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Subheading 1

EUPROMS study Europa Uomo patient reported outcome study The first ever prostate cancer quality of life survey conducted by patients for patients About this presentation This presentation is for prostate cancer patient groups and the general public You are welcome to publicise the results without permission, but must always credit the Europa Uomo EUPROMS study If you reproduce any of the charts, they must be credited to the Europa Uomo EUPROMS study EUPROMS study Background information EUPROMS background 1 EUPROMS stands for Europa Uomo Patient Reported Outcome Study It is the first major study on quality of life after prostate cancer treatment to be conducted by patients themselves It is based on an online questionnaire completed by nearly 3,000 men in Europe It provides a new perspective because most other quality of life studies are conducted by and with doctors in a clinical environment The study began in August 2019 and the first results were reported in January 2020 EUPROMS background 2 Europa Uomo has reported EUPROMS findings at many important medical conferences including: The European Association of Urologists (EAU) Congress 2020 The EAU Section of Oncological Urology annual meeting The European Society for Medical Oncology (ESMO) Congress The European Multidisciplinary Congress on Urological Cancers (EMUC) European Organisation for Research and Treatment of Cancer (EORTC) webinar Findings are also being published in various publications including European Urology Focus magazine EUPROMS background 3 These survey findings provide a “snapshot” picture of the quality of life issues experienced by men with prostate cancer across Europe at a particular point of time They provide information that may help patients and their doctors make decisions about treatments They may help in campaigning for early diagnosis of prostate cancer and promoting approaches such as active surveillance EUPROMS study How the study was conducted The questionnaire 20 minute online survey for men who have received treatment for prostate cancer Available in 19 languages Used validated quality-of-life questionnaires: EPIC-26 and EORTC-QLQ and EQ-5D-5L Responses were anonymous Geographical response Respondent profile Respondent profile Treatment profile The analysis Analysis of the data was conducted by Professor Monique Roobol and her team at Erasmus University Medical Centre, Department of Urology, Rotterdam. Their analysis provided the findings here and in scientific papers. Some of the findings here are based on raw survey responses, and statistical significance has not been calculated or displayed. However, all the findings help to provide vital information for clinical decision-making, making them clinically relevant EUPROMS study Results: general quality of life EUPROMS study Results: Discomfort, tiredness, insomnia EUPROMS study Results: mental health EUPROMS study Results: sexual function EUPROMS study Results: urinary incontinence EUPROMS study Take home messages Take-home messages Take-home messages Take-home messages 3. We need cancer centres with multidisciplinary teams THE GARDEN OF THE CANCER OF THEM © FEFOC 2021 Directors: Professor Jordi Estapé and Doctor Tania Estapé. EDITORIAL In 1891 the German surgeon Max Wilms began to interest in and describe kidney cancer in children, which since then bears his surname. The same year an English painter, Luke Fildes,produced a wonderful canvas entitled "The Doctor", inspired by a terrible personal experience, the death from tuberculosis of his first child, then a year old. Aside from the terrible personal drama, both Fidles and his wife were tremendously impressed by the attitude of the doctor who treated them. And Fidles immortalized him. In the painting, exhibited at the Tate Gallery in London, we are in a poor cabin. Lying between two chairs (of different origins), a girl agonizes. Behind, the mother is seen, collapsed, and, behind her, her partner tries to give her strength. But what dominates the picture is the expression of the Just four years earlier, Picasso produced, in Barcelona, another canvas of medical motif: "Science and charity", which is exhibited in the Museu Picasso of this city Here things are different: in fact, we see an adult woman dying. Near her is a doctor who does not even look at her, her attention is focused on taking her pulse, oblivious to the agony that is lived next to her. Science. On the other side of the bed is Charity. A nun carrying a girl in her arms and tending, the nun, a glass of water to the dying. Both doctors represent, in our opinion, two fundamental trends in medicine. The second represents increasingly dehumanised technology; the first is the real doctor, for whom the patient first. You will

remember the famous phrase issued in usa with doctor. You don't have an algno medical device in your regarding the evaluation of doctors: "Publish a hands, as a sign of their impotence. But the expression on his face is one of deep pain, of concentration, of insignificance. He is the doctor at his peak, bearing witness to his wounded humanity, watching death slip through his fingers the life of that being. or perish", post or be fired. Faced with this challenge, many doctors in large hospitals are launching into a race in search of the dreamed "impact factor". And how is it measured? Through the weight of publications. Patient care and teaching have no impact factor. (continued on page 2) 1 (from page 1) Many patients suffer from this situation:"Hedidn't even look me in the face during the visit", more attentive to the computer and the telephone. Who actually visits patients? Not long ago we experienced a case that may be an example a woman with breast cancer was given a catheter to facilitate chemotherapy. The operation took much longer than had been anticipated. After a few days the corresponding cervical region began to hurt. He went to the hospital. He had an ultrasound. normal. It's a contracture, they explained. After a few days when the pain persisted, he went to his gp, trusted by him. Other scans showed the presence of a considerable thrombus, an obvious cause of the pain. It has been fixed, fortunately. We call for an impact factor for assistance; we demand that doctors should not be forced to compete forcibly and outside the healthcare field; we demand that they have time to be able to assist their patients. It is very neat to care for a patient with prostate cancer. Explain the therapeutic options, give you the right support, be, in a word, authentic doctors. All this comes from the second article by Dr. García-Restoy. DISEASE-CENTERED MEDICINE VS. PERSON-CENTERED MEDICINE (Part 2) One of the biggest healthcare challenges in recent years in developed countries is undoubtedly the care of patients with chronic diseases. To address this, it is crucial that health organizations adapt their organization and that the patient's relationship with the doctor and other professionals evolves so that the sick person is at the center of the system and participates in decision-making. Victor Montori, a diabetes doctor at the Mayo Clinic has denounced from many works and from the foundation The Patients Revolution,as well as from his book with the same title, how industrialized medicine has moved away from the care of people and proposes a "careful" and "gentle" care more focused on the person and less focused on the disease. This new look is based on the models of "cumulative complexity" and "minimally disruptive medicine" that seek to prioritize the vital and health goals of patients and minimize the negative impact that healthcare causes on their lives. This approach confronts the burdens derived from treatment, disease and the obligations of daily life with the patient's ability, which will depend on their personality, education, knowledge of their diseases, functional, cognitive limitations, socio-family support, economic situation, etc. Thus, for example, increasing the number of medicines or introducing drugs whose form of administration or dosage is more complicated can increase the burden of treatment and cause an effect contrary to that desired by hindering its compliance. The imbalance between the burdens and the capacity of the person determines the degree of complexity, that is, the difficulty of the individual to cope with the burdens of disease and many aspects of life. (continued on page 3) (from page 2) Keep in mind that loads and capacity may vary over time depending on clinical factors and changes in social and personal circumstances. From joint deliberation with the patient, doctors should be able to make joint decisions and develop therapeutic plans that are not only effective, but also accepted and acceptable by the patient and his environment. In short, it is necessary for professionals, patients and caregivers to be aware of the complexity derived from the burdens of the disease, treatments and the circumstances of life in the face of the capacities of the sick person, regardless of their condition as a patient. Patients must also assume, within their possibilities, the responsibility for self-care and the role that corresponds to them in decision-making. For their part, organizations and care devices must adapt to provide professionals with the necessary resources so that the care of chronic patients is carried out efficiently and with the utmost respect for the dignity of patients and professionals. Enric Garcia Restoy Medical Internist. Terrassa Hospital. Terrassa consorci Sanitari. QUESTIONS ABOUT SIDENAFIL On the Us Too International Hot Sheet, Dr. Jeffrey Albaugh answers a question asked by a prostate cancer survivor. The question is as follows: I DON'T SEE MANY DIFFERENCES BETWEEN THE GENERIC SIDENAFIL AND VIAGRA. IS THERE A DIFFERENCE? WHY CAN'T I TAKE MORE THAN 100 MLGS? DR. ALBAUGH'S RESPONSE: Thank you for your questions. Both sidenafil and Viagra contain the same chemical, sidenafil. And they must produce the same effects in most men. I have worked with many men who alternated both medications. They told me they found no difference between the two. Sometimes some different effect may occur, but not in terms of the basic drug, sidenafil,but due, in any case, to other components of the tablet. The essential results of these drugs are the same with any of them. And also with tadalafil (Cialis). As for the dosage, if you increase above 100 mlgs., may also

increase your side effects. One of these effects may be to cause a decrease in blood pressure, with increased heart rate. Precisely in the beginning these drugs were investigated as possible hypotensive, but then it was observed that they helped to have an acceptable erection. At the dose of 100 mlgs,the one recommended by the AmericanFDA, they produce a certain hypotensive effect, but this effect would increase with higher doses of these. These reflections are valid for both sidenafil and tadalafil). But remember that your dosages are different. Sidenafil,a maximum of 100 mlg,for tadalafil, a maximum of 20 mlgs. It is not advisable to mix alcohol intake with the use of any of them, since alcohol can also lower blood pressure. It is important that, before starting sildenafil or taladafil,consult with your doctor if youtake other medications, to avoid interference between them. CHEMOTHERAPY IN ADVANCED PROSTATE CANCER An obvious fact in prostate cancer (CP) is that many patients who respond to hormone treatment from the outset, over time, are resistant to it. From 1950 began, in patients resistant to hormone treatment, chemotherapy with alkylating agents (drugs widely used in chemotherapy of other tumors; in the tumor cell they create bridges between the two helical beams of DNA, thus preventing the partitioning of the cell or mitosis and its multiplication). But they were poorly documented studies. It was not until 1972 that Dr. Gerald Murphy and collaborators led a project (the American Cancer Society National Prostate Cancer Detection Project) to scientifically assess the possible efficacy of chemotherapy. To do this they designed a comparative study between an alkylating agent (cyclophosphamide) and 5 fluoruracil (antimetabolyte that competes with an essential amino acid for DNA formation, pyramidine). They saw some benefits, but the studies included few patients to really have value. Later, other cytostatics were tested that not only decreased in many cases the level of PSA (marker of CP) and improved the survival of patients. Subsequently, some more effective drugs have emerged, highlighting the combination of docetaxel with prednisone. We consider very important the potential progress of chemotherapy in CP. Hormone treatment is very effective but its consequences on patients' quality of life are, in our opinion, excessive. Chemical castration has, it is true, advantageously replaced surgical castration. But patients continue to pay a severe price in terms of their quality of life. Chemotherapy, if it progresses, may perhaps in the future replace hormone treatment. Without paying the price of castration. Of course, with the adverse effects of chemotherapy that have the advantage, in general, of happening at a specific time and not castrating patients. We also think that researchers should make progress in the field of hormone treatment, obtaining products that do not focus exclusively on the cancellation of testosterone. Combining progress towards more effective and less toxic chemotherapy and hormone therapy is a challenge worth fighting for. PROSTATE CANCER AND OBESITY In Oncology, diet is increasingly given importance both in the development of the tumor and in its progression. In addition, along with tobacco, alcohol, obesity, sedentary lifestyle and solar irradiation, diet is a factor that can be managed directly by the individual. However, although we found many suggestions, no specific and concrete diet has been detected objectively to prevent cancer or slow its growth. We know that obese people have a higher risk of dying from prostate cancer (CP), developing aggressive CP more often and with a greater chance of recurrence of the disease after initial treatment. Research on the subject, carried out by the Cancer Prevention Study, showed that patients with a body mass index greater than 32.5 kilograms per square meter were 35% more likely to die from CP than those affected with an index equal to or less than 25. It happens that a majority of patients with CP who die do so more from cardiovascular complications than from the disease itself. The great obese are, as we know, more prone to such problems. (continued on page 5) (from page 4) Excessive consumption of fats in the diet is often accompanied by obesity. Its consumption is higher in the USA and in Western European countries, where precisely the percentage of deaths from CP is higher. Thus, in Japan where the incidence and mortality due to CP were low, they have been increasing with the introduction of the dietary model of usa and western Europe. Obesity may be closely related to CP with an increased risk of aggressive disease. Fat cells secrete hormones that can stimulate prostate tumor growth and also, inflammation, which in turn can help the higher degree of aggressiveness of CP in obese people. IN THE FACE OF CANCER, DO MEN HAVE LESS ANXIETY AND DEPRESSION THAN WOMEN? Dr. Tania Estapé Anxiety and depression are two consequences of cancer, the most common. Anxiety refers to fear, to the feeling of threat to the loss of control of the patient, while depression appears more cumulatively, in the medium and long term, when the treatment ends and in moments of reflection, of vital approaches, of the meaning of life. Although these two answers are general, if we compare for different differential variables between the different people, there are different aspects due to some characteristics of the patient profiles. Without a doubt sex is one. In general, women suffer more levels of anxiety and/or depression, if we talk about the general population. This is reflected in the face of cancer as well. There are significantly higher levels of

both anxiety and depression in women with cancer than in men. That is the objective fact. However, we must consider some aspects because the results capture a photograph but perhaps not so much the processes that underlie it. The tests we use in Psycho-oncology to evaluate the different psychological repercussions are usually what is called in psychology very obvious. What does this term refer to? Well, it is very clear to the subject who answers them, in which answers he is manifesting discomfort or fragility. That is, if a test includes the question "Are you sad?", it is very obvious that answering the maximum score offered is marking discomfort. The use of this type of questionnaire is undoubtedly due to a historical fact. In the first approaches in Psycho-oncology, questionnaires from the world of Psychopathology (discipline related to mental illness or disorder) were used. (continued on p.6) (comes from p.5) The results were very poor, because, in general, the cancer patient does not suffer from a disorder but an adaptive psychological and emotional reaction to the situation. So scales are used as we said before more obvious. What about this? Well, people who answer can modify their answers based on several factors. This can be both in one sense (presenting itself as worse than it really is), and in another (suppressing negative responses to appear well-being when there is none. In men with cancer, there is a tendency to get lower scores. We hypothesize that this may be due to a male cultural pattern that is still in place. We see it in men, for example with prostate cancer, who are mostly in an age group where the role assigned to men to be strong still weighs heavily, and that crying or showing weakness or fear is not man's. Therefore, not infrequently, men with clear depressive or anxious traits in the clinic, obtain low scores in the tests administered. In the graph that we attach it is very clear what we explain. We do not want to say that these men are lying or manipulating the result, but that, in some cases, it is conditioned by cultural and self-esteem factors that may prevent them from being sincere or admitting these feelings that they interpret as unsoculine. Not surprisingly, if we look at the history of the support groups of cancer patients, the prostate have been among the last to be formed, because they have a hard time sharing their experiences and being emotionally honest. Even in FEFOC, with 21 continuous years of group, we remember that at the beginning, in 1996, when we raised with urologists and other doctors the possibility of making a group, we saw how most of the men who sent denied any suffering. We believe that we are on the right track by opening a way for men with prostate cancer to share their experiences and establish bonds of cohesion and solidarity in a frank way. Anxiety and depression in men and women with cancer (©Dra. Tania Estapé) MY LIFE IS IMPORTANT. DISCOVERING MY LEGACY IN THE LIGHT OF CANCER Ana Marcela González Ling Postgraduate in Psychology Universidad Nacional Autónoma de México UNAM / Servicio de Psicooncología INCan / OPCION Oncología Few experiences in life confront us as directly with the finite nature of our existence as a cancer diagnosis. Although the prognosis of this dreaded disease has improved significantly with early detection methods and advances in oncology, it continues to be perceived as a fatal disease and this perception is transferred to our collective construction of what cancer is. Even with neoplasms of good prognosis, ideas about mortality are present in 30 to 80% of cancer patients and it is not uncommon for us to start asking ourselves what we have done with our lives. (continued on p.7) (comes from p.6) What am I supposed to do with my life? Have I accomplished my mission? Have I wasted the time that now seems so valuable, or am I reassured by how I've lived? Profound questions to which there is no simple answer. In addition, men have an added burden since historically expectations are high, among them are: forming a family, supporting it, being strong and successful, having assets, containing emotions, leaving their family protected for when they are no longer there and a long etcetera. All this adds a significant emotional burden to people and if we do not express and question these concerns, we may miss the opportunity to observe ourselves through the gaze of the other, to reconstruct and resignify our history. Let's start by making it clear that every life trajectory is important. The wisdom of the country man is as valuable as that of the great businessman. Each person, with their life experience, the accumulation of their crises and their joys, builds a path full of learnings that for viewers is invaluable. In the words of Lin Manuel Miranda in the famed Broadway play, Hamilton: "What is a legacy? It's planting seeds in a garden that you're never going to see." It is so curious the subject of legacy, that we live every day creating it, sowing those seeds that little by little are germinating. It is true that we may not get to see the garden in all its magnitude, but from the present we can begin to enjoy the process of sowing and seeing it germinate. Our legacy can be composed of both material things (goods, property, savings, business, etc.) as of that which is intangible (memories, experiences, life lessons, values, etc.) that is reflected in our daily actions, in our personal relationships and in everything we build day by day. The legacy is transformed into something tangible that Dr. Breitbart and his collaborators have developed as part of Sense-Centered Therapy. This evidence-based therapy for cancer patients addresses legacy as an important element of life

sense that can help people reconnect with the desire to continue living, maintain hope, and decrease symptoms of anxiety and depression. In one part of this therapy, patients can make a legacy project for their loved ones in the way they prefer (text, video, audio, collage, a song list, a presentation, etc.). They address legacy in three dimensions: past, present and future. Let's go back to everything that precedes us. Our parents, grandparents, ancestors, their culture, their beliefs and their context were key to today being who we are and finding ourselves here, with the enormous privilege of living. The lives of our ancestors, whether we know them or not, have a great impact on our reality, we are part of their legacy and that gives us a responsibility to do something meaningful with our lives. What better example about the importance of understanding history than recognizing that the experiences of others inspire us, teach us and that in this way the past always guides the future. Their future is our present and eventually our present will be part of history. The legacy that is built in the present is the great gift we can offer to our loved ones. That gift goes beyond the material that one can build with love for one's loved ones, it also involves the way we live, our values, our way of facing problems, our way of enjoying life, our jokes, our support in difficult times and everything that makes up the way we will be remembered by others. Day by day we build our legacy and we can choose to act how we want to be remembered, choose to live on our own terms. No matter how advanced an illness may be, we always have the possibility to continue creating our legacy, it's never too late to share. Even in adverse situations, where the physical state can be very deteriorated, we can express affection, share our learning and continue to contribute to the world. (continued on p.8) (comes from p.7) The possibilities are endless, whatever our life experience, it is worth being told and listened to attentively. Valuing our life experience and feeling at peace with the life we have lived makes a big difference in how we live the disease process. There are psychological interventions such as Sense-Centered Therapy or Dignity Therapy that help patients to capture their legacy in a tangible way, with the help of a professional, so that they can share it with their loved ones. Sharing your life experience, your memories, your learnings and what is most valuable to you is not only good for patients, it is an invaluable gift to your loved ones. Dare to share your life experience! References Simon, Steffen & Pralong, Anne & Hallek, Michael & Scheid, Christoph & Holtick, Udo & Herling, Marco. 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To acquire the book click For more information about donations click Directors: J.Estapé, T.Estapé Secretary: M.Soler Vaqué Marc Aureli, 14. 08006 - Barcelona Tel. 93 217 21 82 Email: We appreciate the collaboration of: THE CANCER GARDEN OF THEM © FEFOC 2021 Directors: Professor Jordi Estapé and Doctor Tania Estapé. editorial We modestly believe that our book, posted on Amazon, "Prostate Cancer in Heteros, Gays and Bisexuals," is becoming increasingly topical. Apart from many other examples we will add to two: 1) The statements of Mr. Philippe Saman, founder of Ahora Donde-Le Refuge (non-profit association that accompanies and welcomes LGBTIQ young people rejected by their family) in the Contra de la Vanguardia, in which he says that there are still young homosexuals rejected by their parents, today in the XXI century. These children leave their homes, end up homeless and in the street and often prostitute themselves to survive 2) The attacks against the goalkeeper of the German football team, the great Manuel Neuer, because he played some matches of the current Euro 2021 wearing a bracelet with the colors of the flag Because, says the venerable association, that this is giving a political tinge to the party and that UEFA is apolitical and does not want to offend Hungary whose Parliament has approved, driven by its prime minister, homophobic and transphobic legislation that prevents homosexuality from being addressed in educational programmes in schools. The latest news confirms UEFA's negative attitude. It is clear that this is a global issue, involving significant minorities who are discriminated against. The same thing happens with gay and bisexual prostate cancer patients, as we explained in our book which, as we presumed, is of an extraordinary topicality and modernity. Neither in Spanish nor in North American hospitals is the condition usually asked Sexual patients, essential in cancer gay. But, in addition, before an upcoming game in prostate. Munich among the national teams of Germany and Hungary has proposed that the stadium be illuminated with these colors, which has led none other than UEFA to ban

it. (continued on page 2) (from page 1) Let us fight against all forms of discrimination. In our countries too. Also here and now. It is not a thing of underdeveloped countries. Gays and bisexuals suffer continued and diverse discrimination even in the cores of Western civilization. We draw attention to other important contributions in this issue. Dr. Cristina Sans continues to enlighten us with her knowledge and genetic tests; we insist on the importance of the Mediterranean diet, this time no less than in relation to active surveillance, and the essential psychological support of patients who choose this option and, in the growing role of chemotherapy in prostate cancer. Dr. Tania Estapé is the first elected member of the Uomo Board of Europe. Astrid Vimena explains the importance in neuropsychology in the multidisciplinary care of patients. TANIA ESTAPÉ, PSYCHO-ONCOLOGIST OF FEFOC ELECTED MEMBER OF THE BOARD OF DIRECTORS OF EUROPA UOMO FEFOC has been a member of Europa Uomo since its inception. Europa Uomo is the European entity that brings together associations of patients with prostate cancer. FEFOC has a very solid line dedicated to this cancer that has been hidden for a long time. FEFOC has a specific website dedicated to this cancer individual and group psychological care and production of material, such as this magazine, a code, manuals, book and informative videos. With Europa Uomo it has been possible to share experiences from different countries, as well as common work. After a while, FEFOC has taken another step in this organization, promoting its Psycho-Oncologist as a candidate for member of the Board of Directors. Tania Estapé is a Doctor in Psychology and specialist in Clinical Psychology and dedicated to Psycho-oncology for many years. In recent years he has attended the annual general assemblies of Europa Uomo as a Spanish representative. The last two General Assemblies of Europe Uomo were virtual due to the Coronavirus pandemic. This year's took place on june 19 in the morning. It proceeded to vote on the two vacant seats on the Board. Tania Estapé won in the voting and has a new role as a member of the Board of Directors of Europa Uomo. With her entry to the Board Tania Estapé proposes to promote attention to the psychological aspects in prostate cancer, highlighting the role of the patient's partner. We hope that in this new journey new challenges can be met in the fight for the visibility of prostate cancer patients and their families. 20-YEAR STUDY LINKS ONCOTYPE DX®GPS TO RISK OF DISTANT METASTASIS AND DEATH FROM PROSTATE CANCER Cristina Sans. A new publication of the JCO Precision Oncology, referring to the Genomic Oncotype DX® Genomic Prostate Score (ODX GPS) genomic test, already mentioned in previous editions, concludes that genomic testing provides accurate information on the risk of distant metastasis and death from prostate cancer (long-term goals). This objective information can be used dichotomously (positive/negative) beyond clinical parameters. (continued on page 3) (from page 2) Remember that this is molecular information, which complements the results of clinical tests performed in order to know the patient's prognosis. The data from the study, from the U.S. group led by Dr. Klein(Cleaveland Clinic,USA), includes a cohort of 428 patients in follow-up during the years 1987 and 2004. According to Dr. Klein, "a patient with a GPS score of 29 may be a good candidate for active surveillance, while a higher score indicates an aggressive tumor that requires more intense monitoring (...) and according to their life expectancy an immediate treatment (surgery and/or radiotherapy)". This is the longest validation study with ODX® GPS and although it is necessary to confirm these findings with more studies, it is a very interesting fact when assessing active surveillance. This study brings even more robustness to a genomic test that, despite its short time on the market, already accumulates more than 20 studies that demonstrate its validation and clinical utility. The genomic test, ODX® GPS, distributed by Palex Medical and developed by Exact Sciences, is currently aimed at patients with localized prostate cancer of very low, low and intermediate clinical risk, but work is being done on its application to high-risk patients in the near future. For more details of the study, you can access the attached press release in English or directly to the publication, from the link: NEUROPSYCHOLOGY IN ONCOLOGY: Emerging discipline in the healthcare system for multidisciplinary care for the benefit of patients Mtra. Astrid Ximena Romero Hernandez. Postgraduate in Psychology. National Autonomous University of Mexico. Psycho-oncology Service National Cancer Institute In clinical practice it is relatively common to attend cancer patients who have subjective complaints of cognitive impairment, which can range from loss of objects and forgetfulness of information, to work dysfunction and difficulty in making decisions. It is often common for patients to express sadness, irritability, anger and frustration at their current situation, as they no longer perform their daily activities as effectively as before. These alterations consist of the deterioration or dysfunction of different neuropsychological processes such as attention, memory, language, among others. It is estimated that up to 75% of patients experience them during treatment, and in 35% of them the alterations may persist after the end of treatment. One of the treatments associated with these disorders is hormone therapy, also called androgen suppressor therapy, which is

used in patients with prostate cancer whose disease has not spread outside the prostate. This may be due to decreased blood levels of testosterone (a hormone associated with the functioning of memory and learning mechanisms), or cerebrovascular damage. Some alterations have been reported in the ability to make movements aimed at an end, in the ability to spatially locate stimuli in the immediate environment, in the organization, planning and solution to new situations, visual memory, concentration and immediate manipulation of information. (continued on page 4) 3 (from page 3) In contrast, breast cancer patients treated with hormone therapy have consistently demonstrated memory impairment of previously learned concepts and autobiographical memory. If the patient does not have sufficient cognitive resources to mitigate these affectations, their functionality can be compromised and their quality of life decreased. Neuropsychology allows to know the cognitive profile, something particularly complex in cancer patients, since some present risk factors that contribute to the appearance of neuropsychological alterations, such as advanced age, fatigue, sleep and mood disorders, diabetes and hypertension. Based on the cognitive profile, recommendations are made for patients and their families, such as environmental modification programs, external aids (use of alarms, notebooks) and interconsultations with other health professionals. The objective of the neuropsychological approach is the reintegration of patients into their family, work and social environment. In Latin America, the application of neuropsychology in oncology is an emerging field that allows both to understand the cognitive functioning of patients, and to provide them with tools and strategies that allow them to improve their quality of life. Despite the above, neuropsychology in oncology is still little known to some health professionals, limiting the possibilities of diagnosis, treatment and reintegration into the environment. In this sense, it is of vital importance that neuropsychologists in oncology consolidate the bases that allow the development of multidisciplinary teams, through evidence-based clinical practice, training of human resources and research, as well as the dissemination of this area among patients and families to access neuropsychology services in a timely manner. References: American Cancer Societand. (2020). Hormone therapy for prostate cancer. Retrieved from https:// /tratamiento/terapia-hormonal.html Lange,M., Joly,F. , Vardy, J., Ahles, T., Dubois, M., Tron, L., Winocur, G., De Ruiter, M. B., & Castel, H. (2019). Cancer-related cognitive impairment: an update on state of the art, detection, and management strategies in cancer survivors. Annals of oncology : official journal of the European Society for Medical Oncology, 30(12), 1925–1940. https://doi.org/10.1093/annonc/mdz410 Tae, B. S., Jeon, B. J., Shin, S. H., Choi, H., Bae, J. H., & Park, J. Y. (2019). Correlation of Androgen Deprivation Therapy with Cognitive Dysfunction in Patients with Prostate Cancer: A Nationwide Population-Based Study Using the National Health Insurance Service Database. Cancer research and treatment, 51(2), 593–602. https://doi.org/10.4143/crt.2018.119 Wu, L.M., & Amidi, A. (2017). Cognitive impairment following hormone therapy: current opinion of research in breast and prostate cancer patients. Current opinion in supportive and palliative care, 11(1), 38–45. https://doi.org/10.1097/SPC.0000000000000251 CHEMOTHERAPY IN PROSTATE CANCER An obvious fact in prostate cancer (CP), is that many patients with extended cancer, who respond to hormone treatment at the outset, over time are resistant to it. From 1950 began, in some of these patients, chemotherapy with alkylating (drugs widely used in chemotherapy of other tumors; in the tumor cell they create bridges between the two helical beams of DNA, thus preventing the partitioning of the cell or mitosis and its multiplication). But they were poorly documented studies. (continued on page 5) (from page 4) It was not until 1972 that Dr. Gerald Murphy and collaborators led a project (the American Cancer Society National Prostate Cancer Detection Project) to scientifically assess the possible efficacy of chemotherapy. To do this they designed a comparative study between an alkylating agent (cyclophosphamide) and 5 fluoruracil (antimetabolyte that competes with an essential amino acid for DNA formation, pyrimidine). They saw some benefits, but the studies included few patients to really have value. Later, other cytostatics were tested that not only decreased in many cases the level of PSA (marker of CP) and improved the survival of patients. Subsequently, some more effective drugs have emerged, highlighting the combination of docetaxel (semisynthetic derivative of yellish), which interferes with mitosis or cell division), associated with prednisone. In June 2010, the FDA approved cabazitaxel (another yesjo derivative) to be used, also associated with prednisone, for the treatment of patients who in turn were resistant to docetaxel plus prednisone. We consider very important the potential progress of chemotherapy in CP. Hormone treatment is very effective but its consequences on patients' quality of life are, in our opinion, excessive. Chemical castration has, it is true, advantageously replaced surgical castration. But patients continue to pay a severe price in terms of their quality of life. Chemotherapy, if it progresses, may perhaps in the future replace hormone treatment. Without paying the price of castration. Of course, with the adverse effects of chemotherapy

that have the advantage, in general, of happening at a specific time and not castrating patients. We also think that researchers should make progress in the field of hormone treatment, obtaining products that do not focus exclusively on the cancellation of testosterone. Combining progress towards more effective and less toxic chemotherapy and hormone therapy is a challenge worth fighting for. Q ANXIETY ABOUT ACTIVE SURVEILLANCE IN PROSTATE CANCER Tania Estapé ACTIVE SURVEILLANCE = ANXIOUS SURVEILLANCE? Active surveillance in prostate cancer is a "non-treatment" option that is a very interesting and important proposal: patients are candidates not to receive treatments and are monitored for possible changes in their tumor that at some point could indicate the start of active treatments. Active surveillance is a step forward in trying to treat cancer as aggressively as possible in terms of the impact on patients' quality of life. Thus, looking at the history of Oncology we have examples, such as the change from mastectomies in breast cancer to tumorectomies whenever possible. Of course the main objective is healing but it can be accompanied by quality of life or at least a maximum preservation of it, a more global cure of the patient will always be achieved. (continued on page 6) (from page 5) So the "do not treat" that active surveillance entails is certainly a promising option because, as we know, in prostate cancer, the repercussions are often very harsh. Loss of erection and urinary incontinence are two great examples of how the patient's life can be profoundly altered. However, despite the advantages that seem very clear when reading it, there are some factors that make it difficult to choose this option. One of them is the difficulty in coping with having cancer and (apparently) not "doing anything." This first barrier is found in both patients and family members. For them, having their loved one diagnosed with cancer without eradicating it is something that goes against all logic. Our ancestors weigh heavily and provide us with the equation cancer=death, the sooner it is removed the better. We believe that this is understandable, since until now we have been told how advisable it is to detect early in order to be able to act as soon as possible when there is the minimum of a tumor. At this point the barrier is twofold, if it is the case that the patient prefers it, but his family pressures him to have surgery. To the doubts and insecurities of the affected person himself is added the lack of support of the family in this decision. Moreover, daily life with the tumor can be difficult to manage. Patients wake up every morning knowing that they "carry the cancer inside," as one testimony explained. Despite not having the repercussions of treatments, this awareness that your cancer remains in your body and that, at any time it could spread, can generate a high degree of anxiety and fear that, in some cases, can interfere with your quality of life in another way. We refer to the fact that a high level of anxiety often conditions the enjoyment of life, concentration on activities such as reading, filming or social exchange, or work tasks, if the patient is still active. In this sense, patients, despite having the advantage of saving themselves some harsh consequences of treatments, can see their social activities reduced, have insomnia and live with difficulties uncertainty. This is called the fear of progression. In patients already cured, free of disease, we often speak of the fear of relapse, in this case it is that it progresses and spreads. The patient goes into a spiral of doubt: What if it spreads and arrives too late? What if I have made a mistake? What if this is really very serious and that is why I am no longer being treated? This can be compounded by something very common in patients which is comparison. Both the patients themselves and their families will meet other affected patients and family members who have received treatment. What's more, if the patient goes to a support group they are likely to feel alone because they will often hear the stories of others explaining their experience with prostatectomy, the radioterapia.....de again will be assailed by doubts about whether they have chosen correctly. In summary, we consider that there are some channels of communication at different levels: on the one hand, doctors and health professionals report with data, they are based on evidence of how beneficial it can be for patients to opt for active surveillance. On the other hand, patients (and their families) receive with fear and insecurity an option not to be treated when since childhood they have been hearing that cancer is something that must be removed as soon as possible to be able to bet on the cure. It is essential to make a multidisciplinary approach to patient decision-making. Meetings without urgency, being able to give you all the information and the necessary time, will help to be calmer. It has been shown that regretting the decision taken can lead to worse psychological adaptation. Although it is logical that the patient lives with a certain fear, it is necessary to ensure that he can enjoy his life to the fullest. (continued on p.7) (comes from p.6) On the other hand, psychological intervention programmes must be designed. Despite being able to make a multidisciplinary approach to decision-making, there are patients and family members who will not be able to avoid having their degree of anxiety. For this it is necessary to have psychological support tools. MEDITERRANEAN DIET AND ACTIVE SURVEILLANCE J. Gregg, D.D., and collaborators at the University of Texas' Anderson Cancer Center have studied the possible relationship between dietary

type and prostate cancer (CP) progression in men who chose active surveillance. Those who followed a Mediterranean Diet (DM) style diet evolved better than those who did not. Dr. Justin Gregg believes that men with CP are motivated to find something that positively impacts the progression of the disease and improves their quality of life. Well, DM is a non-invasive medium, good for global health and, as shown in your study, has a potential effect to modify the progression of CP. After taking into account known factors that can worsen cp progression (such as age, PSA level, and tumor volume), patients who follow DM decrease the risk that their tumor will grow or progress to a point where they may need treatment. The study included 410 men who chose active surveillance, with localized CP and Gleason grade groups 1 or 2. The mean age of the patients was 64 years. They were passed a questionnaire on eating habits and, according to the results, were divided into three groups. High, medium and low adherence to this diet. The results showed a significant reduction in the risk of tumor progression in relation to the adhesion group, with the most positive results in the degrees of greatest follow-up. The authors wish to study this issue in other patient groups. The importance of this study lies not only in the better overall health of dm adherents but, what is the most remarkable thing about this trial, is that those who choose active surveillance and DM have a lower risk of CP progression. That those who choose active surveillance but are not adherents to DM. SUMMARY OF THE HISTORICAL BACKGROUND OF THE MEDITERRANEAN DIET Some kind readers have been interested in this topic, so review the essential historical facts of the design of this diet. It is worth reviewing a little the origin of one of the greatest goods that our ancestors have bequeathed to us. It originated in the Mediterranean Sea, through the exchange of food culture between various civilizations. Within that sea, it probably began in the eastern Mediterranean, by growing cereals and legumes in various countries. But it was the Greeks and Romans who cultivated the three basic ingredients of that diet: olives and subsequent oil, wheat bread and vines, from which the wine came. This culture spread to the western Mediterranean. (continued on p.8) (comes from p.7) To the original basic ingredients, especially the Roman ones, they added vegetables (onion, lettuce, carrot, cabbage, celery, artichoke, etc.), fruits (figs, peaches, plums, apples, pears, cherries, etc.), nuts (almonds, walnuts, hazelnuts), cheese (with preference for sheep), and, in a very prominent way, original, almost great, fish, seafood and in any case, poultry, but almost without red meat. We also recommend physical exercise. Later, two fundamental aspects enriched the Mediterranean diet. Arab and Muslim contributions. Their influence was enormous in the lands where they settled (from 711 to 1492), specifically in the wide region called Al-Andalus (much of Spain for some or more widespread, also including Portugal and France). Arabs and Muslims introduced rice, eggplants, spinach, oranges and lemons and also underline the importance of diet in overall health. They picked up the principles of Hippocrates. The same year they were expelled from Spain by the troops of Kings Isabella and Ferdinand (1492), Christopher Columbus arrived in America, which meant the addition to the Mediterranean diet of decisive products such as potatoes, tomatoes, corn, coffee and chocolate. It represents perhaps the most important exchange between civilizations and cultures in history. Particularly striking is the adoption of the tomato, the first red fruit in our diet and which was a symbol of this. We see how the Mediterranean diet, after its birth in the eastern Mediterranean, incorporates essential elements from different villages and cultures. Mediterranean diet Since 1960, the decrease in coronary heart problems has been noted in Greece and Spain, when their incidence is compared with that of the United States. Several studies point to our diet as the basis of this difference. Several important organizations point to this, as well as the Dietary Guidelines for Americans,the WHO and the UN, which recognize its value in the prevention of chronic diseases. As for cancer, it is observed that its incidence in the countries of the southern Mediterranean was low when our diet was followed and that it rose progressively when we were imitating the eating style of the countries of the North. Current studies such as the one presented in this issue expand its indications and benefits. On the other hand, the Mediterranean diet is essentially ecological, with its vegetarian predominance and the minimization of animal meat intake. It combats cruelty to animals (our brothers) and the harmful consequences of intensive farms, while at the same time eliminating a food as dangerous to our health as red meat. To acquire the book click For more information about donations click We appreciate the collaboration of: Directors: J.Estapé, T.Estapé Secretary: M.Soler Vaqué Marc Aureli, 14. 08006 - Barcelona Tel. 93 217 21 82 Email: THEIR CANCER GARDEN FEFOC Directors: Professor Jordi Estapé and Doctor Tania Estapé. With a certain pride and much gratitude we inform you that we have concluded a series of 14 videos on prostate cancer, which are already present on you tube. Pride for the work done and thanks, a lot, to the professionals who have collaborated selflessly to obtain a high scientific level at the same time as informative. Let's highlight, first of all, my friend Mr. Fernando Rodríguez Domingo, excellent executive producer of the

