LATE NEWS

CHANGE TO LISTED GUEST SPEAKER - AUGUST 25 AT 7PM

Due to unforeseen circumstances Dr Prem Rashid is unavailable for this meeting. At short notice Dr Phillip Katelaris has kindly agreed to speak on:

Living Well With Prostate Cancer: Diet, Lifestyle, Sexuality and Relationships.

Please join us to hear more on this very relevant topic as a follow up to last month’s presentation.

Diary Dates

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 25</td>
<td>As above</td>
<td>7.00pm</td>
</tr>
<tr>
<td>September 8</td>
<td>Support Group meeting</td>
<td>2.30pm</td>
</tr>
<tr>
<td>September 9</td>
<td>Men’s Health Public Forum</td>
<td>6 for 7pm</td>
</tr>
<tr>
<td></td>
<td>(Level 2 Conference Room)</td>
<td></td>
</tr>
<tr>
<td>September 22</td>
<td>Dr Phillip Katelaris, Urologist</td>
<td>7.00pm</td>
</tr>
<tr>
<td></td>
<td>Questions you’ve always wanted to ask</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(&amp; Continence &amp; the Ad-Vance Sling)</td>
<td></td>
</tr>
<tr>
<td>October 13</td>
<td>Support Group meeting</td>
<td>2.30pm</td>
</tr>
<tr>
<td>October 19</td>
<td>Run for Life @ SAH</td>
<td></td>
</tr>
<tr>
<td>October 27</td>
<td>Men’s Health Forum—Patients/Carers</td>
<td>7.00pm</td>
</tr>
<tr>
<td>November 10</td>
<td>Support Group meeting</td>
<td>2.30pm</td>
</tr>
<tr>
<td>November 24</td>
<td>Visiting Speaker TBC</td>
<td>7.00pm</td>
</tr>
<tr>
<td>December 8</td>
<td>Support Group Meeting - Christmas Afternoon Tea</td>
<td>2.30pm</td>
</tr>
<tr>
<td>December 14</td>
<td>Carols by Candlelight</td>
<td></td>
</tr>
</tbody>
</table>

PCFA’s NEWCASTLE MEN’S HEALTH FORUM—A huge success!

360 people attended the Newcastle City Hall from 9am Sunday 3rd August to hear a wonderful selection of local, Australian and International medical professionals speak on various aspects of prostate cancer treatment options, side effects and outcomes. One of the highlights of the program was to hear from world-renowned Urologist, from the USA, Dr. Patrick Walsh.

Good fellowship was enjoyed and much progress made in outlining the steps being taken to assist men in the Newcastle/Hunter Valley area who, unfortunately, have a higher incidence of prostate cancer than most other areas of New South Wales.
David and I, along with other PCFA advocates and staff, once again, attended this outstanding symposium. 

PCFA was the principle sponsor. It was a couple of days of listening to and interacting with top international and Australian speakers.

It would be a monumental task to give outlines of what all the speakers presented so we will highlight three (two in this edition).

**BIOGRAPHIES:**

**Dr. Patrick Walsh, M.D.**

is best known for his 30 years as the Professor and Director of the Brady Urological Institute and for his pioneering work in the development of ‘the anatomic approach to radical prostatectomy’, which involves nerve-sparing techniques that have reduced the probability of impotence and incontinence. Dr Walsh is University Distinguished Service Professor of Urology, The James Brady Urological Institute, The Johns Hopkins Hospital & Department of Urology, The Johns Hopkins University School of Medicine.

Along with co-workers, he was the first to describe the 5 alpha-reductase enzyme deficiency, to develop an experimental technique for the induction of benign prostatic hyperplasia, to demonstrate the influence of reversible androgen deprivation on BPH, and to characterize hereditary prostate cancer. Together with Janet F. Worthington, he authored the best-selling book for lay people: *Guide to Surviving Prostate Cancer* (available through Amazon.com for $US11.55 + postage … and we can recommend it as a guide every man should have who is diagnosed with prostate cancer!)

**Dr. William (Bill) J. Catalona, MD,**

Professor of Urology is the Director of the Clinical Prostate Cancer Program for the Northwestern University School of Medicine.

