THE WEST WALES PROSTATE CANCER SUPPORT GROUP

REG. CHARITY NO.1229395
www.westwalesprostatecancer.org.uk
Patron: Chris Jones. Television Presenter.

NEWSLETTER DECEMBER 2018

Dear Member/Friend
Welcome to this edition of our Group's Newsletter. If anyone has any items they would like to appear in the next or future newsletters please let me know. All contributions or ideas gratefully received. (DG).

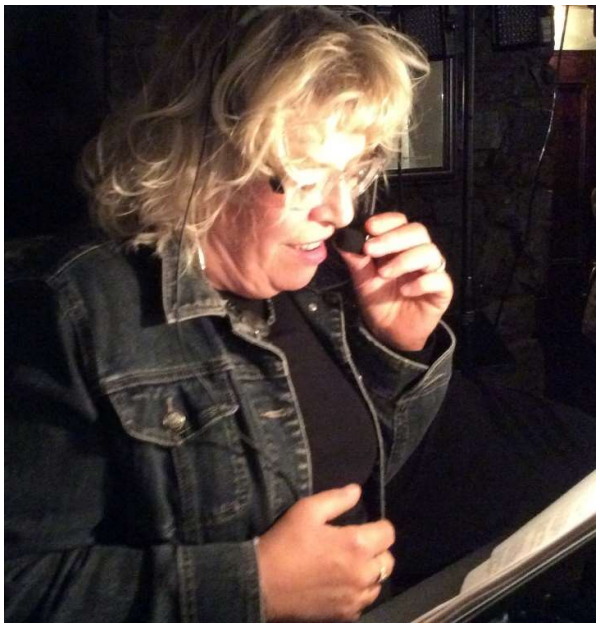
We welcome several new members to the group and hope to see you at future events. We also welcome Ray Paul as a new member of our group's committee. Thank you Ray for agreeing to join us.

David Bunce's Gig at The Penrhiwllan Inn

Dave Bunce (our Treasurer) played guitar and sang at a gig to raise funds and publicise our charity on the 21st September at The Penrhiwllan Inn, New Quay.

David Bunce and Ray Howe at the Penrhiwllan Inn

Chrissie Bunce read a cheeky poem:



Ray Howe did a brilliant job organising the event and the raffle. The whole evening raised £280. Thanks to Ray and the Bunces and all at the Penrhiwllan Inn.
David would like to do several more "gigs" in the future and is looking for ideas from the membership where these could be held. Please get in touch with him if you have any ideas for potential venues. (Please see Contacts list at the end of the newsletter.)

Future collection dates:

David Parmar-Phillips would appreciate offers of help from anyone who feels able to "man" our stand. Please see the Contacts list at the end of this newsletter.
If anyone has ideas for future places we could "collect" from or if you feel you can help in any way please get in touch with Ken or any of the Davids, or chat to us at the next pub lunch. It's not about the money but the opportunity to be seen in the community and get our existence known. It's a chance to interact with the general public and answer their queries where possible or point them in the right direction.

Donations received with our thanks:

Kidwelly Tractor Boys have sent us another cheque for £200.

St David's Church Neath have donated £504 to our group.

We thank all of these people and groups for their generosity.

Here, as promised in the September newsletter, is Jeff's story in his own words:

ADVANCED PROSTATE CANCER. MY STORY SO FAR..... by Jeff Thomas

Overview
PSA at initial diagnosis Feb 2017– 1547. — Extensive bone metastasis (mets) in spine, ribs and skull. Initial treatment monthly Degaralix (hormone therapy) injections, followed by 3 monthly Prostap 3 hormone therapy injections. Then 6 x 3 weekly Docetaxel chemotherapy infusions. A 6 month treatment "holiday", followed by another rise in PSA, which resulted in a further 7 x Cabazitaxel chemotherapy infusions, and currently now on 6 x monthly Radium 223 infusions.....

Before I started this journey and learnt a lot more about Advanced Prostate Cancer, (APca), I would say that this disease crept up on me quietly, in that prior to the end of January 2017 I had no significant outward symptoms, other than general aches and pains, which I put down to age, regular golf games and maintaining a 2 acre plot of land!!

