Norfolk and Waveney

Prostate Cancer Support Group

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New NICE guidance frees Primary Care Trusts to pay for cryotherapy

The National Institute of Clinical Excellence (NICE) has changed its guidance on cryotherapy.

Guidance from NICE governs what treatments can be paid for by the NHS.

NICE's earlier guidance was that PCTs should fund treatment by cryotherapy only in clinical trials.

It now says that this recommendation will be satisfied if surgeons collect data for national analysis.

This means that NHS Primary Care Trusts are now free to pay for the treatment of prostate cancer by cryotherapy provided this condition is met.

The change follows the British Association of Urological Surgeons' annual meeting in June.

Urologists repeated their concern that the NICE recommendation then in force would harm UK prostate cancer survival rates – which are below the European average.

They feared that because of the ethical difficulty of establishing clincial trials PCTs would withdraw funding for them.

Professor Damian Greene, Consultant Urologist at Sunderland Royal Hospital described the change in the NICE guidelines as "Excellent news."

He said, "Patient satisfaction with cryoablation is high due to its minimally invasive approach, which allows returning to active life quicker than with alternative treatments."

Source - Prostate UK website

The change in the NICE guidelines received a warm welcome from vice - chairman David Haines.

Under David's chairmanship the Group decided in 2005 to raise funds to support surgeon Mr. Edwin Ho's cryoablation trial at the Norfolk and Norwich University Hospital.

The Group has given £38,000 of the £50,000 needed to enable Mr. Ho to treat up to 12 patients with recurrent prostate cancer by cryoablation.

David said, "This excellent news justifies our decision to support Edwin Ho's trial and our conviction that this treatment can offer increased quality and extension of life to some patients where no further treatment options exist.

We very much hope that funding will now become available from NHS Norfolk to allow more patients to benefit from this treatment."

Cryoablation is the removal of diseased tissue by freezing the prostate gland to such a low temperature that the tissue (including cancer cells) dies. a minimally invasive procedure. Its benefits are:

- favourable success rates
- low complication rates
- a short recuperation period
- procedure can be repeated if the first cryo-ablation has failed
- for patients who have cryoablation as their initial treatment radiation therapy or radical prostatectomy are still options if the procedure fails

Its cost can be less than half that of traditional treatments.

All members - If you are on the internet, please send us an Email.....

With our membership now over 300, it would save money and work if we could email information to members who are on the internet. Newsletters are published on our website www.prostatesupport.org.uk and members who have internet access might prefer to read it there rather than be mailed a printed copy.

So if you have internet access please send an email to our Website Editor, Harvey Meadows, at:

rvmcolt@hotmail.com

In the Subject box write "NWPCSG - my email address".

In the body of the message write your name and address.

If you are happy NOT to receive a printed copy of the newsletter in future, please say so in your email

We will then let you know by email when the next newsletter is available online.

You can see this newsletter at www.prostatesupport.org.uk

A very big thank you for a very big cheque!

Sprowston Sports and Social Club has chosen us as its charity for the year - and in September donations from local businesses and the generosity of club members and their guests resulted in our chairman, Ray Cossey being handed a cheque for £1,472 for our funds.

At the club's Chairman's Charity Evening, Broadland District Council's Chairman, Mrs Joella Cottingham, and members and guests, enjoyed anecdotes by the Sheriff of Norwich, Roy Waller.

Mr Robert Mills, a leading consultant urologist at the Norfolk and Norwich University Hospital, reinforced the need for early detection and thanked the club for its support.

Ray expressed his appreciation on behalf of our Group to the Club for their tremendous support.

Ray told them of our aim in the near future to promote a screening initiative for men over 50 to give them an early indication of whether they should seek further tests.

He said "We believe this to be an essential tool in the fight to save lives by the early detection of the disease, and your generosity will help us greatly to achieve this aim."

The picture shows Club chairman Don Myers and members of the social club presenting a cheque for £1472. 80p, to Ray Cossey and urologist Robert Mills (centre)

And thank you for the following donations....