He was the first to show that the prostate-specific antigen (PSA) blood test could be used as a first-line screening test for prostate cancer. He is currently conducting research in prostate cancer tumour markers and the genetics of prostate cancer.

Dr. Catalona is an expert in performing the “nerve-sparing” radical prostatectomy, having performed more than 5,000 of these operations. He has served on advisory boards of the American Cancer Society and the editorial boards of several medical journals. His current research is in prostate cancer genetics and tumour markers for prostate cancer.

**Dr Vip Patel** is the director of the Global Robotics Institute at Celebration Health in Orlando, Florida. He leads one of the world’s most experienced robotic surgery teams and travels worldwide to educate physicians and care for patients. He is Editor in Chief of The Journal of Robotic Surgery and Editor of the first ever Robotic Urology textbook. Dr. Patel is world renowned for his contribution to the field of robotic surgery and is committed to personalised patient care and quality outcomes. He is one of the most experienced robotic surgeons in the world and has personally performed almost 2000 robotic prostatectomies.

Our sincere thanks to Prof. Tony Costello, Professor & Head of Urology, The Royal Melbourne Hospital Department of Surgery, The University of Melbourne for again inviting the experts to speak in Australia.

**RADICAL PROSTATECTOMY—PAST, PRESENT & FUTURE**

**Dr Walsh**

Radical prostatectomy was first performed in the United States by Hugh Hampton Young at the Johns Hopkins Hospital via the perineal technique in 1904. In 1947 Terrence Millin developed the retropubic approach. By the 1970’s this procedure was rarely performed because of the side effects. The value of radical prostatectomy came under further attack by Dr Whitmore with his famous saying: “is cure possible when necessary & necessary when possible?” During this era death from cardiovascular disease was most likely. However, there has since been a revolution in medical & surgical management of cardiovascular disease.

**Progress:** There has been major progress by many investigators in areas that apply to radical prostatectomy: anatomy, pathology, surgical technique, quality of life, cancer control, research (by providing tissue for evaluation) and technology.

**Anatomy, Surgical Technique and Quality of Life:** At the time of Dr Walsh arriving at Johns Hopkins, in 1974, radical prostatectomies were rarely performed. He asked the simple question: if it were possible to cure prostate cancer with surgery with few or no side effects there should be less debate on how patients should be treated. He evaluated those side effects and learned that the morbidity arose from a lack of understanding of the anatomy of the periprostatic tissue. Bleeding occurred because the anatomy of the dorsal vein complex and Santorini’s plexus was not charted.
All men were impotent because the location of the autonomic innerva-
tion to the pelvic organs and cor-
pora cavernosa were not known
and incontinence was common be-
cause the anatomic understanding
of the sphincteric complex was in-
correct. This ignorance arose be-
cause the study of peri-prostatic
anatomy in cadavers was difficult
secondarily to artefacts induced by
fixation and compression of pelvic
organs by abdominal viscera.
The solution was to use the operating
room as an anatomy laboratory
and foetal dissections.

Cancer Control: Shortly after the
anatomic approach to radical
prostatectomy was developed PSA
screening came online. It was then
possible to provide curative ther-
apy with less morbidity and to iden-
tify men who had curable disease.
The use of radical prostatectomy
increased markedly. The value of
radical prostatectomy was shown
in the randomized trial carried out
by the Scandinavian Prostate Can-
cer Group where 795 men (mean
age 65) were randomized to watch-
ful waiting or radical prostatectomy.
At ten years men who underwent
surgery had a significant reduction
in progression to metastases
(40%) and death from all causes
(16%). But only men under the
age of 65 at the time of randomiza-
tion had a significant benefit in can-
cer specific survival at ten years:
in the watchful waiting group 19%
died of cancer versus 8.5% in the
surgical group.

These findings have major implica-
tions. In 1983, when only 7% of
men with prostate cancer un-
derwent surgery and radiation therapy
was too under powered to cure, es-
sentially no one was being
treated with curative intent. By
1992 one third of men underwent
surgery and that year 104,000 radi-
cal prostatectomies were per-
formed. The combination of surgery
and PSA screening are largely re-
ponsible for the observed reduc-
tion in prostate cancer mortality in
the US. In 1995 there were
40,400 deaths from prostate
cancer in the US and by 2007
27,050 (a 33% decrease) the
largest decrease in cancer
deaths in men or women for any
cancer during that era.

