



Charity No: 1095439

**PROSTATE CANCER NETWORK**  
**NEWSLETTER**

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**OUR NEW PATRON**

**W**e are delighted that The Very Reverend Nicholas Frayling, the Dean of Chichester Cathedral, is joining our current patrons, The Duke of Richmond and Gordon, Lord Palumbo of Walbrook and Bill Beaumont.



Nicholas has become noted for his work for reconciliation, not only between faith communities but also between Britain and Ireland. His book 'Pardon and Peace' is a reflection on the making of the peace process in Northern Ireland and has been highly acclaimed. He has also lectured and

spoken on reconciliation in Switzerland, France, Ireland, the 'United States', Canada and Israel/Palestine. During his time in Liverpool, he was chairman of the Welfare Organisations Committee of Liverpool Council of Voluntary Service, of the Religious Advisory Panel of BBC Radio Merseyside and of the Mersey Mission to Seafarers.

Nicholas was appointed Dean of Chichester in September 2002. He chairs the Church in Society Advisory Group in the Chichester Diocese and the Diocesan European Ecumenical

Committee.

In accepting the position as one of our patrons, the Dean said that he hoped to play an active part in the work of PCaSO.

Nicholas has become involved with the work of PCaSO because of personal experience of prostate cancer and its aftermath. He gave an excellent talk entitled 'A Prostate Apostate' at our last AGM in March 2008, and addressed the Dorset Branch with another highly entertaining talk at the end of January to an audience of over 90 members.

Nicholas Frayling was born in South London. He trained for retail management, but changed career and became a welfare officer at Pentonville prison. In response to a vocation to the ordained ministry, he studied theology at Exeter University and completed his training at Cuddesdon College, Oxford. After parish ministry in Peckham and Tooting, he moved to Liverpool in 1983 as Canon Precentor of the cathedral. Four years later he became Rector of the ancient city centre parish of Our Lady and St Nicholas, where he stayed for fifteen years.

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## ACTIVE SURVEILLANCE: A RESPONSE FROM DR CHRIS PARKER

*On page 4 of the November issue (No. 25) we reported research by the Royal Surrey County Hospital and the Hampshire Clinic on men eligible for Active Surveillance. Dr Parker adds some further thoughts to the findings and appends a report on the new ProSTART Trial.*

In the last issue of the newsletter, you presented new data showing, for example, that 16% of men with apparently low-risk cancers were found to have Gleason 7 disease at radical prostatectomy. In my view, these new data support the case for active surveillance.

In order to reach that conclusion, it is important to distinguish between active surveillance on the one hand, and watchful waiting on the other.

Active surveillance, first described in 2001, aims to avoid the unnecessary treatment of men with harmless cancers, while still providing curative treatment for those who need it. Surveillance can be thought of as a period of close monitoring in order to inform the choice of whether or not to have curative treatment. For men with apparently low-risk cancers, one or two years of surveillance, with regular PSA values and a repeat biopsy, allows us to learn much more about how an individual cancer is likely to

behave. Most will remain on surveillance with no evidence of cancer progression. But not all.

A significant proportion, perhaps 20-40%, will proceed to radical treatment. This does not mean that they were not suitable for surveillance in the first place. Provided that delayed treatment is as effective as immediate treatment, and the evidence to date suggests that it is, they have not lost out.

In contrast, watchful waiting, which has been used for decades, involves merely waiting, with late hormone treatment for those who ever develop symptoms from their cancer. In other words, watchful waiting is only suitable for those men whose cancers are so favourable, or whose life expectancy is so short, that they do not need to be cured.

In summary, active surveillance is for men who might or might not need to be cured. If we were certain that a man's cancer was harmless, he would not be suitable for active surveillance. He would be suitable for watchful waiting. The fact that some, but not all, men with apparently low-risk disease are found to have higher grade disease at surgery is precisely what would have made them suitable for surveillance!

