Informed Prostate Cancer Support Group Inc.

"A 501 C 3 CORPORATION ID # 54-2141691"

November 2018 NEWSLETTER

P.O. Box 420142 San Diego, CA 92142

Phone: 619-890-8447 Web: http://ipcsg.org

We Meet Every Third Saturday (except December)

Monday, November 12, 2018

Volume 11 Issue 11

Next Meeting
Nov 17, 2018
10:00AM to Noon

Meeting at Sanford-Burnham-Prebys Auditorium 10905 Road to the Cure, San Diego CA 92121

SEE MAP PAGE 10

PROSTATE CANCER
2 WORDS, NOT A SENTENCE

What We Are About

Our Group offers the complete spectrum of information on prevention and treatment. We provide a forum where you can get all your questions answered in one place by men that have lived through the experience. Prostate cancer is very personal. Our goal is to make you more aware of your options before you begin a treatment that has serious side effects that were not properly explained. Impotence, incontinence, and a high rate of recurrence are very common side effects and may be for life. Men who are newly diagnosed with PCa are often overwhelmed by the frightening magnitude of their condition. Networking with our members will help identify what options are best suited for your life style.

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Editor: Stephen Pendergast

WE ARE SEEKING REPLACEMENT FOR SOME OF OUR IPCSG TEAM

Serving in this team can be rewarding and is a way to pay it forward to the group. To offer your services and/or ask questions about functions, Contact any of the individuals at their listed phone number.

FUNCTIONS NEEDED:

1. **President**: IPCSG public relations, research and advice. Lyle LaRosh has performed for 18 years. 619-892-3888
2. **Vice President**: Support all team members, assist in monthly planning and speaker acquisition. *currently vacant* Gene Van Vleet has performed Functions 2, 4, 5 for 11 years. 619-890-8447.
3. **Meeting facilitator**: Monthly planning and speaker acquisition. George Johnson has performed for 8 years. 858-456-2492
4. **Treasurer/Secretary**: Handle banking, accounting, government reporting (see 2)
5. **Hot Line**: Communicate directly with newcomers and handle phone inquiries. (see 2)

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Video DVD's

DVD's of our meetings are available in our library for $10ea. Refer to the index available in the library. They can also be purchased through our website: http://ipcsg.org Click on the 'Purchase DVDs" tab.

The DVD of each meeting is available by the next meeting date.

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IPCSG is a 501c3 non-profit organization and all positions are performed gratis.

October 2018 Meeting
Summary by Bill Lewis

From the October meeting, here are three members' personal stories, in order of earliest to most recently diagnosed.

Chuck Grim is a retired electronics engineering manager. He was diagnosed in February 2010, and has had almost all types of treatment. In June 2010 he had a robotic prostatectomy, but cancer was still present afterward, as evidenced by a rising PSA. In February 2011, he started 1 year of triple androgen blockade (Lupron, Casodex and Proscar). After an F-18 PET/CT scan showed 2 suspicious spots on his ribs, chemo using Taxotere was given (6 treatments, three weeks apart). This was before studies demonstrated that such an early use of chemo gives a significant survival benefit. The prostate bed was irradiated in February 2012, with 39 treatments totaling 79 Grays.

Lupron has helped his survival. He was on it a year, then 2 years off, then 9 months on, and 1 year off. Then back on Lupron, and though it stopped working well after 9 months, he expects to stay on it hereafter. Xtandi (the "super Casodex," which blocks the cellular receptor for testosterone) was added, but stopped working after 9 months, so was discontinued. A bummer! The cancer was rapidly getting smarter than the drugs….

A second round of chemo was given in July 2017, using the newer drug, Jevtana. It was supposed to have fewer side effects, but he couldn't tolerate it, so after 3 doses switched to Taxotere for five doses. This was not fun!! -- But it worked.

This past March, he was accepted into a trial at UCLA, intended to give 4 treatments of Lutetium-177 at 2-month intervals, with the goal being to reduce PSA. His PSA stabilized in the 30-40 range, until after the 3rd dose. His PSA then jumped to 148, and that ended his enrollment in the trial. Shortly after the trial, he started Zytiga (the "super Lupron," which shuts down all testosterone production). His PSA is now 25, down from a high of 168. This has made Chuck happy!

This past August, he started Xofigo treatments, with an infusion every 30 days. It is intended to help with bone metastases. Results are not yet known.

Just a week before the meeting, he started treatment with Keytruda. It is in a new class of drugs called check point inhibitors. Although not FDA approved for prostate cancer, it is being provided on a compassionate use base by Merck (since they would like some preliminary data on its effectiveness on prostate cancer). Keytruda is what cured Jimmy Carter's Melanoma.