However now I know better, it's obvious that whilst over the years I displayed no debilitating or obvious PCa symptoms, the fact that during a routine medical in work in 2007, (which indicated a PSA of 4,) which at the time I was told "was normal for age", now indicates that something was possibly "brewing" all that time ago? (ED: Jeff says he had no PSA tests between 2007 and 2017).

Anyway without further ado I'll now recount my story and treatment plan to date, but before I start I must mention the fantastic service/treatment/care plans that I've received from the NHS, both here in Wales, (mainly Glangwili Carmarthen), and currently in the Bristol Royal Infirmary. The service levels I've received have been nothing short of fantastic, and have been provided in a professional and efficient manner. Thank you one and all.

So, as mentioned above, this all "came to a head", following a golfing holiday in Spain at the end of January 2017. Where after 4 days of golf and some serious drinking sessions, yes, we all treat Golf trips as the rugby trips we all went on for many years in our younger days?? I came home with a severe headache and stabbing pains in my lower back and shoulder regions. Again initially I put this down to my body saying, at (64), it's time to slow down and start thinking about a SAGA holiday!! So I just popped some normal pain killers and carried on regardless!

However after a few days I was still feeling rough so went to the doctors who initially treated me for approx. 2 weeks for shingles? Again no improvement, so on a subsequent visit they arranged for a full blood test to be taken which resulted in the 1st of many visits to the Chemotherapy unit at Glangwili.

During this 1st visit I was seen by Mr Moosa, who undertook an ultrasound prostate biopsy, and gave me his initial thoughts that I had advanced

prostate cancer with possible bone complications and started me on my treatment plan with 2 x Degaralix hormone injections. The following day I had an ultrasound scan on my stomach area which ruled out "mets" in my soft tissue and other organs. The following week I had a full head to toe bone scan in Withybush, (scary as it took over an hour in the tube)!! which confirmed the siteings of multiple mets in my spine, ribs and skull.

I then had my 1st MRI scan in Glangwili (7th March 2017), and was referred to meet with Mr Ng (Urologist), in Llanelli. Following this meeting Mr Ng confirmed all the previous findings, and arranged a follow up CT scan in 3 months. He then referred me to see Dr. Phan (Oncology) in Glangwili who has been in charge of my treatment plan since then.

During my initial consultation with Dr Phan (27/3) she outlined the fact that if I'd presented earlier then I may have been curable, whereas now all we can do is manage "it"!! However as I had no discernible symptoms how could I "present" earlier.

Needless to say this "cut me off at the knees", as I think this may have been my first realisation of how serious my condition was. She then outlined my immediate full treatment plan which would follow the current "gold standard" for PCa treatment of continued hormone therapy coupled with early Docetaxel chemotherapy, and I must say I now have complete faith in her plans for me and can't fault her professionalism either.

She also agreed that whilst there was no actual scientific backing for a change of diet, eating a healthier diet must help, so I immediately gave up beer, red meat, burgers, bacon, sausages and most processed foods, and changed dairy for soya milk. This was replaced with various vegetarian options, eg. quorn sausages, more veg, turkey, chicken and fish. During this initial diet period I lost $1^1/_2$ stone in weight, and I've managed to keep about a stone under my previous weight to this day, which was needed and made me feel a lot better. I also monitor my temperature, toilet habits, food intake and activity levels in my daily diary entries.

Dr Phan also outlined the main side effects of chemotherapy and away we went…….
I started chemo on the 11th April 2017, and undertook the full 6 x 3 weekly treatments without too many issues, in that whilst I lost most of my body hair, which has since grown back, I retained my taste and appetite and positive outlook, which helped me to maintain a healthier intake of food during these treatments.
During these treatments I had several more scans which confirmed that whilst there was no cure to my PCa, my mets were stable and not growing.

Finally for this phase of treatment I had a full blood test in September 2017 which confirmed that my PSA had decreased from 1547 to 225, my testosterone was still suppressed and no change to tumour size. It was then agreed that other than regular 3 monthly PSA checks I would start a treatment "holiday". My next PSA check in November 2017 was 94 which was and is to-date my lowest ever reading.

