THE NEWSLETTER OF
Prostate Research Campaign UK

update

ISSUE No. 21 SPRING 2005

£370,000 for research and training

In March, **Prostate Research Campaign UK** announced further grants of £370,000 for research into all prostate disease. Of this, over £300,000 will be allocated for research with the balance going to the training of a wide variety of health professionals, including specialist urology nurses and doctors and GP nurses country wide. Nine separate research grants were awarded and among these, Professor Neil O'Donoghue FRCS describes five of them.

Mr Sampi Mehta, one of our research grant recipients, threatens our President Tony Kilmister with an imaging transducer during his visit to the University of Sheffield

Responses to irradiation

It is now well established that some families have an inherited predisposition to the development of breast and prostate cancer. We already know that a small proportion of younger men with prostate cancer carry a mutation of the BRCA2 gene and are relatively resistant to radiation therapy.

Dr Eeles and colleagues at the Institute of Cancer Research plan to study a unique population of male BRCA2 mutation carriers with a substantial risk of developing prostate cancer at a younger age which should provide information on the genetic pathways involved and on their responsiveness to radiotherapy.

The role of Insulin Growth Factor

Advances in molecular biology have lead to the identification of growth factors within tissues which influence the continued growth of cells and a number which play a role in the uncontrolled growth of cancer cells. One of the best known is vascular endothelial growth factor which plays a critical role in the development of new blood vessels which are essential for cancer growth and which has lead to trials of new agents in therapy. **The Oxford group** led by **Dr V M Macaulay** have demonstrated the presence of insulin-like growth factor Type 1 which is present in increased amounts in prostate cancer as compared to benign prostate tissue and is reported to become more active in the latter stages of rapidly progressive hormone resistant prostate cancer. This grant for £47,492 is to allow **Mr Ben Turne**y to continue this work in the laboratory using biopsy material from patients and animals.

Genetic changes in Prostate Cancer

If we had better methods of predicting outcomes and distinguishing between the *tigers and pussy cats* of prostate cancer we would know better which patients require radical prostatectomy, radiotherapy, brachytherapy, cryotherapy, high intensity focused ultrasound or can be monitored by active surveillance.

Cancer is due to the progressive accumulation of genetic changes within cells. Early change is associated with local growth within the prostate and further genetic changes allow local extension outside the prostate and eventually spread to distant sites. **Mark Feneley and colleagues** at the Institute of Urology plan to study the genetic changes in men who have done well following radical prosta-tectomy and in men who have developed early recurrence. The aim is to develop a molecular genetic test to guide our management.

Work with stem cells

Many patients on hormone therapy will relapse and develop *hormonal escape*. The outlook for such patients has been bleak until the advent of evidence last year that docetaxel based chemotherapy regimes can achieve a significant survival advantage.

Johann de Bono and colleagues from the Institute of Cancer Research and the

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£370,000 for research & training

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University of York are proposing a novel approach to hormonal escape by isolating prostate cancer stem cells from benign prostate tissue, hormonal sensitive and resistant prostate cancer. The technique of isolating stem cells from the prostate may perhaps provide a key to greater understanding of the molecular biology of the prostate and stem cell cultures provide a method of testing new molecular targeted drugs in the laboratory.

