

REG. CHARITY NO.1129395

www.westwalesprostatecancer.org.uk

Patron: Chris Jones, Television Presenter

NEWSLETTER

SEPTEMBER 2017

Dear Member/Friend

Welcome to the September edition of our Group's Newsletter. We have enclosed a copy of the Tackle Magazine (as we are members of The National Federation of Prostate Cancer Support Groups) and in addition the Community Health Council's "Your Views Matter" leaflet if you wish to give your views on the local NHS services.

AGM report part 1

Our 9th AGM took place at The Halliwell Centre, University of Wales Trinity Saint David, Carmarthen, SA31 3EP on Thursday 29 June 2017. TWWPCaSG Committee wish to thank the more than 60 members, partners, visitors and invited guest speakers for making this such a successful event. Perhaps we could exceed this number for next year's 10th anniversary AGM! Copies of the Agenda, last year's Minutes, the Accounts and the Trustees' Report were available for all to see.

Our new banner pull up screen was on display together with copies of the various leaflets we take to public events such as store collections.

Unfortunately, our Chairman Ken Jones had to tender his Apologies for Absence as he was

unavailable on the day of the AGM but I (David Goddard) had previously agreed with Ken to stand in for him if the need arose. I was very nervous on the day but I only had a few days to worry about the meeting. Thankfully, Ken had already provided me with notes for the agenda, which I tried to follow, and his Chairman's address. He also let me have a copy of his "Thanks to Phil" which, of course, I was happy to read to the assembled members.

After welcoming everyone to the AGM I was pleased to be able to hand over to our new Patron Chris Jones who gave us an account of why he had agreed to be involved with the Group. He had already interviewed Ken on a TV programme and wants to help us in any way he can to further spread the message about Prostate Cancer.

Continuing with the Agenda items we dealt quickly with the Minutes of last year's AGM and any Matters Arising. Then Andrea Prince presented the Accounts which showed that the Group had a very healthy bank balance even after we had given the large donations that were reported in the last newsletter. We

thanked Andrea and her daughter Gina for their financial work during the past years.

Our Small Grants Scheme

New members may be unaware that we are able to offer grants to help with, for example, transport needs (for journeys outside the remit of Hospital Transport), Complementary Therapy or Counselling. The offer comes with a cap of £250. If you think such a grant may be of help to you, please contact David Bunce (our new Treasurer) whose contact details are on the last page of this Newsletter.

The Trustees' Report gave details of our achievements and showed how we continue with Public Education and Awareness; in addition to Helping Members of the Public and Supporting our own Members. Details were given of the ways we are progressing our work and continuing with Fundraising. Most of these have been detailed in past Newsletters. Thanks were given to the Committee Members and the various volunteers who help to keep this Group continuing to do the great work that is done.

Phil Burr had organised the event and co-ordinated the various factors to enable us to have a very smoothly run programme. He was on hand to help me when I needed assistance especially with the Centre staff and facilities (particularly we are grateful to the College's IT department who were essential for the afternoon's main session). At the end of the actual AGM part of the morning session Phil had asked to speak to the Group following his "retirement" from the Committee. This is his speech, reproduced here for those members who did not attend the meeting:

PHIL'S "LEAVING SPEECH"

*I moved to West Wales in September 2006. A fortunate move which quickly led to a 'just in time' prostate cancer diagnosis. There is never a good time to be diagnosed, and 9 years ago was certainly **not** a good time to be diagnosed with prostate cancer in West Wales.*

My cancer was found by an administrative error: a practice nurse ticking the wrong box: my guardian angel. Referral followed quickly, though diagnosis took 6 months, and to the start of treatment, a further 4 months. In September 2007 I had an open prostatectomy at Morriston Hospital; aggressive surgery with no option of nerve sparing. My Consultant had indicated that he thought there was an 80% chance that my cancer had spread. I opted for the 20% chance that it had not! My choice, against some advice, seems to have paid off. I was one of ten men referred to Morriston, following the forced 'ill health' retirement of my Glangwili Hospital Consultant.

I couldn't wait to have my surgery and had neither fears nor misgivings about my treatment choice. I cursed the many delays. I experienced that strange feeling that many of you will recognise; that of being admitted to hospital feeling very fit and leaving, feeling rather the worse for wear.