18/12/17- met with Dr Phan re way ahead. Changed to 3 monthly hormone injections (Prostap 3), and review again Feb 2018.

So we get to January 2018, still on a treatment holiday, feeling ok, and following the submission of a letter from Dr Phan to my insurance company, I re-booked for our annual golfing trip to Spain!?! - which I enjoyed even tho I only drank alcohol free San Miguel.

Details of my Second year of treatment to follow in next newsletter……..and note for the sequel I'm trying to get Daniel Craig to play me???
Jeff Thomas.
(Thanks Jeff for sharing your story with us DG)

News from the Prostate Cancer UK website:
A screening programme could change the lives of men across the UK

'Together we can change the way prostate cancer is diagnosed forever.'

We're delighted to announce that we're looking to fund our biggest ever research project to make a national screening programme a reality. The trial will aim to recruit 20,000 men to determine whether the advances we've made in diagnosis can be brought together to form a national screening programme.

One man who really knows the importance of a screening programme is Tony Collier. He was diagnosed last year with prostate cancer at the age of 60, but it had already spread to his bones. He said, "*It's been so difficult for the family to deal with, we feel as if we're living in a parallel universe. My urologist told me that I could've had the cancer for 10 years. A screening programme could have caught my cancer in time, which would have given me many more years and today I wouldn't be wondering how many Christmases I have left with my family.*"

Prostate cancer often doesn't have any symptoms until it has started to grow and spread outside the prostate. Every year over 9,000 men are diagnosed with prostate cancer too late and told that it can't be cured. A screening programme could help diagnose men before it's too late, so they have a 98 percent chance of surviving ten years instead of just 22 per cent.

Unfortunately, this kind of ground-breaking research doesn't come cheaply. A trial like this would cost about £5 million. That's a lot to raise but it's still a bargain when you compare it against the thousands of lives that could be saved every year.

Of course, we all know that catching cancer early is better – it's not as if this is a new ambition. What is new is the accumulation of 30 years of research that, with your support, has reached a critical mass. We've pulled together research into genetics and the increased risk from family history, biological markers in the blood and new mpMRI scans to give us the accuracy that we need.

In practice the trial would follow these steps:

Men would be invited for a blood test at their GP.

If the test is positive they would be referred to a hospital to have an mpMRI scan.

They would then be referred to a urologist to have a biopsy if the scan couldn't rule out cancer.

This requires the different specialities working together across the whole country and this has never been attempted anywhere in the world before for prostate cancer. The unique structure of the NHS means that we have the chance to make history.'

Lay readers needed

(also from the Prostate Cancer UK website)

'Could you help us make our health information the best it can be? We're looking for men who don't know very much about prostate cancer to look at our information explaining what the prostate is, common prostate problems, and things that can increase your risk of prostate cancer. It should only take a couple of hours and you won't even need to leave your house! No knowledge needed – in fact, the less you know, the better. We just want to know if the information is easy to understand and answers your questions. So if you, or a family member or friend, would like to help, please get in touch!'
(email yourfeedback@prostatecanceruk.org
OR check their website for more info.).
(In the past I have been involved in a similar capacity for a HIFU leaflet. It's not onerous and can help others' understanding "*from a patient's point of view*". DG)

Other recent news items:

1) NHS Wales aims to speed up cancer diagnosis for all

(BBC News 22 November)

Wales will become the first UK nation to introduce a new single waiting time target for cancer patients. This is in an effort to speed up diagnosis and improve poor survival rates for the 17,000 patients who develop cancer every year.

The clock will start on cancer treatment for all patients as soon as it is suspected, not just those

with clear (ED - obvious) symptoms. The two-month target from next June is expected to eventually replace the two-track system. There are concerns that the current cancer targets do not reflect long delays some patients face waiting for diagnosis or treatment.

Health Secretary Vaughan Gething said the change - making Wales the first UK nation to move towards a single cancer waiting time - was the "*right thing to do*". He recognised that existing targets had not been met often enough but said 92% of cancer patients were being treated within target times.