program. As for the different contributions, we advise you to take your time to enjoy these videos and help with its dissemination. We are quite satisfied with the contribution that FEFOC has been making in cancer of prostate. In addition to the videos mentioned and this monthly online magazine, we disseminate a Code with 16 recommendations, a book entitled "Prostate cancer in heteros, gays and bisexuals" or, "Prostate cancer in heterosexual, gay and bisexual men", both present on Amazon. We also have an exemplary support group and a consultation both face-to-face and online. We are also members of the most important global associations in prostate cancer. In this issue we draw attention to the fact that widowers have more advanced prostate cancer than the lucky ones who live as a couple. We also explain the They represent an educational, informative and support wealth that is a treasure for professionals, patients, family members and the general population. which is the "consortium PRACTICAL" (continued on page 2) (comes from page 1) An important issue is the risk of rectitis after radiotherapy and the problems this can pose for gay or bisexual patients. We also warn about the decisive importance of psychological support in patients who choose active surveillance. We collect a table of useful questions for patients with testicular cancer and an interesting article on the need for population literacy in health. WIDOWHOOD ASSOCIATED WITH INCREASED RISK OF ADVANCED PROSTATE CANCER C. Salmon and M.E. Parent, from the French National Institute of Scientific Research show that widowers are more likely to, if they are diagnosed with prostate cancer (CP), do so with advanced CP (published in August 2021 in the European Journal of Epidemiology). It would be further proof of the importance of the social environment in the development of cancer. To do this, they analyzed, within the PRACTICAL* consortium, 14,000 patients diagnosed with CP who compared to 12,000 healthy men. Widowers arrived later at the diagnosis than those married or with a partner, many already with metastases. It is considered, in general, that the transcendental fact of living as a couple leads to a healthier lifestyle. The couple encourages the man to go to the doctor if symptoms occur. Otherwise, the cancer remains undiagnosed for longer and, secondarily, is diagnosed at a more advanced stage. According to the authors, widowers should seek support from family or friends and go to the doctor more frequently. However, let's not forget other factors that help us understand why widowers go later to the diagnosis. The greater tendency to alcoholism of the man alone and the less healthy diet are often cited. And also the psycho-emotional impact of widowhood. Other factors are studied among which Salmon includes not only marital status but also the number of people living with the widower, family structure, close environment (positive neighborhood or negative), as well as other factors. *The PRACTICAL coordination group was founded in September 2008 by Cancer Research UK and the Collaborative Oncology Gene-environment Study (COGS). It is formed by a group of researchers interested in the hereditary aspects of prostate cancer and try to identify genes that may have a role in the development of this disease. Its objective is to combine data from various studies to advance the knowledge of genes related to prostate cancer. PRACTICAL members from various countries (Africa, Australia, Canada, China, Europe, Japan, India, UK, USA). From Spain 5 groups participate. Currently PRACTICAL has data from 133 research groups and has gathered samples from more than 120,000 cases of prostate cancer and 100,000 healthy controls. ACTIVE SURVEILLANCE IN DANGER WITHOUT PSYCHOLOGICAL SUPPORT For months we have been warning of the danger that threatens active surveillance (VA), alternative, in localized and low-risk prostate cancers, to prostatectomy and radical radiotherapy. With the advantage of va lacking physical side effects (such as impotence and urinary incontinence). Reviewing various studies it is observed that approximately 50% of patients who chose VA abandon it and go on to prostatectomy, radiotherapy or hormonal treatment within 5 years of diagnosis. So, as the number of patients with localized, low-risk prostate cancer who choose VA increases, so does the number of those who abandon it. An important work in this regard is that of Dr. A. Finelli, from the University of Toronto, Canada, who analyzed the evolution of thousands of patients with VA. But their study has an important particularity: it was done with out-of-hospital patients, that is, they were not closely controlled like those who, in hospitals, participate in controlled clinical trials. That is, patients from the general population. By age 5, just over 50% of patients in VA had abandoned it, while 49% were still maintaining it and without symptoms of recurrence. The causes behind the abandonment of va are: 1.Symptoms of tumor growth. Age: Younger people are more prone to abandonment. PSA high in the successive controls. 4.Persistence of tumor cells in the Biopsies. Patients controlled by urologists resisted change more than those controlled by radiation therapists. Patients with other associated medical problems. That is, we found no data on the lack of psychological support. Nor is it talked about. Well, be careful because the VA goes against everything that doctors and family members have advised us over the centuries: eliminate cancer immediately! Phrase, by the way, origin of many errors, sometimes irreparable. This leads to the

main problem, which many patients with CP who choose VA usually experience: anxiety, the fear that the disease will evolve badly and become aggressive. And, for us, many of these abandonments are largely due to the lack of adequate support to counteract the anxiety produced by the untreated maintenance of the tumor. The psychological support of patients under VA is a priority for FEFOC, because we are in it the credibility of a fantastic technique to avoid the unintended consequences of active treatments and that they ruin the quality of life of many patients. (continued on page 4) (comes from page 3) We bet on the VA (when indicated) and offer to implement its psychological support. We must play fair: we should not load the VA because we leave an essential complement, psychological support. QUESTIONS BEFORE TREATMENT FOR TESTICULAR CANCER Information to the cancer patient, before treatment, is of vital importance. Good and ongoing communication between patients, their families and the doctors who care for them are very important to obtain informed consent, both within clinical trials and outside of them. ASCO (American Cancer Society, of which we are members) proposes the following (in the realization of which they recommend that the patient be accompanied by someone who can take notes of what is said to be able to reflect on house), in testicular cancer: They are the following: 1. What type of testicular cancer do I have? 2.Can you explain the pathological report to me? about my illness? 3.What stadium am I in? And what does it mean? 4.Would you like to explain my options treatment? Are there clinical trials available to me? 6.Where are they performed and where can I find more information about them? 7.What treatment plan do you recommend? 8.What is the purpose of each treatment? In my case, is it about curing or treating the cancer or both? Who will be part of my treatment team and what will each of them do? How will treatment affect my daily life? Will I still be able to work, exercise, and perform my usual activities? Can this treatment affect my sex life? If so, how and how long? Will treatment affect my ability to have children? Should I contact a fertility expert about a sperm bank before treatment begins? What long-term effects can be associated with my treatment? If I am concerned about treatment costs, who can help me? Where can you find emotional support for me and my family? If I have a problem, who will I be able to call? ASCO recommends that if anyone would like to know more about possible questions, they will find them at www.cancernet/testicular. These questions were designed by ASCO in 2019. ANAL SEX AFTER RADIATION THERAPY FOR PROSTATE CANCER With radiotherapy the rectum can become inflamed, producing diarrhea, sometimes bloody and rectal incontinence In most people, these discomforts disappear at the end of radiotherapy, maximum about two or three months later. In some they may be persistent and require treatment. (continued on page 5) (comes from page 4) This is a serious complication for gay and bisexual people, especially the so-called bottom,since it can make anal sex painful receptive and condition sexual intercourse. In June 2019, the first clinical guideline on anal sex after diagnosis and treatment for prostate cancer (PC) was published. The Guide is the result of consensus meetings between doctors and urologists from the United Kingdom (UK). It is aimed at doctors and gay and bisexual men. The study was coordinated by Sean Ralph, from the Clatterbridge Cancer Centre, Wirral,Liverpool (UK), and presented at the UK Imaging and Oncology Congress (UKIO), founded by Health Education England. (HEE) together with The National Institute for Health Research (NIHR). In summary, the Guide recommends that men refrain from receiving anal sex for periods of time before, during, and after certain CP tests and treatments. Anal sex can be harmful after a prostatectomy or radical radiation therapy. Most doctors, Ralph says, don't ask about sexual orientation or practices, which translates into a lack of information and support. The Guide is based on consensus meetings with the participation of 15 medical oncologists and 11 surgical urologists. They were asked when they considered anal sex safe. The consensus was as follows: Table "ANAL SEX AFTER CP TREATMENT" Before a PSA, less than a week after sex can give an inappropriate result. After a transrectal biopsy (TRUS), less than two weeks may cause bleeding, pain, or increased risk of infection. After a transperineal biopsy, one week (to facilitate recovery of the surgical incision and decrease the pain that could be caused by sexual intercourse). After prostatectomy, less than 6 weeks can cause bleeding, pain, and increased urinary incontinence. During external radiation therapy and two months later it can worsen the acute effects – rectitis – be painful orresultin long-term complications, such as rectal bleeding. Brachytherapy. Participants did not reach conclusions about abstention from anal sex. Medical physicists were consulted who advised abstention for 6 months, after permanent brachytherapy, to minimize the couple's radiation exposure. And two months after temporary brachytherapy. (Continued on page 6) (comes from page 5) Of the 26 participating physicians, only 3 (12%) always asked the sexual orientation of their patients and only 2 (8%) of the 26 always asked if they practiced anal sex, if they perceived that the patient was gay or bisexual. PROSTATE CANCER HEALTH LITERACY FOR GENERAL MALE POPULATION Mtro. Psic. Marcos

Espinoza Bello Postgraduate in Psychology National Autonomous University of Mexico UNAM Psycho-oncology Service National Cancer Institute INCan Mtro.Psic.Mascos Espinoza Bello Valid, reliable information and how it can be used by the male population to take care of their health will always be an objective that every society should seek, specifically, before a pathology such as prostate cancer that currently represents an emerging public health problem. Initially, let's consider health literacy, as the set of knowledge, skills and experiences in health matters that make an individual able to know their own state of health and how they should take care of themselves. (Navarro-Rubio et al., 2016). This concept has gained relevance since it is one of the most relevant predictors of a person's health status along with other social determinants such as age, income level, employment status or educational level even more in a male population that usually has little contact with the health system from a prevention approach. Low health literacy can have adverse effects on the health of individuals, for example in patients with a low level of health literacy: 63% were not physically active, 68% had overweight and lower physical and mental health (Jayasinghe et al., 2016). In another study, it was identified that those patients newly diagnosed with localized prostate cancer with low literacy level had greater emotional distress (Song et al., 2012). In patients with the same cancer, those with higher literacy levels had a 59% lower risk of having a high prostate antigen level than those with low literacy (Jamieson et al., 2021). According to the National Adult Literacy Survey, about 1 in 5 Americans in the general population may lack the literacy skills needed to function properly as patients. (continued on page 7) (comes from page 6) These people are at a disadvantage because they do not have the ability to obtain, process, and understand the information and services about cancer needed to take health care decisions, because this limits oral or written communication in health (Davis et al., 2002), which can be magnified in people in prostate cancer risk representing an older age group and in some cases, with greater psychosocial adversity. What this tells us is that not having the information available, understanding it and taking action on one's own health can have even more negative consequences in countries with a low or medium income. In this context, to implement health literacy programs it is necessary to evaluate what the population knows or knows about the disease, how it is detected and most common symptoms . Therefore, knowing how much men know about prostate cancer, myths and taboos such as the loss of masculinity, can be considered as a first link in the literacy process from a prevention perspective. Qualitatively, some patients report ignorance about where the prostate is located, its function in reproduction or orgasm, have not heard about prostate cancer, and those cases in which they have heard it show shame, do not know what medical studies consist of (prostate antigen, digital rectal examination, biopsy, or even genetic tests), at what age it is advisable to carry out the first analyzes, the information about their sexuality, all the above susceptible to be worked by the health team from prevention. In conclusion, we can affirm that health literacy is a necessary component in the population according to the available evidence, since, without the necessary knowledge, the risks of not having adequate medical care increase, In addition to the physical and emotional aspects being put at risk, in that sense, it is important to continue researching in the Latin American population to incorporate it into health systems. The time has come to talk and incorporate men's health as a strategic issue on the agenda of everyone from prevention. References *Davis, T.C., Williams, M. V., Marin, E., Parker, R.M., & Glass, J. (2002). Health Literacy and Cancer Communication. CA: A Cancer Journal for Clinicians, 52(3), 134–149. *Jayasinghe, U. W., Harris, M. F., Parker, S.M., Litt, J., Driel, M. van, Mazza, D., Mar, C. Del, Lloyd, J., Smith, J., Zwar, N., Taylor, R., & Group, O. behalf of the P. E. into P. (PEP) P. (2016). The impact of health literacy and life style risk factors on health-related quality of life of Australian patients. Health and Quality of Life Outcomes, 14(1). (continued on page 8) (comes from page 7) *Navarro-Rubio, M. D., Rudd, R., Rosenfeld, L., & Arrighi, E. (2016). Health literacy: involvement in the health system. Clinical Medicine, 147(4), 171–175. *Song, L., Mishel, M., Bensen, J. T., Chen, R. C., Knafl, G. J., Blackard, B., Farnan, L., Fontham, E., Su, L. J., Brennan, C. S., Mohler, J. L., & Godley, P. A. (2012). How does health literacy affect quality of life among men with newly diagnosed clinically localized prostate cancer? Cancer, 118(15), 3842–3851. PROSTATE CANCER INFORMATIONAL VIDEOS Dr. Tania Estapé FEFOC has launched this month a collection of 14 videos on prostate cancer. They cover medical, psychological, rehabilitation, nutrition... We also talk about support groups and our book "Prostate Cancer in Straight,Gay and Bisexual". The videos begin with one on Generalities in prostate cancer given by the scientific director of FEFOC, Prof. Jordi Estapé,followed by the main treatments (prostatectomy, by Professor Antonio Alcaraz and radiotherapy by Professor Albert Biete). In number 4, Professor Estapé, and FEFOC psycho-oncologist Dr. Tania Estapé, talk about active surveillance, as a less aggressive option but which, sometimes, in return, implies a high degree of anxiety and restlessness in the patient and his family. Dr. Cristina Sans

talks about a crucial issue, which is the role of genetic tests and Dr. Pilar Manchón on Parametric Nuclear Resonance in prostate cancer. Next, Dr. Tania Estapé talks about the psychological repercussions of prostate cancer on the patient in video 7 and on his family in video 8. The two that follow are about a crucial topic in prostate cancer such as sexuality. Dr. Isidro Bonet approaches it from the medical point of view, giving practical solutions (prostheses ...) and Dr. Estapé brings the psychological and relationship point of view, proposing a new approach to sexual life after prostatectomy. Dr. Montserrat Folch and Ms. Herminia García tell us respectively about aspects such as nutrition and more suitable diets and pelvic floor rehabilitation. Video 13 explains support groups, their importance, modalities and advantages. He also has a testimony from the FEFOC groups, with his partner (who always has a very relevant role). Finally, our book on prostate cancer "Prostate cancer in heteros,gays and bisexuals" ispresented, which is a good source of inclusive information. (continued on page 9) (comes from page 8) These videos have been made thanks to the selfless collaboration of Mr. Fernando Rodríguez Domingo and all the professionals who participate. They can be seen at the following link: To purchase the book click For more information about donations click Image from the collection of videos about prostate cancer Directors: J.Estapé, T.Estapé Secretary: M.Soler Marc Aureli, 14. 08006 - Barcelona Tel. 93 217 21 82 Email: We appreciate the collaboration of: THEIR CANCER GARDEN Directors: Professor Jordi Estapé and Doctor Tania Estapé. EDITORIAL During this month, dedicated to breast cancer, in the news of FEFOC we have dedicated a daily news regarding the most frequent cancer in women, which, of course, we wish you have followed or can see now. It certainly produces a healthy envy to observe, with the greatest respect and admiration, what has been achieved in breast cancer in public information. And, do not hesitate, through the information the pressure on the health authorities and researchers has been achieved, in such a way that the progress in breast cancer has been excellent. Or is it that someone dares to ignore the When will men with prostate cancer take to the streets demanding better, less aggressive treatments? That is why in this issue we dedicate two articles to active surveillance, a huge step in preserving the quality of life of patients, but still subject to the necessary education. continued of those who apply it and the information and support of those who receive it. Attention also to the exorbitant increase in the prices of medicines, which will eat our health system. Remember that in the USA each patient, in general, pays for their medicines and health care, with which many are ruined. Here, fortunately, Swedish women of the 70s demonstrating in Years ago we socialized the health expenditure that a its streets with banners that read "You cut off our chests because you are men." Do you know how this stimulated Fisher and Veronessi until they discovered that lumpectomy plus radiotherapy amounted to mastectomy? we all pay. Which is a blessing for each particular patient, but, do not forget, we pay for it together (extraordinary) but it ruins us at the state level. Capitalist society is unsustainable. (continues on page 2) 1 (comes from page 1) Nietzsche, the greatest of philosophers, draws our attention to the fact that the sick do not feel sick and to the need for the sick not to ask too long for the compassion of others. As for physical exercise in patients with prostate cancer, it begins to be measured objectively. You will see the role of the mioquinas in this regard. ASPECTS OF ACTIVE SURVEILLANCE Jinping Xu and collaborators, most of the Wayne State University, in Detroit, Michigan, USA, publish in Urology, an interesting study funded by the American Cancer Society and carried out with the aim of evaluating the attitudes of the urologists about the treatment of low-risk prostate cancer (PC), with special attention to active surveillance (VA). Let's briefly remember that VA is an option in low-risk CPs, consisting of not treating but controlling the evolution of the disease and, in any case, moving to active treatment (prostatectomy, radiotherapy, hormone therapy) if the CP Progresses. Comparative studies show that survival at 10 years of treatment is similar between VA and active treatments, when applied at the beginning. Va offers the added advantage of lacking side effects (e.g., sexual impotence or urine incontinence or feminization). However, many patients, who chose VA in principle, abandon it, in our opinion due to insufficient information and lack of adequate support, essentially psychological. In this study, 225 urologists were surveyed. Did they offer VA as an initial strategy to their patients with low-risk CP? 65% of urologists did. 87% believed that it was an effective means, little used, while 80% believed that, in the USA, prostatectomy and radical radiotherapy were used excessively. Taking into account that VA is indicated in non-aggressive cases, the answer was given, apparently somewhat contradictory, that 89% agreed to recommend it to African-American patients, despite knowing that they tend to develop more aggressive forms of CP. However, it is true that at the time of the recommendation these patients had low aggressiveness CP. They also observed that many patients, regardless of ethnicity, were not very interested in . VA, probably for fear of CP progression and/or recurrence. In contrast, others, fearing the side effects of active treatments,

preferred VA. A certain contradiction was thus detected between what urologists mostly expressed in favor of VA and the fear of it and preference for active treatments that they observed in many patients. We have been educated and persist in our collective unconscious that, in the face of cancer, in general, it is best to eliminate it as soon as possible. Which is true, as long as we know how to make proper sense of the term before. The before must be rational, data-driven. That "come on Monday that on Tuesday I have a Congress" is not a before, it is something else. Before, yes, but reasoned, objectified, calmly validated. Before means neither hours nor days. (continued on page 3) 2 (Comes from page 2) The researchers conclude that in the USA there is a need for education aimed at explaining va well, its benefits and absence of side effects. MORE ABOUT ACTIVE SURVEILLANCE Dr. A. Finelli and colleagues, from the University of Toronto, publish in the official journal of The American Urologists Association (AUA), Urology, an important study in 8541 patients with low-risk prostate cancer (CP), with an average age of 64 years, and who chose active surveillance (VA), as the first option. Finelli tells us that about 50% of patients who preferred VA move on to active treatment (surgery or radiation therapy, in the period from their initial choice, VA, and 5 years later. While lately the percentage of patients who choose VA has increased significantly, in a space of time of 5 years, many leave it. The fundamental objective of va is twofold: 1. Avoid the side effects of surgery or radiation therapy and 2) Obtain equal results. Of course, patients should undergo more periodic examinations than those who choose active treatment. During the first year of the election, 15% of patients left the VA (that is, 85% remained in it). But only 52% remained in VA at age 5. Those who changed were generally the youngest or those with signs of suspicion (increased PSA or finding of cancer cells in a biopsy). It is very interesting that Finelli, apart from the need for better and less aggressive means to follow these patients, also calls for the continuing education of the doctors who control these patients, who, we add, need very specific support. Finelli also believes that patients who choose VA need to be educated and informed more. INCREASINGLY EXPENSIVE MEDICINES In Annals of Oncology (the journal of ESMO, European Society of Medical Oncology), October 2021. Van Ommen-Nijhof, From The Netherlands Cancer Institute, Amsterdam, and collaborators (among whom we highlight V.P. Retél, psychosocial researcher at the same institute), present two interesting studies, regarding a research aimed at studying the efficient, and therefore more sustainable, use of very expensive medicines. The authors state first and foremost that new drugs in the field of cancer have greatly improved the prospects of many patients. But the cost that accompanies these drugs is enormous. In general, new drugs take a significant part of the pharmaceutical budget, a proportion that will increase in the next ten years. Progressive cost that threatens the survival of health systems. Attempts to limit this cost have not borne great fruit. The authors propose another way to limit it: using these drugs more efficiently, but, of course, maintaining efficacy. 3 (Comes of the pag.3) Clinical trials of new drugs are, in general, led by the pharmaceutical industry itself, which tends to propose high doses and applied for a long time. Can efficacy be maintained using lower doses and for less time? If efficacy is maintained, this would lead to fewer side effects and better quality of life for patients. Interest in efficient research into new drugs is growing a lot among patients, clinicians and researchers. To continue and refine efficient research, trials involving many patients are needed. But, despite the health, social and economic importance, it is very difficult to find financing for them, which usually exceeds the resources of the public system. At the same time, the pharmaceutical industry is not very inclined to fund them, as the fundamental objective of efficient research conflicts with its commercial interests. Van Ommen-Nijhof and collaborators have managed to launch the study they call SONIA, which is based on a new drug, and which subject to the criteria of efficient research, which is called trying to avoid financial toxicity of medicines. The authors emphasize that studies on therapeutic efficiency have been supported by patient associations. The attempt to reduce the dose of medicines would lead to a reduction in pharmaceutical expenditure, which will allow more funds for research or the return of these to the health system or the foundations that help fund it. NIETZSCHE AND DISEASE The greatest of philosophers and, at the same time, extraordinary psychologist Friedrich Nietzsche (1844, in Rocken, Prussia-1900, also in Rocken), is rightly considered by Fernández Arias (Nietzsche, the challenge to two thousand years of classical philosophy History, National Geographic) as "the philosopher of the twentieth century and on his way to becoming the philosopher of the twenty-first century". Nietzsche himself proclaimed himself a "philosopher of the future, who would come alive after death." It aimed to educate us to think for ourselves, as beings responsible for our actions. Thinking for oneself, this is one of the keys, we add, to the balance and quality of life of patients. In the book "Aphorisms" of the German philosopher, edited by Andrés Sánchez Pascual, it is explained in the prologue that Nietzsche was the maximum creator of aphorisms, which the philosopher himself defines as follows: "It is my ambition to say in ten sentences

what everyone else says in a book, what everyone else—they don't say in a book." If before we have alluded to the importance of thinking for oneself, let us now analyze some of Nietzsche's aphorisms regarding the sick and the sick. "UNTIL WE HAVE FORGOTTEN THE DOCTOR AND THE DISEASE WE HAVE NOT HEALED" Indeed, the disease must be overcome and that is why we are investigating the fear of relapse, the greatest source of unhappiness of many cancer patients. (continued on page 5) (comes from page 4) It is an issue that affects everyone and for which we must find a methodology for overcoming it. Precisely the motto of FEFOC is "HEALING WITH QUALITY OF LIFE". I don't see it tries to be positive but to think for ourselves and get to establish the balance with the disease, to annul it as a source of anguish and depression. "DO NOT BE SICK TOO LONG BECAUSE SOON THE PEEPERS BECOME IMPATIENT, FOR THE USUAL OBLIGATION TO MANIFEST COMPASSION, SINCE IT IS VERY DIFFICULT FOR THEM TO MAINTAIN THAT STATE FOR A LONG TIME IN THEMSELVES. AND THEN THEY GO DIRECTLY TO SUSPECT OUR CHARACTER, WITH THIS REASONING: "YOU DESERVE TO BE SICK AND WE NO LONGER DESERVE TO GET TIRED OF COMPASSION" The sick person must avoid being the object of compassion, he must receive the right help he needs for the shortest possible time. Whatever the situation, it must be realized as a unique, thinking and decisive being. But no positivity but responsibility, respect for oneself and others. Finally, the formula of happiness for the German philosopher: "FORMULA OF MY HAPPINESS: A YES, A NO, A STRAIGHT LINE, A GOAL. Please apply it as far as possible. Usually, as far as possible, do not stay in the middle way. PHYSICAL EXERCISE PRODUCES ANTI-CANCER PROTEINS Research led by Professor Newton of Edith Cowan University, published in the journal Medicine & Science in Sports & Exercise, in October of this year warns us objectively that bed and rest may not be best for people with cancer. Edith Cowan University (ECU), which began in 1991, is located in Perth and Bunbury in Western Australia. Its main objectives are to spread knowledge and improve the quality of life of Australians. His research focuses on solving real world problems through social, economic, physical and environmental aspects. The main researcher was Dr. Jin Soo-Kim, from Professor Newton's team- They have focused on a protein, called myokines, that our body produces when it exercises physically. And they've found that these proteins can suppress the growth of a tumor. To do this, they took blood samples from obese patients with prostate cancer, all of them receiving hormonal treatment. (Continued on page 6) (comes from page 5) These patients underwent controlled and continuous physical exercise for 12 weeks. They then took new blood samples. In both samples, the pre-exercise and the subsequent samples determined the level of myokines. The level of myokines increased in patients after physical training. Blood drawn after physical exercise was applied directly in the laboratory on living prostate cancer cells. And its suppressive effect on tumor growth was proven. For Newton this points quite a bit to the fact that chronic exercise creates a cancer-suppressing environment in the body. For the authors, physical exercise can also complement some treatments for prostate cancer, such as testosterone deprivation, which is effective and very prescribed but contributes to the decrease. of muscle mass and increased fat tissue. The result is what we know as sarcopenic obesity (obese, but with little muscle mass), which complicates overall health and cancer growth. During physical training, participants lost fat tissue and increased muscle. Although the study focused on prostate cancer (due to its incidence and the series of problems that affect the quality of life of those affected), they believe that their findings are valid in general, always with the due medical control. Currently, ECU values a study in which patients with advanced prostate cancer are incorporated into a controlled program of physical exercise of 6 months. No definitive results are available, but to date there are some good omens. Although these are patients with a lot of disease and side effects of treatments, for Newton, they are still able to produce anti-cancer "medicine" inside. FINANCIAL TOXICITY AND PROSTATE CANCER IN OTHER CULTURES: A objective of care of the patient, family and health team. Dr. Oscar Galindo Vázquez Psycho-Oncology Service National Institute of Cancerology INCan, Mexico. "Financial toxicity" has become in recent decades a household term used in the discussion of prostate cancer treatments as oncology procedures progress that has gained traction in the medical literature, health insurance plans, and conversations. doctor-patient. (continued on page 7) (comes from page 6) However, as a phenomenon in current treatment, financial toxicity is not fully understood in its concepts, in its economic and psychological effects or by the health professional, by the patient and family, the programs being available mainly at the level of the health system. Financial toxicity is composed of two elements: Objective domain that corresponds to the monetary expenditure of medical care (diagnosis, treatment and support programs), which according to the The World Bank can be termed catastrophic as an expense that exceeds 40% of a family's accumulated post-subsistence income, which is the income after account for expenditure related to

food and basic necessities. Subjective domain, the information reported by the patients themselves (worries, anxiety and emotional distress), which provide a perspective beyond the monetary expenses paid, which is an element fundamental to understand the experience of the patient with prostate cancer and their families. This information allows for a more complete assessment of how patients and their families cope with financial challenges, the emotional distress that comes with it, and how they modify care and care. search for care programs. Expressions such as: "I am worried about the economic problems I will have in the future as a result of my illness" or treatment and "My illness has represented an economic difficulty for me and for my family" are common in prostate cancer patients and their families. Questions like How much will I have to pay for this treatment? Or if I can't afford this treatment, are there others that may cost less that work the same way? They are common in those patients and their families who have the challenge of facing prostate cancer that generates widespread emotional discomfort. But the effect of financial toxicity is also seen in the health team during the medical consultation, being a complex task when oncologists may not feel comfortable or are not prepared to talk. about costs with their patients. This results in a constant relationship between financial toxicity with psychological and work aspects expressed as emotional distress, stigma, anxiety, depression, stress, loss of productivity, lower wages and a lower quality of life. So recommendations that emphasize the reduction of financial toxicity at multiple levels (provider, clinic, hospital and private and government insurance), implementation of standards Reflexive institutional treatment does not yet seem to closely associate the psychological element. Therefore, incorporating psychological aspects can help everyone: the patient, the family and the health team to move with greater empathy, a better quality of life and knowledge of how they live and transit each in the same direction as a team that faces and lives every day the cancer of prostate. To purchase the book click For more information about donations click Image from the collection of videos about prostate cancer Directors: J.Estapé, T.Estapé Secretary: M.Soler Marc Aureli, 14. 08006 - Barcelona Tel. 93 217 21 82 Email: We appreciate the collaboration of: THEIR CANCER GARDEN FEFOC © 2021 Directors: Professor Jordi Estapé and Doctor Tania Estapé. EDITORIAL Dr. Alicia Morgans of the Dana Farber Institute in Boston has amazed us with her approach to prostate cancer treatment. Indeed, apart from therapeutic novelties in advanced cases, it gives a lesson in how to share therapeutic decisions with patients' preferences. In the field in which we now move, that of personalized medicine, it is clear that the patient must have an increasing role in the decisions that affect their quality of life. And for this, choose, as far as possible, how you want to live your life. On the other hand, to emphasize that we deeply believe in the need to know the history of prostate cancer and therefore today we expose a synthesis of the historical evolution of its surgical treatment, which we will continue in successive numberscon We also collected a case of the impact of the diagnosis of biochemical recurrence in a couple of men of another sexual condition, one of them with prostate cancer. We add more knowledge to the important issue of active surveillance and, finally, we review a great novelty: indeed, EUROPA UOMO has elected by vote and for the first time in its history a female member on its Board, our psychologist Dr. Tania Estapé. It is a pride for FEFOC and an important opening of EUROPA UOMO not only for the sex of the new member but, even more so for its quality as a psycho-oncologist, which adds an important sphere of knowledge to the important activities of the organization. European. radiation therapy, etc. Dr. Cristiane Bergerot,psycho-oncologist at the Multidisciplinary Cancer Center in Brasilia, Brazil and member of the Board of Directors of the International Psycho Oncology Society and collaborators. NEW STRATEGIES IN ADVANCED PROSTATE CANCER Dr. Alicia Morgans is a Uro-Oncologist and director of the survivor program at dana-Farber Cancer Institute in Boston. It is very striking that it includes the preferences and thoughts of patients in their clinical decisions. He has done a lot of research on the complications and side effects of current therapies in advanced cases of prostate cancer (AC). Corroborating her concern and dedication to the problems of these patients, she has been, until 2016, President of the committee of doctors of ZERO, a non-profit organization dedicated to the information and support of patients with CP. From an article in Targeted Therapy we have extracted some of his important views about hormone therapy, other options and the methodology for choosing the appropriate treatment in CPa. In the past we only had hormone therapy based on testosterone deprivation (DT). Today the landscape has changed and we have several options. That is why it is essential that doctors have long conversations with patients trying to identify what each patient prefers. However, although we have several options, DT remains the backbone of treatment, either through its intensification or its association with other options (chemotherapy, immunotherapy, targeted therapies or radiopharmaceuticals), even applied in early stages of the disease. outpost. Choosing the treatment is based on guidelines that answer the big question: What do we have that can improve the survival and

quality of life of this patient? The first thing is, logically, to know the medical options that can be beneficial for this particular patient. We then work with the patient to learn about their preferences. One may prefer an intravenous treatment, another one of oral or avoid certain complications. Others may prefer the greatest therapeutic aggressiveness, because it wants to attack the cancer as much as possible. Now we must think about the location or locations of the cancer and its clinical characteristics. Is it in the skeleton or in the nodes or in the liver? Does it grow slowly or quickly? What complications is it causing? We generally use some form of DT intensification, by associating it with other options. And we follow patients very closely, because things change sometimes day by day. When CP becomes resistant to intensified DT, forecasts should already be made, especially if we plan to use PARP inhibitors (poly ADP ribose polymerase, an enzyme of which several cancers are dependent so its inhibitors have an important potential in the treatment of cancer), which require a previous genetic study to know if the patient is sensitive to these inhibitors. In fact, the best thing is that immediately that a patient with CP develops metastases and the genetic study must be carried out to already know in advance whether or not it will be sensitive to PARP inhibitors. Another test that he recommends from the outset is the somatic test, in which the DNA repair genes are determined, the most important being in CPa. BRCA and, BRCA1. With both tests we have precious data for precision medicine and eligibility for new clinical trials as well as those suggesting hereditary CP (in which case family members have the opportunity for screening and a very early diagnosis). and, in the hope of curing a cancer that has barely begun its development). (continued on page 3) (Comes from page 2) The combination of these tests and treatments targeting specific targets in the cancer cell are being imposed in the treatment of PCa. Especially pembrolizumab (antibody or protein that cancels the PD1 cell receptor, responsible for our immune system not attacking cancer cells). and PARP inhibitors, are used more and more early. All this suggests that the advances in CPa will be enormous. It will improve life expectancy and its quality. We recently learned that lutetium/PSMA, within the trial called VISION, prolonged survival without radiographic progression. In terms of drug combination, DT with docetaxel and abiraterone in patients with high-volume metastatic disease sensitive to hormonal treatment prolonged the survival of patients who only received DT and docetaxel. Another important trial, the results of which we are waiting for, replaces abiraterone with enzalutamide. There are many studies, but with one thing in common: the interest in finding new treatments, new combinations and new ways to help patients live longer and better. HISTORICAL HISTORY OF PROSTATE CANCER TREATMENT (CP) In the History of Medicine, CP has been known since ancient times. In the skeleton of a Russian king was found the first case, with an appreciated antiquity of 2,700 years. But the best known is that of an Egyptian mummy, with an antiquity of 2,200 years. Studied at the Archaeological Museum of Lisbon, the mummy corresponded to a male between 30 and 40 years old, with CP and probable metastases in the bones. As early as 1536, the Venetian specialist in human anatomy, Niccolo Massa, described the prostate, which was illustrated two years later by Andreas Vesalius. It was not until about 300 years later, 1853, when we have the first more objective description of cp, by the then surgeon of the London Hospital, Dr. J. Adams, whose contribution he made through a study under the microscope. For Adams it was a very rare disease. Surgery. In 1867, in Vienna, the great surgeon Theodor Billroth (born in Prussia), founder of abdominal surgery and amateur musician, a close friend of Johannes Brahms, was introduced into an almost unknown territory, by practicing the first prostatectomy (removal of the entire prostate) radical perineal by CP, through an incision in the perineum (skin between the scrotum and the anus). In the USA, the first prostatectomy was performed by Dr. William Belfield, in 1885, at Cook County Hospital, Chicago. In 1904, Drs. Hugh H. Young (called the father of American urology) and William Stewart Halsted (this the precursor of modern surgery in breast cancer), performed radical and perineal prostatectomy at Johns Hopkins Hospital. In 1945, Irish urologist Dr. Terence Millin, provided retropubic radical prostatectomy. Dr. Walsh, of Johns Hopkins Hospital, revolutionized CP surgery in 1982 by introducing a surgical modality in which nerve sparing surgery, essential for erection, are not sectioned. Dr. Walsh is known for his pioneering work on what is called "the anatomical approach to radical prostatectomy." By not sectioning the neurovascular packages, the likelihood of impotence and incontinence secondary to classical radical prostatectomy is reduced. (continued on page 4) (Comes from page 3) Jason Engel of George Washington University was the first to perform a robotic prostatectomy in 2004. He used a system called Da Vinci in which the instruments used for prostatectomy move like human wrists, offering all the functions of the hand. It provides the advantages of laparoscopy, but with minor incisions, less blood loss, a magnification of the operative field and a shorter recovery of the patient. *From the book "Prostate Cancer in Heterosexuals, Gays and Bisexuals", by J. Estapé and Tania Estapé novedad FEAR OF RELAPSE IN PATIENTS WITH