I moved into a period of enforced recuperation and reflection. I learned that approximately 70 men from West Wales had been misdiagnosed. Some were told that they had cancer when they didn't. Others were told that they did not have cancer when, in fact, they did. Biopsy samples, including my own, were re-examined. At least one man had his prostate removed though it was non-cancerous. He may well have been one of the 9 men referred to Morriston at the same time as me.

My journey was beset by delay after delay, but, at least I did not have the added misfortune of misdiagnosis. My surgery went well. I have nothing but praise for my surgeon who in addition to his exceptional surgical skills, kept me well informed at all times. During diagnosis I made contact with the 'old' Prostate Cancer Charity. It was the main source of information so crucial to my treatment choice.

I would have given anything to talk to other patients; particularly prostatectomy or radiotherapy patients; the two choices on

offer. But talking to other patients never happened. There was no local support group. I was delighted to have my treatment behind me, but troubled by the difficulties I, and others, had faced. I raised an informal complaint and attended a meeting of Clinicians and Managers at Glangwili. I complained of delay, inadequate information, poor communication and the question of misdiagnosis. What better way to help other PCa patients than campaigning to improve services. I am sad to say that communication problems between hospital departments and between hospital and patient still occur in our hospitals today, though the Key Worker initiative is a very big step forward.

I began to raise funds for the Prostate Cancer Charity via one-man collections but this just didn't seem enough. I knew little of the work undertaken by support groups, nor the challenge of setting one up. But the idea of doing so was beginning to take form.

In March 2007 I wrote to the TivySide seeking help to set up a local support group. One responder, Paul Bolton from St. Dogmaels, offered his help; another offered a donation of £100.00. A third response came from the wife of a newly diagnosed Cardigan patient. Paul and I held an informal meeting; a working pub lunch in St. Dogmaels. The date; 27 March 2008. The West Wales Prostate Cancer Support Group had come about. The rest as they say is history.

Shortly afterwards Ann Bolton joined the committee. A tentative start, but we now had funds, the makings of a Committee and our first member.

We have an unwritten policy of not turning men away who approach us for help and we do have a few members further afield from an already large catchment area. It is my regret that we have fewer members east of Swansea. Unfortunately we have never had the human resources to properly promote our existence to all corners of West and South West Wales.

We gained legitimacy by registering first with Revenue & Customs and then the Charity Commission. We joined the Prostate Cancer Support Federation now known as Tackle, but made it clear that we wished to retain our independence and the right to choose our own destiny.

Our committee grew little by little. At first we counted ourselves lucky to have a quorum at meetings. There was no great appetite for members to join our committee. For a long time I carried the lion's share of responsibilities. Others had commitments which I didn't have. I was grateful to those able to take on additional roles and am most grateful to those who have served long term and given continuity to the committee.

Our Committee maximum of ten members was reached last year for the first time. I wish to thank both these members and also **every** present and **past** committee member who has contributed to the success of TWWPCaSG over the past nine plus years in ways **large** and **small**. Particular thanks must go first to Ron Davies and then Ken Jones for their commitment as Chair over the past 3 years.

We have tried more than once to see how we could trim our ever increasing workload. At our 7th AGM you helped us prioritise our roles. However, we are unlike most support groups. Not only do we offer to support men (and wives and partners) when they contact us, our primary aim, but we take seriously the role of education and awareness and campaigning for better standards of care. We punch above our weight. At a price!

I'm sure we have played an important role in securing better standards, improved staffing, more information and better communication from the LHBs. I know we have been 'thorns in the flesh' particularly to Hywel Dda UHB. They kindly refer to us as 'their critical friends.' We have also donated significant funds to research and to support our hospitals and recently given financial support to some of our members, the latter at your suggestion.

By attending our AGMs, some of you on a very regular basis, by becoming a volunteer, by becoming an Active Treatment Referee, a Helpline 'Operator,' by attending events, by fundraising on our behalf, by donating to our charity you have shown us loyalty and commitment. Thank you. If you have served on our Committee, you have helped steer our organisation and enabled it become what it is today. In so doing we have helped a significant number of men as they have gone through the process of investigation, diagnosis and treatment. Without doubt, we will have helped extend or even save lives. For those that have served the committee long term, you have given the group stability and hopefully longevity. Thank you.

