Chapter 4

The Prostate

4.1 Submissions and other evidence taken by the committee concentrated overwhelmingly on two matters - diseases of the prostate and depression. In this chapter the committee considers the issues with regard to the prostate – research and research funding, diagnosis (including testing and screening issues), treatment and education and awareness.

4.2 The prostate gland is found only in males. It surrounds the urethra where it leaves the bladder and produces a fluid which is a component of semen. The prostate is vulnerable to a number of diseases – particularly acute and chronic prostatitis, prostatic enlargement and cancer. Chronic prostatitis and benign prostate enlargement are considered later in this chapter.

Prostate Cancer

4.3 Cancer of the prostate is a significant health problem and, with the ageing of the population it is likely to become the leading cause of death from cancer in men in the near future.¹ Prostate cancer is the most commonly diagnosed cancer in Australia,² the fifth largest cause of death among men, and, after lung cancer, the second most common cause of death from cancer. It is predicted that the rate of prostate cancer will rise by 3.1 per 100 000 males or 939 extra cases per annum.³

4.4 Over the age of 51 prostate cancer becomes the most common cancer for the remainder of a man's life. ⁴ Regrettably, despite the incidence of this disease there has been a tendency to dismiss it as an inevitable part of the process of ageing:

...there is a concern amongst clinicians that treat prostate cancer and researchers that because it can be labelled as a disease of old men it is not as important. Firstly, younger men can develop prostate cancer, with devastating consequences. That comment still occurs and it is an ageist comment. ... As a practising clinician I do not consider anyone in their 70s to be elderly but have an expectation that men will not lose years of their

¹ The Victorian Prostate Cancer Research Consortium (VPCRC) estimates that diagnoses of prostate cancer will double by 2020. VPCRC submission, p.1. With the decline in smoking, the mortality from lung cancer in men is declining.

² AIHW, *Cancer in Australia: an overview, 2008*, p.4. "The five most common cancers were prostate cancer (16,349 cases), colorectal cancer (13,076), breast cancer (12,265), melanoma of the skin (10,684) and lung cancer (9,182). These five cancers accounted for over 61% of all diagnoses."

³ ibid., p.16

⁴ AIHW, Cancer in Australia, op cit, p.vii

lives or have the morbidity that can occur from disseminated prostate cancer. $^{\rm 5}$

4.5 In this context it is important to remember that, for the purpose of medical statistics, 75 is considered a 'normal' life span, that male life expectancy is now 78 years and that a decision to raise the retirement age to 67 has just been announced. Thus prostate cancer is, and will remain, a significant health issue for men of working age.

4.6 The committee believes that the case for secure long-term funding for research into diseases of the prostate is beyond dispute. The incidence of prostate cancer and its projected increasing incidence is sufficient justification in itself for a considerable research effort and enhanced treatment and support services.

4.7 The benefits that can flow from research which provides for a better understanding of a disease and hence earlier diagnosis and better treatment can be shown by the declining mortality rates for a number of 'common' cancers. Colorectal cancer mortality has fallen by about 40% since the 1980s largely due to improved early diagnosis and treatment; cervical cancer mortality has declined by some 75% since the 1960s since the introduction of the pap smear and deaths from lung cancer in males has fallen by nearly 40% from its peak around 1980 as a result of the reduction in smoking and improved treatment.⁶

4.8 It is difficult to estimate the level of funding for research into prostate cancer because it comes from a range of sources. Specifically with regard to funding through the Commonwealth's principal funding body for medical research, the National Health and Medical Research Council (NHMRC) prostate cancer research has lagged behind breast cancer research. In the years 2000-2008 funding for prostate cancer was \$44.5 million compared with \$88.9 million for breast cancer.⁷ Given that the death rates from these two cancers are similar, that the incidence of prostate cancer is actually greater and that projections for the increased incidence are, by some margin, higher than for any other type of cancer⁸ there is a very good case for an increase in funding in this area.