LOCALIZED PROSTATE CANCER Dr. Cristiane Bergerot is a psycho-oncologist at the Multidisciplinary Cancer Center in Brasilia, Brazil and a member of the Board of Directors of the International Psycho Oncology Society. Dr. Bergerot, along with Drs. Stephen B Williams of St. Joseph Hospital, Orange and Dr. Zachary Klaasen at The Princess Margaret Hospital have published an editorial on the problem of fear of relapse in patients with localized prostate cancer. This article was published in the journal Cancer in August. They have been based on the study of Dr. Meissner et al. These have evaluated patients at a psychological level at two time points (2010 and 2019), using the fear of relapse questionnaire (a test created for this purpose, in its short version), the patient's health questionnaire (called PHQ2 and PHQ4) and generalized anxiety disorder (GAD2), i.e. maintaining moderate to high anxiety levels permanently throughout the day. In a large sample (of 2417 patients) taken from the German Familial Prostate Cancer Database, they were analyzed the aforementioned variables and it turned out that: There is a low proportion of patients with a moderate to severe fear of cancer recurrence (less than 10%). However, in this group, it was found that already at the beginning of the work they had these levels. That is, they already had an increased risk of presenting these emotional symptoms in the follow-up evaluation (maximum 7 years later). In addition, lower levels of education, more years since radical prostatectomy, and not being on cancer therapy at the time of the study were also predictors of more fear of relapse. Levels of anxiety and depression were associated with higher levels of fear of cancer recurrence. It was also a predictor of fear of relapse, the increase in PSA level, after surgery or radiation therapy. Interestingly, younger age and family history of cancer were not associated with fear of cancer relapse. This is an important study that can help clinical practice identify patients at increased risk. It can also help us develop and guide effective treatment to overcome the fear of relapse. Dr. Cristiane Bergerot (continued on page 5) The editorial can be read at: Bergerot, Cristiane & Williams, Stephen & Klaassen, Zachary. (2021). Fear of cancer recurrence among patients with localized prostate cancer. Cancer. 127. 10.1002/cncr.33837. TESTIMONY OF A PATIENT WITH BIOCHEMICAL RECURRENCE* OF PROSTATE CANCER Three years after the radiotherapy, and to my horrible surprise, the PSA, I rose to 6 and, the next month, to 10. With my partner we went as quickly as possible to the doctor of the rays. He was a good person, simple and open. But he, like the rest of the hospital, didn't know exactly what my sexual condition was, they never asked me, but I think something was suspected; especially when, in the last year, I was accompanied by my soul mate. The urologist asked me for some scans. He suspected that the disease had reproduced. As a death row member I did the scans and then came the terrible wait until the next visit. They should be faster. They should share insomnia, doubts and nightmares. At least mine. Finally I was received by the doctor. To our surprise, he told us that nothing was detected, but that the PSA had risen again. He said that I had something like a biochemical reproduction of my prostate cancer, that I was not a separate phenomenon, that the blissful biochemistry saw it with some frequency. And what to do? Hormonal treatment. He explained it to me in quite a bit of detail. And its effects. I heard with real terror the word I feared most: helplessness. First he spoke of erectile dysfunction, but, in Christian, it was impotence. And so it was. I tried to change my role. I went from happy top to resigned, bottom. My partner also tried to change his role, but I saw that he was not happy. Six months passed, we remained the same, although sadder We had to find some solution. We went back to the doctor. He listened to us attentively. And it confirmed the need to follow the treatment, the PSA was not yet normal. But he offered us a variant: the accordion treatment, he said. Accordion' Yes, take the treatment or not, according to the PSA? As long as it was elevated, treatment, when normalized, no. And get a PSA every two months: high PSA, treatment; Normal PSA, no treatment. And come back to life as much as possible. He warned us that not all doctors agree and prefer to give continuous treatment. We do not hesitate, the flasher. It allows us to alternately enjoy a sex life more similar to the one we want. I went back to being top and my partner to bottom. *After the initial treatment of prostate cancer, a continuous increase in the PSA level is sometimes observed, without metastases being detected at the outset. MORE ABOUT ACTIVE SURVEILLANCE Dr. Timilshina and colleagues, from the University Health Networl and the University of Toronto, Canada, remind us that active surveillance (VA) rather than aggressive immediate treatment has become the standard treatment for patients with low-risk prostate cancer (PC) and whose acceptance, that of the VA, has increased significantly in recent years. This data is collected in US Too International, published online by the Journal of Urology. (continued on page 6) (see page 5) They studied 17,000 men with CP in Canada between January 2008 and December 2014. Va acceptance went from 38% in 2008 to 69% in 2014. But half of the patients who chose VA went on to active treatment during the first 4 years of follow-up. What factors most influenced this shift to active treatment? The following: First of all, age. Younger people changed more often than

older ones. So did those with rising PSA. And more those treated in large hospitals. The researchers believe that it is very necessary to establish means on the one hand not as aggressive or invasive as periodic biopsy or as difficult to interpret as PSA. However, subsequent studies show greater continuity of patients in VA. Some of the needs outlined by Timilshina have been met, in part, by a better selection of VA candidates and also by the increasing use of multiparametric nuclear resonance. MEETING OF THE BOARD OF EUROPA UOMO IN ATHENS ON 26 NOVEMBER On Friday, November 26, the Board of Europe Uomo will meet in Athens. Apart from the importance of the meeting itself, we wish to highlight that, for the first time in its history, a female member participates in this institution, Dr. Tania Estapé, coordinator of psycho-oncology of FEFOC and expert, among other things, in prostate cancer. Psycho-oncologist Dr.Tania Estapé Europa Uomo was created in Rome in 2002. Its goal is prostate cancer, trying to improve its diagnosis, treatment, support and quality of life. Europe Uomo 27 groups from various European countries. They conduct research, both nationally and internationally; work with healthcare professionals to help them understand patients' perspectives; support national organizations trying to improve cancer services and awareness. His current priorities are to investigate the quality of life of patients; improve early diagnosis and support its members and help and give voice to patient groups in Europe. During the meeting, important issues will be discussed. PROSTATE CANCER QUALITY OF LIFE SURVEY: EURPROMS 2 As members of Europa Uomo, we are participating in a survey on quality of life in prostate cancer patients. We need your participation in it, to have the maximum possible data of our country. If you have or have ever had prostate cancer or know someone in this situation please take some time to answer it at the following link. Thank you very much, with this you will contribute to improving the lives of many patients: To purchase the book click For more information about donations click Image from the collection of videos about prostate cancer Directors: J.Estapé, T.Estapé Secretary: M.Soler Marc Aureli, 14. 08006 - Barcelona Tel. 93 217 21 82 Email: We appreciate the collaboration of: THEIR CANCER GARDEN FEFOC © 2021 Directors: Professor Jordi Estapé and Doctor Tania Estapé. EDITORIAL In this issue we want to highlight, first of all, an important study by Wayne University,whichcollects the opinions of 225 urologists, from Michigan and Georgia, regarding active surveillance in low-risk prostate cancer. In most countries, active surveillance has been very well received by urologists. This data comes from public medicine, but in the private sphere things can be different. An article published in Hot Sheet (May 2020), by Us Too International, Zang et al. explained that it is unknown if the reduced reimbursement that for these specialists means active surveillance with respect to classic treatments, may be a barrier for some urologists recommend it. In their study they find that active surveillance means lower incomes. According to its conclusions, the In Spain we have observed, in the public system, a remarkable acceptance by our urologists of active surveillance. Returning to the Wayne University study, you will also observe opinions very favorable to active surveillance, an ideal means to preserve sexual potency and urinary continence, but which, in our opinion, as we have already pointed out on previous occasions, it requires specialized psychological support. It is time for the excellent professionals who are urologists to recognize that, no matter how much intimacy they have with their patients, they are not qualified to be their psychologists. And it is not only an opinion since some urologists have told us that they were the real psychologists of their patients and that they did not need the help of psychologists. private or in-systemurologists to Another article of interest is due to the University They have little financial incentive to recommend it. In the public system it is different, since doctors work on salary. from Tampere,Finland, regarding an interesting study in which the possible effect of statins on the results of early diagnosis of prostate cancer is observed. (V I E N E D E L A P Á G . 1) As we did with the history of prostate cancer surgery, today we summarize that of the radiotherapy of this tumor, with special mention to Dr. Bagshaw, justly called the father of radiotherapy. We also offer an overview of prostate cancer prognosis. Finally, we collect an important review on hereditary prostate cancer. WHAT AMERICAN UROLOGISTS THINK ABOUT ACTIVE SURVEILLANCE We must respectfully discover ourselves in the face of the courage and love for statistics of American scientists. When here it is still unclear the role of active surveillance (VA) in prostate cancers (CP) of good prognosis, there they are already asking a fundamental question: What do urologists think of a technique that competes with prostatectomy? It really is an exciting topic. The opinion of expert specialists, urologists, who observe and opine, at least in the USA, on the growing demand, on the part of patients with CP, for the VA. Dr. JinpingXu and collaborators, mainly from Wayne State University,in Detroit publish(Urology)the results of a study whose main objective was to "Evaluate the attitudes and perceptions of urologists about VA and other therapeutic options for Low-risk CP." The study was conducted with urologists from the states of Michigan and Georgia, with financial support from the American Cancer Society. We

summarize part of this article as follows: 225 urologists completed a survey, of which 147 (65%) were from Michigan and 78 (35%) from Georgia. The majority of urologists (99%) provided information to patients about VA and 97% discussed the issue with them. 61% offered patients this possibility, the VA. 97% believed that VA was an effective and underused option (90%), while (80%) believed that surgery and radiotherapy are overused in the USA. The article attends to other considerations that we will surely analyze every day. The indestructible fact is that the time has come for men to partner with FEFOC in our programs for the quality of life of those affected by prostate cancer. Active surveillance is the first stone on such a difficult road. STATINS MAY CHANGE PROSTATE CANCER SCREENING RESULTS A study by Tampere University (Tampere is a Finnish city located in southeastern Finland, 170 kilometers from Helsinki. Its university is young and appreciates offering a multidisciplinary training). This study, published in JAMA and whose first signatory is Dr. Arla Vettenranta, followed by various collaborators from the University, evaluates the results of the screening for prostate cancer depending on whether candidates use statins or not. Statins are drugs that lower the level of cholesterol in the blood, interfering with its production in the liver, with the peculiarity of decreasing the so-called bad cholesterol and increasing the good one, thereby decreasing the risk of formation of plaques in the arteries. (continued on page 3) 2 (Comes from page 2) Well, in the Finnish study (based on data from the Finish Prostate Cancer Screening Trial, which began in 1996), the percentage of low-risk prostate cancers (CP) found was significantly lower in people who they usually took a statin. On the other hand, there were no changes in the detection of High Risk CP. As noted in the study, the use of statins is quite common and their possible effects on CP screening had not been previously assessed. They included a total of 80,000 men. The authors establish some possible explanations for the effect of statins:1) The use of statins improves the accuracy of screening, which would indicate that statins decrease the so-called "overdiagnosis" or excess in diagnosis, i.e. excessive detection of CP without risk due to its slow growth. 2) That people who use statins monitor their health more frequently and PSA detections are performed more frequently. Be that as it may, they are data to take into account to perfect the screening by CP. BRIEF HISTORY OF RADIOTHERAPY (II) After the history of surgery (I) today we expose that of radiotherapy (II) This begins its application in CP at the beginning of the twentieth century. At first, radio implants were used inside the prostate, but with the development of external radiotherapy, they were used using energy sources outside the patient. In the middle of the last century, with the provision of cobalt pumps (which could provide higher levels of irradiation in the depth of the organism), the application of radiotherapy was intensified in cases where surgery was not possible. these are too extensive CPs locally. A step further in CP radiotherapy is due, among others, to Dr. Malcolm Bagshaw, who, in small series of patients, showed the radiocurability of CP. Bagshaw left us in September 2011, irreparable loss of the true father of modern radiotherapy in CP. He developed much of his work at the Stanford University School of Medecine,opened in 1891, in California and one of the most prestigious in the USA. He was known for his so-called "can-do" attitude that he applied to innovation, research, teaching and patient care. He created a great professional and human team. Aside from his immense professional work, he could sometimes be seen off the coast of California, on his bicycle, with his team's doctors, or flying with a glider. When he began his activity in oncological radiotherapy, this specialty was new and experiencing rapid growth. He worked with Kaplan (great radiotherapist and father of modern curative radiotherapy in Hodgkin's disease), both being pioneers in the use of high-energy radiation apparatus, produced by a linear accelerator in the treatment of several cancers, including CP, which today represents the basis of the best radiological treatment of CP. As Professor Richard Hoppe,one ofhis successors, noted, "where Bagshaw really excelled was in the introduction of modern radiotherapy in CP." Bagshaw and colleagues showed that high-dose radiation therapy focused on small fields could be as curative as surgery. In addition, this radiotherapy allowed to preserve sexual potency and decreased the risk of urinary incontinence. (Comes from page 3) On the other hand. later the radiographic study of the tumor was also improved, through the contribution of CT (computerized axial tomography), all with the result of an increasingly effective and less effective treatment toxic to normal tissues around the prostate. Already in 1960, in cases with large tumors, the previous hormonal treatment was initiated, to reduce the size of the tumor and make them more affordable to radiotherapy. The successive modalities of radiotherapy (conformal radiotherapy in three dimensions, intensity-modulated radiotherapy, stereostatic body radiotherapy), have significantly increased their therapeutic precision with respect to the tumor, with less involvement of the surrounding healthy tissues. This has made it possible to apply higher doses to the tumor with fewer undesirable side effects Another modality of radiotherapy, or internal radiotherapy, is brachytherapy (started in 1983) and which consists of the implantation in the prostate of radioactive

'seeds'. Today it is considered that in cases located in the prostate, surgery and radiotherapy have a similar effectiveness. GENERAL PROGNOSIS OF PROSTATE CANCER For statistical purposes, prostate cancers (PC) are usually grouped into three large groups, with different treatments and prognoses: local involvement: CP has not spread outside the prostate; regional involvement: CP has spread to nearby structures or lymph nodes and distant involvement: CP has spread at a distance from the prostate, bones, liver, lungs. Survival data. In general, survival data are offered at 5, 10 or 15 years of diagnosis. They may reflect either the overall survival of all patients considered (regardless of whether they are with or without disease) or, when talking about disease-free survival, it only includes those who, after treatment, persist. without disease. These reflect more the effectiveness of the treatment and the chances of cure. Survival rates are calculated on the evaluation of thousands of patients who have suffered from the same type of disease and at the same stage. These rates are compared with men of similar ages and status, but without CP. For example, if a patient with CP has, according to their stage and other data, a 90% chance of survival, it is their chances of survival relative to people without CP. Next, we collect survival data from patients with CP, from different countries: In Spain, of the global set of patients (regardless of age, stage, Gleason, etc.), overall survival (without taking into account age, histological type or treatment) at 5 years is approximately 85% of patients, according to data from the AECC. It is the third cause of death in men from cancer in Spain (the first is lung and the second colon and rectum). In the United Kingdom (UK), the survival rate is 96.6% at one year of diagnosis; 86.6% at 5 years and 77.6% at 10 years of diagnosis. We offer data from the prestigious SEER (Surveillance, Epidemiology and Final Results Program) in north America, based on the follow-up of patients diagnosed between 2009 and 2015. (continued on page 5) (Comes from page 4) SEER Stage: % survival at 5 years Localized: About 100% Regional: About 100% Metastatic: 31% All combined: 98% SeER figures refer exclusively to the stage of CP in which you were diagnosed. Therefore, it does not do so if the CP subsequently grows, spreads, or recurs after treatment. They also do not include all risk factors, such as the patient's age, general health, PSA level or Gleason grade, what is the response to treatment and other factors that can modify them. In addition, it is possible that these figures have even improved, with the progress of treatments and the fact that the patients assessed here were diagnosed more than five years earlier. In Canada, survival figures are similar to those of the North American SEER, with the only exception that, in metastatic cases, it is 28 per cent. Australia declares an overall survival at 5 years of diagnosis of 95% of patients. We are therefore facing a cancer with a good general prognosis, one of the best in Oncology, but with a series of doubts as to the side effects of treatments in the choice of the various modalities (surveillance). active, surgery, radiotherapy) in localized and/or locally advanced CPs. PROSTATE CANCER – HEREDITARY: A GOAL OF CARE OF THE HEALTH TEAM Dr. in Psychology Oscar Galindo Vázquez Attached to the Psycho-Oncology Service Coordinator of the Research and Development Unit of Psycho-Oncology National Cancer Institute INCan Prostate cancer is an increasingly common type of neoplasm in the world, being an emerging public health problem for the elderly male. This group of patients have various effects on their quality of life such as fatigue, weak urine flow or interrupted flow, erectile dysfunction and affectation in their sexual life, as well as symptoms of depression, anxiety and emotional discomfort. However, even today little is said among the general population about prostate cancer, about its causes, symptoms, treatment, about its needs and how this group of people live. In this context, the role of social support and family in particular is fundamental, mainly because men may not have the social means and be accustomed to sharing their needs and health problems throughout life. (continued on page 6) (see page 5) On the risk factors of this disease a group of these patients are carriers of germinal pathogenic variants in genes of high susceptibility to cancer for example for BRCA1 with a risk of 8.6% at 65 years and for BRCA2 of 15% at 65 years and 20% for life, while the risk for men in the general population is 6% until age 69. So men who meet some high-risk criteria such as: having a first-degree relative (parent or sibling) with prostate cancer before age 55 age, men of 55 or fewer with prostate cancer, and with first-degree relatives with hereditary breast or ovarian cancer or with Lynch syndrome (not associated with polyposis)before age 50 represent a group that could benefit from genetic counseling and multidisciplinary care for the various needs arising from this condition. The identification of families diagnosed with hereditary cancer is important since their members could benefit from effective measures, not only in early diagnosis, but also in the prevention of tumors. In these families it is common to observe several cases of cancer, in some cases, of the same type. They appear in several generations and occur at an early age compared to sporadic cases. To the challenge of understanding the information of genetics, emotional effect of knowing oneself as a carrier of a mutation and its implications at the level of treatment and prevention is added the relevance of talking

about men seen in a good part of cases as stoics and providers, and not as people who also need to convey their needs. Therefore, more literacy programs are required in the general population and in particular in patients who can benefit from genetic counseling. The health system as an organized social response to the problems that arise in a community, specifically requires that male health be considered as one of the values of a society and that more than an emerging problem so far insufficiently treated as prostate cancer. References: Manual of Genetic Counseling in Oncology. Álvarez Gómez RM, Vildal S, Wegman T, Nuñez PM. (2017) CHAPTER 3. Genetics in oncology. Permanyer Mexico City. First edition, Mexican Society of Oncology SMEO. Espinoza-Bello, M., Galindo-Vázquez, Ó., Jiménez-Ríos, M. A., Lerma, A., Acosta-Santos, N. A., Meneses-García, A. A., & Sánchez-Sosa, J. J. (2020). Psychometric properties of the Functional Evaluation Scale for the Treatment of Cancer, prostate version (FACT-P), in Mexican patients. Surgery and Surgeons, 88(6), 745-752. https://euproms.ydeal.dev/ To purchase the book click aq ui For more information about donations click Image from the collection of videos about prostate cancer From FEFOC we wish you a happy holiday and a prosperous new year. Directors: J.Estapé, T.Estapé Secretary: M.Soler Marc Aureli, 14. 08006 - Barcelona Tel. 93 217 21 82 Email: We appreciate the collaboration of: THEIR CANCER GARDEN © FEFOC 2021 Directors: Professor Jordi Estapé and Doctor Tania Estapé. EDITORIAL AJULYONEBRAIN CANCER? As is well known, on July 14, 1789, the storming of the Bastille took place in Paris, with the end of the old regime and the beginning of the French Revolution (here the glorious Marseillaise could sound). In 1790, French citizens celebrated national reconciliation. Similar airs sound in prostate cancer (CP). Modernity advances unstoppable. For example. Active surveillance in CP makes its way as the first option in very low-risk CP. The psychological support of the patients who choose it is a necessity of the first order. The liquid biopsy opens an avenue Genetic tests in women, who of course do not suffer from CP, allows, among other things, to facilitate special and early care of their children and grandchildren when their mother or grandmothers have certain genetic changes that increase, in males, the risk of CP. And, at the same time, it opens an early door to its prevention and early diagnosis. Artificial Intelligence shows great potential to improve the diagnosis of CP, improve the determination of the Gleason grade and collaborate in developing countries , where the lack of enough pathologists is evident. The PANDA project is the first and encouraging response in this regard. On the other hand, we draw attention to another positive fact: the progressive increase in the flowered, to allowdiagnostic diagnosis incidence of coming testicular cancer extraordinarily precozeincruento of possible metastases. Since 1970, it tends to decline. 1 DOES THE INCIDENCE OF TESTICULAR CANCER DECREASE? Testicular cancer (CT) is the cancer most commonly diagnosed in young adults. Fortunately, its curability rates are very high. Perhaps more worrying was the continued increase in its incidence since 1970. This phenomenon was more visible in Caucasian men. The causes of this increase are unknown. Reese and collaborators, from ruhr Bochum University, (university located in the Ruhr region, Germany. It was founded in 1962 and began its activities in 1965, being the first new German public university after the end of the Second World War), published the results of a study on the incidence of TC. It shows, especially in the USA, that the incidence of TC has been increasing progressively since 1970. And perhaps another fact of great interest is that the increase was not only observed in white men, traditionally more affected by TC than men of other ethnicities, but that, at present, the TC increased in All Peo men, from 1970 the upward curve tends to flatten and therefore, to decrease the progressive increase in the incidence of this cancer. According to data from the American Cancer Society, in 2021 9,470 cases of CT were diagnosed in the USA, mostly seminomas. Some 440 men would have died from it. In fact, CT is not very common and is suffered by one in 230 men. The average age is 33 years at the time of diagnosis. However, 6% is diagnosed in children and adolescents, while 8% occurs in people over 55 years of age. As we said, the prognosis is very good since it is estimated that 1 of each die from its cause 5,000 men. A hopeful fact is that the curves of increased incidence of TC tend to decrease lately. Let's look forward to future results. We would not like to end this note without acknowledging the merit of the Bochum University which, in 1981, awarded the recently deceased Desmond Tutu the degree of honorary doctor by that university. And that happened before Tutu became archbishop and received the Nobel Peace Prize. Type of recognition that in these parts are usually granted for strange reasons. LOCALLY ADVANCED PROSTATE CANCER : DEFINITION AND TREATMENT OPTIONS Locally advanced CP comprises various T3 or T4 situations, where the CP may have spread and affected *The capsule of the prostate or outermost layer of the prostate (T3a). *The seminal vesicles, two glands located behind the prostate and that store semen (T3b). *Lymph nodes near the prostate (N1) *Urinary bladder (T4) *Straight (T4) * Prostate wall (T4) Such a diversity of situations means that, when treatment is reached, it must be

personalized on a case-by-case basis. Treatment options. They are as follows: *External or internal radiotherapy , associated with hormonal treatment (see below). *Hormone treatment only . *Prostatectomy, associated with radiotherapy, hormone treatment or both. *Wait and see (which is very different from active surveillance). (Comes from page 2) Directions. They are as follows: In T3 cases, the cure rates are similar with radiotherapy and prolonged hormone therapy or with surgery (prostatectomy) with or without radiotherapy, with or without hormonal treatment. In T4, the most commonly used treatment is the association of radiotherapy followed by hormonal treatment. Hormone therapy alone would in any case be indicated in elderly people. Another option, wait and see. To purchase the book click TWO REASONS WHY WOMEN SHOULD BE TESTED FOR CARRIERS OF THE GENOMIC MODEL OF PROSTATE CANCER True, women cannot develop prostate cancer (CP), but Dr. Peterson gives us two good reasons to be tested for the gene that predisposes to the development of CP in their children and/or grandchildren. Dr. Caroline Peterson (director of the Cancer Screening and Prevention program at the Kettering Health program in Washington) offers women two reasons for this: Your child or grandchild may inherit a gene that indicates an elevated risk of developing CP. You will not, of course, develop this cancer, but you can pass the risk on to your immediate offspring. Genes that predispose to CP may also indicate an increased risk of developing breast or ovarian cancer by the woman herself. Dr. Peterson and her team study patients' family history to estimate the risk that they carry the gene. Currently, up to 36 genes can be detected, of which 14 indicate the genetic risk of developing CP. But these 14 genes also warn about other hereditary cancers (breast, ovary, colon, uterus, pancreas and melanoma). As Dr. Peterson does, we must distinguish the presence of the BRCA 1 and BRCA 2 genes in men or women. Men with BRCA 1 and BRCA 2 positive have an increased risk of CP, breast and pancreatic cancer. But some of these genes also increase the risk in their female relatives of developing breast, ovarian, or colon cancer. The HOXB13 gene. If a woman is a carrier of this gene, it tells us that she can have it without any specific health problems. But if you pass it on to your male children or grandchildren, they may be at higher risk for CP. Even her father, that of the carrier woman, may have it and have passed it on to his daughter. And every man who knows that he has inherited this gene can, should, be subject to early surveillance in case he develops CP. (Comes from page 3) Today a new and magnificent stage is opening in the prevention and early diagnosis of cancer in general and in that of the CP in particular. Genetic testing allows for very early warning. If so far we have suffered from poor cancer prevention (apart from the usual negative economic interests, for example, tobacco, junk food, etc.), now things can change significantly for the better. We would not like to end without paying tribute to our dear colleague and friend, vice president of FEFOC, Dr. Elías Valverde Llor, who for years had the vision of the importance of genetics in CP. LIQUID BIOPSY, NON-INVASIVE DIAGNOSIS OF PROSTATE CANCER METASTASES Sometimes patients with apparently localized prostate cancer (PC) do not respond to treatment and soon develop or are developing metastases, hitherto impossible to diagnose. But liquid biopsy, study of tumor traces in the patient, is a bloodless means (you do not have to open or cut, just extract a little blood, saliva or urine), which allows a very early diagnosis of possible metastases. Liquid biopsy is a non-invasive diagnosis that makes it possible to diagnose circulating cancers. Liquid biopsy Fluid is not only obtained from blood, but also from urine and saliva. In the present case , the samples were extracted from the blood of the patients Dillinger T and collaborators from the Medical University of Vienna, Austria, publish in the journal Molecular Cancer an important study in which they show how they identify fragments of tumor DNA from patients with CP, circulating in their blood. They use liquid biopsy to study these circulating fragments. We are therefore facing a remarkable advance. That will allow very early treatments in cases of resistance to usual treatments or suspicion of metastasis. It may also be used in the assessment of response to hormonal or chemotherapeutic treatment. PATHOLOGY OF PROSTATE CANCER When biopsy samples for the diagnosis of prostate cancer are studied under a microscope, several changes can be found. They are as follows: PIN (intraepithelial neoplasia of the prostate) is a lesion that may be precancerous. There are two types of PINs, one with few alterations from the normal ones (or low-grade PINs); another with very altered cells and different from normal cells (high-grade PIN). Between 30 and 40% of the latter, high-grade PINs, are precursors of CP. If diagnosed, their evolution is followed very closely, through biopsies and multiparametric nuclear resonance, because the risk of developing CP is very high. As for low-grade PINs, they do not usually represent problems during the life of the person affected. The causes of PINs are unknown to date. When we diagnose a CP it is possible that, in addition, PINs are found that have not produced symptoms. (Comes from page 4) ADENOCARCINOMA. It is the most common of the PCs (90%). It develops from the glandular cells of the prostate. Most adenocarcinomas have very slow growth and do

not tend to extend beyond the gland. But others, on the other hand, tend to grow rapidly. The remaining 10% of CPs consist mainly of six other types: The first is ductal adenocarcinoma, which forms in the cells of the ducts (ducts) of the prostate. It grows faster than glandular adenocarcinoma. It is not very sensitive to hormonal treatment, so its treatment is based on surgery and chemotherapy. The transitional, also called urothelial cancer, is found in cells near the urethra. However , it is more common for this type of cancer to start in the urinary bladder and invade the prostate. It is treated with surgery and/or chemotherapy. Squamous cell carcinoma develops in the fat cells that line the prostate. It is fast-growing, usually diagnosed in advanced stages. It is treated following the general lines of glandular adenocarcinoma. Carcinoid forms in the nerve tissue of the prostate. Its growth is very slow. If it does not give symptoms it is not usually treated. If, on the other hand, you give them, you are a candidate for surgery. Sarcoma forms from the muscle cells of the prostate. Fast growing and surgical treatment. Small cell carcinoma , fast-growing and difficult to diagnose early, as it does not raise the PSA level. Surgical treatment. ASAP. They stand for "atypical small acinar proliferation". A biopsy has been performed and cancer cells are found under the microscope, but there are very few, so making a diagnosis of cancer is not easy In these cases a new biopsy is usually recommended in some months. PIA (proliferative inflammatory atrophy): The cells of the prostate are smaller than normal and signs of inflammation are associated in the biopsied area. PIA is not cancer, but it is thought to be a precursor to high-grade PIN and cancer risk. To purchase the book click ARTIFICIAL INTELLIGENCE CAN IMPROVE THE DIAGNOSIS AND GRADE OF PROSTATE CANCER Kimmo Kartasalo and collaborators, from the Department of <Medical Epidemiology and Biostatistics of the Karolinska Institutet, Stockholm, Sweden, together with several international collaborators have completed an important study in which artificial intelligence (AI) was validated in the diagnosis and graduation of prostate cancer (CP) or Gleason grade *. The results were published in the journal Nature Medecine (January 13, 2022). This journal publishes research results that address the needs and goals of medicine. (continued on page 6) (see page 5) AI applied to Medicine offers the possibility of reshaping many aspects of Medicine, while at the same time it can greatly improve the experiences of doctors and patients. This study shows that AI systems can identify and graduate tissue samples from patients with CP, samples that came from various countries. The international validation took place within a system called PANDA (from Prostate cANcer graDe Assesment), which brought together 1290 AI experts who were challenged to rapidly develop systems that would establish the grade of PCs with great precision... To do this, they used 10616 digitized prostate biopsies. Today a current problem in the diagnosis of CP is that different pathologists can reach different conclusions regarding the same pathological tissue samples. This can negatively influence the therapeutic decisions that are made on different bases by clinicians. Evaluations are still subjective, so many variations in valuation are observed, which can translate into an undervaluation (Gleason below what it really is) or supra valuation (Gleason above its reality). In any case, it would result in treatments by default or by excess. The researchers believe that AI has enormous potential to improve these assessments , although many problems in its use still need to be solved. The evaluation of CP biopsies using AI has great potential to improve the quality of diagnosis at a lower cost than the current one. It's not about AI replacing pathologists, but acting as a valuable complement to prevent diagnoses from escaping and aiding in accuracy by establishing Gleason's grade. And it can also be an important help in developing countries, where there is a great shortage of pathologists. * GLEASON GRADES Grade 1: Gleason of 6 or less (low activity CP) Grade 2*: Gleason of 3+4=7 (INTERMEDIATE AGGRESSIVENESS CP) Grade 3*: Gleason of 4+3=7 (CP of intermediate aggressiveness) Grade 4*: 8 Gleason (High Grade CP) Grade 5*: Gleason 9 to 10 (High Grade CP) Taken from the book "Prostate Cancer in Heteros, Gays and Bisexuals", by FEFOC. We attach a copy of the invitation to attend the screening of a film documentary about Professor Jordi Estapé. Given the limitations of the pandemic, we need you, if interested, to confirm your attendance at: If you wish to be accompanied , you must also state the details of each of your companions. Hoping to greet them on February 8. Receive an attentive greeting, FEFOC For more information about donations click. :www. youtube. /UCMOFY1FLcbVOCshefrj6mkQ/ Prostate Cancer Video Collection Directors: J.Estapé, T.Estapé Secretary: M.Soler Marc Aureli, 14. 08006 - Barcelona Tel. 93 217 21 82 Email: We appreciate the collaboration of: THEIR CANCER GARDEN Directors: Professor Jordi Estapé and Doctor Tania Estapé. EDITORIAL According to US data, as a result of the pandemic, cancer screening programs have slowed down , especially in colon and breast cancer, which suggests a worse future for the prognosis of these diseases. At the same time, the controversy over screening in prostate cancer is reopened , given the limitations of PSA, both by excess and by default. But some studies point to an increase in advanced and/or metastatic cases that

they attribute to less screening. We will analyze this data for future issues of this journal. Some kind patients have asked us for information about nuclear resonance cases, between three countries. They seem few, but already in the previous issue of Cancer of them, we collected the main problems that Western researchers of this cancer encounter. Being the scarcity of cases to nourish clinical trials perhaps the most important obstacle (do not misinterpret this statement: magnificent that there are few cases), but situation that implies less progress, which is acquired through these trials, which require many patients for objective statistical evaluations, key to the progress of cancer treatment. Professor Biete explains, in an excellent way, the controversy, ancient and unresolved, between prostatectomy and radical radiotherapy, in localized prostate cancer. multiparametric in prostate cancer , which Finally , we have an important stake . we offer below . We draw attention to the application of active surveillance in testicular cancer and we collect another initiative in penile cancer, another international initiative that has already collected 200 contributions. One, in prostate cancer, on possible inequalities in the attention to the patients with this diagnosis, depending on whether it is its geographical location. The second, in so far as psychological support for adolescents with cancer of testicle. MULTIPARAMETRIC NUCLEAR RESONANCE Parametric nuclear resonance (MRI) is the most effective imaging technique, since it makes it possible to obtain images with greater precision of the prostate than those obtained so far. MRI provides detailed images of the prostate and surrounding tissues. It has become a key exploration in the diagnosis and treatment choice of CP. It allows to study the prostate in a total way. It is not a painful test. Its duration is around 30-40 minutes. If the test is negative, it is almost certain that the patient does not have CP, which prevents many biopsies. If suspicious alterations are observed, biopsy will be recommended . *During the biopsy this scan helps a lot to identify the areas of the prostate, most likely to be affected. This is a great advance, since it avoids blind punctures, which greatly increases the effectiveness of the biopsy. If a CP is detected, the MRI is very useful to help establish the TNM or extension of the tumor, that is, if it has spread beyond the prostate or not. Thus, the involvement of the seminal vesicles and structures adjacent to the prostate can be ruled out or confirmed. * Currently, MRI is also fundamental in the choice of patients for active surveillance (see below), to be a candidate for which strictly localized cases are necessary. *A step forward in the effectiveness of MRI has been taken by a new technique, image fusion biopsy, which, through super-specialized computerized programs, allows the joint use of TRUS (described above) and MRI. This further increases the identification of suspicious areas. The results of the MRI are classified into five possibilities, using the PI-RADS (Prostate Imaging Reporting and Data) system: PI-RADS1. Very low risk, the presence of clinically significant CP is very unlikely. PI-RADS 2. Low: Improbable PI-RADS 3: Intermediary: Equivocal. PI-RADS 4: High: Probable PI-RADS 5: Very high: Very likely. PI-RADS 1 and 2, represent the improbability of CP; 3 rules out CP, but greater vigilance is recommended because there are somewhat dubious image data, while 4 and 5 suggest the opposite, the high probability of its presence and the need for biopsy to confirm it. or discard it. TESTICULAR CANCER: RISK FACTORS There is general agreement that there are three fundamental factors that increase the risk of developing testicular cancer (CT). They are as follows: CRYPTORCHIDISM It is the most documented causal factor of TC. During gestation, the testicles are located in the abdomen of the fetus. Towards the 7th month they descend and are placed in the scrotal pouch. If they don't we have a case of cryptorchidism that can be unilateral or bilateral. Already in 1973, F.K. Mostofi (author together with Isabell A. Sesterhenn from Histological typing of testis cancer), observed an incidence of cryptorchidism of 3.4% in 2000 CT patients . In contrast, only 0.25% of patients in a control group without CT suffered from it. A person with cryptorchidism is 14 times more likely to have CT than a person without it. FAMILY HISTORY Given the low frequency of CT, it is also rare, from a global point of view, the detection of family cases. If a person has a sibling with CT, he has between 8 and twelve times more the possibility of developing it than the population without this background; if the affected was the father, the comparative risk is between two and four times more. In these family cases, the TC is very heritable, passing from generation to generation. But still has not been detected genetic change determinant of the familial CT. CARCINOMA OF THE TESTICLE IN SITU In many and diverse cancers it is common, either in a diagnostic examination or accompanying a cancer, to find one or more carcinomas in situ. We define this entity as a grouping of abnormal cells that, at the time of diagnosis, have not spread or metastasized, but with the potential to acquire cancerous characteristics, which This clinical situation is also known as stage O. Taking advantage of the occasion, let us remember the great scientist, Georgios Papanicolaou, who invented the test that bears his surname, which has saved millions of lives and represents the greatest advance oncological of all times, early diagnosis. Nor do we forget his brilliant wife, Andromachi Mayrogeni Papanicolaou, who accompanied him on his

American adventure. Known in the USA as Mary, she collaborated in the laboratory with her husband. He became a kind of guinea pig, offering his cervix for the repeated smears (extension of a sample of a fluid from our body on a glass lamella for study under the microscope) that helped create the test. Well, between 80% and 90% of TCs is an alteration known as carcinoma in situ germ cell or GCNIS, so it is considered that GCNIS, is currently the largest known risk factor for developing CT. On the other hand, neither smoking nor cycling nor obesity nor height have been shown to be risk factors for CT. ADVANCES IN PENILE CANCER The low frequency of penile cancer (PSC) means that it is difficult for doctors to have enough experience in its diagnosis and treatment. As we said in the previous issue, it is essential to gather diverse experiences to achieve progress. On the other hand, patients, embarrassed by their disease, delay going to the diagnosis. Much remains to be done in CPE. We collect some of the words about it in Urologic Times from Dr. Curtis A. Pettaway, from the Department of Urology at Anderson Cancer Center, Houston, Texas and co-ordinator of InPACT, the International Penile Advanced Cancer, which includes patients from the USA, Canada and UK. We have chosen your feedback about treatment modalities in relation to the quality of life of these patients. The main thing is still early diagnosis, which requires that in the event of a penile injury you should go to your doctor as soon as possible, without being ashamed of something that, in its deepest sense, is not anyone's fault. And the smaller the tumor, the more likely it is to avoid aggressive treatments. The detection of the inguinal sentinel node is also applied in CPE, when its study is necessary. The sentinel node avoids many more aggressive surgeries. According to Pettaway, in recent years there have been advances in surgery and radiation therapy. A very important example in localized cases of CPE, in which surgery with an attempt to preserve the affected organ is much more frequent. Minimally invasive surgical techniques , such as laparoscopy and robotics, have a very important place in the non-aggressive treatment. It is accepted that with them the tumor can be controlled and that it is not necessary to leave a negative surgical margin as wide as before, which increases the chances of preserving the penis. For this, the collaboration of the plastic surgeon is essential, with which more aesthetic results are obtained. As for radiotherapy, one choice is interstitial brachytherapy, with which the penis is preserved and its amputation is avoided. Precisely the InPACT group, which Pettaway coordinates, also studies which should therapeutic strategies in advanced CPE. In localized cases, InPACT studies, 1) The possibilities of surgery as the only treatment in localized cases; 2) If the combination of chemotherapy or chemo-radiotherapy with surgery can improve the results and 3) Cuál of these last treatments produces better results with fewer adverse effects. InPACT is an international group that has already collected 200 patients. WILL IT IMPROVE THE EARLY DIAGNOSIS OF PROSTATE CANCER? One of the biggest current controversies in prostate cancer (CP), is the usefulness of screening campaigns, so we try to improve them. So far these campaigns have been based on the determination of the PSA. But this one alone does not work, because the proportion of false positives it produces disables it. Or it even leads to the discovery of non-aggressive TKs that many of them are not supposed to have even developed. For some years now, the role of human kallikrein (Hk2) in the early diagnosis of CT has been evaluated. hK2 is another glycoprotein that, like PSA, belongs to the family of human kallikreins and shares up to 80% of structural homology with it. Unlike PSA, its expression is greater in cancerous tissue than in benign tissue. (continued on page 5) (comes from page 4) Professor Wald (UCL Institute of Healtj Informatics, Queen Mary University, London) and collaborators recently publish in the Journal of Medical Screening an important contribution to better diagnosis early prostate cancer , using an algorithm based on age and two CT markers, PSA and hK2 (human peptidase kallikrein). And they note that with their method they can reduce the number of false positives by 75% compared to using PSA alone, but maintaining the same proportion in the diagnosis of prostate cancers. This can allow the development of a safer and more accurate screening in prostate cancer, thus reducing the excessive diagnoses and treatments that follow the use in PSA screening alone. PROSTATE CANCER : RADIOTHERAPY OR SURGERY, THE ETERNAL DILEMMA ALBERT BIETE Professor of Journalism. University of Barcelona Senior consultant. Clinical Hospital For years it has been debated which therapeutic option is best for the curative treatment of prostate cancer: surgery or radiotherapy. We must bear in mind that, apart from the prostate tumor, there are many other factors to consider and that can condition the therapeutic proposal. Examples of them are age, obesity and associated pathology: diabetes, hypertension, cardiovascular diseases, etc. Surgery for prostate cancer is called radical prostatectomy and can be performed by laparotomy (classic abdominal incision) or laparoscopy (less invasive and more modern technique). In the latter you can intervene through the use of a robot. This type of operation has nothing to do with the resection of benign prostate adenomas, which is much simpler. . In cases of high risk or if there is suspicion of metastatic involvement of neighboring lymph

