

PHAROS

A beacon of hope in the darkness

Newsletter of the Reading Prostate Cancer Support Group (RPCSG)

Issue 60: June 2016

Website: www.rpcsg.org.uk

THE JUNE MEETING

The June meeting was quite well attended by 47 people. The Chairman started by congratulating Paul and Jane Sefcick on the occasion of their 50th wedding anniversary. Paul is an ex-member of the committee, having acted as the Secretary. In place of acknowledgements of their anniversary by family and friends, Paul suggested to them that they make a contribution to our group. As a result, we have received a donation of £250 for which we are very grateful and give our sincere thanks to Paul and Jane, and best wishes for their future.

The Chairman then introduced our guest speaker, Dr Fawaz Musa, who is a histopathologist at the Royal Berkshire hospital.

Dr Musa said that he is part of a team in a unit that analyses tumour samples from a wide range of cancer types. Dr Musa is the team specialist in prostate cells.

A slide was shown, listing the three most common cancers in 179,443 occurrences of cancer in men, in the UK in 2013:

| | |
|---------------|-----|
| Prostate | 26% |
| Lung | 14% |
| Bowel | 13% |
| Other cancers | 47% |

Prostate biopsy samples are usually taken in a quantity of 10, being 5 from each side of the prostate. In some cases, a quantity of 20 or more may be taken. Each sample is a core of tissue of diameter 1mm and length about 15mm. The biopsy samples can sometimes miss a cancerous area, or may be taken near to the edge of a tumour, hence cannot be guaranteed to reach the most affected area of the prostate. As the samples are taken from the rear of the

prostate, they may not reach as far as the front of the prostate. Ideally an MRI scan should be taken first, giving doctors an indication of where the tumour lies, enabling targeted sampling.

Dr Musa showed a number of slides of different grades of prostate cancer cells, and it was apparent that a well trained eye is needed to identify the cancer cells. A great aid in identifying cells is the staining process, whereby the samples are soaked in certain chemicals that will add colour to the sample, making it easier to identify the rogue cells.

Dr Musa explained the Gleason grading system. After identifying the presence of cancer cells, the most populous type is graded in the range of 3 to 5. Grade 3 cells are the least aggressive, as they are only a little differently formed than normal cells. Grade 5 is the most aggressive type and have an appearance that is much different from normal cells. Then the remainder of the cancer cells are graded.

The Gleason grade is allocated, being the first number plus the second number. Dr Musa gave an example; suppose that 80% of the abnormal cells were Gleason grade 3, and the 20% remainder were grade 4, then the Gleason grade would be 3+4. Conversely, if 80% cells were grade 4, and the remainder were grade 3, the Gleason grade would be 4+3.

(Editor's note: If all of the cancerous cells identified are of just one grade, then that grade number is used twice in the assigned grade. For example, if all of the cancerous cells are grade 4 and there are no other grades present, the grade assigned will be 4+4.

Cells in the Gleason grades of 1 or 2 are now thought of as normal cells, and so the lowest Gleason grade assigned is 3).

Dr Musa said there is a trend towards using a grading system known as the ISUP (International Society of Urological Pathology) Grade. The mapping of Gleason to ISUP grade is shown below:

| 2005 Modified Gleason Grading | 2015 ISUP Grade |
|-------------------------------|-----------------|
| 3+3, 3+2, 2+3, 2+2 | 1 |
| 3+4 | 2 |
| 4+3 | 3 |
| 4+4, 3+5, 5+3 | 4 |
| 4+5, 5+4, 5+5 | 5 |

(Editor's note: In ISUP Grade 1, the Gleasons containing the number 2 are in grey font as grade 2 is no longer used - the lowest Gleason grade for a tumour is 3).

Following a prostatectomy, a further analysis of the gland is carried out, to establish the Gleason at the time of the surgery and to establish whether there is a clear margin (i.e. the cancer has not reached the edge (capsule) of the gland).

THE WOODLEY AWARENESS EVENT

On Saturday 25th June we held an awareness event at the Pagoda in the Woodley shopping area. We had posters, information boards and a table of leaflets, and several volunteers from the RPCSG group. We handed out leaflets, and whenever members of the public showed more interest, we engaged them in some conversation. We kept a tally of the number of members of the public thus contacted.