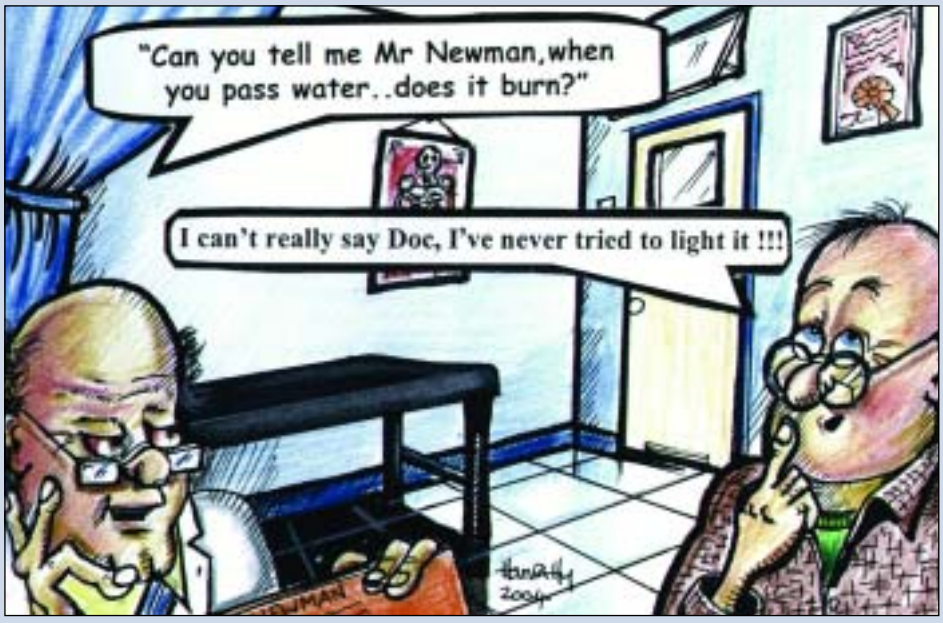
Imaging for BPH assessment

In current clinical practice we use relatively simple ultrasound techniques for visualising and assessing the volume of BPH (Benign Prostatic Hyperplasia) patients' prostates. There has been relatively little research in the use of more sophisticated imaging such as MRI.

The prostate is composed of glandular tissue embedded in a fibro-muscular stroma and produces the major proportion of semen. BPH develops in the transitional zone of the prostate close to the urethra and is characterised by a variable increase in prostate volume and a relative increase in the fibro-muscular stroma over glandular tissue. This expansion in prostate volume may obstruct urinary drainage and produce the common clinical symptoms of the disease. **David Buckley and Charles Hutchinson** from the University of Manchester are proposing to use sophisticated MRI scanning techniques to study (1) volume changes (2) blood supply and (3) relative changes in stroma and glandular components in BPH. It is expected that this will provide new insights into BPH and lead to new methods of assessment of response to therapy.

Training

Finally, we mention one of our training grants. 44 year old consultant urologist **Chris Anderson** has just spent a month at the University Clinic in Leipzig in Germany, studying innovative laparo-scopic surgical techniques and operating under the guidance of world-authority Professor Gens-Uwe Stolzenburg.



Are we lowering the tone?

This cartoon is one of many from the diary of Graham Newman, entitled *The Far End of a Fate*. Graham's diary is an irreverent, funny and moving account of his battle with Prostate Cancer, and is stuffed with anecdotes, sensible advice and personal reminiscences. Those of us that have been privileged to read it have found ourselves full of admiration for the author, a retired policeman, who also lectures to self-help groups and runs a website for disabled people. We are now trying to get the Diary published. Graham intends to give any proceeds to charity, so if you would like to help, please do contact us.

Thumbs down from Audit Office

The Audit Office February report *Tackling Cancer: Improving the Patient Journey* updates a larger 1999 - 2000 survey. To compile it, they sent questionnaires to 7,800 patients with breast, bowel, lung and prostate cancer in 49 NHS trusts. Of the 4,300 who responded, nearly 700 were prostate cancer patients.

Overall, the Audit Office found that services had *broadly improved*. For example, 58% of all respondents were seen within two weeks of referral by their GP compared with 46% in the earlier survey. Patients referred as urgent by their GP were almost universally seen by a specialist within two weeks.

It was clear from the report, that more action is needed in some areas, particularly prostate cancer.

The detailed questionnaire results illustrate the relatively poor service experienced by prostate cancer patients. They show that you wait longer at the start and you have more appointments cancelled. You would have liked more information and are less likely to have understood what you have been told and, for you, there is a greater likelihood of there being no discussion about your diagnosis, prognosis or treatment. You are less likely to have had a named nurse in charge of your care. On discharge from hospital, you are less likely to have had your home situation taken into account and are less likely to have been told of support or self help groups. In summary, for prostate cancer patients all aspects of diagnosis and treatment are sub standard when compared to the experiences of other cancer sufferers.

