

A Patient's Guide to Prostate Cancer



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Tailoring Technology to Treatment

This booklet is written by leading urologists for men and their families who would like to know more about prostate cancer. It is not intended to be a definitive textbook, but aims to provide a basic understanding of the disease, its diagnosis and treatment. Other booklets in this series explore the treatment options described in this general guide in more detail. These more specialist booklets may be given to you by your doctor or they can be viewed and downloaded through the internet at: www.prostatebrachytherapycentre.com

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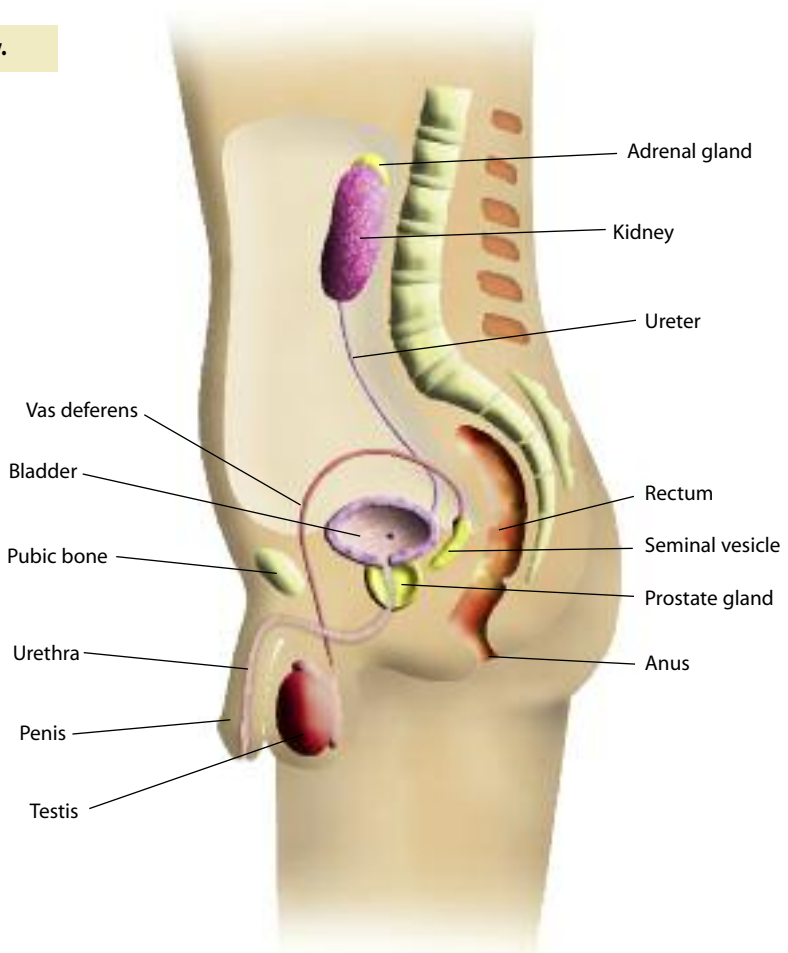
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Introduction

What is the prostate and where is it?

The prostate is a small gland, about the size of a walnut, which lies just below the bladder. The tube draining the bladder, called the urethra, passes through the centre of the gland, to the penis.

Anatomy.

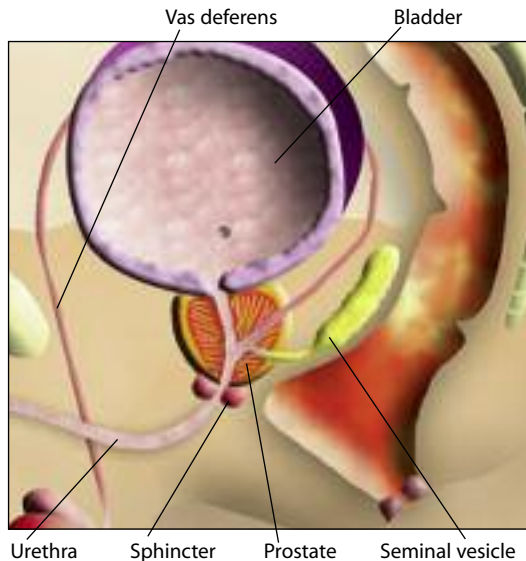


The valve mechanism, or sphincter, maintains continence and stops urine leaking out of the bladder. It is located below the prostate gland and encircles the urethra.

What does the prostate do?

The prostate gland is a part of the male reproductive system. It develops at puberty and continues to enlarge throughout life.

The prostate acts rather like a junction box. It allows the tubes that transport sperm from each testicle and the tubes that drain from the seminal vesicles to meet and then empty their contents into the urethra. The seminal vesicles consist of two pouches that provide nutrients for the sperm and lie immediately behind the prostate.



At the point of orgasm, sperm, seminal vesicle fluid and prostatic secretions enter the urethra and mix together, forming semen. This is then ejaculated out through the penis by rhythmic muscular contractions.

What controls the growth of the prostate gland?

The growth of the prostate is controlled by testosterone, the male sex hormone. Most testosterone is made by the testicles, although a small amount is also made by the adrenal glands, which lie on top of each kidney. The hormone goes into the bloodstream and finds its way to the prostate. Here, it is changed into dihydro-testosterone (DHT), a more active form which stimulates growth of the gland. The prostate gradually enlarges with ageing, resulting in symptoms such as reduced urine flow and a feeling of incomplete emptying of the bladder, having passed urine. This enlargement is usually benign (non-cancerous).