Chuck has had problems with depression, but started treatment with a Psychologist and a Psychiatrist shortly after his original biopsy. The medicine he takes has been very helpful.

He concluded: "I am glad to still be here. I have great support from my wife Mary Kay and daughters Andrea and Katie. The IPCSG has been a great help in this journey."

Michael Brekka is 60 years old, married 30 years, with 3 children, and works in Architecture & Real Estate Development. He has no family history of prostate cancer, except one older brother diagnosed at age 50 and apparently cured by cryotherapy.

After his baseline PSA of mid-2008 doubled by mid-2011, he had a 12-core biopsy and Gleason 4+3=7 cancer was found in all 6 cores on the left side. After many consultations with many doctors, and an out-of-pocket Color Doppler study by Dr. Bahn, it was concluded that the cancer had possibly spread outside of the prostate gland, making surgery a poor option. Instead, he chose to go the route of hormone therapy for three months before getting radiation treatment (for two months, ending in April 2012) with a second 3-month Lupron shot as he started the radiation. He also had 45 days of Casodex in connection with the first Lupron shot. This was to prevent the cancer "flare" that can otherwise occur.

His PSA was undetectable while on the Lupron, and was still only about 0.2 after a year, when his testosterone was fully recovered (over 600). Gradually the PSA has risen (at an increasing rate), reaching about 8. Recent imaging studies included CT, PET/CT F-18 & Axumin scans, and mp-MRI. He had a 20-core guided biopsy. The prostate cancer was evident in the same location as before, but it was confirmed that the cancer was contained within the prostate, with no evidence of cancer in bones or lymph nodes. Targeted biopsy results: all cores were positive, with the Gleason score: 3+4=7.

Mike's incontinence, impotence and stricture score was 13 to 15 (70% favorable), but he was concerned that future treatments might have a negative influence on these issues. His treatment options included various forms of radiation (IMRT, Brachytherapy with permanent seeds or "High Dose Radiation" with temporary seeds), Cryotherapy, HIFU, Surgery, ADT (Lupron or other drugs), Irreversible Electroporation (Nano Knife) or Immunotherapy drugs.

He chose High Dose Radiation for its very high effectiveness, and modest side effects, done by Dr. Albert Chang, a world expert who recently moved from UCSF to UCLA. Mike had been interested in Irreversible Electroporation (see prior IPCSG talks by Drs. Schwartzberg and Stehling, available from this author), but learned that the effectiveness is significantly lower (70% vs. 95%). Also, insurance does not cover the cost of about $30,000.

The HDR procedure involved Insertion of 17 hollow needles through the perineum into the prostate, with a radioactive "pin" inserted briefly (45 seconds) into each hollow needle, three times over two days (with an overnight stay in the hospital), and with the whole procedure repeated a week later. The radioactive treatment itself was not particularly painful, but the "before and after" was excruciating! Brutal! He had a few months of incontinence and some ED, but is recovering well. The cancer dies off over a period of months, so he has not yet had a follow-up PSA test. His co-pay was $3,000 of the $35,000 cost.

Bill Lewis is 66, and married with 5 adult children. He's a chemist with a passion for experimentation. At his diagnosis in November 2015 (PSA = 9; Gleason = 8), the cancer had already spread to a dozen places in his bones. By the following May, after unsuccessful alternative medicine treatment, his PSA was 73, and he had over 100 bone metastases. Median survival in such cases is 6-9 months!

Based on info shared at IPCSG meetings, and internet searches, he started triple androgen blockade (same as Chuck Grim used; see

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above), and instituted many "lifestyle factor" changes described in a book "Radical Remission," that describes nine key changes that were among those made by people who survived cancer "against all odds." In nine months, his PSA dropped to 0.2 and all but two of his metastases had disappeared, in a repeat bone scan.

The nine most common factors described in the book, and used by Bill, were 1. Radical diet changes (lots of vegetables, no sugar or milk, little meat except for fish), 2. Taking control of your health (his own case management, as all IPCSG members do!), 3. Following intuition ("gut impressions" or inspired thoughts), 4. Using herbs and supplements (discussed below), 5. Releasing suppressed emotions (clearing his negative emotional history), 6. Increasing positive emotions (especially daily funny videos), 7. Embracing social support (including going to IPCSG meetings and getting away from being an introvert), 8. Deeping your spiritual connection (his faith in God and Jesus Christ, and prayer and religious practices), and 9. Having strong reasons for living. Two other factors mentioned in the book were exercise (i.e., his 20 miles biking to/from work, and resistance exercises 3X weekly at a gym) and energy medicine (see below, regarding muscle testing and grounding).