Technology: The revolution has
been in the introduction of ro-
botic radical prostatectomy. The
advantages being magnification
and reduced blood loss. The
disadvantages: the absence of
haptic (sense of touch) feed-
back, expense and the possibility
of compromised cancer control.
Robotic surgery has ‘raised the
bar’!

Now urologists found the need to
improve their techniques. The
introduction of external beam
radiotherapy meant it was nec-
essary to reduce the side effects
of radical prostatectomy. And
so, with the advent of robotic
radical prostatectomy there is a
need to improve open radical
prostatectomy which has oc-
curred. It was obvious patients
did not have to be hospitalised
for so long, they did not need as
much pain medication and the
operation could be performed
through a smaller incision. A
recent study, by Dr Walsh & oth-
ers, found that both techniques,
robotic and conventional RP,
provide comparable short-term
discharge recovery including
time to normal and full activity,
driving and post discharge nar-
cotic use.

It has also been possible to im-
prove the recovery of potency in
men undergoing nerve-sparing
RP. Dr. Mani Menon has pio-
nereed the concept of releasing
the levator fascia (and in his
case prostatic fascia) higher on
the prostate.

Dr Walsh and his team devel-
oped a procedure similar to that
described previously. Thus men
with normal sexual function pre-
operatively who underwent bilat-
eral nerve-sparing, high anterior
release of the levator fascia, ei-
ther unilaterally or bilaterally, im-
proved sexual function following
surgery.

The results of a survey using
SHIM (Sexual Health Inventory
for Men)........ greater than 21
preoperatively against a SHIM
score of greater than 15 post-
operatively, there has been an
outcome of 77% in men who did
not undergo high anterior release
to 93% in men who did undergo
high anterior release. The major
impact of this surgical technique
is improved accuracy in preser-
vation of the neurovascular bun-
dle with less traction during the
apical dissection, rather than
preservation of anterior nerve
fibres. Because these excellent
results occurred in patients who
underwent an interfascial dissec-
tion, leaving the prostatic fascia
on the prostate, we believe that
the nerves in the prostatic fascia
only provide innervation to the
prostate and do not supply innerv-
ation to the corpora cavernosa.
Regardless, these improved out-
comes occurred because robotic
prostatectomy provided a chal-
lenge which was met with open
prostatectomy.

Positive Surgical Margins:
Willett Whitmore quoted: “There
is no better way to cure cancer
that is confined to the prostate
than total surgical removal”.
There is great variation in the fre-
quency of positive margins in the
presence of organ confined dis-
ease. In a recent study at Johns
Hopkins of over 7,500 men with
organ confined disease the fre-
quency of positive margins was
only 1.8%.

Why do positive margins occur?
Because the prostate cancer is
multi-focal. If a patient has a le-
sion in the left apex it does not
mean that he doesn’t have multi-
focal disease on the right. Thus,
using proper surgical technique the entire prostate needs to be removed. As it is possible that the definition of positive margins by surgical pathologist varies at different institutions the problem will be addressed at an International Society of Urological Pathology conference on the definition of positive margins in 2009. However, it is clear that the ultimate answer is experience, experience, experience. One notion is that until individuals had performed approximately 200 cases then a plateau was not reached.

Too Many Treatments, Too Few Answers: There are many competing modalities for the treatment of localised disease and the real question is how do they compare to surgery and how can we find out? Dr Walsh indicated a recent multi-institutional study on quality of life and satisfaction with outcome among prostate cancer survivors who underwent radical prostatectomy, external beam radiotherapy or brachytherapy. The figure which compared outcomes was a model of clarity making it easy for urologists and patients to understand the relative morbidity of these procedures. The challenge will come in comparing cancer control in these three groups. Following surgery cancer control is defined as an undetectable PSA and following radiation it’s defined as the nadir + 2 ng/ml. The surgical definition is sensitive but not specific and radiation definition is specific for clinical failure, but not as sensitive. How can cancer control between these two be compared? Radiation oncologists have elected not to define cure. Urological Oncologists need to develop a definition of failure for surgery that predicts end points similar to the nadir + 2ng/ ml definition.

