cancer, and I am among them

LARRY PYNN

More from Larry Pynn

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Dr. Martin Gleave performs prostate surgery on a patient at the Vancouver General Hospital. BEN NELMS / PNG

The moment Dr. Kenneth Poon strode across the waiting room and shook my hand, I knew it was bad news.

The gentle, hopeful eyes of the caring urologist surgeon displayed a sense of loss this day. He sat with me in his office and officially rendered the verdict: “You have prostate cancer.”

He also said I wouldn’t remember most of what he said next, and he was right.

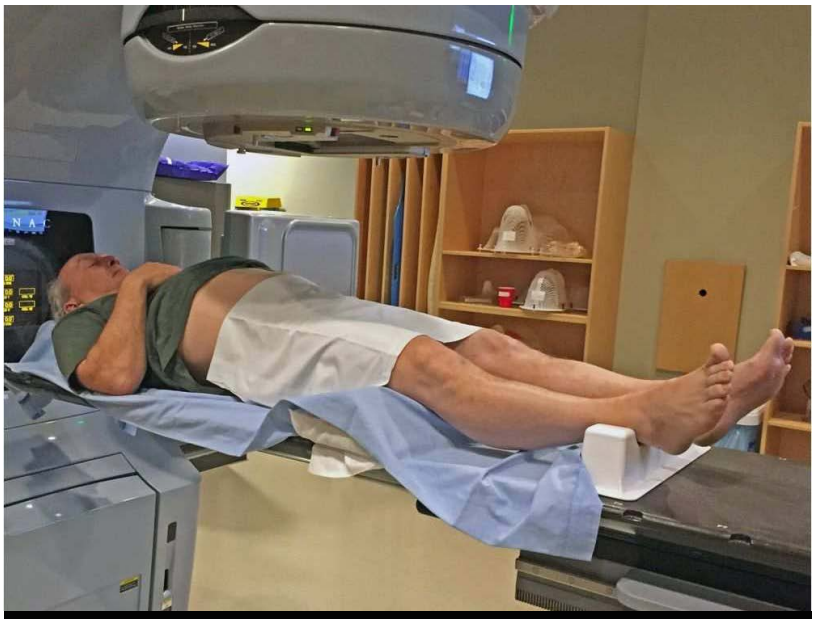
What I do recall are tears welling up in my eyes at the shock of it all. I had no immediate family history of prostate cancer. And I had lived a life of adventure: solo hikes across the Northwest Territories, white-water canoe trips down remote B.C. rivers, cage-diving for great white sharks in Mexico. I even slipped into the prestigious New York-based Explorers Club.

None of that made a damn bit of difference now. A far greater challenge lay

ahead.

One in seven men will be diagnosed with prostate cancer during their lifetime.

Look around the office, think about your friends and family. Who will be next?



Vancouver Sun reporter Larry Pynn receiving external beam radiation treatment for prostate cancer at the B.C. Cancer clinic in Vancouver. HANDOUT / PNG

"It's absolutely devastating when you're told," confirmed Wally Oppal, former attorney general and B.C. Court of Appeal judge.

He was with friends in Las Vegas when his specialist, Dr. Larry Goldenberg, called with the bad news.

"I broke down and cried for an hour," he said. "The numbers are pretty daunting, how many men in Canada die from this."