4.9 Prostate cancer remains relatively poorly understood and thus presents particular problems of both diagnosis and treatment. As an internal organ, changes to

⁵ Prof. J. Best, Chair, Victorian Prostate Cancer Research Consortium, committee transcript, 9 April 2009, p.41

⁶ AIHW, *Australia's Health*, op cit, pp. 45-46

⁷ NHMRC funded research into cancer and other malignant neoplasms 2000 – 2008, the Cancer Dataset, <u>http://www.nhmrc.gov.au/grants/dataset/disease/cancer.php</u> (accessed 14 May 2009). In making this comparison the committee does not wish to engage in any 'men v women' debate. The similarity of death rates from the two diseases and a range of other matters makes this a valid comparison.

⁸ AIHW, *Cancer in Australia*, op cit, p.16

the prostate are not immediately obvious and, at present, no definitive test short of a biopsy (which extracts tissue samples from the prostate for examination) is available.

4.10 The committee was told by a number of witnesses at its hearings that, where a cancer does exist, the nature of that cancer is also difficult to determine. Prostate cancer can be largely passive or very slow growing and have no noticeable affect on a patient (hence the saying that more men die with it than of it). Alternatively the cancer can be aggressive and metastasise (grow beyond the prostate itself) leading to serious illness and death.

4.11 At present the ability to determine which type of cancer a patient has is limited:

The disease is highly variable. You can have two cancers that look alike down the microscope. One of them will be quite indolent and the other one will be quite aggressive. ...and we have got no marker for that at all.⁹

4.12 This problem is compounded by the fact that cancer may be dispersed throughout the prostate and have different characteristics:

The thing is that it is a multifocal disease. It is, to a large degree, in the periphery of the prostate but there are different cancer foci and it is believed that they probably arise independently and therefore may have different propensities for aggressive progression of the disease.¹⁰

4.13 The difficulties associated with diagnosis flow on into treatment. At present there are limited treatment options, particularly for non-invasive therapies.

A diagnosis of prostate cancer also impacts on quality of life, due to the current inability to determine and advise the sufferer on the likely course of his disease. This leads then to a combination of clinical and psychosocial impacts....¹¹

Research Priorities

4.14 It was put to the committee by the Institute of Biomedical Research and Innovation that the priority areas for research into prostate cancer are:

- Development of new predictive and diagnostic tools to identify men at increased risk of developing PC and enhance early detection of the disease;
- Development of new prognostic markers to distinguish between aggressive and nonaggressive cancers to inform treatment options and minimise impacts on patient quality of life; and

⁹ Associate Prof. D. Horsfall, National Project Manager, Australian Prostate Cancer BioResource, committee transcript, 30 April 2009, p.4

¹⁰ ibid., Prof. D. Horsfall. p.8

¹¹ Australian Prostate Cancer BioResource, submission 22, p.1

• Development of new therapeutic options that target the genetic and biomolecular factors that underlie specific prostate cancer types.¹²

These priorities were reflected in other submissions from professional groups.

4.15 If significant advances are to be made in the identification and treatment of prostate cancer, research must be supported over the whole spectrum of relevant activities. Professor James Best summarised these as:

...biomedical laboratory-based discovery research; clinical research, which goes out of the laboratory to involve patients in the research; population based research, where we might look at the prevalence of prostate cancer and whether it is increasing, decreasing et cetera; and finally health services research, which is how is prostate cancer treated and how might we improve the treatment.¹³

4.16 The committee strongly supports continued and increased funding for organisations engaged in research and other activities, such as health promotion and public education across all these areas.

The Australian Prostate Cancer BioResource

4.17 Underlying progress in all these areas is a need for research material, specifically tissue collected from prostate cancers.

Medical researchers will undoubtedly uncover the secrets of prostate cancer variability that give rise to this complex disease. Discoveries will come from studying the biology, pathology and clinical outcome of tissues from a large number of men with the disease,... More importantly, the more cases studied the more likely we will unravel the full spectrum of disease...¹⁴

4.18 Only by being able to examine a large number of tissue samples and follow the progress of the disease over a period of ten to twenty years will researchers be able to make progress:

... prostate cancer tissues really form the basis for all of Australia's prostate cancer research, into biomarkers of diagnosis, prognosis—that is, outcomes—and therapeutic response.¹⁵

4.19 A further reason for the importance of human tissue in prostate cancer research is that the use of laboratory animals does not provide a practical alternative:

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¹² Queensland University of Technology, Institute of Health and Biomedical Innovation (IHBI), submission 52, p.1

