THEIR CANCER GARDEN

# EDITORIAL

F **E F O C : MEMBER OF EUROPE UOMO , USTOO AND MALE CARE**

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 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.

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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.

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 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).

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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.

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# 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)\*

1. 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.
2. 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.
3. 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.
4. 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
5. 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.
6. 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.
7. 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.
8. 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.
9. 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 .

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1. 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.
2. 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).
3. 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.
4. Rehabilitation needs. Likewise, studies aimed at the rehabilitation needs of patients with CP, essential to design precise interventions for them.
5. 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.

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To purchase the book click [**here**](https://www.amazon.es/C%C3%81NCER-PR%C3%93STATA-HETEROS-GAYS-BISEXUALES-ebook/dp/B08QRZ3XNJ/ref%3Dsr_1_1?__mk_es_ES=%C3%85M%C3%85%C5%BD%C3%95%C3%91&crid=1XUVW0UQ1NR7N&keywords=cancer%2Bde%2Bprostata.%2Bjordi%2Bestape&qid=1646068723&sprefix=cancer%2Bde%2Bprostata.%2Bjordi%2Bestape%2Caps%2C109&sr=8-1)

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 **Prostate Cancer Video**  Collection





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