Wally Oppal at his office in Vancouver. ARLEN REDEKOP / VANCOUVER SUN

The prostate is a small gland that produces a milky fluid that forms a large

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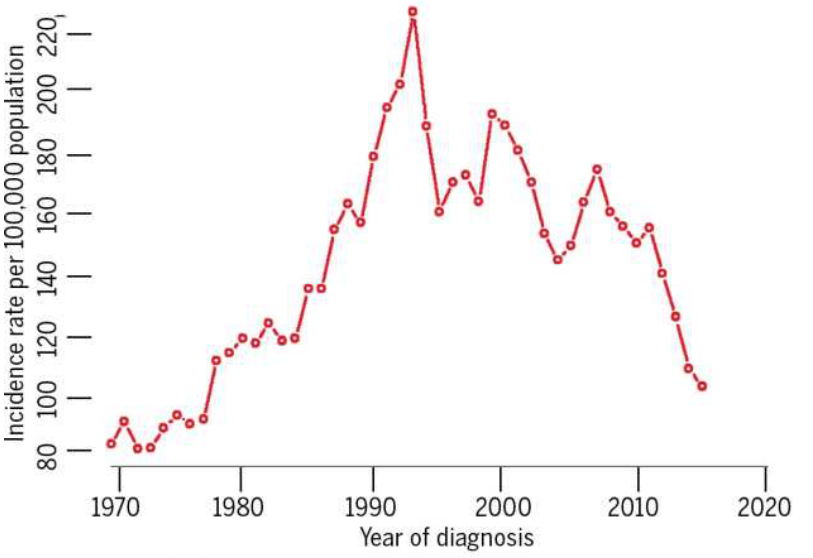
portion of semen. It is located under the bladder and wraps around the urethra, the tube that carries urine from the bladder through the penis.

What I also soon realized is that well-meaning friends are prone to say things like, “Men die of something else before they die of prostate cancer” or “Uncle Joe’s had it for years and he’s doing just fine.”

The fact is, every man’s journey and every man’s outcome is different — and the treatment can seem worse than the disease.

The universally positive message is that prostate cancer moves slower than other cancers, and that the medical community has made great strides over the decades in diagnosing and treating the disease.

PROSTATE CANCER INCIDENCE, B.C., 1970-2015



Note: Age-standardized statistic *Source: B.C. Cancer Registry*

“We’ve seen huge developments,” said Stuart Edmonds, vice-president of Prostate Cancer Canada. “The rate of prostate cancer deaths has gone down by 50 per cent over the last 25 years. We know that survival is close to 100 per cent after 15 years if it’s caught early.”

One cold reality remains: Prostate cancer killed an estimated 620 men in B.C. last year — often, those diagnosed late in life. Nation-wide, the disease kills 11 men on average every day.

PROSTATE CANCER

BY AGE: New prostate cancer diagnoses in B.C. in 2015.

Age Group	# of Cases
<40	0
40-59	351
60-79	1829
>79	495
Total	2675

BY STAGE: Distribution of prostate cancer, 2014-15

Stage	# Cases	Percentage
I	665	12.3
II	2617	48.5
III	725	13.4
IV	784	14.5
Unknown	600	11.1
Total		5391

DEATHS: Number of prostate cancer deaths in B.C. by age in 2015.

Age Group	Number of deaths
<40	2
40-59	15
60-79	224
>79	325
Total	566

Source: B.C. Cancer Registry

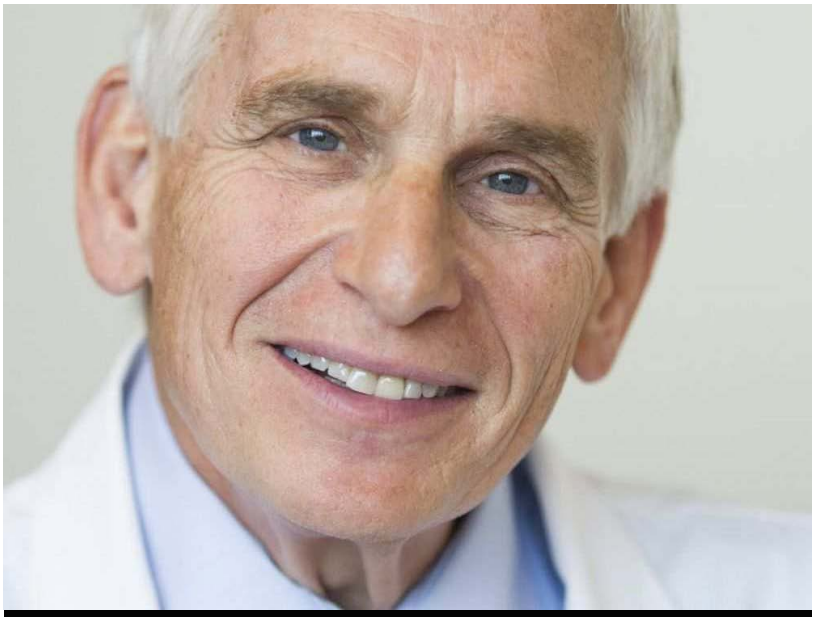
Getting the jump on prostate cancer

Right from the beginning, prostate cancer puts up hurdles.