What is prostate cancer?

Normally in the prostate, as in the rest of the body, there is a continuous turnover of cells, with new ones replacing old, dying ones. In a cancer, the balance between the new and old cells is lost, with many more new ones being made and older cells living longer, as the process of planned cell death has been disrupted.

The malignant growths are known as prostate cancer. They differ from benign enlargements in that the cancerous cells can spread (metastasise) to other areas in the body. However, sometimes the cancer can be detected before it has spread outside the prostate.

How does prostate cancer spread?

Cancer cells can spread by directly growing outwards through the capsule (outer covering of the gland) into the neighbouring parts of the body, such as the seminal vesicles or bladder. They may occasionally spread through the bloodstream and implant and grow in the bones of the spine. Finally, cells can spread through lymph vessels. These vessels are like a second system of veins, except

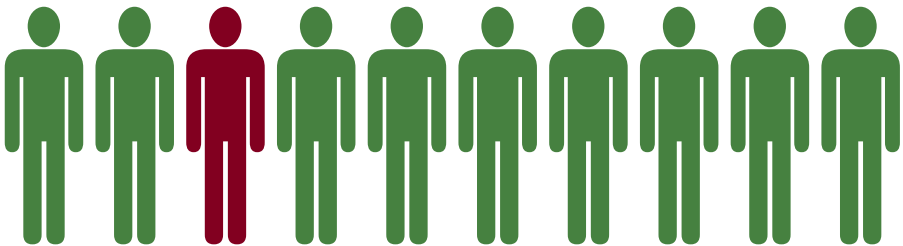


that, instead of blood, they contain a milky fluid that is made up of the cells' waste products. Lymph vessels drain via lymph nodes (special bean-shaped filters), to finally empty back into the blood circulation, and it is these lymph nodes that can also become invaded by cancerous cells.

How common is prostate cancer?

Prostate cancer is now the most common cancer in males in the UK, with nearly 20,000 men being diagnosed with the disease and 10,000 men dying from it each year. However, there have been many recent advances in detecting and treating prostate cancer, and patients who are diagnosed early can now have a high chance of cure.

Prostate cancer rarely occurs before 50 years of age and is most commonly diagnosed in men in their 60s and 70s. Indeed, it seems almost inevitable



that, if one lives long enough, prostate cancer will occur. However, this does not mean that all men will be aware of the cancer, need any treatment, or even die because of the disease.

Why does prostate cancer occur?

The real answer to this question is not known. Nevertheless, there are a number of factors that can increase the chance of developing prostate cancer. Relatives of patients with prostate cancer have an increased risk of developing the disease themselves, especially if their father or brother were affected. The disease is more common in the Afro-American population and rarer in the Chinese. There also appears to be a link with people living in urban areas exposed to pollution and those consuming large quantities of dietary fat.



Symptoms and Diagnosis

What are the symptoms of prostate cancer?

There are often no symptoms associated with early stage prostate cancer. As the disease progresses and the tumour enlarges, it may press on the urethra, which runs through the gland, and obstruct the flow of urine during urination. In this situation, the patient may notice a weak, interrupted stream of urine that requires straining to produce and, on completion, he may still feel that the bladder is not empty. However, these symptoms are not specific to prostate cancer and are most commonly found in benign (non-cancerous) enlargements of the gland.

Blood in the semen may be a sign of prostate cancer, although again this is a common finding and not normally related to malignancy. If the tumour has spread to the bones, it may cause pain. The spine is the most common site for this to occur.

Who treats prostate cancer patients?

This is the job of a specialist team of hospital doctors and nurses, including a Urologist (surgeon) and an Oncologist (physician specialising in radiotherapy and chemotherapy for the treatment of cancers). Usually, following an examination by the patient's General Practitioner (GP), the GP will make arrangements for the patient to see the

Urologist, so that a full range of tests can be carried out and an assessment of the prostate made.



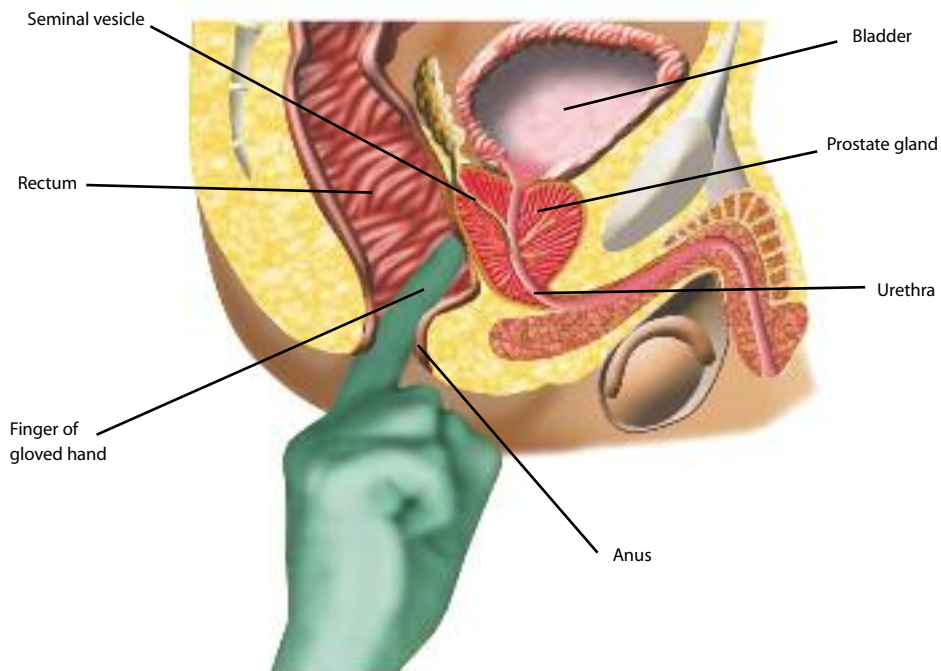
How is prostate cancer diagnosed?