To avoid becoming "castrate resistant," Bill had planned to try T-base hormone therapy, a version of intermittent treatment with hormone suppressors and blockers. Instead, he found the Compassionate Oncology Medical Group in Los Angeles, and has since been treated by Dr. Bob Leibowitz and his partner Shahrooz Eshaghian. They use a "three-pronged" approach to treating prostate cancer, proven with twenty years of success. For cases like mine, the first prong is ADT using an improved version of Triple Androgen Blockade, which was originally developed by "Dr. Bob." This is used for a limited period of time, to avoid "castrate resistance." The second prong is chemotherapy, using three agents (Taxotere, Carboplatinum and Emcyt), given in smaller weekly doses 3X per month, instead of a single-agent large dose every 3 weeks. The third prong is an "antiangiogenesis cocktail" containing thalidomide to prevent growth of new blood vessels, since tumors cannot grow larger than 2 millimeters in size without their own blood supply. The cocktail also contains an immune system booster called Leukine, and a variety of other prescription medications that have been found to have anti-cancer activity, though originally used for other purposes.

Bill has had these treatments since January of this year, and expects to go on Dr. Bob's maintenance program by the end of November, which involves continuing the cocktail, and adding high-dose testosterone supplementation. Side effects from the blockade, chemo and cocktail have been mild; mainly some fatigue for about 3-1/2 months, and some peripheral neuropathy, both now resolving. Bone and MRI scans have been carried out since the talk last month, and show the cancer has regressed satisfyingly.

In addition to the treatments from the Compassionate group, Bill has used a variety of supplements, identified from internet reports and confirmed by "muscle testing." These include Agaricus Blazei mushroom extract to build the immune system, an immune support called Immucare II, Turmeric powder and extract, apricot kernels, Airborne (antiviral), rutaecarpine and oxaloacetate. He also uses a blend of flaxseed oil and cottage cheese from the "Budwig diet," and a blend of supplements called MitoXcell, which improve the functioning of mitochondria in each cell. These subcellular units manufacture all the energy that powers our bodies, including healing energy, and also regulate apoptosis ("programmed cell death"). Damaged or poorly functioning mitochondria can lead to cancer. A significant damaging factor is inflammation, and a little-known practice called grounding or "earthing" can greatly reduce inflammation. This was described in the talk, and references are included with the slides, which the author will provide on request. One other practice Bill has followed is the weekly self-injection of sterilized urine, which has been shown to improve the immune system.

With all these practices, treatments and supplements, Bill has no detectable remaining metastases, an undetectable PSA, no symptoms of the cancer, and better apparent health than before he was diagnosed with cancer.

Questions:

Doesn't testosterone feed prostate cancer? There is a dose-response curve, so that little or no testosterone inhibits growth, and "some" allows growth, but very high doses inhibit growth, and are even directly toxic to the cancer cells.

What about Michael continuing on Lupron, instead of having the HDR treatment? He was advised that this could work for a time, but it would only "push the problem down the road," as the cancer would eventually come back, and would likely be more aggressive then.

Comment from George Johnson: What causes prostate cancer? Dr. Huggins reported in 1941 that surgical castration was an effective "cure" for prostate cancer. Later, a doctor found that men with low testosterone had a higher degree of prostate cancer than those with higher testosterone. At an American Urological Association meeting, he was almost booed off the stage. It turned out that dihydrotestosterone was a key factor and that Dr. Huggins' conclusion was based on a single patient! George left his testosterone in the 500 range, and took Casodex and Avodart (which suppresses dihydrotestosterone), and kept his PSA down for ten years. There isn't good research on the cause of prostate cancer. The controversy continues.

Grounding methods? You can walk barefoot (on ground or moist grass or sand) or use a pad or wrist strap connected to the earth, in bed at night. The "Earthing" book describes this, and Bill Lewis has emailed details to a half-dozen members since the talk last month. Many diseases, including cancer, are promoted -- if not caused -- by inflammation, which in turn is caused by free radicals, which are molecules with an unpaired electron. The "missing" electron can be supplied from the earth.

What about CBD (Cannabidiol) oil? Bill Lewis was sent a sample, but it did not pass his doctor's muscle test, so he didn't use it. Some people claim a benefit.

What about the extra radiation Michael was getting in having HDR treatment after earlier radiation treatment? He felt the high success rate, and low irradiation of non-target tissues, were reasons to go ahead. How long have HDR patients been tracked, in determining the 95% success rate? Michael believes it has been ten years of data.

IRE issues? Irreversible electroporation is considered both by Michael Brekka and Bill Lewis to be in its infancy, and shows promise, especially for stimulating the immune system, but it's very expensive now. Ron Abbott noted that a new, lower-cost version is expected next year.