There are currently urgent and non-urgent routes to getting treatment:
If you are urgent - and the signs of cancer are obvious - you're referred by your GP to hospital and your treatment is supposed to start within 62 days.
But if you symptoms are more unclear, vague or there is a suspicion it *could* be cancer - you might face months of being sent around different parts of the health service before cancer is diagnosed. Only when that happens does the clock start - and then you're on a non-urgent 31 day route. It might seem faster but you've been already waiting.

So, treating **all** suspected cancers the same - and all getting a 62-day treatment target from the point it is suspected - will aim to see more of these "non-urgent" patients faster too, and enable more to survive.

Not only that, but because the non-urgent pathway does not measure how long people have been bouncing around the NHS system before a decision is taken to start treatment, the experts argue it's impossible to find out where the real delays are.

Mr Gething said health boards would "*shadow report*" the new target alongside the existing ones. He said:
"*Through dual reporting of the single cancer pathway, Wales will be the first UK nation to move towards a single waiting time measure for cancer. It is reflective of our aspiration to support early diagnosis of cancer and ensure fast and effective treatment for all patients.*"
Doctors say there are "considerable challenges" with rising demand, while they aim for earlier diagnosis to push Wales up the league tables for cancer survival in Europe.

Prof Tom Crosby, medical director of the Wales Cancer Network, said he believed the single cancer pathway was ambitious but the aim was to improve patient chances as well as their experience and also be a "platform" for improving access to diagnostic screenings and tests, which would be coming under increasing pressure.
"*This has the potential to transform our diagnostic cancer services in Wales and I believe Wales would be leading the way in this regard,*" he said, adding "*Scotland are very interested in what we're doing while England are looking at something a little more modest, focusing just on the diagnostic part of the journey. But we think access to treatment after the patient has had the diagnosis is also a really important thing to do.*"

2) Blasting prostate tumours with radiotherapy after the disease has spread CAN increase the chances of survival, experts say.
(Daily Mail 22 Oct 2018)

Targeting the source of advanced prostate cancer with radiotherapy after the disease has spread can increase survival chances by 11 per cent. Experts say the 'monumental findings' could change how advanced cancers are treated.

Patients whose prostate cancer has spread are typically given hormone therapy to reduce or stop the production of testosterone, as the molecule can encourage the cancer's growth.
But these findings suggest radiotherapy – which uses high-energy radiation to kill cancer cells – is also effective. It was previously thought there would be little benefit in blasting the prostate tumour if the disease had spread to other parts of the body.

Professor Charles Swanton, Cancer Research UK's chief clinician, said: '*This is a monumental*

finding that could help thousands of men worldwide. Adding radiotherapy to current treatment shows clear benefit for this subgroup of men with prostate cancer.

If we can understand exactly why these men benefit from the additional radiotherapy treatment, we could hopefully use this approach to benefit even more patients.'

In the study, scientists enrolled 2,000 men who were all at an advanced stage of the disease in the clinical trial. Half were given standard treatment while the other half received standard treatment and radiotherapy to the prostate – the site of the primary tumour.

Among men treated with additional radiotherapy whose cancer had spread to their lymph nodes and or bones nearby, researchers found that around 80 per cent survived for at least three years. This fell to 70 per cent of men who were given the standard hormone treatment. No benefit was seen among men whose cancer had spread further, according to the findings published in The Lancet.
The research, presented at the European Society for Medical Oncology Congress in Munich, Germany, suggests radiotherapy as well as hormone therapy should be standard care where prostate cancer has spread nearby.

Dr Chris Parker, lead researcher of the study based at the Royal Marsden Hospital in London, said: '*Our results show a powerful effect for certain men with advanced prostate cancer. These findings could and should change standards of care worldwide.*
Until now, it was thought that there was no point in treating the prostate itself if the cancer had already spread because it would be like shutting the stable door after the horse has bolted. However, this study proves the benefit of prostate radiotherapy for these men. Unlike many new drugs for cancer, radiotherapy is a simple, relatively cheap treatment that is readily available in most parts of the world.'