The doctor will initially ask the patient questions to check their general medical health and see if they are experiencing any symptoms associated with prostate cancer (although, as has been mentioned, such symptoms are not specific to prostate cancer).

Physical examination

Having made a general examination, the doctor will then need to perform a rectal examination to feel the gland. A gloved, lubricated finger is inserted into the back passage (rectum) to check the size and shape of the prostate gland.

Digital rectal examination.



Blood test

The prostate can be evaluated by testing for the level of a particular protein in the blood called PSA (prostate-specific antigen). Prostate enlargement tends to cause an increase in the level of PSA, with malignant tumours (cancers) producing a greater increase than benign enlargements. However, other conditions can also cause PSA to rise, such as a urinary infection. Therefore, although a slight elevation in the PSA may indicate prostate cancer, it is by no means definite.

Ultrasound examination and biopsy

The prostate can be imaged with ultrasound, a device often used to scan pregnant women. To visualise the prostate, a well-lubricated probe, similar in size to a finger, is inserted into the rectum, and images of the prostate appear on a screen. This technique also provides pictures of the seminal vesicles and the tissues surrounding the gland. The images produced help to identify areas within the gland that may be malignant, but the only way to prove there is cancer present is to take a biopsy (a small piece of tissue obtained by a special needle).

If a biopsy is to be performed at the time of the ultrasound scan, the patient will be forewarned. A small needle is inserted alongside the ultrasound probe, which can then be moved to the area of the gland in question. The procedure is no more painful than giving blood, due to the use of local anaesthetic. The doctor will give the patient an antibiotic to help prevent any infection occurring.

Typically, 10-12 biopsies are normally taken, which are then analysed in the laboratory, and a diagnosis obtained. After the procedure, it is quite common for the patient to see some blood in his urine, semen and stools, but this usually settles over a week or two.

Bone scan

Once a diagnosis of prostate cancer has been made, if spread is suspected (usually by the level of PSA), a bone scan can be used to see if the tumour has invaded bone. For this painless test, a tiny, harmless quantity of a radioactive agent is injected into a vein. This makes its way to any cancer deposits

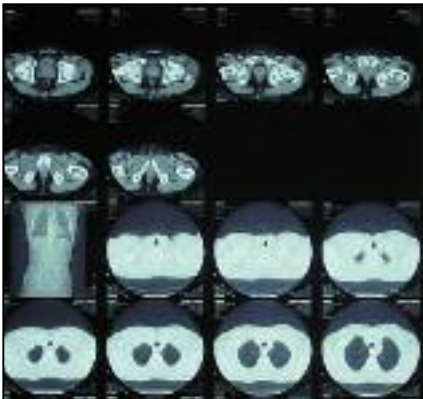


within the skeleton and sticks to them. After a few hours, the patient is scanned by a special camera, similar to an x-ray machine, which detects these deposits, if present.

Other tests

Two other types of scanning machines are available. A computer tomography (CT) scan or a magnetic resonance imaging (MRI) scan are sometimes used to obtain detailed pictures of the prostate and the surrounding tissue. Both are quite painless. The CT scanner uses x-rays and MRI uses magnetic fields to produce their images.

All of these tests will help the doctor to assess the stage and grade of the prostate cancer.

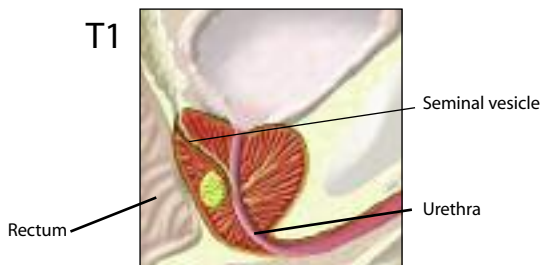


What does the stage of a prostate cancer mean?

The stage of a prostate cancer refers to how far the cancer has spread. The classification commonly used to stage prostate cancer in the UK is shown here in a simplified form. (The prefix T is used by convention to identify the tumour stage, i.e. T1 or T2).

It is very important to remember that although all prostate cancers have the potential to progress, it usually takes years to pass from Stage 1 to 4.

Stage	
1	Earliest stage, where the cancer is so small that it cannot be felt on rectal examination, but is discovered in a prostate biopsy or in prostate tissue that has been surgically removed to 'unblock' the flow of urine (as in a transurethral resection of the prostate – TURP).
2	The tumour can now be felt on rectal examination, but is still confined to the prostate gland and has not spread.
3	The tumour has spread outside the gland and may have invaded the seminal vesicles.
4	The tumour has spread to involve surrounding tissues such as the rectum, bladder or muscles of the pelvis.



What does the grade of a prostate cancer mean?

The grade of a cancer is the term used to describe how aggressive the disease is and whether it will progress quickly (months) or slowly (years). The grading assessment is made by a Pathologist in the laboratory, looking at the prostatic cells under the microscope. The grading system used for prostate cancer is known as the Gleason Scoring system, named after the Pathologist Donald Gleason, and ranges from 2-10.