It is little surprise, therefore, that the highest response rate to the survey came from the prostate cancer patients.

Sir John Bourn, Head of the National Audit Office, noted: 'There is no room for complacency – even if only 10 per cent of patients with major cancers were dissatisfied with some aspect of their care, that amounts to over 10,000 people a year. We look to the NHS to continue its drive for improvement in patient care, particularly with respect to patients with prostate cancer'.

We whole-heartedly endorse this call for positive action.

Access To Medicines: Understanding NICE

by Dr John Graham, Consultant in Clinical Oncology

The NHS in the UK

The NHS in the UK is unique in that care is provided free at the point of use. That is to say, a patient attending an NHS hospital is able to get treatment without paying for the service on the day. This is very different to healthcare systems in many other parts of the world where patients take personal insurance for healthcare and, if they are not covered, they are not treated.

With a population over 60 million where less than 15% of people have private health insurance, the NHS is the major healthcare provider in the UK. With ever increasing demands upon the service, factors other than clinical effectiveness must be subject to scrutiny.

Background to NICE

NICE (National Institute for Clinical Excellence) was established as a Special Health Authority by the Department of Health in April 1999. One of the primary objectives of the new organisation was to address the so-called 'postcode-lottery' for accessing certain treatments. Alarming stories had emerged where a patient covered by one health authority had access to a certain treatment, whereas a patient in a neighbouring health authority did not. This 'inequity' was a clear issue that needed to be addressed. Guidelines issued by NICE would carry the remit to be adopted by all health authorities, without exception. Whilst NICE has not been developed to dictate clinical decisions, the rationale is that if NICE have approved a technology, it should be available for all patients.

NICE and Europe

NICE bases its recommendations on a critical review of both clinical and cost-effectiveness data. This is a major difference from the way the European authorities license a new product. Whilst the EMEA (European Medicines Evaluation Agency) focus on the areas of safety, efficacy and quality, NICE also consider a fourth area of cost-effectiveness.

This is a key consideration in an environment such as the NHS, where resources are not infinite. Essentially there are numerous demands placed upon the NHS and thus it is very important that interventions are not only clinically effective, but also cost-effective. Cost-effectiveness is a form of analysis that evaluates both the clinical data and the costs of the intervention. A treatment is deemed cost-effective if the balance between the costs of providing that treatment, and the benefits derived by patients and the wider society, are well-balanced.

It is important to note that decisions made by NICE do not come with funding. This is often a very difficult situation for local authorities to manage. For example, although NICE may say product 'x' is both clinically and cost-effective and should be available for use, there is no allocation of separate funding for this technology. The local authority must manage their budgets accordingly and their approach has been to prioritise technologies reviewed by NICE.

NICE Guidance

NICE produces guidance within the NHS in England and Wales in three areas of health:

- The use of new and existing medicines and treatments (technology appraisals)
- The appropriate treatment and care of patients with specific diseases and conditions (clinical guidelines)
- Whether interventional procedures used for diagnosis or treatment are safe enough and work well enough for routine use (interventional procedures)

'NICE Blight'

NICE tends to review technologies where there is likely to be a significant public health impact and cost implication. For those products not selected, there has been a scenario termed 'NICE-Blight'. What this means is that health authorities have been unable to allocate funding for a certain technology and cite the lack of a NICE recommendation as the primary reason for not prioritising this area. To address this situation the Department of Health have instructed all local authorities that the absence of NICE guidance should not be cited as a reason to withhold treatment that clinicians believe to be effective for patients.

Impact for Research

Delays in guidance do carry an impact for on-going research. Guidances provide a basis for current standard practice. New trials and research go beyond current practice but require existing standards against which they can be compared. If, in the UK environment, new technologies are not incorporated into current standards there is a consequent impact for future research and trials.

Case Study - Taxotere

Docetaxel (Taxotere) is a chemotherapy agent that has recently been licensed by EMEA for use in patients with metastatic hormone refractory prostate cancer in combination with prednisone. Docetaxel is one of the most active chemotherapy agents available today and is also used extensively for the treatment of breast and non-small-cell lung cancer.