### PROSTART

A clinical trial in men with favourable risk  
**PRO**state cancer comparing active  
Surveillance Therapy Against Radical Treatment

This trial aims to compare the long-term outcome of men who have treatment straight away, with that of men who receive treatment only if and when their disease shows signs of progressing. Over 2000 men with low-risk disease (i.e. T1/T2a, Gleason 6, PSA < 10) will take part internationally. They will be allocated to one of two groups. One group will receive immediate curative treatment of their choice (surgery or radiotherapy or brachytherapy). The other group will receive active surveillance. That is, they will be closely monitored with regular PSA tests and repeat prostate biopsies, and they will receive the curative treatment of their choice if there is evidence of disease progression.

In order to make it a fair comparison, this a randomised trial in which men will be allocated to one group or the other by chance, and not by patient or clinician preference. Thus the trial is only suitable for those men who would be willing to be allocated to either group.

Initially the trial will run in 6 UK centres (Torbay, Cardiff, Glasgow, Manchester, Royal Marsden and Taunton). If recruitment in these centres is satisfactory, then the trial will open nationwide.

For more information please contact the Trial Office at the Institute of Cancer Research, Royal Marsden Hospital, Sutton, Surrey SM2 5PT (020 8661 3425).

E-mail: [prostart-icrcstu@icr.ac.uk](mailto:prostart-icrcstu@icr.ac.uk)

### PCASO AGM

PCASO Annual General Meetings, held in March/April, now rotate between the four regional groups and the Dorset Branch. With the 2008 meeting in Southampton, the upcoming AGM is therefore in Basingstoke; 2010 will be in Chichester, and in 2011 the Dorset Branch will be the hosts.

This year the meeting will be held at the Basingstoke Group's usual venue, the ARK Centre, North Hants Hospital, at 6.30pm. The Hospital is well signed on the Basingstoke ring road. The ARK Centre, is signed on entering the hospital, and is to the rear of the site, where there is a special free car park for the centre.



Professor Stephen Langley, from the Royal Surrey County Hospital, Guildford, and one of the country's leading experts in the field of brachytherapy, will be the speaker at this meeting. Professor Langley has called his talk 'Prostate Brachytherapy: Pinhole Surgery for Prostate Cancer'.

A Calling Notice and Agenda should be enclosed with this newsletter. The minutes of the last meeting are available on our website and are also available on request from the Secretary.

We look forward to seeing you there!

## FOUR YEARS SWIMMING THROUGH PORRIDGE

SANDY TYNDALE-BISCOE

Just over four years ago I took over, from David Rowlands, the responsibility of representing PCaSO on the Prostate Cancer Charter for Action and in the Prostate Cancer Advisory Group (PCAG). Four years is long enough for anyone to do that sort of job – apart from anything else, it is the job of an ‘ankle biter’, and there is the risk that, after a while, one may come too friendly with the owners of the ankles. The time has come to pass that mantle on to a new and fresher set of teeth.

The two roles are connected, but not the same. The Charter for Action is a coalition of over twenty non-government organisations that share the aim of raising awareness of and improving treatment of prostate cancer, and it is considered by some (in particular by those who play the major roles in it) to be a powerful voice influencing Department of Health policies. This it does through PR activities, by direct lobbying of parliamentarians, and through representation of certain of its signatories (including PCaSO) on the PCAG, which is chaired by the ‘Cancer Tsar’, Prof. Mike Richards, who is a nice man, but who, by his own admission, can have little direct effect on what actually happens in the Health Service.

What has been achieved? The answer at first sight seems pretty depressing. One attends meetings and the same topics seem to be coming up each time, with no new answers, and little practical effect. Sometimes ‘new initiatives’ such as the Cancer Reform Strategy, are fanfared which claim to be going to change everything, but in truth such things are often exercises in waffle done so that an impression may be given of a Government getting things done. The fact is that the Health Service is not managed from the centre, and the freedoms that individual trusts possess are such that guidance from that quarter can be, and is, largely ignored if it costs money.