¹³ Prof.J. Best VPCRC, op cit, p.41-42

¹⁴ Australian Prostate Cancer BioResource, submission 22, p.1

¹⁵ Prof. D. Horsfall, op cit, 30 April 2009, p.2

The reason that biobanks and specimens taken from men are so important to a biomedical researcher in prostate cancer is that you do not have mouse models to work with. Mice do not get prostate cancer. You can make them do that if you genetically manipulate them, but it is not something that occurs spontaneously.¹⁶

4.20 The importance of being able to follow the development of a disease in individual patients is a product of the currently unpredictable nature of the disease:

...approximately 30 per cent of men operated on will fail that treatment. Their cancer will have already escaped the prostate by the time they are operated on. We cannot pick these people. Those patients will relapse in about three to seven years after the operation.¹⁷

4.21 The principal prostate tissue collection in Australia is the Australian Prostate Cancer BioResource, established in 2004, which currently collects tissue samples from more than 10 hospitals throughout Australia.¹⁸ The committee is particularly concerned to ensure that this BioResource receives secure, long-term funding to enable it to carry out the full range of activities in support of research. It was initially funded by the Commonwealth Bank of Australia, Prostate Cancer Foundation of Australia and Andrology Australia and has received funding from the NHMRC. The NHMRC grant runs until 2009 and renewal is currently under consideration.

4.22 The committee is advised that the BioResource faces a number of limitations imposed by resources which prevent it achieving its full potential. Financial constraints act at both the collection and research stages. Consent of patients to participate in the program has to be obtained and tissues have to be collected and stored according to uniform procedures. At present the BioResource relies,

...on the goodwill of the institutes, the medical schools that are associated with the institutes and the pathologists who are doing things for us gratis, although they are very busy.¹⁹

4.23 As a result of practical arrangements within hospitals, the scheduling of operations and availability of pathologists for example, tissue is not collected from a proportion, up to 30%, of men who have consented to participate in the program.²⁰

4.24 The BioResource needs to maintain the current rate of tissue collection until at least 2014 to ensure that there is a sufficient number of tissue samples and that these samples have been followed over a long period of time.

¹⁶ Prof. G. Risbridger, Monash Institute for Medical Research, committee transcript, 8 April 2009, p.28

¹⁷ ibid., p.4

¹⁸ Other collections are held by researchers in Victoria and Western Australia.

¹⁹ Prof. D. Horsfall, op cit, p.7

²⁰ ibid., p.3

4.25 At the research stage the BioResource would be much more effective if it could produce a greater range of blood and tissue products to supply to researchers. As described in its submission the production of,

serum and plasma extracted from blood, DNA from blood cells and prostate cancer tissue, RNA from prostate cancer tissue, and micro-arrays of tissue cores of selected prostate pathologies and disease outcomes. These materials are used for the discovery of markers of diagnosis, prognosis and therapeutic response, and for determination of cancer-related mutations and predictive genetic variations.²¹

4.26 In addition to these research activities the BioResource requires an accessible web-linked database which would enable researchers to "... view the collection on the database online to determine which patient tissues are relevant to their research study...".²²

4.27 The committee is advised that the current level of funding,

...provides part of [the Project Manager's] salary and the salaries of four tissue collectors, one at each node, and a small amount of maintenance for each of those nodes. It is really only about half what we want.²³

4.28 It should be noted that staffing of the BioResource has been delayed and the National Project Manager only works part-time to try end ensure that existing funding can be made to last until the end of 2009.²⁴

4.29 The question of some element of self-funding of the BioResource through cost-recovery was raised in the committee's hearings. This raises the conflict between putting a price on a product to ensure that users value it appropriately and discouraging its use by setting a price that is a disincentive to use. The committee was advised that it does not charge university and other non-profit institutions. At present it does not supply the private biotechnology industry but should it do so in the future then the issue of charging for tissue will be reviewed.²⁵

4.30 The committee does not wish to make a recommendation with regard to a precise level of funding for the BioResource; that is a matter for government and the relevant professional funding bodies. However the committee would wish to endorse the importance of the BioResource as fundamental to the conduct of the very necessary research into prostate cancer.