Simon Grieveson, of Prostate Cancer UK, said he hoped it would lead to an immediate change in how patients are treated. He added: '*These results show for the first time, that it could also be effective in treating some men diagnosed with advanced prostate cancer whose disease has started to spread to the lymph nodes or nearby bones, when given in addition to hormone therapy. We now want to see the use of radiotherapy extended to this group of men without delay, providing them with an additional treatment option and precious extra time with their loved ones.*'

3) Bullseye! New prostate scanner that hits the cancer bang on target
(Daily Mail 1st October)

Report from Dr Alison Tree (consultant oncologist at the Royal Marsden Hospital in Sutton).
The new radiotherapy machine we are trialling — called MR Linac — is a complete game-changer. If trials are successful, it could one day mean patients need only one session of radiotherapy, and could suffer no adverse effects.

Radiotherapy, where we use high-energy X-ray beams to shrink tumours, is extremely effective. But targeting the beams so they hit only cancerous tissue can be difficult, and healthy tissue may be damaged, leaving many patients with side-effects — in prostate cancer, for instance, this can lead to bowel and bladder problems and erectile dysfunction. These can be temporary, but about one in 20 men having radiotherapy is left with long-term damage to the rectum.

Until now, we've needed to add a 1cm to 1.5cm margin of error around the tumour at which we were directing the radiation, to ensure we got the cancer — and while this has been reduced over the years, often to just a few millimetres, it means we can still accidentally damage healthy tissue.

The new technique overcomes this risk because it does two things: it effectively combines an MRI scanner with a radiotherapy machine and scans the patient in real-time — the patient has the treatment inside an MRI chamber — to

locate the cancer accurately, while simultaneously administering radiation. This is something we have never been able to do before. It's like levelling up on a computer game.

With traditional radiotherapy, a patient would have had a CT scan to locate the tumour, then markers — three tiny gold pellets — would have been inserted into the prostate: these show up on X-rays during radiotherapy so we know roughly where to aim the radiation.
Being able to watch the cancer on a screen in real-time is significant because a patient's anatomy is not the same each day, and the tumour can move. For example, breathing or a bowel or bladder movement can alter the position of prostate cancer even during a radiotherapy session. Usually we treat a larger area than where the tumour is to account for this potential movement. But we can easily miss the tumour and damage healthy tissue.

With the new technique, the real-time MRI will pick up any movements and the radiation can be adjusted accordingly there and then, so it hits only cancer cells. Treatment can even be paused to adjust to any changes spotted on the scan on the screen.
It takes a bit longer than standard radiotherapy — a session lasts 45 minutes, compared with the usual ten to 20 minutes (generally patients need 20 sessions of radiotherapy) — but it is worth it due to the significantly lower risk of adverse effects.

For the patient, the radiotherapy session is quite similar. But instead of lying on a bed with a radiation machine over the target area, as with the traditional treatment, they are put inside an MRI chamber. We then administer radiation while they are in the chamber.

Barry underwent radiotherapy to treat his prostate cancer last month and was the first of the 30 patients in our trial, which is being overseen by the Royal Marsden Hospital and the Institute of Cancer Research.

Ours is only the third centre in the world to treat patients with this form of radiotherapy (the other two are in the Netherlands), although it will be available at The Christie in Manchester next year.

Last week I was at a conference in Toronto, Canada, where the seven founding members of an international consortium that has been working on the MR Linac met to talk about our latest findings. Knowing we had treated Barry, our first patient, only days before, made it exciting and was the culmination of more than four years of working on this project.

It is thrilling to see the treatment in action, but we need to finish the trial before we can say it is superior to traditional radiotherapy. Using what we learn from the prostate trial, we will then test the technique in rectal, bladder and gynaecological cancers — and then move on to pancreatic and lung tumours, which are more complex to treat.

It is my dream that one day a patient will only need one session of radiotherapy. If our method is proven to be safer than traditional radiotherapy, we'll be able to give the full dose of radiation in one go, without fearing side-effects. We'd be able to tell a patient they have cancer and that we can cure it with radiation in a single day. It is a long way off, but it's what we're working towards — and this is a step in that direction.