The Pathologist will identify several of the prostate cancer cells in the biopsy. Having identified the largest and second largest areas of cancerous cells, he or she will assign each area a number known as the Gleason grades. These grades range from 1-5, with Grades 1-3 tumours least likely to spread and Grades 4 and 5 most likely.

The Gleason score is calculated by adding the two Gleason grade numbers together – thus, the score ranges from $1+1=2$ to $5+5=10$. Therefore, a Gleason

Gleason Scale – Appearance of Tissue



Least aggressive

(Gleason score 2-6)

Moderately aggressive

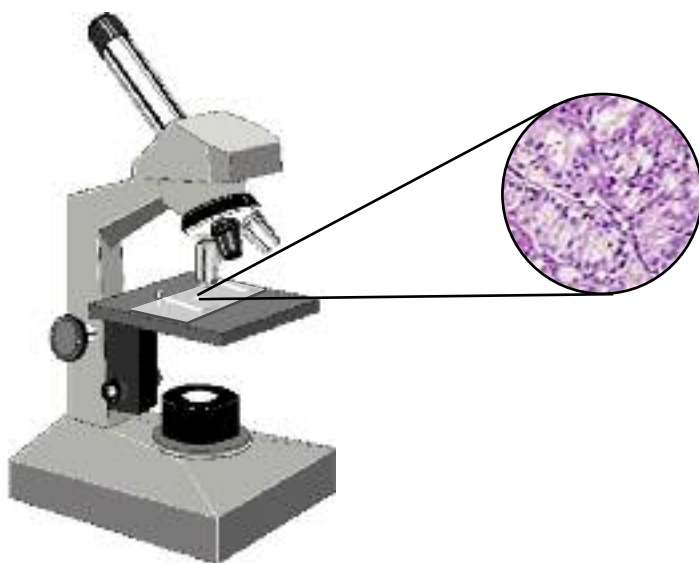
(Gleason score 7)

Most aggressive

(Gleason score 8-10)

score of $3+2=5$ suggests that most of the cancer is Gleason Grade 3, with a smaller amount of Gleason Grade 2. Prostate cancers with a Gleason score of 7 or greater will always contain at least some Grade 4 tumour and hence have a worse prognosis.

Understanding of the pathological grading is of great importance for both the clinician and the patient, as it will determine which treatment options are available, as well as their likely success. Many regional cancer centres will arrange for a specialist Pathologist to review the microscopic slides of a patient's prostate cancer cells to confirm the diagnosis before treatment begins.



Treatment

How is prostate cancer treated?

At present, there is no definite evidence as to which is the best treatment for prostate cancer, especially for early stage T1 or T2 tumours, and different Urologists may have differing views. One of the reasons for this is that some patients with early stage disease may live 10 years or more if no treatment at all is used. Therefore, more involved therapies have a hard act to beat. However, in other patients, the disease can be much more serious. Unfortunately, whilst it is possible to generalise, it can be difficult to predict what course the prostate cancer will take in any individual.

Also, the side-effects of treatment must be balanced against the overall benefit of therapy. For example, there is little point in undergoing major surgery to take out the prostate if the tumour has spread to areas where it cannot be removed.

The treatment of prostate cancer is determined by the stage and the grade of the disease as well as the PSA. There are a number of treatment options for every stage, each with their own advantages and disadvantages. Thus, the therapy needs to be tailored to suit each individual patient. It is possible to cure patients with prostate cancer at an early stage, but even if cure is not a possibility, the disease can normally be kept in check for a number of years.

What are the treatment options in prostate cancer?

The different treatment options available to patients diagnosed with prostate cancer are described below. It is important that any patient with such a diagnosis is aware of the different treatments, and they should feel free to discuss these with their Urologist and Oncologist. Some patients feel surprised that they are being offered a choice of different treatments and naturally feel inadequately prepared to make such an important decision. This is a common feeling, which the information in this and the related booklets should help to dispel. One of the prime reasons for including patients in the decision-making process of their treatment is that surgery, external beam radiotherapy and prostate brachytherapy have the same chance of curing an individual, when such curative treatment is deemed necessary. Only these three therapies have been endorsed by the 2008 NICE Guidelines on prostate cancer treatment. Currently, prostate cryotherapy and HIFU are not recommended for routine treatment, due to the lack of evidence to demonstrate their effectiveness.

Whatever therapy is undertaken, the patient will need regular follow-up examinations, which will involve a PSA blood test and possibly scans or x-rays, for a number of years.

Active surveillance

If their cancer has been diagnosed accidentally, during an operation to remove prostatic tissue blocking the urinary stream or by a PSA blood test and biopsy, and the patient has no symptoms, a “wait and see” policy may be chosen.

This does not mean “do nothing”, but the patient will

be regularly monitored by the doctor and if problems develop, appropriate action taken. During this observation period, seeing how quickly the PSA rises can assess the severity of the condition. Frequently, patients opting for such a treatment strategy will be offered a repeat prostate biopsy 2 years after diagnosis, to ensure the grade of the cancer has not worsened. If treatment is ultimately required, curative therapies may still be offered, although often hormone therapy (see page 25) is the treatment of choice. With such a regimen, patients commonly live for a number of years and this option is frequently chosen by patients with low grade cancers and/or who are elderly.