- Mrs Donmall, family and friends in memory of Neville Donmall - £452
- Mr George in memory of his father - £60
- Mr Green in memory of Mr L George - £20
- Mr Chesham - £10
- Gifts from relatives and friends of John Drew to mark his 70th Birthday - £500
- Feltwell Golf Club - £50
- Sprowston Methodist Church badminton club £50
- Mrs L Winter sale of greeting cards - £11.

Gift Aid Tax Credit in 2007/8 - £734

Forty-two golfers - 21 gent and lady pairs - took part in a Stableford Competition at Costessey Park Golf Club, in September - resulting in £370 being donated to our funds. It was organised by Group member John Newman and our chairman, Ray Cossey, both seniors' committee members at the club.

Picture shows Ray (back row, left) and John (back row, right) with winners Mike Oxbury - joint runner-up (left), John Thrower- joint winner (centre) and Brian Hardy - joint runner-up. The other joint winner was Pat Waby'

And special thanks to Ray and Vera Allen.....
Their latest car boot sale at Hingham in October raised £1032 - bringing the total their sales have produced for the Group's funds to over £8000!

A few weeks ago I met up with a golfing-friend, Dr. Donald Hunter, a retired GP. I mentioned my frustration with some of the medical profession, because of their resistance to any suggestion of the desirability of some form of national PSA screening programme, especially for men over 50. Dr. Hunter stated his strong belief in PSA testing and wished me well in my endeavours to get the-powers-that-be on side.

A few days later a letter arrived from him, enclosing a copy of a medical paper he had written a few years ago, on the subject of PSA testing. I have his permission to reproduce it, so as to share it with you. I think it makes very interesting, thought-provoking reading. Ray Cossey - chairman N&WPCSG

Prostatic Specific Antigen (PSA) and Prostate Cancer

Some time ago, a member of my local golf club handed me a cutting from a local newspaper headed '*Prostate cancer test is useless*'.

The article went on to state that researchers in America suggest that the PSA test was a poor predictor of the severity of prostate cancer, and a lot of unnecessary treatment resulted from the discovery of a raised PSA.

I thought there could be some truth in this, but it didn't warrant the heading of the article. Professor Stamey in his article in the 'Journal of Urology', from which the newspaper quoted, did not suggest the PSA test was useless but that its usefulness as a routine screening test for prostate cancer was strictly limited.

I decided to collect case histories of patients I saw in the surgery, which could refute this statement. Cases came surprisingly quickly.

Indeed I could have gathered the information from my local golf club, where in a group of about forty seniors, four were found to have carcinoma of the prostate diagnosed with the help of a raised PSA during the last year.

However, I will restrict myself to cases I actually saw in the surgery of which I have full details.

Case One – Age 73 - Mild urinary symptoms with increased frequency and nocturia. Nothing obvious on examination. PSA 7.2

Referred to a urologist and subsequent prostatic biopsies showed T2a Gleason 6 Carcinoma of the prostate.

Referred to the oncology department for consideration of radiotherapy. The patient decided against radiotherapy in favour of active-surveillance, with regular monitoring of the PSA and subsequent PSA 6.7 and more recently 8.1. Radiotherapy to be recommended if there was a further rise.

Discussion - It could be said that a biopsy was unnecessary as the patient decided against active-treatment in spite of the presence of carcinoma. However, it was probably better for the patient to know exactly where he stood and the PSA was a good indicator, and monitoring is vital in deciding whether to offer radiotherapy.

Case Two - Age 79. Fit and active.

Came to the surgery to discuss urinary symptoms, in the form of hesitancy and occasional nocturia. He had had a BUPA medical a few months previously. PSA was mildly elevated, at 6.7. He was referred and biopsies showed adenocarconoma of the prostate, stage T2b, Gleason 8. CT and bone scan showed no evidence of spread and he was treated with radical radiotherapy after mitial treatment with an antiandrogen and a GHRH analogue. Tolerated treatment very well. To be followed-up with further PSA's.

Discussion - PSA again vital in reaching a diagnosis and future monitoring of treatment.

Case Three - Age 59.Very fit.