I believe there will be a need for The West Wales Prostate Cancer Support Group and for its Trustees, Committee Members & Volunteers for a long time to come. I also believe that our committee is in better shape than ever thanks to our newer committee members and committee members in waiting. Please continue to give them your support.

Across the UK, prostate cancer research, awareness, diagnosis and treatment have all made great strides in the past 9 years of our existence; yet you will still be needed.

I haven't mentioned that word pride. I am immensely proud of our achievements over the last 9 years. Thank you for the friendships which are evident whenever we meet. Thank you for being good friends to me, for your wise counsel and for your support.

I felt I had no choice but to set up the group. Thank you for joining me and now hopefully carrying on the good work into the future. (PB 29 June 2017).

AGM report part 2

At the AGM we took the opportunity to present Phil with a gift from the Committee (see the photo on the centre pages of this issue). I think that he thought it was a very heavy box of chocolates but it turned out to

be an engraved sun dial to complement his beautiful garden. (DG)

The day continued before lunch with our first guest speaker Dr M Phan (Consultant Oncologist at Singleton Hospital, Swansea). She gave us a full insight into developments in the treatment of Advanced Prostate Cancer. This included details of the Proton Beam Therapy machine in Newport where the beam can be stopped before affecting the hip, etc. and has fewer side effects. (**This is the first such machine in the UK! DG**). Patients having High Dose Brachytherapy treatment are referred to London using the Individual Patient Funding Requests form (IPFR). Dr Phan answered questions from members about HIFU and Alternative/Complementary treatments amongst other issues. She did ask that we (the Group) continue to campaign on behalf of patients. (We certainly will. DG).

After thanking her for a great presentation and Q&A session we stopped for a lovely buffet lunch which gave us all a chance to talk to other members.

The afternoon session was to have been a presentation by Mr James Wright on the UROLIFT Procedure for Enlarged Prostate (BPH). However, upon checking with him just a week before the AGM, Phil Burr was informed that this was not possible. (Long story) But thanks to the tenacity of Phil he contacted Professors Iqbal Shergill (Wrexham) and Raj Persad (Bristol) to ask if they knew anybody who could give such a presentation to us. They both responded immediately to say they would have loved to do this personally but they were already committed to their duties. However, Mr Shergill suggested that if we could organise things with the Halliwell Centre staff he would give us a video link presentation from Wrexham! The Centre staff were brilliant and before we knew it they and Iqbal had tested the link on the day before and uploaded two videos on UroLift (which he reported on in our March issue) and HOLeP (Holmium Laser Enucleation of the prostate which is a modern alternative to the standard Transurethral

Resection of the Prostate (TURP) procedure and is another treatment that he performs).

So, on the day, we experienced a brilliant use of technology whereby Iqbal was able to see us and we could see him on a projection screen. He talked us through a PowerPoint presentation interspersed with close up videos of both procedures in graphic detail. This was followed by a Q&A session where he answered all of our questions fully and with good humour. I know that he enjoyed it as much as we did. He definitely "saved the day" and we are really grateful to him for giving us an hour of his valuable time. And we had the bonus of finding out about the HOLEP treatment.

The final informative session of the day was by Sarah Russell-Saw and Rachel Kersey on How Macmillan Supports Cancer Patients in Wales. They also handed out literature and talked privately to some members.

The AGM closed just after 3:15pm. Thanks to all who assisted with and participated in this, our 9th, AGM.

The new Committee

We met on the 12th July. David Bunce has agreed to take over from Andrea Prince as Treasurer and Chris Bunce as Secretary from Di Bell. Thanks to these two new recruits and their contact details are included later in this Newsletter. Chris wrote about David's "journey" in the March 2017 Newsletter. Both Andrea and Di will remain as Committee Members and we thank them for their sterling work in the past. Huw Phillips has decided to stand down and we thank him for his contributions to the Group.

