

ACTIVE SURVEILLANCE

Compiled by Charles (Chuck) Maack – Prostate Cancer Advocate

When a man posts a request for comments regarding Active Surveillance to the prostate cancer support lists he is going to get a multitude of replies from other patients among which will be reasonable suggestions and references as well as many that will include little information, and likely none from a physician. When I save information I try to combine it with other information with the intent to provide more than one reason supporting a choice. One man made note that Medical Oncologist Stephen Strum's remarks, below, appear to be merely philosophizing. I rather see his remarks as providing medical expertise that identifies tests that patients and most urologists may not even be aware and thus would not have even considered. In my opinion, he does so as an experienced, caring physician who has been there, done that, having treated thousands of patients with advanced prostate cancer since 1983, so recognizes the value of those tests in the big picture of a patient's health.

Active Surveillance is receiving more support as a viable option. See the attached link.

<http://www.nccn.org/about/news/newsinfo.asp?NewsID=235>

It appears that patients considering Active Surveillance should request that tissue samples from biopsy have immunohistochemical staining with H&E, P63/AMACR and Ki-67, since the Ki-67 biomarker is a proliferation antigen that is detected by this process. When a tumor cell tests positive for Ki-67, the tumor is actively growing. In a study, when greater than 7.1% of the tumor cells stained for Ki-67, there was a significantly increased risk of distant metastasis and death due to prostate cancer. See: <http://tinyurl.com/p3a6xo> and <http://tinyurl.com/odbf7u>.

Active Surveillance with delayed treatment appears to be a safe option for younger men with low-risk prostate cancer. To track progression, PSA was measured every 3 months, transrectal ultrasound (TRUS) was performed every 6 to 12 months, and repeat prostate needle biopsy was done at 12- to 24-month intervals. (PLEASE NOTE: In men undergoing active surveillance, the anterior region of the prostate should be specifically sampled on repeat biopsies.) Progression was defined as PSA velocity greater than 0.75 ng/mL/yr, a rise in Gleason score, or greater than 50% increase in lesion size on TRUS. (My note: Which would indicate the time

when a treatment option would be determined)

<http://www.cancernetwork.com/article/showArticle.jhtml?articleId=201300285>

Prostate Calculator to have some idea of your status based on your diagnostics:

<http://www.prostatecalculator.org>

And here is another recommended test for those considering the Active Surveillance approach:

May 12, 2008 — The urine test for the PCA3 gene, already marketed for use in diagnosing prostate cancer, could also be useful in prognostication. It might have clinical application in selecting men with low-grade and low-volume tumors who would be suitable candidates for active surveillance, say researchers writing in the May issue of the *Journal of Urology*.

Full article:

<http://www.medscape.com:80/viewarticle/574379>

One of the foremost pathologists in the nation regarding prostate cancer, David Bostwick of Bostwick Laboratories, provides the PCA3 test – marketed as PCA3Plus. May I suggest that you review the URL below to learn more about this innovative test and consider this addition to your testing if considering Active Surveillance. You can then arrange with your local physician to do the required DRE massage of your prostate gland followed by a urine sample to then be sent to Bostwick Laboratories,. I have been advised by a representative of Bostwick Laboratories that the PCA3Plus test is covered by Medicare. For patients without insurance or whose insurance may not cover the cost of this test, the test costs approximately \$150.00. Here is info re PCA3Plus to identify the presence of prostate cancer and you can contact Bostwick Laboratories if you want to learn more:

<http://www.bostwicklaboratories.com/Home/Services/Prostate/PCA3Plus.aspx>

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Glen Allen, VA 23060
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<https://www.bostwicklaboratories.com/patientservices/primary.html>

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Active Surveillance may spare two-thirds of men with early prostate cancer the side-effects of treatment, without compromising their survival. Continuing studies seek to identify the optimum schedule of PSA testing and repeat biopsies, the appropriate indications for intervention, the long-term efficacy of surveillance in comparison with immediate radical treatment. Active surveillance provides excellent opportunities to identify markers of prostate cancer behavior, and to test novel therapeutic strategies. Active Surveillance may prove to be the start of a paradigm-shift in the management of early prostate cancer. (As concluded in: <http://www.prostatecancerwatchfulwaiting.co.za/ActiveSurveillance.pdf>)

The following are excerpts of remarks made by Medical Oncologist Stephen B. Strum to a patient considering “watchful waiting:” “GS 6, apparently normal DRE, core tissue involvement not mentioned. My comments here would be that validation of the Gleason score by an expert reader in PC should always be done. There is great variability in the skills of homo sapiens & physicians are no different. There is an old joke that goes like this: What do you call a person who graduates medical school first in his class? Doctor. What do you call a person who graduates medical school last in his class? Doctor. This is not a criticism but a reality that human talent follows a bell-shaped curve. As someone who was trained in hematopathology—the pathology of lymph nodes, bone marrow & spleen--I have seen gigantic variations in the skill levels of pathologists submitting tissue for second opinion at a major university in which I trained. Secondly, watch & wait is a stupid concept since we have a finding (a diagnosis of a malignant disease) that should be signaling us that the system has a defect in it. It is a red flag that should tell us that attention needs to be given to avoid a greater injury. Therefore, the term watchful waiting (WW) or even the term I coined to supersede WW, AOS (Active Objectified Surveillance) should be abandoned, in my opinion. The term I would like to see used is Pro-Active Integrative Care (PIC). Maybe this should even be altered to PIM--Pro-active Integrative Management. What does this mean? The condition we think of as health depends on the health of interconnected units, similar to the circuitry of an electronic device with a host of connectors, transistors, resistors, capacitors & the like. It is a Swiss watch with interconnecting gears, both small & large, but requiring the integrity of all to have the watch healthy & deliver accurate time. In the setting of a new diagnosis of PC,