He came with mild urinary symptoms, in the form of frequency, and requested a PSA. This was 7.7 and he was referred to a urologist. Biopsies showed adenocarconoma of the prostate, Gleason 3 & 4 (MRI T2a). He decided on active surveillance. However his PSA rose to 9.5 and subsequently he was treated with radical radiotherapy following androgen deprivation. He tolerated treatment well and his latest PSA was 0.8.

Discussion - PSA pivotal in reaching initial diagnosis and useful in confirming effectiveness of treatment.

Case Four - 76 year old farmer.

Had chronic arterial fibrillation and asthma. He was on Warfren. Minor urinary symptoms and asked for PSA. This was 9.7 and he was referred. Before deciding on a biopsy a further PSA was done, with a free/total ratio. This was 13.2 with a free/total ratio of 22%.

This was thought acceptable. In view of his age and medical history it was decided not to proceed to a biopsy but to continue monitoring his PSA.

Discussion - Because of his medical history the patient agreed that his life expectancy was not infinite and even if he did have prostate cancer it was likely that it would be at an early stage and unlikely to give him any trouble.

I wonder why the free/total ratio of the PSA is not done more often. No doubt it is more expensive, but it must be cost effective if it reduces the need for biopsies.

Summary

There seems little doubt that the estimation of the PSA is very useful in leading to the diagnosis and monitoring the effectiveness of the treatment of carcinoma of the prostate.

I am sure that some cases could be suspected on rectal examination, but this is by no means fool-proof as it relies on the experience and expertise of the examiner.

As for the adage '*if you don't put your finger in, you put your foot in it*', mainly concerning patients complaining of lower-back pain, the PSA provides a good alternative.

The appropriate action can be taken if the age related value of the PSA reaches the recommended referral range.

It is unknown how the outcome would be affected if the test was not available.

But the main point is that in primary care it is often the only indication for referral leading to the early diagnosis of malignancy.

It is true that the longer we live the more likely it is that we will develop some cancer cells in the prostate, but this should not deflect us from attempts to diagnose the more aggressive tumours with the aim of reducing the risk of premature death, and maintaining the quality of life of those who are otherwise fit and active.

D. McA. Hunter MBBS LRCP MRCS Dobstr RCOG - Retired G.P.

Big C, working with Norfolk & Waveney Cancer Patients & Carers Partnership Group, brings you:

Norfolk Against Cancer Day 2008

FRIDAY 28th NOVEMBER

9.30am - 4.15pm

KING'S CENTRE,

King Street Norwich

Book your **free** place today

- Help to improve the care and support given to cancer patients in Norfolk & Waveney
- Hear from leading care and health professionals
- Have your say about the future of cancer care in Norfolk
- Meet representatives from cancer support groups, charities, cancer patients and carers
- Find out about volunteering and fundraising opportunities

To book a place call 01603 619900 or visit:

www.big-c.co.uk/norfolkagainstcancer to download a booking form.

"I am delighted to be chairing the first Norfolk Against Cancer day, which is kindly being hosted by Big C. It is important that we use this event to pool our

experiences and knowledge to promote an active partnership between patients, families, clinicians, managers in the NHS and of course charities to benefit all those in Norfolk who are affected by cancer now and all those who will be affected by cancer in the future. "

Dr Ian Gibson MP

There are still a few places left for our

Christmas Lunch

Friday 5th December

Glen Lodge Bawburgh

12.00 for 12.30

Price per person: £16.50

Traditional roast or vegetarian option

Deposits £10.00 each to be collected during October

For reservations please contact David Haines (01603 881213)

The next

Open Meeting

(plus Christmas Raffle)

will be on

Monday December 1st

7- 9

Rob Mills, Consultant Urologist,

will speak on

"Latest Developments in Prostate Surgery"

East Atrium Norfolk and Norwich University Hospital

Donations of prizes and seasonal refreshments welcome

How to Contact Us

Write to:

Norfolk & Waveney Prostate Cancer Support Group, c/o Urology Dept, Norfolk and Norwich University Hospital, Colney Lane, Norwich, NR4 7FP

Telephone - Specialist Uro-oncology Nurses:

Claire, Sallie or Wendy at the Norfolk and Norwich University Hospital 01603 289845

Angie or Wendy at the James Paget Hospital 01493 453510

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