Phil's Story - Instalment No 6

I thought it appropriate that I offer some explanation for the hiatus in *My Story*. Please accept my apologies for the lapse of 9 months since my last instalment. This has been due to a number of issues conspiring against Anne and me. In particular, it is now clear to us that Anne's worsening health problems make it impossible (at least for the foreseeable

future) for her to contribute, to this issue, her account of the last 16 years of living with a grumpy old man! (Quite simply, her wellbeing varies such that she is not well enough, long enough, for her to gather her thoughts on paper) On a brighter note, I have also been keen to bring you some positive news, which I am now able to do, so hopefully, what follows, will make the wait worthwhile!

Bad News

In December 2016 I reported that my PSA the previous October was 14.3. This represented a 3 point rise in 6 months and a time to double of some 3 years. This disappointing situation worsened and by May 2017 my PSA was 20.5 reflecting a doubling time of around 12 months. It was clear to me and confirmed at my Follow-up Appointment at Salford Royal Hospital on 10 May, that my tumour was adapting to the hormone treatment that had been so successful since 2001. It's not true to say that my Prostag injections are no longer effective but rather, they are no longer as effective as they had once been. This is exactly what I was told was likely to happen in 2001 by my then Oncologist. He explained it, at that time, as the tumour adapting to my reduced testosterone levels and finding a "work round" to enable it to become more active again.

... and Good News

For many years, prior to May 2017, I had been aware that (for me!) a PSA level of 20 would be the trigger for intervention with what is known as Secondary Hormone Treatment (SHT): knowledge that has been a comfort to Anne and me. So when I was told, on 10 May, that the time had come, I was not at all surprised, indeed I was relieved to have it confirmed that I would commence SHT immediately. Because the Prostag is still having some beneficial effect I am continuing with the 12 weekly injections which are now supplemented by a daily dose of Bicalutamide (50mg) in the form of Casodex. The really good news is that now (Aug 17) my PSA has dropped to 9.0 - more than halved in 3 months!!! It has been suggested that this fall

should continue and my SHT could be effective for as long as 2 years. I have not looked that far ahead since my diagnosis in 2001. I am also mindful of the fact that I was advised, 16 years ago, that my (primary) Hormone Treatment (Zoladex/Prostap) should be effective for up to 10 years!!!

There's no such thing as a free lunch!

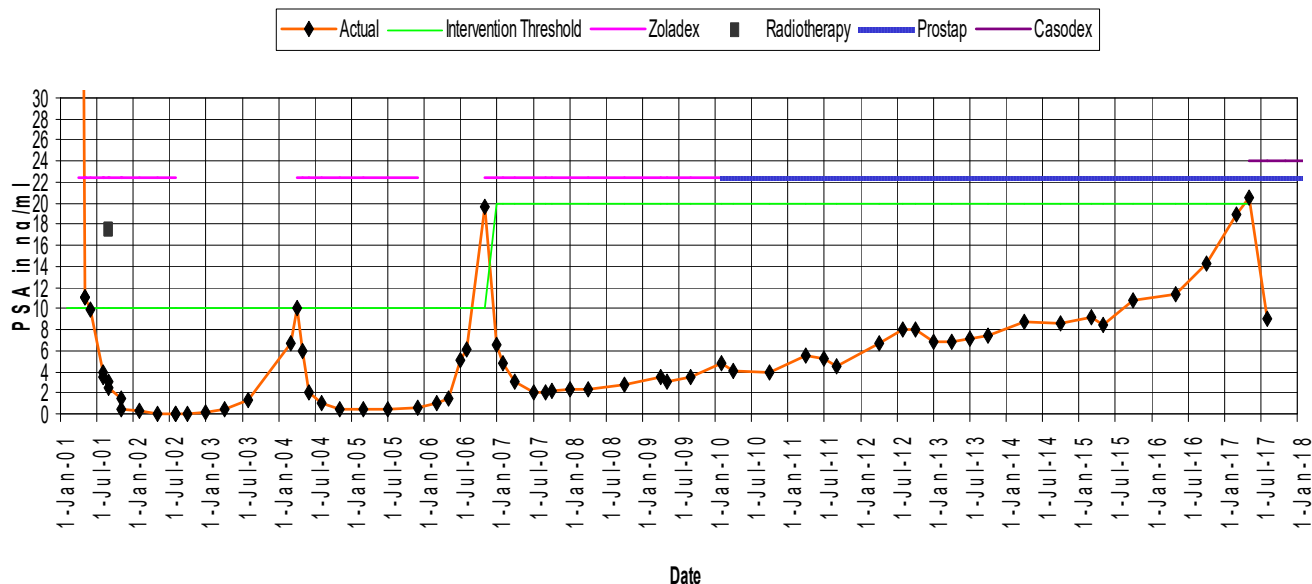
Anne and I are obviously delighted with the effect that the SHT is having on my PSA but there's always a price to be paid! The side effects of Casodex are much as you would expect of hormone treatment. I remain on Prostap and continue to deal with its side effects so I am experiencing little that is new and attributable to Casodex. What I have noticed is a worsening or exacerbation of some long term side effects. My biggest issue is fatigue. I'm certain that this is significantly worse now and I am trying to break into the