First, the decision to have a PSA (prostate-specific antigen) blood test and perform a digital rectal exam.

Second, if the results are worrying, to have a urologist conduct a biopsy to obtain samples of the prostate for analysis.

Third — and this is a big one — deciding what to do should the biopsy confirm you have prostate cancer.



Dr. Larry Goldenberg of the Vancouver Prostate Centre. GERRY KAHRMANN / PNG

“It’s challenging,” said Goldenberg, director of development and supportive care with the Vancouver Prostate Centre (www.pcscprogram.ca). “In medicine, when it’s not black or white, there’s a lot of due diligence to be done.”

BY THE NUMBERS

Canadian prostate cancer statistics as of 2017

1 in 7 ⇨ Canadian men who will be diagnosed with prostate cancer in their lifetime.

21% ⇨ Percentage of all new cancers in men that are prostate cancer.

21,300 ⇨ Men diagnosed in 2017 with prostate cancer in Canada.

4,100 ⇨ Estimate of number of Canadian men killed by prostate cancer in 2017.

-3.3% ⇨ The annual drop in prostate cancer deaths since 2001 thanks to improved testing and better treatments.

Source: Canadian Cancer Society, 2017

Prostate cancer can also represent a man’s first brush with death.

“Men tend to move through the first half of their life with minimal need for interaction, with oftentimes a sense that nothing can break down,” said Dr. Martin Gleave, executive director of the Vancouver Prostate Centre. “For some, the first brush of the fear of a lethal diagnosis is with an elevated PSA, which places them in a higher-risk group of having prostate cancer.”

Partners are also affected by the disease.

“It’s been a journey for me, as well,” said Clare Andersen of Burnaby, whose husband, Rene, learned he had prostate cancer in 2012. “When you get the diagnosis of cancer, everyone goes into shock, the Big C.

“In retrospect, it would have been nice to have all the information we have now at that time. A lot of it was done online. We didn’t know anyone with the same diagnosis. We had no one to talk to.”

Typically, men choose between surgical removal or brachytherapy radiation, either of which may be combined with external beam radiation and androgen replacement therapy, so-called hormone therapy.

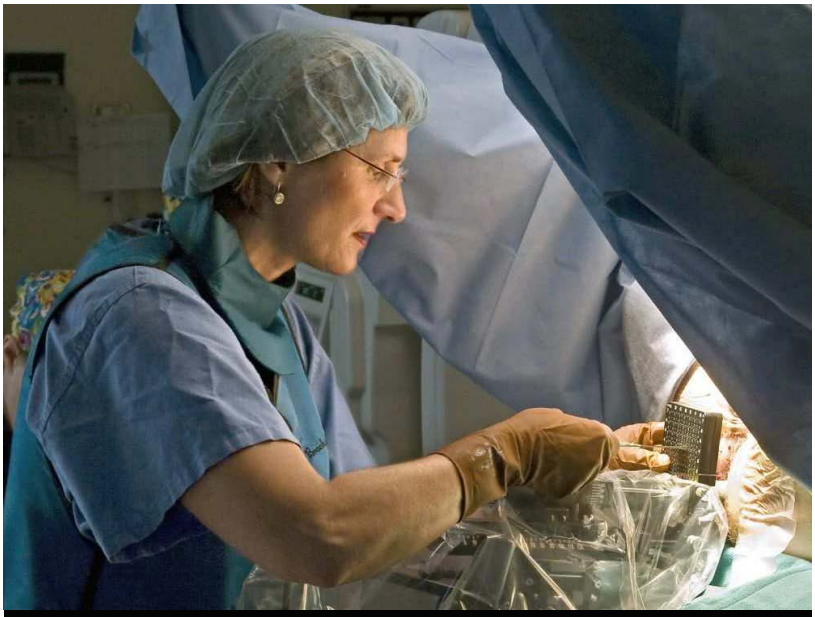
Surveillance rather than treatment is recommended for slow-growing cancers not posing an immediate threat.

A turf war erupted between the surgical and radiation camps in 2009.

B.C. Cancer issued a news release about a study in the Journal of Urology based on the agency’s brachytherapy radiation program. It found that in 1,006 men treated from 1998 to 2003, 95 per cent of patients didn’t have a recurrence following brachytherapy. That led to the claim that brachytherapy can be seen as a “likely cure of prostate cancer.”

