Radiation Proctitis: An overview

With a large number of prostate cancer patients having undergone radiation treatments, the inevitable question arises: what damage can radiation therapy do?

At the PCAO’s January meeting, Dr. Hussein Moloo of the Ottawa Hospital described in considerable detail the effects of radiation treatment. What follows is an overview from his powerpoint presentation.

What is Radiation Proctitis?
- Acute – direct damage from radiation
- Chronic – usually 9-14 months after exposure (Can occur any time after...up to 30 years!!!)
- Small blood vessels feeding the mucosa get damaged – chronic ischemia (low blood supply)
- This area is prone to bleeding, strictures

What are the Symptoms?
- Diarrhea
- Bleeding
- Pain/urgency
- Incontinence
- Obstructed defecation
- Small bowel radiation – fistulas, small bowel obstruction, small bowel bacterial overgrowth
- Injury to genitourinary tract – fistulas, urethral stenosis, cystitis

Screen for Colorectal cancer
- Higher risk of colorectal cancer post radiation

Treatment
- Lots of different treatments...
- Base treatment on type of symptoms
  - Mild:
    - i.e. patients with small amount of rectal bleeding
    - A lot of these will resolve without any treatment
    - Stool softeners
  - Other Treatments:
    - Dilation
    - Sulfasalazine/aminosalicylates (oral or enemas)
    - Steroid enemas
    - Sucralfate enemas

Even more...
- Hormonal (estrogen)
- SCFA enemas
- Flagyl
- Formaldehyde
- Vitamin A, C, E
- Endoscopic therapy: argon plasma coagulation, lasers, bipolar/heater probes

Surgery:
- For intractable problems with strictures/pain/bleeding
- High rate of needing colostomies

Dr. Hussein Moloo is a general surgeon at the Ottawa Hospital. He currently has a colorectal fellowship at the University of Ottawa’s Centre for Minimally Invasive Surgery.
leadership Team Meeting  | january 28, 2010

Treasurer’s Report – Bank balances for month ending December 31st 2009 as:

- Alterna Savings & Chequing Account – $11200.68
- Savings in Trust – $3946.16
- Manulife Bank Business Advantage Account – On Budget

The Membership Drive response from October 1st is: 280 renewals for $12,745.00. $355.00 of this was deposited in January and is not reflected in the above balances.

Additional $235.00 from Canada Helps. 2009 tax receipts, except those received in 2010, have been mailed.

Administrative Report – Normal activity on the web site and Help Line. Gerry Gilbert volunteers to handle canteen nutrition breaks. Still looking for a volunteer to take over from Ron Marsland in assigning volunteers to Outreach Activities. Report tabled on discussions with the Ottawa Regional Cancer Foundation. Wilf Gilchrist and John Dugan will represent PCAO on the Do It For Dad organizing committee. Theme for 2010 = “Men’s Wellness” with funding for the Cyber Knife, a $3.5 M cancer tool. The PCC Support Group Affiliation Agreement committee reported on deliberations. Concern with funding, name change, Do It For Dad. and other items reviewed. Final report next month leading to eventual document signing. Murray indicated no volunteers to take on Secretarial duties. Diane offered to provide translation service required for our new PCAO Brochure once the PCC and PCAO issues are finalized.

Membership Report – Bill Dolan satisfied with our January meeting except the business session was too long. We must respect our speakers’ presence and the reason our members attend meetings. No need to have a business segment longer than 15 mins. We will consider alternate speaker and town hall meetings. Bill also commented on plans for topics and speakers as well as video presentations to support alternate programming. Diane expressed plans for meetings of our Women’s Group, possibly including male members.

Mentoring = This continues to be an important segment. It deserves publicity to attract the newly diagnosed. Pat Dolan will direct our efforts on getting the word out. A new member has volunteered to assist Harvey Nuelle on a request from Nordion for a PC presence at a Wellness Fair. Other requests expected soon.

Outreach = Jan and Tom Clapp have asked us to support a breakfast fundraiser April 24th with proceeds toward PCAO. We provided items to spice up the morning. “Game Breakers,” a local sports card store, has asked us to support a PC Awareness Benefit Day April 13th. They are inviting all sports card enthusiasts to join them with proceeds to PCAO.

Communications – Richard Bercuson and John Dugan are having discussions with a firm to provide graphics support for the Walnut. This edition of the Walnut reflects those discussions.

We have about 1500 copies of ATP in the printer’s inventory.
Sir Andrew Lloyd Webber has written an excellent first-hand account of his own recent prostate cancer diagnosis. It appeared in the Feb. 3 edition of Mail Online whose website can be found by typing into Google: Andrew Lloyd Webber + prostate cancer

Look for the link to dailymail.co.uk. It should be one of the first 3-5 results.

The article is too lengthy to reproduce in The Walnut. However, men are urged to read it online.

Here is how it begins:

When I was told that I had prostate cancer what hit me most was not the news about my nether regions but the reaction of my PR honchos.

“Say you are run-down, need a hospital check up! Say you have an infection, E.coli sounds good.” (I didn't know that I had actually got an infection – more of this later.)