The new license for docetaxel in combination with prednisone has been greeted with significant enthusiasm by clinicians and patients alike. The reason has been the significant improvements observed in terms of survival, pain, PSA response and quality of life, compared to current standard treatment.

Whilst the EMEA have reviewed the data for docetaxel and provided the product a license for metastatic hormone refractory prostate cancer, guidance from NICE is still awaited. As mentioned previously, the absence of NICE guidance cannot be cited as a reason to withhold treatment. However, once NICE guidance is available it will help to address any inequalities in access to this new and important treatment for thousands of patients in the UK.

For further information about NICE you can visit www.nice.org.uk

If the PSA rises after treatment

Prof Roger Kirby reviews the options

Prostate cancer, like its sister breast cancer, is sometimes a difficult tumour to cure. Around one third of all men undergoing removal of the prostate (radical prostatectomy) experience a rise in the PSA marker eventually, and the relapse rate after external beam radiotherapy is even higher. The risk factors for recurrence include an initial PSA of more than 10 ng/ml, a tumour which looks aggressive when examined under the microscope (ie a high Gleason score) and tumour which extends to the edge of the excised prostate when examined by the pathologist (surgical margin).

PSA recurrence after radical prostatectomy is usually defined as two consecutive rises above a value of 0.2 ng/ml. The timing of this observation is critical because an early and steep rise of PSA may indicate the presence of bone or other secondaries (metastases), which will require treatment by hormone therapy to reduce androgen stimulation of the cancer (usually with 3 monthly injections of Zoladex™ or Prostap™). A progressive PSA rise a year or more after surgery is more often associated with recurrence of tumour in the vicinity of the excised gland (the *prostate bed*) though this may be difficult to demonstrate on MRI scanning or ultrasound-guided biopsy. A six week course of radiotherapy which involves 10 or so minutes of treatment per day is effective in 85% of cases, but may cause troublesome side effects of diarrhoea and rectal bleeding, however these are usually temporary. In general the PSA value declines to less than 0.2 ng/ml within a few months of treatment and remains below that value. A subsequent rise is usually an indication for hormone treatment, which, provided a bone scan confirms that no bone metastases are present, can be accomplished with the anti-androgen Casodex™ at a dose of 150 mg/day. This tablet rapidly reduces the PSA, but does cause breast swelling and tenderness in the majority of patients. This may be minimised, either by irradiation of the breast buds prior to treatment or by taking the oestrogen receptor blocker tamoxifen at the same time as the Casodex™.

A number of treatment options available.

Two consecutive PSA rises after external beam radiotherapy is also suggestive of a failure of primary therapy and indication for second line treatment. Since the prostate remains in situ, a biopsy of the gland is usually performed, which may confirm the presence of residual cancer. Bone and MRI scans are usually negative. In this situation, a choice of treatment exists: salvage radical prostatectomy can be technically difficult and carries a significantly greater risk of urinary incontinence compared with the operation in an un-irradiated patient, but can be curative. Recently cryotherapy has been advocated, however care must be taken not to damage the rectal wall as a fistula (an abnormal connection) between the bladder and rectum may result, which requires complex surgery to repair. Hormone therapy with, for example, Zoladex™ or Casodex™ is almost always effective in reducing the PSA but it does not completely eradicate the disease and has a negative impact on sexual function.

Of late, evidence has been accumulating that there exists a group of men who are more likely to suffer PSA recurrence after either surgery or radiotherapy who can be predicted on the basis of their PSA, Gleason score and surgical margin status. In these *high risk* individuals there may be a case for employing supplementary therapy - either radiotherapy or hormone treatment - with a view to preventing or delaying the rise in PSA. Trials are currently evaluating this more pro-active approach. This has already been shown to be effective in breast cancer, and also seems likely to be the way ahead in a selected subset of men with prostate disease.