"virtuous circle" of being more active which should result in me having more energy to be more active... We'll have to see! I am also aware that my bowels are not as regular as they used to be. For me "it" was always just after breakfast but now I can be "caught out" anytime, more than once per day or even completely miss a day or two occasionally. I'm hoping more "All Bran", fresh fruit and exercise will help....

That's all folks (for now at least)!

I think after 6 Instalments and nearly 8,000 words I've said enough - at least for the time being! I hope that what I've written has been worth reading. There is however one last issue that I need to deal with - my PSA Chart. I know that Group Members, with whom I have discussed my PSA record, have always been interested in its fluctuations. So I thought it's about time I let you all see for yourselves:

Philip Battison Whole Timeline
PSA Level since referral to Mr Betts in February 2001
NB. PSA at Diagnosis in March 2001 = circa 100



Notes relating to my chart:

I've maintained this chart for 16 years and update it with each PSA result prior to Follow-up Appointments. It has always proved a useful discussion aid during those appointments. Indeed Mr Betts has often commented to the effect that "my chart" is keenly anticipated prior to each Consultation!

Treatment summary:

1 st course of Zoladex	April 2001 to August 2002	3 weeks of radio therapy	September 2001
2 nd course Zoladex	May 2004 to March 2006		
3 rd course Zoladex	November 2006 to February 2010	(changed by GP to Prostap in Feb 2010)	
Prostap	February 2010 to present		
Casodex (SHT)	May 2017 to present		

The Chart shows (better than any tabulation of values) the variation in my PSA (orange line) over the last 16 years. It clearly illustrates the response of my PSA to basic (primary) Hormone Treatment (horizontal pink and blue lines), to the periods of Treatment Holidays (the gaps in the horizontal pink line) and, most graphically, the impact of my commencing Casodex (Bicalutamide) in May 2017 (the horizontal plum line at the right hand side of the chart). The vertical scale (max 30) has been chosen to best illustrate my PSA variation (0.05 to 20.6). This (0-30) vertical scale range means that my initial PSA values of 80 - 120 in Feb/Mar 2001 are, quite literally, off the scale! Please also note that the PSA values for the horizontal pink, blue and plum lines are arbitrary, as is the value for the black rectangle.

When viewing the Chart, **do please remember that we are all different (as are our tumours!) and we all respond differently to treatment**, even to the same treatment. What works well for me may not be so effective for someone else. This is particularly so in terms of the effective life of hormone treatment.

Phil Battison, August 2017

Thanks Phil for this update and for publishing your PSA Chart, it certainly helps us to better understand your "journey". Thanks also for your help with the Newsletters and please give Anne our Best Wishes. (DG)

Phil Burr's Retirement Presentation



Phil Burr receiving his "retirement" gift from David Goddard at the 2017 AGM

Fundraising

As he announced at the AGM Brian Slate is running the Bristol half marathon on Sunday 17th September, followed by Cardiff on the 1st of October.

"I am running these events and fundraising for the group. At the age of 71 I consider this somewhat of a challenge."

Donations can be sent to Brian at his home address or alternatively given to him at our December luncheon meeting.