I suggested saying I was having a boob reduction. That didn’t go down well.

“Say what you want,” they chorused. “But don't use the dreaded ‘C’ word. Do not say you have cancer.”

Why? I thought. I have prostate cancer.

Sir Andrew Lloyd Webber writes about his PC experience

Next Monthly Meeting

Thursday, February 18, 2010

6:30-7:30 pm: Mentoring for newly diagnosed in the Shalom Room

7-7:15 pm: Association business

7:15 pm: The meeting will feature a DVD film recorded from Dr John Mulhall’s presentation titled: "Sexual Problems in the Male Patient with Cancer-Erectile Dysfunction.” After the film we will have a “round table discussion” with all members hopefully contributing.

We meet the third Thursday of each month at St. Stephen’s Anglican Church, 930 Watson Street. Follow the Queensway to the Pinecrest exit and proceed north, past the traffic lights, to St. Stephen’s Steet on the left. Parking is at the rear of the church.

Please remember your contribution for the St. Stephen’s food bank.

Variation in prostate cancer control among surgeons

From 2010 American Urological Association Education and Research, Inc.

It has long been known that patient outcomes and complications after prostate surgery vary among surgeons to a greater extent than may be accounted for by chance.

In an article to be published shortly in the Journal of Urology, Bianco et al. have now reported that such so-called “heterogeneity” is also evident even among experienced, high volume surgeons. In other words, which of two experienced, high volume surgeons that a patient gets treated by may impact his long-term outcome post-surgery.

The authors studied data from 7,725 patients with clinically localized prostate cancer treated by a total of 54 surgeons at 4 major American academic medical centers between 1987 and 2003. Biochemical recurrence was defined as a serum PSA level ≥ 0.4 ng/ml, followed by a higher level. The core results of this study were as follows:

- There was statistically significant heterogeneity in the prostate cancer recurrence rate that was independent of surgeon experience (p = 0.002).
- 7 experienced, high volume surgeons had an adjusted 5-year prostate cancer recurrence rate < 10 percent.
- 5 experienced, high volume surgeons had an adjusted 5-year recurrence rate rate > 25 percent.
- Significant heterogeneity was still evident after the authors made appropriate allowances for possible differences in patient follow-up, patient selection, and stage migration.

The authors conclude that a patient’s risk of recurrence after radical prostatectomy may differ depending on which of 2 surgeons the patient sees and gets treated by – even if the surgeons have similar experience levels.

continued on page 5
The PCA3 test is currently available in Canada, but is not covered by provincial health plans. Clinical trials are being conducted in Canada and the US on the PCA3 test to further evaluate the safety, accuracy and utility of the test.

Patients can request the PCA3 test but must pay for it ($375) at the moment. Some insurance companies reimburse patients for the cost of the test. The test is produced by a US company called Gen-Probe and the kits can be brought into Canada by any lab that would want to offer it. Due to the limited clinical data and the high cost of the test, physicians do not routinely use the PCA3 test.

The current number of publications on evaluation of PCA3 is limited. Therefore in order to support an expanded regulatory approval and payment by provincial health plans, Gen-Probe is conducting clinical trials in Canada and the US to determine the benefit of the PCA3 test for men at risk for prostate cancer.

PCC will continue to monitor the clinical data published in peer-reviewed journals pertaining to the PCA3 test. If the data support its use, it may be helpful for teasing out patients that have a negative biopsy and continue to have high PSA levels and who should have repeat biopsies. It could also be used as a potential adjuvant to a persistently rising PSA with multiple negative biopsies as an indication for MRI or transperineal biopsy.

PCC will monitor the progress of ongoing PCA3 clinical trials and evaluate new data. In summary, PCC is not currently advocating general use of the PCA3 test until Gen-Probe completes their clinical trials and obtains the necessary federal regulatory approvals.

Who should be screened, and when?

As with mammograms for breast cancer screening, prostate cancer screening has become somewhat controversial, with some experts offering different advice.

Generally, it is still recommended that starting at age 50, all men should have a yearly PSA and a digital rectal exam. However, African-Americans, who are statistically more likely to get prostate cancer, and men with a family history of the disease should start at age 40. Family history increases the probability of prostate cancer by four to seven times above the average.

Prostate cancer is the most common cancer in men, and the second leading cause of cancer death among men, second only to lung cancer.

Why is screening controversial?

First of all, the PSA is far from a perfect test, though for now it’s what we have. You can have an elevated PSA and not have cancer, and you can have a normal PSA but still have cancer. That’s why it’s important to have a baseline exam. I’ve had patients who had “normal” PSA levels, but because they were higher than their baseline numbers, we knew to investigate further.

Two studies published in The New England Journal of Medicine on whether screening reduces deaths due to prostate cancer came up with different results. The American study included many men who had previously been screened, and those with cancer were eliminated from consideration. But the European study had mostly men who were never screened, and therefore more of them were diagnosed in the course of the study, showing a greater benefit for screening.

Overall, the studies did show a 20 to 25 percent reduction in the risk of death from prostate cancer among men who had regular screenings.

