PHAROS

A beacon of hope in the darkness

Newspaper of the Reading Prostate Cancer Support Group (RPCSG)

Issue 24: May 2013

EDITOR'S FOREWORD.

I would like to pass on a hint to anyone who is to undergo a PSA blood test. Your PSA level can be temporarily increased by the activities of riding a bicycle or motorcycle, or having an ejaculation. (Note my careful use of 'or' rather than 'and', as I realised that my first attempt at this sentence could have been interpreted as a raised PSA by having an ejaculation whilst riding a bicycle). Advice is to avoid these activities for at least 24 hours before a PSA blood test. I only discovered this after cycling to the surgery for my first PSA test, and subsequently I avoided these activities for at least three days before any test. I enjoy cycling but have not ridden my bicycle since my biopsy more than six months ago, and definitely not since my prostatectomy in January, in case of affecting my internal bits.

The above will apply to anyone prior to treatment, but I am not sure whether it applies post-treatment. I will play safe anyway and observe the precautions.

TRAVEL INSURANCE.

We have not visited travel insurance for quite some time. I would like to gather together members' experiences so that we may all benefit when it comes to renewal time. This is especially interesting to me, as I renewed my annual multi-trip Europe travel insurance in September last year (£70.03 for two people) and at that time I had a holiday already booked for May 2013. I was later diagnosed with prostate cancer and then had radical prostatectomy in January 2013. I informed the travel insurance broker (Employee Advantage) of my condition, and was told by a company representative that any holiday already booked at diagnosis would be covered, but that any later bookings would be covered only on satisfactory replies to a set of questions by them, which may result in increased premiums, or exclusions from cover. This was a surprise to me, as I thought that once a premium had been paid for 12 months cover in advance, then any subsequent new illnesses would be covered during the remainder of the term of the cover.

I was told the questions that I would have to later answer for cover for later trips, one of which was an ambiguous "Are you taking strong painkillers?" I asked the rep for the company definition of 'strong', and advised him that I was taking Ibuprofen and Tramadol and asked him to tell me whether they are classed as strong or not. He could not provide any answers. I politely suggested that the company is asking the wrong question. I think that we all know the importance of answering insurance company questions accurately, otherwise they can void any claim. I will have to be very careful at renewal in September of this year.

I then started to use the internet to explore the issue of travel insurance, for both illnesses and age, and found there is extensive cover of the subject. It seems that many companies will not offer cover for cancer patients. I found the article below very interesting and it mentions some problems when having treatment abroad, and the fact that you cannot rely on the EHIC card, which in many cases is not having the effect that it should. It also lists some companies that will offer cover for cancer patients, although possibly at an elevated price: *http://www.thisismoney.co.uk/money/holidays/article-2307958/Travel-insurance-illness--EHIC-covers.html*. In this article it mentions Eurotunnel as a provider with few questions

asked. I believe that this also applies to Saga when you book one of their holidays.

I have concluded that the way forward may be to buy cover for individual holidays rather than annual multi-trip, as dependent upon how many trips you expect to take in a year, the cost of individual covers could be less than a multi-trip policy.

A further issue is age. I have found that there are a reducing number of companies offering cover as age increases, with increasing difficulty around the age of 70 and over.

I would like to compile a list of travel insurance companies that members have found useful, and those that are less useful. I would like to hear from members about their experiences, by emailing me at *newseditorRPCSG@yahoo.com*. Has anyone used the banks' packaged current accounts including travel insurance?

Any information provided will be strictly confidential.

THE MAY MEETING (3rd May 2013).

Dr. Fawaz Musa is a Consultant Histopathologist at the Royal Berkshire Hospital. He gave an excellent presentation on the 'Pathological Diagnosis of Prostate Cancer' covering the main areas of: Prostate Cancer, The Causes, Symptoms, Diagnosis, Grading, Staging and Treatment.

Dr. Musa is one of the histopathology team of six people who examine and report on biopsy samples. They handle about 800 samples per year of all types, of which about 7%-10% are from prostate glands. Dr. Musa explained that prostate cancer is the most common cancer in men, and is rarely found in men under the age of 50. In 2007 prostate cancer accounted for 24% of male cancers, followed by lung cancer (15%) and Colorectal cancer (14%).

The Causes: The causes of prostate cancer are not clear, however the risk is greater if having a father or brother with the disease, and being of Afro-Caribbean or Afro-American origin carries a higher risk. Prostate cancer is mostly slow growing, but in a small proportion of men can be quickly growing, requiring earliest treatment. Interestingly, only 1 in 25 men with prostate cancer will die from the disease.

Symptoms: The symptoms of the disease are mainly with urination: difficulty in passing, increased frequency, a feeling of incomplete emptying, and rarely, blood in urine. However, all these symptoms may be from an enlarged prostate (BPH, or Benign Prostatic Hyperplasia). In the case of advanced cancer, weight loss and pain in bones, loins, pelvis or lower back may be experienced.

Diagnosis: This comprises DRE (Digital Rectal Exam) whereby the prostate is felt through the rectal wall (although this examines only the rear portion of the prostate), PSA blood tests (although an elevated reading can be caused by other things), a prostate biopsy (the definitive test for PCa (Prostate Cancer)), and CT/MRI/Bone scans, to asses whether the cancer has spread.