²¹ Australian Prostate Cancer BioResource, submission 22, p.3

²² ibid., p.3

²³ Prof. D. Horsfall, op cit, p.7

²⁴ ibid., p.7

²⁵ ibid., p.11

The committee recommends that the Commonwealth Government ensure that the Australian Prostate Cancer BioResource is provided with sustainable funding at a level that would enable it to complete its tissue collection and carry out the necessary work in support of prostate cancer research outlined in this chapter.

4.31 An important aspect of research is the translation of that research into better patient outcomes. It was explained to the committee that the institutional pressures of attracting research funding and building a professional reputation can come into conflict with the need to engage with the general community either by publishing in non-specialist media, working through groups such as Andrology Australia and the Prostate Cancer Foundation or through community groups such as Rotary. At present the incentives, for example the ranking of publications in journals, tend to favour the former activity.²⁶

4.32 The committee has no ready answer to this problem. However it does emphasise the need for continued support for organisations such as the prostate Cancer Collaborations, Andrology Australia and the Prostate Cancer Foundation as vehicles for bringing together researchers from different areas, facilitating coordination of research and providing the lay reader with accessible information on technical matters such as prostate cancer testing and screening.

4.33 It would also be valuable if 'community outreach', which is encouraged by research institutions, could also be given more weight in ranking researchers and making funding decisions.

Screening and Testing²⁷

4.34 This is a key area for research into prostate cancer. An effective screening program can have a significant impact on the morbidity and mortality of a disease. The three national cancer screening programs operating in Australia at present are for breast cancer, cervical cancer and colorectal cancer. Deaths from each of these diseases have been reduced considerably since the introduction of screening programs - cervical cancer deaths have halved from 4.0 deaths per 100,000 women in 1991 to 1.9 deaths per 100,000 women in 2006; deaths from breast cancer have decreased from 31 per 100,000 in 1991 to 22 per 100,000 in 2006.²⁸ The national screening program for colorectal cancers is too recent to have yielded significant results.

4.35 As indicated above prostate cancer can take a number of forms with widely varying prognoses. The ability to diagnose the disease at an early stage and to

²⁶ This issue is considered in more detail in the committee transcript, 8 April 2009, pp.32-34

²⁷ The committee has used the term screening to refer to the surveying of populations who have no symptoms but are selected on the basis of some general factor such as sex or age group, for example taking a pap smear or carrying out mammography, and testing to refer to a test administered to a patient showing symptoms.

²⁸ AIHW, Cancer in Australia, op cit, p.viii

distinguish the various types of cancer and treat them appropriately is vital. The current inability to do so leads to a situation where,

...men [are] being over-treated for cancers that they do not need to be treated for, but we have at least 3,000 men a year who are not getting treated, because they are dying from it. They probably could have been saved if we knew more about what sort of cancer they had and that they needed radical treatment. That is the number one need...²⁹

4.36 The question of population based screening for prostate cancer using the Prostate Specific Antigen (PSA) has been the subject of considerable research and debate both in Australia and internationally. An editorial in the *Medical Journal of Australia* (MJA) commented "A particular characteristic of the debate has been the polarisation of views...to the point where, at times, constructive debate has been constrained".³⁰

4.37 Tests which provide a reliable indicator of the presence of cancer and enable clinicians to distinguish aggressive from indolent cancers would have a significant impact on prostate cancer treatment. To be effective the method of screening should have a high level of sensitivity, meaning that it indicates positive results with a high level of reliability (and yields a low level of 'false negatives' which result in cases of the disease being missed). The method should, ideally, also have a high level of specificity; that is it should identify those who do not have the disease with high reliability and thus avoid 'false positives' – indicating that people who are in fact disease free have the disease which may lead to further, unnecessary invasive testing or treatment.