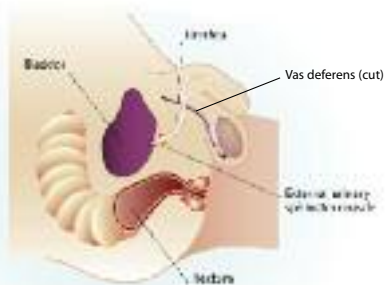
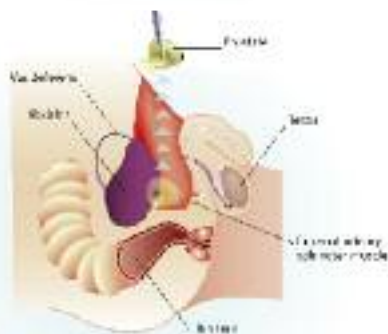
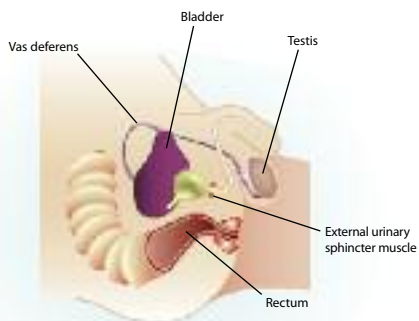
Prostate surgery: Radical prostatectomy

Radical (curative) prostatectomy is an operation to remove the entire prostate and seminal vesicles. This operation can be performed through an incision in the



lower abdomen (a radical *retropubic* prostatectomy) or through an incision made between the anus and scrotum (a radical *perineal* prostatectomy). In specialist centres, the prostate can also be removed by a keyhole or laparoscopic technique. The latest keyhole technique involves using a surgical robot to assist the surgeon. These are complex, major operations that usually require a hospital stay of between 1 week for open operations to 3 days with keyhole surgery. Patients leave hospital with a catheter in place which bridges the join between the bladder and urethra whilst it heals; they then return to hospital 10-14 days later for the catheter removal. Such procedures should not be confused with conventional prostate surgery – transurethral resection of the prostate (TURP) – where only the tissue blocking the urinary flow is removed, leaving part of the gland behind.

The advantage of surgery is that it is a one-off procedure and provided the cancer is confined to the prostate, will hopefully cure the disease. It avoids the side-effects of



Prostatectomy.

radiotherapy and is thought by some to be the most effective form of treatment for early prostate cancer.

However, there are risks associated with radical prostatectomy. It is a major operation and involves a number of weeks of convalescence to make a full recovery. Unfortunately, the prostate lies very close to both the sphincter that controls urinary continence and the nerves that produce penile erections. In the past, removal of the gland often caused damage to these structures, resulting in a significant risk of postoperative urinary incontinence and impotence (inability to achieve an erection).

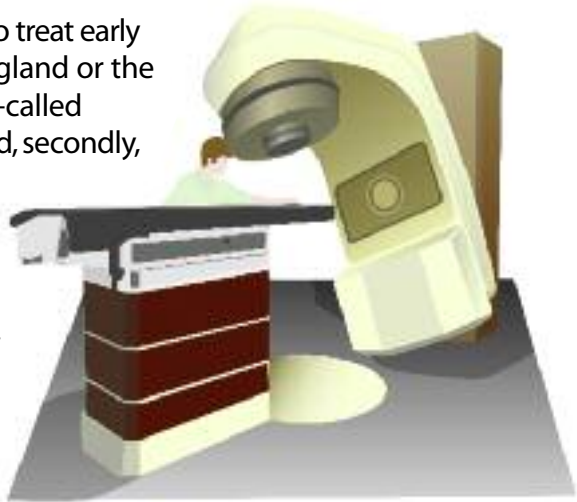
Newer surgical techniques have reduced the recurrence of impotence and severe incontinence is now uncommon. Furthermore, there are a number of new therapies to treat such side-effects, should they occur. Radical prostatectomy, more than any other prostate cancer treatment, is highly dependent on the experience and skill of the surgeon. Few Urologists in the UK are currently trained in keyhole or robotic techniques, due to the lack of training opportunities and the lengthy learning curve of the procedures.

For more information on radical prostatectomy, please read *A Patient's Guide to Radical Prostatectomy*, which should be available at your hospital or may be viewed and downloaded from the internet at: www.prostatecancercentre.com

Radiotherapy: **External beam or brachytherapy**

Radiotherapy involves directing high-energy radiation rays at the tumour, aiming to destroy the cancerous cells and leave the healthy ones intact. It may be used

in two situations: firstly, to treat early cancers confined to the gland or the surrounding tissues (so-called *radical radiotherapy*); and, secondly, to treat tumours that have spread to the bone and which are causing pain (*palliative radiotherapy*). Radiotherapy is a painless procedure, like having an x-ray, although there can be troublesome side-effects associated with the treatment.

