NOTES OF PROSTATE CANCER SUPPORT GROUP MEETING
HELD AT DOLPHIN SURGERY
THURSDAY 17 NOVEMBER 2016

Peter (Chairman) welcomed everyone to the meeting. He reported that David Barwell (ex committee member) had recently died and gave a fitting tribute to him. Peter also reported on the recent PSA testing event in Burgess Hill, organised by PCaSO and Burgess Hill Lions, when 280 men turned up to be tested.

Dr Philip Savage, Consultant Medical Oncologist Presentation

Dr Savage explained his presentation would cover a little of the history of PC treatment, significant recent developments in treatment with drugs for metastatic prostate cancer (PC), and future treatments. He quoted we have about 47,000 PC cases annually in the UK; some do well, with about 11,000 deaths annually. We are now looking at more complex medical procedures. He advised that as well as being a huge problem, this is a huge issue for running the health service and funding treatment.

There have been significant management changes for PC over the past 5 years and this will no doubt change again over the coming 5 years.

He explained that it was back in 1941 that Charles Huggins' undertook studies on PC and effects of castration on advanced carcinoma of the prostate gland back, and this won him the Nobel prize 25 years later for that work. He published a paper looking at the effects of castration or removing testosterone. All of the treatments including chemo and drugs were considered, but by far, the most important treatment is removal of testosterone production.

We have the Stampede Study which compared hormone therapy alone with a combination of hormone therapy and one or more other treatments for prostate cancer, the aim being to see which treatment is best for prostate cancer that has spread outside of the prostate gland.

In the 80s there were 5 drugs for all types of cancer, by 2010 we had 33 new drugs with a further 12 by 2016 and we are seeing the impact of this for PC today. Dr Savage outlined 'management guidelines' for metastatic PC back in 2010 were as follows:

1st line - Androgen Deprivation Therapy
- Orchiectomy or GNRH

2nd line for castration resistant disease
- antiandrogen
- corticosteroids
- oestrogen or ketoconazole

3rd Line Docetaxel 3 weekly schedule to be considered for symptomatic, castration refractory disease

Graphs were shown indicating improvements in survival rates from more recent changes in treatment.

There have been a number of trials in continental Europe, USA and UK (Stampede) looking at the survival improvements to be gained from giving chemotherapy (usually Docetaxel) alongside hormone treatment. The results of the trials are complex, and don't all necessarily agree, but there are significant benefits to survival time if the chemo treatment is given at the right point, in terms of how the cancer is presenting, rather than just being left until the hormone treatment ceases to be effective in controlling the cancer.

By 2015 we had two new drugs, Abiraterone and Enzalutamide (British Inventions).

Abiraterone was developed at the Royal Marsden in London, and this can reduce testosterone to almost nil. Abiraterone is taken daily with steroids. Some side effects. In people who have had chemo the average increase in survival is about 4 months. People can stay on treatment for up to 2 years. Enzalutamide (expensive)also drops testosterone production. No steroids are needed. Side effects - can make you tired, sometimes increases Blood Pressure. 50% of patients benefit and it works for about 8 months giving an average of 6 months longer life. 78% will respond to Enzalutamide.

Cabitaxel is a new chemo drug with some toxicity. 25% of people will benefit by between 3 and 6 months. Benefits are much higher if you have not had chemo before when it will work twice as well with 8-10 months benefit.

Radium 223
This is given to those who have had chemo and Enzalutamide where the cancer has spread to the bones with no other spread. Treated in Brighton not H.Heath. Benefits are increase in survival rates by about 3.5 months. Reduces chance of bone fractures. Not suitable for all patients.

Intermittent Androgen Deprivation
In patients with advanced PC who respond well to treatment, it is possible to have cycles of treatment with zoladex/Prostap instead of continuous treatment.This approach allows a period away from the side effects of low testosterone. Patients feel better, their hearts and bones are healthier and there is little if any detrimental impact on the PC.

'Management Guidelines' 2015 for metastatic patients -
Established Patients progressing whilst on ADT:

1st Line,
- Enzalutamide/Abiraterone

2nd and 3rd Line for Castration Resistant Disease
- Abiraterone/Enzalutamide
- Cabazitaxel
- Radium 223 (bone disease only)

In 2015 and 2016 Guidelines for 'Management of Metastatic PC'
For Newly Presenting metastatic patients:

1st line is Androgen Deprivation Therapy
- orchiectomy or GNRH
- consideration of early Docetaxel Chemo

2nd and 3rd line for castration resistant disease
- Enzalutamide/Abiraterone
- Cabazitaxel
- Radium 223 (bone only disease)

WHAT IS NEXT?