4) Twin radiation blasts that curb prostate cancer could prolong thousands of lives
(Daily Mail 5 November)

The lives of thousands of men could be prolonged with a new treatment that uses radiotherapy to mount a 'twin attack' on prostate cancer. It simultaneously blasts the prostate with radiation from outside the body while using 'tumour-seeking' radioactive drugs internally.

A trial led by Queen's University Belfast has already been tested on 28 men with advanced prostate cancer. Early results show the approach is safe and in some cases has led to remarkable improvements, paving the way for a larger trial of 1,500 men next year.

Lead researcher Professor Joe O'Sullivan said:
'*This is the first trial of its kind anywhere in the world. It is hoped that combining the two forms of radiotherapy will be more effective than existing hormone treatment… and extend the life expectancy of men whose treatment options are otherwise limited. It's a radical approach to treating advanced prostate cancer. We get the cancer under control with hormone therapy and chemotherapy, then kick the tumour when it's down.*'

The new technique is aimed at attacking prostate cancer that has spread to the bones – about 10 per cent of all prostate cancer cases, affecting roughly 5,000 men a year. In the past radiotherapy was usually used only for localised prostate cancer which is at an early stage and has not spread beyond the prostate. But doctors are increasingly using the treatment for advanced cases, which seems to prolong survival. While it is not a cure, it can even eradicate some tumours.

The new approach combines two existing forms of radiotherapy – volumetric modulated arc therapy (VMAT) to target prostate cancer cells in the pelvis, along with a type of internal radiotherapy drug called radium 223 that targets the disease in the bones.

VMAT is delivered externally with a machine called a linear accelerator, in daily hospital visits over two months.

Radium 223, also known as Xofigo, is a relatively new drug given intravenously in a course of six monthly injections. (ED - see Jeff's story earlier).

Because both techniques are already used on the NHS, Professor O'Sullivan, clinical director of the Northern Ireland Cancer Centre at Belfast City Hospital, believes the new approach could be rapidly adopted if trials are successful. '*There are 60 centres in the UK which are probably equipped to do this now,*' he said.

The results of the initial study will be published in February, but Professor O'Sullivan said they had so far been positive.

Owen Sharp, of the Movember Foundation, which helped fund the trial, said:
'This is an exciting development. For men with advanced disease, these types of programmes might enable them to live longer.'

5) The oxygen-boosting precision medicine that could make radiotherapy work for more men
(Prostate Cancer UK website November)

Our research comms officer, Ruby Kell, explains how a promising new test we're funding could help identify men whose radiotherapy is likely to fail, then target them with a commonly-used drug that will stop the treatment from being thwarted.

Many of us are aware of the importance of radiotherapy for men with localised prostate cancer. It has the potential to provide a lasting cure that will keep men free of the disease for the rest of their lives. The problem is radiotherapy doesn't work in the same way for all men. Some find that their cancer comes back after treatment – and this time in an incurable form. We urgently need a way to spot the men whose radiotherapy is more likely to fail, so that we can intervene with drugs that can level the playing field and make sure all men get a fair chance at eliminating their prostate cancer.

<u>Why does oxygen-deprivation thwart Radiotherapy?</u>

Luckily we're on the case.
Prostate Cancer UK and Movember began funding Professor Ananya Choudhury at The Christie, Manchester, in 2016 to delve into what stops radiotherapy working for some men, and find out what we can do about it. Now two years in, Niluja Thiruthaneeswaran, a PhD student working with Professor Choudhury, updated us on the progress of the project at our event, Funding the Future, which celebrated the progress made in prostate cancer research thanks to the donations we receive from your gifts in wills.

Niluja explained that research from her lab, and others, has shown part of the reason radiotherapy fails for so many men is because their tumours are oxygen-deprived, or hypoxic. "*Hypoxia is a condition where the body is deprived of oxygen,*" she said. "*An example of this is when your body is at altitude, but this can also happen at the cellular level in tumours. That's a huge problem for us as it increases their resistance to radiation.*"

Without oxygen, the damage caused by radiotherapy beams can be reversed and repaired by the resilient cancer cells. These are the cells that come back with a vengeance, throughout the body, when cancer relapses.