Adjuvant Treatment For High Risk Disease and Salvage Treatment for Biochemical Failure: In men who are not cured by surgery the most common form of adjuvant and salvage therapy used by urologists has been hormonal therapy. Dr Walsh has never been an advocate for early hormonal therapy based on the VA Cooperative Research Group’s Study 1 which looked at early orchidectomy versus delayed hormonal therapy. In this study there was no difference in overall survival in patients with either non-metastatic or metastatic disease. A paper from the American Society of Clinical Oncology concludes that in metastatic or progressive prostate cancer immediate versus delayed androgen deprivation results in a moderate decrease (17%) in prostate cancer mortality, a moderate increase (15%) in non-prostate mortality, and no overall survival advantage. Does the 17% reduction in prostate cancer mortality make it worthwhile? Dr Walsh answers with a resounding ‘no’ because the improved cancer specific survival is an artefact. Because hormonal therapy increases death from other causes men do not live long enough to die from their cancer.

Therefore urological oncologists need to explore new innovative approaches to adjuvant and salvage therapy. Early hormonal therapy has been a major obstacle in developing innovative approaches for high risk men. For example, the evaluation of adjuvant versus early salvage radiation at first PSA failure following radical prostatectomy (SWOG 8974) and adequate accrual for adjuvant chemotherapy trials, eg TAX - 3501. Leadership is required from the Society of Urologic Oncology.

The following major challenges for the future are: 1) Imaging: accurate techniques to estimate the extent and location of tumour within the prostate; 2) cohort studies: for comparison of cancer control and quality of life with competing forms of treatment; 3) adjuvant trials: to improve cancer control in men who are not cured by surgery alone.

* * * * * * * * * * * * * * * * * * * * * *

ROBOTIC RADICAL PROSTATECTOMY

Dr Vip Patel

Dr Patel introduced Robotic surgery as being a “computer assisted mechanical device controlled by the surgeon”. The aim of any radical prostatectomy is the ‘trifecta’: cancer control, continence and potency. Modern day surgical robots are a form of computer-assisted surgery using a “master-slave relationship” in which the surgeon is able to control the actions of the robot in real time, using the robot to improve upon his/her vision, dexterity and overall surgical precision.

In the US robotics has had a dramatic impact on the treatment of prostate cancer. With an annual incidence of 230,000 cases prostate cancer is the most commonly diagnosed cancer in males. Dr Patel’s experience extends over a period of 4.5 years with some 1500 prostatectomies having been performed. The average age of these men is 60.7 years and the media pre-op Gleason score is 6 with clinical stage 75% T1c.

Robotic surgery allows for minimal invasive surgical techniques relying on small half-inch incisions encircling the surgical field in order to insert small scopes and instruments. This makes possible a reduction or complete elimination of the “collateral damage” required to gain access.
You can support PCFA by purchasing your Christmas Cards through [christmascards4charity.com.au/pcfa](http://christmascards4charity.com.au/pcfa)

An excellent choice is available for your personal cards. However, you can also personalise corporate Christmas cards, with your choice of verse and company logo. Orders need to be in Multiples of 50. 10% discount if ordered by October 10th otherwise 5% discount applies.

---

**FATHERS DAY 5 SUNDAY 7TH SEPTEMBER**

8.30AM TO 1.30PM

Come along for a great family fun day out. Heaps of entertainment and activities for the whole family. Get fit and have fun, all for a great cause.

**Fun for the Kids:** “Po” from Kung Fu Panda; baby animal farm; free pony rides; free giant jumping castle with obstacle course.

Bring your kids and the grandchildren!


---

Robotic surgery has provided the technology to address limitations of earlier technology which included loss of a natural 3-D image, depth perception and articulated movements. Surgical robots relieve some of these limitations by providing fine motor control, magnified 3-D imaging and articulated instruments.

The da Vinci system is based on three components:

1. a master-slave, software-driven system that enables intuitive control of laparoscopic instruments with six degrees of freedom;
2. A stereoscopic vision system displayed in an immersive format; and
3. A system composed of redundant sensors to provide maximum safety in operation.