We had 12 volunteers helping at the stand at various times throughout the day, in shifts of two hours, from 9.00 a.m. to 5 p.m. In that time we contacted 214 members of the public, who received leaflets, booklets or other information. This was a very successful day, with generally good weather apart from a couple of showers. Many thanks to those who volunteered to help out.



The first shift of the day set up a display of information



The volunteers enthusiastically displaying one of our information banners

IMPROVEMENTS IN TREATMENTS

The Daily Mail recently published a story about a man who had survived prostate cancer, thanks to developments in treatments. I think that stories of one person are generally not of much interest, as we are all different and react differently to the same treatment. However, the story is quite encouraging as it details the treatment of a man called Ian, over a period of about 12 years - at the start of which he was given two years to live.

In 2003 Ian suffered an increasing need to use the toilet during the night, and was

given a blood test that found a PSA level of 72.6. A biopsy and scans revealed he had prostate cancer that had spread to his bones.

Ian sought a second opinion, that confirmed the original diagnosis. He was offered and accepted, drugs trials which Professor Johann de Bono said had saved Ian's life.

Ian first used the hormone drug Bicalutamide, that blocks testosterone that feeds the growth of the cancer cells. His PSA started to rise in November 2004, and he was told that surgery was not an option because the cancer had spread beyond the prostate, and radiotherapy was too risky because the original tumour was too large, putting surrounding organs at risk of damage

In April 2005 he started a combination of the chemotherapy drug Docetaxel - to kill the rapidly dividing cancer cells - and an antibody to block the receptors on the surface of cancer cells. This was successful until March 2006, when his PSA started to rise again. In September 2006 Ian started a new trial of the chemotherapy drug Radium 223 (a radioactive injection that homes in on cancer cells). Three months later he used the drug Abiraterone alongside the Radium 223. Four years later his PSA started to rise again, and he was given a genetic test that showed that he had the faulty BRCA2 gene. In September 2010 Ian started treatment with the drug Olaparib, which is aimed at cells with BRCA genetic mutations.

By early 2013 the Olaparib started to lose effectiveness, but his tumour had shrunk to such an extent that he was able to undergo the radiotherapy known as Cyberknife.

In January 2016 MRI and CT scans and blood tests showed an all-clear for prostate cancer and the secondary cancer in his bones.

This story is a remarkable account of treatment and recovery, and demonstrates the value of clinical trials. I think that all of the treatments that Ian undertook are now part of standard treatments, and it is largely thanks to these trials, that we now have an extensive range and effectiveness of treatments available as standard treatments.

You can read the full detail about this story in this web page:

<http://www.dailymail.co.uk/health/article-3581811/Ian-given-just-months-live-12-years-s-cancer-free-s-secret.html>

(Editor's note: You can see a report of the Cyberknife treatment in my newsletter of December 2013. Please email me if you would like a copy of that issue. You can read some detail of this treatment at this web page:

<http://www.royalmarsden.org/document.doc?id=54>)

DATES FOR YOUR DIARY

1st July 2016

The guest speaker at the July meeting will be Matt Poll, who will give a talk on the subject of 'Talking Therapies'.

24th July 2016

This is the 'Boys Beating Cancer' fun run at the Newbury Showground, at which we will hold an awareness stand. Everyone is invited to attend this event and if desired, to take part in the 'run' aspect of it. We would appreciate any volunteers to help to man our stand at this event.

5th AUGUST 2016

This group meeting will be an 'Open Session' at which everyone will have an opportunity to talk to other members, particularly those who have undergone the same treatment as yourself.

24th August 2016

This is the date for our popular Summer Social at the Calcot Hotel in Reading. It is an evening event with a hot and cold buffet meal with vegetarian options, and a choice of two desserts. Also a quiz and raffle.

2nd SEPTEMBER 2016

This group meeting will have a talk by Susan Tyne, whose subject will include the role of exercise and Pilates in relation to prostate cancer.

Steve Parkinson
Newsletter Editor.
NewsEditorRPCSG@yahoo.com

DISCLAIMER

This newsletter does not offer medical advice. Nothing contained in 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.

This newsletter may refer to named providers and their products or services, and such reference expresses no inference upon any aspect of any provider's business, services or products, and expresses no recommendation or preference for any such products or services.