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If you would like to contact any of the 3 speakers, contact Gene Van Vleet at genevanvleet@outlook.com or 619-890-8447 for their contact information. The video of these presentations, including the PowerPoint slides, will be available via the website shortly before the next meeting, or at that meeting.

FUTURE MEETINGS

- Meeting Date SPEAKERS

November 17 - Dr. Richard Lam Prostate Cancer Breakthroughs of 2018

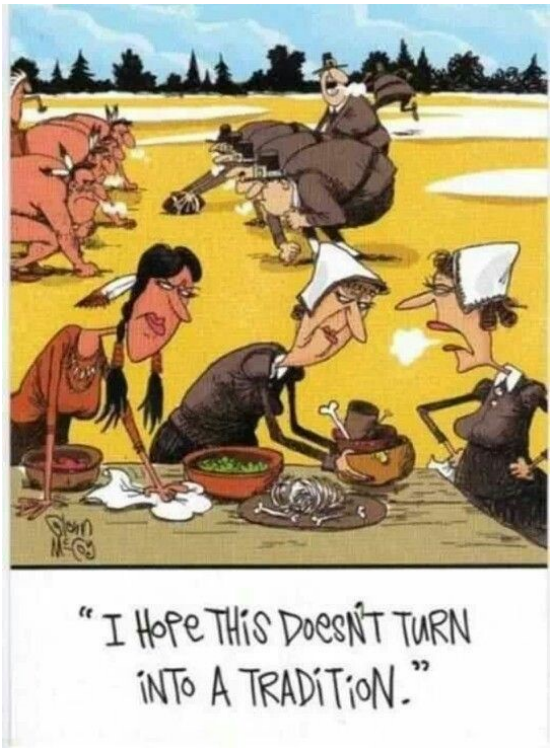
- A board-certified internist and oncologist, Richard Lam, MD is the director of clinical research has been specializing full time at Prostate Oncology Specialists in the treatment of prostate cancer since 2001.

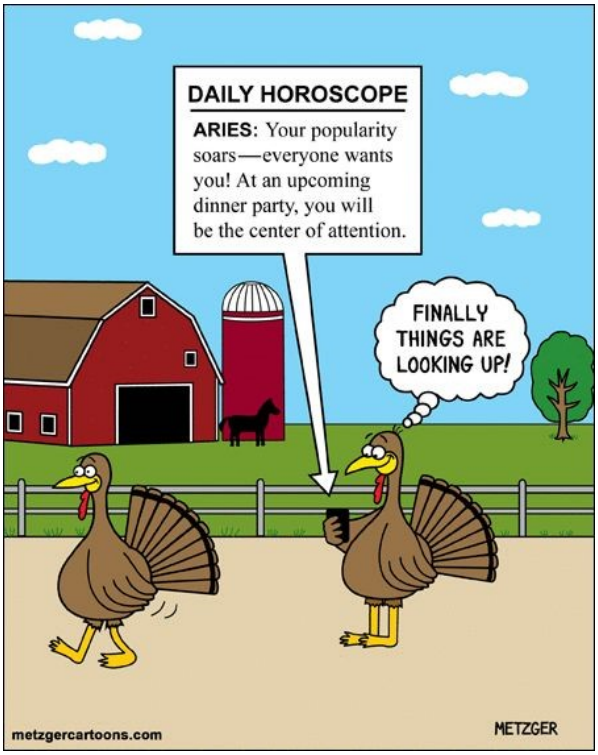
Dr. Lam has written numerous articles based on his research and is an active member of the American Society of Clinical Oncology and the American Society of Hematology. Dr. Lam continues to promote prostate cancer awareness and education by giving lectures at various medical conferences and prostate support groups throughout the country. He is particularly interested in utilizing state-of-the-art therapeutics for advanced prostate cancer.

January 19, 2019 - TBD

- **For further reading: https://spendergast.blogspot.com/2018/11/prostatecancer-news-2018-11.html**
- **For Comments, Ideas and Questions,**
  email to Newsletter@ipcsg.org