nodes, prostatectomy may be associated with a lymphadenectomy usually of the obturator nodes. Radiation therapy can be done with two different techniques. One is brachytherapy with radioactive iodine seeds , which are implanted in the prostate by anesthesia and ultrasound control. They are permanent implants that give a high dose of radiation, but very limited to the prostate. The other technique is external radiotherapy using a linear accelerator. The radiation beam, modulated to be directed only to the prostate with a margin of safety, delivers a daily dose up to the total estimated to guarantee the destruction of the tumor. 3D simulation and IMRT (Dose Modulated Intensity) or SBRT (Stereotactic Radiotherapy) techniques allow the administration of high doses in a hypofractionated way with an intense effect antitumor. Classic long-lasting treatments, 38 fractions in a month and a half, for example, have been cut in half. Surgery and radiation therapy have advantages and disadvantages. Prostatectomy removes the entire gland that contains the tumor. The risk is that most are peripherally located and obtaining free margins can be difficult. Due to this or being an aggressive tumor, with PSA (Prostate Specific Antigen) greater than 10 or Gleason index greater than 6, radical surgery is discouraged due to the high risk of being left microscopic tumor remains that will cause recurrence. In fact, this situation is not uncommon, with PSA levels that increase progressively and force the performance of rescue radiotherapy. The latter has, of course, more risk of side effects than in a situation with an intact prostate. (continued on page 6) (comes from page 5) Two complications can have radical surgery: one, rare in expert hands, is urinary incontinence. The second, much more frequent, is impotence. If you want to preserve the bandeletas with the erector nerves there is a risk of increasing the number of cancer recurrences. However, if it is well indicated and there are no signs of aggressiveness or involvement of the capsule, the results of radical prostatectomy are good and very satisfactory from an oncological point of view. Interstitial radiotherapy with iodine seeds or temporary implantation of iridium needles is reserved as an alternative to surgery in initial cases and with a good prognosis. Fractional external radiotherapy, much more common, is performed either as a rescue in biochemical recurrences (increasing PSA) after surgery or as an exclusive treatment. The main side effect can be rectal inflammation and bleeding, rectitis, fortunately nowadays rare with modern technology. In cases of persistence of tumor activity after uncontrollable radiotherapy by hormone blockade treatment, surgical rescue may be attempted. **Numerous comparative studies have been conducted between surgery and radiotherapy. The results in relation to local control are discreetly superior to those of the former, although survival is similar. But if the characteristics of the patients are examined in detail, it is noticed that in most of the published series there is a bias, a negative selection. in the radiotherapy group. Indeed, in the radiotherapy group , an increase in tumors is always detected in more advanced stages, of greater volume or with more factors of poor prognosis. The same happens with the prevalence of factors that discourage surgery, such as obesity, advanced age, associated serious pathology or anesthetic contraindications. Finally let's say that the surgery manages to obtain an exact posterior staging through the anatomo-pathological study. This is not possible with radiotherapy, which, despite imaging tests, always has a risk of understatement that can be quantified by 20%. **In daily practice, radical surgery is usually indicated in cases with a better prognosis and more favorable: younger patients, with tumors with a good prognosis, limited and without associated pathology. In the rest, which are numerous since prostate cancer is typical of advanced age, radiotherapy is usually indicated. The issue of drug-refractory impotence should be discussed beforehand with the patient, especially the youngest. In many cases the indication of radiotherapy is decisive since the surgical option is not contemplated. In others, pros and cons should be discussed with the patient in a neutral and objective manner in order to make the best decision. Fortunately, either with surgery alone or with subsequent radiotherapy or with radiotherapy, the local control is very satisfactory, greater than 80% and survival as well, although it is not necessary to underestimate the small percentage of very aggressive tumors with high potential for distant spread . State-of-the-art linear accelerator installed at the Hospital Clínic de Barcelona STUDY ON INEQUALITIES IN THE CONSEQUENCES OF TREATMENT IN PROSTATE CANCER: AN AUSTRALIAN WORK BASED ON GEOGRAPHY Dr. Tania Estapé The scope of treatments and, as a consequence, the effects of them, in prostate cancer, are different according to geographical areas. Unfortunately, there are still inequalities in this regard. A recent study in Australia has examined inequalities in the functional effects of prostate cancer and its treatment in prostate cancer survivors . The work aimed to examine the toxicities of the treatment and its effect on the functionality and therefore, the decrease in the quality of life of prostate cancer survivors. The work has been done by contacting patients from the Victoria Prostate Cancer Registry in Australia, with a sample of 10,924 patients. The researchers used the functional results in these patients, using the "Expanded Prostate Cancer Index Composite" test,

applied after prostate cancer treatment . This is a specific quality of life scale for prostate cancer patients . They focused on the relationships between socioeconomic status and geographical distance, central variables of the study, To avoid bias, these variables were controlled by clinical aspects and Pathological. 7690 patients responded. The researchers made a functionality map from the results. In general, differences were observed by socio-economic status, in the direct sense: the poorer the status, the worse the quality of life. However, there are some nuances to this overall result: in rural Australia the tendency was to worse results in the functionality of these patients. Thus, living in rural areas far from health centers, plus socioeconomic precariousness are predictors of worse outcome in the quality of life (functionality) of patients. As a detail, to say that, although in urban areas, there are better data, it cannot be generalized, because there was greater heterogeneity: in those areas people with worse socioeconomic status, again result in a worse result in their quality of life from prostate cancer treatment, and even in survival. It should be noted that of both data, the one that showed statistically significant differences was the poor socio-economic status, while the geographical area showed the aforementioned differences (rural versus urban) , but it did not become significant in the authors' analysis. The authors conclude that it is necessary to focus on geographical aspects in the care of patients with prostate cancer. They point out that it is very important to take care of the quality of life and functional capacity of these men who, even cured, can suffer from various problems that interfere with their adaptation to life after cancer. You have to have a vision that includes these nuances, such as the area of residence and / or the socio-economic level of the patients. It is possible that, even if this study is focused on Australia, the results can be extrapolated to other countries. That is why we want to end this article with the following phrase from Martin Luther King: "Of all forms of inequality, injustice in health care is the most shocking and inhumane." (s i g u e e n l a p a g . 8) (v i e n e d e l a p a g . 7) Bibliographic reference of the work: Koo, K., Papa, N., Evans, M. et al. Mapping disadvantage: identifying inequities in functional outcomes for prostate cancer survivors based on geography. BMCCancer22,283 (2022). https://doi.org/10.1186/s12885-022-09389- 4Add some text. CARE NEEDS IN ADOLESCENTS AND YOUNG ADULTS (AYA) WITH TESTICULAR CANCER. Dr. Oscar Galindo Vázquez Psycho-Oncology Service InstitutoNacionaldeCancerología INCan, Mexico. Psychosocial care for adolescents and young adults (AYA) with cancer is a need that this group of patients and their families require. AIAs often do not receive age-appropriate specialized care due to a lack of knowledge and programs of how their needs differ from those of children and adults. older adults with cancer. This group of young patients are more likely than other populations to be diagnosed with testicular cancer which is the most frequent between the ages of 15 and 30, a period of life in which people are usually active in different areas of their lives. Although it is possible to successfully treat most testicular cancers, even when diagnosed at an advanced stage, more multidisciplinary programs of care are required during treatment and the period of follow-up to address the different effects on their quality of life: Needs in emotional well-being, social, affectation in sexual life, financial toxicity, changes in self-image, labor and school reintegration are aspects little studied, as well as the effects on their informal primary caregivers who face the challenge of supporting young patients with very particular needs. In the psycho-oncological aspect the fear of cancer recurrence is very reported, for example there is a young population that adapts functionally, however others have greater dysfunction which it affects their quality of life. This transition in life can take months in which some side effects during treatment will go away, while long-term side effects such as fatigue and involvement in sex life can take time. or even be a sequel in some cases permanent. Developing programs with valid and reliable procedures that channel this group of AYA patients to specialized programs will be a challenge for a more inclusive clinical care in oncology, even more so in countries of medium and low income where this issue is still pending attention. Alternatives can be programs via social or virtual networks for which the young population presents a greater use of these technologies, which would increase the probability of their use and feasibility. (continued on page 9) (comes from page 8) Several multidisciplinary groups have begun the development of these programs in Spanish, now the challenge is to consolidate them, disseminate them and make them reach in a timely manner to the AYAS and their families to generate a community of health care in Oncology more empathetic with the needs of the youngest. Galindo-Vázquez, O., Álvarez-Avitia, M. Á., & Alvarado-Aguilar, S. (2012). Psychological aspects of sexual affectations in patients with testicular cancer. Revista mexicana de urología, 72(5), 256-263. Vázquez, O. G., Álvarez, M. A., & Alvarado, S. (2013). Anxiety, depression and coping in patients with testicular cancer in treatment and follow-up period. Psycho-oncology, 10(1), 69-78. To purchase the book click For more information about donations click. :www. youtube. /UCMOFY1FLcbVOCshefrj6mkQ/ Prostate Cancer Video Collection Directors: J.Estapé, T.Estapé

Secretary: M.Soler Marc Aureli, 14. 08006 - Barcelona Tel. 93 217 21 82 Email: We appreciate the collaboration of: ********** FEFOF belongs to EUROPA UOMO since 2004 THEIR CANCER GARDEN EDITORIAL F E F O C : MEMBER OF EUROPE UOMO , USTOO AND MALE CARE Directors: Professor Jordi Estapé and Doctor Tania Estapé. © FEFOC 2022 The month of April is dedicated to testicular cancer, a tumor fortunately of low incidence and that was and is the protagonist of one of them greatest successes of chemotherapy Antineoplastic, essentially due to the introduction of cisplatin, cancer of young men should be taken into account, given its enormous curability and relative ease of diagnosis, provided that the population at risk (of 18 to 40 years) is warned about it. It is also striking that every time our Ministry of Health makes a sensible recommendation, it has so much uninformed opposition. We say this on account of alcohol and the Mediterranean diet, as at the time happened with beef and veal, so unhealthy. For our part, we congratulate the ministers who dare to fight for the health of the population. para men of another sexual condition. We also give space to the different surgical modalities in patients with penile cancer, in relation to sexual intercourse after treatment. The team of Phoebe Tsao and collaborators, from the University of Michigan, USA, has deepened the study of the psychological repercussions in prostate cancer patients receiving hormonal treatment. It is an issue of enormous importance. It is evident that the aggressiveness of hormonal treatment with respect to quality of life should make us reflect on whether we provide proper support to these patients. The optimal thing would be for other researchers to design drugs that did not involve chemical castration. Someday we will have them. Meanwhile, let's arm ourselves, hand in hand with psycho-oncologists to give adequate support to the thousands of patients who continue for a long timea Prostate cancer support groups are not easy, for various reasons that we have been exposing. Today we dedicate a space to draw attention to a specific problem that occurs with respect to the groups of this cancer, but treatments. APRIL, MONTH DEDICATED TO TESTICULAR CANCER The objective is to inform and stimulate especially men between 18 and 40 years old, to have their testicles examined monthly, since, between these ages, there is the highest incidence of testicular cancer (CT). This dedication during April also allows to expose and take into account the advances in its diagnosis, treatment and research. It should be noted that CT is probably the cancer with the best prognosis, with a survival of 95% of those affected, beyond 5 years of diagnosis, practically cured mostly. The history of TC is a success story: With them, one of the most important advances in chemotherapy has been achieved , through the association of three drugs, vinblastine, bleomycin and cisplatin, especially the latter. As usual, chemotherapy involves important secondary problems, so less traumatic options are currently being investigated; but no one takes away, from this therapeutic weapon, the enormous success obtained in CT., similar to the one that was obtained in its day with the association of vincristine-prednisone in acute lymphoblastic leukemia, in a way outstanding in children. We go through that a causal factor of great importance is cryptorchidism, or lack of descent of the testicle to the scrotum. They are also at higher risk if there are cases in immediate family members, although there are few family cases. Men diagnosed with AIDS have an increased risk of developing CT. Finally, people who have suffered a CT scan are at greater risk than the population without this history of suffering from it in the other testicle. CTs are overwhelmingly (90%) tumors of germinal origin, These cells are the ones that produce sperm. The testicles are composed of several types of cells, so when diagnosed under the microscope, various ct modalities can be found. The current history of TC begins in the 60s of the last century. The biggest sign of alarm was the detection of a lump in a testicle, although it is not uncommon for it not to give symptoms of entry. Globally, CT is very rare, accounting for only 1% of all cancers. But it is good to remember, especially, young men, to watch their testicles. These are soft to the touch so whenever they notice an increase in size, or consistency or a lump, in one or both testicles, they should go to their doctor, always remembering the good prognosis of this disease, but, as is the norm in Oncology, the sooner the diagnosis the better the treatment. CT usually does not usually cause entry pain . The best time to feel them is in the shower, when the testicles are descended. If the doctor considers the change detected in the testicle suspicious, he or she will order imaging studies and, eventually, a biopsy of the suspicious area. If the diagnosis of CT is confirmed, we will enter the treatment, which combines various means, with very good results. SUPPORT GROUPS FOR MEN OF ANOTHER SEXUAL CONDITION (GB). Many BG men would like to attend support groups for CP patients. These groups have proven to be a very effective source to offer information and support in various diseases, such as breast cancer. Women of another sexuality already have it complicated in these groups. But, in CP, there is a shortage of groups even for HS (for the reasons already expressed of the double taboo status of the CP) and the added homophobia. GB who have tried to be part of a group of HS, have had it

complicated. For example, often the wife or partner of the heterosexual accompanies them, or the relationship of the group with respect to the female partner is very frequent. The GB are quite restricted to express themselves and, even more, to go with their partner. And how to face the very frequent discussion about sexual relations? Many think that it would be best to go to support groups only for GB. This remains to be seen, given the enormous difficulties previous to even creating support groups for HS in CP. Diverse research shows that, because of their emotional reactions and the side effects of treatments, EBs feel a lot of shame, stigma, and discomfort when they have CP. Shame and stigma that starts from suffering from homophobic experiences and previous discrimination. CP will alter your own self-esteem and relationship with your partner (spontaneity, rejection, depression, and anxiety). Therefore, a great challenge for them is to find urologists, radiation therapists and oncologists educated in the great sensory complexity faced by GB with CP. And appropriate support groups, in which a safe, confidential, understanding and free environment is created, in which EBs can express and discuss their sexual orientation, lifestyle, aspirations and projects. THE MINISTRY OF HEALTH RECOMMENDS THE MEDITERRANEAN DIET Today, April 27, 2922, the Ministry of Health proposes: a) That in bars and restaurants alcoholic beverages be eliminated from the menu of the day and that b) It be followed as much as possible the so-called Mediterranean diet. These two proposals, so elementary, have produced, in several media, ironic comments. A very frequent one, "with what we have gone through with the pandemic and now they want to take away our wine"; "they want to regulate everything"; "this will hurt the business" Hardly any reference has been made to the Mediterranean diet, but no one has defended it. But what world do we live in? Does the fact that the Ministry of Health decides to increase healthy habits justify ironic comments? Reducing the consumption of alcohol as, with excessive prudence is done with that of tobacco, are synonymous with an advanced, modern society. As in his day they wanted to do with the excess consumption of meat and a little more hang the minister of consumption. It is not about regulating everything, it is about implementing healthy data, such as reducing the consumption of alcohol and meat. Let us insist again and again on the benefits of the Mediterranean diet, a paragon of wisdom. It is not known exactly that some of it decreases the risk of cancer in general and prostate cancer in particular. But there are the results. The incidence of cancer was low in Mediterranean countries when this diet was the most frequent, while it increases as we abandon it. We congratulate from here the Ministry of Health and the Ministry of Consumer Affairs. And that nothing happens to them, because remembering good habits is not always accompanied by praise, but rather on the contrary. There are so many vested interests ! SEXUAL RELATIONSSUPPORTING TREATMENT FOR PENILE CANCER The effect of penile cancer (PSC) on sexual intercourse depends on the treatment received. The doctor tries to apply the best treatment that, in addition, preserves sexuality as much as possible. We take these recommendations from the magnificent Cancer Resarch UK group. Sex after radiation therapy. It may take time to recover. Radiation therapy may decrease the ability to have and/or maintain an erection. It can also affect the surrounding nerves for a while. Inflammation of the penis can make erection difficult and painful . But most side effects usually go away or improve after treatment. Thus, many patients can recover their sexual intercourse as before radiotherapy. Sex after surgery. It depends on the modality of surgery according to the location or extent of the CPE: Initial CPE localized. Extensive removal of the affected area does not usually change sexual intercourse. Removal of the head of the penis, with reconstruction (glandectomy). The ability to erection is preserved although perhaps it can decrease the sexual sensation. 3). Removal of a part of the penis (partial penectomy). Sexual intercourse can be maintained, being possible erection and orgasm without the head of the penis. Penetration is possible. About 50% of men treated in this way maintained erection and sexual intercourse. Removal of the entire penis (total penectomy). An adaptation is needed in the way sexuality is expressed but a complete relationship can be developed. It is necessary to talk openly with the couple and seek the means for mutual satisfaction. After penile reconstruction (phalloplasty). It is indicated when a partial or complete penectomy has been required. It is done after a while to check if there is no reproduction of the tumor. Plastic surgeons use skin and muscles from other parts of the patient's body to perform phalloplasty. Erection is possible once performed. In fact, it is major surgery that can have complications, so it is necessary to dialogue with the surgeon to know the possibilities and consequences. HIGH INCIDENCE OF ANXIETY AND DEPRESSION IN PATIENTS ON HORMONE THERAPY Tania Estapé Patients with prostate cancer who require treatment consisting of hormonal blockade suffer a significant risk of suffering psychological consequences. This procedure can lead to anxiety and depression. Now the group led by Phoebe Tsao of the University of Michigan in the United States of America, has done important research on the subject. In this research, a comprehensive

analysis of patients diagnosed with prostate cancer from 2001 to 2015 has been carried out. These data have been taken from the Clininformatics Mart database, which is considered representative of various types of patients, of different ages and economic modalities in their benefits. of health. (continued on page 5) (comes from page 4) In this study , data from patients with prostate cancer were analyzed. The researchers selected the 37388 patients treated with hormone blockade. Among these, they found that 10.6% had an established diagnosis of anxiety or depression. When assessing data on whether this group had received any psychological and/or psychiatric treatment, 1892 (i.e. 47.7%) had not received any documented treatment. 10 (0.3%) received psychotherapy, and the rest received psychotropic drugs. Among the latter group, 33.3% (i.e. 1321 men) were prescribed an antidepressant (serotonin reuptake inhibitor), while 744 (18.8%) were prescribed an anxiolytic, specifically benzodiazepines. The average time it took for men with hormone blockage to obtain a diagnosis of anxiety or depression was 9.3 months after starting therapy. Overall, it was family doctors who prescribed psychotropic drugs (72%). It is interesting to note that the percentage of patients who received treatment for their mental health (47.7%) was similar to that of men without prostate cancer (49.1%). However, it was significantly lower than that of men with prostate cancer with other treatments (52.7%) The authors point out that these data need to be investigated further and future research that can provide more information about the treatment of mental health problems in men with prostate cancer in general, and with hormonal treatment in particular. As has been seen in the data, very few receive psychotherapy. Prostate cancer support groups may be a good option. If you are interested in participating in FEFOC, please write to . The full study can be seen at: Tsao, P. A., Ross, R. D., Bohnert, A., Mukherjee, B., & Caram, M. (2022). Depression, Anxiety, and Patterns of Mental Health Care Among Men With Prostate Cancer Receiving Androgen Deprivation Therapy. Theoncologist,27 (4), 314–322. https://doi.org/10.1093/oncolo/oyab033. Group of patients with prostate cancer To purchase the book click For more information about donations click. :www. youtube. /UCMOFY1FLcbVOCshefrj6mkQ/ Prostate Cancer Video Collection Directors: J.Estapé, T.Estapé Secretary: M.Soler Marc Aureli, 14. 08006 - Barcelona Tel. 93 217 21 82 Email: We appreciate the collaboration of: ********** FEFOF belongs to EUROPA UOMO since 2004 THEIR CANCER GARDEN EDITORIAL F E F O C : MEMBER OF EUROPE UOMO , USTOO AND MALE CARE Directors: Professor Jordi Estapé and Doctor Tania Estapé. © FEFOC 2022 First of all, we highlight the invaluable collaboration of an Italian patient, who, given his diagnosis of prostate cancer , chose the active surveillance, attitude and choice that we recommend for patients who meet the clinical conditions required for it. We also take this opportunity to congratulate the urologists, who are increasingly numerous, who offer this alternative. Perhaps we allow ourselves to remind you that the patient who follows the active surveillance, needs a lot of support, of course that provided by the urologist responsible for the control of the patient but without forgetting that oncological urology is and should be fully multidisciplinary and, in this context, much more importance should be given to psycho-oncologists in the specialized support of these patients. Three doctors, one in Antwerp and two in Toronto, have studied recent in-depth protocols targeting castration-resistant and metastasis prostate cancer . In two of them it is concluded that both improve several aspects of these patients. However, it caught the attention of the aforementioned doctors that the control arm (generally understood as the one that will receive the best treatment known to date) in two studios (The Profound and The Vision) is sub standard. A serious issue that needs to be thoroughly reviewed. We also dedicate a space to describe what theranostics is. Simultaneous modality of diagnosis and treatment that offers great prospects for the future. Dr. Sprenkle takes advantage of the recent Last month dedicated to testicular cancer to recommend monthly testicular self-examination, going to the doctor at the slightest sign of suspicion. (continued on page 2) We are putting together a manifesto for the rights of certain minorities to the treatment of prostate cancer. It is time for us to position ourselves in favor of a more modern Medicine, overcoming ancient barriers, especially when some of them can harm the future of many patients. And although it goes beyond the limits of this magazine, we declare our pain because in Spain, in the MIR call, there have been many vacancies of family doctor. How is it possible? The egg yolk of the Health is the general practitioner. We tend to a Medicine of the foot, the eye, the pancreas ... and forget the human being who carries them. We frequently see elderly patients who take up to 23 pills a day, the result of the various specialists who have visited them, no doubt with good will, but separated, the patients, from their integral being. Generalists provide us with empathetic, sustainable, humane and effective medicine. We must provide incentives to future generalists, not only so that they do not refuse to perform Family Medicine , but so that we all enjoy a global Health, not compartmentalized. A PERSONAL TESTIMONY OF ACTIVE SURVEILLANCE AS AN OPTION IN

PROSTATE CANCER I am Cosimo Pieri, member of the Italian Association of Prostate Cancer Patients and the Board of the European federation EUROPA UOMO, which brings together these associations for the 27 countries of the community European. So far my 5-year experience in active surveillance (VA) has been very positive. In my opinion this is the result of many actions carried out in the last 10 years by the entire community of health professionals, patient associations and research. I am 68 years old, I live in Milan, Italy, I retired after 43 years as a computer communications sales manager, I am married and I have two daughters. Health prevention was always present in my family. I was exposed to the danger of cancer as early as age 48 when melanoma was discovered in situ on my skin. Although it was considered low risk from the beginning, it showed that something in our body can get out of control. Since 2010, at the age of 58, my prostate was already being controlled, due to a reduction in urinary efficiency that was due to benign hyperplasia that underwent surgery in 2013. Then I moved on to annual prostate checkups. But in 2017 at the control visit, the urologist found a suspicious nodule, the PSA value doubled in 2 years (although low in absolute value, from 0.7 to 1.4). The doctor suggested an MRI and then a biopsy. And so came the diagnosis of prostate cancer (CP), with a gleason 3+3, grade 1.At that time I had no specific knowledge about this disease and possible treatments and was obviously scared. I have to say that my urologist's approach was very good. Why? His approach was multidisciplinary and helped me very effectively to understand the possible treatments without pushing myself for any of them but clearly suggesting the VA, due to the low degree and index of gleason. (continued on page 3) (comes from page 2) After this I contacted the Association Europa Uomo Italia with the purpose of knowing more about CP and treatments to be able to verify if my decision was correct. I learned the evolution that has taken place in this regard. While in the past most diagnoses like mine led to prostatectomy with potentially significant side effects on the patient's quality of life, extensive clinical data and research over the past ten years they paved the way for the VA as the best decision for cases like mine. I also understood that many men who did not trust this option in recent years have serious side effects. The knowledge I acquired from the Patient Association Europa Uomo helped me at that time to be able to maintain control against psychological pressure especially in the first year after the diagnosis to avoid change options. The general information about VA is very limited, many people around you are afraid to know that with a cancer diagnosis, you do not do any surgical treatment or radiotherapy. This is the reason why I decided to give my support and time to Europa Uomo Italy and also to the Board of Europe, to further strengthen and grow the action of the association for patients with CP of the 27 European local associations of Europe Uomo. The aim is to raise awareness among men in 27 branches in local countries in Europe Uomo, about early diagnosis and the effectiveness of the multidisciplinary approach at all stages, from early detection to treatment in the worst cases. Because of my experience, I am very focused on the best possible implementation of the VA, while the associations are analyzing all cases of CP treatment for all grade levels. We are collaborating with the European Union's Central Health Commission to promote early diagnosis programmes for CP in the 27 countries, which in total reach a population of around 250 million men. It is not easy and especially now with the pressure of Covid and with countries with very different approaches, beliefs and taboos towards cancer. Our partnerships are also focused on creating VA culture. Therefore, many actions must be carried out in collaboration with the main European institutions and associations of health specialists to optimize their implementation throughout Europe and, in parallel, increase early detection for avoid overtreatment . My case shows that the significant efforts of CP communities in recent years are producing a good multidisciplinary approach with the consequent increase in VA. At the same time to say that patient associations have a very important role in the dissemination of CP. Cosimo Pieri IMPORTANCE OF MONTHLY TESTICULAR SELF-EXAMINATION Dr. Preston Sprenkle, associate professor of Urology at the Yale School, stressed the importance of monthly self-examination of the testicles, very important since it allows to identify initial tumors and therefore very curable, through less intensive treatments. than in more advanced tumors. The examination should be monthly, which allows to objectify if there is any significant change, especially if any lump of hard consistency is palpated. According to Dr. Sprenkle, such a self-examination should be started at age 15, since it is a tumor that is frequently diagnosed in young people. He also recalled that the risk of testicular cancer increases if there have been familial cases of this tumor. Given the variety of treatments, it is imperative that , as in the vast majority of tumors, the management of patients is addressed by multidisciplinary teams, with surgeons, radiation therapists and medical oncologists within the so-called Board or Committee. of Tumors. Sprenkle's definition is very important but leaves out many specialists: psychologists, physiotherapists, specific specialist according to disease... Let's add a few words to highlight the multidisciplinary nature of

cancerous disease. At all levels of this (prevention, early diagnosis, diagnosis of the disease and its extension, therapeutic strategy and control and post-treatment support), the old concept of the oasis doctor has been overcome: one who believes he knows everything about something or something. all. Con la superacion de la cirugía como ■único treatment was observed that multidisciplinary approaches were more effective than unidisciplinary approaches. It is worth saying that there is still some specialty that stoically resists progress, wrapped in its ivory tower . EARTHQUAKE IN THE DESIGN OF CLINICAL TRIALS IN PROSTATE CANCER? First of all, let us highlight the opportunity and courage of Drs. Simon Van Vambeke (ZNA Hospitals, Antwerp, Belgium), Francisco Vera-Badillo (Queens University, School of Medicine, Department of Oncology, Ontario, Canada) and Bishal Gyawali (also from Queens University), to point out, in AscoPubs, Journal of Clinical Oncology, May 2022, a dubious use of the so-called control arm of recent clinical trials, in castration-resistant and metastasis prostate cancer (mcRPC). (continued on page. 5) (comes from page 4) The essence of phase III of the clinical trial is the comparability between the new treatment and the previous best, that is, the one applied to date, previously established its effectiveness. When a new drug or a new strategy has made its way, we need to compare it with the current treatment, to objectively determine if the new treatment is more effective and / or less toxic than the previous one. Van Vambeke and colleagues draw attention to the significant number of drugs, specifically in castration-resistant and metastasis prostate cancer, which are authorised on the basis of data that do not prove their superiority over current (or standard) treatments, due to the use of substandard control arms (i.e. lower than the current standard treatment). Continuing with these authors, the use of substandard controls exaggerates the clinical effectiveness of the new drug and can mislead doctors, patients and regulatory and health agencies. Here are two examples, both in CPCRm. First, they cite the study called "The profound trial", in patients, with a mutation in a DNA repair gene and who had progressed at least under treatment with enzalutamide or abiraterone. The new drug under study was olaparib. On the other hand, the patients of the control group received treatment at the choice of their doctor, who could choose between enzalutamide or abiraterone, (under whose treatment 20% of patients had already been treated and his disease progressed). The remaining 80% were not given chemotherapy when they progressed. Secondly, "The vision trial" examined the use of a radioligand (a compound that locates cancer cells and is associated with a radioactive particle with therapeutic capacity to destroy these cells, previously located by the ligand), bound to 177Lu-PSMA-617. The researchers concluded that the patients thus treated achieved an increase in overall survival and prolongation of disease-free progression (based on the comparative study of the images of metastases). Again, the control arm was poorly defined and many patients who were candidates for chemotherapy and Radium-223 did not have this option. Van Vambeke et al. conclude that the absence of the best treatment as a control results in inferior treatment of patients included in the control arm, which contribute philanthropically to the progress of the Oncology. They cite the Helsinki principles, including that "no patient should be harmed as a result of their participation in a clinical trial." And, on the other hand, it can lead to conclusions about the efficacy of new treatments, at least debatable in its strategy. WHAT IS THERANOSTICS OR THERANOSTICS? * It is the combination of two well-known terms: THERApeutic and DiagNOSTICS or TERApéutica and DiagNÓSTICA and means the use of the combination of a radioactive product to identify or diagnose and a second product also radioactive that carries, by the same route, for therapeutic purpose said drug to the tumor and its metastasis. DIAGNOSTIC PHASE. The tumor cells are covered by a membrane. In the membrane there are various proteins that can serve as a specific target for anti-cancer products. Identified, they are injected intravenously, reaching all parts of the body. Where the protein in question is located, the radioactive product will be deposited , whose action we can identify by PET-CT. THERAPEUTIC PHASE. Once the tumor is located, we can now replace the radioactive product used in the diagnosis with another, equally radioactive but with therapeutic capacity to destroy the cells with this protein and without affecting those that lack it . New diagnostic and therapeutic agents are being developed, which will enable the identification, diagnosis and treatment of prostate cancer. Theranostic drugs will allow an extraordinary specificity of treatments. Theranostics can mean a big step forward in cancer treatment . Diagnose and treat in the same strategy, which can also avoid the undesirable effects of drugs, since the theranostics will act on specific changes in tumor cells and not in healthy ones. In this same issue we collect the opinion of Dr. Van Vambenke and collaborators, regarding clinical trials, one of those they cite is precisely a sample of theranostics, the Vision trial, in cancer of prostate resistant to castration and with metastasis. It may be a breakthrough, but it is inexcusable that some doubts are seen to the methodology of the study. *Writing SOME REFLECTIONS FOR MEN OF ANOTHER SEXUALITY WITH PROSTATE CANCER (CP)* Active

surveillance (VA) appears as a great option in localized cases of low aggressiveness. But the anxiety of those who choose it is very serious, being aware that they are carriers of an untreated tumor. Some authors note that only 10% of patients who choose VA maintain it. That is, after having accepted it, only ten out of a hundred patients do not opt for treatment, before the symptoms demand it. Such is their anguish. That is why we consider it essential that these patients receive the greatest psychological support, very specialized and continuous. Informed choice. Be that as it may, patients must have all the reliable information necessary for them to choose freely, according to their roles, preferences and lifestyles, the treatment they consider most appropriate. For those affected by CP, who meet the conditions indicated at the time, the VA is an option to consider in depth. Sexual activity is a very important aspect in the identity of all men, and especially in gay and bisexual (GB), so sexual impotence can lead many of them to a serious personal crisis. Thus many feel in sexual inferiority, see their self-confidence diminished, abstain from sex and come to feel isolated socially and in their sexual relationship. As for erection, many patients believe that the use of injections into the penis and various devices to facilitate sexual intercourse make the act unnatural and decreases the spontaneity of sex. You have to make a pact and seek a balance between healing and maintaining sexual function as much as possible. VA, when indicated, is likely to be the answer The impact of treatments, in which heterosexuals (HS) and BG are compared, has been little evaluated. But clear differences are detected. A firmer erection is required for anal penetration than for vaginal penetration, so it is possible that effective treatments for erectile dysfunction are effective in HS and not in BG. More on erection, some studies have suggested that only a quarter of BG, after CP treatment, had an erection with sufficient firmness for anal sex. And in others, that only 40% of BG that had the penetrative role before treatment, could be maintained as penetrative. In another study, only 8% of BG treated remained penetrative, compared to 42% who were from before treatment. Role change. For many GB, changing sexual role after treatment is not always a solution to overcome side effects on sex. Because the sexual role can mean an important part of the identification and identity of each one. Some studies point to the difficulty in changing the penetrative role for the receptive one, especially if the couple was receptive. Sincerity with the couple. Many HS and GB adapt to the new situation and initiate activities without vaginal or anal penetration as the case may be. It highlights here the need for great communication and sincerity between both members of the couple, while learning other non-sexual techniques in the sense strict to relate. Thus they discover other sensitive areas of the body. Other problems. We insist on the problem of anal pain after radiotherapy and the absence of the prostate after prostatectomy. Its stimulation during penetration produces a lot of pleasure, which then decreases significantly . (continued on page 8) 7 (comes from page 7) Effects of treatments on sexual behavior. We need to conduct an in-depth examination to identify the effects of treatments on sexual behavior and functioning, so that the sexological understanding of the experience of CP in men of all sexual conditions can be advanced. Incidence and prevalence of sexual problems according to types of treatment. We need empirical studies to quantify the incidence and prevalence of sexual problems and effects according to type of treatment (critical to inform health professionals). Treatment preferences . We propose comparative studies on treatment preferences in GB and HS, which can confirm whether GB choose surgery, more or less than HS. Rehabilitation needs. Likewise, studies aimed at the rehabilitation needs of patients with CP, essential to design precise interventions for them. Training of professionals. Identify training needs for healthcare professionals treating GB with CP and develop appropriate curriculum so that they can meet the needs of this population. CASE: With prostatectomy my whole life has changed, for the worse. My role was top, now I'm bottom and an almost useless top. My partner, KJ.F. is he baffled. Will he adapt to being top or does this fruitful love end right here? I resign myself to being bottom, what a remedy, but I long for my role forever. But my penis is flaccid, it does not serve for penetration. I have tried viagra and other medications without success. I have been taught how to achieve adequate anal dilation and, since I do not have a prostate, to enjoy the pleasant sensations originated in the anus. But what does he think, what does he feel? Maybe it gives both being top and bottom and the key is actually to find pleasure regardless of position. We have to talk. I'm dying to know what he really thinks. *From the book "Prostate Cancer in Heterosexuals, Gays and Bisexuals", by J. Estapé and T. I estapé. . To purchase the book click For more information about donations click. Prostate Cancer Video Collection Directors: J.Estapé, T.Estapé Secretary: M.Soler Marc Aureli, 14. 08006 - Barcelona Tel. 93 217 21 82 Email: We appreciate the collaboration of: ********** FEFOF belongs to EUROPA UOMO since 2004 THEIR CANCER GARDEN EDITORIAL F E F O C: MEMBER OF EUROPE UOMO, USTOO AND MALE CARE Directors: Professor Jordi Estapé and Doctor Tania Estapé. The negative consequences of the