One major area of activity which initially seemed promising, but which in the end turned out to be little short of disastrous, was the Prostate Cancer Risk Management Programme, the Department of Health’s *Apologia* for there being no prostate cancer screening programme. For want of space I cannot go into detail here (for that, see the companion article in the latest issue of *Prostate Matters*), but suffice it to say that, after a promising start in which we were invited to participate in an apparently open consultation process that was going to lead to a major revision and updating of the guidance given to GPs and men considering a PSA Test, the exercise rapidly turned sour. The result is that the revised guidance, which is just about now being sent to GPs throughout the land, fails to acknowledge any of the advances in our knowledge about the PSA Test, its weaknesses and, above all, how it can be used intelligently to assist in the detection of early stage prostate cancer, when it can be cured. It is little better than the dreadful document published in 2002.

Most depressing of all has been that, once it became clear that this so-called consultation process was a sham, my attempt to persuade the Charter for Action to withdraw from the process received little support from other Signatories, and, very much against my advice and the views of other patient groups, it was decided to take up the Department’s offer to include an anodyne ‘Insert’ into the PCRMP guidance, which effectively endorsed it. The Charter signatories thereby chose to ignore the views of representatives of nearly 5,000 patients and, instead, followed a route where political expediency was more important than the lives of hundreds of men who will, as a result of this flawed guidance, be denied a PSA test by their GPs.

To add irony to this unhappy situation by the fact that all this has been happening at a time when, as part of the Cancer Reform Strategy, the Department is launching the National Awareness and Early Detection Initiative (NAEDI), seemingly oblivious to the fact that, for prostate cancer at least, it was also deprecating the one test that might give hope of the early diagnosis necessary for the Initiative to have any benefit.

But perhaps one can be too pessimistic. Not all is gloom. The Charter has undoubtedly achieved something in two areas: we have been monitoring observance by PCTs of the NICE Improving Outcomes Guidance (IOGs), and raising awareness of the crucial shortage of Clinical Nurse Specialists, where prostate cancer is served about half as well as breast cancer.

Above all, participation in these fora has provided a unique opportunity for me, as a simple patient, to hob nob with some seriously knowledgeable experts in the field, and to learn from them and, to some extent, to influence their thinking. Dr Chris Parker, of the Royal Marsden, one of PCaSO’s valued medical advisors, whose knowledge I deeply respect, but with whom I profoundly disagree on the merits of PSA testing in symptomless men, was kind enough to say a couple of years back that what the Charter for Action needs is “another five or six Sandy Tyndale-Biscoes”. What he meant, I think, is that argumentative patients’ representatives, asking difficult, and sometimes stupid, questions, can act as the ‘grit in the oyster’ to develop thinking by those who know what they’re doing. I like to think that this has been happening to some small extent. One of the best moments was when Heather Payne, one of the country’s leading oncologists, told me that she’d finally been convinced that all men over 50 should know their PSA; for a moment, I thought it was all worth while. But that was two years ago. Now David Smith will take the battle further into enemy territory. Perhaps, by the time he’s done four years of it, we will have hope of an early detection test for prostate cancer, and the real prospect of reduced deaths.

## HIFU: A PATIENT'S VIEW

ROGER PICKFORD

*One of our members from Alton relates his recent experience of HIFU treatment*

I am told that any article needs a beginning, a middle and an end. I'm OK with the beginning and the end – it's the middle bit that is difficult, as I was 'away with the fairies' when I overheard these three surgeons discussing their favourite type of patient. One said he liked accountants because, when you open them up, everything inside is numbered. Another one said he preferred electricians because everything is colour-coded. A third insisted that MPs are the easiest to operate on: they have no guts, no heart, no backbone and the head and backside are interchangeable!

PCaSO Newsletter No. 23 (May 2008) reported that the first person in the UK to have received HIFU treatment had to go to Brussels for it. I was lucky; I just had to go 12 miles up the road to the North Hants Hospital at Basingstoke and I believe I was about the 30th person to have had the procedure there.

Initially I went to my GP for advice on my frequent nightly trips to the loo. My PSA result was a bit above normal for a chap of my age. After something like six to seven years of watchful waiting with a rising PSA I was referred to Mr Richard Hindley at the North Hants hospital. The biopsy showed no cancer but my PSA continued to rise. A second biopsy a year later still showed no result. Because of this I was then referred to Mr Simon Bott for a template biopsy. This meant being given a general anaesthetic for the test, which took 2-3 hours. This special biopsy revealed localized prostate cancer *underneath* the prostate, which was why the other biopsies missed it. The options were active surveillance and radical surgery, with radiotherapy or HIFU in between these two extremes. Having read up on all the procedures, Mr Bott emailed me more information.

