PHAROS

A beacon of hope in the darkness

Newsletter of the Reading Prostate Cancer Support Group (RPCSG)

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THE MARCH 2024 MEETING

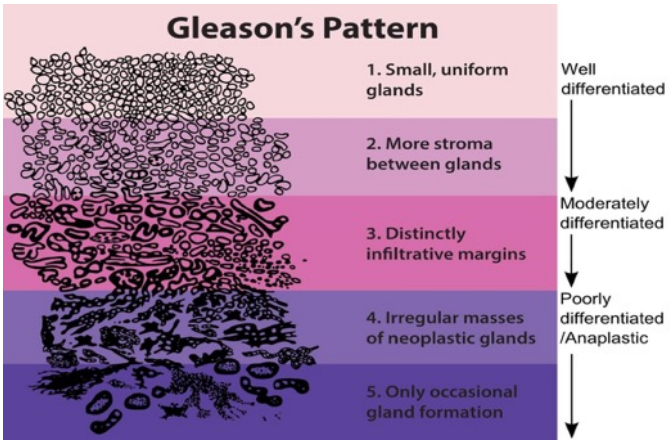
The March meeting was an interactive Question & Answer session at which questions on any aspect of prostate cancer could be raised. Members had been invited to submit their questions either to our medical email or to ask new questions at the meeting. Answers were provided by our hospital liaison nurse Beverley along with urology nurse Sammi Kaur-Gill. Both Sammi and Beverley are Clinical Nurse Specialists with great experience in urology.

The Q&A session was very popular and there were many questions from the audience during the evening. Beverley and Sammi first described the PSA measurement and the Gleason score that are two items that often need explanation. The following is a summary of the talk and questions raised:

A normal prostate gland produces a protein called PSA (Prostate Specific Androgen). Prostate cancer cells produce more PSA and so an elevated PSA level suggests that cancer cells may be present. The PSA level will rise as the cancer cells multiply. The table on the right shows the normal values of PSA at different ages. A raised PSA does not necessarily mean the cancer is present, as other things can cause a raised PSA such as cycling, an enlarged prostate, an infection or a digital rectal examination. Biopsies are usually, but not always, carried out to determine whether cancer is present. PSA level after treatment is dependent upon the treatment received, and a useful indicator is whether the PSA level is stable rather than its measurement value.

AGE RANGE (Years)	NORMAL PSA (ng/ml)
All ages	<4.0
40 – 49	<2.5
50 – 59	<3.5
60 – 69	<4.5
>70	<6.5

The Gleason score is a measure of the aggressiveness of prostate cancer and can only be measured by a histopathology laboratory that looks at biopsy samples through a microscope and then assigns a grade to the cells seen. Normal cells are seen as regular and well defined cells, whereas cancer cells appear irregularly spaced and have indistinct edges. The Gleason scale originally ran from 1 (least aggressive) to 5 (most aggressive) but as there is little difference between grades 1 and 2 the scale now runs only from 3 to 5. Beverley showed a diagram of the appearance of cells of different grades, as in the picture on the right.



The Gleason score consists of two numbers (e.g: 3+4). The first number is the grade of the most prolific cancer cells, the second number is the grade of of any less prolific cancer cells seen. For example if a a histopathologist sees that the majority of cells are grade 3 and there is a lower presence of grade 4, the score would be 3+4. If all of the cancer cells seen are of one grade only then the number is repeated, e.g. if a pathologist saw only grade 4 cells and no other grade of cells, then the Gleason score would be 4+4.

Sammi (left) and Beverley

The following is a summary of the questions asked, and their answers.

Hormone treatment lowers the PSA level and on completion of treatment the PSA can rise as cells settle down, and again an important factor is whether the PSA stabilises.