ON THE LIGHTER SIDE





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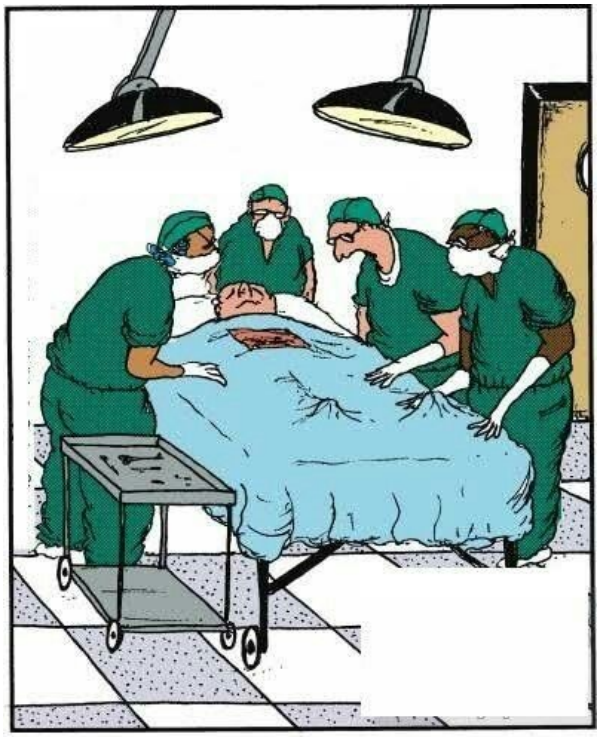
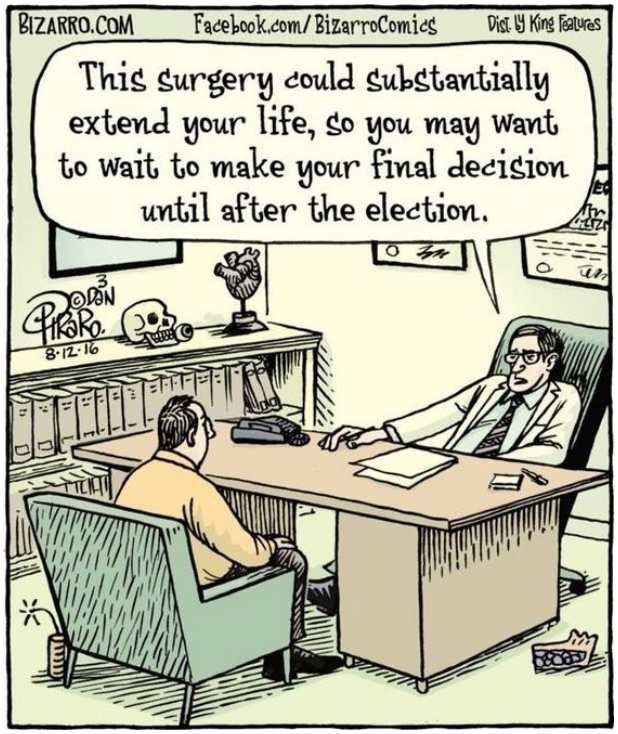
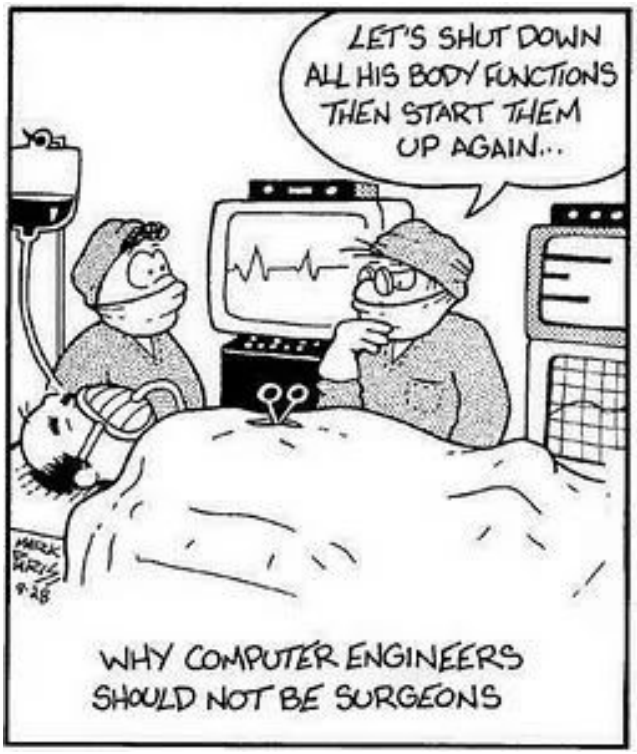


"I have no idea what that thing is either. Let's just take it out, stitch him up, and see if he gets better."





Notable Articles

www.medscape.com

Radiotherapy Gives Long-Term Disease Control in Prostate Cancer

Pam Harrison

October 29, 2018

SAN ANTONIO — Long-term outcomes from a series of separate studies all support the continued efficacy and tolerability of different forms of radiation therapy (RT) in the treatment of localized, mostly low- and intermediate-risk prostate cancer. This is the message of a session here at the American Society for Radiation Oncology (ASTRO) 2018 annual meeting (abstracts 59-63).