My next appointment was with the oncologist who, in her considered opinion, only advised radiotherapy. I suggested HIFU, but the usual reasons were given: not enough history, not approved by NICE, too new, and every other reason she could think of – even though it has been used for the last eight years in America and on the continent. So I thought I would go and see my local GP for advice. "What is HIFU?", he asked. He suggested a 'wait and see' policy. The next appointment with Mr Bott was to discuss the result of my conversation with the oncologist. My Gleason score by now was 6 and PSA 18.4 and still rising. I said what about HIFU? Straight away he said: "Yes, HIFU, that's what we will do; you fit the profile very well."

Having made the decision, the Macmillan Urology Nurse Specialist explained in great detail what the procedure was, what it entailed and what to expect. This was quite a confidence booster, as it all sounded so simple and straightforward. A few days later I had a bone scan, an MRI scan, the pre-assessment, the usual MOT with another armful of blood taken. Later on in the week I had a visit at home from a nurse to explain and teach me how to self-catheter, a necessary technique after HIFU treatment. She said if you can't self-catheter then there is no operation. That is a good enough threat to make anyone do it! I had already purchased a urine bottle and a pair of jogging pants. I also bought a

new car as, after what the nurse specialist had told me, I was confident it would be a success.

I was admitted to the hospital in March last year and the nurses did everything possible to make me comfortable and relaxed. After taking two preparations to 'clear out the system' I was prepared for the operation, and it was about five hours before I was returned to the ward with the dreaded catheter inserted and a bag dangling down from the bed. I can now say this is no problem; I experienced no trouble at all with it or passing urine, and it was really my ignorance that made me dread having this catheter. An hour later I went for a stroll round the corridors and felt absolutely fantastic.

The nurse gave me two bags of goodies to go home with, a measuring jug with a sheet of paper to record my 'voids', several dressings and a DIY kit. I was home that same evening on a very excited high. I felt no pain. The next day I went out in the car with my wife while she did some shopping. I just drove the car in and out of garage, as I wasn't allowed to drive for five days due to the anaesthetic and insurance. After the weekend the nurse, who checked on me each day, phoned and told me to turn the catheter off so as to try and fill my bladder. I passed water as normal, with no pain or problems, no drips or incontinence. On the sixth day I drove to the hospital to have the catheter removed, with no subsequent problems.

At two and a half weeks after the procedure my activities were right back to normal, except I was careful when lifting, when I might get a few drips. My water was still tinged with red, which was the rubbish still coming out. At three weeks afterwards I found that I had a few spots on my pads and I still got small flakes of debris when passing water. Five weeks after the procedure a solid lump blocked my water flow, and I had to self-catheter for the very first time. Eventually I passed another lump and the flow was restored. The nurse kept in touch, and when another lump of prostate happened it was no problem, as I knew what to expect. Eight weeks' later I had an appointment with Mr Hindley to hear the result. There were two patches of cancerous cells which were dealt with. In all, they removed 60-70% of the prostate. My PSA was then 0.03 and is now stable at about 1.6.

The cost of HIFU at Basingstoke is £2-3000, much cheaper than conventional surgery, as they are one of the few hospitals that own their own equipment. What made me decide on HIFU was the fact there were no incisions, so little risk of hospital-acquired infection, recovery time is relatively short; there are fewer side effects, 99% of cases are continent, there is no need for an overnight stay in hospital, and the fact that the procedure can be repeated should I need further treatment. I would have liked to have spoken to someone who had been through the procedure before I had to make a decision. So what did I think of it? Fantastic; and the treatment I had at Basingstoke was superb.

At a GP visit in November I saw a different doctor. On looking at her computer she said "What's HIFU?" Say no more. I now have a brand new pair of jogging pants and one unused bottle for sale. I'm keeping the car, though!