4.38 The MJA editorial referred to above identified the problems as arising from,

...the fact that PSA is not a test for prostate cancer and has no threshold level providing a high sensitivity and specificity...a raised PSA level often commits men to the invasive procedure of transrectal ultrasound (TRUS) guided biopsies.

and concluded that,

If the diagnostic process were non-invasive and treatments with curative intent were not associated with significant unwanted effects, few would quibble about whether it is appropriate to be tested.³¹

4.39 Two recent studies, one in the United States and the other in Europe, have produced conflicting results and interpretations and as a consequence, did not provide

²⁹ Dr C. Hovens, VPCRC, committee transcript, 9 April 2009, p.43-44

³⁰ Medical Journal of Australia, 2007; 187(9):501-502

³¹ ibid.

conclusive results that might have settled the debate.³² Andrology Australia drew three conclusions from the results of these studies:

- The results of these studies are relevant to Australian clinical practice and provide the best evidence to date that there is a significant level of uncertainty about the use of PSA test as a population-wide screening marker for prostate cancer;
- Both studies highlighted the issue of over diagnosis as a result of screening and the consequent interventions (and side effects) that would not occur otherwise;
- The studies highlight that newer and more specific prostate cancer markers are needed before an effective population-wide prostate cancer screening program could be recommended or implemented.³³

4.40 As will be discussed further below, treatment for prostate cancer can be invasive and carries with it a number of risks. Thus when evaluating the utility of a screening program it is necessary to compare the outcomes of unnecessary treatment, which may result either from false positive results or from over-treatment in the absence of a clear understanding of the particular cancer being treated, with the benefits of mass screening.

4.41 At present it is the general consensus among medical scientists and the Cancer Councils in Australia is that the PSA does not meet these criteria and that, consequently, population screening using the PSA would not be justified.

4.42 Developing a better understanding of the relationship between PSA results and prostate cancer was given as an example of the sort of research that would be facilitated by the proposed longitudinal study on men's health. "One of the biomedical parameters that we would undoubtedly collect in that longitudinal study could be PSA levels from these men. Then that would give you exactly the information that you would need and it would be informative for people to know what does happen to people's PSA levels and what did happen to those men in terms of their tumour".³⁴

4.43 However testing for prostate cancer where a man has general symptoms or a family history or simply a desire to monitor their own health status should be encouraged. Testing currently relies on a combination of a PSA test and digital rectal examination. Should these tests indicate the presence of an abnormality of the prostate

³² See discussion of these studies at, *Doubts raised over US study on prostate cancer screening test*, Urological Society of Australia and New Zealand, 24 March 2009; Prostate Cancer Screening, ABC Health Report, 23 March 2009 <u>http://www.abc.net.au/rn/healthreport/stories/2009/2520425.htm</u> (accessed 14 May 2009)

³³ Jury still out on PSA testing, Andrology Australia, 3 April 2009, <u>http://www.andrologyaustralia.org/pageContent.asp?pageCode=WHATSNEW1742</u> (accessed 14 May 2009)

³⁴ Prof. V. Marshall AC, Centre Director, Freemasons Foundation Centre for Men's Health, University of Adelaide, committee transcript, 30 April 2009, p.46

then the patient would be referred for a biopsy, which is the only definitive test for prostate cancer that is currently available. The Prostate Cancer Foundation recommends that all men,

...from [age] 50 onwards would go to his GP and have a conversation about prostate cancer. If they are concerned about prostate cancer, they should have the blood test, the PSA, and they should also have a physical digital rectal examination to feel whether there is any growth on the prostate.³⁵

4.44 The committee endorses the efforts of the Cancer Councils, Andrology Australia and the Prostate Cancer Foundation to make men aware of the importance of seeking medical advice should they have an indication of a problem with their prostate or any of the risk factors, such as family history, which might suggest an elevated risk.

Treatment

4.45 The significant variations in the behaviour of prostate cancer and the difficulty in identifying the probable behaviour of the cancer in the individual patient lead to considerable difficulties with treatment; "The issue for prostate cancer is that we do not know which men to treat..., because we do not have markers that are prognostic."³⁶ This can lead to confusion and anxiety for patients and their families and may contribute to people undergoing unnecessary or inappropriate treatment.