"The reason some people don't adopt new types of radiation is the fear that there could be more toxicity beyond 5 years," session co-chair Daniel Spratt, MD, associate professor of radiation oncology, University of Michigan, Ann Arbor, told Medscape Medical News.

"But from trials of stereotactic body radiation therapy (SBRT) to ones on hypofractionation or the use of hormone therapy, there really wasn't any increase in toxicity — they all appear to be safe," he commented. "So I think it will all come down to patient convenience, fewer treatments, and lower cost, as fewer treatments are less costly, so the trials that are still on-going are all trying to shorten sessions down to five treatments in total and we await those trials with interest," he added.

As Amar Kishan, MD, University of California, Los Angeles, discussed in a news briefing, traditional conventional RT for low- and intermediate-risk prostate cancer involved the delivery of small daily doses of radiation over an extended timeframe, typically 8 to 9 weeks.

"The so-called fractionation of radiation is thought to help preferentially kill tumor cells and minimize chronic tissue damage," Kishan explained.

Somewhat uniquely, prostate cancer appears to be more sensitive to higher doses of radiation per treatment session, "suggesting that shorter radiation courses — in other words, higher doses per treatment in fewer total treatments — could be efficacious," he added.

SBRT pushes this hypothesis to the limits by condensing the treatment course to four and five sessions — which explains why SBRT is alternatively known as "extreme hypofractionation" or "stereotactic ablative radiotherapy," Kishan observed.

What radiation oncologists have been waiting for is confirmation that long-term results of SBRT are not, indeed, accompanied by higher late toxicity rates compared with other types of RT.

Now They Have the Answer, and That Answer Is No

As presented by Alan Katz, MD, Flushing Radiology Services, New York, at a median follow-up of 108 months, 515 patients with prostate cancer, most of whom were low- and intermediate-risk, were treated with robotic SBRT at doses ranging from 35 to 36.25 Gy in 5 fractions on consecutive days. Approximately 100 patients received androgen deprivation therapy (ADT) as well as SBRT.

"For the entire cohort, the 10-year biochemical recurrence-free survival (bRFS) was 93%, 81%, and 66% for low-, intermediate-, and high-risk patients, respectively," Katz reported, "while biopsy-proven local failure was found in 2%, 6%, and 10% in the same three risk groups, respectively," he added.

Results were even better for favorable, intermediate-risk patients among whom disease-free survival (DFS) rates at 10 years were highly comparable, at 89%, to rates in low-risk patients, at 93%, Katz noted.

Conversely, intermediate-risk patients with unfavorable features had outcomes that were similar to high-risk patients: DFS rates at 10 years were only 63% in intermediate-risk patients and 66% in high-risk patients.

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Grades 2 and 3 late genitourinary (GU) toxicity was higher with the higher fractionation dose, at 14.6%, compared with 8.2% for the lower fractionation dose, but there were no differences in grade 2 gastrointestinal (GI) toxicity between the two schedules.

"For sexual scores, there was a significant drop off of approximately 35% to 40%," Katz observed.

"But this is in a group of men with a median age of 70 years, so there is going to be some significant drop off in sexual function anyway, so it's hard to tell exactly how much comes from the treatment or just from the aging process," he noted.

Interestingly, the use of ADT in higher-risk patients did not appear to improve long-term disease control.

"Prostate SBRT continues to demonstrate excellent local control and excellent quality of life now out to 10 years," Katz concluded.

"And given that most failures were not local, we hypothesize that dose escalation will not translate into improved bRFS," he added.

Moderately Hypofractionated Therapy

Long-term outcomes evaluating the effect of hypofractionated RT for prostate cancer are also limited, commented Ibrahim Abu-Gheida, MD, Cleveland Clinic Foundation, Ohio. Hence, the 10-year outcomes of a study in which investigators treated 854 patients with a moderately hypofractionated scheme (70 Gy in 28 fractions at 2.5 Gy per fraction) are of particular interest.

Patients again had localized prostate cancer spanning the whole risk spectrum: the study included both favorable intermediate-risk patients and unfavorable intermediate-risk patients as well as low- and high-risk participants.

At 10 years, the bRFS rates were 88% for low-risk patients, 78% for favorable intermediate-risk patients, 71% for unfavorable intermediate-risk patients, and 42% for those with high-risk disease.

Prostate cancer-specific mortality rates were actually low at 10 years ranging from 2% in the low-risk group to a high of 15% in the high-risk group, and 5% in both groups of intermediate-risk patients.

The cumulative incidence of late grade 3 and higher GU toxicity was low, at 2%, as was the incidence of late grade 3 and higher GI toxicity, at 1%.

