The Digital Examiner

www.prostaidcalgary.org

December 2019 Number 243

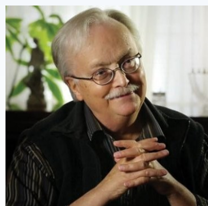
Hello Members and Friends

PROSTAID Calgary

invites you and your spouse or a friend to

Celebrating You

Who: Our Members, Volunteers, Donors & Sponsors.
When: Tuesday, December 10, 7 - 9 pm.
Where: The Hotel at Grey Eagle Resort & Casino.
3777 Grey Eagle Drive, Calgary, AB.
Food: Canapés and One Free Drink. Cash Bar.
Why: Just for Fun.
Music: CK Sax of Calgary.
What to Bring: A Huge Smile.



Our meeting this month will be a social "mix and mingle" event at The Hotel at Grey Eagle Resort and Casino. NOTE: We will not have a general meeting with a speaker or focus group meetings in December at the Kerby Centre.

Now that November and Movember are behind us, our Directors thought we might Celebrate You. We hope to see You on December 10, 7-9 pm at The Hotel at Grey Eagle Resort & Casino.

As 2019 comes to a close, we'd like to thank a whole bunch of people for their efforts to spread our message about prostate cancer, including: our Members, Volunteers, Corporate Sponsors, Donors and especially our Speakers.

PROSTAID Calgary is supported by the community and exists for the community. **Click here to reach our On Line Donation Page at Canada Helps.** If a donation is meaningful to you, it's meaningful to us. Income tax receipts issued.

Stewart Campbell, PROSTAID Calgary

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Click here to help us to continue our good work by donating on-line

PROSTAID Calgary
is a proud member of the Prostate Cancer Canada Network of support groups.

Checking PSA is not stepping onto a slippery slope to inevitable biopsies

Dr. Larry Goldenberg is professor of Urologic Sciences at UBC, chair of the Canadian Men's Health Foundation and director of supportive care at the Vancouver Prostate Centre.

Too much ink and angst have been spilled in debating whether the PSA blood test should be used to screen for prostate cancer.

After 35 years in urology, I do not want to return to the pre-PSA era when men regularly hobbled into my clinic on crutches because prostate cancer had spread to their bones, who required removal of their testicles to give them a few months of relief from their pain.

The PSA test has allowed us to:

- Detect cancer at an earlier stage, and
- Reduce the number of men with widespread metastasis from 40 per cent to less than 5 per cent.

I do agree that the test is not perfect. It has:

- False-positive and false-negative results, and
- Leads to over-diagnosing men with very early-stage cancers that we might be better off not knowing were present.

But simply checking PSA is not stepping onto a slippery slope to inevitable biopsies, surgery, radiation and chemotherapy; *it is just a single decision point*.

PSA screening is like a fishing expedition where the goal is to catch the large fish and toss back the small ones, which may grow over time and be caught at a later date. If a prostate cancer is caught early, and its characteristics are such that it is unlikely to grow quickly, we offer active surveillance and defer therapy unless it changes over time.

If we catch a life-threatening cancer at an early stage (*which is common these days*), we have a chance to control or even cure it. In this way, we can avoid over-treating cancers and not risk "missing the boat."

"Experts" who recommend against PSA screening do so because they look at data and only ask one question: Does PSA screening save lives? (*Indeed, the most modern and best studies suggest that the answer is: Yes*.) But this misses an important point.

Early detection is not just about preventing death. It is also about reducing pain and suffering, even if these men don't die of their cancer. This reality is not addressed in the research studies that are the basis of recommendations against screening.

Let's not throw out the baby with the bathwater. The PSA to a urologist is like a stethoscope to a cardiologist: it is simply a tool to be considered in context of the whole patient and interpreted with medical expertise.

Scientists continue to search for the "holy grail"test that will allow us to separate the good from the ugly without the need of a biopsy. Until then, any harms of PSA-based screening can be minimized by good clinical practice.

Over the past decade we have learned that:

- A very low PSA test in a man in his 40s means that he is highly unlikely to develop serious cancer during his lifetime.
- Annual screening is not necessary, unless he has other risk factors.
- But if his level is high, then he needs to see a specialist to discuss his risks of having prostate cancer.

We call this "smart screening." A rational approach can avoid excess biopsies, and even those that turn out to be negative will have been worth doing for peace of mind.

So for now, we need the PSA. We need to acknowledge the subtleties of its interpretation and to discuss the implications with the patient and his partner.

I am fully biased in favour of PSA testing because many of my patients would be dead today if they had not had it. Unlike many anti-screener academics, I've spent too much of my professional life giving people bad news when I could have given them hope.

Reference: Vancouver Sun. November 15, 2019.

Redesigning Prostate Cancer Screening Strategies to Reduce Overdiagnosis

Its remarkable that even though 30 years have passed since PSA was introduced into clinical practice, researchers and clinicians are still debating its value for PCa screening.