In about 10% of Prostate Cancer there will be a connection with the BRCA gene.

Olaparib Study
Olaparib is a targeted therapy which stops PARP working.

- For patients with DNA repair defect such as BRCA1/2
- For patients without these DNA defects the response rate was 2 out of 33 (6%)

- Side effects are tiredness and anaemia
- Drug is licensed for treatment of Ovarian cancer and currently further trials for PC

This is likely to be a very successful treatment.

Immunotherapy in PC
Manipulation of the immune system is now a mainstream form of modern cancer treatment. Drugs including Ipilumimab, Nivolumab and Pembrolizumab are routinely used in some cancers incl. melanoma, lung cancer. An early study looking at the role of Nivolumab (PD-1) in patients with Prostate Cancer was negative with no benefits seen.

Early Evidence of Anti PD-1 activity in Enazlutamide-resistant Prostate Cancer
(A recent small study in USA)
10 heavily pretreated advanced PC patients treated with Pembrolizumab
3 of these patients PSA went down to very very low from being very very high(55,30 and 16 weeks)
3 stable disease (50, 47, 30 weeks)
4 showed no response

Prostate Cancer Update
Whilst we are using the majority of the same tools as five years ago, we are using them differently which has shown dramatic benefits. Injection therapy and chemo early on gives people at least an extra year's life.

- Patients with newly presenting metastatic cancer should be assessed re concurrent ADT (Androgen Deprivation Therapy) and chemotherapy.
- Initial ADT alone remains a treatment option for some patients
- Relative benefits in high volume vs low volume disease
- Enzalutamide is active and well tolerated even in elderly/frail patients with metastatic PC
- New treatments with PARP inhibitors and Immunotherapy may offer considerable benefit

It may be that in 5 years time the first objective of treatment will be the same. What we will do next will be much more complicated determined by genetics' structure and PSA situation. The world is changing very quickly!

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On behalf of the members and Support Group Committee, Peter thanked Dr Savage for an extremely interesting and informative presentation. Questions were taken.

Circuit Training for PC Patients

Terry (Committee) reminded members that at our March meeting Prof. Robert Thomas talked about the latest research findings on the impact of diet and exercise on cancer survival and quality of life. NICE (National Institute for Health and Care Excellence) recommends a twice-weekly supervised exercise programme for prostate cancer patients on hormone treatment.

Terry has since established whether this exercise programme is available in our area and identified 3 things; Firstly, that all cancer patients in Horsham and Mid Sussex GP Commissioning Group area are entitled to be referred to exercise programmes via the Mid Sussex Well-being Centre. Secondly, there is a pool of appropriately qualified Macmillan trainers based at the Emirates stadium as part of Albion in the Community Charity, carrying out training programmes in the Brighton and Hove area, and thirdly, they were in discussion with the Mid Sussex Well-being Centre about extending the programmes to Mid Sussex.

At our July meeting Siobhan Meaker, the Sussex manager for this programme came and talked to us about what was on offer and the application leaflets she brought were in fact taken up by lots of you.

As a start, a circuit training programme for cancer patients has been set up at Bolney's new village hall, Rawson Hall, at 10.30am on Tuesday mornings. Terry has started attending and explained there is a lot of emphasis on muscle resistance work which is totally appropriate for those on hormone treatment. It helps to combat the muscle loss caused by the drugs and each exercise position has difficulty options meaning that no-one needs to worry about being over-stretched. The cost for the first 10 weeks is £1 per session and then it goes up to £3. They need more people to sign up if they are to continue into 2017.

If any of you is interested, you can self-refer. Tel number is on the form and also on the Lifestyle page of our Website. Do come along for a 1-2-1 session with Liz Mooney who runs the programme. If she thinks there are any issues where training needs to be endorsed by a health professional she will let you know (01273 668591).

Next Support Group Meeting

It was suggested to members that we have an Open Meeting in March when they will have the opportunity to discuss different topics, either as a large group or 1-2-1 together with refreshments. Any suggestions for topics you wish to discuss should be emailed to Jenny on jennyleauk@aol.com

Next Meeting Thursday 9 March 2017 (second Thursday of the month instead of our usual third Thursday).

J Lea
20.11.16