CANOPY CANCER CARE

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Transcribed by: DCM

3 July 2018

Professor Peter Gilling
Urologist
Urology BOP
PO Box 56
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Email: reception@urobop.co.nz

Dear Peter

Re: **Ian ARMSTRONG DoB 19/05/1953 NHI JCP2375**
2-415 Oceanbeach Road, , Mount Maunganui 3116
☎ 07 5752365, Mob: 021 504093, Email: ian@ianharmstrong.com

Diagnosis:
Likely metastatic castrate-sensitive prostate cancer – pending PSMA PET scan.

Summary:

02/05/2018	Robot-assisted radical prostatectomy to remove Gleason 4+5=9 acinar adenocarcinoma. Preop PSA=14. Prior to surgery, staged as cT2c N0, however, histology upstaged to pT3a N1, (4/5 LN+). Extraprostatic extension, but margin negative. LVI+. Seminal vesicle negative.
06/06/2018	MRI Turbo STIR staging shows no bony metastases.
13/06/2018	PSA=15.
29/06/2018	PSA rise to 18.
03/07/2018	Seen in private medical oncology clinic – for re-staging with PSMA PET scan. Likely to commence ADT + either early docetaxel or abiraterone.

Reason:
Discussion about management of his prostate cancer.

History:
Ian is a 65-year-old gentleman that came to the clinic today with his wife, Patti. His history is summarised above. In May of this year, he underwent a robot-assisted radical prostatectomy to remove a prostate cancer. Preop investigations revealed a likely T2c prostate cancer, however, histological analysis post-op upstaged the cancer to pT3a with 4/5 lymph nodes positive as well. The cancer was a Gleason 4+5=9 acinar adenocarcinoma.

With the results of the surgery, a staging MRI Turbo STIR scan was arranged. This showed no bony metastases. Given the high Gleason score and nodal spread, Ian was referred to the clinic today for a discussion about management.

Current Status:
Ian remains well and is almost entirely asymptomatic of the prostate cancer. Since his surgery, he has noticed some urinary dribbling and is requiring pads to contain this. This is improving over time, however. He experiences nocturia one or two times a night. Energy levels are normal and appetite and weight have been stable. In the postoperative period, Ian did have some abdominal discomfort, but this has now improved. Stools have been a bit softer and more frequent than usual, (three times a day), but with no blood loss PR or melena.

Past Medical History:
1. Several BCCs removed from skin.
2. SCC removed from right arm followed by adjuvant radiotherapy.
3. Melanoma excised from chest three years ago.
4. Hypertension.
5. Hyperlipidaemia.

Medication:
1. Cilazapril 2.5 mg OD
2. Lipitor 20 mg once nocte

No known drug allergies.

Social History:
Ian lives with his wife, Patti in Mt Maunganui. He frequently runs marathons and exercises daily, running, walking and in the gym. Ian has worked as a Director of many businesses. He has Southern Cross Health Insurance which covers 100% of his medical expenses. He also has financial savings that he would be prepared to spend on therapy that may not be covered by his insurance policy. Ian quit smoking in 1982. He drinks roughly 12 glasses of wine a week. I have advised him to cut down.

Family History:
Mother diagnosed with breast cancer in her 70s, but died of other causes.

Examination:
Height 183 cm. Weight 86.7 kg. ECOG 0.
No lymphadenopathy palpable in cervical or supraclavicular regions. No bony tenderness on palpation of the spine. Cardiovascular and respiratory examinations were normal. Abdominal examination revealed healing laparoscopy scars, but no evidence of infection. There were no masses or organomegaly palpable.

Discussion:
Ian had a radical prostatectomy plus lymph node dissection, however, his PSA has continued to rise postoperatively, (most recent recording=18).

This likely indicates residual prostate cancer elsewhere in his body. So far, staging investigations have failed to identify any metastatic spread. A PSMA PET scan may be more helpful in elucidating the volume of disease.

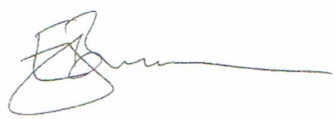
I have told Ian that given the rising PSA, I strongly suspect there is spread beyond the pelvis. If this is true, we are likely dealing with an incurable malignancy. Having said that, we can offer treatment to control the cancer for a period of time, keeping it suppressed for as long as possible.

Ian was understandably disappointed and upset to hear that the cancer was likely incurable. Despite this, he faced the news bravely and pragmatically.

Treatment:
It is very likely we will need to start androgen deprivation therapy (ADT) to control the prostate cancer, however, I would like to do this after a PSMA PET scan. Occasionally, ADT can cause PSMA PET scans to go falsely negative. Once Ian is established on ADT, we may need to consider either early docetaxel or early abiraterone. Recent research has shown that adding either of these on top of ADT increases long-term survival for aggressive prostate cancers. I have not gone into detail about these treatments today as it would be too much information for one visit. We will cover this properly at the next meeting. If the PSMA PET scan does confirm widespread metastases, my advice would be to adopt an aggressive approach with androgen deprivation therapy plus either docetaxel chemotherapy or abiraterone.

Plan:
At the end of the consultation, Ian and Patti understood all of the above information and had no further questions. I will arrange a PSMA PET scan to be done as soon as possible and then see Ian back in clinic with the results. After that, we will look at beginning ADT and have a further discussion about treatment options.

Yours sincerely



Dr Elliott Brenman, BMBS, MRCP (UK), FRACP
Consultant Medical Oncologist

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