"This fractionation schedule appears to be acceptable for patients across all risk groups," Abu-Gheida observed.

"High-dose moderately hypofractionated RT for localized prostate cancer continues to show excellent oncological outcomes with a low incidence of toxicity over long-term follow-up," he concluded.

Both ASTRO and its sister organization in Europe have recently endorsed hypofractionation as the standard approach to the treatment of localized prostate cancer, as published data are now strong enough to support this approach, Kishan noted.

Dose Escalation at 20 Years

However, Dario Pasalic, MD, University of Texas MD Anderson Cancer Center, Houston, would tend to disagree with Katz's hypothesis (as above) that dose escalation will not translate into improved bRFS, as he presented a study which found that dose escalation does make a difference.

Conducted between 1993 and 1998, that study involved 301 patients with low- to high-risk prostate cancer randomized to external beam radiation at doses of 70 Gy or 78 Gy with no accompanying neoadjuvant or adjuvant hormone therapy.

At a median follow-up of 14.3 years, freedom from failure rates were 53.8% for those who received 70 Gy, compared with 74.3% for those who received 78 Gy (P = .0018).

The significant difference between the two groups was largely driven by improvements in both bio-

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chemical and distant failure, as Pasalic observed.

For example, biochemical failure rates were 24.4% in the lower-dose group compared with 13.5% in the higher-dose group (P = .05), and distant failure rates were 17.4% in the lower-dose group compared with only 5.3% in the higher-dose group (P = .020), he noted.

This group of patients offers unique insight into the impact of increased radiation dose. Dario Pasalic, MD

The higher-dose fractionation group was also associated with a lower rate of distant metastases, at 5%, compared with 11% for the lower-dose fractionation group.

"Death from prostate cancer was trending toward significance and was nearly halved by dose escalation," Pasalic concluded.

"This group of patients offers unique insight into the impact of increased radiation dose," he added.

Standard Versus Hypofractionated RT

Although shortened, higher-dose hypofractionated RT is gaining the upper hand for the treatment of localized prostate cancer, the standard approach can still hold its own.

This finding comes from a 10-year, head-to-head comparison of conventionally fractionated intensity -modulated radiation (C-IMRT) therapy with hypofractionated IMRT (H-IMRT) for localized prostate cancer.

C-IMRT was delivered at a total dose of 78 Gy in 38 fractions at 2 Gy per fraction and H-IMRT was delivered a total dose of 70.2 Gy in 26 fractions at 2.7 Gy per fraction.

"High-risk patients were scheduled to receive 24 months of ADT, and some intermediate-risk patients were offered up to 4 months of ADT," Vladimir Avkshtol, MD, Fox Chase Cancer Center, Philadelphia, Pennsylvania, told delegates. Equal numbers of men in both groups took ADT.

Approximately 150 men were randomized to each group and close to 30% of the cohort were high-risk.

At a median follow-up of 130 months, biochemical failure rates were similar in both groups at 21.2% in the C-IMRT group versus 25.4% in the H-IMRT group. The incidence of biochemical and/or clinical disease failure was also similar in both groups at 25.9% for patients treated with C-IMRT compared with 30.6% of those treated with H-IMRT.

Rates of prostate cancer-specific mortality were also similar at 2.7% for C-IMRT and 4% for H-IMRT. At 10 years, 78.4% of men in the C-IMRT group were still alive compared with 71.1% in the H-IMRT group.

The main difference between the two treatments was rates of metastatic disease, which were lower at 5.3% for those treated with the standard approach compared with 12.7% for those treated with the hypofractionated approach (P = .06).

"Previously published work showed that long-term quality of life changes were similar in both groups," Avkshtol concluded.

"This phase 3 trial supports utilization of moderate hypofractionation in intermediate- and high-risk prostate cancer," he suggested.

Upfront or Delayed RT

Timing of RT has not been widely explored, making noteworthy the results of a phase 3 trial evaluating the optimal sequencing of dose escalated RT given either 4 months after initiating ADT or concurrently on day 1 with ADT. The ADT used in this particular study consisted of goserelin plus bicalutamide.

A total of 438 intermediate- and high-risk prostate cancer patients — but not low-risk patients — were included in the trial, noted Shawn Malone, MD, University of Ottawa, Ontario, Canada.

At a median follow-up in excess of 12 years, there were no significant differences between the two

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treatment groups in terms of DFS, at 81% for the delayed RT group and 86% for the upfront group.

Local control rates were also very high and similar in both groups, at 96% for the delayed group and 94% for the upfront group, and distant DFS rates were similarly high, at 99% and 96% for the delayed versus upfront RT group, respectively.