Grading: Dr. Musa described that prostate biopsy samples are received in the form of cylinders of tissue about 1mm in diameter and 15-20mm in length, usually five from each side of the prostate gland. The samples are treated in a solution overnight and then dissected into 3 micron slices, and later can have markers added which improve the contrast between cancerous and non-cancerous cells making identification easier. He then showed a series of slides illustrating the views under a microscope of the various degrees of cancer grades. The audience struggled to see the differences between cancerous and non-cancerous cells and their grades, but Dr. Musa explained that to his trained and experienced eye, there were definite differences between cancerous and non-cancerous cells and grades. The audience appreciated this fact!
Cancer is graded according to the Gleason scale, which has been around for a long time. The Gleason scale runs from 1 to 6, but scales 1 and 2 are small, and grade 2 has been combined with grade 3, so only grades 3 to 5 are used. The histopathologist looks at the most populous cancerous cells and gives them a first grade, and then the second most populous cells are graded. If the most populous cells are grade 3 and the

second most populous cells are also grade 3, then the Gleason score is 3+3. If the second most populous cells were grade 4 then the score would be 3+4=7. Scores are classified as Least Aggressive has a score of 6, Moderately Aggressive has a score of 7. and the Most Aggressive has a score of 8 or more.

Staging: A rating system known as TNM is used to assess the stage of a cancer. The letter T stands for tumour and is followed by a number in the range 1 to 4.
T1 means a small tumour within the capsule
T2 is a tumour within the capsule but large enough to be felt by DRE or seen by ultrasound.
T3/T4 has spread outside the capsule.

Treatment: Although Dr. Musa's area does not extend to treatment, he listed the possible treatments as Active Monitoring, Surgery, Radiotherapy, Brachytherapy, Hormone Therapy and Cryotherapy, and described each in general terms.

In conclusion, Dr. Musa said that it is frustratingly difficult to determine whether a cancer is slowly or quickly growing; prostate cancers can become more aggressive, but the time taken to do this can vary from a few years up to 30 years or so. He hoped that advances in medicine are likely to yield better identification of this, possibly by DNA or gene based methods.

The audience then had several questions, during which Dr. Musa gave some more detail of tumour T3:

T3 is sub-divided into T3a and T3b. T3a is a cancer that has spread beyond the capsule but not invaded surrounding areas. T3b has extended outside the capsule and invaded surrounding tissues, primarily the seminal vesicles.

Our appreciation was expressed to Dr. Musa in the form of a gift of a bottle of a liquid treatment, to be taken by mouth as often as desired!

FUTURE MEETINGS

The plan for future meetings is as below – this is provisional and confirmation of each event will be sent out shortly before each meeting:

7 June 2013: Dr. Neil Derbyshire – Consultant Radiologist, with a specialty interest in cross sectional imaging.

5 July 2013: Geoff Morris from Prostate Cancer UK will tell us about the work of the charity.

2 August 2013 : An open meeting

FUTURE EVENTS

It is planned to again have a presence at the Earley 'Green Fair' on 8th August 2013.

NEW MEMBERS.

We welcomed two new members with their partners at the May meeting. All members are welcome to contact any of the support contacts below, should they need any support for their condition.

SUPPORT CONTACTS

For any member who would like some help or support from the Group, or simply would like to chat with someone – perhaps another member who is or has been in a similar situation – any of the members below can be contacted:

Steve Allen	01189 266 747
Ian Forrester	01189 789 857
Keith Jackson	01189 842 999
Paul Sefcick	01635 34778
Graham Cook	01189 691 668
Steve Parkinson	01189 785 268

Please note that in issue no. 23 a digit was omitted from Paul Sefcick's number – this has been corrected above.

RPCSG WEB SITE

Laurie Fineman has some imminent other commitments, but is close to setting up a draft website.

INTERESTING ARTICLES

In issue no. 23 I gave a link to the story of Dr. Roger Kirby, and also in issue 23 there was a report of the debate on whether PSA testing is good, or not recommended. I found an article about this on the radio, but realised that it was in fact just over 12 months old. It was a BBC transcript of an 'Inside Health' broadcast - I must make a point of listening to this programme more often, as it can contain items of interest. Anyway you may like to read the transcript at *http://www.bbc.co.uk/programmes/b01dhs1c*. It includes some other items and then Roger Kirby and others debate whether PSA testing is good or to be avoided. I am not sure that I know what Mr. Wong's point was!

FINAL NOTE

Please note that capital letters in email addresses are for readability only and can be typed in lower case when sending emails.

Steve Parkinson
Newsletter editor.
NewsEditorRPCSG@yahoo.com

DISCLAIMER

The newsletter does not offer medical advice. Nothing contained on the newsletter is intended to constitute professional advice for medical diagnosis or treatment or to advocate or recommend the purchase of any product or use of any service or guarantee the credentials or appropriateness of any health care provider. Members are strongly advised to consult with an appropriate professional for specific advice tailored to their situation.