...we were seeing too many patients coming into our clinics not knowing what their treatment options are. We work in a urology department, so we offer surgery and that is all we offer. Unfortunately, men were coming into the clinic and not being aware that they could have a whole plethora of other treatment options, including radiotherapy and cryoablation—a whole range of different things.³⁷

4.46 The committee is not qualified to canvass the relative merits of various treatment options. However it did receive a considerable volume of evidence about the impact on patients of having to make decisions on treatment when faced with a range of options and in many cases insufficient support and advice:

...there are a large number of treatment options available for prostate cancer patients and, from a psychological point of view, this can be a very daunting task. Patients are often asked to make their treatment decision themselves, so without specific guidance from their treating urologist or doctor. Often patients and their families can feel a sense of paralysis around which decision to make.³⁸

³⁵ Mr A. Giles, Prostate Cancer Foundation of Australia, committee transcript, 8 April 2009, p.84

³⁶ Prof. G. Risbridger, committee transcript, 8 April 2009, p.35

³⁷ Dr. A. Wootten, Department of Urology, Royal Melbourne Hospital, committee transcript, 8 April 2009, p.41

³⁸ ibid., p.37

4.47 A second source of anxiety is the range of morbidities which can result from treatment including:

failed cancer control, incontinence of the bladder or the bowel, sexual dysfunction and psychological trauma. These morbidities seem to have a very big impact in terms of patient quality of life later on down the track and also how they cope with these difficulties psychologically.³⁹

4.48 In evidence to the committee representatives of *beyondblue* made a similar but more general point:

We are now doing a lot more work in the areas of cancer, such as prostate cancer, and major operations....The surgeon does a good job but no-one is looking after the mind of the person. ...We are not very sophisticated in the holistic medical approach as opposed to dealing with specific individual issues. I think that is an area where we have to make a great deal of inroad in the years to come.⁴⁰

4.49 This is a major health issue. The committee heard that a large survey of patients in NSW found that over 50% of patients had some psychological support need and that just under 50% had a need for support relating specifically to changed sexual functioning after treatment for prostate cancer.⁴¹ Prostate cancer sufferers also suffer from depression at 2 to 3 times the community average and general psychological disorders are present in between 25% and 47% of cases. Some studies also indicate that suicide is more prevalent among older men with prostate cancer, perhaps as much as four times more common.⁴²

4.50 Support for patients and their families both at the time of a diagnosis of prostate cancer and in the longer term as they undergo treatment and live with the results of it is clearly an area requiring much greater attention.

...in our work running support groups for men with prostate cancer that there was consistent feedback from men saying that they did not have enough support around the time of diagnosis, they did not know about the different support agencies, they did not know that there were different treatment options, they did not know that there were treatment options for sexual dysfunction or where to get pads—a whole range of different things that they just felt they were not being provided information about.⁴³

4.51 The efforts of the various organisations which seek to promote public awareness of all these problems have made a significant difference. The quality of

³⁹ ibid.

⁴⁰ The Hon. J. Kennett, op cit, 9 April 2009, p.3

⁴¹ Dr. A. Wootten, op cit, p.38. These findings come from a NSW Cancer Council study.

⁴² Prostate Cancer Foundation of Australia, *National Prostate Cancer Information Pack, Pilot, Final Report* (April 2009), p.7. The introduction to this report provides a useful summary of recent research into the psychological impact of prostate cancer.

⁴³ Dr. A. Wootten , op cit, p.41

information that is available is excellent as are the links to support groups. However more needs to be done to reach all prostate cancer patients and to maintain contact with them.

4.52 During its hearings the committee was advised that a pilot project to test a National Prostate Cancer Information Pack was underway. This is an initiative of the Prostate Cancer Foundation and of practitioners in the field. The pack was modelled on the Breast Cancer Foundation's *My Journey* kit which is distributed to all patients at the time of a diagnosis of breast cancer. The purpose of the pack is to provide "...credible, non-biased and consistent information about treatment options and ongoing quality of life issues in the context of localised prostate cancer".⁴⁴

4.53 The report of the pilot project indicates almost unanimous support for the pack among patients and a strong support for the major components. To be effective approximately 18 000 Packs would have to be distributed every year.⁴⁵

The committee recommends that the Commonwealth Government provide funding to the Prostate Cancer Foundation to ensure that the Prostate Cancer Information Pack program proceeds.

4.54 Outcomes for patients diagnosed with prostate cancer vary considerably depending on place of residence and income. Patients in rural and regional areas have a 21% greater mortality than those in capital cities. Mortality is also related to income, with significantly higher mortality rates from prostate cancer among socially disadvantaged men.⁴⁶ These figures reinforce the need for improved services to be provided throughout Australia.