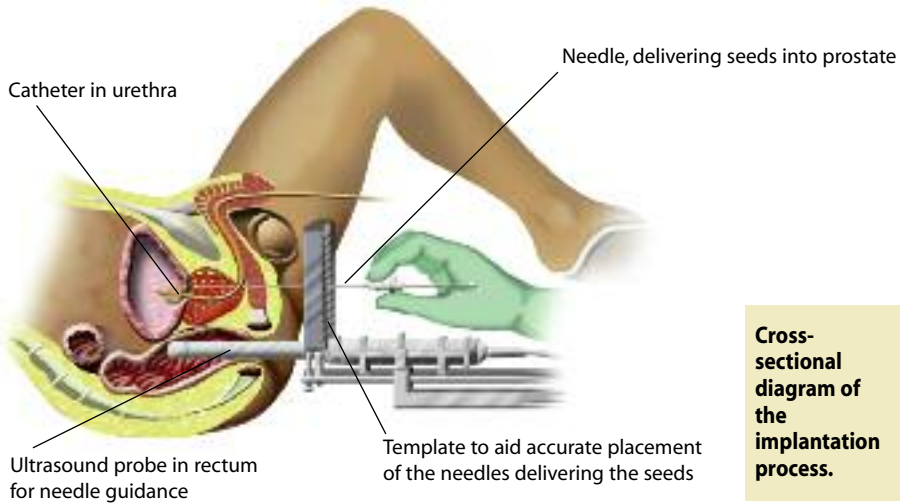


Radical radiotherapy for a tumour localised to the prostate may be either given by *external beam radiotherapy* or by *brachytherapy*.

External beam radiotherapy

Radical (curative) external beam radiotherapy involves beams of radiation passing through the body to be targeted onto the prostate, which is a process similar to x-rays. The treatment is given on an out-patient basis with the patients attending their local cancer centre for five days a week for 4–7 weeks. At each visit, the patient will receive a small fraction of the radiation dose until the therapy is complete.

For more information on radiotherapy, please read *A Patient's Guide to External Beam Radiotherapy*, which should be available at your hospital or may be viewed and downloaded from the internet at: www.prostatebrachytherapycentre.com



Cross-sectional diagram of the implantation process.

Brachytherapy

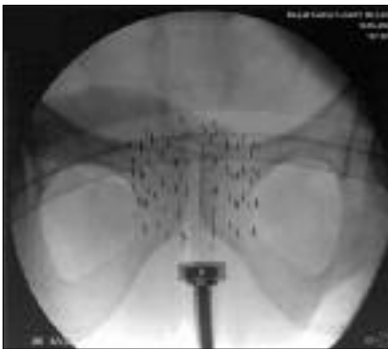
Radical (curative) radiotherapy can also be given using radioactive seeds that are approximately half the size of a grain of rice. These seeds, typically 60-120 in number, are inserted directly into the cancerous prostate gland through delivery needles under ultrasound control. The needles are passed through the skin behind the scrotum and in front of the anus to reach the prostate. The procedure is performed under an

anaesthetic. It has the advantage of being either a day case or overnight stay procedure, with patients rapidly returning to normal activities.

This procedure was first developed in the 1980s. The long-term results of brachytherapy in curing patients with



¹²⁵ Brachytherapy implant.



Post-implant x-ray of seeds in prostate gland, with the ultrasound probe in the rectum.

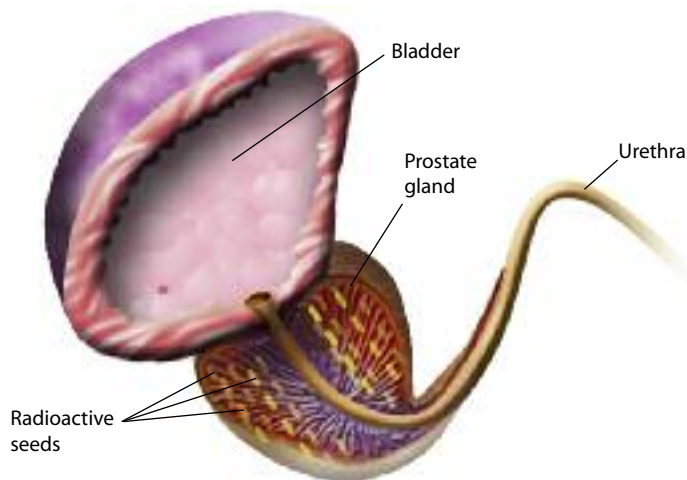


Illustration showing the seeds lying in the prostate gland after implantation.

prostate cancer have been shown to be as good as for radical prostatectomy or external beam radiotherapy. It is now the only minimally invasive treatment for prostate cancer endorsed by NICE, 2008.

The advantage of radical radiotherapy is that it can cure early prostate cancer without the need for a major operation. It rarely causes loss of urinary control, and impotence is less common than with surgery.

The side-effects of radiotherapy, in general, are normally limited to patients having radical rather than palliative treatment. External beam radiotherapy is lengthier than surgery and often causes tiredness, nausea, and diarrhoea, as well as frequent and painful urination. Although most of these side-effects settle in time, some will occasionally persist.

