittent therapy. For patients who had extensive disease spread, those in the intermittent therapy arm of the trial lived about six months longer than those in the continuous therapy arm. However, the latter results were not found to be statistically significant.

According to Dr Hussain, for the past ten years or so, “the conventional belief has been that intermittent therapy should be done in the ‘good prognosis’ patients, so what we’re seeing now is something unusual.”

Dr Hussain presented research from an international phase III trial that included more than 1500 patients whose prostate-specific antigen (PSA) fell to 4ng/ml or lower after seven months on continuous hormonal therapy. The men were randomised to either continuous or intermittent therapy, and ultimately the men on intermittent therapy received half the dose received by those in the continuous therapy group. The primary objective of the study was to assess if overall survival with intermittent therapy achieved comparable survival with continuous therapy in men with metastatic prostate cancer.

Dr Hussain explained the study’s rationale, saying, “It is virtually a fact that when patients go on hormone treatment over 90% will go on progressing, and this progression happens because the cancer cells adapt. When you deprive them of the male hormone, the cells say, ‘Well, we don’t care.’ Some of them die, but some of them are injured and they begin to self-protect.” She went on to say that when the researchers designed the trial the thinking was that it was best to deplete the androgen and then, when the cells are injured, reintroduce the hormone so that the cells will stay addicted to it. In this way, clinicians hoped to continue to prolong the duration of response. In trials that tested this earlier on, there was no appearance of harm. Dr Hussain thinks that the reason they were able to detect harm in this new study was because of the large patient sample and due to the fact that it contained the purest population with regard to disease stage.

After a follow-up of 9.2 years, men with minimal disease spread had a median overall survival of 7.1 years in the continuous group and 5.2 in the intermittent group. Conversely, those who had extensive disease spread had a median overall survival of 4.4 years in the continuous group and 5 years in the intermittent group. For men with extensive disease, intermittent therapy was found to be noninferior to continuous therapy, while in men with minimal disease continuous therapy is the preferred treatment.

Several new treatment agents have emerged since Dr Hussain’s study began, and she points out that, “because of the new discoveries there are trials being planned to bring in some of the new drugs that are hormonally based into this population, to see if we can push the bar up.”

Hussain went on to say that, “if you delay the cancer from progressing on primary hormone treatment - if you delay death, and then death occurs because of something else, (unrelated to the cancer) then the mission is accomplished in terms of controlling the cancer.”

Reference.

MORE PROOF THAT HEALTHY HABITS FIGHT DISEASE

New studies look at ways to stop smoking and fight cancer, heart disease and obesity.

REFERENCE. Robert Preidt, HealthDay News, June 2012

Five new studies offer more evidence that healthy habits and preventive care can protect against disease. The studies looked at how eating fish reduces the risk of colon and rectal cancer; how regular teeth cleaning improves cardiovascular health; how primary-care doctors can help patients lose weight; how low-dose aspirin can reduce cancer risk; and how hypnosis and acupuncture can help people quit smoking.

In one study, Chinese researchers reviewed 41 studies published between 1990 and 2011 and concluded that regularly eating fresh fish reduces the risk of colon cancer by 4% and rectal cancer by 21%. Colon cancer is the third leading cause of cancer death in the Western world. Previous research has found that people who live in countries with high levels of fish consumption are less likely to develop colon or rectal cancer.
Letter One:

Dear Editor,

The article about the new MRI was interesting. I had one about 3 weeks ago at a private hospital. The procedure took 20 minutes, and from what I can gather only 2 people were involved.

This basically replaced a need for a biopsy. The latter-mentioned procedure involved a surgeon, an anaesthetist, at least 2 theatre staff and a myriad of clerical staff along the way. Not to mention half a day in hospital and feeling uncomfortable if the drugs doesn’t agree with you (viz, me). Most of the hospitalisation cost for this procedure was covered by either Medibank or Medicare or Bupa, but regrettably the cost of the MRI itself of $570 was NOT.

The logic of not covering the MRI procedure eludes me.

Name and Address provided.

Editor’s note

The rationale for all charges and fees for MRI investigations is determined by Government policy both past and present.

Letter Two:

How do you know when your new cancer drug is working better than expected? And why are drug trials discontinued?

When they shut down the clinical trial so that every participating patient can receive it. The drug Zytiga is kind of a big deal.

The FDA approved its use last year for advanced prostate cancer patients who had already received chemo but whose cancer had still metastasised. The results are so stupendous that the trial was cancelled to allow every patient access to the drug.

Name and address provided.

Editors note

See this QPCN articles, this edition on Drug and Clinical Trials For Cancer, and new health technologies and clinical trials.

TELL YOUR STORY TO READERS OF QPCN (Anonymity preserved if requested)

For assistance with your writing, contact the Queensland Writers Group, which is located in the Queensland State Library and offers seminars and advice to budding writers and authors.

