KELOWNA PROSTATE CANCER SUPPORT & AWARENESS GROUP

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The lead article in this month's newsletter is about Dr. Kim Chi and his work at BC Cancer. This doctor as the article discusses is not only the Chief Medical Officer at BC Medical, he is a Medical Oncologist specializing in Prostate Cancer who still sees patients on a regular basis and is also involved in a lot of Prostate Cancer research.

For those of us living in the Interior of B.C. this has been a much cooler Spring than normal, hopefully the weather will begin to get better sooner rather than later so those of us who have planted some of our annuals will see them survive and grow and not die off and we have to go and get replacement plants. I believe the Farmer's Almanac mentioned that it would be a cooler Spring this year.

If anyone receiving this newsletter wishes to have their name removed from this contact list, please let me know and I will remove your contact information.

This is Personal – Dr. Kim Chi

The following is an excerpt of information that was published online by BC Cancer Foundation on February 9, 2022 and was written by Dr. Kim Chi January 12, 2022.

Dr. Kim Chi, Chief Medical Officer, BC Cancer shares why he pursued a career in oncology, specializing in prostate cancer.

I wear many hats in my career. As chief medical officer at BC Cancer, I oversee a system that delivers cancer care to the province of B. C. As a medical oncologist, I see individual patients every week. As a senior research scientist, I strive to change the way the world sees this disease.

But at the heart of all my roles are the people who are facing cancer. The bonds between patient and physician are, many times, the strongest as a person navigates one of the most serious illnesses they will ever face.

I build close relationships with my patients as I help them decide the best course of action in what can be very difficult decisions around treatment and help to see them through it.

This is personal because even though I've dedicated my life to providing better outcomes for cancer patients, I have also lost people close to me. My father passed away over two years ago from colon cancer, which was diagnosed very late. My uncle also died of prostate cancer several years ago.

Likewise, too many times I have had to tell someone that there are no more effective treatment options available that will help them. It's an incredibly difficult conversation. And it never gets easier.

But everyday I get up and go to work knowing that I will be a part of something good, or even great. Sometimes it's big: getting government funding for a new treatment or program, or finding out a clinical trial or research project has new, interesting, or even life-saving, results. And sometimes it's more individual: a patient come in feeling better, or is having a positive response to a new treatment we've started.

That's what keeps me going every day.

"One of the reasons I chose to specialize in oncology is because of the science. Nowhere else in medicine do things move as quickly from bench (research) to bedside (treatment). It never fails to amaze me that a discovery in the lab one day can quickly go on to improving lives the next."

I've seen massive improvements in the way we diagnose and treat cancer during my career. We went from non-specific cytotoxic chemotherapy-based treatment to a much more targeted approach. One that uses biological information about a person's cancer to determine a treatment program, and therapies that harness the body's immune system to attack cancer much better.

In particular, I'm so proud to have been a part of the incredible gains we've made in treating prostate cancer, where we've entered a new era of precision medicine, over the last decade.

Recent advancements include the introduction of more potent hormone therapies earlier in the course of the disease. As well, Prostate-Specific Membrane Antigen (PSMA) – PET a new imaging technology that is much more likely to catch cancer spread earlier than traditional scans, is game-changing when it comes to managing - and – curing this disease. We're working hard to improve access to these life-changing scans to individuals all across the province.

All of this provides an enormous amount of hope for the most commonly diagnosed cancer, and the third-leading cause of death, in men in B.C.

WITT'S WITT (ON THE LIGHTER SIDE) –

I just never understood how the little drummer boy's parents could just send him outside alone at night to play his drum until my daughter brought a recorder home from school!!!

How Active Surveillance has Changed the management of Prostate Cancer –

The following is a brief excerpt of information obtained from the *Urology Times* in March, 2022, and was written by *Kara L. Watts, MD.*

Active surveillance is really a new approach to managing prostate cancer that arose in the beginning of the 2000s. But if you look back over time at what has happened with treatment for prostate cancer, it really traces all the way back to the early 1900s. In 1904, the very first perineal radical prostatectomy was performed at Johns Hopkins University. It wasn't until 1945 that the first radical retropubic approach was introduced by Terrance Millin, MD.