Walking on Hadrian's Wall

Walk the Wall

Many of our readers will be familiar with the amazing exploits of the intrepid group that take on a severe physical challenge every year to raise funds for us. After three years running marathons, they went on in 2003 to climb Kilimanjaro and followed this with an equally daunting assault on Mount Kinabalu last year. It is an extraordinary group, based around some key figures (whom we will not embarrass by naming) who have raised over one million pounds in sponsorship: each year they are our single largest income generator, thanks to the generosity of those who support them.

Team leader Roger Kirby

This year they are giving mountains a rest. In view of our *Million Prostate Miles* campaign they have decided to cross Britain, coast to coast, along Hadrian's Wall. True to form they felt that the challenge needed to be spiced-up and have cut one day from the recommended time to cover the 84 miles: they will now have to average about 17 miles a day, no easy feat over five days.

They are also determined to raise more than last year's total of some £290,000. Once again the walkers will fund all the costs from their own pockets, so that every penny, every pound, will go towards the charity. We do hope that you can help – either by sponsoring the team or encouraging your family and friends to do so. Special Gift Aid Forms can be ordered on the enclosed Events Form.

Or you could join the walkers; there is still space for a few more

Who's having fun fundraising?

Pants in Park

We need your help to make the fun run in Battersea Park on Father's Day, 19 June 2005 a big success. We need participants for the 5km run/walk. Registration is £5 per person. And, of course, we need sponsors!

If you don't want to run then come along and help us with the *back office* work: marshalling, registration, lost children etc. there will be lots to do on the day!

The theme is similar to the now well known *Moon Walk* but instead of men or women running in a bra, the idea is for the runners to wear their pants on the outside of their running shorts, Superman style. Prizes will be given for the best and worst pair of pants and everyone taking part will receive either a medal or rosette.

This will be a fun day out for all the family, there are plans to have a steel band, children's entertainment, a food and drinks trailer and much more to keep the none runners happy as well as the runners.

Walking Miles

While Malcolm Ridley was recovering from his radical prostatectomy, he heard how our supporters had raised funds by climbing both Kilimanjaro and Kinabalu. He then heard of the plans this year to cross Britain along Hadrian's Wall as part of the *Million Prostate Miles* campaign, and decided he would also undertake a sponsored fundraising event: he chose to follow the mediaeval pilgrims route from Winchester to Canterbury and has rapidly proved himself to be a top-class fundraiser - he already has pledges of nearly £12,500!

Shirley and Richard Killick are also planning a sponsored walk. Their choice is the beautiful Ridgeway Trail in the Chilterns from Stokenchurch to Ivinghoe Beacon. They estimate it will take them three days. Quite enough for two septuagenarians!

Sailing Miles

Consultant Urologist, Mike Hehir is eating up the miles on the water. He is planning to leave his home port of Port Edgar on the Forth in his 9 metre Najade Bermuda sloop yatch to sail round Scotland and Ireland for 33 days to raise funds as part of the Million Prostate Miles campaign. There will be lots of stopovers on the way in Scotland and Ireland both of which he will circumnavigate anticlockwise. We will put his full itinerary on the web site.

You can support Mike either by making a donation. If you or someone you know, lives in any of the ports he will visit and wants to wish him well or help with raising local awareness of his trip please tell them about Mike's trip. Any local newspaper would be pleased to tell Mike's story and publish a picture of his boat.

Forties evening in Chorleywood Memorial Hall

Dancing Miles

A group of people touched by prostate cancer in Chorleywood and Rickmansworth have been operating as the local branch of the charity for a couple of years. In January they ran their third fund raising event, a hugely successful forties evening that raised just over £2,000.

With unlimited energy, they are now planning their next event, a pig roast with jazz band in Sarratt on 21 August.

TO GET INVOLVED

If you would like to take part in, help, sponsor or otherwise get involved with any of the fund raising efforts described above please contact Lesley in the Putney office on 0208 877 5840

Charity Golf Day

The Rotary Club of Langley and Iver are hosting a charity golf day 50% in aid of **Prostate Research Campaign UK** on Thursday 9 June at Richings Park Golf Club.