Contact details:- Brian Slate. 9 Manor Crescent, Llanllwch, Carmarthen SA31 3RJ. Tel. 01267 782099. Email: brian.slate@sky.com
Any sponsorship will be much appreciated and we wish him all the best in his endeavours.

Pub Lunch Reminder No 1

Our next pub lunch will be on Monday 2nd October at 12:00 at The Rose & Crown, Lammas Street, Carmarthen, SA31 3AE.

Pub Lunch Reminder No 2

Our Christmas gathering this year will be on Monday 4th December at 12:00 at Nantylffin Motel, Clunderwen, Pembrokeshire, SA66 7SU.

If you wish to join us at these lunches please contact Gill Lewins, Tel 01348 873 596 or email cglewins@btinternet.com circa 2 weeks before the event.

Donations received

The grand total collected by Ray Howe at the charity night that he had organised in the Penrhiwllan Inn, New Quay on 30 June amounts to £3627.87. Thank you Ray and all those involved in this event.

Ken Jones and Ron Davies went to collect a cheque for £500 from the Carmarthen Mayors appeal on 30th May.

£25 has been received from the Newcastle Emlyn branch of Merched y Wawr.

Donations given:

On behalf of the Group, Phil Burr presented a £100 cheque to the Skanda Vale Hospice in support of their annual sponsored walk event held in May.

Morrison Hospital Donation

Phil Burr reports:

"The Group has previously offered the Hospital a donation towards a fusion biopsy machine. But the Hospital has now decided not to go ahead with this purchase. They will use the Prince Phillip Hospital machine if needed.

They are interested in procuring a template biopsy machine and it may be that they will ask us to contribute towards this once they have quotations for the machine and have considered them." (PB)

We'll keep you updated on this. (DG)

Recent news

1) Men dangerously unaware of family link to prostate cancer new research finds.

People are being urged to have vital talks with their relatives and GP about the most common cancer in men, after a new study reveals half of all UK men don't know about their increased risk of the disease if other family members have had it.

Two-thirds of men with a family history of prostate cancer are dangerously unaware of their increased risk of the disease and half of all UK men don't know that a family link makes you two-and-a-half times more likely to get it, according to new research by Prostate Cancer UK.

It's prompted urgent calls from the Charity for men and their families to have a potentially life-saving talk about the disease with their relatives and doctor. Especially since an accompanying study showed that only 1-in-10 GPs are likely to always ask a man whether any close relatives have had the disease. Although where men did take the lead and initiate a discussion with their doctor, it found their experiences were overwhelmingly positive.

Angela Culhane, Chief Executive of Prostate Cancer UK. says:

"We need men to feel empowered to take control of their own health, find out their family history and proactively ask their GP whether they need tests for the disease due to their risk of developing it.

Currently this isn't happening nearly enough and the increased risk due to family history of prostate cancer is being dangerously overlooked by both men and their GPs. This must change.

Every single one of us can do our bit to reduce the number of men who lose their lives to prostate cancer every year in the UK. Ask your dads, brothers, grandads, husbands, partners and friends about prostate cancer and urge them to book an appointment with their doctor if they have a family history of the disease.

Our ultimate goal is to develop more accurate diagnosis methods, so that no man slips through the net. But until we reach that point, awareness of the risks and willingness to take action remain the best way to catch the disease early - and we all need to play our part."

2) New blood test results reveal potential of liquid biopsies to deliver precision medicine for prostate cancer.

Researchers at the Institute of Cancer Research have created a powerful new three-in-one blood test, which could help doctors monitor whether a treatment is working and how a man's cancer is responding. This new blood test has revealed the potential for liquid biopsies to help select patients for treatment and monitor their response for early signs of treatment resistance.

Professor Johann de Bono and his team have unveiled the results of blood sample analysis from men with hormone resistant prostate cancer, who were taking part in a clinical trial of a drug called olaparib. This work, funded in part by Prostate Cancer UK, revealed that changes in the amount of cancer DNA circulating freely in the men's blood was closely linked to how well the treatment was working for them.

