

East Lancashire Prostate Cancer Support Group Newsletter



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See you at the next meeting usual
time and place

2pm—4pm



Next Meeting Thursday 5th December The Christmas Celebration Starring the Chairman's (Dave) Christmas Pud Recipe

(See Page 16 for the Entertainment) Everybody is Welcome!



INGREDIENTS

1x bottle of cheapish whisky

1x two portion Christmas pudding (250-400g).

2x dessert spoons brown sugar

2x cinnamon sticks

METHOD

Cut pudding into six slices and place all the above into a sealed jar.

Turn every couple of days for two weeks.

*Sieve the liquid through a cloth / coffee filter papers until clear then pour
back into the old whisky bottle.*

*Squeeze and reform pudding into portions, clingfilm and freeze until
needed.*

When required , steam in a pan add custard and ENJOY.

Europa Uomo *The European* *Prostate Cancer* *Coalition Survey*

I saw your group listed on the Tackle website and I thought you and your support group members might be interested in the following information on our Quality of Life project .

I write to you on behalf of *Europa Uomo* or The European Prostate Cancer Coalition, which comprises national and regional prostate cancer organisations in 27 countries across Europe from Iceland in the West to Armenia in the East. Tackle UK has been one of our most important members and in recent years prominent members of Tackle have been officers of the Europa Uomo Board, most recently Ken Mastris our immediate past Chairman.

Europa Uomo is currently conducting a patient-organised and managed, Quality of Life Survey across Europe. On completion we will have a report compiled on the patient view on living with prostate cancer unaffected by any other stakeholder in the prostate treatment world. We have hired a UK firm Cello Health to organise the questionnaire, receive and process the responses so that complete anonymity is assured. The survey uses the standard EORTC and EPIC QoL questionnaires.

We would like to invite any of your group's members who have had a prostate cancer diagnosis to take part in this survey and contribute to building a clear and Europe-wide picture of the real quality of life for men with prostate cancer. The survey is so confidential we won't even know if anyone from your organisation takes the survey, but we live in hope. It can also be completed by a partner or family member on behalf of a patient unable to complete it themselves. The link to

the survey is below.

Follow the link here:

<https://www.qualityoflifesurvey.co/wix/p1874284546.aspx>

It takes about 15-20 minutes to complete - it is all on-line. and when the patient clicks the last question the survey responses are automatically transferred to Cello Health. We never see the responses - just the results and the anonymised aggregate answers.

The Survey has, as of today, been completed by more than 2100 prostate cancer patients and, as we would like to ensure the most representative sample of prostate patients in Europe for a QoL survey, we hope your prostate patient members will participate.

Please feel free to forward this email to any other group or prostate organisation that might have prostate cancer patients in membership. The Survey is currently due to close on 15 November and we will be happy to make the results known to your group when published next March .

FYI our head office is in Antwerp. Our current Board of seven is drawn from Norway, Finland, Germany, Cyprus The Netherlands, Belgium and Ireland.

We also publish a *free* weekly Prostate Cancer newsletter - *Update* in English - see link which also includes our website address, currently under reconstruction.

All previous issues are available on our website:

<http://www.europa-uomo.org/newsletters/>

Thank you so much for your attention - I hope you and your members will find the survey worthwhile. We believe it can play an important part in highlighting the disease and improving early detection and more effective and patient-friendly treatment, across wider Europe.

Best regards

John Dowling

Vice-Chairman - Communications

+353 87 2474217

Dealing with Prostate Cancer

A cautionary tale in two Parts

by

D A Ball

Notes:

In both Parts I use *italics* to draw attention to something that is *important*.

Part One describes my Prostate cancer experience and useful lessons learned.

Part Two is about how probabilities are used to describe prostate cancer; it is not necessary to read it but it does help inform the lessons of Part One

Disclaimers

I am not a prostate cancer expert, I simply describe my experience; for medical advice you should seek expert help.