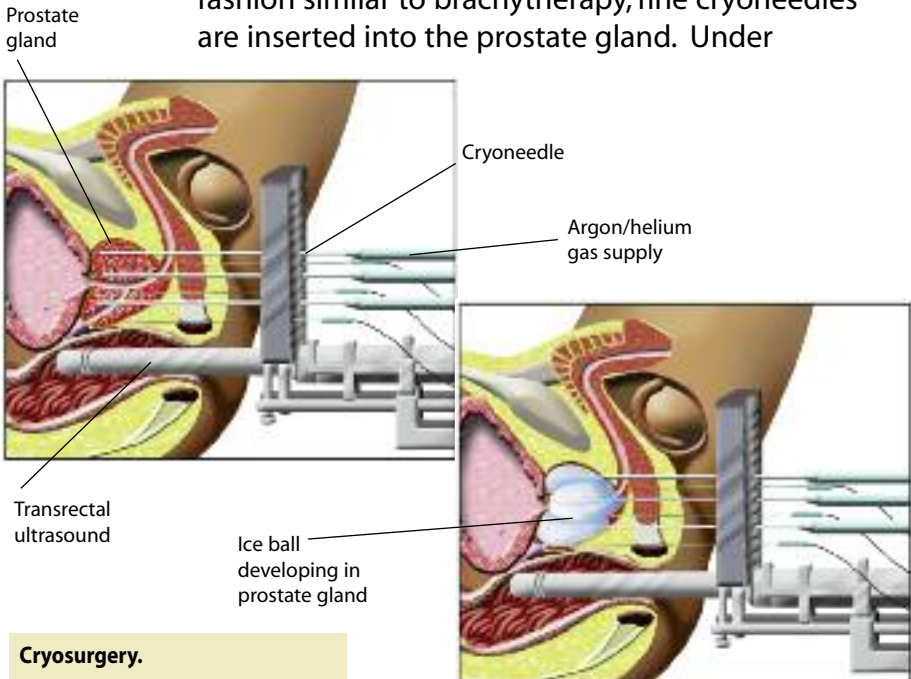
With brachytherapy, the side-effects are usually confined to the urinary system, with patients temporarily experiencing a slow flow and urinary frequency. Very occasionally (less than 5%), patients may even experience difficulty in passing urine at all after the

treatment and require a catheter (tube draining the bladder through the penis) for a short period, normally a week or two, before their urinary symptoms settle. However, incontinence is rare and impotence seems least common with this form of treatment.

For more information on brachytherapy, please read *A Patient's Guide to Prostate Brachytherapy*, which should be available at your hospital or may be viewed and downloaded from the internet at: www.prostatebrachytherapycentre.com

Cryosurgery

Cryosurgery uses extreme cold to destroy the prostate tissue. Using transrectal ultrasound in a fashion similar to brachytherapy, fine cryoneedles are inserted into the prostate gland. Under



Cryosurgery.

anaesthetic, argon and helium gases are used to freeze, then thaw, the prostate, causing destruction of the tumour. Temperature can be as low as -140°C . A warming device and temperature sensors protect vital neighbouring structures, such as the rectum, bladder and sphincter muscles.

Patients typically stay in hospital overnight and are discharged home with a urinary catheter for 2 weeks, to allow the swelling of the prostate to reduce. Cryosurgery is a newer technique being investigated in only a small number of specialist centres in the UK. The impotence rate is higher than with other treatments and incontinence can occasionally occur. Although it has been used to treat men with newly-diagnosed prostate cancers, it is currently primarily reserved for patients with recurrent prostate cancer after treatment by radiotherapy.

For more information on cryotherapy, please read *A Patient's Guide to Prostate Cryosurgery*, which should be available at your hospital or may be viewed and downloaded from the internet at: www.prostatecancercentre.com

High intensity focused ultrasound (HIFU)

HIFU treatment involves focusing high intensity sound waves on the prostate, which generate high temperatures over 80°C and cause tissue destruction.

These sound waves are generated by a special transrectal ultrasound probe that allows the prostate gland to be visualised and targeted. The aim of the treatment is to obliterate the cancerous tissue, whilst preserving neighbouring organs.



The procedure is performed under anaesthetic and takes approximately 3 hours. Some centres routinely perform a telescopic prostate operation to rebores the prostate, TURP, before treating with HIFU. When used with curative intent, the success rate is uncertain and risk of impotence seems high. Whilst the concept of the device is appealing, its real place and value in the treatment of prostate cancer has yet to be established and, at present, the technique is considered experimental.

For more information on HIFU, please read *A Patient's Guide to HIFU*, which should be available at your hospital or may be viewed and downloaded from the internet at: www.prostatecancercentre.com

Hormone therapy

When the cancer has spread beyond the prostate, going to either the lymph nodes or bones, hormonal therapy may be very effective at shrinking the tumour and reducing the side-effects of the disease. It does not provide a cure, but will often keep the cancer in check for a number of years.

Some patients are given a course of hormone therapy before having radical radiotherapy. This is useful if the cancer has spread outside the confines of the prostate gland, but has not yet reached the lymph nodes or bone.

As mentioned earlier, the prostate gland and prostate cancer are under the influence of testosterone, the male sex hormone, which drives the tumour to grow and spread. By blocking the body's



production of testosterone, or blocking its action, the growth of the tumour may be greatly reduced. There are a number of ways to administer such hormonal therapy (see below). Whatever technique is chosen by the patient, certain side-effects are common, such as hot flushes, a loss of sexual desire, impotence and occasionally breast tenderness, or more occasionally breast enlargement.

Surgical orchidectomy

The parts of the testicles that produce testosterone may be surgically removed by a small operation, called an *orchidectomy*, which can be performed as a day case procedure. This has the advantage of being a one-off treatment, which does not rely on the patient remembering their medication, and tends to cause less breast problems. However, the operation is irreversible and an option that some men find unacceptable. It is not true that men develop a high-pitched voice after such a procedure!



Injection therapy

Injection of an agent, known as an *LHRH analogue*, has a similar effect to removing the testicles, but is reversible and doesn't involve an operation. The injection is given every one or three months by either a doctor or nurse, or the patients can be taught to inject themselves. This new approach to



injection therapy has proven very popular with some patients who have been able to master the technique without any difficulty.