A round of golf in teams of four plus an excellent buffet lunch costs £40 per player. High handicappers of both genders welcome welcome. Full details from Roy Bain, Acorns, Church Lane, Wexham, Slough SL3 6LE or phone 01753 524894.

Running Miles

Your editor sat next to Jane Dawoodi, a senior incontinence nurse at The London Clinic, during the performance of the Rape of Lucretia and learnt that she will be running the London marathon for **Prostate Research Campaign UK**. He sponsored her. She completed the course in four and a half hours. She would welcome some late sponsorship from you!

Thanks to Mr Armstrong of Kettering who sent us his £50 sponsorship for completing the 10K annual Daffodil Run at Castle Ashby in February.

Giving us a hand

Readers will recall that, in our last edition, we sought support for a fundraising Chicago Bridge evening, hosted by Andrew Robson at his famous club and organised by Louise Anderson. In the event it was a huge success, thanks to the hard work and support of everyone involved.

Andrew and his team quickly put everyone at their ease and provided help - and even prizes - when needed. Colin Gouldsbury's catering company, Quisine, produced a delicious meal at cost price, a generous benefactor produced theatre ticket vouchers for the winning pairs and Louise made sure that the whole event ran like clockwork.

We are also extremely grateful to all those players who supported the event - over 80 - plus those who were unable to attend but who sent in donations.

Thanks to everyone's generosity the event raised nearly £1,900.

Impotence the dreaded side effect

It had been a good day and I came home on a *high*. My husband, Peter, was working upstairs so I shouted a cheery 'hello'. He shouted back. Two words. 'It's positive.' 'What's positive?' I asked. His head appeared over the stairwell, his face grey and strained. 'The test. It's positive. I've got malignant prostate cancer.'

After more tests and much agonising we made an appointment with a surgeon in Basingstoke who performs key-hole surgery for the condition.

The surgeon showed us a video and explained how he worked. At the same time, we half-heard the surgeon's warnings about possible problems. If the tumour had invaded the nerves, or if they were damaged during the delicate surgery, he would be incontinent and unable to raise an erection. We heard he had a good chance of total recovery. That was what we clung to and prayed for.

I was married to a 'stranger'.

During our five-years of marriage, we'd led an active, satisfying love life. We couldn't imagine it not happening. I think we were both in denial. Peter rang a patient based self-help group he found on the Web to see if they could offer advice *just in case*. The guy manning the phone line was receiving hormone treatment and didn't know what the consequences of radical surgery might be. The weekend before the op we made mad, passionate love. Later, we admitted to one another that we wondered if it might be our *last time*.

When the five hour long operation was over, the surgeon came to see us and told us that thankfully, the cancer appeared to have been contained inside the gland and he'd managed to preserve those vital little nerves. Peter said he felt he'd been kicked by a horse in the stomach and I was convinced in my relieved ignorance and innocence that the worst was over.

Back home, I tried to keep things *normal* and went on kissing and cuddling him and showing him affection as I've always done. I wanted him to feel secure and to prove to him that making love was not the be-all and end-all of our life together. To his dismay, he had no sexual desire and Viagra, prescribed on the NHS, had no effect at all.

And it got worse. Suddenly, my formerly loving husband stopped responding to my touch. He no longer put a protective arm round my shoulder. He stopped holding my hand. When I approached him physically, he moved away. 'Go away,' he'd say. 'I'm busy. I'm tired.' I tried to ignore it. He'd had cancer. As far as we knew, he was now cancer free. But, his physical cancer had been replaced by a cancer of coldness, spiralling out of control and demolishing our previously loving relationship. I was married to a *stranger*. Finally I cracked and started to sob and I couldn't stop. He seemed so insular and I thought he didn't want me any more.

I didn't realise then that not only was Peter a *stranger* to me. He was a stranger to himself. For all his outward bravado, he felt emasculated, just as some women feel defeminised when they lose their breasts. He'd lost control of this *foreign body* of his in more ways than one. For the first time in his life, he was unable to get a spontaneous erection. We needed help, we needed to talk to others but we knew of none.