You’ve practiced urology for 40 years. What’s your opinion of screening?

First off, I personally have my PSA test done yearly.

Second, it’s important to remember that 20 years ago, more than 60 percent of men with prostate cancer couldn’t be cured, mostly because their cancers were too advanced by the time they were detected. Today, thanks to better detection, 91 percent of men with prostate cancer have localized, mostly curable cancers.

So until we have a genetic test or a better test than the PSA, I believe screening should proceed as recommended. Men should discuss this with their family doctors or urologists to decide what is best for them, given their age, history and other health issues.

And on the subject of testing, many men ask me about “watchful waiting” — the idea that some cancers that are so small, they need not be treated, only monitored. Let me just say that we have no test to tell us which cancers will be aggressive and which ones won’t. Until we do, doctors have little choice but to treat the cancers we find.

Dr. Jerrold Sharkey is a prostate cancer educational consultant in Palm Harbor, FL, who was in full-time urological practice for 40 years.
The American Heart Association, the American Cancer Society, and the American Urology Association have come together to issue a joint “science advisory” on androgen deprivation therapy (ADT) and cardiovascular risk. The document has also been endorsed by the American Society for Radiation Oncology.

The entire document is available on line, on the web sites of the various organizations. The “New” Prostate Cancer InfoLink recommends this science advisory as a resource document for prostate cancer support group leaders and other prostate cancer educators.

We can summarize the key findings of this science advisory as follows:

1. ADT can adversely affect traditional cardiovascular risk factors, including serum lipoprotein levels, insulin sensitivity, and obesity.
2. Recent studies have reported a relationship between ADT and an increased risk for cardiovascular disease in patients with prostate cancer.
3. At this time, there are no definitive data on whether ADT is associated with an increased risk of cardiovascular death.
4. There may be a real relationship between ADT and cardiovascular risk in at least some men with prostate cancer.
5. At this time, patients for whom ADT is believed to be beneficial should be treated by their normal clinician and do not need referral to internists, endocrinologists, or cardiologists for evaluation before initiation of ADT.
6. Also, at this time, there is no role for specific cardiac testing or coronary intervention in patients with cardiovascular disease before initiation of ADT.
7. Physicians treating patients for prostate cancer should carefully weigh the potential benefits of initiating ADT against any possible risks in each individual patient.
8. Patients being treated with ADT for prostate cancer should be referred to their primary care physician for periodic follow-up, because of the metabolic effects of androgen deprivation.

In addition, the science advisory points out that all patients with a history of heart disease should always receive secondary preventive measures as recommended by the American Heart Association and other expert organizations, including, when appropriate, lipid-lowering therapy, antihypertensive therapy, glucose-lowering therapy, and anti-platelet therapy.
Hear Ye!  Hear Ye!  Hear Ye!

Outreach Program

We have an urgent need for someone to be responsible for our volunteer Outreach Program. Ron Marsland has been in charge of this for a few years and now has to give it up for personal reasons. Ron has volunteered to train his replacement. This could be a couple, husband and wife, and will not take more that 5 to 8 hours a month at the most dependent on our outreach activities. You will be provided with all the tools needed to make the necessary telephone contacts. Please see or call John Dugan at (613) 837-1921 to discuss this in more detail. Help us to help others.

Defibrillator Training

St.Stephen's Anglican Church now has defibrillators installed in various locations. Members of the congregation have been trained to use them. We have been asked if we have any members who have had training on the use of these life-saving devices. If you have had such training or would be interested in taking a training course, please contact Murray Gordon for details. It would be wise to have a number of our members trained in their use in the event of sudden need during one of our meetings.

Meeting Decorum

Members are reminded to show their hands for question recognition and use the available floor microphones during the meeting question and answer segments. In this way all attendees can hear both the question and the guest speaker’s answer. It’s also expected that members with a question will stand in respect for both the speaker and the audience. Please do not pose questions that are obviously beyond the speaker’s capabilities or do not conform to the requirements of good taste or social convention. It’s essential our guest speakers leave with a comfortable feeling and be readily available if called upon again.

New Wellspring Centre gets funding

by Linda Eagen
President and CEO | Ottawa Regional Cancer Foundation

This is an exciting day for cancer survivors and patients in our community. I am pleased to confirm to you that the Ottawa Regional Cancer Foundation has received $1.7 million in infrastructure funding to build Wellspring Ottawa.

The Honourable John Baird, Canada’s Transport and Infrastructure Minister and the Honourable Madeleine Meilleur, Ontario’s Minister of Community and Social Services, made the announcement during the annual Cancer Foundation Telethon.

This important funding will allow the Cancer Foundation to build Wellspring Ottawa adjacent to the Richard and Annette Bloch Cancer Survivors Park, with doors scheduled to open in 2011.

Wellspring Ottawa is a vital project for our community and will impact thousands of local residents by providing much needed psychosocial services to cancer patients and their families. You can find out more about exciting new developments on the project by visiting our website at www.ottawacancer.ca

Thank you for your continued support and generosity!