Because there can be an initial rise in testosterone after the first injection, a two week course of anti-androgen tablets (see below) is normally prescribed to stop this effect. Hot flushes, breast tenderness and impotence are common side-effects with this form of medication.

Anti-androgen tablets

This therapy involves taking tablets to block the action of testosterone. They work by either lowering the level of testosterone in the body, or by blocking its action on the prostate gland. The tablets, which are taken each day, may be used alone to treat prostate cancer, or in combination with an LHRH analogue (see previous page). All of the available medications have side-effects such as breast tenderness or enlargement, although some have fewer effects on sexual desire and potency.

Chemotherapy

Chemotherapy involves powerful drugs to attack the cancer cells and try to prevent them growing. It is a second line of defence for patients with advanced stage prostate cancer that is no longer controlled by hormonal therapy. There are a number of different agents currently available, with new drugs having recently been launched which appear effective in controlling the disease in its later stages.

Conclusion

How does one cope with the diagnosis of prostate cancer?

The diagnosis of prostate cancer may change the lives of both the patient and his family. It is quite normal at times for patients or their loved ones to feel frightened, angry or depressed. These are natural reactions, which for most people are helped by sharing their concerns and feelings. Patients may find comfort in discussing their problems with other prostate cancer patients. They should bear in mind, however, that no two individuals or tumours are the same. The patient's doctor is the best person to discuss their own condition – to avoid a little knowledge being a worrying thing!

Whilst prostate cancer is a serious disease, it can be very effectively managed – or, indeed, cured – if treated early.





Are there any organisations for patients with prostate cancer?

The hospital looking after the patient, or the patient's GP, are the best initial sources of further information and guidance. Pages 31-32 list some addresses and websites of organisations that specialise in treating and supporting patients with prostate cancer and the associated side-effects that may occur.

10 questions you need answered when choosing your prostate treatment

1. What is my PSA?
2. What is my clinical stage?
3. What is my Gleason score?
4. Do I need a bone scan, CT or MRI?
5. Has the cancer spread outside the prostate gland?
6. Is the prostate cancer curable?
7. Am I young and fit enough to attempt curative treatment, or is the condition not life-threatening?
8. Which of the treatment options are suitable for me?
9. How many patients has your doctor treated using this technique and what are their success and complication rates?
10. Does this hospital specialise in prostate cancer treatments?

Useful addresses and websites

The Prostate Cancer Charity

www.prostate-cancer.org.uk

First Floor, Cambridge House, 100 Cambridge Grove,
London, W6 0LE.
Tel: 020 8222 7622 Helpline: 0800 074 8383
For information about prostate cancer.

The Prostate Brachytherapy Centre

www.prostatebrachytherapycentre.com

*'The UK's largest centre for prostate brachytherapy,
with experience of over 1400 successful procedures.'*
Tel: 0845 50 50 560

Everyman

www.everyman-campaign.org

Everyman, The Institute of Cancer Research
Freeport LON922, London SW7 3YY
Tel: 020 7878 3810 Fax: 020 7153 5313
e-mail: everyman@icr.ac.uk
*Dedicated to male cancers, promoting awareness and raising money for research.
Has opened the UK's first male cancer research centre.*

PCaSo Prostate Cancer Network

www.pcaso.com

PO Box 66, Emsworth, Hampshire PO10 7ZP
Helpline: 0845 650 2555
To improve the diagnosis, treatment, care and support to those troubled by this cancer.

Macmillan Cancer Support

www.macmillan.org.uk

89 Albert Embankment, London SE1 7UQ
Tel: 020 7840 7840 Macmillan Cancerline: 0808 808 2020
*Provides information on Macmillan nurses and the help that they can provide for patients
and their families.*

The Bladder and Bowel Foundation

www.bladderandbowelfoundation.org

SATRA Innovation Park, Rockingham Road,
Kettering, Northants NN16 9JH
Nurse helpline for medical advice: 0845 345 0165 Counsellor helpline: 0870 770 3246
General enquiries: 01536 533255 Fax: 01536 533240
'For people with bladder and bowel problems.'

Irish Cancer Society

Information Officer, 43-45 Northumberland Road, Dublin 4
Tel: 00 353 1 2310 500 Helpline: 1 800 200700 (available only in Eire)
*Helpline service, staffed by nurses, to give information and advice on all aspects of cancer care.
Open 9am – 5pm weekdays.*

Useful website addresses and support networks

British Prostate Group

c/o BAUS, 35-43 Lincoln's Inn Fields, London WC2A 3PE

Tel: 020 7869 6950 Fax: 020 7404 5048

An interest group around prostate disease, involving both clinical and scientific research, particularly in prostate cancer.

The Sexual Dysfunction Association

www.impotence.org.uk

'To help sufferers of impotence (erectile dysfunction) and their partners.'

The Prostate Project

www.prostate-project.org.uk

'A local charity supporting male health.'

The Prostate Cancer Centre

www.prostatecancercentre.com

'Providing a single point of referral to specialists at the forefront of the treatment of localised prostate cancer.'

Tel: 0845 370 3700



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Patient Information

Hospital Details:

Consultant:

Urology Nurse Specialist:

Telephone:

PSA:

Clinical Stage:

Gleason Score:

.....ng/ml

T.....

..... + =

Imaging Results:

Bone scan

MRI/CT

Other

Next Hospital Appointment:

Next PSA level test:

1. 2.

3. 4.

Notes:

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Tailoring Technology to Treatment



The Prostate Brachytherapy Centre
Guildford, Surrey
Tel: 0845 50 50 560