After eight weeks, the total concentration of cancer DNA in the blood had dropped by nearly 50 per cent in men for whom the treatment worked, while it increased by around two per cent in men who did not respond to treatment. This in turn corresponded to the men's survival time. Those whose levels of circulating tumour DNA dropped after eight weeks survived an average

of seven months longer than the men whose levels didn't fall.

This suggests that a blood test - or liquid biopsy - could routinely be used in the future to tell how well a man is responding to treatment much earlier than is currently possible, so he can make a timely switch to a treatment that might work better.

"Our study identifies, for the first time, genetic changes that allow prostate cancer cells to become resistant to the precision medicine olaparib," says Professor Johann de Bono, adding: "From these findings, we were able to develop a powerful, three-in-one test that could, in future, be used to help doctors select treatment, check whether it is working and monitor the cancer in the longer term.

We think it could be used to make clinical decisions about whether such PARP-inhibitor drugs, like olaparib, are working within as little as four to eight weeks of starting therapy. Not only could the test have a major impact on treatment of prostate cancer, but it could also be adapted to open up the possibility of precision medicine to patients with other types of cancer as well."

The researchers also did a more detailed analysis of the DNA to look at what had changed at the point that the men's cancer progressed. They found a number of new genetic changes, including mutations in some cases that directly cancelled out the effect of the drug. This sort of in-depth analysis could not only help tell researchers when the disease stops responding to treatment, but more importantly, why it is no longer responding. In turn, the identification of new gene alterations could suggest new treatments that might work better.

Dr Matthew Hobbs, Deputy Director of Research at Prostate Cancer UK says:

"To greatly improve the survival chances of the 47,000 men diagnosed with prostate cancer each year, it's clear that we need to

move away from the current one-size-fits-all approach to much more targeted treatment methods. The results from this study and others like it are crucial, as they give an important understanding of the factors that drive certain prostate cancers or make them vulnerable to specific treatments. However, there is still much more to understand before the potentially huge benefits of widespread precision treatment for prostate cancer will reach men in clinics across the UK."

(On the subject of blood tests Editor David Goddard would like to hear from any member who, following treatment, may have had problems having a PSA test OR obtaining the results. My number is 01239 851802 or email address - dandj.glenview@gmail.com)

3) New STAMPEDE trial results show earlier abiraterone could improve survival of men with advanced prostate cancer.

British researchers have discovered that combining two drugs can dramatically boost survival rates among men suffering from aggressive prostate cancer.

By adding Abiraterone to standard hormone therapy, they cut the death rate by 37 per cent, compared with that for men on normal hormone therapy alone.

Professor Nicholas James of Birmingham University, who led the trial, said:

"These are the most powerful results I've seen from a prostate cancer trial - it's a once-in-a-career feeling. This is one of the biggest reductions in death I've seen in any clinical trial for adult cancers.

Abiraterone is already used to treat some men whose disease has spread but our results show many more could benefit. In addition to the improvements in survival and time without relapse, the drug reduced the rates of severe bone complications, a major problem in prostate cancer, by more than a half."

The clinical trial, run by Cancer Research UK and believed to be the biggest cancer trial in the world, included about 1,900 men diagnosed with advanced prostate cancer which had not spread. Half were given the standard hormone therapy treatment known as Androgen Deprivation Therapy (ADT), while the other half were given ADT plus the drug Abiraterone.

Usually, Abiraterone is given to men who have stopped responding to ADT but the study found that giving it much earlier, and in combination with ADT, reduced the risk of dying by 37 per cent. It also lowered the chance of the cancer getting worse by 71 per cent.

4) New injection could stop impotence and incontinence in men receiving prostate cancer treatment.

A new injection could spare men the side effects of prostate cancer treatment, such as impotence and incontinence. The drug, called topsalysin, being trialled by British doctors, is injected into tumours to kill them, but leaves surrounding healthy tissue and nerves intact, and is being hailed as a major breakthrough in treatment of the disease.

Most existing treatments carry a high risk of damaging healthy tissue surrounding the tumour. But the smart drug is activated only by the presence of a chemical called prostate specific antigen, found only in the prostate. Doctors say the drug could help thousands of men without the risk of devastating side effects.