Gleave countered that B.C. Cancer minimized brachytherapy’s potential side-effects and effects on quality of life, and that the study involved men at low risk of developing aggressive cancer in the near future. The study was based on a median followup of five years, so it’s premature to call the treatment a likely cure, he said.

Goldenberg said that brachytherapy “is not at this time a cure or a likely cure until there is more experience with it and longer-term studies.”



Dr. Mira Keyes, a radiation oncologist with B.C. Cancer, performs a brachytherapy procedure involving the placing of radioactive seeds in a man's prostate. B.C. CANCER AGENCY / PNG

Dr. Mira Keyes, B.C. Cancer's head of brachytherapy in Vancouver, told The Vancouver Sun: "We anticipated surgeons might be critical of what we said. We discussed and chuckled that some might not like it, so we were very careful about how to word it."

These days the two sides adopt a more conciliatory tone.

"There are two curative options for men, both with excellent outcomes," Gleave said.

Is the deck stacked in favour of surgery?

What I've learned from my journey as patient and reporter is that the odds are stacked in favour of removal of the prostate.

The Ministry of Health crunched the numbers at my request, and found that during the fiscal year 2016-2017, 180 brachytherapy procedures were conducted on B.C. residents in this province compared with 969 radical prostatectomies. That's a ratio of more than 5-to-1 in favour of surgical removal.

If physicians agree the two procedures both yield good results, then why such a discrepancy?

The desire to have the cancerous organ removed is one factor. Says Goldenberg: "Quite often the wife is sitting there going, 'I want it out.' And he's saying, 'What do you mean you want it out?'"

Because urologist surgeons are the ones who diagnose the prostate cancer and inform the patient, their prejudices must also be factored in.

"There's an innate bias," Goldenberg said. "We all are professional and we all believe in what we do. As honest health care providers, we have to take a step

back.

“There are situations where I will twist an arm, and say I really think surgery is better for you. Most of the time, I’ll say they’re both good. You have to kick the tires.”

Surgeons also employ a variety of methods: traditional open surgery, laparoscopic surgery with smaller incisions or — in hospitals equipped with the technology — robotic-assisted laparoscopic surgery.

Arguments in favour of robotics include: better magnification; reduced bleeding, pain and risk of infection; faster recovery; closer monitoring of the surgeon’s skills; and better ergonomics for the surgeon. Sixteen per cent of 658 prostate surgeries performed last year at Vancouver General Hospital/UBC Health Sciences involved robotic technology.

“The nurses call it my boy toy,” said Goldenberg, whose father has prostate cancer. “It’s a big video game, a wonderful instrument.”

Dr. Martin Gleave in his office in Vancouver. BEN NELMS / PNG

Gleave sticks by the open method, arguing: “My outcomes are as good, for half the price.”

A 2017 study published in the journal, BMJ, found the availability of new technologies such as robotic systems in England attracted prostate-cancer patients to surgery centres rather than evidence of quality of care. Previous research showed that patients are willing to travel to centres other than their nearest hospital for cancer surgery.

Said Goldenberg: “When I need my prostate out, I’m going to find an experienced robotic surgeon. Full stop.”

While Goldenberg is a proponent of “good, honest, balanced education,” sometimes that is not enough.

“I think not enough (patients) are referred for radiation,” he said. “Every one of my patients is asked if they’d like to see a radiation doctor, and I’d say 50 per cent of them say yes.”

Oppal opted for surgery in March 2007 without consulting a radiation oncologist.

“Larry (Goldenberg) told me, ‘You might think that I’m biased because I’m a surgeon,’ but he said — and I bought into this — that once you have the surgery you get rid of it (the cancer), provided they get it all, whereas if you had the beads and all the alternatives you’re shrinking the tumours so it could come back at any time.”

Patients need to know that surgery and brachytherapy have different side effects.

Oppal’s PSA readings ever since his surgery have been negligible, but he’s had to deal with issues surrounding incontinence and impotence. “I was leaking for a long time. I had a sling put in … and that helped me a lot.”

A sling involves positioning a synthetic mesh-like tape around part of the urethral bulb, slightly compressing the urethra and moving it into a new position to help overcome urinary incontinence.