Q: During Active Surveillance what factors are taken into account before treatment?
A: PSA can fluctuate during Active Surveillance, during which regular MRI scans and PSA measurements are taken (every 4 months or so). Many factors are taken into account such as whether the tumour is localised, the amount of cancer cells, the PSA level at diagnosis, whether it is stable or rising, the time for PSA to double, the Gleason score, and the patient's lifespan. Also the recommendations of members from the urology team are considered.

Q: PSA measurements seem to have changed recently.
A: A system using Abbott machines is being used that does not provide a figure if the PSA is less than 0.025 (which is considered to be an undetectable reading), instead the PSA result is stated to be 'less than 0.025'. Above 0.025 the exact measurement is provided but it may only be to two decimal places. The pituitary and adrenal glands produce a small amount of PSA and so the level cannot be zero.

Q: What is the maximum PSA?
A: A patient had a PSA of 22,000 due to a very unusual and rare tumour. Another person had a level of 6,000 and was fit and healthy. Again, the target is a PSA that is stable.

Q: How is Gleason assessed over several cores?
A: For example, if a core has only grade 3 cells and there is some grade 4 in any other core then the score would be 3+4 and the treatment would be that appropriate to grade 4 tumour cells.

MRI before biopsy enables biopsies to be targeted
The MDT discusses all cases, and if a patient has a non-cancer biopsy but the radiologist suggests that there may be a problem, the case is further reviewed.

Q: After a negative MRI then a positive biopsy should I have had a second MRI before a treatment decision was made?
A: The MDT reviews all cases and looks for correlation between the MRI and biopsies and will arrange further tests if necessary.

Q: When can Enzalutamide and Abiraterone be used?
A: Enzalutamide and Abiraterone are very similar drugs with slightly different side effects and can be used before chemotherapy as they enhance the effectiveness of chemotherapy. The organisation NICE has said that the NHS can only prescribe one of these two drugs, once one of them has been used the other cannot be used.
There is now a triple therapy using Docetaxal, Darolutamide and LHRH implant, this new treatment can be used on newly diagnosed metastatic patients.

Q: Can a patient switch between drugs?
A: There is a window after starting to use either Enzalutamide and Abiraterone for the patient to switch to the other in the event of adverse reactions or intolerance to the first drug but after that window it is not possible to swap between them.

Q: Erectile Dysfunction after treatment.
A: There is an andrology clinic for penile rehabilitation that patients can be referred to after surgery. Nerves that cause erections form a mesh around the outside of the prostate gland and if these are damaged or removed during surgery then erectile problems can occur. After surgery damaged nerves can possibly recover after 2 or 3 years. The objective of the surgeon is firstly to save life by removing the cancer and the preservation of nerves is secondary. The surgeon will use the MRI and biopsies to decide how many nerves he can preserve on either side.

Q: Does Retzius technique cause less nerve damage?
A: The Retzius space is an area in front of the prostate that can damaged during access to the prostate for surgery. A new prostatectomy technique known as Retzius sparing approaches the prostate from below and avoids the Retzius space. It is more difficult, takes longer and few surgeons are able to perform it. The technique has been found to produce similar continence end results as non-Retzius sparing but results in a quicker recovery of continence, by a few months.

Q: What research is taking place?
A: The guest speaker at the next group meeting will be Fola Fakorede who is a research nurse at RBH and will talk about research.

Information: A trial was conducted about 6 years ago to determine how many men with a Gleason of 3+3 were treated rather than have Active Surveillance. Since then MRI has become more widely used and now a screening trial using MRI has started, that may lead to a national prostate cancer screening programme. However there is some concern that authorities are waiting for the outcome of the trial that could take about 7 years, before a decision on screening is made.

After prostatectomy there are usually issues with incontinence that should clear in a few months. If incontinence is a problem after one year then a patient can be referred to the Continence Service.

Sammi and Beverley were thanked for their very useful information and responses.

RPCSG WALKS AND COFFEE MORNINGS

There was a walk held in March, at Dinton Pastures. It was very pleasant with a refreshment stop at the café.

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