The footnotes are to help clarify terms used in the text and are not medical definitions.

Preface

In the UK some 40,000 men are diagnosed with prostate cancer each year, it is the second main cause of death in men. For *nine out of ten* over the age of 70 the cancer grows slowly and old age and its infirmities will find something else to carry them off before the prostate cancer can do it. For the misfortunate *one in ten* the cancer is *aggressive* and without treatment they will *die from it*. The '*probability*' of dying from it is much less with early treatment *and yet* each year 11,000 men still *die from it*, mostly because they do not *find out in time* that they have an *aggressive* prostate cancer.

Without some kind of early warning, and an effective response to it by your GP, you won't *even know* that you *have* a cancer until clinical symptoms appear. If you don't know that you might have a cancer you will not, of course, take steps to find out if it is *aggressive*. A *voluntary* general screening programme for men over the age of 60 could perhaps save many lives by alerting you in time.

Much of the argument against general screening is underpinned by *statistics*. I deal with statistical interpretations in Part Two.

The cost argument says that if *nine out of ten* will die from something else it is not worth the cost of testing for it. Counter argument. If *you* are one of the misfortunate *1-in-10*, the cost is outweighed by the benefit, at least for the patient if not for the accountant.

Argument: It is '*not worthwhile*' for the NHS to carry out screening because '*most*' tests, and particularly the usual first early warning indicator of prostate-specific antigen, (PSA), do not give *certain* answers.

Counter argument: Little *is* certain about prostate cancer diagnosis until the later stages of the disease, but for a higher risk person that is not a good reason to do nothing when more could be usefully done. Newer and more reliable tests are coming and in any case, a sudden change in PSA is a more reliable warning and enough to encourage a follow up by doing some simple tests such as a DRE, which is a good warning. One of the newer tests, an EPI may soon become available. Although there is no certainty about any tests, if all three tests suggest a possible cancer, the probability is higher and then a biopsy, or perhaps a PET, is surely a reasonable precaution to take to improve diagnosis.

Argument: A prostate-specific antigen, (PSA), does not give *certain* answers and sometimes a false one, therefore an incorrect cancer warning would unnecessarily frighten those older men who could be misdiagnosed as having a prostate cancer and we should not offer them. Counter Argument: Many men may, (*after the implications are properly explained to them*), decide that they do not want to do anything about it: if they are happy to live with the chance of being one of the 10%, then the choice should be theirs but it must be a choice, NOT decided for them. Some men might instead prefer to further lower the chances of death rather than to die through inaction.

Part One

A Cautionary Tale

My case history

*Yesterday upon the stair
I saw a man who wasn't there
He wasn't there again today
I do so wish he'd go away.*

*The 'man on the stair' is a possible prostate cancer, many men just wish it would go away - which is why
this is a cautionary tale.*

My Prostate Cancer Experience

What I did right

After reaching 50 years of age I got an annual blood profile test to see if I had any early indicators of future diseases that had been responsible for the majority of early deaths in my family going back a couple of hundred years, reasoning that catching any such a disease early would give me a better chance of living longer.

Two years ago, *before any other clinical symptoms appeared*, a profile showed a jump in my PSA and thus warned of a possible prostate cancer. I had done the right thing and found out early that I *might* have a prostate cancer.

What I did wrong

I should have confirmed or diminished the '*probability*' that I had a prostate cancer with further tests, but I didn't; nor when I accidentally found out that I really *did have prostate cancer* did I try to find out if it might be *aggressive*. Instead, I was persuaded by the medical response to my elevated PSA that it was "*not unusual for someone of my age and that a PSA test was unreliable*" and I trusted in the *mantra* that even if you have it '*you will 'probably' die with it not from it*'.

Beware! That mantra is a statistical interpretation not a medical diagnosis.

