THEIR CANCER GARDEN

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**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.

1. 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.
2. 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.
3. 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.

1. 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.
2. 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).

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1. 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.
2. 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.
3. 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.

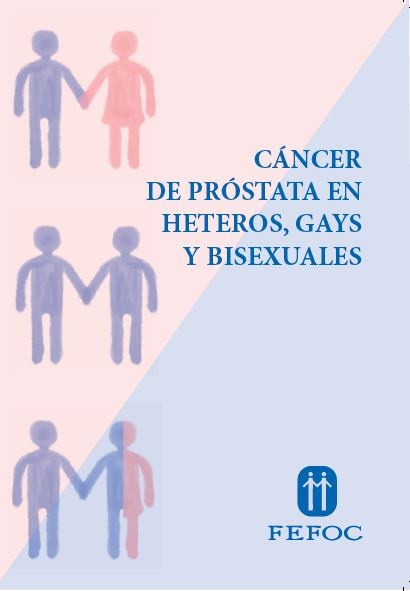
Dr. Walsh, of Johns Hopkins Hospital, revolutionized CP surgery in 1982 by introducing a surgical modality in which nerve sparing surgery, essential for erection, are not sectioned.

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.

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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)

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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.

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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.

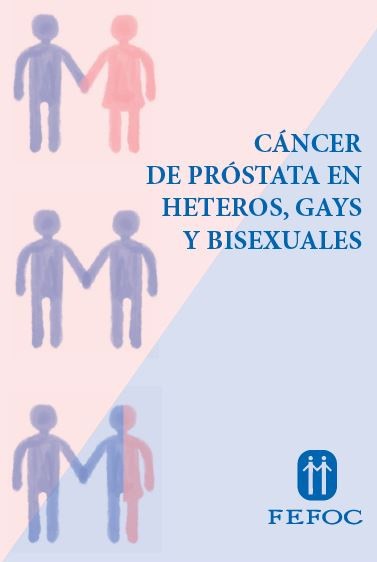
His current priorities are to investigate the quality of life of patients; improve early diagnosis and support its members and help and give voice to patient groups in Europe.

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:

[**https://euproms.ydeal.dev/**](https://euproms.ydeal.dev/)



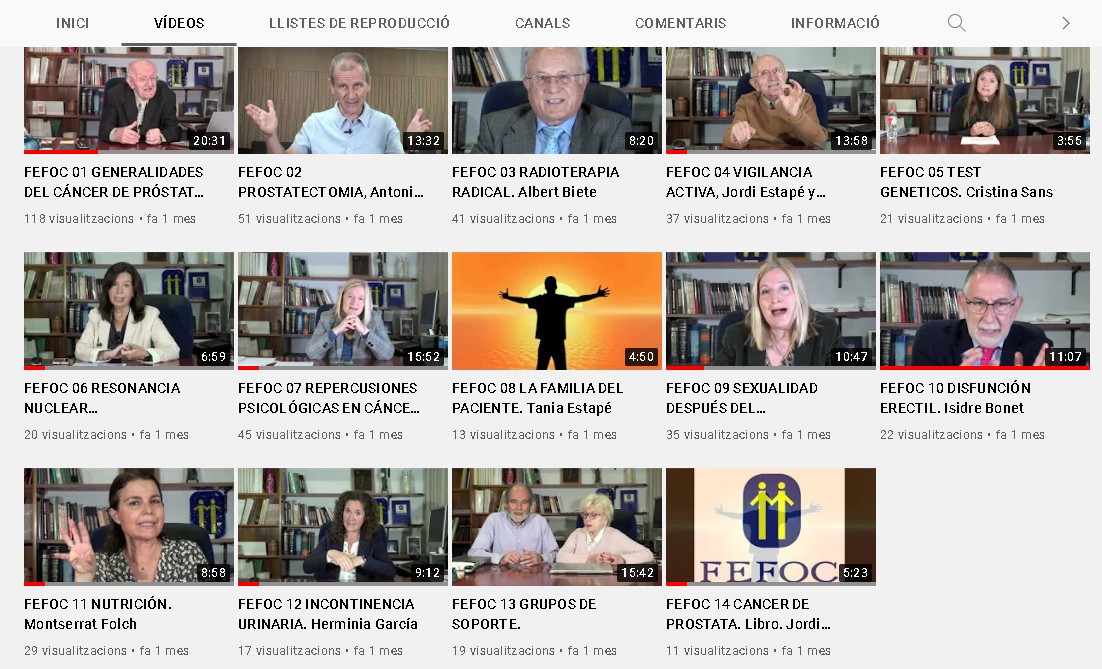
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# Image from the collection of videos about prostate cancer





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