A US Preventative Services Task Force has see-sawed from:

- Stating the PSA testing was a personal decision of the individual man in 2008.
- Concluding that moderate to high certainty harms outweigh benefits in 2012.
- Recommending shared decision-making between the patient and doctor in 2018.

In his article, Dr. Vickers presents three simple, established and accepted propositions about PSA screening, and argues that these lead to some straightforward conclusions:

- PSA screening has both harms and benefits.
- As current practised, the harms and benefits of PSA screening are finely balanced.
- Extensive knowledge has developed on how to increase the benefits and decrease the harms of PSA screening.

Key elements to an effective approach to PSA screening:

- Get consent.
- Do not test, diagnose, or treat unless the patient will benefit from it.
- Use effective treatment.

Reference: Andrew J. Vickers. Department of Epidemiology & Biostatistics, Memorial Sloan Kettering Cancer Center, New York, NY.

Perspective on Prostate Cancer Screening

No biomarker has had more profound impact on the approach to cancer diagnosis, staging and monitoring after treatment than the PSA test. The introduction of the PSA test as a diagnostic tool to monitor and detect prostate cancer occurred in the 1980s. The test was far more sensitive to other tests available at that time.

There is now clear evidence from large population-based randomized trials that early detection and related management by PSA screening reduces a man's risk of dying from prostate cancer. Noteably, extensive use of PSA testing contributed to a 40 - 50% reduction in PCA mortality in the US from 1993 to 2015. However, the widespread adoption of PSA testing of asymptomatic men, combined with liberal criteria to perform a prostate biopsy led to harms associated with over-diagnosis and over-treatment of tumors that would never have caused harm during a man's lifetime.

Many organizations publish guidelines for PSA screening. Below is the Memorial Sloan Kettering Cancer Center recommendation for PCa screening.

1. Start the conversation about PSA testing at age 45.
2. Engage in shared-decision making about the benefits and harms of PSA testing.
   - Consider using a decision aid.
3. Adapt the rescreening interval for a man's age, general health, and PSA level:
   - If the PSA is ≥1 and ≤3 ng/ml, return for PSA testing every 2 - 4 years.
   - If the PSA is ≤1, return for PSA testing every 6 - 10 years.
4. End PSA testing at:
   - Age 60 years, for men with PSA ≤1 ng/ml.
   - Age 70 years, unless a man is very healthy and has a higher than average PSA.
   - Age 75 years, for all men.
5. Consider biopsy if the PSA is greater than 3.0 ng/ml, after considering several factors including:
   - Repeating the PSA test (because of natural fluctuations or test variation).
   - Performing a digital rectal examination and the work-up and analysis for BPH.
   - Perform additional tests that improve the specificity of the total PSA and reduce the number of men needing to undergo prostate biopsy, i.e. tests such as free-to-total PSA ratio, Prostate Health Index, 4Kscore (before initial or repeat biopsy decisions) or the urinary PCA3 test (before repeat biopsy).
6. If a man is diagnosed with PCa after PSA testing and biopsy:
   - Consider active surveillance for low-risk disease.
   - Refer men with high-risk disease for curative treatment, preferably at a high-volume hospital.

Reference: Sigrid V. Carlsson and Hans Lilja. Clinical Chemistry 65:1 24-27 (2019).

4Kscore Discriminates PCa and Aggressive Disease in a Multiethnic Population

Introduction and Objectives: The four-kallikrein panel, marketed as the 4Kscore, has been demonstrated to improve prediction of aggressive prostate cancer compared to PSA alone or PSA in combination with free PSA. However, to date, the development of the 4Kscore has been limited primarily to White or African American men. Here we prospectively evaluated 4Kscore in a study of African American (AA), Latino (LA), Japanese (JA), Native Hawaiian (NH) and White (WH) men in a Multiethnic Cohort (MEC).

Methods: Pre-diagnostic blood levels of free, intact, total PSA, human kallikrein-related peptidase 2 (hK2) and microseminoprotein-b (MSP) were measured among 2,227 PCa cases and 2,189 controls. Analysis compared the discriminative ability of the 4Kscore compared to PSA alone for overall prostate cancer, Gleason-Grade Group (GGG) 2 or higher, and aggressive disease (Gleason >7, non-localized disease, or death from prostate cancer) within and across all racial/ethnic groups.

Results: Improved discrimination of the 4Kscore over PSA was observed in each racial/ethnic group for overall prostate cancer as well as for aggressive disease. The addition of MSP to the four-kallikrein panel did not substantially improve the discrimination for overall prostate cancer or aggressive disease.

Conclusions: In this multiethnic study, the superior ability of the 4Kscore panel over PSA shown for overall prostate cancer and aggressive disease indicates that 4Kscore has broad clinical utility.