Why do many doctors not draw attention to a warning from a PSA test, or when you draw their attention to it, give the advice, '*you will 'probably' die with it not from it*'? Because it is true! At least it is *statistically* true, but *statistics* are no comfort if you subsequently find out that you are amongst the ill-fated *1-in-10* who has an aggressive prostate cancer and particularly if you find that out too late because then the *probability* becomes that you may die from it.

I was wrongly persuaded to ignore a warning signal - a sudden jump in my PSA level. If things had been left like that I would probably die from prostate cancer. I may have been saved by a lucky break:

Whilst recovering from a heart bypass operation I was visiting the USA and my blood pressure went haywire. I went to see a local doctor and she said: "Your blood pressure is fine, but you should see a urologist because your PSA has *jumped* since the last time you had it measured"; (I had sensibly taken along all my blood profile history). She it was who alerted me to the to the possible significance of such a *PSA jump*. It was surely sensible to try to confirm it? So I reluctantly went to see the USA urologist thinking that I had nothing to lose other than the cost of a consultation: Good decision, bad news. He did a digital rectal examination, (DRE, (an undignified couple of minutes procedure to feel with a finger if there is a lump in the prostate), and diagnosed a probable cancer, thus supporting the PSA warning. His was not a '*statistical interpretation*' it was a *diagnosis*. I had two tests and two warnings!

The urologist advised that I should have a biopsy. I did not want to suspend my post bypass operation medication, so unconvinced that I might have an aggressive cancer, I deferred having one. I did do *something* sensible, though, I paid for an MRI scan. Good decision, bad news. That too showed that I had a tumour. Three tests, three warnings!!

What should I have done next? Confirm the possibility and find out if it was *aggressive*, but trusting in the *mantra* I decided on *watchful waiting*. Delay in starting treatment for an aggressive cancer is unwise; I was betting on a statistic, a low *probably* that if I had a cancer it would not be *aggressive*; it was a grave mistake.

Choosing not to suspend my cardiac treatment I instead paid for an EPI. It estimated my Gleason score as $3+4 = 7$ just above the threshold of a signal of an *aggressive* prostate cancer. A PSA alone, or even a jump in a PSA, may be unreliable *but 4 consecutive tests with the same tell-tale result* were starting to add up to something perhaps?

Back in the UK I again paid to be referred to a UK oncologist. Good decision. The new oncologist, like his US fellows, recommended a biopsy and *once again* I foolishly decided to '*watchfully wait*', but asked for another MRI. That was one of the few smart things that I did. Good decision, bad news. The cancer had increased markedly in size since my last MRI, another blood test showed my PSA had also jumped again and by more than 0.7.

At last the scales fell from my eyes. 9 vital months had been lost in trusting in a '*statistical interpretation*'. I *finally did* what I should have done much earlier and had a biopsy. A biopsy is disagreeable but *will* give a fair indication that a cancer is *aggressive*. Mine was.

Probability may have indicated that *only 'one in ten'* men need to act. *I was now one of them* and I needed to act fast because so much time had been lost, time in which the cancer had grown alarmingly.

The urgent need now was to quickly determine if the cancer had *spread outside the prostate*, i.e., that it had not *metastasised*. To find out if it had metastasised I had a PET. Bad news, good news; it indicated an *aggressive* T3b (locally advanced cancer). It had spread to the seminal vesicles, the 'escape route' out of the prostate to neighbouring tissue and bones and had started to penetrate the capsule surrounding the prostate; but *probably* had not yet escaped.

This tumour had its foot on the accelerator and preventing a spread *was now essential!* My oncologist recommended *immediate* hormone therapy to be followed by radical radiation treatment.

I asked what would happen if I declined hormone and radiation therapy, (which like all prostate treatments can have disagreeable side effects), and continued with '*watchful waiting*'. He said it will spread and you could be dead within a few years. Well that rather did decide things because all the alarm bells were now deafening. Did I really still stand more chance of '*being knocked down by a double decker bus*' as I had been told?