As for his sexuality, Oppal said: “I remember going to Larry (Goldenberg) six months out and I said: ‘I can’t get it up. You’ve got to help me.’ He said: ‘Would you rather be six feet under?’”

If the nerves surrounding the prostate can be spared during surgery, the chances of continued sex are improved.

This is how Oppal describes sex today: “Not as good as it was before. But it’s fine. I use it (Viagra) periodically, but not very often.”

For the record, he is 76 years old.

The Vancouver Prostate Centre offers a Prostate Cancer Supportive Care Program (prostatecentre.com/PCSC), with educational courses for men, including one labelled “primary treatment decision-making” that allows attendees private time with a urologist and an oncologist. Program manager Monita Sundar said that in 2015, 389 men participated in the program in Vancouver. That’s just 15 per cent of the 2,675 men diagnosed with prostate cancer that year.

The province in 2017 provided $6 million to help expand the program, which, Sundar says, is now running in Victoria and Kelowna, with Surrey and Prince George next in line — in addition to Telehealth programs planned for remote communities.

Other courses address diet and exercise, which should be important to men regardless of whether they have prostate cancer. There are also tips on how to maintain sexuality, and how to survive the considerable side effects of hormone therapy, which can include hot flushes, weight gain, fatigue, enlarged breasts, shrinking penis, loss of bone density and muscle mass, mood swings including an increased tendency to cry, and failure to achieve an erection or, if you can, achieve an orgasm.

In short, treatment can seem almost as devastating as cancer itself.

Canadian-born researcher Charles Huggins won the Nobel Prize in 1966 for his research into the relationship between hormones and prostate cancer,

including the use of castration as a way to stop the production of testosterone upon which the cancer feeds.

Today, hormone therapy achieves the same results.

Every three months, a contracted nurse comes to my home, where I lay on the living room couch as she or he injects Zoladex, a drug that releases slowly, into my abdomen. This week, I received the fifth and last needle in my series of treatments.

Helping men make the right choice

To help men canvas all options before making a decision, Ontario has created a “treatment pathway” that maps out “all treatment options” available to men with prostate cancer, including consultations with both a urologist and radiation oncologist.

Queen’s University also offers an online support program, decisionhelp.qcancercare.com.

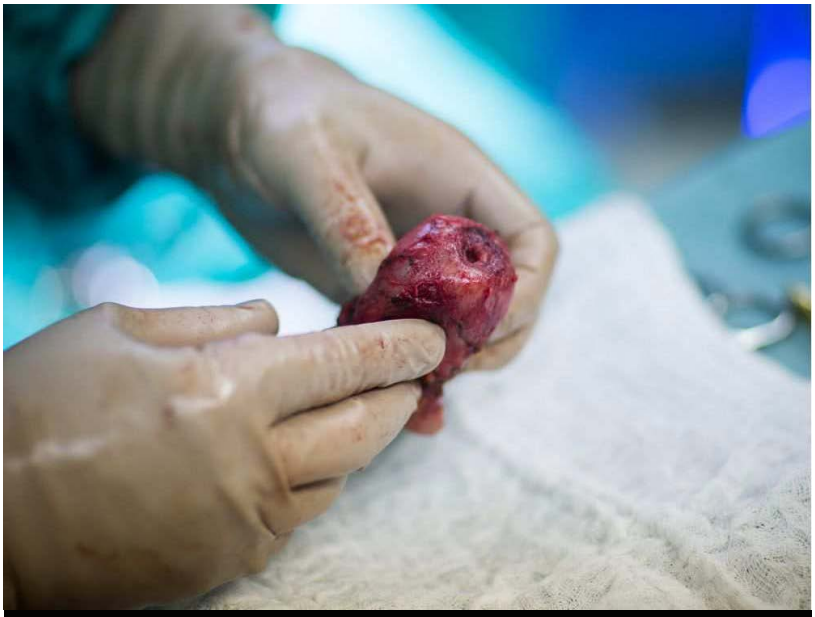
And Prostate Cancer UK has developed a “best practice pathway” on treatment of prostate cancer that states, in part: “Where there is more than one appropriate treatment available, then men should be able to speak to the relevant clinicians … concurrently — e.g. if surgery and radiotherapy were both options the man should be able to discuss these options with both a urologist and an oncologist.”