Thankfully, Niluja said there is hope for hypoxic men. "*If you have a low hypoxia score, we can offer drugs that increase oxygen levels,*" she explained. "*These have been around for a long time, but the biggest issue is that we haven't been able to identify which patients need them.*"

Finding the genetic signature of hypoxic men

That's where her Prostate Cancer UK-funded project comes in. Professor Choudhury, along with Niluja and the rest of the team, is creating a test that will pick out hypoxic men from the crowd. With the right men identified, doctors can prescribe the oxygen-boosting drugs that will put the curative-power back into radiotherapy.

"*Knowing from the moment of diagnosis if a tumour has low levels of oxygen will make a big difference,*" says Professor Choudhury. "*It will allow doctors to offer a patient hypoxia-targeted treatment that is likely to increase the effectiveness of radiotherapy and, with it, the chances of cure.*"

The team's test will consist of a genetic 'signature' – a specific combination of genes that, when put together, will reveal a picture as to whether a man's tumour is hypoxic or not.

At the event, Niluja told us the team have already scoured publicly available databases of genes from thousands of men with prostate cancer to find 28 genes that are linked to hypoxic prostates and could form the basis of their test. Now they need to take what they've learned and develop a test to detect these 28 genes in men.

"*Any kind of test that we develop needs to be non-invasive and convenient for the patient so it doesn't delay his treatment,*" said Niluja. "*It needs to be robust and reproducible so we can reliably predict response to radiotherapies.*"
The team's answer to a non-invasive test is to use the prostate biopsies that are already taken at the point of diagnosis. This avoids men having to undergo any extra procedures, and also means doctors can tell if a man is hypoxic as soon as he's diagnosed, so the right treatment can be given as quickly as possible.

Clinical trial of test planned in next two years

Over the coming year, the researchers will collect over a thousand of these biopsy samples, using them to develop a hypoxia test that can be used in a clinical trial in the next two years. The team are confident that once they hit clinical trials, they'll be home and dry as Professor Choudhury says a similar test they've developed for cancer of the head and neck already works well. This research has come a long way, and is set to make a major impact on men. But it needs one last push to take it from the lab to the all-important clinical trial stage, where men will start to feel the benefit.

News in brief:-

1) New operation on the NHS will transform life for thousands of men suffering from a common prostate condition
(Daily Mail 28 October)
Update on previous articles about UroLift and Professor Iqbal Shergill's talk at our AGM 2017)

Prostate treatment will end the need for surgery and impotence inducing drugs.

The new UroLift procedure will move an enlarged prostate aside so urine can pass.

Patients will be able to leave hospital the

same day and have less risk of side effects.

The UroLift procedure is currently available in half of the hospitals in **England**, but the Government announced it will be on a fast-track scheme.

(Watch this space for news for Wales).

2) Call for hospitals to use high-tech scans to diagnose prostate cancers when they can still be cured (The Institute of Cancer Research website)

Modern, sophisticated scans should be used in hospitals to pick out men whose prostate cancers have only spread to a limited number of sites, so they can be offered the chance of cure, a new assessment concludes.

Researchers found evidence that modern imaging tools such as PET and MRI were better than standard CT scans at telling apart cancers that had spread to a limited number of sites from those that had spread more widely.

Using these modern scans could give some men the option of treatment focused specifically on the sites of spread – giving them a better chance of survival and potentially sparing them the side-effects of treatments that affect the whole body.

The study is published in the journal The Lancet Oncology, and received support from Cancer Research UK and the Belgian charity Fonds Cancer.

3) First-ever prostate cancer treatment uses gold nanoparticles to destroy tumorous cells (UTHealth Nov. 8, 2018)

A small clinical trial using gold nanoparticles that act as tumor-seeking missiles on a mission to remove prostate cancer has begun at The University of Texas Health Science Center at Houston (UTHealth). It is the first trial of its kind in the world.

The nanoparticles, or nanoshells, are made of small layers of silica glass formed into a sphere and wrapped in a thin layer of gold. The shells seek out and saturate cancerous cells, and their advanced vibrational properties are then harnessed to cause the tumorous tissue to pulse with extreme temperature when light is applied through a laser specifically designed to excite the particles.