In the end, help came through my job. In April last year, I was invited to a press conference to launch a campaign called ***Ignorance Isn't Bliss***, sponsored by the **Prostate Research Campaign UK** and initiated by international yachtsman and prostate cancer patient, Kit Hobday. Peter came with me and it was a revelation.

Apart from other journalists and medical professionals, the guests included a range of prostate cancer sufferers, including some famous faces, with their partners. Everyone was talking openly and honestly about this disease, its detection, its cures and its side effects. It was a great relief to *come out* and find we were not alone.

A year down the line and Peter's condition has improved immeasurably on both counts. He talks to other men about his prostate cancer. Best of all, our love life is back on course. It is more loving and meaningful than ever, and I have finally got *my* husband back.

He will need to be checked for the next 14 years. That's a small price to pay for a healthy life.

*This article by **Andrea Kon**, appeared in a longer version in Woman's Weekly.*

Welcome Andrea

We welcome Andrea Kon to the **Prostate Research Campaign UK** team. Andrea is a professional journalist who writes, among other things, on relationships, health and women's issues. She herself has been touched by the consequences of prostate cancer and is keen to raise awareness of the dangers of prostate diseases amongst men. Perhaps more importantly, she believes in harnessing the energies of the women in the lives of men in the *at risk* age group. She is helping the charity by writing articles for a wide variety of journals and using her contacts to place articles in suitable media.

One step ahead

Dr Ian Gibson MP chaired a meeting in the House of Commons on 22 March on *Improving Outcomes in Prostate Cancer*. The call to action which resulted from this meeting called for, among other things, an *education campaign amongst healthcare professionals about prostate cancer to ensure a better quality of life and outcomes for patients*. It was pure coincidence that, exactly one week before, our Trustees had allocated a sum of money for just this!

Standing orders

We have dedicated and generous supporters. Without you we would not be able to provide information, nor support education and research. We do, however, miss out on regular Gift Aided giving by Standing Orders to your bank or building society. Please consider completing the Standing Order form enclosed with this copy of Update. Even a modest amount given regularly soon mounts up.

In the genes - John Sapsford's story

I spend nine months of the year out of the UK, much of it in the US. There, the benefits of early detection of prostate cancer are well known and widespread. Supermarkets have prostate cancer awareness days – seemingly on a fairly regular basis. There, they urge men to have an annual test from the age of 40.

A good friend's twin brother died of the disease in his early 50's almost four years ago and my friend was only diagnosed (after low PSA tests) because of his urologist's conviction that he must have the disease because he was a twin.

Globe-trotting John Sapsford at one of his favourite watering holes

The standard six sample biopsy found nothing – but the twelve sample biopsy did!

A Kiwi friend in the US, who has three brothers who have experienced the disease, kept asking me how I'd feel if, by not having the annual check, I caught the disease too late and it killed me. How, he asked, would I ever explain that to my three young daughters. 'Sorry girls I'm going to die of this thing because I was too busy to spend ten minutes a year having a blood test!'

Despite all this indirect knowledge of prostate cancer reaching me over a five year period I had still never had a PSA test and I was now 52. The summer of 2003 changed that. My father, at the age of 75. was diagnosed with the disease. It had spread to the bones and the future would be shorter than it might otherwise have been. As the urologist put it to him – 'this is what is probably going to kill you unless you have an accident'.

Dad was devastated and distraught. He thought that year was going to be his last. It was at this time that I started looking into the disease more and the various alternatives we had for treatment.

I soon learned that by having one male relative with the disease made me something like five times more at risk. My dad had a younger brother and I thought that I must tell him to go have the check.

My uncle was in his late 60's but without an ounce of fat on him and running probably 5-10 miles four or five times a week. He was relaxing on a garden bed when I went round to tell him the bad news. As the C word came out he looked at my Aunt and I was ushered back in to the house.

He shook me with the comment 'I had that a couple of years ago'. I was now something like twelve times as likely to get the disease and worse was yet to come as he proceeded to tell me that another of my uncle's had some problem with the prostate but nobody knew exactly what that problem was!