Flash forward almost 40 years, where the modified technique for radical prostatectomy was introduced by Dr. Patrick Walsh, MD. The goal of this was to reduce bleeding and avoid injury to the neurovascular bundle. Around this time, in the early 1980s, in when the [prostate-specific antigen] PSA blood test was discovered as a screening test for prostate cancer. In the late 1980s the first template for the transrectal ultrasound guided prostate biopsy was developed, and so our ability to diagnose prostate cancer started to shift. At this point, all prostate cancers that were being diagnosed were being treated either with radical surgery, so an attempt to remove the entire prostate and seminal vesicles, or radiation therapy.

Flash forward about 15 years or so, in 2002, the very first report of active surveillance – it was called watchful waiting at the time – was published. It looked at the efficacy and the use of active surveillance, instead of actively treating a lot of these clinically localized, low-risk prostate cancers. This coincided with a lot of national data showing risks of the side effects associated with over treatment, but the detrimental effects of booth surgery and radiation, particularly for low-risk, clinically localized disease.

There have been a number of studies that have looked at the uptake of active surveillance after it was first introduced in 2002. It really dramatically increased, mostly in the past 2 decades, but particularly in 2010. An analysis in the United States, from the [Surveillance, Epidemiology, and End Results] SEER database, looked at data from 2010 to 2015, and at least across the United States, the rate of uptake in active surveillance went from single digits for low-risk disease to 40% to 50% on average. But what also emerged from this as well as other analyses is that there is really considerable variation in uptake by geographic region in the United States, but other factors as well, such as ethnic group, socioeconomic status, and other factors.

The other point I would make is that, in addition to the uptake and the widespread use of active surveillance for men with low-risk disease, a lot of our national organizations have guidelines supporting the use of this. Our own American Urological Association guidelines from 2017 gave a grade A, which is a strong recommendation that active surveillance should be recommended as the best available care option for men who have very low-risk disease and the preferable option for those who have low risk disease. This is a complete change from what we were doing even just 20 years ago.

What makes active surveillance an innovation in the area of cancer care?

Active surveillance is an innovation because it's truly a departure from the idea that all prostate cancers or cancer, in general, needs to be treated. This was really one of the first developments in the world of prostate cancer, and in doing so, avoiding the potential side effects that are related to radical treatment but doing so in a way that it was systematic with very vetted and sell-studied and published data with long-term follow-up up to 20 years to ensure that we are offering appropriate recommendations for men and ensuring follow-up for them as well.

Interestingly, since active surveillance really took off, the pendulum of treatment for prostate cancer has continued to shift. If we think about prostate cancer treatment 50 years ago, and before that, it was all radical treatment, if men were even candidates for treatments of surgery, radical surgery, or radiation. Then the pendulum shifted for men with low-risk disease to introduce the concept of active surveillance and not treating, but actively following and monitoring their cancer, and the rates that it rose.

The Kelowna Prostate Cancer Support & Awareness group does not recommend treatment modalities or physicians: However, all information is fully shared and is confidential. The information contained in this newsletter is not intended to replace the services of your health professionals regarding matters of your personal health.

The Kelowna Prostate Cancer Support & Awareness Group would like to thank Janssen - and TerSera for their support and their educational grants towards our newsletters and our support group.

UP COMING MEETING DATES FOR 2022 –

Due to the COVID-19 virus we are still NOT holding monthly in person Support Group Meetings.

NOTE: We are hoping to be able to hold our first in person meeting after over two years in September. I will keep in touch with everyone.

NOTE: Many of our past newsletters are available for viewing and printing through our website. - www.kelownaprostate.com

- A big *Thank You to Doris at Affordable Web Design for all her work on our website.*