COVID-19 pandemic, apart from many other population sectors, have a particularly negative impact on health professionals and cancer patients . The exhaustion of the former is terrible. Spain has an enviable health system in many aspects but it cannot be denied that, pandemic aside, sharks (investment funds, some insurers with the support of political parties), stalk our system of health, with the jaws wide open, trying to devour it, that is, privatize it. During the pandemic, which is still ongoing, insufficient support has been given to our professionals who have multiplied to nobly try to cover and plug holes, to the point of exhaustion. We must all fight to keep our health system untouchable and recommend it to other peoples. Health is not at stake. With health should not be enriched investment funds, this serious disease of the West. We have come a long way to make Social Security a universal good in Spain. But now the struggle is different, it is the fight against those who want to privatize our health system. When an investment fund arrives at a company, the first thing that happens is the dismissal of workers. Coincidentally, the number of health professionals in Spain employed in Social Security is decreasing. Please read carefully the first article in this issue of "Their Cancer Garden". There is even talk (will it be a joke?), of hospitals without Doctors. Patients have seen their diagnoses and treatments delayed and delayed, predicting that cancer survival will go. (Continued on page 2) (Comes from page 1) Moreover, you will find two contributions to the progress of radiotherapy in prostate cancer, a succinct description of the prostate gland and its functioning. We also offer the summary of an original study of prostate cancer in Hispanics, where it is observed how the genetic acts modulated by the environmental. And other things. We appreciate the collaboration of Dr. Mendoza with his important review of pain in cancer patients. IMPACT OF THE COVID-19 PANDEMIC ON THE CARE OF CANCER PATIENTS The doctors. Kainat Saleem and Diwakar Davar publish in asCO Daily News of May 2022, a major review entitled "The impact of the COVID-19 on cancer care and outcomes". Both work at the University of Pittsburgh Medical Center. The main points that stand out are the following: The COVID-19 pandemic has had a severe and negative impact on case presentation, treatment and cancer management. This has led to an emigration (advance) of stages and a foreseeable global increase in premature mortality , with special impact on marginal populations . In addition, the pandemic has caused an unprecedented assault on the morale of health professionals. Already from the start. Cancer patients were classified as a particularly vulnerable subgroup. Health professionals quickly adapted to the new situation, highlighting among others telematic communication, designing therapeutic strategies with greater intervals in their application, abbreviating radiation therapy guidelines and preferring oral administration guidelines to intravenous radiation therapy in chemotherapy. But we're just trying to understand the multiple effects of COVID-19 on cancer incidence, on treatment outcomes, and their side effects. We are in the midst of a wave caused by likely increases in stages at diagnosis and a predictable increase in premature mortality in various tumor types. There is already some data indicating a decrease in survival rates in breast, colon, uterine cervix, and melanoma cancers. Global studies indicate that these negative effects will affect a third of the population due to the lack of access to treatment and almost half of the cancer centers report that 10% of the population lost at least one treatment cycle . Support strategies should be established for these groups. As for health professionals, the rate of affectation or burnout (exhaustion) is alarming. An American study in 13,000 doctors from different specialties showed burnout in almost half of these. A third of oncologists also suffered from it. Collectively, those most affected were women, nursing assistants, attending physicians, social workers, and professionals of color. We are in an unprecedented series and grave situation. It is up to everyone, but especially the health authorities, to urgently and responsibly seek solutions to these problems. ADVANCES IN THE TREATMENT OF BIOCHEMICAL RECURRENCE OF PROSTATE CANCER Alan Pollack, M.D., cedars-Sinai Medical Center (in Los Angeles, California; (founded in 1902 is a non-profit hospital that visits both insured and uninsured patients) and international collaborators, publish in The Lancet an important comparative study on the best treatment in men than after prostatectomy experience an increase in PSA, which usually indicates that the disease is not cured. If no metastasis is found, in this situation the irradiation of the intervened prostate area is usually carried out, since, in most cases not metastatic, it is there where the problem. But the authors show a new and more effective therapeutic by adding to the classic radiotherapy on the prostatic surgical bed, hormonal treatment plus irradiation of the patient's pelvic nodes. To do this , they launched a phase III comparative study in which they included 1716 patients, which were randomized into three groups: Group 1. The classic radiotherapy on the surgical bed. The median survival of this group was 71% at 5 years. Group 2. In addition to the same modality of radiotherapy as group 1, hormonal treatment of androgenic control (of short duration). The median survival of this group at 5 years was 81% of patients. Group 3. Radiation therapy to the surgical bed,

hormonal treatment (also of short duration), and irradiation of the nodes of the pelvis. The survival of patients in this group was 87% at 5 years. If confirmed, these results mean significant progress in the treatment of patients who, after prostatectomy, do not develop metastases but their PSA level progressively increases. VARIATIONS IN LOCALIZED PROSTATE CANCER IN HISPANICS Dr. Brandon A. Mahal and colleagues from sylvester Comprehensive Cancer Center, University of Miami Miller School of Medicine, Memorial Sloan Kettering Cancer Center and other groups observe, in a study published in Prostate Cancer and prostatic Disease, that Hispanics with localized prostate cancer (CPL), have significant variations in tumor aggressiveness and are less likely to be treated when they have high-risk disease. Overall, Hispanics are more likely to have higher-risk CPLs than non-Hispanics. But if Hispanics are separated by country of origin, there is a lot of variation in the risk of developing with advanced disease. In this regard, Mahal and collaborators subdivided the patients according to their country of origin. They gathered no less than 895,000 patients and found many variations. Thus, for example, those of Mexican origin had a higher risk of suffering from high-grade disease and with less possibility of receiving the most advanced treatment. On the other hand, the descendants of Cubans were less at risk and closer to non-Hispanics. For Mahal and collaborators, the variations imply of course the genetic background but also environmental, social and cultural influences such as the type of health insurance coverage, diet, physical exercise, pollution, etc. (Continued on page 4) (Continued on page 3) It is interesting to observe how the indisputable genetic predisposition is modified within a broad and variable set of general conditions. Establishing subgroups that contain genetic and non-genetic aspects can have an important impact on the way we diagnose and treat our patients from different backgrounds. ANATOMY OF THE PROSTATE In a study we conducted, it has caught our attention that many patients treated for prostate cancer asked us "what is the prostate?" and "what is it for ?" We offer a somewhat synthetic explanation that if other readers prefer that we expand it we will gladly do so. The prostate is a gland about the size of a chestnut or ping-pon ball. It usually weighs between 20 and 25 grams. It is located below the urinary bladder and surrounds the upper portion of the urethra, the tube that carries urine from the bladder to the outside, and in front of the last portion of the large intestine, the rectum. Male reproductive system In the anatomical situation of the prostate and its relationship with the organs that surround it, the basis of the side effects of the different treatments is found. A gland is an organ whose function is to make and secrete substances essential for the functioning of our body. The main function of the prostate is to produce the fluid that nourishes and carries sperm (seminal fluid). It is important for reproduction, since its fluids are essential for the survival of spermatocytes (produced in the testicles) and, in addition, it helps the exit of semen during ejaculation. Most CPs start in the back of the prostate and near the rectum (called the peripheral area), which is accessible through the so-called digital examination or digital rectal examination of the same. SECONDARY CANCERS AFTER RADIATION THERAPY FOR PROSTATE CANCER Radiation therapy is both a curative and palliative treatment in prostate cancer (PC). However, it should be borne in mind that, in healthy tissues near the irradiated area, radiotherapy can somewhat increase the risk of developing a second cancer. These cancers are known as secondary cancers. These cancers include rectal cancers, urinary bladder cancers and acute myeloid leukemia. That is why radiotherapy has become increasingly focal, reducing the risk of secondary cancer by decreasing the healthy irradiated area around. Modern radiation therapy techniques are designed to prevent this exposure. (Continued on page. 5) (Comes from page 4) Dr. Kisdhan Pithadia of the National Cancer Institute in Bethesda, Maryland, presented at the last meeting of the American Society of Clinical Oncology (ASCO) a major comparative study between the two more advanced radiation therapy (three-dimensional conformal radiation therapy and intensity-modulated radiation therapy), applied to the CP to see if the risk of secondary cancer was different with both techniques. Three-dimensional conformal radiotherapy uses a computer that produces a three-dimensional image of the tumor, which makes it possible to identify the CP very correctly and apply the maximum possible dose, while avoiding as much as possible the irradiation of healthy tissue. surrounding. On the other hand, intensity-modulated radiotherapy allows the dose to be concentrated in the tumor with great accuracy. It is performed by means of external radiotherapy techniques that emit beams of radiation whose intensity is variable, which allows to obtain the great objective of reducing as much as possible the irradiation in healthy tissues. around and concentrate and adapt it to the tumor. It uses photons and protons that adapt to the shape of the tumor. According to these researchers, this second technique decreases the risk of secondary cancers of the rectum and urinary bladder. Phitadia et al . relied on a retrospective study of 45,811 men with nonmetastatic CP diagnosed between 2002 and 2010, according to data from Surveillance, Epidemiology and End Results (SEER) and Medicare. The patients' ages ranged from 66 to 84 years

old. The results showed an overall decrease in the risk of developing a secondary cancer (specifically in the rectum or urinary bladder) after CP radiotherapy in favor of intensity-modulated treatment, which they consider to be due to a more precise approach of radiotherapy on the tumor due to this modality. PAIN IN CANCER PATIENTS: A COMPREHENSIVE APPROACH Pain is one of the most common symptoms in cancer patients (it occurs between 4.2% and 79%) and although its initial intensity does not differ according to gender, it is considered important in clinical decision-making in the male population. It should be noted that pain is not related in all cases to advanced disease, because it can occur from diagnosis, during treatment and in patients with disease metastatic or terminal. Therefore, it is a relevant public health problem and a major cause of suffering and disability. Pain is a complex sensation that can occur at the neurophysiological, biochemical, psychological, ethnic, cultural, religious, cognitive and environmental levels. These factors could be involved in pain perception and tolerance in the male population, however, available data on the role of gender-related factors , in patients with Cancer pain is still limited. Symptoms are usually an indicator of disease progression in the cancer patient; for example, in patients with advanced prostate cancer, pain is recognized as an important indicator of survival. In general, however, patients are afraid to recognize it as a sign that the cancer is progressing. On the other hand, 55% of these patients feel they have to live with it daily, 45% sometimes ignore it and 39% have trouble talking about it. It should be noted that patients who have a caregiver are more likely to talk about their pain at every doctor visit compared to those who do not. (Continued on page 6) (Comes from page 5) In addition, most patients with bone metastases notice it before their metastatic diagnosis, indicating the need for greater guidance on the evaluation of this symptom and the need for a better understanding of the impact. of pain in the lives of patients. In the oncological population, its relationship with various psychological variables has been reported, such as: symptoms of anxiety, symptoms of depression and catastrophization; psychosocial as: quality of life and social support; and physical as fatigue. In the same way, the importance of the role played by gender in cancer pain has been highlighted, in this sense, it is reported that men indicate less indecision to take analgesics, lower pain intensity and a higher percentage of adequate pain management. Additionally, they have a higher probability of analgesic adherence. Meanwhile, in patients experiencing postoperative pain, males are reported to use higher doses of opioid analgesics for management. Psychological interventions are a fundamental part of the multidisciplinary approach to pain. The evidence and efficacy of these interventions has been summarized over the past four decades within systematic reviews and meta-analyses. So there is a solid research base that establishes the efficacy of psychological interventions on adults and young people with pain. According to recommendations from the Cochrane Review Group on Pain, Palliative and Supportive Care , it is suggested to use Cognitive Behavioural Therapy (CBT) as a standard comparison of treatment, due to its robust efficacy. In this sense, CBT has shown consistency in terms of positive effects to modulate the perception of pain in the oncological population. However, we have no knowledge about this type of evidence-based intervention specifically tailored to the needs of the male population with cancer pain, so it is a pending within this field of research. As part of the psychological treatment within the comprehensive approach to pain management in the male oncological population, it is suggested to include: Psychoeducation about cancer, pain and pharmacological/non-pharmacological treatments , Trainingon the specific needs of men, Relaxation techniques , and Rcognitive structuring . In conclusion, male patients have difficulty talking about their pain, possibly believing that this makes them look weak or vulnerable. Psychological treatment is essential within multidisciplinary care in men with cancer pain; Likewise, the need to continue investigating the multifactorial characteristics of pain, the possible role of sex and the biological and psychological characteristics related to gender for thus generate new strategies to improve the management of cancer pain . Psic. Luis Alberto Mendoza Contreras Postgraduate in Psychology, National University Autonomous of Mexico / Psycho-Oncology Service, National Cancer Institute (INCan) (Continued on page. 7) (Comes from page 6) References: Drudge-Coates, L., Oh, W. K., Tombal, B., Delacruz, A., Tomlinson, B., Ripley, A. V. ,... & Shore, N.D. (2018). Recognizing symptom burden in advanced prostate cancer: a global patient and caregiver survey. Clinical Genitourinary Cancer, 16(2), e411-e419. Eccleston, C., Keefe, F. J., & de C Williams, A. C. (2021). Basic and applied psychology in PAIN: where we have been and where we are headed. Williams, A. C. , Fisher, E., Hearn, L., & Eccleston, C. (2021). Evidence-based psychological interventions for adults with chronic pain: precision, control, quality, and equipoise. Pain, 162(8), 2149-2153. To purchase the book click For more information about donations click. Prostate Cancer Video Collection Directors: J.Estapé, T.Estapé Secretary: M.Soler Marc Aureli, 14. 08006 - Barcelona Tel. 93 217 21 82 Email: We appreciate the collaboration of: ********** FEFOF belongs

to EUROPA UOMO since 2004 THEIR CANCER GARDEN EDITORIAL F E F O C : MEMBER OF EUROPE UOMO , USTOO AND MALE CARE Directors: Professor Jordi Estapé and Doctor Tania Estapé. © FEFOC 2022 We must return again and again to the advantages for the quality of life of patients with prostate cancer, localized and low risk, in being objectively informed of the advantages of non-treatment, that is, of active surveillance as a first option, before prostatectomy or radical radiotherapy. Active surveillance (VA) is being imposed in most countries. Probably its pioneers were the Swedish urologists. Today, perhaps it is the United States that gathers the greatest acceptance towards it. Be that as it may, we congratulate each other and with the greatest respect, we congratulate all the health professionals who have contributed to such incredible progress. Do not be as a doctor explained a few days ago, on a TV in Barcelona, that the non-treatment came to be a ruse of the AdministrationToday we offer several articles about success and the growing demand from the VA. But alarm observe how its indication varies greatly according to the environment in which the patient operates. For example, in the canton of Zurich, the difference of acceptance of the VA, comparing the patients treated at the Zurich hospital or abroad thereof, by other means in that canton, it's alarming. We also draw attention to the effectiveness of physical exercise at home with virtual control and the convenience of reducing as much as possible the image controls that may cause irradiation to patients. with stage I testicular cancer . On July 4, Dr. Tania Estapé participated in "The day of the patient", within the Congress of the UAE (European Urology Association). to save money. There is everything in the vineyard of the a Sir , it is rightly said. SOME REFLECTIONS ON THE CHOICE OF TREATMENT IN PROSTATE CANCER AND SEXUAL DIVERSITY. Active surveillance (VA) appears as a great option in cases of prostate cancer (PC), localized of low aggressiveness. It is essential that these patients receive psychological, specialized and continuous support. Be that as it may, patients must have all the reliable information necessary for them to choose freely, according to their roles, preferences and lifestyles, the treatment they consider most appropriate. For those affected by CP, who qualify to be candidates for the VA, this is an option to consider in depth. Sexual activity is a very important aspect in the identity of all men, so sexual impotence can lead many of them to a serious personal crisis. Thus many feel in sexual inferiority, see their self-confidence diminished, abstain from sex and come to feel isolated socially and in their sexual relationship. As for erection, many patients believe that the use of injections into the penis and various devices to facilitate sexual intercourse make the act unnatural and decreases the spontaneity of sex. You have to make a pact and seek a balance between healing and maintaining sexual function as much as possible. The VA, when indicated , may be the answer. The impact of treatments, comparing heterosexuals (HT) and gay or bisexual (GB), has been poorly assessed. But clear differences are detected. A firmer erection is required for anal penetration than for vaginal penetration, so it is possible that effective treatments for erectile dysfunction are effective in HS and not in BG. Some studies have suggested that only a quarter of GB after classic PC treatment had an erection firm enough for anal sex. And in others, that only 40% of GB that had the penetrative role before treatment, could be maintained as penetrative. In another study, only 8% of BG treated remained penetrative, compared to 42% who were from before treatment. Role change. For many GB, changing sexual role after treatment is not always a solution to overcome side effects on sex. Because the sexual role can mean an important part of the identification and identity of each one. Some studies point to the difficulty in changing the penetrative role for the receptive one, especially if the couple was receptive. Many HS and GB adapt to the new situation and initiate activities without vaginal or anal penetration as the case may be. It highlights here the need for great communication and sincerity between both members of the couple, while learning other non-sexual techniques in the strict sense of relating. Thus they discover other sensitive areas of the body. We insist on the problem of anal pain after radiotherapy and the absence of the prostate after prostatectomy. Its stimulation during penetration produces a lot of pleasure, which then decreases significantly. Effects of treatments on sexual behavior. We must conduct an in-depth examination to identify the effects of treatments on sexual behavior and functioning, so that the sexological understanding of the experience of THE CP in men of all sexual conditions. INCREASES ACCEPTANCE OF ACTIVE SURVEILLANCE IN LOW-RISK LOCALIZED PROSTATE CANCER Dr. Matt Cooperberg and collaborators from the University of California, San Francisco (UCSF), presented at the annual meeting of the American Urology Association, New Orleans, Louisiana, USA, from May 13 to 16, 2022, within the CaPSURE (Cancer of Prostate Strategic Urologic) program Research Endeavor), with data from 240 UROLOGICAL GROUPS USA, a study on the acceptance of active surveillance as a non-therapeutic option in low-risk prostate cancer. For various reasons, from the diagnosis of localized and low-risk CP (CPLBR), it is not always necessary to opt for a classic

immediate treatment, such as prostatectomy or radiotherapy. It is possible to defer, postpone treatment and even never do it, if the CP does not grow and does not cause symptoms. Deferred treatment has two modalities, "wait and see" (in people of generally advanced age and/or with associated diseases and/or with limited life expectancy) and "active surveillance" (in patients otherwise healthy and with good life expectancy, who do not want to be treated for the side effects of prostatectomy and/or radical radiation therapy, and that they will only be treated if their cancer begins to grow and develop.) Returning to the study of Cooperberg et al., about ten years ago most men diagnosed with CPLBR, received immediate treatment with surgery or radiotherapy, both with great healing potential but with serious side effects, which usually profoundly altered the quality of life of patients. But recent studies indicate that those affected are increasingly opting for active surveillance. Data from Cooperberg et al. from 240 urological groups show that 60% of North American patients with RCRCP prefer non-treatment. Since 2014, when the study began, this percentage has more than doubled, going from 26.5% to 59.6% in 2021. For Matt Cooperberg, these results show that the use of active surveillance is going in the right direction, but that progress still needs to be made. Indeed, in countries with a long tradition of active surveillance, such as Sweden, the percentage of acceptance of active surveillance has been established in 80% of cases. But Cooperberg explains that, in his hospital, 95% of cases have been reached that opt for active surveillance. A few days ago we were embarrassed to listen to a television program dedicated to health issues. They interviewed a radiotherapist from a private center in Barcelona who came to tell us that the Administration promoted non-treatment and that he recommended brachytherapy (internal radiotherapy) and that, according to him, it produced 0% side effects. Comparing certain people to real scientists like Matt Cooperberg is embarrassing. According to Dr. Howard Parnes, Chief of the Prostate and Urologic Cancer Research Group at NCI's Division of Cancer Prevention, who was not involved in Cooperberg's study, "If a patient meets The criteria for being diagnosed with a CPLBR, active surveillance should be a central part of the conversation with your urologist." ACTIVE SURVEILLANCE IN ZURICH Drs. C. Poyet and collaborators of the University Hospital of Zurich publish (European Urology, February 2022) an analysis on the use of active surveillance in low-risk localized prostate cancer (CPLBR), as patients are treated in that hospital (where all patients are evaluated in an interdisciplinary Committee) or outside it. Poyet and colleagues point out that active surveillance (VA) has been introduced precisely to avoid overtreatment in patients with RSCLC. There is already an extensive literature showing that VA is safe, which is recommended as the first therapeutic option for these patients. But, they point out, despite these recommendations, the use of va varies greatly from one hospital to another. To investigate this question, they collected data from the tumor registry of the canton of Zurich, between 2009 and 2018. They registered 3393 men with CPLBR, 3131 from the canton (Switzerland consists of 26 cantons or former states) from Zurich and 262 from the University Hospital, from the same city. In the canton, 502 patients received VA (16%) while in the hospital 146 patients (55.7%) were indicated. Over the years, the percentage of VA in the canton increased very little, going from 12% in 2009 to 16.2% in 2018, while in the hospital it went from 35.4% in 2009 to 88.2% in 2018. In conclusion, they comment that the VA, in the canton of Zurich, has a low percentage and has not increased in the successive years studied, contrary to the recommendations in favor of the VA. By contrast, about 90% of CPLBR patients seen at the Zurich hospital followed VA. The authors believe that continuing education in the urological community is needed in this regard and advise patients with CPLBR to request a second opinion to access hospitals with tumor committees . Multidisciplinary. IDENTIFYING SAFE MEANS TO DETECT RECURRENCE AFTER SURGERY FOR TESTICULAR CANCER J.K . Joffe et al. publish the results of the TRISST trial, in April 2022, in the Journal of Clinical Oncology, Mar 17, 2022 (Identifying Safer Ways to Look for Recurrence after Testicular Cancer Surgery originally published by the National Cancer Institute"). TRISSTsignifies"TrialofImagingand Surveillance in Seminoma Testis. Seminoma originates in the cells of the testicle called germ cells, which produce sperm. It is a tumor with a very good prognosis. In its stage I, healing is close to 100% of cases. For the evolutionary control of patients, CT scans are usually performed. But it is worrying that, usually in the case of young patients, that, if they receive many CT scans, an excess of irradiation will occur in them. The TRISST study from the National Cancer Institute investigated whether CT could be replaced by magnetic resonance imaging (MRI), which prevents irradiation, or a SURVEILLANCE PROTOCOL with CT but less frequently than usual. The key point, apart from decreasing irradiation, was to see if the new strategies are also useful in detecting recurrence if it occurs. (Continued on page. 5) (comes from page 4) A study led by Cafferty et al. suggest (Journal of Clinical, March 2022) Oncology, that MRI has an efficacy comparable to CT, By using the former, the risk is suppressed of irradiation without, and this is the most important thing,

decreasing its effectiveness in the detection of recurrences of the disease. On the other hand, they also showed that the frequency of CT scans and RNMs can be decreased. The trial they called TRISST included 669 men treated by surgery for early-stage seminoma . To objectify the periodicity of CT scans or RNMs, four strategies were followed : *Seven TACs spread over 5 years. *Seven RNMs in three years. *Three TACs in three years *Three RNMs in three years. With a median follow-up of 6 years, the results in patients followed by MRIs or lower frequency of CT scans were no worse than those observed with seven CT scans in 5 years, r it also induces undesirable exposure to irradiation and with a very low number of recurrences. However, the authors caution about the fact that the patients included in TRISST were at low risk, so these data cannot be applied, without more, to patients with testicular cancer at higher risk. They also draw attention to the fact that MRI is more expensive than CT and that there are more experts skilled at interpreting a CT scan than an MRI. PHYSICAL EXERCISE IN CANCER SURVIVORS The Prostate Cancer Foundation recalls and recommends (July 2022), the benefits of physical exercise in cancer survivors. It has been demonstrated, they say, that this activity improves the quality of life and physical functioning of patients. But, according to their data, only between 10 and 30% of survivors perform adequate physical exercises. In prostate cancer, aerobic exercises after diagnosis, following this Foundation, reduce the risk of tumor recurrence or death, up to 60% of patients. It is true that the sedentary lifestyle has increased with the Coronavirus pandemic but it has made it possible for Dr. Christina Dieli-Conwright, and collaborators from the Dana Farber Institute to review physical exercise programs. in patients' homes. To do this, they studied 12 exercise systems carried out in patients' homes and adapted by the restrictions imposed by the pandemic. The different exercises were: *Self-directed, without external supervision, or, * Self-directed, but with external virtual information (through online videos, expert messages and periodic calls for information control). In this review, the authors did not intend to study the two methods at home comparatively. But the study allowed them to get preliminary information about home physical exercises and identify areas to investigate. (Continued on page 6) (comes from page 5) For example, much greater adherence to exercises was observed when they were helped virtually. Even in patients with breast or prostate cancer, greater adherence was observed, in these cases followed virtually, than in similar cases followed personally before the pandemic. The researchers conclude that virtually supervised physical exercise is possible, safe, and can improve survivors ' problems such as fatigue and anxiety. More research is needed to see if they can also improve physical functionalism and survival. They consider that a very important parameter is the safety of the participants. For example, the need for virtually controlled patients, if they use exercise devices, to learn their use well to maximize effectiveness and minimize the risk of injury. Cancer patients may have a variety of symptoms and other health conditions that may affect their ability to perform certain exercises. Home exercise eliminates some problems (displacement, contamination by potential germs), but they present other problems (lack of space in case and technological access). PARTICIPATION IN THE EUROPEAN CONGRESS OF UROLOGY FEFOC On 1-4 July, the congress of the European Association of Urology took place in Amsterdam. This congress is medical, and brought together various professionals of Urology to share their work and research. As usual, a day was dedicated to patients. In this congress a space is given for patients to present posters and communications on various topics. In this sense, sessions were scheduled on kidney, bladder, prostate cancer, as well as one dedicated to fatigue, urinary incontinence and life after cancer. The session on prostate cancer was organized by Europa Uomo, the European federation of prostate cancer patient associations of which FEFOC is a representative and is part of the Board of Directors (with the psycho-oncologist Tania Estapé as a member of it). The panel was moderated by Dr. Eamonn Rogers, Irish urologist. It discussed quality of life in patients with prostate cancer, early detection and the active surveillance option as a proposal for patients with low-risk prostate cancer. (Continued on page. 7) (comes from page 6) In this sense, Dr. Tania Estapé offered a communication entitled "Is this the true revolution? An understanding among low-risk prostate patients and their doctors that the best treatment may be no "treatment" at all! How this approach is becoming the leading treatment in these low-risk patients." In this 10-minute talk, Dr. Estapé summarized the psychological problems of active surveillance. This option is for patients with low-risk prostate cancer and consists of periodic follow-up with tests and follow-up visits. The advantage is that the consequences of prostatectomy and/or radiotherapy are avoided. Thus, the patient does not suffer from erection problems and urinary incontinence, problems that interfere with the quality of life. However, there are other disadvantages, especially psychological ones. The patient may feel confused by the feeling of not doing anything and leaving the tumor inside their body. We have all learned that when there is a tumor it is best to eradicate it as soon as possible from the body to prevent it from spreading. Thus, active

surveillance can induce high levels of anxiety and uncertainty. It is assumed that the patient is in better condition to enjoy life, but it is not always possible because of the doubt about whether they have chosen correctly. Sometimes hypervigilant behaviors develop, that is, being permanently alert to changes and bodily discomfort with the fear that it is an indication that the tumor is Progressing. The patient's family has a role in all this as well. Many times it pressures the affected person to opt for active treatments. . Again weighs the scheme that in the face of cancer we must actively fight and do "something" against it. There are several alternatives to try not to be a victim of anxiety and fear and learn to live with active surveillance, such as trying to take control of the situation by looking for truthful information (always limited in time so as not to enter a loop of increasing anxiety.) It is necessary to try to lead a life as normal as possible and, if necessary, seek a support group or psychological treatment. Groups are not always suitable if the other participants have received active treatments, as this will make the man with active surveillance doubt more than if he has done the right thing. Treatments are becoming less aggressive and it is necessary to bet on it to avoid too aversive consequences on the quality of life. This can lead to psychological challenges to learn to live with the uncertainty that is generated. To purchase the book click For more information about donations click. Prostate Cancer Video Collection Directors: J.Estapé, T.Estapé Secretary: M.Soler Marc Aureli, 14. 08006 - Barcelona Tel. 93 217 21 82 Email: We appreciate the collaboration of: ********** FEFOF belongs to EUROPA UOMO since 2004 THEIR CANCER GARDEN © FEFOC 2022 F E F O C: MEMBER OF EUROPE UOMO, USTOO AND MALE CARE EDITORIAL In breast cancer there is a global agreement for the celebration of the day and month dedicated to raising awareness about this disease. In prostate cancer (PC), as far as we know, there is no such agreement. At least there are two celebrations, those that do it around June 15 and those that dedicate the month of September to it. Before explaining the historical background of both respectable positions, let us remember that this celebration intends, in the case of the SC, * Increase public awareness about this disease. * Facilitate early diagnosis . *Educate about your risk factors and alarming symptoms . * Demand greater means for research. In 1994, U.S. Congressional Senators Dole and Richardson proposed that similar actions be carried out in the United States during the month of June. The initiative was This initiative was internationalized in 2002, at a Congress held in Vienna. Already a year earlier, Senator USA Burns supported this initiative and stated that Prostate Health Month should be held annually. In 2003 President Bush supported this initiative but with an important change: instead of dedicating the month to the fight against male diseases in general, he proposed the creation of the "National Prostate Cancer Awareness Month". In 2015, the Obama Administration designated September as National ProstateCancer Awareness Month. In summary, there are apparently two celebrations, one, in June that fights against diseases of men in general, including the CP, and another in September, which does so specifically against the CP. This concreteness made that, since always FEFOC celebrates this activity in September. soon accepted by all governors of a the USA States and their large cities. But what was approved was the commemoration of men's diseases, including the CP, based on the worst overall male health compared to female. (Continued on page 2) (Comes from page 1) Apart from these considerations, in this issue of "Their Cancer", we offer several articles that show advances regarding the effectiveness of active surveillance, also in African Americans; they warn us of the risk of suicide and its possible warning signs; a new indication of the anti-androgen darolutamide; some interesting statistics and progress in studying long-term testicular cancer risk factors. FDA APPROVES SECOND THERAPEUTIC INDICATION FOR ANTI-ANDROGEN DAROLUTAMIDE Darulatamide is a potent antiandrogen that blocks male hormone receptors. It is administered orally, always along with a hormonal medication that causes chemical castration. It is approved to try to delay the appearance of metastases in advanced CP, thereby improving the quality and quantity of life of those affected. In the ARAMIS study comparing darolutamide versus placebo (substance without pharmacological activity), the median survival without metastasis of patients treated with darolutamide was 40.4 months for 18.4 months for those receiving placebo. Its most frequent side effects are fatigue, pain in the extremities and decrease in neutrophils (class of white blood cells or leukocytes, which defend us from infections). Once this indication has been accepted, on August 8, 2022, Bayer* announces that the US Food and Drug Administration has approved a second one for darolutamide. In this case it refers to the study known as ARASENS, in patients with CP, sensitive to hormonal treatment but, in this case, already with metastases. The study consisted of the following: randomization of patients between two treatments. 1) Darolutamide + docetaxel and 2) Docetaxel, plus both groups receiving the same androgen deprivation therapy. Well, survival was significantly higher in the first group, with a reduction in the risk of death of 32%, the delay in the onset of pain in the first group was also greater. The incidence of side effects was similar in both

groups. *El día de hoy, Bayer (U.S. FDA Approves Additional Indication of NUBEQA® (darolutamide) in Combination with Docetaxel for the Treatment of Metastatic Hormone- Sensitive Prostate Cancer (mHSPC).) with- Docetaxel-for-the-Treatment-of-Metastatic- Hormone-Sensitive-Prostate-Cancer) comunicó la aprobación por la FDA de la indicación complementaria para darolutamida + docetaxel en el tratamiento de pacientes adultos con cáncer de próstata hormonosensible metastásico (CPHSm). SUICIDE RISK From Dr. Tania Estapé, in the book "Prostate cancer in straight, gay and bisexual". Although the emotional reactions in the cancer patient are defined as normal or coherent to the situation, it is important not to fail to take into account some risks that the patient ends up suffering from some type of more severe disorder, especially when there is a history. It would be because of the vulnerability of these men that a news story such as a cancer diagnosis could cause a relapse. It is especially important to detect the risk of suicide that may occur in some patients. It is higher in men under depressive processes, but it should not be dismissed that high levels of anxiety could induce an autolytic attempt. It should never be ruled out, because sometimes there are people who try to commit suicide and apparently did not present this risk, but then writings or notes have been found where it was reflected very clearly. What are the indications that we must take into account in this regard? The following clues may be helpful: (Continued on page 3) (Comes from page 2) -More or less clear verbalizations of a desire to die: there are patients who express it clearly, but others in a more subtle way. A very common way is when the patient says that he wishes he could sleep all day. It is indicating to us a clear desire to disconnect from a painful reality. We must include here those expressions that indicate a decrease in self-esteem, or feeling of uselessness or of being a burden. The logic behind this is that it is better to disappear to stop being a nuisance for everyone. -Express intention to abandon the treatment: when a man more or less clearly comments if it is worth continuing with the treatment, or that he is getting tired of it, you have to be careful, because it is indicating a tiredness of living. -Loss of hygiene: it is important to keep in mind that one of the aspects that depression entails (especially the most serious) is a loss of interest in oneself, including self-care. When this is detected, which can be very subtle and progressive, it is also a warning sign of a process of abandonment and self-interest . -Decrease or elimination of pleasurable activities, or activity in general: when a person stops being active, reduces the things he does and stops enjoying those he liked before, it is also an important indicator of suicide risk . We should not always be aware of what the patient tells us or what he does, but if certain indications should serve as an alarm to be able to assess the need to go to a specialized professional. IS ACTIVE SURVEILLANCE EFFECTIVE IN AFRICAN AMERICANS? Pincus et al. (of The Southeast Louisiana Veterans Health Care System), publish in The Oncologist of August 3, a major study on the effectiveness of active surveillance in African American patients, in a 5-year follow-up study. A total of 228 prostate cancer (PC) patients in risk group 1* were included in the study, of which 154 were non-Hispanic African Americans and 74 non-Hispanic Caucasian Americans. The study noted that there was no difference in disease progression between the two groups, neither in discontinuation of active surveillance nor in survival. Therefore, they conclude that active surveillance is a safe option for patients with group 1 CP (that is, those with very low or low risk), regardless of race. It really is a novel and important contribution. Until now there was non-objective agreement about the worse prognosis of African American patients compared to Caucasian Americans. Great lesson for those who pontificate about good and evil, about science, without objective bases. *Grade 1: Gleason of 6 or less (low aggressiveness CP) Grade 2*: Gleason of 3 + 4 = 7 (CP of intermediate aggressiveness) Grade 3*: Gleason of 4 + 3 = 7 (CP of intermediate aggressiveness) Grade 4: 8 Gleason (high grade CP) Grade 5: 9 to 10 Gleason (high grade CP) SOME INTERESTING STATISTICS About 1.5 million men are diagnosed worldwide with prostate cancer (PC) each year. CP is, worldwide, the fourth most common cancer. As is often the case in Oncology, the distribution of cases and mortality is not uniform, varying greatly depending on the part of the globe we are talking about. As an example, we collect the ten countries with the highest incidence of CP and the ten with the highest mortality. Male hormone We take this data from the Livestrong website, from the journalist María Masters, which, entre otras ocupaciones, col abora con Me n's Health. The data come from the World Research Cancer Fund, which in turn took them from the Global Cancer Observatory, the WHO and the International Agency for Research on Cancer. DO MODIFIABLE FACTORS HAVE PROGNOSTIC VALUE IN TESTICULAR CANCER? S.D. Fossá and collaborators, from Oslo University Hospital (one of the largest hospitals in Europe, with great dedication to education, research and select patient care), publish in the Journal of Clinical Oncology, 40 (23), 2022, a major study on testicular cancer. The main objective was to assess whether some modifiable adverse health data acted as prognostic factors for global mortality and the appearance of a second, unrelated cancer. with

the testicle, in survivors of this disease. They included 775 patients diagnosed between 1980 and 1994. They established two groups; a) Surgery alone, 272 patients and b) In addition, 503 patients were treated with cisplatin, a drug generally accepted in the treatment of this cancer. The platinum group was divided, according to the dose received, into b1, equal to or less than 630 mlgs, 124 patients and b2, platinum greater than 630 mlgs, 379 patients. In all of them, age, treatment and some previous comorbidity (for example, hypertension or diabetes) were assessed as non-modifiable factors and as modifiable (that is, those that depend largely on the patient's will or variable circumstances of their environment), low socioeconomic status, unhealthy lifestyles, likely depression, and neurotoxicity. Overall mortality at 20 years was 14%. The factors that increased the overall risk of mortality were advanced age, platinum subgroup b2 and the presence of some non-modifiable comorbidity. Modifiable factors , such as lifestyles and psychosocial health, which were significantly associated with the overall increase in mortality , also acted as risk factors for mortality. The relationship with the appearance of a second cancer was not detected. Fossá et al. warn health professionals who treat testicular cancer that they must attend to the solution of these modifiable factors (psycho-social state, lifestyles and depression), especially in those patients receiving high-dose platinum (B2). Healthy diet To purchase the book click For more information about donations click. Prostate Cancer Video Collection Directors: J.Estapé, T.Estapé Secretary: M.Soler Marc Aureli, 14. 08006 - Barcelona Tel. 93 217 21 82 Email: We appreciate the collaboration of: ********** FEFOF belongs to EUROPA UOMO since 2004 THEIR CANCER GARDEN © FEFOC 2022 F E F O C : MEMBER OF EUROPE UOMO , USTOO AND MALE CARE EDITORIAL A few days ago we heard on the RAC radio program of Mr. Jordi Basté the impressive testimony of a teacher whose name we did not retain and whose first surname is García. She is a Catalan teacher and works in a public school near the La Mina neighborhood. Most of his students are of Moroccan origin. In her class they speak in Catalan but, according to the teacher, the vehicular language of 100% of students is Spanish. At the start of the World Cup in Qatar, the students begged the teacher to allow them to use their tablets to follow the matches. Apparently, this issue had reached some educational authorities. They proposed a series of resources: cut the wifi in the hours of transmission of the matches; prohibit tablets or mobile phones for the duration of the World Cup. All negative as the peculiar coach of But there was a giant of innovation, Professor Garcia. What came up with this genius of integration and innovation? He did not allow the watch of the games during school time but in return he promised his students that he would film a summary of them, but he would screen them in silence. Who should replace the speakers?, the students themselves, commented the plays But yes, we are in Catalan class: "In this language". That's great. Our admiration for Professor Garcia whom we wish to greet. Because it is a model of innovation and integration. Precisely what we intend with the "Cancer of theirs". Deliver the innovations that occur and help integrate them for the good of prostate, testicular and penile cancer patients. football, the Dutchman Van Gaal. In this issue we offer news about the active surveillance, minorities, telematic consultation and insomnia. IN THE UNITED STATES, LOW-RISK PROSTATE CANCER IS NO LONGER THE MOST WIDELY DIAGNOSED Dr. Leonardo Borregales et al., Urologic Oncology, Weill Cornell Medical Center (research unit and medical school of the private New York University Cornell. Initiated in 1898, throughout their fruitful work they have had 3 Nobel Prizes), published in the Journal of The National Cancer Institute, a review of 438,000 patients diagnosed between 2010 and 2018 with prostate cancer (PC). As basic points of the study they used the degree of Gleason of the patients, the level of PSA and the presence or absence of distant metastases . They observed, among many other data, that the percentage of cases of lower risk PC (Gleason group 1) in patients who had been treated with radical prostatectomy, had decreased from 32% to 10%. first work at the US level showing that CP Gleason 1 (again, the least aggressive) is no longer the most frequently diagnosed type of PC. For the authors, this low percentage of 10% of CP Gleason 1 shows that these low-risk cancers, although diagnosed, are treated less frequently, corroborating the growing acceptance of active surveillance, both by physicians. and patients . For Dr. Leonardo Borregales, it is stimulating to observe how urologists in the USA move from the excessive use of radical treatments to active surveillance. As a negative fact, it should be noted that, in the same study, there was an increase in the percentage of high-grade and metastatic PC, from 2% to 5%, probably due to the problem in the early diagnosis of PC, since it has been questioned the efficacy of PSA for such diagnosis. It is clear that we need other strategies or other means to achieve an early diagnosis of PC that does not lead to excessive treatments, as before, but without taking into account that they tend to increase high-grade and metastatic PC. This represents a decisive dilemma to be resolved. INSOMNIA One of the most frequent problems in patients with PC is insomnia. In fact, many people, even without cancer, suffer from it transiently or

permanently. When we are worried or afraid or sad, one of the first things that is affected is sleep. Alertness makes it difficult to go from wakefulness to sleep, and it is common to stay in the waking state . Insomnia can be of three types that are not exclusive: First phase or conciliation insomnia: it consists of having difficulties falling asleep. It is the most frequent insomnia, one goes around in bed with nervousness and tension and takes longer than usual to fall asleep. Second phase insomnia or recurrent awakenings: it may be that the patient has fallen asleep without problem or not, but this type of insomnia causes him to wake up during the night one or more times and be a while without being able to go back to sleep. (Continued on page 3) (Comes from page 2) Third phase insomnia or early awakening: it can also coincide with one or both types of insomnia above, but in this case what happens is that one wakes up earlier than expected, and already He can't go back to sleep. For this to happen , the individual must feel unwell or that "it's too soon." So, if it is 10 minutes or something like that we will not consider it third phase insomnia, but if it is an hour or more yes. As the saying goes "at night all cats are brown", this means that, in any of these three cases, it is highly likely that the patient (or his relative) will start thinking about cancer, with disastrous imaginary consequences. Which in turn makes it less easy for you to fall asleep and you enter a closed circle. The organization of health is extremely heteronormative. Gay and bisexual patients with CP are "erased" as one American gay patient, writer Perry Brass, puts it. The psychological effects of cancer, in general, and prostate cancer in particular, are similar in any person, but it is true that the contexts and vital circumstances of the patient mark their consequences in the face of diagnosis. To purchase the book click. We must therefore add in gay or bisexual patients, one more risk factor. In several studies it has been shown that they feel "invisible" and that the doctor advises them to "come with your wife", so it is clear that the sexual condition is something that is obvious as Important aspect when valuing the patient as a whole. However, some studies show that BG men with CP have more psychological problems, and more fear of relapse. Less satisfaction with the doctor's care has also been found. It is logical that an important factor, such as communication with the doctor, has an influence on the psychological profile and coping of the patient. We already come from a time of taboo sexuality, in which many patients found little or no space to explain their fears or doubts about their sex life . If we add the lack of inclusion regarding sexual condition, it is normal for the patient to feel isolated and alone. As we have seen, this contributes to aggravate a possible degree of depression. The fear of sexual and couple repercussions, plus detecting that it does not fit into the standards of care and medical attention, can aggravate anxiety and fear at the same time . *Taken from the book "Prostate Cancer in Straight, Gay and Bisexual". By J. Estapé and T. I stood. CAN THE TELEMATIC ONCOLOGY CONSULTATION REPLACE OR COMPLEMENT THE FACE-TO-FACE ONE? At the recent congress of the ESMO (European Society of Medical Oncology), Dr. Deborah Schrag, from Memorial Sloan Kettering Cancer Center, New York, USA, presented some important reflections on this subject. *Before the Covid-19 pandemic, telematics medicine was reserved for patients living in remote areas. But, with the pandemic, a hybrid model was established, to reduce the risk of contagion as much as possible. That is why, says Schrag, we now have a lot of data to begin to assess the new situation. *A clear advantage of telemedicine is geographical. Geographically dispersed patients more easily receive information and support. *Patients have benefited from having access to their electronic records, including physician feedback, study results through images and findings Pathological. * A problem arises when it comes to communicating bad news. Many patients prefer to wait to receive them in person, since that is when the doctor can better explain both the results and the new options and provide better support. Many doctors consider that the patient, who has received the bad news telematically, may feel very anxious , unbearably anxious while waiting to speak directly with a doctor. Another risk is that you take advantage of the interval to enter the Internet with the possibility of receiving inadequate information. *An advantage of digital medicine is that it allows real-time monitoring of symptoms, rather than waiting weeks for face-to-face consultation. Cancer is a chronic disease and everything that improves doctor-patient communication is positive. *The doctor can have a day-to-day control, so he can adjust the treatments, stopping them or modifying them. Dr. Schag sees telematics medicine as a great benefit. Most of his patients have adapted to it. The problem, he says, is how telematics medicine is integrated with the current health system, how to answer the multitude of questions that arise every day. The topic proposed by Dr. Schag is of great topicality and importance. Telematics medicine is here to stay. We will not miss the past times, focused almost exclusively on the face-to-face, which also raised certain criticisms. And let's not oppose progress. We believe that studying how telematics medicine is integrated into the health system and finding solutions is fighting for progress. Let the Galileo Galilei of the day be welcomed at all times. Health teams will need to acquire other skills to cope with new