"This is incredibly exciting because we can now deliver a drug which is only active in the prostate, and will not damage nerves, the rectum or bladder." says Tim Dudderidge, consultant urological surgeon at University Hospital Southampton NHS Foundation Trust, who treated the first UK patients on the multi-centre study.

Earlier studies carried out at University College London Hospital found topsalysin killed

cancer cells in about half of men with low-to-intermediate-risk prostate cancer, and there were no significant side effects.

The drug is injected into the prostate through the area between the genitals and the back passage. Patients have a general anaesthetic, or a local anaesthetic with sedation, for the 30-minute procedure. Doctors use MRI images and biopsy samples, fused with ultrasound images, relayed via a probe in the rectum, to ensure they inject the drug into the right part of the prostate.

Mr Dudderidge adds: *"The prostate is situated in a tricky part of the body. What makes this new drug so attractive is that it is activated only in the gland. It's potentially ground-breaking. This drug could be a massive step forward in the reduction of side effects."*

Diet Protocol Menus

Following her article in the last issue here are 2 more recipes from Gill Shepherd:-

FISHERMAN'S PIE. (Serves 2-3 people)

INGREDIENTS

FILLING

350gms (12oz) white fish (OR mix of white fish, smoked haddock & salmon)
285ml (1/2 pint) milk
50g (1oz) plain flour
1 tablespoon lemon juice (OR white wine)
1 teaspoon dried dill (OR dried parsley)
2 shelled hard-boiled eggs (OPTIONAL)
Salt & pepper

TOPPING

450gms (1lb) freshly boiled potato (OR a mix of ordinary potato & sweet potato OR instant mash if time is short!)
25gms (1oz) butter
2 tablespoons milk
25gms (1oz) grated cheese (OPTIONAL)

Pre-heat oven to 200°C/180°C (Fan Oven)/Gas Mark 6

Place fish in a medium size saucepan with just enough milk to cover & simmer for 5-10 mins.

Strain off milk & reserve. Flake fish into large pieces, discarding bones & skin. Melt butter in a saucepan, then stir in the flour & gradually add all the remaining milk and fish liquid. Season & cook gently until thickened, stirring all the time. Mix fish (& quartered hard-boiled eggs if desired) gradually into sauce along with the lemon juice & dried herbs. Pour into a buttered baking dish & set to one side.

Mash potatoes (OR mixed potatoes) with the milk & butter. Spread evenly over fish & sprinkle with grated cheese, if required. Bake for 30-40 minutes until browned.

N.B. Skimmed milk & "low-fat spread" can be substituted to lower fat/calorie content.

"I have included quite a few OPTIONALS to provide some variety if making this recipe more than once during your "low-fibre diet" duration!"

LEMON DRIZZLE TRAYBAKE CAKE. (Cuts into 12 squares)

INGREDIENTS

CAKE

120gms (4 ½oz) butter OR baking spread.
120gms (4 ½oz) caster sugar
175gms (6oz) S.R. flour
2 eggs
1 teaspoon baking powder
3 tablespoons milk
Grated zest of 1 lemon

N.B. I add a tablespoon of lemon curd to my mix, it doesn't need to be the "top-quality" & it does add a lovely extra tang with no added fibre.

TOPPING

100gms (4oz) granulated OR caster sugar
Juice of 1 lemon

Pre-heat oven to 180°C/160°C (Fan Oven)/Gas Mark 4

Line a 4cm deep 30cm x 23cm (12" x 9") tin with baking parchment or greaseproof paper. Measure the cake ingredients into a large mixing bowl & beat for about 2 mins until smooth. Turn mixture into the prepared tin & level with a knife or back of spoon. Bake for 20-25 mins. While

cake is cooking, mix sugar & lemon juice for the topping. When cake is golden brown, just firm to the touch & shrinking slightly away from the sides of the tin, remove from oven. Brush topping over the surface of the HOT cake & allow to soak in. When cool, lift cake onto cooling rack & cut into 12 pieces. (One could substitute juice of an orange, pink grapefruit OR a lemon & lime for variation)

Serve warm or cold. It's lovely as a pudding or as a cake with a cup of tea or coffee!

Thanks Gill, that's made me very peckish (DG).

Kind regards to you all.

David

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