## NEWS IN BRIEF

### THE PCASO QUESTIONNAIRE

A Questionnaire, with an explanatory letter, is enclosed with this newsletter. With over 700 patients, including the Dorset Branch, this will give us a strong voice to present the data obtained at regional and national level, so we do urge as many as feel able to take a few minutes to support this. It is completely anonymous. An addressed envelope is enclosed, but we felt that, as a charity that takes pride in extremely low administrative costs, members would not begrudge the cost of a stamp to return it. A copy will also be available to download off our website.

Thank you to those who returned the pilot questionnaire; it has helped enormously in refining the questions, and there is no need to complete a new one, as your results have already been recorded.

### DONATIONS RECEIVED

PCaSO acknowledges with grateful thanks donations from the Deerfold Trust and the Saddler's Company, and the many generous donations received from individual members and their friends. We know that several members who had 'special' birthdays kindly requested donations to PCaSO instead of presents, and their contributions are much appreciated. Since November donations have totalled well over £1400.

### COLLECTIONS

A big 'thank you' to all who help out at our supermarket collections, and especially to those that braved the cold at our last two events. £810 was collected at Port Solent on 2-3rd January – an excellent result considering the weather and the time of year. The next fixed collection is on 5-6th June at Tesco, Havant. If you can help by sparing no more than an hour or two, it will be much appreciated. Ray Marsh has agreed to help co-ordinate volunteer collectors, so please get in touch with him on 01962 864764.

### PCASO CHRISTMAS QUIZ

Winners of our Christmas Quiz and details of the money it has raised will be announced in the next issue of this Newsletter in May. Members' help in distributing the quiz is much appreciated.

### CANCERWISE, CHICHESTER

are running sessions of Dru Yoga especially for men affected by cancer. This aims to create balance, harmony and relaxation – an optimum environment to recuperative health. Contact Diane on 01243 778516.

### OPEN GARDENS

The Dorset Branch is organising a series of weekend events at the Luscombe Valley Railway, in the gardens of Mr & Mrs Knott, at 17 Brudenell Avenue, Canford Cliffs, Dorset, all the money raised going to the Dorset Branch of PCaSO. There will be rides on various miniature steam trains. Dates are the weekends of: 18-19th April, 25-26th July, 5-6th September and Sunday 19th December. All are welcome!

## DIARY DATES 2009

See 'News from the Groups and Branches' on page 6 for full details of venues and contacts.

**February 24:** Basingstoke Group meeting, ARK Centre, 6.30pm. Speaker: Jane Bywater, St Michael's Hospice, will talk on Palliative Care.

**March 3:** Partners Group meeting, Hogs Lodge Inn, Clanfield, 12.30pm.

**March 4:** Southampton Group meeting, Taunton's College, 6.30pm. Speaker: Dr Kate Jenkins (Salisbury District Hospital) – 'Managing the Emotional Impact of Prostate Cancer'.

**March 17:** West Sussex Group meeting, Chichester Baptist Church, 6.30pm. Speaker: Dr Mary Webb – 'Producing the NICE Guidelines for Cancer'.

**March 25:** Dorset Branch meeting, St Mark's Church Hall, Talbot Woods, Wallisdown Road, Bournemouth BH10 4AE, 7.30pm. Patients' Forum.

**March 31: PCaSO AGM,** ARK Centre, Basingstoke, 6.30pm. Speaker: Prof. Stephen Langley (Royal Surrey County Hospital, Guildford) – Prostate Brachytherapy.

**April 23:** Fareham Group meeting, Ferneham Hall, 2.30pm. Speaker: Louise Walker – 'Sexual Problems with Prostate Cancer'.

**April 28:** Basingstoke Group meeting, ARK Centre, 6.30pm.

**May 20:** West Sussex Group meeting, Woodlands Centre, Rustington, 6.30pm. Speaker: Mhairi Donald – 'Diet and Cancer'.

**May 26:** Basingstoke Group meeting, ARK Centre, 6.30pm.

**May 27:** Dorset Branch meeting, St Mark's Church Hall, Bournemouth, 7.30pm.

**June 3:** Southampton Group meeting, Taunton's College, 6.30pm.

**July 16:** Fareham Group meeting, 2pm. Venue to be announced in May newsletter.

**July 21:** General meeting, Chichester Baptist Church, 6.30pm. Speaker: Declan Murphy (Guy's and St Thomas's Hospital, London) – robotic surgery.