challenges IN ACTIVE SURVEILLANCE, CAN MULTIPARAMETRIC NUCLEAR RESONANCE REPLACE BIOPSY AT THE END OF THE FIRST YEAR? This is an issue of enormous topicality and importance, as the indication for active surveillance in very low-risk prostate cancer increases, that is, the Gleason 1 group (CP G1) and some Gleason 2. Remember that active surveillance (VA) consists of not trying to enter the patient with CP G1 and only doing so if the disease evolves in a negative way, that is, it progresses over time. As we know from the Hamdy et al. study (which we've talked about several times in this journal), about 50% who choose VA never needed treatment. (Continued on page 5) (Comes from page 4) Therefore, the patient must undergo periodic reviews that tell us if the CP G1 is still inactive, and therefore the patient, if he wishes, can continue without treatment, or, if, on the contrary, the disease has progressed and the patient must be treated. Crucial, fundamental issue in the follow-up of CP G1 patients. To do this, we must equip ourselves with very efficient means. How are they usually monitored? As follows, with adaptations according to the experience of the various hospitals: A strategy is established year after year: First year: PSA testing every three months; digital rectal examination once or twice a year. At the end of this first year, the biopsy is repeated to assess whether the PC grows or not. After that, biopsies will depend on your doctor's judgment and possible symptoms. From the second to the fourth year: PSA determination every 3 or 6 months; Digital rectal examination every 6-12 months. From the fifth onwards: PSA determination every 6 months; Digital rectal exam every 12 months. Repeated biopsies are a noticeable nuisance for patients, a source of anxiety and a small risk of possible infections. In all this process, the periodic practice of multiparametric nuclear resonance (MRI) is fundamental, which avoids many unnecessary biopsies and erroneous diagnoses. Doan et al. From the University of Sydney, Australia, they published, in the Journal of Urology , a study in which they examined the effectiveness of MRI in detecting the failure of active surveillance. To do this, they studied 172 patients with CP G1 and some G2 who underwent an MRI followed by prostate biopsy. Then they followed the following protocol: PSA every 6 months; annual digital rectal examination and an MRI at the end of the first and second year of follow-up. If at any point in the study the PSA increased significantly or the MRI showed signs that the tumor had progressed, a biopsy was performed. In the absence of problems, a biopsy was performed at the end of the third year of the trial. The effectiveness in detecting that there was no progression of the disease by MRI was quite high, about 86% of cases. Results that have raised a controversy among those who believe that this high percentage of effectiveness allows skipping the biopsy at the end of the first year, while others believe that in this way they can stop diagnosing a Percentage sensitive cases of progression. The advancement of medicine is obtained through polemics and contradictions. Medicine is not an exact science. Doan et al. announce that they will continue to follow up their patients, to offer more definitive results. Once again, patients, well informed of course, have the floor. Nuclear resonance SOME THOUGHTS ON PROSTATE CANCER IN HOMOSEXUALS To refer to the problem of prostate cancer in men of another sexual condition, it is mandatory to define what we understand by minorities. Minorities are characterized by two fundamental aspects, one quantitative (minorities are always less in quantity than majorities) and the other qualitative (how this majority influences the minority). This second aspect is the fundamental one. If the relationship between majorities and minorities were only quantitative, there would be no problem. But every majority decisively influences the events of the corresponding minority. Majorities tend to destroy, despise, torment the minority that corresponds to them. Does this mean that man is evil by nature? Many authors agree in the affirmative. Machiavelli alluded to the duality of the human condition, perhaps good in origin but bad in its social contact. The human being can be good on an individual level but terrible when he is part of a majority. The gang rapes, the dramas that are lived in the schoolyards, the massacres of thousands of innocents at the hands of the corresponding minority, even the systematic elimination of Jews by the majority Nazi regime, are examples of it. For Rousseau, man is good by nature, but society corrupts him. Nietzsche sums it up with his famous phrase, "Man, this error of nature." An example of the majority over the minority is the case of Oscar Wilde, the brilliant Irish writer. Casado had two children with his wife. But one day he met the son of the Marquess of Quensberry, Douglas, whom he called Bossie. Such was Douglas' beauty that Wilde fell deeply in love with the boy. I think Wilde discovered his true sexual condition there. He was the lover of Douglas and other boys and practically abandoned his wife. He was not bisexual. His relationship with Douglas deeply irritated the Marquess of Quensberry who threatened him in a famous letter in which he mistakenly called Wilde "somdomite". Wilde, advised by his friends, decided to denounce the marquis. But, at trial, the marquis' lawyer turned the lawsuit on its head, saying Wilde was committing indecency on young boys. The chief justice then asked Wilde to recant, to which, with extraordinary courage, he refused and was sentenced to two years' hard labour in

the horrific Reading jail . Most could not accept Wilde's so-called indecent acts that were only the expression of his authentic sexuality. It was the year 1895 but today, the year 2022, situations as brutal as those experienced by Wilde occur. Beatings, homicides, boys aged 18-20 beaten by their parents for revealing their sexual condition and expelled from their homes. There is even a Foundation that is dedicated to welcoming these boys. If Wilde raised his head, "hopefully," he would be surprised to observe that things regarding homosexuals have not fundamentally changed. Here we declare that the ethical thing is to be or be with minorities, in their many facets. To purchase the book click For more information about donations click. / u c m/c h / C O F Collection of videos about prostate cancer Directors: J.Estapé, T.Estapé Secretary: M.Soler Marc Aureli, 14. 08006 - Barcelona Tel. 93 217 21 82 Email: We appreciate the collaboration of: ********** FEFOF belongs to EUROPA UOMO since 2004 THEIR CANCER GARDEN © FEFOC 2022 F E F O C: MEMBER OF EUROPE UOMO, USTOO AND MALE CARE EDITORIAL LABOR ISSUES (1)* From the diagnosis of PC, many affected people think about the moment when they will recover their normal life and, therefore, return to work. You don't have to run, because the parenthesis has been very hard. Returning to work is essential for many, while not so essential for others; For example, those who do not yet look physically capable. The problem of returning to work after treatment is complex and needs to be analysed from different points of view. A key issue is that the patient decides whether to explain the truth about their illness and treatment or prefer to hide it. Telling the truth can have consequences, from firing to harassment at work, to force the But, taking into account that the patient will need some exceptions in the day to day work, surely it is best to explain to the employer or boss the diagnosis and possible limitations . And explain as soon and as clearly as possible about how you think about the problems you will face because of the CP. Let him know that sometimes you may not feel well and may need some extra rest. Surely your employer or boss will allow you to adopt a flexible schedule. You may be able to do some of your work at home. Will he be able to rest from time to time ? Today, many entrepreneurs have a positive attitude. In principle, it is wise to seek the complicity of the boss and co-workers. employee fires on his own. But there are some employers, especially if they have not had other similar cases in the company, who find it difficult to accept the new situation of their employee. It can be positive to show them a brochure about PC. (Continued on page 2) (Comes from page 1) Then you have to take into account the treatment received and the side effects. *From the book "Prostate cancer in heteros, gays and bisexuals". UROLOGISTS. IN THE USA, THE MOST STRESSFUL MEDICAL SPECIALTY The Occupational Information Network (O*NET) (1) classifies Urology as the most stressful occupation in the USA. Classification they made analyzing the levels of professional stress in 873 different jobs. The definition of the specialization of urologists, according to such organization refers to those doctors who specialize in conditions affecting the urinary tract and also with diseases that affect the reproductive system. Regarding stress, LUGPA (2), a non-profit urological association, believes that the growing shortage of doctors is a dominant factor in its stress, together with the massive delay in care, a consequence of the Covid-19 pandemic, which have caused a significant increase in medical demand, with a progressive increase in waiting times for patients. But these factors will tend to increase, in part due to the progressive withdrawal of urologists, as deduced in another study, published in JAMA Network Open, in which a series of models are projected that show the progressive decline in the number of active urologists between 2020 and 2060. To which LUGPA adds another important stressor, which is rising inflation along with a reduction in urologists' earnings of 4.5%. Add to all this the very difficult situations when making decisions in very complicated patients, such as urological patients; the need to create a significant level of trust with such patients and develop communication skills, with respect, transparency and patience. Aspects that make this specialty particularly rewarding at the professional level. The Occupational Information Network (O*NET) is a free, American online database that helps students, people without work, companies and professionals with hundreds of job definitions, with data from about a thousand different occupations. LUGPA (Large Urology Group Practice Association) represents more than 1800 private urologists in the USA. It offers its associates information on new technologies as well as support and resources that allow them to maintain the highest level of care for patients with acute and chronic diseases of the genitourinary system. PHYSICAL EXERCISE BENEFITS PATIENTS WITH PROSTATE CANCER, EVEN THOSE IN ADVANCED STAGES OF THE DISEASE. Jin-so Kim and collaborators from Edith Cowan University , in Australia, publish (Research outputs 2014 to 2021), an important work on the suppressive effect of myokines on tumor growth, including in patients with advanced prostate cancer This public university resides in Perth, Australia. It was created in 1991 and is named after Edith Cowan Dircksey, the first woman elected to the Parliament of Australia. It is alreadyknown that physical exercise offers many

benefits to patients, but a study carried outby the Edith Cowan University (ECU) has shown how beneficial it can be for those affected by prostate cancer (PC), even in stages advanced disease. In this regard, ECU had previously observed that in patients with PC, the level of proteins known as myokines or myokines increased through physical exercise. Myokines have the ability to stop tumor development. But in the current study they observed 9 patients multi treated for PC and in advanced stages, These patients performed intensive exercise for 34 minutes. Before, after and 30 minutes after the end they determined their myokine levels . Well, their level had increased immediately after exercise, but they returned to their levels 30 minutes later. The serum of patients taken to in vitro studies achieved a 17% elimination of the growth of PC cells. The study should continue but the potential activity of myokines, even in cases of advanced PC, is striking . Perhaps it would be the explanation that patients with advanced PC who perform physical exercise have better survival than those who do not exercise. The authors consider that the appropriate dose to obtain these positive effects would be about 20 minutes including (provided that the doctor responsible for the patient does not think that it could be counterproductive for other health reasons). Some resistance exercises that increase muscle growth to stimulate the production of myokines. PROSTATE CANCER IN HETEROS, GAYS AND BISEXUALS It is dedicated to all men, whether straight, gay or bisexual, with suspected or diagnosed prostate cancer (PC) and its treatment, to their families, friends, to the health personnel who diagnose, treat and support them and the general public interested in the subject. At the time of diagnosis of PC, about 90% of cases are in the early, local or regional stage, curable, which partly explains that most patients will not die of this disease; but, here lies one of the fundamental issues, many of them will suffer the unwanted consequences of treatments. It is an issue of great individual, family and social importance , for three main reasons: Because PC affects men, regardless of their sexual condition. That is why we include here and in a specific and open way , gay and bisexual men. These, as for the PC, suffer a double taboo: on the one hand, that of the CP, so silenced in our occiety and in the media and, on the other, discrimination because of their sexual condition , that It can have an impact on the assistance N receives. (Comes from p. 3) Experiences with CP are different in heterosexual (HS), gay and bisexual (GB). Written or via the internet, information for everyone is scarce, but for the GB it is practically nil. In general, both health personnel and administrations usually assume that patients are HS. Everyone fills out admission papers in hospitals, in which the sexual condition is not usually requested or included . On the other hand, GBs do not usually find specific information leaflets in waiting rooms or CP consultations, so they are pushed to adapt to HS strategies. Finally, a decisive and novel aspect of the treatment has burst with strength and hope for men with PC located in the prostate and low aggressiveness. Along with the classic treatments, prostatectomy and radiotherapy (which, together with high cure rates, can cause serious secondary problems, with very frequent alteration of quality of life), a third modality arises, active surveillance, or treatment (if necessary), deferred. In which case, a truism: without treatment there are no side effects. Our goal is: Prostate cancer : cure with quality of life. CASE. If we compare the DNA of everything that breathes and moves on our planet, all animals are very similar. But small differences translate into big changes. Apart from technology, music also separates us from other animals. But I want to add a third differential characteristic: the attitude towards sex. While humans have developed a wonderful sexual relationship, the other animals have only developed and maintained the reproductive sexual aspect. With few exceptions, males have a brief and primitive sexual relationship, females do not even know. Among humans, getting a bilateral relationship with the couple, caressing, touching, reaching orgasm together or separately makes many exclaim, after the climax, "This is paradise, now I can die, because it is impossible to be happier than I feel now." This comes to mind because prostate cancer and its treatments threaten the best of the human being, shared sexuality. Prostate cancer is one of the great enemies of maximum happiness. LITTLE PROGRESS IN PENILE CANCER Dr. Philippe E. Spiess is a urologist at the Moffit Comprehensive Cancer Center, (started in 1981, located in Tampa, Florida, USA, dedicated to patient care, research and education). Spiess reports that, in the USA, mortality from penile cancer (CPE) increases although the incidence remains stable. This shows that the treatments we have are of little effectiveness, and that the research devoted to them has been rather scarce. (Continued on page. 5) (Comes from p. 4) EPC is rare in developed countries, while it is more prevalent in regions of Africa, Asia and South America. In total, worldwide and according to data from the American Society of Clinical Oncology and cited by Spiess, 36,068 cases were diagnosed in 2020. From the histological point of view, the most frequent EPC is that of squamous cells. The prognosis depends on its extent at the time of diagnosis. When it is precocious it is curable by surgery. The overall survival at 5 years of diagnosis in the USA is 65% of patients while that of patients with local disease is 80% and only 9% in metastatic patients.

However, probably due to lack of attention toCPE, survival tends to decrease. They point to the need to identify and develop more effective treatments in patients with metastases. TEN TIPS FOR RESPONDING TO A PROSTATE CANCER DIAGNOSIS On the online page (zerocancer.org), of the North American foundation Zero cancer, dedicated to prostate cancer, which in 2021 merged with US Too (of which FEFOC is a member), we find (source: Donald W.-CTCA) some advice on the diagnosis of prostate cancer due to an extraordinary patient, Donald W, a veteran of the US Navy who, a month after his father died of cancer, died robotic prostatectomy for prostate cancer, at Cancer Treatment Centers of America (CTCA). We translate the following tips from the original: Take a step back to process. I approached the situation calmly and logically knowing that prostate cancer is aggressive or slow-growing. Don't rush into your decision. I evaluated all of my medical options and got a second opinion from another medical expert who was not affiliated with the same practice as the doctor who provided the initial diagnosis or treatment recommendations. The second opinion assured me that I was correctly diagnosed and gave me the best treatment recommendation for me. Know your options. I asked about all possible treatment options. I wanted to know if this required immediate action or if I had time to make a decision. Know that watchful waiting or active surveillance may be viable options. Do your research. I researched all the treatment options and side effects of each treatment, then delved into side effects that could affect my quality of life, including erectile dysfunction and incontinence. The potential impact on my quality of life was important to me. Research your care team and credentials. Once I chose my treatment option, I researched the doctor who would perform the procedure, their skill level, and their specific experience for the procedure I had. I wanted to know how many procedures I had performed and their level of success. (Comes from page 5) Lean on your loved ones. I recognized early on that my cancer diagnosis also affected my closest family and friends . I knew that his support for me was very important for my healing. Don't shut down and close your loved ones when you need them most. Find a mentor. I trusted other prostate cancer patients and military veterans whom I knew and learned a lot from them. They supported me and were there to help me overcome this crisis. I also volunteered with various organizations to help other men in the future deal with a prostate cancer diagnosis . Don't be afraid of support groups. I started a support group and attended support groups, both in person and online. I wanted to get other people's first-hand perspectives on what they experienced. As a result, I gained a wealth of knowledge that I wouldn't have known otherwise. Be an empowered patient. Managing prostate cancer is a battle and you must be committed. I found that I had to invest time and energy to make informed decisions about treatments. I learned that a cancer diagnosis is not a death sentence. Knowing this helped me manage expectations and be prepared for what the future may hold. Develop a plan of attack. I researched many different hospitals and cancer centers to find the best medical equipment for me. I wanted the opportunity to be able to fight with the support of my spouse and loved ones. I learned how to develop my treatment plan, then reviewed it with my mentors as well as my spiritual, psychological , and medical care teams. Finally, I learned after finishing my treatment that it was possible to stay active, heal, maintain my strength, and live a long and productive life. Penile cancer To purchase the book click For more information about donations click. / u c m/c h / C O F Collection of videos about prostate cancer Directors: J.Estapé, T.Estapé Secretary: M.Soler Marc Aureli, 14. 08006 - Barcelona Tel. 93 217 21 82 Email: We appreciate the collaboration of: ********** FEFOF belongs to EUROPA UOMO since 2004 THEIR CANCER GARDEN © FEFOC 2022 F E F O C : MEMBER OF EUROPE UOMO , USTOO AND MALE CARE EDITORIAL (2) As for treatments, the more aggressive the treatment, the more recovery time will be necessary, from days to weeks. After prostatectomy, you have to wait a few weeks. If you do hard physical work, avoid lifting weights and avoid excessive activities, surely your recovery period will be longer, do not run to work. Conversely, if you work in an office, you will likely be able to return to work after four weeks. As for other treatments, reinstatement is usually feasible sooner. Of the possible side effects and return to work, the most feared effect is urinary incontinence . Surely the patient will be forced to go many times to the toilet. It is appropriate that But don't stop drinking the fluids you used to, because dehydration can make the situation worse. Then comes the follow-up, which will last for years. The patient will need some time for subsequent visits and analysis. It is good to try to make hospital appointments for the beginning of the day or at the end of it. The doctor can provide an information note for the employer, explaining the treatment received and the follow-up visits and controls that will be required. In general, a patient treated with prostatectomy is usually quite recovered fifteen days after this, so we can think within 4 to 6 weeks before rejoining. Regarding radiotherapy, there are patients who do not Use diapers for the duration of incontinence leave work during treatment,a and carry several spares. There are responsible entrepreneurs who place the patient near the sink. except if they

feel significantly tired. Fatigue is a complication of radiation therapy that can be maintained for a more or less prolonged time. (Continued on page 2) (Comes from page 1) It is right to inform the employer of the treatment received and, in this case, the reason for his fatigue. Hormone treatment can cause hot flashes. It is prudent to work near a window or provide yourself with a fan or fan. Many employers doubt that the patient will be able to perform the same job as before treatment . But some research proves that CP treatees return to work with the same capacity as their company colleagues . As for co-workers, it's also best to tell them, if they didn't already know about it, your diagnosis and treatment. A frequent problem is that their colleagues are often uncomfortable with the new situation and do not know how to deal with it. In any case, each patient must decide what and to whom they want to communicate their problem. Be that as it may, returning to work helps a lot the self-perception of control of the disease and of one's life and its circumstances. But never do you return to work until you feel completely fit for it. Only you can know. PLACE OF THE PATIENT IN THE CHOICE OF TREATMENT It is said that for five thousand years medicine has been a matter of doctors, although later nurses, psychologists, physiotherapists, dieticians, biologists, etc., were added to the medical team. For many years doctors knew what was best for patients. Doctors decided on treatment without patients actually participating in the decision-making process. Doctors usually have little time to report, leaving even less time for patients to ask their questions. When there is more than one treatment option, as is the case with prostate cancer, the explanation of the different possibilities (essential for the informed person to choose) is brief and, often, deviated by the weight of the type of specialist who is informing (surgeon, radiotherapist, oncologist, etc.). But the days when patients were left out of decisions are long gone. The information age is changing these things, giving due prominence to the sick person. What do doctor/patient relationships currently consist of or should consist of? Before deciding on treatment, the doctor collects all the precise information about the patient's disease, in order to be able to present a review of the facts and a detailed discussion about the possibilities of treatment. In this way the patient can know the pros and cons of each of the treatments. From this moment on, it is the patient who must choose. since, after all, it is he and he alone who will have to live with the results of his choice. The person must decide what he considers best for himself. It is even possible that the person, once informed, decides to pass the decision to the doctor. Very well, it is his right, to decide for himself or to delegate to the doctor. (Continued on page 3) (Comes from page 2) What if the doctor doesn't agree with my choice? First of all, the patient should carefully listen to the doctor's arguments. An open line of communication should be established between patient and physician. The doctor's reasons are usually totally legitimate. However, if the doctor does not accept or respect the patient's decision, the patient is within his rights to seek another doctor to do so. Why do some doctors get angry when the patient tells them what they think is best for them? You have to be careful, as many patients decide without being well informed. They have read a book or someone has told them this or that. The doctor is specialized and usually has many years of experience. Even if you think you have read a lot, I think you should use your knowledge precisely to improve understanding with your doctor and open doors for communication. So what should I do? Inform yourself properly. For example, enter the FEFOC (www.cancerdeprostata.org) page, specific to this cancer or others like it, where you will acquire a good degree of knowledge about the diagnosis and treatment of prostate cancer. Your case is unique, since it is yours, therefore, individual. Know well the situation of your disease, ask questions to doctors and nurses. Collect them in writing. Reflect on the answers. When you feel well informed, go back to the doctor and explain your decision. Then listen to the doctor's arguments. Do not attempt to commit The opposite error to that of the lack of information on the part of the patients: that is, do not want to impose your opinion on doctors now. Listen. Should my wife or partner be involved in choosing my treatment? Cancer is a disease that affects not only the patient, but his partner, the entire family, friendships and relationships and work. Essential point is the place of the woman of the patient with prostate cancer . The partner will live, from the diagnosis, influenced by the results, both of the bad news and of the consequences of the treatments. She lives the problem 24 hours a day . She must participate in information and decisions. Ask him what he thinks, what he fears, what he hopes, what he wants. Have him accompany her to the hospital, to attend conversations with doctors and nurses. Encourage her to raise her issues and ask questions. You must share your feelings with her. Discuss naturally your worries, fears, insecurities towards the future and towards your life and your quality of life, according to the choice you make and the possible consequences. PROSTATE CANCER SUPPORT GROUP (CP) The support group is a tool to help people who have gone through or are going through a similar situation. It usually refers to issues related to an illness or in the accompaniment of patients. It consists of periodic meetings of people who coincide in that circumstance being more or less homogeneous

according to the possibilities or the convenience of mixing or not situations. What types are there? Support groups can be of various types, according to different variables: Open or closed: refers to the fact that the group can start with some members and then is open to incorporate new people who are interested or who need to go. The closed ones will not admit new members in their course. Indefinite or not: there are groups that can have a finite time period and start and end at that same time and others that are indefinite. Self-help or professionally led. There are groups that are led by one or more professionals (usually two maximum) and others that are called mutual aid groups in which group meetings are held without Professional. In the latter there is an intermediate type in which the leader of the group can be a patient (non-professional) but who is advised by professionals who supervise the development of the meetings and intervene if necessary. Group objectives: Support groups are also defined by the objectives with which they are set. So we have: Psychoeducational group: groups that have the purpose of providing information of interest to the participants, of everything related to their illness or problem from a rigorous and professional point of view. Indirectly, it contributes to psychological well-being and improving quality of life, although they are not the main objectives. You can count on the itinerant presence of professionals who come to talk about a specific topic in one or a few sessions. Psychotherapeutic group: it is a group where the objectives are of a psychological type almost exclusively and are addressed with psychotherapy guidelines that are carried out at home and then discussed and addressed in the group. What is me? It depends on the circumstances and the person. From we always recommend the presence of the professional, because, although it may seem easy, support of this type requires experience and experts. Unfortunately the experiences of people in groups without professional advice are not highly recommended. In addition, it is misinformed enough because many of those present have as baggage having lived the disease in the first person, an aspect that seems very important, but perhaps it is not enough to inform, and give support to other patients. What if I don't want to go? The group is a valid support tool but at no time is it better or worse. It may be necessary or can help at specific times or become a permanent support. (Continued on page 5)
(Comes from page 4) Everyone must determine how they feel or what it brings to them. Therefore, it can be useful to try it when in doubt. It's okay to decide that you prefer not to go, or to decide that you no longer need it. But given the opportunity, maybe we recommend at least trying it to see if it can really help us. This does not apply to psychotherapy groups that are usually professionally indicated . What if I need help but in the group I don't feel well or I get to seehow I talk about my things? You can always ask for individual psychological help, or couple if it is the case. As we have been saying, the group is a tool but there are others available and they are not exclusive. Where do I go? a support group that has been operating since 1998. The meetings are monthly and are on the second Thursday of each month at 10.30. The group is psychoeducational and indefinite and is led by professionals, an oncologist and a psychologist on a permanent basis and some professionals to provide certain information sporadically. Ask for : Tel. 93-2172182 or by email : PSA INCREASE Cancer is a disease characterized by the multiplication of cells, so its diagnosis requires examining whether there is such multiplication and if the cells show alterations compatible with cancer. It follows that, apart from other tests that we will now detail, for the definitive diagnosis of PC, biopsy is absolutely essential. But first we must consider other aspects. PSA (prostate specific antigen). The first suspicion that something is happening in the prostate usually gives us urinary symptoms such as those described above and / or an increase in a substance known as PSA. PSA is a protein only produced in the glands of the prostate, by their cells, whether normal or cancerous. It is determined by blood tests. Its blood level is measured in units called nanograms (millionth of a gram) per milliliter (one-thousandth of a liter) and is expressed as ng/mL. In principle, the probability of having CP increases with the increase in your level. It is generally accepted that a PSA less than 4 ng/mL is synonymous with absence of PC; between 4 and 10 a probability interval is established; typically, 25% of men in this interval have CP; if it is greater than 10, there is usually CP in half of those explored. But there are many exceptions; so, for example, some men with PSA lower than 4 have CP, while others with elevated PSA do not. It is clear that, although PSA is an important test to suspect the presence of a PC, other tests, which will be seen later, are needed to reach a diagnosis of certainty. (Continued on page 6)
(Comes from page 5) In addition, an increase in PSA, regardless of what can cause PC, may be due to other factors, which must be taken into account: Benign prostatic hyperplasia, common with increasing age. The prostate is enlarged in size, but it is a benign growth, there is no CP. Age. With increasing age, although the prostate does not have any alteration, it is common for the PSA level to increase. Another important possibility is the manipulation of the prostate, either for diagnostic purposes (digital rectal examination) or by ejaculation, prostate massage or penetration into anal sex. These procedures (ejaculation, massage and penetration) make

it easier for the PSA to leave the prostate and pass into the blood, so that, if it is tested soon , easily We will find abnormally high levels of PSA (not real), which can confuse the doctor, make him suspect a possible CP and lead to other tests, not only unnecessary but potentially aggressive. Therefore, an important warning: two to seven days before the determination of the PSA it is mandatory that everyone avoid ejaculation, prostate massage and anal penetration. Prostatitis: infection and/or inflammation of the prostate, which also increases PSA. Bicycle: contradictory data, but some argue that the saddle can press on the prostate and cause the emission of PSA into the blood. Male hormones: If you are taking testosterone supplements , they can also increase PSA. PSAITIS OR ANXIETY RELATED TO PSA OUTCOMES -We know real cases of anxiety attacks in healthy men in relation to this test. PSA carries a high level of anxiety for men, as they await their results with fear of relapse. It seems that while waiting for the results they have more present than ever the sword of Damocles over their heads, waiting to know if it will fall on them. or not, and they will be able to go on with their lives until next time. This type of anxiety, in Anglo-Saxon countries is called PSA anxiety, or playing with humor with its acronym, the analysis to promote stress and anxiety (in English: to Promote Stress and Anxiety). In Spanish we have coined the term Psaitis. -This anxiety consists of nervousness, tachycardia and sweating, with negative thoughts, regarding the possibility that indicates a recurrence of PC, plus negative fantasies about the worst possible scenario. Ideas about a future in which the CP would have reappeared, such as "I will not be able to bear it", "how we will", "what will happen to my family " appear strongly. It is an anxiety difficult to overcome, because it is very localized in time and closely related to a wait, with not tolerating the uncertainty of not knowing. In more severe cases, the person may begin to manifest functional pain, that is, as a result of their own anxiety that, in a way, confirms their suspicions that "something bad is happening", with checking behaviors such as going to the bathroom often to check if they urinate well, if They feel pain, they bleed... In turn, these discomforts generate more anxiety. (Continued on page 7) (Comes from page 6) -In most patients, a negative result, i.e. according to which everything is fine, serves to calm down. But there are some cases, more resistant, whose relief lasts very little, and soon begin again with suspicions of worsening, interpretation of discomfort as signs that the PC reappears. -In these cases it may be indicated to go to a specialized professional, especially if the interference with the quality of life is important. In any case, trying to focus on the present, not anticipating or being too aware of bodily changes, can be a good idea. It is also necessary to accept anxiety as part of coping with the disease and try to live and enjoy as much as possible, despite it, not against it. Unpleasant emotions are necessary for survival, and when they are coherent, it is better to accept them than to try to fight them. PSA-Test Results To purchase the book click For more information about donations click. / u c m/c h / C O F Collection of videos about prostate cancer Directors: J.Estapé, T.Estapé Secretary: M.Soler Marc Aureli, 14. 08006 - Barcelona Tel. 93 217 21 82 Email: We appreciate the collaboration of: ********** FEFOF belongs to EUROPA UOMO since 2004 1 EUPROMS (Europa Uomo Patient Reported Outcome Study) EUPROMS Europa Uomo’s study on quality of life after prostate cancer treatment SUMMARY OF FINDINGSEUPROMS (Europa Uomo Patient Reported Outcome Study) 3 2 EUPROMS (Europa Uomo Patient Reported Outcome Study)Contents EUPROMS (the Europa Uomo Patient Reported Outcome Study) is the first ever prostate cancer quality of life survey conducted by patients for patients. About EUROPROMS 4 About the questionnaire 4 Geographical response 5 About the respondents 5 About the analysis 9 Reporting the study results 9 How we hope the results will be used 9 EUROPROMS findings 10 1. General findings about quality of life 11 2. Findings about discomfort, tiredness and insomnia 12 3. Findings about mental health 14 4. Findings about sexual function 17 5. Findings about urinary incontinence 21 Key messages from EUPROMS 25 Further information 28 Links 30 EUPROMS (Europa Uomo Patient Reported Outcome Study) 5 4 EUPROMS (Europa Uomo Patient Reported Outcome Study)The EUPROMS study (Europa Uomo Patient Reported Outcome Study), which reported in 2020, is the first ever prostate cancer quality of life survey conducted by patients for patients. This booklet, written by André Deschamps, Chairman of Europa Uomo, and health writer Simon Crompton, is a non-academic overview of its findings. Europa Uomo (Italian for Europe man) is a European advocacy movement representing 27 prostate patients’ groups in countries across Europe. Quality of life for men with prostate cancer is intrinsic to all Europa Uomo’s work. Early diagnosis brings quality of life benefits because the effects of cancer and its treatments are likely to be far greater if diagnosed late. High quality, personalised treatment in specialised centres can also bring better quality of life. Up until now, good research about the effects of prostate cancer and its treatments on day-to-day living has been thin on the ground. This means that treatment choices and policy decisions may not always be based on sound evidence. So in 2019, Europa Uomo commissioned Europe-wide research on the quality of life of

men with prostate cancer – the first time such research has been conducted by patients themselves. It was based on an online survey exploring experiences of treatment and life afterwards. Based on nearly 3,000 responses, the survey findings provide a new perspective. Most other quality of life studies are conducted by doctors in a clinical environment, when patients are visiting for treatment or check-ups. The EUPROMS questionnaire was completed by men in their own time, in the comfort of their homes, meaning they had more time to consider their answers and might have felt more at ease to say how they really feel. About EUPROMSThe findings here present an overview of what EUPROMS discovered, and are designed for a general, rather than a scientific, audience. They are a “snapshot” picture of what quality of life issues are being experienced by men with prostate cancer at a particular point of time. The study could not look at individual respondents’ medical condition before treatment, or the details of how prostate cancer patients differ from the population in general. That would have been a different kind of study. The findings provide information that may: • help patients and their doctors make decisions about treatments • help in campaigning for early diagnosis of prostate cancer and promoting approaches such as active surveillance You are welcome to publicise the results or charts without permission, but they must always be credited to Europa Uomo’s EUPROMS study. About the questionnaire • 20-minute online survey for men who had received treatment for prostate cancer • Available in 19 languages • Used validated quality-of-life questionnaires: EPIC-26 and EORTC-QLQ and EQ-5D-5L • Responses were anonymous EUPROMS (Europa Uomo Patient Reported Outcome Study) 7 6 EUPROMS (Europa Uomo Patient Reported Outcome Study)Geographical response There was a wide response across 25 countries, but there was an under- representation from Eastern Europe and some under-representation from Southern Europe. About the respondents • 2943 responses from 25 countries • Average age: 70 • Average age at diagnosis: 64 • 82% live with a partner • Most had had surgery as first treatment As you will see from the distribution graph of age at first diagnosis, more than 50% of respondents were diagnosed before they were 65 (see page 7). This counters the idea that prostate cancer is a disease of old men.Most respondents were living with a partner, which is important given the effects that treatment can have on sexual function. There is a slight bias in respondent profile towards a higher level of education.Age of respondents Age at diagnosis Average age of respondent: 70 yearsAverage age at diagnosis: 64 years4% 6 13 21 26 19 10<55 55–59 60–64 65–69 70–74 75–79 80+11% 17 24 24 16 6 2 University entrance certificate Entrance certificate for a higher technical college Comprehensive school Intermediate secondary school Lower secondary school or equivalent Other NoneLiving situation Education 14% Alone82% With partner 3% With other family31% 28 13 11 7 8 1300+Number of respondents 100–299 50–99 1–492,943 responses 25 countries Norway: 506 Sweden: 386 Belgium: 339 Germany: 253 The Netherlands: 244 France: 234 Denmark: 188 UK: 187 Poland: 109 Portugal: 75 Italy: 71 Austria: 66 Finland: 65 Spain: 55 Lithuania: 52Other (mainly Cyprus): 38 Ireland: 26 Latvia: 11 Hungary: 10 Estonia: 8 Slovak Republic: 8 Switzerland: 7 Czech Republic: 3 Bulgaria: 1 Greece: 1 EUPROMS (Europa Uomo Patient Reported Outcome Study) 9 8 EUPROMS (Europa Uomo Patient Reported Outcome Study)Most patients had only received one treatment up to the start of the survey. About 60% of respondents had received radical prostatectomy, so the overall results will be influenced by the effects on quality of life of that particular treatment. About the analysis Data was analysed by Professor Monique Roobol and her team at Erasmus University Medical Centre, Department of Urology, Rotterdam. Some of the findings here are based on raw survey responses and statistical significance has not been calculated or displayed. However, the findings may help provide vital information for clinical decision-making. Reporting the study results The study began in August 2019 and the first results were reported in January 2020. Since then, its findings have been reported and discussed widely, for example at: • The European Association of Urologists (EAU) Congress 2020 • The EAU Section of Oncological Urology annual meeting • The European Society for Medical Oncology (ESMO) Congress • The European Multidisciplinary Congress on Urological Cancers (EMUC) • A European Organisation for Research and Treatment of Cancer (EORTC) webinar Findings have also been published in various publications including European Urology Focus magazine. How we hope the results will be used The EUPROMS findings provide a “snapshot” picture of the quality of life issues experienced by men with prostate cancer across Europe at a particular point of time. They provide information that may help patients and their doctors make decisions about treatments. They may also help in campaigning for early diagnosis of prostate cancer and promoting approaches such as active surveillance.Three 300Four 70 One 1,937Two 636Most common first treatments: 1. Surgery 2. External beam radiotherapy (EBR) 3. Active surveillance (AS) Most common second treatments: 1. Surgery and EBR 2. Androgen deprivation therapy and EBR 3. AS and surgeryNumber of treatments per person EUPROMS (Europa Uomo Patient Reported Outcome Study) 11 10 EUPROMS (Europa Uomo Patient

