PHAROS

A beacon of hope in the darkness

Newspaper of the Reading Prostate Cancer Support Group (RPCSG)

Issue 25: June 2013

EDITOR'S FOREWORD.

I have received a few replies to my request for members' experiences of travel insurance taking account of prostate cancer occurrence. Please will any other members send to me very soon, any anecdotes, experiences, complaints and recommendations concerning travel insurance to me. I will summarise members' input in a month or two – in confidence of course.

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Please see the section later titled 'RPCSG Website'. Laurie Fineman will most grateful for the assistance of anyone who can contribute to the set-up and design of our web pages. We want to make our new website one of the best around, so if you have an artistic flair for web page design, please contact Laurie.

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I have often wondered how PSA is measured so precisely. A reading of 1 ng/ml means that the PSA cells weigh one thousand millionth of a gram in one sixth of a teaspoonful of blood. Not only is this quite a phenomenally small amount to measure, it can be measured to three or more decimal places. I found a superb site that describes the different generations of methods for PSA measurement. It says that there are different measurement methods, and laboratories can give differing values, so recommends patients to stay with one laboratory for consistency.

The article can be seen at http://www.prostatecancerwatchfulwaiting.co.za/PSA101.html

This article includes:

- Interpretation of PSA level
- Causes of elevated PSA
- An account of variability in successive measurements
- Mentions three different methods of PSA measurement, and gives a short description of the immunoradiometric assay method
- Factors that can cause a temporary increase in PSA.

The last point is worthy of a paragraph of its own as follows:

CAUSES OF TEMPORARY PSA INCREASE

In newsletter #24 I listed some causes of temporary increase in PSA levels. It is quite essential to try to avoid the activities for the times quoted, to avoid an unrepresentative PSA reading. The article referenced above similarly gives causes and the timescales over which they are effective. The timescales are more rigorous than the ones that I gave, so it is better to use the figures below that I have extracted from the article:

- Digital Rectal Examinations can elevate the PSA level, so if a DRE and a PSA test are needed close together, blood for a PSA reading should be taken before a DRE.
- Ejaculation can raise PSA for 48 hours
- Motor cycling and vigorous cycling, including exercise bicycles, can raise PSA by up to three times for up to a week
- The irritants alcohol and coffee are best avoided for 48 hours before a PSA blood test.

THE JUNE MEETING (7th June 2013).

Dr. Neil Derbyshire, Consultant Radiologist, gave an excellent presentation on imaging systems, that was both very detailed and very informative. He also showed examples of the application of the imaging systems to tumours in many parts of the body, including the prostate.
Dr. Neil explained the many imaging systems in use today, some of which have been fairly recent innovations. The various systems give different types of information, and it is quite powerful when more than one imaging system is applied to a patient, and can yield better information on the precise size, location and nature of tumours than was previously possible. There are new machines being introduced that have much higher resolution than at present, and will enable more acceptable diagnosis methods and treatments. The drawback of them is the expense! These machines giving more detailed scans raise the possibility – probably in the not-too-distant future, of treating only the tumour within an organ, rather than the removal of the organ in total. However this raises some ethical issues, such as the risk involved in carrying out tumour only treatment, in that if only the tumour within a prostate is treated and the remainder of the prostate is not treated, the possibility of a return of the cancer is possibly increased.

Some detail of Dr. Neil's presentation follows:

Staging is carried out to help select the best treatment for cancer, options are active surveillance, hormone treatment, radiotherapy/brachytherapy, prostatectomy, HiFu (high intensity focused ultrasound), and treatment for metastases. A multi-disciplinary team discusses each patient and recommends a treatment. It takes into account PSA value, Gleason score, the tumour staging by MRI, and considers whether the tumour has spread.

Staging arrives at a classification known as TNM. The 'T' is tumour grade, in the range T1 to T4. The 'N' is either 0 or 1 dependent upon whether the lymph nodes have been invaded, and the 'M' is 0 or 1 dependent upon whether the tumour has spread to other parts of the body (metastasised). Treatment takes account of all of the above, and also the age and health of the patient, and also of course, the patient's choice.

Dr. Neil then described the characteristics of several imaging systems. These include X rays (radiographs), Ultrasound, CT scans, MRI scans, nuclear medicine, and Positron Emission Tomography.

Radiographs.
These are the Xray photographs that we are familiar with. The photographs can be enhanced by a previous intravenous urogram – the injection of iodine into the blood, which effectively improves contrast.

Ultrasound is a non-invasive scan, often used for monitoring foetal development. Prostates can be examined by a probe introduced rectally.

CT (Computed Tomography) scanning.
This uses X rays, and produces multi-planar images (image slices through the body). Originally taking about 30 minutes to obtain, modern scanners rotate around the patient whilst the patient platform is moved forward, producing a helical scan and enabling 'slices' to be seen along the length of the body. Drawbacks are the fairly high dose of radiation needed, and the lack of tissue discrimination, which can be improved by the use of oral or intravenous dyes.