I routinely assess as many of these different "gears" or functions to make sure that none are out of balance. Almost invariably there are some findings that need fixing. For example: Bone integrity as measured by QCT bone density, Deoxypyridinoline (DPD) along with the history of use of exercise or not. Lipid status in the form of a NRM LipoProfile (newest & best test) or VAP cholesterol (excellent test for lipid status now superseded by the NRM LipoProfile) or at least a basic lipid panel consisting of cholesterol, LDL, HDL, & TG (triglyceride) levels. Vit D status as measured by at least 25-OH D3 levels which are abnormally low in 80-90% of all men with PC that have consulted with me. Omega 3 fatty acid & omega-6 fatty acid status which affects production of prostaglandins & leucotrienes which can stimulate PC growth. The best test for this is done via Mayo Medical Labs and is called an EFA (essential fatty acid profile) (12-14 hour fast and no alcohol for 24 hours before blood draw).

<http://216.245.161.151/TestView.aspx?testID=7754&searchfor=82426>

Other factors which affect health & interact with PC include thyroid status as measured by usTSH (ultra-sensitive thyroid stimulating hormone), Free T4 & T3 & RT3; homocysteine (HCY) & hsCRP (hypersensitive C-reactive protein) as well as sensitive tests of renal function which are almost always ignored which include random urine ratio of albumin to creatinine or the most sensitive test of renal function called Cystatin C. When we do not ignore these issues, even decades before a diagnosis of PC is made, we fine tune the health of the patient and avert problems later on. The above approach is real & significant in light of articles we see where the impact of total health is related to our treatment of PC. DRE (digital rectal examination). TRUSP (transrectal ultrasound of the prostate) at intervals perhaps of every year to 2-3 years pending stability. Endorectal MRI with or without spectroscopy if item above not done or if you wish further imaging input. PAP (Prostatic Acid Phosphatase) every 2 years to make sure that a PC confined to the prostate is not approaching a critical PAP threshold of 3.0 or higher which confers a poorer prognosis in the face of RP, or any form of RT." (My note: Point being, despite opting to delay treatment, it is important to look into other diagnostics to correct what may be other health deficiencies as well as continue close attention with diagnostics to be aware should one's PC suddenly show aggressive development.)

And here is an interesting recent study from October 2009:

<http://tinyurl.com/ykyqjgt>

Hidden prostate cancer tumours evade treatment: study

Canadian researchers have found that some hidden prostate cancer tumours cannot be diagnosed with the current procedures. Researchers at Toronto University say their findings explain why some men with elevated prostate specific antigen (PSA) levels who are carefully monitored and undergo repeated negative biopsies still develop aggressive prostate cancer. They say these hidden tumours located on the top of the prostate evade traditional diagnostic procedures, including ultrasound guided needle biopsy. In their research, published Thursday in the British Journal of Urology International, the Canadians say that magnetic resonance imaging (MRI) is the best tool to reveal such tumours. As part of their research, a team of urologists, surgeons, radiologists and pathologists studied 31 patients who had positive biopsy results and tumours on top of their prostate as shown on MRI. They found that MRI was able to help diagnose hidden prostate tumours 87 percent of the time. “Our findings identify a specific high-risk group who tumours are difficult to diagnose because of location. These men benefit from MRI which guides the biopsy procedure with a high degree of accuracy,” said study author Nathan Lawrentschuk, urologic oncology fellow at the university. “The research team call the clinical presentation of elevated PSA and repeated negative biopsy results ‘prostate evasive anterior tumour syndrome’ (PEATS),” he added. Lead researcher Neil Fleshner said: “Knowing about PEATS may also be important for men already on ‘active surveillance’ – patients with slow-growing prostate cancer who are being regularly monitored through PSA and biopsy. “Every man does not need an MRI, but knowing about PEATS will help identify those who do.”

From the foregoing, close attention to testing and monitoring diagnostics is of absolute importance by both the physician as well as by the patient. The importance to the patient is insuring that his physician is paying close attention by scheduling necessary testing and monitoring.

(For patient perspectives having opted for Active Surveillance, go to Terry Herbert’s website

<http://www.yananow.net/Experiences.html>)

Disclaimer: Please recognize that I am not a Medical Doctor. I have been an avid student researching and studying prostate cancer as a survivor and continuing patient since 1992. The comments or recommendations I make are not intended to be the procedure for you to now follow; rather, they are to be reviewed along with the comments or recommendations of others for your own further research, study, and discussion with the physician providing your prostate cancer care to come to your own, personal conclusion.