Reported Outcome Study)EUPROMS findings1. General findings about quality of life Taken overall, respondents' quality of life is good. Chart G1 shows all the respondents rating their quality of life from one to seven, and the percentage in each category. But some aspects of life are much better than others. Chart G2 shows how different aspects of quality of life are affected after treatment. The lower the score, the lower the quality of life. It's clear that lack of sexual function, and to a lesser extent incontinence, affect men's quality of life much more than other treatment after-effects. *EPIC-26 scorer(G2) How does treatment affect quality of life? (Quality of life scores*. Lowest score indicates most troublesome effects) Urinary incontinence Bowel effects Worse quality of life Better quality of lifeSexual function 88Hormonal problems 81 Urinary obstruction 847227Patients' sex lives are affected most after treatment*EORTC-QLQ-C30Very poor Excellent 1% 3.58 9.819.7 35.922.1(G1) Quality of life during the past week Very poor to excellent (% of all respondents) Men surveyed in EUPROMS1 2 3 4 5 6 7 13 EUPROMS (Europa Uomo Patient Reported Outcome Study) 12EUPROMS (Europa Uomo Patient Reported Outcome Study) 2. Findings about discomfort, tiredness and insomnia Looking at specific aspects of quality of life after prostate cancer treatment, when it comes to pain and discomfort, this increases as men move through the treatment stages. More than three times the pain and discomfort are reported after chemotherapy compared with early stage treatments (D1).For tiredness, more than one third of men who had received chemotherapy said they had felt tired in the past week – twice the number of other treatment groups (D2). And with insomnia, the study found men were affected more after radiotherapy with ADT and also after chemotherapy (D3). The effects nearly double as treatment progresses. *EQ-5D-5L questionnaire(D1) Which treatments are linked with pain or discomfort? (% of respondents saying they were in moderate, severe or extreme pain/discomfort at time of survey*) Active surveillance Radical prostatectomy Radiotherapy Radiotherapy and ADT Chemotherapy7.5 10.4 14.3 34.17.9% Men who have received radiotherapy plus ADT and chemotherapy experience more discomfort than other treatment groups*EORTC-QLQ-C30(D2) Which treatments are linked with tiredness? (Respondents who said they have been quite or very tired in the past week*) Active surveillance Radical prostatectomy Radiotherapy Radiotherapy and ADT Chemotherapy11.9 16.8 15.7 36.613.4% More than a third of men who have received chemotherapy say they feel tired *EORTC-QLQ-C30Men who have received radiotherapy plus ADT and chemotherapy experience more insomnia than other treatment groups(D3) Which treatments are linked with insomnia? (Respondents who said that have had 'quite a bit' or 'very much' trouble sleeping in the past week*) Active surveillance Radical prostatectomy Radiotherapy Radiotherapy and ADT Chemotherapy13.7 16.1 24.6 28.914% 15 EUPROMS (Europa Uomo Patient Reported Outcome Study) 14EUPROMS (Europa Uomo Patient Reported Outcome Study) 3. Findings about mental health The study found that men experience roughly equal levels of anxiety in the first and second line of treatment, and anxiety and depression tend to diminish after treatment ends (M1). 1 238 36 59%66 24 827 10 437 20 735 18 8Second line of therapy or laterFirst line of therapyOn active surveillancePreviously, but not currently, receiving treatment Men experience roughly equal levels of anxiety in first and second line treatment(M1) How depressed/anxious are men at different stages of treatment? Not Slightly Moderately Severely Extremely But a recurrence can affect mental health a great deal. More than half of the respondents who had a recurrence rate the effect on their mental health as six or more on a scale of one to ten – in other words, it had a significant effect (M2). The study found that 42% of men who have been treated for prostate cancer say they are anxious or depressed to some extent (M3, page 16).Not at all ExtremelyMore than half of men with a recurrence gave a score of six or more(Respondents who had a cancer recurrence on a rating scale of 1 to 10) 1 2 3 4 5 6 7 8 9 10(M2) How much does a recurrence of prostate cancer affect mental health? 671615 1014 8 8 8 8% EUPROMS (Europa Uomo Patient Reported Outcome Study) 16 17 EUPROMS (Europa Uomo Patient Reported Outcome Study)Which treatments are most linked with mental health problems? Chart M4 shows that the problems seem to get worse the more advanced the cancer, when men are more likely to be receiving ADT and chemotherapy. Active surveillance seems to be associated with higher levels of depression or anxiety than treatments such as radical prostatectomy and radiotherapy. This may be related to the long-term worry that can be brought by regular testing, and the fact that treatment decisions may still have to be made. (% of respondents saying they were moderately, severely or extremely depressed or anxious at time of survey*)(M4) Which treatments are linked with mental health problems? Active surveillance Radical prostatectomy Radiotherapy Radiotherapy and ADT Chemotherapy 27.618.31311.815.1%Men who have received radiotherapy plus ADT and chemotherapy experience more depression and anxiety than other treatment groups *EQ-5D-5L questionnaire 4. Findings about sexual function When it comes to sexual function after treatment, the

study indicated that quality of life is better after prostatectomy than radiotherapy (S1). This may be surprising, given the risks of nerve damage during surgery. But the difference between radiotherapy and radical prostatectomy is small and may not be clinically relevant. Slightly 27.7%(At time of survey*)(M3) What proportion of men who have been treated for prostate cancer are anxious or depressed?Extremely 0.5% Severely 3.7% Moderately 10.8%Not at all 57.4% 42% of men say they are anxious or depressed to some extent *EQ-5D-5L questionnaire *EPIC-26 scores Worse quality of life Better quality of life17 Active surveillanceActive surveillance – radical prostatectomyRadical prostatectomyRadical prostatectomy – radiotherapy Radiotherapy Radiotherapy–Androgen deprivation therapyChemotherapy(Quality of life scores*. Lowest score indicates worst effects)(S1) How is sexual function after different treatments? Radiotherapy is related to worse quality of life than prostatectomy 57262115 1812EUPROMS (Europa Uomo Patient Reported Outcome Study) 19 18 EUPROMS (Europa Uomo Patient Reported Outcome Study)Looking at how different treatments affect sexual functioning (S4, see page 20), more than half of men who have had a prostatectomy find that sexual functioning is a big or moderate problem for them. Sexual functioning seems to be a less significant problem after radiotherapy: 44.5% for radiotherapy had significant problems compared with 54.5% for prostatectomy. Quality of life scores for both treatments are obviously low compared with active surveillance. Comparing these figures to the general population, the average EPIC sexual function score for men without prostate cancer is 55.8, which is clearly very similar to the active surveillance score here. How big a problem is sexual functioning after treatment? Chart S2 shows it is a big or moderate problem in around half of men. When asked how they rated their ability to function sexually, around three quarters of men with prostate cancer rated it as poor or very poor (S3). For comparison, it is interesting to look at a 2017 study of men of slightly older age (average age 74.5) who did not have prostate cancer, which used the same EPIC-26 measures (Venderbos et al, PMID: 28168601). It found that 50% of these men rated their ability to function sexually as poor or very poor. Clearly, this is a significantly lower percentage than the 76% of men with prostate cancer in our study. *EPIC-26 scoresVery poor 56%Very good 2% Poor 20%Fair 14%Good 8%(S3) How do men rate their current ability to function sexually after treatment? (All respondents*) Three in four men who have been treated for prostate cancer rate their current ability to function sexually as poor or very poor. *EPIC-26 scoresBig problem 28%No problem 17% Moderate problem 22%Small problem 18%Very small problem 15%(S2) How big a problem is sexual functioning? (All respondents*) Half of all men responding said that sexual function has been a moderate or big problem after treatmentEUPROMS (Europa Uomo Patient Reported Outcome Study) 20 21 EUPROMS (Europa Uomo Patient Reported Outcome Study)This is a clearer finding than we saw in chart S1, where sexual function values were quite similar between radiotherapy and prostatectomy. But both findings indicate that, when it comes to sexual function, the two major first treatments for prostate cancer have an important effect on quality of life. Only 34% of men have tried medications and devices to improve erections, so there's clearly a need to give men more advice on these approaches to help overcome any problems (S5).5. Findings about urinary incontinence Looking at incontinence, prostatectomy is related to lower quality of life than radiotherapy. Other treatments show fewer effects (U1).*EPIC-26 scores(Prostatectomy patients only*)(S4) How big a problem is lack of sexual functioning after surgery? More than half of prostatectomy patients say lack of sexual function is a significant problem to them.54.5%33%12.5 % Big problem or moderate problemSmall or very small problemNo problem (Radiotherapy patients only*)How big a problem is sexual functioning after radiotherapy? 44.5 %40%15% Big problem or moderate problemSmall or very small problemNo problem (All survey respondents) (S5) How many prostate cancer patients have tried medications and devices to improve erections? No 66%Yes 34% *EPIC-26 scores Worse quality of life Better quality of life100 10071 73 Active surveillanceActive surveillance – radical prostatectomy Radical prostatectomy Radical prostatectomy – radiotherapy Radiotherapy Radiotherapy–Androgen deprivation therapyChemotherapy(Quality of life scores*. Lowest score indicates worst effects)(U1) How is continence after different treatments? Prostatectomy is related to worse quality of life than radiotherapy65 9286 EUPROMS (Europa Uomo Patient Reported Outcome Study) 23 22 EUPROMS (Europa Uomo Patient Reported Outcome Study)Overall, 61% of the men surveyed said they lacked some urinary control (frequent dripping or no control) (U2). Those who have had a prostatectomy report less urinary control than those who have had radiotherapy or other treatments, and this results in a lower quality of life related to urinary symptoms. Comparing the surgery figure with active surveillance suggests that surgery doubles the rate of incontinence. What does this mean for patients in practical terms? The survey asked men how many incontinence pads they use each day, and across all the survey respondents over a third use one or more pads a day

(U3). Of respondents who had had a prostatectomy, half were using pads. To put this into context, a 2017 study of men with roughly the same age profile who had NOT been treated for prostate cancer found that around 10% wear pads (PMID: 28168601). So there is clearly a significant effect here. The survey found that 17% of men judged dripping and leakage to be a big or moderate problem (U4, see page 24). And if you break down this figure into those who have received prostatectomy and radiotherapy, treatment *EPIC-26 scoresAfter radiotherapy plus ADTDuring active surveillance After radiotherapy aloneAfter surgery plus radiotherapyAfter surgery alone(Proportion of all men surveyed with frequent dripping or no control*)(U2) What proportion of men lack urinary control after treatment? 61% of men treated say they lack some urinary control (occasional dribbling to complete lack of control)18.2% 17.9 10.6 9.9 7.2 *EPIC-26 scores(All survey respondents*)(U3) How many pads do men who have been treated usually use? 37% of men use one or more incontinence pads every day after treatment7% 62.5%None 22%One a day 8.5%Two a dayThree or more EUPROMS (Europa Uomo Patient Reported Outcome Study) 25 24 EUPROMS (Europa Uomo Patient Reported Outcome Study)received is a clear influence on this problem. For prostatectomy patients 67% say dripping and leakage is a problem. While 48% of radiotherapy patients say that dripping and leakage is a problem (U5). Key messages from EUPROMS *EPIC-26 scores(Prostatectomy patients only*)(U5) How big a problem is dripping and leakage after surgery? 67% of prostatectomy patients say dripping and leakage is a problem20%47%33% Big problem or moderate problemSmall or very small problemNo problem (Radiotherapy patients only*)How big a problem is dripping and leakage after radiotherapy? 9%39%52% Big problem or moderate problemSmall or very small problemNo problem*EPIC-26 scores(All survey respondents*) (U4) How big a problem is dripping and leakage? 17%41%42% Big problem or moderate problemSmall or very small problemNo problem 58% of men who have been treated for prostate cancer say dripping and leakage is a problem *EPIC-26 scores(Prostatectomy patients only*)(U5) How big a problem is dripping and leakage after surgery? 67% of prostatectomy patients say dripping and leakage is a problem20%47%33% Big problem or moderate problemSmall or very small problemNo problem (Radiotherapy patients only*)How big a problem is dripping and leakage after radiotherapy? 9%39%52% Big problem or moderate problemSmall or very small problemNo problemEUPROMS (Europa Uomo Patient Reported Outcome Study) 27 26 EUPROMS (Europa Uomo Patient Reported Outcome Study)There are three main take-home messages from the EUPROMS findings. The first is that active surveillance should be always be considered, because overall it best protects quality of life. The contrast between active surveillance and other approaches is particularly clear in terms of incontinence and sexual function.2. Early detection is key Active surveillance Radical prostatectomy Radiotherapy Radiotherapy–Androgen deprivation therapy Chemotherapy 0 5 10 15 20 25 30 35 40Discomfort Tiredness Insomnia Mental health(% of patients with moderate, severe and very severe problems) The second message is that early detection of prostate cancer is of the utmost importance. The more advanced the prostate cancer at diagnosis, the worse the effects of treatment on quality of life. The research clearly shows that many symptoms that affect quality of life are experienced more severely with treatments associated with more advanced prostate cancer. Finally, high quality treatment and support are essential. The EUPROMS results show the severe effects that can come with treatment for prostate cancer. Men need all the expertise and experience they can get during treatment and after, with information and support at each stage of the journey. Every man with prostate cancer should be treated in a cancer centre with multidisciplinary teams. 1. Active surveillance should be considered as the first treatment in order to ensure the best quality of life Incontinence Average EPIC score Sexual function Average EPIC score Active surveillance Radical prostatectomyRadiotherapyRadiotherapy–Androgen deprivation therapy Chemotherapy100 57 2118 1712100 92 86 73EUPROMS (Europa Uomo Patient Reported Outcome Study) 29 28 EUPROMS (Europa Uomo Patient Reported Outcome Study)Further information The quality of life measures used The survey questions were composed, and their responses analysed, on the basis of three validated measures used widely in Europe to evaluate patient quality of life. They are: EQ-5D-5L – used to evaluate generic health status EORTC-QLQ-C30 – used to evaluate quality of life related to cancer EPIC-26 – used to evaluate quality of life related to prostate cancer specifically The findings presented in this paper summarise some of the detailed findings arising from EUPROMS, using these measures. Impact of EUPROMS Since early 2020, the EUPROMS findings have been widely reported at conferences, in journals, at conferences and webinars. The publication of the European Commission's Beating Cancer plan has made the findings even more pertinent. The plan, published in February 2021, raises the prospect of prostate cancer early detection programmes throughout Europe. Europa Uomo has been campaigning vigorously for such measures, pointing European politicians towards the

findings of the EUPROMS study. Early detection clearly affects quality of life. EUPROMS found that quality of life scores are best in patients where the cancer is discovered in an early, curable stage. So efforts toward early detection and awareness are essential to avoid unnecessary deterioration of quality of life. The EUPROMS quality of life study substantially contributed to the inclusion of prostate cancer early detection in the Beating Cancer plan, so special thanks must go to all the patients who took time to answer the survey: their efforts have made a difference.What happens next? Campaigning and information work needs to continue, to provide evidence supporting the need for early detection, awareness and treatment and care improvements. That is why Europa Uomo is now planning a follow-up to EUPROMS study to strengthen the research base and fill possible gaps. At time of writing this booket, the EUPROMS 2 questionnaire was being prepared. EUPROMS (Europa Uomo Patient Reported Outcome Study) 31 30 EUPROMS (Europa Uomo Patient Reported Outcome Study)Links Europa Uomo owes a huge debt of thanks to those who have supported EUPROMS, in many different ways. They include: • Professor Monique Roobol, Lionne Venderbos and Sebastian Remmers from the Department of Urology at Erasmus MC, Rotterdam • The European Association of Urology • Our EUPROMS sponsors: Bayer, Ipsen and Janssen Particular thanks go to every one of the 2,943 people who responded to the EUPROMS questionnaire. Credits This booklet was compiled by: Simon Crompton, editing and writing Wesley Fernandes, graphics Hils Tranter, design You can find out more about the EUPROMS study by following the links below: PowerPoints and summaries Early presentation of findings by Europa Uomo Chairman André Deschamps, January 2020 Main findings presented to the European Association of Urology (EAU) by André Deschamps, July 2020 New findings on mental health from EUPROMS announced, November 2020 New accessible presentation of results launched, November 2020 Accessible presentation available in 17 languages Journal papers and conference reports Presentation at EAU , July 2020 Presentation at EMUC (Multidisciplinary Congress on Urological Cancers), November 2020 Paper on chemotherapy effects in Annals of Oncology, September 2020 Paper in European Urology Focus presenting EUPROMS results, December 2020 " Particular thanks go to every one of the 2,943 people who responded to the EUPROMS questionnaire. "AcknowledgementsEUPROMS (Europa Uomo Patient Reported Outcome Study) 32 www.europa-uomo.orgEuropa Uomo Central Office Tel +32 3 644 17 89 europauomo@skynet.be www.facebook.com/EuropaUomo https://twitter.com/europa_uomoProstate cancerInformation for Patients English- 2 - About the prostate

Table of contents This information was produced by the European Association of Urology (EAU) and updated in May 2021. This chapter contains general information about prostate cancer. If you have any specific questions about your individual medical situation you should consult your doctor or other professional healthcare provider. No website or leaflet can replace a personal conversation with your doctor. Contributors: Mr. Eamonn T. Rogers, Galway (IE) Assoc. Prof. P. Cornford, Liverpool (UK) Mr. John Dowling, Dublin (IE) Dr Keith Ritchie, BSc, MB BS, retired GP and metastatic prostate cancer patient, Kent (UK) This information has been reviewed by a lay panel.- 3 - About the prostate What is the prostate? The prostate is a small gland that forms part of a man's reproductive system. It is about the size of a golf ball and surrounds the tube that empties urine from the bladder, called the urethra. It is normal for the prostate to swell as a man gets older, but if the swelling gets too big, it can block the urethra, making it difficult to pass urine . This swelling is called benign prostate enlargement or BPE. BPE is not cancer. In most cases, BPE is not a serious health concern and is a treatable condition. What does the prostate do? The prostate makes a thick white fluid that mixes with sperm from your testicles to make semen. It also produces a protein called prostate-specific antigen or PSA. PSA helps reduce the thickness of semen, so it is thinner and more fluid. Do men have hormones? Hormones are chemicals that carry messages around the body. In men, a hormone called testosterone is made by the testicles and controls how the prostate works. Testosterone is responsible for a man's sex drive and getting an erection. For this reason, you may hear testosterone called a "sex hormone". Do trans women have a prostate? Yes. If you are a trans woman or a non-binary individual assigned male at birth, you have a prostate. Some trans women may have had genital reconstructive, or gender reassignment, surgery. Although converting a man's anatomy to a woman's anatomy involves removing the penis and the testicles, this surgery does not remove the prostate. If you are taking hormones or testosterone blockers, these may reduce the risk of prostate cancer by lowering your testosterone levels. It is still very important to have a prostate check if you have any known symptoms or are at increased risk of prostate cancer.Prostate cancer Urine Urine, or pee, is often called a waste product. This is because it is produced by the kidneys, which are responsible for filtering toxins from the blood. Protein Proteins are found in every cell in the body. Antigen Typically, an antigen is a substance that causes your immune system to produce antibodies. Although PSA is called an antigen, biochemically, it is an enzyme which means it causes a chemical reaction. In the prostate, this chemical reaction is the reduction in the thickness of the semen. bladder scrotumurethrapubic bone prostaterectum seminal vesicles ©2018 patients.uroweb ALL RIGHTS RESERVED Male reproductive system Pathway of sperm ©2020 patients.uroweb ALL RIGHTS RESERVED Ureter Bladder Seminal vesicle Ejaculatory duct Prostatic urethra Prostate gland Vas deferensEpididymis TesticlesUrethra- 4 - We know it can be a difficult conversation to have, but we encourage you to speak to your doctor. About prostate cancer What is prostate cancer? Our bodies are made up of trillions of tiny cells, which are the basic building blocks of all living things. Cells continuously divide to make new cells. It is how we grow and how the body heals itself. Sometimes a cell becomes abnormal. It is not fully understood why this happens, but when abnormal cells keep dividing and make more and more abnormal cells, eventually a lump of tissue forms, called a tumour. Not all tumours are cancerous. Benign means the tumour is not cancer, but it might still grow in size. Malignant means the tumour is cancer. Some malignant tumours grow very fast, while others grow much more slowly. If a malignant tumour is left untreated, it may spread to other parts of the body. This spreading of cancer cells is called metastasis. For detailed cancer information, take a look at our About Cancer page. Prostate cancer means there are cancer cells inside the prostate that have formed a malignant tumour. If you have recently been diagnosed with prostate cancer, you are not alone. Prostate cancer is the most common cancer among men in Europe, but there are treatment options. What causes prostate cancer? The exact cause of prostate cancer is unknown. But certain things increase a man's chance of developing it. These are called risk factors. Having a risk factor for cancer does not mean a man will get prostate cancer; it just means he has an increased risk . What are the stages of cancer? What does localised, locally-advanced, and metastatic mean? If you have been

diagnosed with prostate cancer, you may have heard the terms localised, locally-advanced, or metastatic. All of the different terms can feel overwhelming. Cancer cellsAbnormal cells Normal cellsNormal cells Tumour, rapidly growing invading cells Cancer breaks through the membrane Cancer cell detaches and can spread to other parts of the bodyNormal cells Basement membrane ©2021 patients.uroweb ALL RIGHTS RESERVED ©2020 patients.uroweb ALL RIGHTS RESERVED ©2020 patients.uroweb ALL RIGHTS RESERVEDBenign lump of tissue (tumour) Malignant lump of tissue (tumour)- 5 - Cancer is often described in stages. These are used to explain the size of the tumour and how far the cancer has spread. Although there are different ways of describing the stage of cancer, one of the simplest ways to understand it is using numbers from 1 to 4. We have described the stages in their simplest form below. Understanding stages and cancer terms Stages 1 and 2 “Early” or “localised.” Stages 3 and 4 “locally-advanced.” Stage 1 The tumour is contained or “localised” in the prostate. The cancer is in the very early stages, and the tumour is too small to be felt during a prostate check . Stage 2 The tumour is within the prostate. It is still small, but it may be felt during a prostate check and may be visible on a scan . The cancer cells are dividing, and there is an increased risk of the tumour growing and the cancer cells spreading. Stage 3 The tumour has started to break through the wall of the prostate, and the cancer cells may be in the nearby tubes that produce semen. This is called “locally-advanced cancer” because the tumour has grown immediately outside the prostate but has not spread to other or “distant” parts of the body. Stage 4 The tumour has grown outside the prostate. The cancer cells may be in or around the bladder (such as the bladder neck or urinary sphincter), the back passage (rectum), or in the pelvic floor muscle, which lies underneath the prostate at the base of the pelvis. Metastatic disease and metastasis Prostate cancer can spread to the local lymph nodes or bones and even organs such as the liver, lungs, and brain. This spread of cancer cells throughout the body is called “metastasis”, or you may hear it called “metastatic prostate cancer.” When cancer spreads or metastasises to other organs, it is referred to as metastatic disease.Stage 1 Pubic bone Tumour ProstateBladderSeminal vesicles Rectum ©2018 patients.uroweb ALL RIGHTS RESERVED Stage 2 Pubic bone Bladder Seminal vesicles Rectum Tumour in two prostate lobes ©2018 patients.uroweb ALL RIGHTS RESERVED Stage 3 Tumour ProstatePubic bone Bladder Seminal vesicles Rectum ©2018 patients.uroweb ALL RIGHTS RESERVED- 6 - Sometimes, cancer cells are found in the pelvic lymph nodes but have not spread elsewhere in the body. This is called node-positive disease, rather than a metastatic disease, as the cancer cells have not spread to other lymph nodes or organs around the body. Node-positive disease can be treated. You may be offered surgery to remove the diseased lymph nodes, radiotherapy of diseased lymph nodes and/or hormone therapy . What do grades of cancer mean? Stages and grades are different. Stages inform your doctor of the size of the tumour and how far the cancer cells have spread. Grades give your doctor an idea of how fast the tumour might grow, and cancer might spread. In general, a lower grade indicates slower-growing cancer, and a higher grade indicates a faster-growing one. If you have been diagnosed with prostate cancer, your doctor may refer to your “ Gleason score ” which is a common way of grading prostate cancer. Your Gleason score will help your doctor plan and discuss your treatment options with you. Your doctor may also refer to an “ ISUP grade ” . This is another tool used for grading cancer. Risk of prostate cancer What increases the risk of getting prostate cancer? Four main risk factors increase a man’s chance of developing prostate cancer. If you feel you have any risk factors for developing prostate cancer, you should speak to your doctor. Age Age is the biggest risk factor for prostate cancer. In Europe, prostate cancer is commonly diagnosed in men over 65, but it can happen in younger men. Ethnicity Black men have twice the risk of developing prostate cancer than white men. Asian men, on the other hand, have a lower risk. It is unknown why a man’s ethnicity or race increases or lowers his prostate cancer risk.Metastatic disease Brain metastasis Bone metastasisSpinal metastasisLung metastasis Liver metastasis Prostate tumourPelvic lymph nodes ©2018 patients.uroweb ALL RIGHTS RESERVED Gleason score The Gleason score is used after a biopsy has been taken and a pathologist has looked at the cells. The score helps your doctor predict how the cancer might behave and the treatment you need. ISUP grade The International Society of Urological Pathology (ISUP) grade categorises prostate cancer into 5 groups from 1 to 5. The lower the ISP grade, the better your prognosis is.Stage 4 Bladder neck Tumour Urinary sphincterPubic bone Rectum ©2018 patients.uroweb ALL RIGHTS RESERVED- 7 - Genes Genes are made of DNA. They contain “information” that determines our traits. For example, having red hair is a genetic trait passed from generation to generation. Processed foods Processed foods include ready meals, takeaways, savoury snacks, cakes, and biscuits. Obese Obese means you are very overweight, with a lot of body fat, which puts you at risk of serious health problems.Family history We all inherit our genes from our parents.

Some prostate cancers may be linked to genes passed from generation to generation by either parent. Although a man's risk of developing prostate cancer increases if he has a family history, most men who get prostate cancer do not have a family history. If you have close family members diagnosed with prostate cancer under the age of 60 and are concerned about your risk, speak to your doctor. Diet It is well-known that eating a balanced diet and doing regular physical exercises keeps you healthy. A balanced diet includes eating plenty of vegetables, fruit, and fibre, and limited red meat, processed foods , high-fat foods, sugar, and alcohol. Men who are very overweight or obese may increase their risk of developing prostate cancer. Symptoms What are the symptoms of prostate cancer? Prostate cancer may cause no signs or symptoms in its early stages. More advanced prostate cancer may cause signs and symptoms, such as: • difficulty passing urine • a less powerful stream of urine • blood in the urine • blood in the semen • bone pain (commonly in the back) • losing weight without trying • problems controlling bowel movements • erection problems called erectile dysfunction Difficulty passing urine and a less powerful stream of urine are commonly caused by an enlarged prostate, called benign prostate enlargement, or BPE (previously called benign prostatic hyperplasia or BPH). BPE is not cancer and is a treatable condition. If you or a family member are experiencing any of the above symptoms, it is important to get a prostate check . It can feel frightening when you experience symptoms that may be cancer, but it is always best to get checked. How should I approach my doctor? If you feel frightened, anxious, or embarrassed about prostate problems, it is always best to speak to your doctor. If you have previously visited the doctor but not managed to talk about your symptoms, now is the time to speak up. It is important to find the words that are right for you. We have listed some potential "icebreakers" for you below. Why not say them aloud and see which one feels the most natural to you. You may even find rehearsing what you want to say boosts your confidence and comfort level.- 8 - • I want to ask you about a men's health issue • I'm having some problems that I want to talk to you about • I think I might have a prostate problem • I'm having some problems peeing/weeing • I'm having some problems getting/keeping an erection • My friend/brother/father/uncle has been diagnosed with prostate cancer • I'm worried about prostate cancer • I've had blood in my pee/wee/semen Just remember, your doctor is a healthcare professional. He/she will listen to you and discuss the best way forward. Tests What checks and tests are available for prostate cancer? While you may have heard about "screening" for cancer, for example, mammograms to check for breast cancer, not all countries have a prostate cancer screening programme. For this reason, it is very important to get a prostate check if you have any of the known symptoms or family history of prostate cancer. Digital rectal examination (prostate check) A prostate check, or digital rectal examination, is a quick and simple test to see if you might have a prostate problem. It involves your doctor inserting a gloved and lubricated finger into your back passage (rectum) to feel your prostate. Digital rectal examination We realise this might seem embarrassing, but the examination is over very quickly. You may be aware of some pressing and get a brief urge to pass urine, but the examination itself is not usually painful. Prostate-specific antigen (PSA) test Prostate-specific antigen or PSA is a protein produced only by the prostate. A PSA test is a simple blood test that measures the amount of PSA protein in your blood. It can help to diagnose or rule out prostate cancer as a cause of your symptoms. If PSA levels in the body are high, it could be a sign that something abnormal is happening in the prostate. High PSA levels do not mean you have prostate cancer, but high PSA levels should be investigated to rule out prostate cancer. Download our PSA testing leaflet for more information. What happens if you are 'at risk' of prostate cancer? There is no single test for prostate cancer. Your doctor will discuss the available tests with you and use the results to see if you are "at-risk" of having prostate cancer. Your risk is based on several factors, including your PSA level and the results of your prostate examination, as well Digital rectal examination to feel the size, shape, and consistency of the prostate. ProstateRectum Protein Proteins are found in every cell in the body. PSA level PSA is a protein made only by the prostate gland. The amount of PSA in your blood is called your PSA level.- 9 - as your age, family history, and ethnic group. If you are "at risk," you should be referred to a hospital to discuss further tests. Such tests might include an ultrasound, CT scan, MRI scan, or bone scan. MRI Magnetic resonance imaging, or MRI scan, creates pictures of the inside of your body using magnets and radio waves. An MRI scan provides a detailed look inside your prostate. The results will help your doctor decide if you need to have a biopsy. It may also help your doctor find out if any cancer cells have spread to other parts of your body. During the MRI scan, you will be asked to lie on the scanner bed. The scan itself can take some time (30 to 40 minutes) to complete. The bed will move into the scanner, which is like a narrow tunnel. There is a 2-way intercom inside the scanner, so you will be able to communicate with the radiographer the whole time. You will also be given a device to hold in

your hand with a panic button. If you feel anxious during the scan, just let the radiographer know by pressing the button. The scan itself is painless, but it can feel uncomfortable as you have to lie very still. It is also very noisy inside the scanner, and you will be given ear defenders to wear. Some people find it claustrophobic inside the scanner and have said wearing a sleep mask helped ease their fear. Having an MRI scan You may need to have an injection of dye, called a contrast. The dye helps tissue inside your body show up more clearly on the scan. This is usually given via a cannula in your arm. You may feel the dye passing through your veins as either a warm or cold sensation. Some men have said it feels as though you will lose bladder control. So although this won't happen, it can feel uncomfortable, but it is not painful. CT scan Computed tomography, or CT scan as it is commonly known, uses x-rays taken at different angles. These x-rays are sent to a computer which creates a 3-dimensional (3D) image of the inside of your body. A CT scan does not take very long to complete. The results may help your doctor find out if any cancer cells have spread to other parts of your body.Radiographer A radiographer is a healthcare professional who is a specialist at diagnosing illness and injuries using x-ray images. Cannula A cannula is a thin tube inserted into a vein. MRI scanner CT scanner ©2021 patients.uroweb ALL RIGHTS RESERVED ©2021 patients.uroweb ALL RIGHTS RESERVED MRI scan CT scan- 10 - During the CT scan, you will be asked to lie on the scanner bed. The bed moves forwards and backwards through the hole of the scanner. You will be able to communicate with the radiographer the whole time. Having a CT scan You may need to have an injection of dye, called a contrast. The dye helps tissue inside your body show up more clearly on the scan. This is usually given via a cannula in your arm. You may feel the dye passing through your veins as either a warm or cold sensation. Some men have said it feels as though you will lose bladder control. So although this won't happen, it can feel uncomfortable, but it is not painful. Bone scan Your doctor might recommend that you have a bone scan to determine if cancer cells have spread to your bones. Before the bone scan, you will need to have radioactive dye injected into a vein in your arm or hand. Only a small amount of radioactive dye is used, and it is safe. You will need to wait for 2 to 3 hours for the dye to travel through your veins and into your entire body before the scan itself takes place. During the bone scan, you will be asked to lie on the scanner bed. The scanner will move very slowly down your body and take pictures. The scanner will pick up any abnormal areas of bone, called "hot spots." Not all bone abnormalities are cancer, and the scanner may pick up other conditions, such as arthritis. Having a bone scan This can be an extremely stressful time for you, especially waiting for the results. If you are struggling to cope, try not to hide your emotions. Talk to your family and friends. If you have not done so already, speak to your doctor about professional support, such as counselling services or local support groups. PSMA PET-CT Scan PET-CT scans use a mildly radioactive drug to show up areas of your body where cancer cells are more active than normal cells. Prostate-specific membrane antigen, or PSMA, is a protein found on the surface of prostate cancer cells. PSMA PET-CT scans look for areas of the body where the PSMA protein is found, showing the presence of prostate cancer cells. Although PSMA PET-CT scans are not commonly used, there is evidence to suggest that this type of scan is more accurate than others at detecting if your cancer has spread to other parts of the body. In time, PSMA PET-CT scans will likely become the standard scans used to detect the extent of prostate cancer spread throughout the body.Radiographer A radiographer is a healthcare professional who is a specialist at diagnosing illness and injuries using x-ray images. Cannula A cannula is a thin tube inserted into a vein.Bone scanner ©2021 patients.uroweb ALL RIGHTS RESERVED Bone scan- 11 - Ultrasound An ultrasound uses sound waves to send images to a computer. This allows your doctor to see inside your body. An ultrasound of your prostate involves your doctor or a sonographer inserting a lubricated wand-like device, called a probe, into your back passage (rectum). The examination does not take long. It might feel uncomfortable, but it is not usually painful. Biopsy A biopsy of the prostate is the most accurate way of seeing if you have prostate cancer. However, a biopsy involves your doctor using a thin needle to take small tissue samples from your prostate. Because of this, a biopsy is only done when other tests strongly suggest you have prostate cancer. Biopsy samples are sent to a laboratory where a pathologist looks at them under a microscope to check for cancer cells. The results will help your doctor plan and discuss your treatment options with you. There are 2 main types of prostate biopsy: 1. a trans-rectal ultrasound biopsy, or TRUS 2. a trans-perineal biopsy It is important to discuss the risks and benefits of each procedure with your doctor to make sure it is the right one for you. Trans-rectal ultrasound biopsy (TRUS) During a TRUS biopsy, your doctor will insert a lubricated ultrasound probe into your back passage (rectum). The ultrasound probe scans the prostate, and an image appears on a screen. The doctor uses this image to guide where to take the biopsy from. You will be given a local anaesthetic to numb the area and minimise any discomfort from the procedure.

Patients who have a TRUS biopsy are at risk of developing a severe infection, known as sepsis. You will be provided with detailed information about the known risks before you consent to have the procedure done. Trans-perineal biopsy Your doctor will insert a lubricated ultrasound probe into your back passage (rectum) to see the prostate during a trans-perineal biopsy. The biopsy needle will then be passed through the skin between the testicles and the back passage. A trans-perineal biopsy is commonly done under local anaesthetic , so the area will be numbed to minimise any discomfort from the procedure. It is becoming more popular because it is thought to have a lower risk of serious infection.Sonographer A sonographer is a healthcare professional who is a specialist at performing ultrasounds. Pathologist Pathologists are doctors who diagnose diseases by examining cells and tissue samples. Probe A wand shaped device that produces sound waves which send images to a computer. This allows a doctor to see inside the body. Local anaesthetic A local anaesthetic temporarily numbs an area of the body. It is usually given as an injection.- 12 - Common treatments What treatments are available for prostate cancer? There are different treatments for prostate cancer. The treatment you are offered will vary depending on your age, overall health, and your tumour's stage and grade. Your doctor will discuss the results from your diagnostic tests and your treatment options with you. The main treatments include monitoring the cancer, surgery to remove the prostate, radiotherapy, and hormonal therapy. What are the most common side effects of prostate cancer treatments? The prostate is close to the bladder and rectum. It is surrounded by a delicate network of nerves and blood vessels that enable you to get an erection. Treatments for prostate cancer can affect your urinary, bowel, and sexual functioning. It is important to communicate with your doctor about any side effects you are experiencing as you undergo treatment. Ongoing communication will enable your doctor to manage your side effects as early as possible. Leaking urine It is normal to experience some loss of bladder control (called urinary incontinence) and leak urine after surgical or radiation treatment, but for most men, this will improve over time. For more information, see our section on what it is like living with prostate cancer . Bowel problems Damage to the rectum caused by surgery or radiation therapy can lead to bowel problems, including bleeding from the rectum, diarrhoea, or an urgency to go to the toilet. But this is very rare. Some men find they have softer stools during radiotherapy, but this resolves in time after the treatment has stopped. Erectile dysfunction Some treatment can damage the nerves and blood supply to the penis, making it difficult to get or keep an erection, called erectile dysfunction. Unfortunately, erectile dysfunction is the most common side effect of prostate cancer treatment. However, there are options for managing this during treatment. Most men (with intact nerves) see an improvement over time once treatment has stopped. For more information, see our section on what it is like living with prostate cancer . Monitoring cancer Monitoring means your doctor will keep a close eye on you rather than recommending treatment straight away. You may feel fearful or angry about monitoring your cancer rather than receiving treatment. But all treatments have side effects, and your doctor will not recommend treatment if he or she believes the risks outweigh any benefit you might get. There are two types of monitoring. Check with your doctor which type you are being offered.Diagnostic tests Diagnostic tests are used to confirm or rule out conditions and diseases. They can include blood tests, scans, and biopsies. With intact nerves If you are undergoing surgery, depending on the stage and grade of your cancer, you may be offered nerve-sparing surgery. Nerve-sparing surgery aims to reduce the risk of erectile dysfunction and leaking urine. Unfortunately, some cancers cannot be removed without cutting or damaging the nerves, meaning you might always need treatments to help get an erection. - 13 - Active surveillance The aim of active surveillance is to avoid unnecessary treatments. If your doctor has recommended active surveillance, you have low-risk prostate cancer, which has been found at an early stage. Your doctor does not anticipate that the cancer will cause you any immediate symptoms or problems. Active surveillance may continue for many years if your prostate risk does not increase, but it requires you to follow a scheduled regime which includes PSA tests, prostate checks, as well as an MRI and/or repeated prostate biopsies. Up to half of men on active surveillance never need treatment. If the tests show that your tumour is growing or changing at any stage, you will be offered treatment. Your treatment options, such as surgery, will aim to cure the cancer. Watchful waiting The aim of watchful waiting is to delay or to avoid the side effects of treatment. If your doctor has recommended watchful waiting, you may not be well enough to have surgery or radiotherapy. It could also be because your doctor does not anticipate that the cancer will cause any problem in your lifetime. Your doctor will prepare a follow-up plan with you, including what checks and tests you will have and how often. Some men on watchful waiting may still need treatment. If the tests show that your tumour is growing at any stage, or the cancer cells have started to spread to other organs, you will be offered treatment. The treatment offered will aim to control the spread of the cancer