Keyes — who is also my oncologist — would like to see something similar in B.C.

“In a way, it’s a complex disease with many different options,” she said. “We’d like every patient to have an opportunity to talk to a surgeon, but also be sent to the cancer clinic and have a discussion with a radiation oncologist … as to what the best treatment is. Every patient should have that opportunity.”

Ideally, Keyes would like men to visit a multi-disciplinary clinic where they could see both specialists at the same time. It’s a common sense way for men in shock from a cancer diagnosis to get proper guidance.

Edmonds, of Prostate Cancer Canada, observed that men initially diagnosed can “shut off” and find it challenging to navigate the health system. “It’s tough because there’s so much information and you need some guidance.” He says a national standard for helping men make their treatment decision “would be valuable” as opposed to a hit-or-miss system, province by province.



Dr. Martin Gleave removes a patient's prostate during surgery at Vancouver General Hospital. BEN NELMS / PNG

Often the treatment decision is obvious, but sometimes it can go either way. Factors typically include the nature of the cancer, how far it has spread, and the physical and psychological characteristics of the patient, including age.

Keyes said surgery is a better option for men already suffering from urinary problems or with large prostates. Brachytherapy is a good option for patients whose medical conditions are perhaps compromised by other medical ailments that preclude surgery.

"The majority of patients could actually have either," she said.

The benefits of brachytherapy, she argues, are that fewer men have incontinence issues (no wearing of pads), sexual function is better preserved, and the recovery time is reduced.

Age of the patient and their history are also factors in continued sexuality.

"It's like playing the piano," Goldenberg says. "If you can't play before your treatment, you ain't playing it after. They won't admit it's not what it used to be, but they still want to have it. It's part of your manhood."

As for radiation, he says: "Patients may regret having radiation if they're looking for a bathroom every 15 minutes, or they're bleeding in their urine or worried they're going to poop in their pants. Choose your poison."

The side effects of external beam radiation typically wear off over a few months, brachytherapy over one year, Keyes said.

Goldenberg agreed that brachytherapy avoids the general anesthetic associated with surgery and the risk of complications. "I had an old teacher when I was training say: 'Larry, if you walk in the barnyard, every once in a while you're going to step in it.' Nothing in medicine, certainly not in surgery, is foolproof."

Gleave points out that if the cancer returns, men have more options after surgery. "If the PSA comes back, you can come in with hormone therapy and

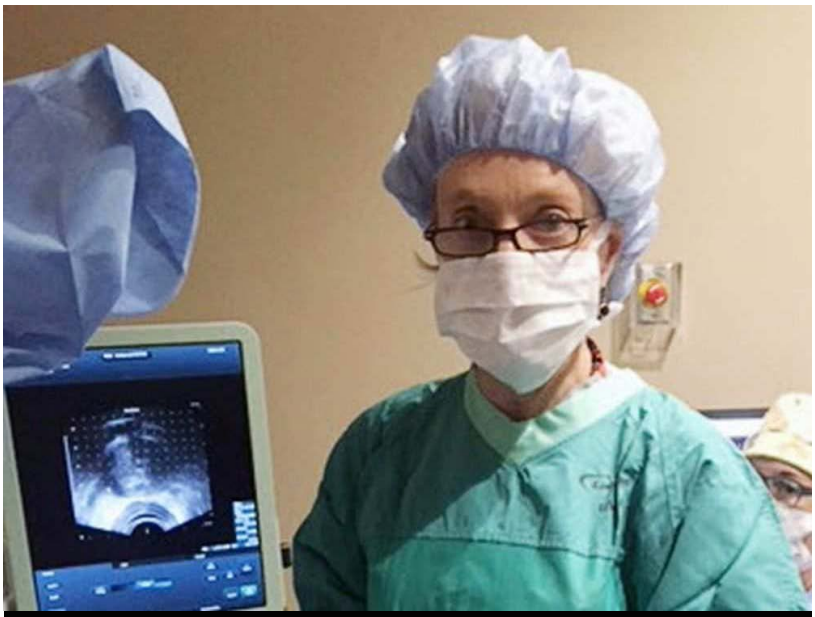
radiation … two potential cracks at a cure." He added: "The advantage of surgery is you get pathology, you know much more precisely what the extent of the cancer is. Your PSA load is zero right away."