**July 29:** Dorset Branch meeting.

## NEWS FROM THE GROUPS AND BRANCHES

### BASINGSTOKE GROUP

At the November meeting Dr Teresa Guerrero Urbano, consultant clinical oncologist at the North Hants Hospital, updated us on radiotherapy and cancer clinical trials. With no January meeting, the next meeting is on 24th February, with a talk by Jane Bywater from St Michael's Hospice on Palliative Care. The group is hosting the PCaSO AGM on 31st March.

Meetings are held at the ARK Centre, North Hants Hospital, Aldermaston Road, Basingstoke RG24 9NA on the last Tuesday of each month, at 6.30pm. There is ample free parking in the centre's car park. Contact: Barry Shoubridge (01344 625378), basingstoke@pcaso.com.

### SOUTHAMPTON GROUP

Unfortunately Dr Gerhardt Attard, from the Royal Marsden Hospital, was unable to attend the meeting on December 3rd, but he was able to send the slides of his presentation, and to answer questions relayed by mobile phone. Mike Hollingworth ably hosted the meeting and was able to interpret the Powerpoint presentation, any questions on which were answered by Dr Attard by phone. The next meeting is on 4th March, with a talk by Dr Kate Jenkins on managing the emotional impact of prostate cancer.

Meetings are held quarterly on the first Wednesday of the month at Taunton's College, Hill Lane, Southampton SO15 5RL at 6.30pm. All are welcome. Contact: Mike Hollingworth (01794 322952) southampton@pcaso.com.

### WEST SUSSEX GROUP

The final meeting of 2008 at Rustington was a Patients' Forum, at which three members described their experiences of their treatments for prostate cancer. This was well attended, and such meetings are becoming a successful formula, which will be repeated in November 2009. Ian Graham-Jones spoke of the success of his laparoscopic prostatectomy four years ago, followed by Roger Pickford, whose experience of HIFU is recounted in his article on page 4. John Luhr's report of his succession of treatments of radiotherapy, hormonal treatments and brachytherapy gave a mixed message of inefficiency and muddle in the NHS administration and the appalling aftercare during one night at the Royal Surrey County Hospital, contrasted with the evident care and expertise of his surgeons in his brachytherapy treatment at St Luke's Cancer Centre.

The next meeting of the group is at Chichester Baptist Church, Sherborne Road, Chichester, PO19 3AW when Dr Mary Webb will be speaking on 'Producing the NICE Guidelines for Cancer'. The group meets bi-monthly alternately at Rustington and Chichester at 6.30pm.

Contact: Ian Graham-Jones (01243 371128) or Roger Bacon (01903 775602), westsussex@pcaso.com.

### FAREHAM GROUP

Mike Phillips has agreed to take over the organisation of the Fareham group meetings, and Mike hosted the first meeting of the new year, a General meeting, at which the speaker was Dr Claire Aukim-Hastie from the Department of Pharmacy and Biomedical Sciences at Portsmouth University. Claire described the area of her research (to which PCaSO is contributing some funding), finding the ability to distinguish 'tiger' prostate cancers from 'pussy-cats'. Her team compare patients with Gleason 6 to those with Gleason 8+ by looking at tissue and serum samples, thereby avoiding invasive tests and repeat biopsies. Her research, which was described in some technical detail, is proving promising on a small number of patients, and sampling over a larger group is the next stage.

Because the normal 2nd Thursday of April is too close to Easter, the next meeting will be on 23rd April at Ferneham Hall, Fareham, at 2pm. Thereafter the group is considering moving to a less expensive venue for some of its meetings. We hope to announce further developments in the next issue of this newsletter. Contact: Mike Phillips (07931 362982), fareham@pcaso.com.

