THEIR CANCER GARDEN

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### EDITORIAL

During this month, dedicated to breast cancer, in the news of FEFOC [(www.fefoc.org)](http://www.fefoc.org/) 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.

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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.

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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**

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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.

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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.

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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

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"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.

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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.

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**Image from**  **the**  **collection**  **of**  **videos**  **about**   **prostate**  **cancer**





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