and manage any symptoms you have. Surgery Radical prostatectomy You may be offered an operation to remove your prostate, called a radical prostatectomy. There are 3 different ways of removing the prostate: laparoscopic or “keyhole” surgery, robot-assisted keyhole surgery , or open surgery . Your doctor will discuss the surgery method, which is most appropriate for you. A radical prostatectomy is a major operation, and each method has its risks. The aim of the surgery is to cure the cancer. Radiotherapy Radiotherapy uses high energy x-ray beams (radiation) to destroy cancer cells. There are two different types of radiotherapy: 1. external beam radiotherapy 2. brachytherapy Radiotherapy treatment is painless, but there are side effects caused by both types of treatment that may cause you problems. Your doctor will discuss your options and the potential side effects with you. External beam radiotherapy External beam radiotherapy uses a machine, called a linear accelerator, or LINAC, to give the radiation treatment from the outside of the body. Using the machine, the radiographer can direct the treatment to an exact point on your body. The aim is to destroy the cancer cells inside your Laparoscopic During laparoscopic, or keyhole, surgery, a surgeon will remove the prostate using several small cuts in your tummy. The surgeon will also use a small camera, called a laparoscope, to help them see the prostate clearly during the procedure. Robot-assisted keyhole surgery Robot-assisted keyhole surgery is done by trained surgeons, so it is only available in certain hospitals. It is sometimes called RARP or RALP. During the procedure, the surgical equipment is attached to robotic arms, which are controlled by the surgeon. Open surgery Open surgery involves one large cut into your tummy or the area between your scrotum and back passage. Radiographer External beam therapy is given by a trained therapeutic radiographer. Therapeutic radiographers specialise in treating cancer using radiotherapy techniques.- 14 - External beam radiation therapy Machine Radiation beamProstate Rectum Urethra and the surrounding areaPossible positions of the machine body without damaging healthy tissue or organs. External beam therapy is often given in addition to other prostate cancer treatments, particularly hormone treatments (also called Androgen Deprivation Therapy or ADT). Having external beam radiotherapy treatment Before you have external beam radiotherapy, you will need a CT scan . The results will help the radiographer work out the exact point and dose of radiotherapy. A permanent mark will be made on your skin to ensure the radiation beam is directed to the same position at every treatment session. Brachytherapy Brachytherapy is a radiation treatment given from the inside of the body. Small, radioactive metal pieces, commonly referred to as “seeds,” are inserted directly into the prostate under a general anaesthetic . Radiation is slowly released from the seeds over a few months. The radiation destroys the cancer cells inside the prostate, but it limits radiation that reaches the nearby tissues and organs. Your doctor will discuss any concerns you might have about radiation and advise on modern techniques to reduce this risk. Having brachytherapy During the procedure, an ultrasound probe will be passed into your back passage (rectum). This helps the doctor work out how many seeds to inject into the prostate and exactly where they should be placed. The stage of your cancer will determine the dose of radiation your doctor advises. Hormone therapy Testosterone causes prostate cancer to grow, so the most common way of controlling how much testosterone there is in your body is to have hormone therapy. This is also known as androgen deprivation therapy or ADT. Your doctor may recommend hormone therapy to reduce the amount of testosterone in your body. It is usually available as injections, implants, tablets, or a nasal spray. CT scan A CT scan uses x-rays taken at different angles to a 3D image of the inside of your body. General anaesthetic A general anaesthetic is a controlled way of forcing you to fall asleep, so you are unaware of the procedure being done. Testosterone A hormone, or chemical, made by the testicles which controls how the prostate works. BrachytherapyBladder Prostate Balloon catheterRadiation source (“seeds”) Needle to insert the seedsTemplate Rectum Ultrasound probe - 15 - Some men may have hormone therapy before, during, or after radiotherapy or chemotherapy . Other men may only have hormone therapy. Hormone therapy is used for all prostate cancer stages, but it is the main treatment for men with advanced prostate cancer . Your doctor will discuss your treatment options with you. LHRH agonists LHRH agonists are usually given as injections or implants. They work by blocking messages from the brain that tell your testicles to make testosterone. Treatment with these drugs is sometimes called “chemical” or “medical castration.” This is because the effect on the body is the same as having your testicles removed. Common LHRH agonists are shown below. All drugs have a generic name and a name given by the pharmaceutical company that produces them. This is called a trade name. Generic name Trade name(s) Buserelin Suprefact® Goserelin Zoladex®, Reseligo® Leuprorelin or Leuprolide Eligard®, Staladex®, Enanton®, Prostap®, Lucrin®, Lutrate® Triptorelin Decapeptyl SR®, Salvacyl®, Diphereline®, Gonapeptyl® Your doctor will discuss which LHRH agonists treatment

is recommended for you. It is common for the body to produce a testosterone surge when you first start LHRH agonist treatment. This is called a “flare”. Flares can make your symptoms worse to begin with, and they may cause the tumour to grow quickly for a short time. Because of this, you will also be given tablets to take, known as anti-androgen . These tablets stop testosterone from reaching the cancer cells, so they cannot grow. LHRH antagonists LHRH antagonists work in a slightly different way to LHRH agonists. They prevent the testicles from making testosterone but do not cause flares as LHRH agonists do, so you will not need to take anti-androgen tablets. Degarelix (Firmagon®) is the LHRH antagonist treatment available in Europe. It is given as a monthly injection under the skin. Orchidectomy Some men may be offered an operation to remove their testicles. This is called an orchidectomy, or surgical castration. An orchidectomy is a straightforward operation. It is usually done using a local anaesthetic, but it can be done under a ‘general’ anaesthetic. With both types of anaesthesia, you will not feel anything during the surgery. If you have a ‘local’ you will be awake the whole time and if you have a ‘general’ you will be asleep during the procedure. Once done, an orchidectomy cannot be reversed, so you need to be sure this is the right treatment option for you. Advanced prostate cancer Cancer that has spread from the prostate to other parts of the body through the bloodstream. LHRH Luteinising hormone-releasing hormone (LHRH).- 16 - Anti-androgens Anti-androgens are a group of drugs that stop testosterone from entering the cancer cells, preventing the cells from growing. They are usually given alongside other hormone treatments or radiotherapy . But you may be offered anti- androgen treatment on its own to see if it will shrink your tumour. If you are prescribed anti-androgen tablets, you will also need to have regular blood tests. This is to check your levels of blood cells and how well your liver and kidneys are working. Your doctor will discuss which anti-androgen drug best manages your stage of prostate cancer. You may want to know the names of the different anti-androgen drugs that may be available to you. Please be aware that some of the drugs listed may not be available across the whole of Europe. Generic name Trade name(s) Bicalutamide Casodex®, Bicalutamid® Flutamide Flutasin®, Flutamid® Nilutamide Anandron® Cyproterone Cyprostat® Apalutamide Erleada®, Erlyand® Darolutamide Nubeqa® Enzalutamide Xtandi® Abiraterone Abiraterone (Zytiga®, Yonsa®) is a different type of hormone therapy. It is usually offered to men with advanced prostate cancer whose cancer does not respond to other treatments. It is taken as tablets rather than injections. Like other hormone treatments, it works by stopping the body from producing testosterone, but differently from other treatments. Abiraterone treatment is not a cure, but it can help keep the cancer under control and help with some of your symptoms. If you choose to take abiraterone, you will also have to take steroid tablets. Taking steroids in combination with abiraterone will lower your chances of having side effects of the treatment. Chemotherapy Chemotherapy is usually offered to men who have been diagnosed with advanced prostate cancer and are fit enough to tolerate the treatment. Chemotherapy is not a cure, but it can help keep the cancer under control. Common chemotherapy drugs include: 1. Docetaxel 2. Cabazitaxel Chemotherapy is a powerful medication that destroys cancer cells in the body. It is given directly into your bloodstream through a vein. The drug travels around your whole body, killing any cancer cells it finds. Sometimes healthy cells can also get damaged during treatment.Advanced prostate cancer Cancer that has spread from the prostate to other parts of the body through the bloodstream.- 17 - Chemotherapy can cause various unpleasant side effects. Each man reacts differently to the treatment but choosing to have chemotherapy is not an easy decision. Take your time discussing the potential side effects and benefits with your doctor, as well as your family. Other treatments High intensity focused ultrasound (HIFU) High intensity focused ultrasound, or HIFU, uses ultrasound beams to generate heat, destroying areas of the prostate containing cancer cells. It is usually only given to men with early-stage prostate cancer. The treatment can be given to the whole prostate if you have several tumours or given to a small area of the prostate. Both methods are done under a general anaesthetic or a spinal anaesthetic . During the procedure, an ultrasound probe is gently passed into the back passage (rectum). The probe is surrounded by a cooling balloon to protect your back passage from the heat. As well as generating heat, the probe also produces ultrasound images of the prostate. This helps your doctor see the tumour(s) more clearly. Having HIFU treatment HIFU is a specialised technique and is not available in all hospitals. In some countries, HIFU may be available as part of a clinical trial. Cryotherapy Cryotherapy involves having thin needles inserted into the prostate through the skin between the testicles and the back passage (rectum). Once in place, gas is passed through the needles and freezes the tumour(s), destroying the cancer cells inside. It is usually only given to men with early- stage prostate cancer. The treatment can be given to the whole prostate if you have several tumours or given to a small area of the prostate. Both methods are done under a general anaesthetic or a spinal anaesthetic . HIFU treatment Balloon

catheterBladder HIFU probeProstate Tumour Rectum ©2018 patients.uroweb ALL RIGHTS RESERVED Early-stage Early stage cancer means your cancer is Stage 1 or Stage 2. This means the tumour is contained, or “localised” in your prostate. General anaesthetic A general anaesthetic is a controlled way of forcing you to fall asleep, so you are unaware of the procedure being done. Spinal anaesthetic A spinal anaesthetic numbs the lower half of your body, so you will not be able to feel anything during the procedure.Cryotherapy Balloon catheterBladder Needle to apply the freezing temperaturesTemplate Rectum Ultrasound probeProstate after CSAP ©2018 patients.uroweb ALL RIGHTS RESERVED- 18 - Having cryotherapy treatment During the procedure, an ultrasound probe is gently passed into the back passage. The probe produces ultrasound images of the prostate to help your doctor see the tumour(s) more clearly and make sure the needles are inserted correctly. Cryotherapy is a specialised technique and is not available in all hospitals. In some countries, cryotherapy may be available as part of a clinical trial. Living with cancer What is it like living with prostate cancer? Living with prostate cancer can affect your everyday life, work, and relationships. You may experience side effects from treatment, even when the treatment has finished, which can affect your physical health. You may also be worried about your cancer coming back, which can greatly impact your mental health. It is important to know that you are not alone. Talk to your doctor about local support groups or counselling services that may be helpful to you and your loved ones. Physical and emotional effects Extreme tiredness Extreme tiredness, or fatigue, is very common in men with prostate cancer and can affect everyday tasks, social activities, sleep, and overall concentration. If you are feeling fatigued, you should not drive. Some men cope better with fatigue than others. If you are usually active, you may feel frustrated by an extreme lack of energy. These feelings are normal. Sometimes small changes to help improve your fatigue can help you feel in control of your cancer. Leaking urine If you have had surgery to treat your prostate cancer, then you may find you leak urine. This is entirely normal. Some men find they only leak a little, and some men find they leak a lot. For most men, the leaking lessens over time. Leaking urine can feel embarrassing, but there are products you may find helpful. Incontinence pads line your underwear and absorb any leaking urine. They are discrete, so no one will know it is there. Talk to your doctor about other treatments and products that may be helpful to you. Difficulty passing urine If you are having difficulty passing urine, it may be because your tumour is causing your prostate to press against the urethra. Your doctor may recommend medication or an operation to remove part of your prostate, called a trans- urethral resection of the prostate, or TURP. This operation will not cure your cancer but will help you pass urine much more easily. Sex and relationships Being diagnosed with prostate cancer can affect your desire for sex. You might feel down, angry, or stressed, and these emotions can change your feelings about sex. Urethra The urethra is the tube that empties urine from the bladder.- 19 - Some treatment can damage the nerves and blood supply to the penis, making it difficult to get or keep an erection, called erectile dysfunction . If you have had hormone therapy , this can also affect your desire for sex. If you have a partner, talking about sex and how you are dealing with your cancer can help. It can be difficult talking about sex, but your doctor can help you get treatment and support. Emotions Being told you have cancer can be a big shock, even if you had prepared yourself for the possibility of your tests being positive. Advances in science, medicine, and technology mean that many people are cured of cancer or live with it for many years. Despite this, a cancer diagnosis can cause different fears and emotions for you and your loved ones. Living with prostate cancer can affect your everyday life, work, and relationships. If you are struggling to cope, try not to hide your emotions. Talk to your family and friends. If you think speaking to a professional might help, ask your doctor for the details of local counselling services to get you the help you need. Hormone changes Testosterone is mainly made by the testicles and controls how the prostate works. Hormone therapy lowers the amount of testosterone in your body, which can affect your overall mood, including your desire for sex. You may feel tearful or angry, or just not your usual self. These feelings are normal and can be caused by hormone therapy. Practical issues Will I be able to work? For some men, returning to work helps them get back to everyday life. But not everyone can continue working. You may decide to work part-time or take early retirement. There is no right or wrong answer. You may need to take time off work, depending on the treatment options offered to you. You may also need to take extra breaks at work, particularly if you are feeling exhausted. You might find it helpful to look at your company policies and employee handbook or speak to the Human Resources department at your workplace for more advice. Will I be able to travel? If you drive, you need to be very careful about how your treatment is affecting you. Do not drive if you are tired or do not feel well. If you plan to travel abroad, having cancer can affect where you go and how long you go away. Having cancer should not stop you from travelling. Still, it may affect travel insurance, car hire insurance, what

you need to take with you, and the activities you do while you are away. Palliative care If you have advanced prostate cancer , you may hear the term supportive, or palliative, care. The focus of palliative care is to manage any pain you have and help find ways of coping with distressing symptoms. It also provides support for your family and for people looking after you. Palliative care is not just for men in the final stages of their life, but it does include support to help you prepare for this. Various professionals will be on hand to help manage Advanced prostate cancer Cancer that has spread from the prostate to other parts of the body through the bloodstream.- 20 - your symptoms and offer you and your family the emotional and practical support you need. The type of professionals and services available to you will depend on your needs and your local area. Recurrence What happens if the cancer comes back? It can be extremely difficult to find out that your cancer has come back. All of the thoughts and feelings you had when you were first diagnosed can come back too. These feelings and fears may even be stronger than before. Some men find that using the same coping mechanisms they did during their first cancer diagnosis helps them deal with another cancer diagnosis. For many men, even when the cancer comes back after treatment, it may still be slow-growing, and they continue to live long and active lives. Your doctor will discuss your treatment options with you. If your cancer has come back, you may hear it called “recurrence,” as well as other terms like local, locally-advanced, regional, distant, or metastasis. These terms can feel very overwhelming. Local recurrence The new tumour is in the prostate again. The cancer has not spread to other parts of the body. If you have local recurrence, you might be offered further treatment to get rid of the cancer again. Regional or locally-advanced recurrence The cancer has spread to the area just outside the prostate, but it has not spread to other parts of the body. You might be offered further treatment to get rid of the cancer again. Distant or metastatic recurrence The cancer has spread, or “metastasised,” to other parts of your body. There may also be cancer cells in your blood or bones. Treatment can no longer cure the cancer. Hearing that your cancer cannot be cured is distressing and can be a shock. There still may be treatments to help control the spread of the cancer cells, such as hormone therapy or chemotherapy . Your doctor may start talking to you about supportive or palliative care . The focus of palliative care is to manage any pain you have and help find ways of coping with distressing symptoms. Palliative care is not just for men in the final stages of their life. Men with metastatic recurrence may receive palliative care for many months or years.- 21 - My notes and questionsThe development of this chapter was funded by Ferring Pharmaceuticals. Its content has been independently developed and approved by the EAU Patient Office. European Association of Urology PO Box 30016 NL-6803 AA ARNHEM The Netherlands e-Mail: info.patientinformation@uroweb.org Website: patients.uroweb.orgPSA: Why should I get tested? Information for Patients English- 2 - What is the Prostate? Table of contents This leaflet was produced by the EAU Patient Information Working Group. It contains general information about prostate cancer detection and does not replace an individual consultation. Decision aid tools exist to help you decide whether or not to start an early detection pathway. None of these tools replace a consultation with your doctor. Talk to your doctor about the pros and cons of prostate cancer early detection before you decide if you want to be tested. If you have any specific questions about your individual medical situation you should consult your doctor or other professional healthcare provider. Author Dr. Selçuk Sarikaya, Ankara, Turkey Reviewers Dr. Mark Behrendt, Utrecht, the Netherlands Mr. Phil Cornford, Liverpool, United Kingdom Ms. Franziska Geese, Berne, Switzerland Prof. Nicolas Mottet, Saint-Etienne, France Dr. Ricardo Pereira E Silva, Lisbon, Portugal Prof. Monique Roobol, Rotterdam, the Netherlands Prof. Dr. Hendrik Van Poppel, Leuven, Belgium Mr. André Deschamps, Europa Uomo, Brussels, Belgium You can find detailed information about the diagnosis and treatment of prostate cancer at our website: http://patients.uroweb.org/prostate cancer This information was last updated in February 2020.- 3 - What is the Prostate? • The prostate is a gland located in the lower urinary tract, under the bladder and surrounding the urethra • Only men have a prostate • It produces the fluid that makes up a part of the semen. The prostate helps to push out the semen during ejaculation. It is part of the male reproductive system. • A healthy prostate is about the size of a walnut

and has a volume of 15-25 millilitres (ml) What is prostate cancer? Prostate cancer is an abnormal cell growth in the prostate that can spread uncontrollably into surrounding tissues and to other parts of the body through the bloodstream or lymph nodes. In 2018 more than 450,000 new prostate cancer cases were diagnosed and over 100,000 men died of prostate cancer in Europe. Prostate cancer-related deaths are among the top three of cancer deaths for men. In recent years prostate cancer related deaths are rising again despite the existence of screening methods. That is why the EAU recommends PSA (Prostate Specific Antigen) testing for the early detection of prostate cancer.Unless it is far advanced, prostate cancer shows no clear symptoms (asymptomatic) and men are normally not aware it has developed. If the disease is not discovered and diagnosed in its early stages, men can develop symptoms such as bone pain due to the cancer spreading. Early detection is aimed at finding this asymptomatic cancer in an early stage where it can still be cured and stopped from moving to an advanced stage. What is PSA? Prostate-specific antigen, or PSA, is a protein produced by the prostate gland that is present in the male's blood. PSA levels rise when there is a benign enlargement of the prostate, or an infection of the prostate, also known as prostatitis, or prostate cancer. Who should get tested? Prostate cancer early detection should be offered to healthy and well informed men over the age of 50 and men over 45 years of age, who have a known family history for prostate cancer or are of African descent. Sometimes, depending on your personal situation, there are reasons not to be tested. Talk to your family doctor about the pros and cons of prostate cancer early detection before you decide whether to be tested or re-tested, especially if you have other health concerns. How is testing done? Testing should always involve: • PSA testing (blood test) • Digital rectal examination (DRE) A digital rectal examination is used to check the prostate for any abnormalities. It involves a healthcare provider feeling the prostate by inserting a finger into the rectum (Fig. 2). PSA testing is one of the most often used tools to diagnose prostate conditions. The PSA-level is determined by a blood sample to test the risk of prostate cancer. Depending on the PSA Testing Fig. 1: Pathway of sperm. ©2020 patients.uroweb ALL RIGHTS RESERVED Ureter Seminal vesicle Ejaculatory duct Prostatic urethra Prostate glandBladder Vas deferens TesticlesEpididymisUrethra- 4 - PSA-level (normal or elevated) further testing may not have to happen or, more testing may be needed. If your PSA is too high or if the digital rectal examination feels abnormal, it may mean you are at risk of having prostate cancer. Together with your healthcare professional and according to your risk and medical history, the next step may be: • to repeat the PSA test to make sure the elevated level is not temporarily e.g. caused by an inflammation • to use a risk prediction tool which, on the basis of more information, such as your age and size of the prostate (next to the digital rectal examination and the PSA test), calculates your personal risk of having prostate cancer • to perform an MRI of the prostate which produces a detailed image of your prostate, enabling your doctor to see if there are any potential suspicious areas If considered needed, these exams might lead to a prostate biopsy. A biopsy involves taking samples of the prostate with a needle to look at under a microscope. The tissue is looked at to see if it has cancer and if so, how aggressive it is. I feel healthy, why should I be tested? PSA testing involves a simple blood test, your health insurance or national health service will normally cover the costs and it can be done by your family doctor or urologist. It will show if you are at risk of getting prostate cancer and is the only way for finding it early. Based on your personal risk and other conditions you may have, you can determine an early detection strategy/interval together with your family doctor. This means that you are tested at set times. Are there other reasons for the PSA value to be elevated? Yes. The PSA value that is found in your blood, is a single current view of your PSA level. Any form of prostate irritation can cause test values to be high. Benign, or non-cancerous enlargement of the prostate, a lower urinary tract infection or prostate irritation (sports, intercourse, urinary catheter) may lead to PSA elevation. Earlier values, medical history and risk factors are therefore important when thinking about retesting or further diagnostics. Benefits • A PSA test may help find prostate cancer at an early stage. Cancer is easier to treat and is much better managed if it is found in its early stages. • It will also let you know if you are at risk of getting prostate cancer in the future. Limitations • A PSA level that is high does not always mean that you have prostate cancer (a false-positive result). Other conditions you may have can raise PSA levels such as an enlarged prostate or a prostate infection • In few cases, the PSA level may be low even though cancer is present (a false negative result) • PSA testing may find a cancer that would never have given symptoms. This is referred to as over-diagnosis: finding a cancer that is not likely to cause poor health or to present a risk to a man's life Potential risks of PSA testing Because of its limitations, PSA testing can possibly lead to unnecessary further testing (such as a biopsy) which, if prostate cancer is found, might then lead to overtreatment (such as an operation or radiation therapy). Many (40%) of the tumours would not end up causing major health problems. Follow-up of these

tumours is advised. This may lead to anxiety and stress. By not measuring your PSA, you will not risk false positive measurements and the resultant stress, retesting and biopsy, but this might also cause the missing of an early (treatable and curable) cancer. Late detection might mean the cancer is found at a more advanced stage with worse cure-rates.Fig. 2: digital rectal examination. ProstateRectum 5 - Summary • PSA testing helps finding prostate cancer at an early stage when it is more likely to be cured • Remember, not everyone with a high PSA level will have a cancer and not everyone who is found to have a cancer will need treatment • Talk to your family doctor about the risks and benefits and whether this test is right for youEuropean Association of Urology PO Box 30016 NL-6803 AA ARNHEM The Netherlands e-Mail: info.patientinformation@uroweb.org Website: patients.uroweb.orgThe impact of COVID-19 on men with prostate cancer across Europe COVID-19 is likely to disproportionally impact the same demographics as prostate cancer3,4,5 Reference number: ONC_2020_0099_APELet's Talk CAMPAIGNProstate Cancer The Let's Talk Prostate Cancer Campa ign The COVID-19 pandemic has led to unprecedented disruption of health systems, economies and everyday life.1 Healthcare systems across Europe have mobilised immense efforts to respond to the crisis and support those affected as well as their families and carers. It is a particularly worrying time for cancer patients as the impact of their condition and its treatment means that they are at an increased risk from the pandemic.1,2 The Let's Talk Prostate Cancer expert group is a pan-European initiative – organised and funded by Astellas Pharma Europe Ltd – bringing together representatives of stakeholder organisations from the EU prostate cancer community. Its aim is to raise awareness of the needs and challenges of those affected by prostate cancer across Europe. This document highlights the impact that COVID-19 has on those affected by prostate cancer as well as the unique opportunities for improving prostate cancer care that healthcare systems should consider as part of the long-term recovery from the pandemic. The impact of COVID-19 on prostate cancer patients COVID-19 appears to disproportionally impact the same demographics as prostate cancer.3,4,5 Early data suggest that older men, and especially those from a black and minority ethnic background, are more likely to die from COVID-19.4,5,6 This is the same part of the population that is also likely to be impacted by prostate cancer. Prostate cancer is already a major health challenge - responsible for 25% of all new male cancers and 10% of male cancer deaths, accounting for 107,000 deaths across EU Member States in 2018 alone.7,8 In the EU, more than two million people are living with prostate cancer.9 For every 100,000 people living in Europe in 2018, there were 159 new cases of prostate cancer diagnosed, compared with 145 new breast cancer cases.10,11 Nonetheless, policy attention to prostate cancer has remained low. What is more, prostate cancer is increasingly diagnosed at an advanced stage,11 with those affected often experiencing health inequalities,12 stigma13 and health system failures14 resulting in sub-optimal patient outcomes. Without policy action, there is a risk that COVID-19 will increase the challenges already facing prostate cancer patients across Europe: This project has been organised and funded by Astellas Pharma Europe Ltd. Date of preparation: July 2020 1Approximately 37,000 men may be affected by delays in diagnosis across Europe for every month of lockdown8 Date of preparation: July 2020 Reference number: ONC_2020_0099_APEMore than 2 million men are living with prostate cancer across Europe9Accessing prostate cancer diagnosis, treatment and support The severe disruption of the prostate cancer care pathway caused by COVID-19 is likely to further impact on patient outcomes: Delays in seeking help Accessing health services for non-COVID-19 reasons has become more challenging and many men with signs and symptoms of prostate cancer may have delayed seeking help because of these access hurdles, or because they are concerned about being exposed to the virus.14 This may mean that they are more likely to present with prostate cancer which has already spread. Delays in diagnosis Early data from clinical practice suggests that fewer patients have been seeking medical advice during the pandemic, which could lead to an increase in late or missed diagnoses for cancer patients in future.15 Approximately, 37,500 men are diagnosed with prostate cancer across Europe every month.8 This means that for every month of lockdown, these men may experience difficulties in receiving a timely and accurate diagnosis. Disruption of care support As part of the treatment pathway those affected often require ongoing monitoring and support either to evaluate the impact of their treatment or to assess whether their cancer has progressed, so that the right treatment can be provided at the right time.16 Delayed or postponed outpatient appointments can further increase anxiety and worry for those patients currently on active surveillance or progressive treatment plans.17 Delays in access to treatment Almost 9,000 men die every month across Europe as a result of prostate cancer.8 This illustrates the importance that those affected receive access to the right treatment at the right time. Prostate cancer treatments including surgery, chemotherapy and

radiotherapy have all been affected by COVID-19.17 This will create a backlog of patients requiring urgent treatment once healthcare systems have responded to the immediate pressures of the pandemic. In addition, many men with prostate cancer will be immuno- compromised and therefore require shielding. This is likely to create anxiety for men and their families, and additional complexities for the healthcare systems that support them. Health inequalities Those affected by prostate cancer are already experiencing healthcare inequalities that span across socio-economic and ethnic backgrounds,18 affecting every aspect of their care. With Black, Asian and minority ethnic (BAME) communities at an increased risk of dying or suffering serious ill-health as a result of COVID-19, the health inequalities faced by the prostate cancer community will further increase unless targeted action is taken to support affected communities in accessing help.4 2Stigma Treatment for prostate cancer can cause emotional distress, guilt, isolation and anxiety. Many patients feel uncomfortable talking about the condition to close friends, family and healthcare professionals.13 This stigma,13 together with a reluctance to engage with the healthcare system during this time of crisis might cause men not to seek the medical advice they require, further delaying access to vital support and treatment.17 This might not only lead to the progression of their disease but also impact on their mental and psychological wellbeing as a result of prolonged self-isolation and anxiety.14 The combination of disrupted prostate cancer services and the direct impact of the COVID-19 pandemic means that it is now more important than ever that the needs of prostate cancer patients and their families are not forgotten and addressed in a timely manner. The way forward: Supporting prostate cancer services recovery from the pandemic As healthcare systems respond to the pressures caused by the pandemic, there are examples of best practice emerging in prostate cancer care across Europe which should be emulated. It is vital that healthcare systems capitalise on these opportunities and make prostate cancer a central part of their COVID-19 recovery process. These innovations across the prostate cancer care pathway include: Increased care provision in the primary care setting: capacity pressures in the hospital setting caused by the pandemic have seen an increased role for GPs in the provision of care for those affected by cancer.19 As access to specialist care is likely to continue to be limited for some time, new care provision models including within the primary care setting should be considered. This will not only alleviate pressures across the prostate cancer care pathway but also enable easier access to care and support for those affected. Remote consultations for outpatients: the rapid transition from physical attendance at outpatient clinics to virtual appointments is resulting in new ways of delivering care within most healthcare systems across Europe. The pace and scale of this transformation varies but provides new opportunities to increase the accessibility, responsiveness and efficiency of care, particularly at a time when many patients may be concerned about attending hospitals. Adoption of digital technology: to support the move to virtual outpatient monitoring, healthcare systems have started to implement new technologies enabling better remote monitoring and facilitating patient self-evaluation and self-care. For men with prostate cancer, many of whom are undergoing active surveillance or ongoing monitoring of the effects of treatment, these technologies and practices could mean further quality of life improvements – without as many regular visits to hospital. Best practice models emerging from the pandemic response provide opportunities for improved prostate cancer care Reference number: ONC_2020_0099_APENew models of care are evolving around remote consultations and digital care provisionStigma compounded by prolonged isolation and anxiety can impact on the mental health of those affected13,14 Date of preparation: July 2020 3REFERENCES 1 Cancer Research UK, How coronavirus is impacting cancer services in the UK, April 2020 2 Karol Sikora, The potential impact of COVID-19 on cancer mortality in the UK, May 2020 3 Cancer Research UK, Prostate cancer incidence by ethnicity, accessed May 2020 4 IFS Deaton, Are some ethnic groups more vulnerable to COVID-19 than others, April 2020 5 New Scientist, Why are men more likely to get worse symptoms and die from covid-19?, April 2020 6 Public Health England, Disparities in the risk and outcomes of COVID-19, June 2020 7 Health and Environmental Alliance (HEAL), Health costs in the European Union: How much is related to EDCS?, 2014 8 Ferlay, J et al, Cancer incidence and mortality patterns in Europe: Estimates for 40 countries and 25 major cancers in 2018, European Journal of Cancer, 2018 9 European Association of Urology, Prostate Cancer: Recommendations to lower the risk and mortality of the most frequent cancer in men, 2018 10 European Cancer Information System, Estimates of cancer incidence and mortality in 2018, for all cancer sites EU 28, 2018 11 Hu et al, Increase in Prostate Cancer Distant Metastases at Diagnosis in the United States, 2017 12 Lloyd-Sherlock, PG et al, Institutional ageism in global health policy, British Medical Journal, 2016 Prostate Cancer Foundation, Black Men less likely than nonblack patients to adopt active surveillance, May 2019 Prostate Cancer UK, Prostate cancer and your risk, 2019 13 European Association for Research and Treatment of Cancer (EORTC),

Prostate cancer: the silent man’s disease, EORTC, 2017 14 Lai, Alvina; Pasea, Laura; Denaxas, Spiros; Chang, Estimating excess mortality in people with cancer and multimorbidity in the COVID-19 emergency, April 2020 15 GP Online, Millions of patients ‘avoiding calls to GP’ during COVID-19 pandemic, April 2020 16 European Association of Urology, Prostate Cancer (PCa) Guidelines, 2020 17 Prostate Cancer UK, Coronavirus (COVID-19) and prostate cancer, accessed May 2020 18 Watson, M et al, Racial differences in prostate cancer treatment: the role of socioeconomic status, 2017 19 Jones D, Neal R, Duffy S et al, Impact of the COVID-19 pandemic on the symptomatic diagnosis of cancer: the view from primary care, April 2020 The Let’s Talk Prostate Cancer campaign was launched in November 2019 to address the challenges faced by people living with prostate cancer in Europe. The campaign is organised and funded by Astellas Pharma Europe Ltd. and brings together a multi-disciplinary group of experts from across the region including representatives from Europa Uomo, The European Oncology Nursing Society (EONS), The European Cancer Patient Coalition (ECPC), The European Association of Urology (EAU), and The European Association of Urology Nurses (EAUN). Reference number: ONC_2020_0099_APEThe response to this crisis has seen health professionals and organisations work together in new ways, presenting unique opportunities to unlock the capacity and innovation for improved prostate cancer care across Europe. This is why the Let’s Talk Prostate Cancer expert group is calling on European policymakers to make prostate cancer a priority and to work within the EU institutions to give Member States the tools, guidance and incentives to ensure they have the best possible prostate cancer plan for their country, including the dissemination and application of European guidelines.16 Together with Astellas, the Let’s Talk Prostate Cancer expert group has launched a Call to Action aimed at European and national policymakers, outlining recommendations for how healthcare systems can address the challenges faced by the prostate cancer community. These include ensuring that prostate cancer is recognised as a policy priority, encouraging research into healthcare inequalities affecting individuals with prostate cancer and promoting care provision by multidisciplinary and multi-professional teams. To find out more about the Let’s Talk Prostate Cancer campaign or to receive a copy of the Call to Action, please contact the LTPC Secretariat provided by Incisive Health at LTPC@Incisivehealth.com Let’s Talk CAMPAIGNProstate Cancer Date of preparation: July 2020 4Home » Treatments » Transurethral resection of the prostate (TURP) Table of Contents [hide] TURP is the standard surgery for BPE. The aim is to remove the part of the prostate which causes the symptoms. The procedure is done through the urethra without making an incision in your lower abdomen (Fig. 1). This type of surgery is known as a minimally invasive treatment. For TURP you will receive general or spinal anaesthesia. Once you are under anaesthesia, the doctor uses a resectoscope to enter the bladder through the urethra. This is a type of endoscope with a wire loop which uses a high-frequency electrical current to cut the prostate tissue. The resectoscope also has a camera which allows the doctor to see a high-quality image of the prostate on a video monitor. During the procedure, the doctor removes the enlarged part of the prostate in small pieces with the wire loop (Fig. 2). The doctor then flushes the cut tissue out of the bladder and the urethra through the resectoscope. After the operation, a catheter is placed in your bladder to drain urine. It is also used to continuously flush your bladder and urethra with a sterile solution to prevent blood clots. You will need the catheter for 1-3 days until the urethra is healed and you can urinate on your own. Today, TURP is the preferred surgical option for men with moderate to severe symptoms caused by BPE. Your doctor will advise you in detail about how to prepare for the procedure. You must not eat, drink, or smoke for 6 hours before surgery to prepare for the anaesthesia. If you are taking any prescribed medication, discuss it with your doctor. You may need to stop taking it several days before surgery. Usually, you can leave the hospital 2 or 3 days after surgery. The length of hospital stay can vary in different countries. There may be some blood in your urine for several days. You may also suffer from urgency and feel pain when you urinate, which can last up to several weeks. For 4-6 weeks after the surgery: Avoid having sex for 2-3 weeks. After TURP, you may suffer from retrograde ejaculation. This is a chronic condition where semen can no longer leave through the urethra during orgasm. Instead, it goes into the bladder and later leaves your body during urination. You need to go to the doctor or go back to the hospital right away if you: The EAU Annual Congress 2019 achieved the Patients Included™ status. Patients Included™ status is self-assessed. Read more. This information was last updated in April 2023 Home » Treatments » Radical prostatectomy Table of Contents [hide] Radical prostatectomy is the removal of the entire prostate and the seminal vesicles. For radical prostatectomy you will receive general anaesthesia. Discuss with your doctor the advantages and disadvantages of radical prostatectomy and if it is right for you. Radical prostatectomy can be performed as an open or

laparoscopic surgery. For open surgery, the surgeon cuts the abdominal wall or the perineum to access the prostate directly. The prostate and the seminal vesicles are removed. In locally-advanced prostate cancer, the surgeon will also remove any other tissue that is affected by the tumour. Then, the bladder and the urethra are attached together (Fig. 1b). The doctor inserts a catheter to help the urethra and bladder heal. Usually, the catheter is removed after 7 days. In laparoscopic surgery, the surgeon inserts small plastic tubes into your abdomen. Through these tubes, the surgeon can insert the instruments needed to remove the prostate. One of the small tubes is used to insert a camera which allows the surgeon to see a high-quality image of your prostate on a video monitor. Laparoscopic surgery can also be done with the help of a surgical robot system. For the removal of a localised tumour or a locally-advanced tumour with radical prostatectomy, open and laparoscopic surgery appear to be equally effective. If the cancer could spread or has spread to lymph nodes in the pelvic region, your doctor may decide to remove pelvic lymph nodes during radical prostatectomy. This animation shows how a robot-assisted radical prostatectomy (RARP) is performed. Your doctor will advise you in detail about how to prepare for the procedure. You must not eat, drink, or smoke for 6 hours before surgery to prepare for the anaesthesia. If you are taking any medication, discuss it with your doctor. You may need to stop taking it several days before surgery. Your doctor will advise you on when to start taking it again. Usually, you can leave the hospital between 3 and 7 days after surgery. The length of hospital stay can vary in different countries. You may experience minor pain in the lower abdomen for some weeks after open radical prostatectomy. After the surgery, you may suffer from urinary incontinence or erectile dysfunction. You may need treatment for these conditions. You need to go to your doctor or go back to the hospital right away if you: The removal of pelvic lymph nodes may cause lymphorrhea. This is a leakage of lymph fluid on the skin. The fluid leads to skin damage, and may cause an infection. Discuss the treatment of lymphorrhea with your medical team. Radical prostatectomy may cause stress urinary incontinence (SUI). This is because the prostate surrounds the urethra, helping it to resist the pressure of a full bladder. If your prostate is removed this may have an effect on how much pressure the urethra can resist. There are several treatment options to improve or cure SUI. Another common risk of the surgery is erectile dysfunction. Because the surgeon may need to remove tissue outside of the prostate, there is a risk that vessels and nerves are damaged or removed during surgery. This is a common cause of erectile dysfunction. During surgery, the surgeon tries to keep the nerves to the penis undamaged. The success of this depends on the aggressiveness of the cancer and where the tumour is located. If necessary, your doctor can recommend treatment for erectile dysfunction. Keep in mind that the main goal of radical prostatectomy is to remove the tumour and cure you. Radical prostatectomy is a surgical treatment option to remove the entire prostate and surrounding tissue. If the tumour is limited to the prostate gland, the surgeon will try to keep the nerves that lead to the penis intact during surgery. This is called nerve-sparing surgery. Even if nerve-sparing surgery is successful, temporary ED is common after radical prostatectomy. This is because your nerves are so delicate that they are affected by the slightest injuries. If any injury happens during surgery, the nerves stop transporting signals to the blood vessels in the penis. It can take up to 2 years for the nerves to recover. The blood vessel running to and from the penis can also be affected by the surgery. As a result, less blood will flow to the spongy tissue of the penis, and damage it. Because of the damage it can be more difficult to recover from ED. In some cases, nerve-sparing surgery is not possible because the tumour has spread outside of the prostate, or for other reasons. Recovery of erectile function after non-nerve sparing surgery is unlikely but not impossible. Discuss your concerns and possible treatment options with your doctor. After radical prostatectomy for prostate cancer, your doctor will plan regular follow-up visits with you. Routine follow-up lasts at least 5 years. During each visit, the doctor will test the level of prostate-specific antigen (PSA) in your blood. In some cases, you may need a digital rectal examination (DRE). Follow-up is important to monitor how you recover from surgery, to check your general state of health, and to detect possible recurrence of the cancer. If during follow-up the PSA level shows that the prostate cancer has not been completely removed you may need additional treatment to remove all tumour cells. Discuss with your doctor which option is best for you. The European Cancer Patient Coalition (ECPC) works for a Europe of equality, where all European cancer patients have timely and a■ordable access to the best treatment and care available, throughout their life. ECPC believes that cancer patients are the most important partners in the ■ght against cancer and against all the cancer-related issues a■ecting our society. Policy makers, researchers, doctors and industry should recognise cancer patients as co-creators of their own health. Read more. European patients have taken up their responsibility for control of the disease by establishing the European Prostate Cancer Coalition, “Europa Uomo”. Read more. The EAU Annual Congress 2019 achieved the Patients

Included™ status. Patients Included™ status is self-assessed. Read more. Copyright 2023 - European Association of Urology - All rights reserved This information was last updated in April 2023 Home » Videos » Robot-Assisted Radical Prostatectomy video This animation shows how a robot-assisted radical prostatectomy (RARP) is performed. Radical prostatectomy is the removal of the entire prostate and the seminal vesicles. For radical prostatectomy you will receive general anaesthesia. Discuss with your doctor the advantages and disadvantages of radical prostatectomy and if it is right for you. Click here to learn more about Radical Prostatectomy. Click here to learn more about Robotic surgery in urology. This animation is brought to you by the European Association of Urology, supported by an educational grant from Intuitive Surgical Sàrl. The editorial content in this video is written independently of the sponsor and judged free of any conflict of interest. The information in this video is of a general nature and is not intended as a substitute for professional advice. The EAU Annual Congress 2019 achieved the Patients Included™ status. Patients Included™ status is self-assessed. Read more. Copyright 2023 - European Association of Urology - All rights reserved This information was last updated in April 2023

Subheading 2

This is some more text for the second page.