The artfulness of the *mantra* is in offering a low risk choice as naturally attractive and in such a way as to play down the penalty should it *still* happen despite the low risk. The argument is that if *most* of us will probably die of something else anyway, why undergo disagreeable tests with possible unpleasant side effects when the chances that they are necessary are so low? The answer to that is: because low chance or not, if you should be one of the unfortunates who are numbered in the *1-in-10* then you will die.

With such a high chance of survival and given the uncomfortable consequences of living for years with the knowledge that one has a cancer but not knowing if it will eventually become *aggressive*, not telling someone he has a cancer may be a kind choice. But the choice should surely be for the patient to make and not be a choice of possible euthanasia chosen by someone else?

A sad truth

Despite *the mantra* assurance of 'nothing to be concerned about' I was in mortal danger. I luckily found out, by accident, that I really did have a prostate cancer. Fortunately I then also had the resources and the opportunity to get an MRI and then further tests. There are thousands of men in the UK who will not have my

luck and my advantages and who might be unaware that they have a cancer and afterwards find out, too late, that it is *aggressive*. *This Paper is for them.*

Lessons that I learned which could be useful

1) Don't play Russian roulette. The *probability* of blowing your brains out is only a modest one in six, but no sensible person takes such a modest chance if the consequences of a bad break are so catastrophic. Taking the bet that you are in the '*nine in of ten*' is playing Russian roulette. The chances that you will survive are comfortingly high but the consequences should you make a bad bet are catastrophic. If you have a warning that you might have a cancer, take steps to either confirm or to reduce that possibility by having further tests and if you *do* seem to have one, find out if it is *aggressive* without wasting time.

2) More reliable tests are in the pipeline but until they are introduced a jump in PSA can be a useful, if not certain, first cancer warning. As a first line of defence you cannot be worse off by using it and it is better than waiting until clinical symptoms appear. If you have a cancer and a PSA misses it, you have lost nothing, because you are no worse off. If instead, it says that you may have a cancer then being frightened for a little while before more tests say that is unlikely seems a small price to pay for playing safe.

3) You cannot reduce the *probability* of having prostate cancer, nor, if you have one, the *probability* that it may be *aggressive*; but you CAN do something to improve the *probability* that you will die of something else by detecting it early and having treatment *in time* - and the choice should be yours.

Conclusion

The jump in my PSA was dismissed using a misleading mantra; through other sufferers I realised that its use is so common that I suspect that a doctor's response is not a reasoned diagnosis but is something institutional. The NHS should *stop* presenting a statistic as a diagnosis. Permitting the 'auto-response' of "you are *probably likely to die with it rather than from it*" is essentially a statement that no further action is planned; that is misleading because it persuades the unknowing patient to accept that verdict and in 10% of cases that could be fatal. The choice should be consensual, *how happy are you to live with maybe being one of the 10%?*

The NHS should also usefully consider offering *voluntary* general prostate cancer screening from 60 years of age, or earlier for those with a family history of it.

Epilogue

Will the hormone and radiation treatment succeed for me?

It *probably* will - as long as I started the treatment in time; who knows?

I am convinced that:

1) Had I not been wrongly *persuaded* by the 'mantra' to discount my suddenly elevated PSA and if...

2) I had had further simple tests to support or disprove that first warning and if...

3) I had had a biopsy or another more certain test *as soon as I knew* that a cancer was *probably* present and started the treatment when it was shown to be aggressive....

The probability of a successful outcome would have been higher.

Note: I have described only my experience and treatment. There are a lot of different treatments amongst which are 'watchful waiting', prostatectomy, brachytherapy, hormones and radiation. Your experience will probably be different to mine but the common issues are the way probabilities can be presented as diagnosis that encourage complacency and delays early diagnosis. It is sensible to inform yourself as best you can of your condition and to try to understand the language in which probabilities are expressed to help you make a more informed choice with your physician. Read on....