Contact qldwriters@qwc.asn.au, Ph 07 3842 9922

PROSTATE CANCER FAQ’s FOR NEW READERS, No.1

The prostate is the gland below a man’s bladder that produces fluid for semen. Prostate cancer is common among older men. It is rare in men younger than 40. Risk factors for developing prostate cancer include being over 65 years of age, family history, some ethnic groups, and some genetic factors.

Symptoms of prostate cancer may include:
- Problems passing urine, such as pain, difficulty starting or stopping the stream, or dribbling
- Low back pain
- Pain with ejaculation

Your doctor will diagnose prostate cancer by feeling the prostate through the wall of the rectum or doing a blood test for prostate-specific antigen (PSA). Other tests include ultrasound, x-rays, or a biopsy.

Treatment often depends on the stage of the cancer. How fast the cancer grows and how different it is from surrounding tissue helps determine the stage. Men with prostate cancer have many treatment options. The treatment that’s best for one man may not be best for another. The options include watchful waiting, surgery, radiation therapy, hormone therapy, and chemotherapy. You may have a combination of treatments.

FORWARD A COPY

Forward a copy of QPCN to a friend, a neighbour or relative.
The key to conquering prostate cancer is prevention, greater awareness and early diagnosis.

Contact details:
Queensland Prostate Cancer Foundation News (QPCN)
Mail: PO Box 201, Spring Hill Qld 4004
E-mail: qpcn@cancerqld.org.au
Phone: via Cancer Council helpline 13 11 20
Important privacy information
You have received this magazine because you have provided your contact
details to Cancer Council Queensland or to a Prostate Cancer Support Group
(PCSG). The primary purpose of collecting your contact details was to enable
support, resources and information to be offered to you as a person affected
by or interested in prostate cancer. Your contact details are held in the local
office of Cancer Council Queensland. Cancer Council Queensland ensures
compliance with the Privacy Act, and does not use or disclose your details
except as you might reasonably expect. You may access your details and
you may request that we correct or amend (ie update) or delete your details.

If you are a member of an affiliated PCSG you will initially receive by post
or email your local group’s newsletter, the monthly Queensland Prostate
Cancer News (QPCN), and the national quarterly Prostate News. You may also
receive other communications from time to time such as advice on upcoming
symposia, news or surveys from research establishments, details of open
clinical trials and guidelines being reviewed. You may ‘opt-out’ of any of these
services at any time, ie you will no longer receive any material of that type, by
letting us know your wishes. QPCN is available online at http://www.pcfa.org.
au/qld/newsletter.htm. Should you receive multiple copies, please let us know
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LETTERS TO THE EDITOR
May be forwarded to the QPCN at the above address or
e-mail. As the editor of your newsletter I welcome and
encourage your feedback, and will attempt to address
areas of your concern regarding prostate cancer. Tell us
about your individual experiences, and help to share the
load of men and their families affected by prostate cancer.

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THOUGHT FOR THE DAY
It is never too late to become what you might have been. Anon.

Brisbane PCSG – 2012 meeting program
- Cancer Council Queensland, 553 Gregory Terrace, Fortitude Valley.

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<th>Date</th>
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<tr>
<td>Oct 10</td>
<td>“Exercise and Prostate Cancer” – Vicky Graham – Exercise Physiologist University of Queensland</td>
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| Nov 14 | Associate Professor John Hooper - MMRI

‘Prostate Cancer Research at the Mater, a collaborative model.’

Partners of Men with Prostate Cancer meet on the 4th Wednesday of each month between 6pm and 8pm at Cancer Council Queensland’s
Gregory Terrace building. Members come together to share, learn and support each other in a warm open environment. Light refreshments
are provided and there is parking underneath the building. For more information phone Wendy Marshall on 07 3878 4567.

Contact Details
Queensland Prostate Cancer News
Mail: PO Box 201, Spring Hill Qld 4004  Email: qpcn@cancerqld.org.au  Phone: via Cancer Council Helpline 13 11 20
Prostate Cancer Foundation of Australia and Queensland Chapter Council
Mail: (PO Box 10444) Adelaide Street, Brisbane, QLD 4000
Email: queensland@prostate.org.au  Phone: 07 3166 2140

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office of Cancer Council Queensland. Cancer Council Queensland ensures
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except as you might reasonably expect. You may access your details and
you may request that we correct or amend (ie update) or delete your details.

If you are a member of an affiliated PCSG you will initially receive by post
or email your local group’s newsletter, the monthly Queensland Prostate
Cancer News (QPCN), and the national quarterly Prostate News. You may also
receive other communications from time to time such as advice on upcoming
symposia, news or surveys from research establishments, details of open
clinical trials and guidelines being reviewed. You may ‘opt-out’ of any of these
services at any time, ie you will no longer receive any material of that type, by
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