### PARTNERS GROUP

The Partners group meets on the last Tuesday of every other month throughout the year. We meet at 12.30 for lunch at the Hogs Lodge Inn, Clanfield, just off the A3. We welcome new partners to join in the informal get-together of like-minded ladies. Contact: Jo Tyndale-Biscoe (01243 572223), ladies@pcaso.com.

### DORSET BRANCH

In December we held our third annual Social Evening, which was again very successful and much enjoyed by more than 80 members and friends who attended. Organised and hosted by Malcolm Brooks and Tony & Margaret Shepherd, they would like to thank the very many people that made the event run so smoothly. The opening Chairman's address was followed by a concert and bingo sessions, all much appreciated by the many friends present.

At the January meeting The Very Reverend Nicholas Frayling gave a talk entitled 'A Prostate Apostate', telling some highly entertaining stories of his working life in Liverpool, where he spent some 19 years in the ministry (see page 1). Following a chance diagnosis of prostate cancer, Nicholas spoke of the importance of awareness and regular PSA testing, and the hope of screening under the NHS. He also mentioned the importance of having a GP well informed and proactive in advising his/her male patients. He concluded his talk with an account of finding a suitable supplier of bicycle saddles for men without prostates - check out: [www.derriair.com](http://www.derriair.com)!

Contact: Tony Shepherd (0202 893615), dorset@pcaso.com.

# GUIDELINES FOR HEALTHY EATING

CLAIRE GILL

Claire Gill, Macmillan Dietician at the Basingstoke and North Hants Hospital, gave a talk to the Basingstoke group last year. Her notes are kindly reproduced below. The information is not suitable for people who are not eating enough and are currently receiving chemotherapy, malnourished people and people following special diets for other medical reasons.

Just as a healthy diet and lifestyle help protect against other cancers, they can also help to reduce prostate cancer risk. Remember that there are many factors that together predict your risk of prostate cancer. Research suggests that, whatever a person's age, genetic background or developmental history, their diet and lifestyle plays a role in determining whether or not they develop prostate cancer.

The most recent comprehensive review of the scientific literature published by the World Cancer Research Fund (International) in November 2007 makes recommendations for cancer prevention. This includes advice that, after treatment, cancer survivors should also follow these recommendations to prevent recurrence. It highlights the fact that diets high in calcium (around 1.5g per day, which is greater than the average recommended daily intake) probably place men at an increased risk of prostate cancer. Foods high in lycopenes (tomatoes, tomato products, grapefruit, watermelon, guava and apricot) and selenium (nuts, cereals, meat, cheese, tuna, legumes) probably decrease the risk of prostate cancer (*selenium supplements however, are not recommended – see below*).

Taking steps towards a healthier diet and lifestyle can lessen the impact of other risk factors such as being overweight and weight gain. It's good to remember that a healthy weight can be considered the weight that is within the healthy range for your height. But it is also important to have good weight control – so, if you are making dramatic changes to your diet to lose weight only to regain it again ('yo-yo dieting'), this is not particularly healthy.

## The World Cancer Research Fund suggests eight diet and lifestyle recommendations to help lower prostate cancer risk.

### 1: Be as lean as possible within the normal range of body weight.

Keep your body weight within healthy weight range for your height (BMI 20-25), avoid weight gain and increase in waist circumference throughout adulthood.



### 2: Be moderately physically active (equivalent to brisk walking) for at least 30 minutes every day.

As fitness improves, aim for 60 minutes or more of



moderate (or 30 minutes or more of more vigorous) physical activity every day. Limit sedentary habits such as watching television.

### 3: Limit consumption of energy-dense foods and avoid sugary drinks.

Consume energy-dense foods (such as fried foods, baked goods, puddings, confectionery and fats or oils used in meal preparation) sparingly. Avoid sugary drinks; consume 'fast foods' sparingly, if at all.



### 4: Eat mostly foods of plant origin.



Eat at least five portions/servings (at least 400g or 14oz) of a variety of fruits and non-starchy vegetables every day. Eat relatively unprocessed cereals (grains) and/or pulses (legumes) with every meal. Limit refined starchy foods. People who consume starchy roots or tubers as staples should also ensure intake of sufficient non-starchy vegetables, fruits and pulses (legumes).