Part Two

Probabilities and their role in diagnosing Prostate Cancer

There are lies, damned lies and statistics

Why statistics and probabilities figure in diagnosing Prostate Cancer

There is no *certainty* in most of the tests for the presence of prostate cancer, nor is there certainty in determining if a prostate cancer is *aggressive*, so the results of tests are rightly presented as *probabilities* using terms such as: 'maybe', 'might have', 'could be', 'chances are', etc.

Probabilities are just a way of interpreting a *statistic*. In my narrative the relevant *statistic* is the measure of the usual number of deaths in men aged over the age of 70 who have a prostate cancer who will die because of it - as it happens, one in ten of them.

A statistic is usually expressed as a percentage chance of something happening, but when it is further confidently explained as by 'that mantra' it may be statistically correct but it encourages inaction that could lead to death. My own experience related in Part one is a good illustration of how it can influence such a response.

How you can draw different conclusions from the same statistical truth

Equally valid but different *presentations* of the *same statistic* can influence a patient's understanding of his condition.

As a suitable example consider: When aged over 70, of those men *who have* a prostate cancer:

'9 out of 10 will probably die with it, not from it'.

Or:

'1-in-10 'will probably die from it'.

Both presentations are equally valid, yet being told that you stand a '*one-in-ten*' chance of *dying from it* might change your reaction from complacency, (encouraged by the mantra: '*You will probably die with it, not from it*', way of presenting that statistic), to a desire to act to further reduce the low *probability* of death, by getting treatment in time.

Whilst it may be *statistically* true that there is a *9-in-10* chance that your cancer will not kill you, that *presentation* does *not* say whether YOU PERSONALLY are *included* in *9-in-10*. The statistic just says that you have a 90% chance of dying from something else. It sounds good and it *is good*, but telling a patient that '*You will probably die with it not from it*' is better more likely to be right if further tests do not suggest an *aggressive* cancer.

This would be more balanced presentation: "*The test is not that reliable, but it shows a possible prostate cancer. We could do a few more different tests to see if they agree, but don't worry, even if they show that you might have one, as only 10% are aggressive at your age, you are more likely to die of something else. **If you are not comfortable to live with 10% chance of it being aggressive, there are other different tests to check that out and then early treatment is usually very effective.***"

Getting informed

The more you know about prostate cancer the more it will help you to understand what the professionals are telling you. It helped me to realise that the initial advice that I was given could lead to an early death and to seek more accurate advice.

There are hundreds of published research papers articles, Internet pages and promotions from clinics on the subject. I read a lot of these and additionally 5 books on the subject. All 5 books were useful and broadly consistent. I found the most useful was by a US oncologist/urologist in this field who was himself diagnosed with the condition (and at quite a young age, relatively speaking). The book is aptly called 'The Decision' and is by Dr. John McHugh. I found his approach to the unwelcome indications of a cancer and his criteria for deciding what he would do and which treatment he would select to be very useful. I did not use the same criteria because my age, diagnosis and available treatments were different to his, but his logical, analytical and informed approach seemed sensible to me and I adopted it.

I just wish that I had adopted it earlier.

Smart software can diagnose prostate cancer as well as a pathologist

Chinese scientists and clinicians have developed a learning artificial intelligence system which can diagnose and identify cancerous prostate samples as accurately as any pathologist. This holds out the possibility of streamlining and eliminating variation in the process of cancer diagnosis.

It may also help overcome any local shortage of trained pathologists. In the longer term it may lead to automated or partially-automated prostate cancer diagnosis. Prostate cancer is the most common male cancer, with around 1.1m diagnoses ever year, worldwide¹ (for comparison, that's around x4 the number of men who live in Copenhagen). Confirmation of the diagnosis normally requires a biopsy sample, which is then examined by a pathologist. Now an artificial intelligence learning system, presented at the European Association of Urology congress in Copenhagen, has shown similar levels of accuracy to a human pathologist. In addition, the software can accurately classify the level of malignancy of the cancer, so eliminating the variability which can creep into human diagnosis.