Said Goldenberg: "A lot of people will say, 'Doc, what do you suggest? I'll do what you tell me to do.' That puts the pressure on us. A fair bit of people have remorse. They wish they'd gone the other way."

Goldenberg contributed to a study led by the University of Saskatchewan and published in the medical journal BJU International in 2007 that found one year after surgery for localized prostate cancer, four per cent of 130 men with a mean age of 62 years old expressed regret over having their prostates removed.

"Men reported feeling less masculine, having less sexual enjoyment, difficulty in getting and maintaining an erection, and discomfort when being sexually intimate after surgery," the study found.

Low-dose brachytherapy involves the permanent placement of radioactive seeds into the prostate. Men who undergo this procedure are cautioned against small children sitting on their laps immediately after the procedure and to carry a doctor's note when going through border crossings or airport security for fear of setting off alarms.



Dr. Juanita Crook is a Kelowna-based radiation oncologist who performs high-dose-rate brachytherapy on prostate cancer patients. HANDOUT / PNG

An alternative form is high-dose-rate brachytherapy, practised in B.C. only in Kelowna. The procedure involves temporarily placing a super-radioactive seed in a series of needles, typically 16, in the prostate. Men walk out of the hospital without being radioactive.

Comparative studies between the low and high dose versions are still underway, although the radiation journal BJR in 2012 described high-dose-rate brachytherapy as "at the forefront of innovation in radiotherapy" and "an invaluable tool in the armamentarium for the radiation treatment of prostate cancer."

In my case, I had limited options because my cancer was detected late in the

game.

I had a PSA reading of 3.0 in January 2014, which jumped to 8.8 almost two years later in December 2015 — a missed opportunity to be referred to a urologist for further investigation.

By the time I was seeing Poon at age 61 in late 2016, my PSA had reached 10.0.

Gleave subsequently told me that as a guideline men in their 60s should have a score under 4.5.

Poon also discovered significant hardening of the right side of the prostate — something not detected during the digital rectal exam by my family doctor. “I missed it,” my family doctor later acknowledged.

And yet the Ministry of Health considers the digital rectal exam — not the PSA test — as the “standard method in B.C. for early detection of prostate cancer.”

The Gleason score is a grading system used to estimate the aggressiveness of a cancer, and is based on analysis of multiple prostate tissue samples obtained through a biopsy. It is an uncomfortable procedure, to say the least. You are awake, flinching repeatedly as a needle — which sounds like a stapler — extracts one piece of your prostate after another.

In hindsight, the psychological effects are worse than the physical pain.

My Gleason score was 3+4 = 7/10, which put me in a high-intermediate category.

Poon suggested I go the private route for an MRI, to avoid waits in the public system. He has one foot in private medicine, at False Creek Healthcare Centre in Vancouver.

But my family doctor put out an emergency request and I got an appointment in a week at Peace Arch Hospital in White Rock. The results showed the cancer had spread beyond my prostate into the surrounding tissue, but, fortunately, a bone scan determined it had not metastasized in the bones.

Because the cancer had moved beyond my prostate, surgery was no longer an option.

After consulting with her colleagues, Keyes recommended I choose high-dose-rate brachytherapy, which offered a better chance of targeting the area where the cancer had spread.

Dr. Juanita Crook conducted the procedure in May 2017, followed by more than four weeks of external-beam radiation at B.C. Cancer in Vancouver, in addition to the hormone treatments.

In short, the medical system tossed everything it could at it, given my “high risk” category.

With any luck, I’ll return to some sense of normalcy late this year as the hormone treatments wear off and my body begins to produce testosterone again. Then it’s a waiting game, regular PSA checkups to see who wins the battle — me or the cancer.

If such a disease can have a silver lining, it is the fact that it causes you to re-examine your life, how you can be a better person, how you can improve your lifestyle, how to give your body a fighting chance.

As I go forward, I try not to look over my shoulder for the silent killer, and instead focus on the future. The path ahead may not be clear, but I accept it with a renewed sense of purpose and passion for life — for however long that might be.

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Prostate Cancer

A five-part series

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Part 4: Intimacy and sex after prostate cancer

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