### 5: Limit intake of red meat and avoid processed meat.

People who eat red meat (beef, pork, lamb, goat) should consume less than 500g (18oz) a week, very little if any of which should be processed (e.g. smoked, cured, salted meats or meat products containing chemical preservatives).



### 6: Limit alcoholic drinks.

If alcoholic drinks are consumed, limit to not more than two drinks a day for men and one drink a day for women.

### 7: Limit consumption of salt. Avoid mouldy cereals (grains) or pulses.

Avoid salt-preserved, salted or salty foods; preserve foods without using salt (using refrigeration, freezing, drying, bottling, canning or fermentation). Limit consumption of processed foods with added salt to ensure an intake of less than 6g (2.4g sodium) a day. Do not eat mouldy cereals (grains) or pulses (legumes).



### 8: Aim to meet nutritional needs through diet alone.

Dietary supplements are **not** recommended for cancer prevention.



- It's also a good idea to choose foods that are low in salt, prepare food without charring and store food safely.
- Very importantly, do not smoke or use tobacco in any form.

## CONTACTS

### Patrons:

The Duke of Richmond and Gordon  
The Very Rev. Christopher Fraying  
Lord Palumbo of Walbrook  
Bill Beaumont, OBE

### Founder and Life President:

David Rowlands

### Chairman: (chairman@pcaso.com)

Sandy Tyndale-Biscoe 01243 572223

### Secretary: (secretary@pcaso.com)

Ian Graham-Jones 01243 371128

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### Pastoral Counsellor: (pastor@pcaso.com)

Rev. Norman Last 01243 374174

### Additional Responsibilities

*Sandy Tyndale-Biscoe:* Prostate Cancer Charter for Action, mentoring co-ordinator, webmaster.

*Jim Stansfeld:* NCRI, Federation of Prostate Cancer Associations, British Prostate Group representative.

*Ian Graham-Jones:* publications and newsletter editor, librarian.

*Geoff Bailey:* mailings and distribution, general membership enquiries.

*Roger Bacon:* Prostate Matters editor, NHS Sussex Cancer Network representative.

*Mike Hollingworth:* NHS Central South Coast Cancer Network representative, NCRI and Southampton Clinical Trials Unit.

*David Smith:* Collections co-ordinator.

*Helpline:* Sandy Tyndale-Biscoe, Jim Stansfeld, Ian Graham-Jones.

### Group and Branch Contacts

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#### Basingstoke Group:

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#### West Sussex Group:

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## THE LAUNCH OF THE ROBOT

On 26 November the daVinci® robot was formally opened at Heatherwood and Wexham Park NHS Foundation Trust Hospital by the Parliamentary Under Secretary of State at the Department of Health, Professor the Lord Darzi of Denham, KBE who is internationally respected for pioneering work in the advancement of minimally invasive surgery. This equipment is now one of 14 da Vinci robots in the UK, but so far the only one in the South of the country and in our region.



This form of robotic surgery is suitable for a range of other complex operations as well as prostatectomy. For those unaware of this new technology, robotic surgery is not (readers will be relieved to hear) in any sense performed by a robot. The surgeon has complete control over the instruments and the operation from a console separated from the operating table, and his movements are replicated by the robotic arms. His surgical team is present at the operating table. The system is thus ideally suited to those trained in minimally invasive techniques.

Heatherwood and Wexham Park has two highly skilled consultant urologists using the new system for prostate cancer surgery, Mr Omer Karim and Mr Marc Laniado.

Mr Karim, who performed prostate research at the Johns Hopkins Hospital, USA, is one of the few formally trained robotic surgeons in the UK and has performed hundreds of robotic prostatectomies. Marc Laniado has been performing laparoscopic surgery for kidney and prostate disease after a period at the Cleveland Clinic, USA. Since then, he has taken up robotic surgery to enhance the results and is now performing robotic surgery regularly.

Further details can be found on

[www.windsorurology.co.uk](http://www.windsorurology.co.uk)

and some patient experiences on

<http://groups.google.co.uk/group/windsorurology>.



Marc Laniado

AND  
FINALLY ...