Dr. Neil then showed a series of images of CT scans of renal flow, leg arteries, a humerus fracture, and coronal arteries. Also illustrated was a very impressive virtual colonography – a 3D picture of a colon that included a fly-through navigation pathway.

MRI (Magnetic Resonance) scanning.

This technique does not use Xrays and so is safer, instead it uses very powerful magnets, and gives an image produced by the way in which protons return to their prior state after being disturbed by a magnetic field. This technique is somewhat slow and noisy. Several slides were shown of MRI scans of brain, pituitary, spine, knee, and bone metastases.

MRI DWI (Diffusion weighted imaging).

In this technique, the intensity of the image reflects the rate of water diffusion, and thus highlights areas of water mobility, which

suggest some pathological change (i.e. possible tumour development). This technique is very good with acute strokes, abscesses and infarctions.

PET (Positron Emission Tomography)

This technique uses an isotope to look at the rate of metabolising of tissue, hence this technique is a functional imaging technique. Tumours tend to metabolise very rapidly and hence cause a raised level of tissue activity which is detected by the PET.

Dr. Neil then described mpMRI, which is a multi-parametric application of MRI, that brings together high resolution scans, DWI, Dynamic Enhancement and Spectroscopy. This technique is more accurate at locating tumours within a gland, and helps to prevent the need for prostate biopsies, can guide biopsies to areas of the prostate, and can guide focal treatment. However this raises the issue of whether focal treatment carries some risk of recurrence as only part of a prostate gland would be treated. This technique needs a very high magnetic field and at present is not in routine use. Some slides were then shown that dramatically show the additional information that mpMRI techniques can offer. In conclusion, mpMRI is very much 'work in progress' and the question of the merits of focal against radical treatments is ongoing.

Dr. Neil then answered questions from the audience. Mr. Keith Jackson thanked Dr. Neil and presented a gift as a token of appreciation.

CONGRATULATIONS

Congratulations to member Mike Linstead, who has survived a 100km bicycle ride sponsored challenge, and raised a large amount of money for charity. The following message is from Mike:

"Thanks to those of you who sponsored me on behalf of Prostate Cancer UK in the Nightrider 100k through central London on 8/9 June. I'm pleased to say I did it! A total of 6 and half hours in the saddle, with 3 short breaks along the way, made a total of 7 and a quarter hours in all.
It was tiring, but a great atmosphere, and wonderful to see London lit up at night.
If anyone still feels like donating, my website is open until 8 July at www.virginmoneygiving.com/MikeLinstead.
So far I have raised £820 including GiftAid.
Thanks very much
Mike"

Mike (second from left) in his cycle group, displaying their medals. They all represented different causes.

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:

5 July 2013: There will be two representatives from Prostate Cancer UK: Mr. Geoff Morris, and Dawn Fishley who is a Community Nurse Specialist. They will tell us about their roles in Prostate Cancer UK.

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. We will need volunteers to help to man the stand and promote awareness of prostate cancer. More information will be provided at the next meeting.

NEW MEMBERS.

We welcomed four new members and one partner at the June meeting.

It is always good to see new members at our meetings, and we wish our new members

well and invite them, and indeed all members, to get in touch with any of the support contacts below should they want to discuss any matter relating to prostate cancer.

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

RPCSG WEB SITE

Laurie Fineman has made a very good start on our websites by setting up a test website and designing a draft front page. Laurie would really appreciate any assistance and input from anyone who can contribute to the artistic design of a front page, and later for the other web pages.

If you would like to contribute to the setting up of our web site, please email Laurie at *laurence@sterwick.co.uk* and Laurie will make some arrangements. Any offers of assistance will be greatly appreciated.

'ROBBIE THE ROBOT' APPEAL

You should have received an email from the Chairman regarding the appeal for the robotic laparoscopic Da Vinci machine, also known as 'Robbie the robot'.

The machine is leased and under the terms it is due to be removed from the Royal Berks Hospital to be used elsewhere. After many negotiations with the leasing company, it has been agreed that Royal Berks Hospital can acquire the machine, but in order to do so a fund of around £461,000 is needed by September 2013. All members are asked to help in the quest by making a donation towards this worthy appeal. Many of us, including myself, have benefited from treatment by this machine. Any donations by members will be most gratefully received, so I would encourage you all to make a donation, and to spread the word about this appeal to friends and family.

You can donate by either of these links:

www.justgiving.com/24peaks2013 which is a donation via Mr. Adam Jones' 24 peak challenge. Although the challenge has now taken place, I believe that his donation website is still open.

http://www.justgiving.com/robbietherobot is a web page for contributing directly to the robot machine appeal.

INTERESTING ARTICLES

Dr. Roger Kirby has been referenced recently in my newsletters. Here is another article in which he appears. This one was published in the Daily Mail of 12th March 2013 and gives an account of three experts in the prostate cancer field, who contracted the disease themselves:

http://www.dailymail.co.uk/health/article-2291798/Prostate-cancer-In-cruel-twist-fate-prostate-cancer-experts-ALL-hit-disease-Their-stories-vital-reading-men--loved-ones.html

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