The oscillation kills the cancer cells while preserving the healthy tissue, avoiding the nerves and urinary sphincter.

This procedure is the first in the world that is precise enough to potentially avoid negative ramifications like urinary incontinence or sexual impotency.

Diet protocol menus:
Here are two more suggestions from Gill:

MULTI-VARIATION BEEF CASSEROLE.
Serves 4.

INGREDIENTS.
800g lean Braising Steak (diced).
2 Tablespoons Olive Oil.
150g lean Streaky Bacon (chopped).
2 large Carrots, peeled and chopped.
1 med. Parsnip, peeled and chopped OR ¼ Swede, peeled and chopped.
1 tablespoon Plain Flour.
1/2 teaspoon Ground Ginger (OPTIONAL).
500ml Beef Stock.
OR 500ml Beef Stock/Red Wine.
OR 500ml Beef Stock + 2 teaspoons Worcestershire Sauce.
OR 500ml Beef Stock/leftover 'flat' Beer OR Guinness.
OR 500ml Beef Stock + 2 tablespoons Tomato Ketchup.
OR 1 large can Oxtail Soup.
Salt and Pepper.

METHOD.
Toss the braising steak in the plain flour with the ground ginger added, if desired. Heat the oil in a large flameproof casserole and brown the beef in batches.
Add the chopped, lean streaky bacon and the

carrots, parsnips OR swede. Saute together until lightly browned and then add the chosen stock mixture, season and stir well.
Bring up to boiling point, cover and cook in a pre-heated oven 170degrees C/Gas Mark 3 for 1hour 30mins-2 hours until really tender.
NB This casserole is ideal for cooking in an electric slow cooker.

To Serve:
New Potatoes (peeled).
OR Creamed Potatoes + 1 dessertspoon chopped Chives.
OR Jacket Potatoes (NO skin).
OR Crusty White Bread and Butter.
OR Fresh, Crusty White French Stick spread with a mix of butter, mixed herbs and a pinch of garlic salt wrapped in foil and baked in the oven alongside the casserole for at least the last 20mins of cooking.
OR White Rice.
OR Dumplings.

Recipe for Dumplings.
125g Self Raising White Flour.
50g shredded Vegetable Suet.
Pinch Salt.
1 teaspoon dried Mixed Herbs (OPTIONAL).

METHOD.
Sift the flour and salt into a bowl. Stir in the suet, herbs (if used) and about 5 tablespoons water to make a fairly firm dough.
Shape the mixture, with floured hands, into 4-6 balls and drop on top of the casserole for the last 20-25mins of cooking time.
BUT increase oven temp. to 220degC/ 200degC Fan/Gas Mark 7 and cook until light, fluffy and golden brown.

TREACLE SPONGE MICROWAVE PUDDINGS.
Serves 4.

INGREDIENTS.
100g Butter OR Sunflower Margarine.
100g Soft Light Brown Sugar.
100g Self-Raising Flour.
1 teaspoon Mixed Spice.
1 Egg, beaten.
4 tablespoons Golden Syrup.
Custard to serve.

METHOD.
Lightly grease 4 x 150ml ramekins and line the bases with non-stick baking paper.
Beat together the butter/margarine and sugar in a bowl until light and fluffy then stir in the flour, spice and beaten egg.
Divide the mixture between the ramekins and cover each with a disc of baking paper.
Cook together in a microwave on HIGH for 2-2½mins, then leave the sponges to rest for 3-4mins to finish cooking.
Turn the puddings out onto the serving plates and drizzle each with 1 tablespoon of golden syrup.
Serve with custard.
Note:
Warmed SEEDLESS Raspberry Jam, Bramble Jelly or Lemon Curd can be substituted for the Golden Syrup but omit the mixed spice and use ½ teaspoon Vanilla Essence in the basic mixture.
(Thanks again Gill).

Best wishes for Christmas and the New Year from David Goddard on behalf of the Chair and Trustees of TWWPCaSG

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