The system consists of three separate units:

**The Console** which is positioned remotely from the patient and connected by a cable to the video cart and the surgical cart. The console houses a stereo viewer. The surgeon’s hands are inserted into free-moving ‘masters’ or finger controls, which convert the movements of the surgeon’s wrist and fingertips into electric signals. These are then converted to computer commands to direct the robotic instruments to perform the same movements in the operative field. The console has controls for 3D viewing, motion scaling (5-1 means that five units of motion of the surgeons hands are reduced to one unit of motion for the instruments) and tremor filtration.

**The Video cart** has two video camera control boxes and two light sources, plus a synchronizer.

**The Surgical cart** supports either 3 or 4 robotic arms. Surgical instruments are attached to the robotic arms through an adapter.

Disadvantages include the lack of tactile feedback, bulky robotic arms with large excursion arcs, limited instrumentation and the inability to move the surgical table when the robot arms are attached to the ports.

Operative time has been reduced to 75 minutes; hospital stay for 97% of cases of less than 24 hours and catheter time from 4-7 days (with a mean of 5.6). Reduced intraoperative blood loss has been regarded as one of the hallmark advantages of laparoscopic prostatectomy. Early identification and precise ligation of vessels facilitates this limitation of blood loss.

Robotic Assisted Laparoscopic Prostatectomy (RALP) is performed through several small incisions and is associated with minimal post-operative pain. It has been proposed that RALP can potentially result in better continence or an earlier return of continence as a result of improved preservation of urethral sphincter, increased urethral length and a water-tight anastomosis (joining of the urethra to the bladder).

Younger age, better pre-operative potency, and extent of neurovascular bundle preservations are factors that have been shown to affect post-operative return of erectile function. Damage can occur as a result of thermal or traction injury, direct incision, or incorporation of the nerve into hemostatic sutures or clips.

What’s next? New small robots, nano robots, single port access robots, open inside of the body via single access, natural orifice surgery, no holes, integration of imaging during surgery.

Men’s Health Forum at SAH Level 2 Conference Room
September 9th, 6 pm for 7pm

Topics for the evening include:

• General Preventative Healthcare, fitness, diet & weight management
• Prostate Enlargement & Cancer
• Diabetes

Guest speakers - Exercise Myths & Misconceptions — Ms Emily Cook
Nutrition & Healthy Eating — Ms Helen Parish
Prostate Enlargement — Dr Phillip Bergersen
Diabetes — Ms Therese Cameron

Prostate Cancer Support Group Details, Jacaranda Lodge — Cancer Support Centre

Group Leaders:
David Sandoe OAM 9983 0877
Pam Sandoe OAM sandoe@optusnet.com.au
Ron Mead eppingmead@gmail.com
Graham & Adele Staggs gstaggs@accsoft.com.au

Cancer Support Centre:
Margaret Adams support@sah.org.au
Nerolie Gate support@sah.org.au
Phone Ron, Graham & Adele, Margaret & Nerolie on 9487 9061

Useful websites:
www.andrologyaustralia.org            www.beyondblue.com.au

www.beyondblue.org.au is an Australian organisation providing information about depression to consumers, carers and health professionals.

For rural & remote readers:  www.raplink.org.au
RAPLINK is a self-funded organisation linking communities with information and resources

You have received this newsletter because you have provided your contact details to us as the Prostate Cancer Support Group (PCSG) at the Sydney Adventist Hospital. The primary purpose of collecting your contact details was to enable support, resources and information to be offered to you as a person affected by or interested in prostate cancer. We do not use or disclose your details so as to ensure we comply with the Privacy Act.

As a member of an affiliated PCSG (with Prostate Cancer Foundation of Australia) you will initially receive by post or email our group newsletter and the national quarterly Prostate News. If you are not receiving Prostate News please contact PCFA on www.pcfa.org.au or on the phone number listed below. You may also receive other communications from time to time such as advice on upcoming symposia, news and guidelines being reviewed. You may ‘opt-out’ of any of these services at any time, ie. you will no longer receive any material of that type, by letting us or PCFA know your wishes.

Please contact Nerolie Gate on 02 9487 9061 regarding the newsletter or PCFA on 1800 22 00 99 regarding Prostate News.

Disclaimer: The information in this newsletter is not intended to be a substitute for professional medical advice, diagnosis or treatment. Always seek the advice of your qualified medical professional.