To cut a long story short, I had some tests (positive) and a radical prostatectomy carried out by the (so I was told) number one surgeon in the country.

Everything went well with the op and my three quarterly checks to date have all found negligible PSA levels and I'll have my final quarterly check in April. Sex has still to be rediscovered and I will try some medication to help in that direction.

I still feel positive about life and so thankful to have caught it early. I'm now looking at ways that I can help provide more awareness of the disease and the regular checking for men approaching their 50's.

John Sapsford, a staunch supporter of the charity, is currently in the final production stages of his film, *Lost Dogs*, due to premiere in Bristol later this year. He hopes, in the future, to produce a film trailer to raise awareness of prostate cancer and the benefit of regular checks.

Space age prostatitis treatment

While the cause of so-called chronic prostatitis sometimes called chronic pelvic pain syndrome is unclear, it seems that the formation of small calcium stones in the prostate might be the culprit. These may be caused by nanobacteria, discovered by NASA scientists in the 1990s and suspected of being the culprit putting astronauts on long fights at risk of getting kidney stones.

Scientists at the Cleveland Clinic, Florida under Dr Shoske have found that therapy designed to eliminate nanobacteria may alleviate prostatitis symptoms in men who haven't been helped by other treatments.

Shoske's team theorized that elimination of prostatic stones may relieve the prostatitis symptoms. They evaluated the use of a treatment developed to eradicate calcification formed by nanobacteria in a trial involving 15 men. All of them had experienced symptoms for more than nine months despite conventional treatments, and showed signs of prostatic stones on ultrasound.

The daily treatment consisted of tetracycline intended to knock out the nanobacteria, a proprietary supplement that has been shown to help with prostate problems, and a rectal suppository of a compound that binds to calcium and can dissolve stones.

After treatment for three to four months, the average score on a standard prostatitis symptom index had declined from 25.6 to 13.7, with significant reductions in pain and improved quality of life.

The researchers now intend to explore the role of nanobacterial infection as a cause of prostatic stones, and whether these stones are indeed a cause of prostatitis.

Love and Loss Opera Success

The world-renowned mezzo-soprano Catherine Wyn-Rogers, lost her father to prostate cancer five years ago. She was devastated but decided to do something positive to raise awareness about and funds for research into this Cinderella of diseases.

Ginny Jory Photography

The cast being thanked by Humphrey Burton CBE

Ms Wyn-Rogers explains: 'My father was 78 in February 1999 when he was diagnosed after complaining of back pain. He had jokingly talked about suffering from 'old man's disease' because he had to get up in the night to visit the bathroom, but no one suspected the underlying cause might be cancer. It all happened so slowly that we were hardly aware he had a problem. And he was a typical man who hated consulting doctors unless he was forced into a surgery visit. Women are much more likely to seek medical help for problems than men. If it is not diagnosed soon enough, it can spread to the bones, as it did in my father's case. I was on holiday in Cornwall when he was diagnosed and I rushed home, shattered by the news. For him it was too late for surgery. He was not a suitable candidate for chemotherapy or radiotherapy. In the end he underwent hormone treatment, which prolonged his life for another few months. Prostate cancer is linked to testosterone, the male hormone, and can be slowed by the patient receiving female hormone medication.

Ginny Jory Photography

Catherine Wyn-Rogers (right) was introduced to HRH The Duchess of Gloucester in the interval

'I decided to sing Benjamin Britten's Rape of Lucretia because, although it is a tragic opera, it not only embraces the love of one human being for another but it is also about loss. Watching my father suffer during the 11 months from diagnosis to death was tragic, and my family lost a beloved husband and father.'

Catherine persuaded other international opera stars, including Geraldine McGreevy, Sir Thomas Allen, and Leigh Melrose, to join her in performing free of charge. The Rape of Lucretia, in aid of **Prostate Research Campaign UK,** was conducted by Steuart Bedford and held at St John's Smith Square in London on 23 March. Humphrey Burton CBE introduced the concert to a packed church of over 400 people including our patron, HRH The Duchess of Gloucester. All agreed it was a most memorable evening.

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