4.55 Health services in regional and remote Australia generally suffer from "...larger client capture areas, smaller populations, fewer general and specialist medical professionals per population, and fewer services".⁴⁷ While the provision of advanced hospital based services can only be addressed by improving patient transport and support services to ensure that they receive high quality treatment, local services providing education and awareness programs to encourage men to seek medical advice and better support services, post-diagnosis should be provided through regional hospitals, health centres or general practice.

4.56 The committee notes, and fully supports, the Commonwealth Government's support for a program to place specialist breast cancer nurses in health centres predominantly in rural and regional Australia. The program, developed in collaboration with the McGrath Foundation, is to provide:

⁴⁴ National Prostate Cancer Information Pack, op cit, p.4

⁴⁵ This figure is based on the number of prostate cancer diagnoses per year.

⁴⁶ Prostate Cancer Foundation of Australia, submission 72, p.2

⁴⁷ AIHW, Australia's Health, op cit, p.87

...specially trained registered nurses...[to] provide vital information, care and practical and emotional support to women diagnosed with breast cancer, their families and carers.⁴⁸

4.57 The Prostate Cancer Foundation has been providing scholarships to nurses undertaking training in the treatment and support of prostate cancer patients for some years but there is no program to appoint prostate cancer nurses nationwide. The committee is advised that PCFA is undertaking a study of the viability of such a program.

4.58 In view of the various factors discussed in this chapter; incidence, mortality, difficulties surrounding diagnosis and treatment, the psychological impact on patients and their families and regional variations in outcomes, it is clear that a similar need exists among prostate cancer sufferers and their families. A program to appoint specialist prostate cancer nurses should be established.

The committee recommends that the Commonwealth Government expedite funding for the provision of specialist prostate cancer nurses, particularly in rural and regional Australia.

Non-cancerous diseases of the prostate

4.59 Benign prostate enlargement is a very common but not life-threatening condition. It is estimated to affect 25% of men in their 40s increasing to some 75% in their 70s. It can be little more than a source of discomfort but if left untreated may affect the functioning of the bladder and, in extreme cases, kidneys.⁴⁹ Various treatments are available, ranging from drug therapies to surgery depending on severity. Bacterial prostatitis is the result of infection and, again, can be treated with drugs or surgery depending on the severity of the condition.

4.60 Chronic prostatitis, non-bacterial inflammation of the prostate, is poorly understood in Australia, even by doctors and is certainly under-reported. Evidence to the committee suggests that "...awareness of the condition and its treatment is still poor, despite its prevalence and severity"⁵⁰ and affects between 10 and 20% of men in Australia.⁵¹

 ⁴⁸ The Hon Nicola Roxon MP, Minister for Health and Aging, New Breast Cancer Nurses for Regional Australia,13 October 2008.
<u>http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr08-nr-nr134.htm</u> (Accessed 18 May 2009) The committee notes that the Prostate Cancer Foundation and the Cancer Council of Victoria already offer scholarships to encourage registered nurses to undertake a training course specialising in prostate cancer care.

⁴⁹ Andrology Australia, Prostate Enlargement or BPH, 2006 <u>http://www.andrologyaustralia.org/pageContent.asp?pageCode=PROSENLARGE</u> (accessed May 2009)

⁵⁰ Prof. J. Best, submission 30, p.1

⁵¹ Prof. J. Best, committee transcript, 9 April 2009, p.53

4.61 In extreme cases it can be the cause of severe pain and leave its sufferers leading 'lives of quiet desperation'. It may be a result of inflammation of the prostate or of muscle tension in the pelvic area and can be alleviated to some extent by anti-inflammatory drugs or physiotherapy.

4.62 All of these conditions are susceptible to treatment and benign prostate enlargement and bacterial prostatitis can become serious problems if left untreated. They are much more common than prostate cancer. However men may be discouraged from seeking medical advice when experiencing symptoms because of a fear of a cancer diagnosis. This emphasises the importance of greater awareness of the various diseases that may affect the prostate both among the general public and general practitioners and of encouraging men to seek medical advice at an early stage.

The committee wishes to thank all those who made submissions to this inquiry and participated in the committee's public hearings.

Senator Cory Bernardi Chair