Reference: Christopher Haiman, Peggy Wan, Alisha Chou, Los Angeles, CA; Emily Vertosick, New York, NY; Lynne Wilkens, Loic Le Marchand, Honolulu, HI; Andrew Vickers*, Hans Lilja, New York, NY. The Journal of Urology Vol. 201, No. 4S, Supplement, Monday, May 6, 2019

MyHealth.Alberta.ca

Prostate Cancer Screening: Should I have a PSA test?

A key question for each man entering mid-life (age 40 - 45) is whether he should start testing for his prostate cancer risk using PSA on a regular basis or whether his spouse or friends should encourage testing for prostate cancer risk.

Alberta Health Services has an excellent web-based channel presenting all sorts of information about men's health and wellness, including PSA testing. To get AHS's view on PSA testing, visit www.myhealth.alberta.ca.

For Peer Support about Prostate Cancer

- Attend a general meeting for a live presentation and Q&A provided by leading prostate cancer specialists.
- Join one of our private focus groups i.e. Newly Diagnosed, Warriors, Ladies and Caregivers.
- Borrow publications from our Library.
- View > 100 video presentations on our YouTube channel.

New in Our Library - Available at our Monthly General Meetings

The Best Treatments Strategies for BPH

John Edward Swartzberg, MD, FACP

Dr. Swartzberg is Professor of Urology at the Brady Urological Institute of the John Hopkins Medical Institutions in Baltimore, Maryland. He has extensive experience with surgery for both benign and malignant diseases of the prostate, for bladder injuries resulting from obstruction, and for incontinence resulting from long-standing obstruction or surgical injury.

Some points from the publication:

- It's a sure thing that sooner or later, as a man ages, his prostate is going to make its presence known.
- Many men don't even realize they have a prostate until they alerted to some "below the belt" issues:
    - ◊ Prostatitis
    - ◊ Benign prostate hyperplasia i.e. enlarged prostate
    - ◊ Prostate Cancer
- BPH or enlarged prostate causes 40 to 50% of men who reach their mid-century mark to have difficulty urinating and to suffer from nocturia, or excessive night-time urination.
- By age seventy, 70% of all men have BPH and 25% of them will require treatment.

This publication is easy for a lay-person to read and has lots of illustrations to help in understanding. A questionnaire is provided to help readers understand the severity of the symptoms from BPH.

Dr. Swartzberg emphasizes that if you think you have BPH symptoms, that you should contact your doctor immediately, and ….. the sooner the better.

Obstructive BPH symptoms may include:

- Frequent & urgent need to urinate both day & night
- Difficulty starting urination
- Weak urine flow
- Stopping and starting urine flow while urinating
- Feeling unable to completely empty the bladder
- Unexpected bed wetting

Irritative BPH symptoms may include:

- Frequent & urgent need to urinate both day & night
- Leakage of urine before getting to the bathroom
- Sexual dysfunction and changes in circulation

If you think you've got BPH, this publication is well worth reading.

Depression and Anxiety

Sagar V. Parikh, MD

Dr. Parikh is Professor of Depression and Clinical Neuroscience and Professor of Health Management and Policy School of Public Health, University of Michigan, and Associate Director of Michigan Comprehensive Depression Center.

The 2019 Depression and Anxiety White Paper is an up-to-date guide to understanding the causes, symptoms and management of mood disorders including:

- Depression and bipolar disorder.
- Anxiety disorders ranging from panic and generalized anxiety to obsessions and compulsions, post-traumatic stress, and phobias.

The publication provides:

- An overview of what medical specialists know about mood and anxiety disorders.
- Reports on the latest studies and medical advances.
- Feature articles on special topics including:
    - ◊ Caregiver burnout.
    - ◊ How to keep the strain from snowballing into depression.
    - ◊ What to do when a depression treatment doesn't work.
    - ◊ Switching antidepressants. The transition isn't always smooth.
- Replies to "Ask the Doctor" questions from patients.

Life on Androgen Deprivation Therapy

This educational program is ideal for PCa patients (and their partners) who will be on ADT for at least 6 months. Patients are encouraged to join the program before they start ADT or as soon as possible after starting on ADT.

Online classes are available monthly. All classes are held at 4:00 PM Mountain time. **Upcoming date:** Tuesday, December 17. **To Register:** visit www.lifeonadt.com

Thank you to our Sponsors and Community Partners

Janssen, Bayer, astellas, CanadaHelps.org giving made simple, Wild Wednesday, Lions International, Spolumbo's, Kerby Centre, Fountain Tire Crowfoot – We're on this road together, Michener Allen Auctioneering Ltd., MNP LLP, Calgary Foundation, Mighty Oak Promotions, Rotary, Calgary Stampeders, AGLC Alberta Gaming & Liquor Commission, Calgary Football Officials Association, Prostate Cancer Canada, Village, West Canadian Digital Imaging Inc.