Late grade 3 and higher GI toxicity rates were higher in the upfront group, at 4.5%, compared with 2.8% for the delayed sequencing group, as was late grade 3 GU toxicity, at 5.1% versus 1.9%.

Nevertheless, Malone concluded that the sequencing of RT given in combination with ADT did not influence clinical outcomes. In addition, the durable outcomes seen in both groups support the benefit of treating this group of prostate cancer patients with ADT in combination with dose-escalated RT regardless of when RT is given.

ADT With and Without RT

A previous report of the RTOG 9408 study (N Engl J Med. 2011;365:107-118) demonstrated that at 10 years the addition of 4 months of ADT before and during RT improved all relevant endpoints in early localized prostate cancer.

At the ASTRO meeting, Christopher Jones, MD, Sutter Medical Group and Cancer Center, Sacramento, California, gave a long-term update on the results. They show that the addition of short-term ADT to radiotherapy, given at a dose of 66.6 Gy in 1.8 Gy fractions, continued to provide superior disease control at a median follow-up of 18 years, although the earlier overall survival advantage seen at 10 years in favor of additional ADT was no longer apparent.

At a median follow-up of 18 years, rates of biochemical failure were slightly higher than they were at 10 years, occurring in 37% of patients in the RT plus ADT group and 51% of the RT alone group ($P < .01$), Jones noted.

Similarly, rates of distant metastases at a median of 18 years were again slightly higher than they were at 10 years, occurring in 8% of the RT plus ADT group and 12% of the RT alone group ($P = .01$), Jones added.

Patients in the RT plus ADT group also were less likely to experience local progression, at 12%, compared with 18% for those receiving RT alone ($P < .01$).

Late grade 3 GU toxicity rates, at 6.2% in the additional ADT group versus 5.3% in the RT alone group, were similar between the two groups, as were rates of grade 4 GU toxicity, at 1.4% and 0.1% in the two groups, respectively. Rates of late grade 3 and 4 GI toxicity were very low in both groups.

"Survival differences at 10 years are still important as all survival curves go to zero at some point," Jones said.

"But these results continue to support the conclusion that the addition of short-term ADT benefits men with intermediate-risk, though not low-risk, adenocarcinoma of the prostate," he concluded.

Malone has reported receiving honoraria from AbbVie, Amgen, Astellas, AstraZeneca, Janssen, and Sanofi, and travel expenses from TerSera. The other presenters have reported no relevant financial relationships.

American Society for Radiation Oncology (ASTRO) 2018. Abstracts 59-63. Presented October 22.

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Send comments and news tips to news@medscape.net.

Cite this article: Radiotherapy Gives Long-Term Disease Control in Prostate Cancer - Medscape - Oct 29, 2018.

NETWORKING

Please help us in our outreach efforts. Our speakers bureau consisting of Lyle LaRosh, Gene Van Vleet and George Johnson are available to speak to organizations of which you might be a member. Contact Gene 619-890-8447 or gene@ipcsg.org to coordinate.

Member and Director, John Tassi is the webmaster of our website and welcomes any suggestions to make our website simple and easy to navigate. Check out the Personal Experiences page and send us your story. Go to: https://ipcsg.org/personal-experience

Our brochure provides the group philosophy and explains our goals. Copies may be obtained at our meetings. Please pass them along to friends and contacts.

FINANCES

We want to thank those of you who have made special donations to IPCSG. Remember that your gifts are tax deductible because we are a 501(c)(3) non-profit organization.

We again are reminding our members and friends to consider giving a large financial contribution to the IPCSG. This can include estate giving as well as giving in memory of a loved one. You can also have a distribution from your IRA made to our account. We need your support. We will, in turn, make contributions from our group to Prostate Cancer researchers and other groups as appropriate for a non-profit organization. Our group ID number is 54-2141691. Corporate donors are welcome!

If you have the internet you can contribute easily by going to our website, http://ipcsg.org and clicking on "Donate" Follow the instructions on that page. OR just mail a check to: IPCSG, P. O. Box 4201042, San Diego CA 92142

Directions to Sanford-Burnham-Prebys Auditorium
10905 Road to the Cure, San Diego, CA 92121

Take I-5 (north or south) to the Genesee exit (west).

Follow Genesee up the hill, staying right.

Genesee rounds right onto North Torrey Pines Road.

Do not turn into the Sanford-Burnham-Prebys Medical Discovery Institute or Fishman Auditorium

Turn right on Science Park Road. Watch for our sign here.

Turn Left on Torreyana Road. Watch for our sign here.

Turn Right on Road to the Cure (formerly Altman Row). Watch for our sign here.