“This is not going to replace a human pathologist” said research leader Hongqian Guo (Nanjing, China), *“We still need an experienced pathologist to take responsibility for the final diagnosis. What it will do is help pathologists make better, faster diagnosis, as well as eliminating the day-to-day variation in judgement which can creep into human evaluations.”*

Prof. Guo's group took 918 prostate whole mount pathology section samples from 283 patients, and ran these through the analysis system, with the software gradually learning and improving diagnosis. These pathology images were subdivided into 40,000 smaller samples; 30,000 of these samples were used to 'train' the software, the remaining 10,000 were used to test accuracy – the results showed an accurate diagnosis in 99.38% of cases (using a human pathologist as a 'gold standard'), which is effectively as accurate as the human pathologist. They were also able to identify different Gleason Grades in the pathology sections using AI; ten whole mount prostate pathology sections have been tested so far, with similar Gleason Grade in the AI and human pathologist's diagnosis. The group has not started testing the system with human patients.

Prof. Guo continued *“The system was programmed to learn and gradually improve how it interpreted the samples. Our result show that the diagnosis the AI reported was at a level comparable to that of a pathologist. Furthermore, it could accurately classify the malignant levels of prostate cancer. Until now, automated systems have had limited clinical value, but we believe this is the first automated work to offer an accurate reporting and diagnosis of prostate cancer. In the short-term, this can offer a faster throughput, plus a greater consistency in cancer diagnosis from pathologist to pathologist, hospital to hospital, country to country.”*

Artificial intelligence is advancing at an amazing rate – you only need to look at facial recognition on smartphones, or driverless cars. It is important that cancer detection and diagnosis takes ad-

vantage of these changes.”

Commenting, Professor Rodolfo Montironi (Professor of Pathology, Polytechnic University of the Marche, Ancona, Italy) said:

“This is interesting work which shows how artificial intelligence will increasingly step into clinical practice. This may be very useful in some areas where there is a lack of trained pathologists. Like all automation, this will lead to a lesser reliance on human expertise, but we need to ensure that the final decisions on treatment stay with a trained pathologist. The really important thing though, is that we ensure the highest standard of patient care. The future will be interesting.”

Professor Montironi was not involved in this work – this is an independent comment.

The software was developed in conjunction with Nanjing Innovative Data Technologies, Inc (they were not involved in funding this work, see notes for funding details). The newness of the system means that there is no information yet on costs or on implementation.

The authors note some limitations to the work. There were more samples of Gleason Grade 3 and 4 than other grade, which maybe influence the AI calculation to some extent. They are also looking for suitably objective standards to allow direct comparison of Gleason Grade with the AI.

PATIENT VOICE PROJECT



Potential activities

October 2019

In September, Prostate Cancer Research Centre visited Tackle Prostate support groups in the North West, specifically the East Lancashire Prostate Cancer Support Group and the Droylsden Prostate Cancer Support Group. Through these workshops we sought to find out more about the more challenges faced by men with prostate cancer, centring on a number of questions including: the main challenges they face during treatment, access to information, services and support, and research priorities.

The main issues that were consistently brought up by the men and their families focused on the lack of information around side effects of treatments; knowledge, agency and personalisation in the decision-making process when it comes to treatment; signposting to additional support information (i.e. financial, transport and mobility) and support groups at point of diagnosis; and, GP specialist knowledge and understanding.

In terms of potential solutions, we are considering the following:

1. Patient Information Hub – there is a lot of very useful information available both online and in print with regards to prostate cancer and it can often be difficult for patients to navigate. This encompasses a wide range of topics from diagnosis and treatment to financial and emotional support. We propose that the creation of a Patient Information Hub to signpost people to all the useful information provided by PCUK, Tackle Prostate, ourselves and others. This would act as a "one-stop-shop" for all prostate cancer information and guidance.
2. Identifying and debunking misinformation – with over 50% of the most shared cancer articles on Facebook (in 2016) consisting of medically discredited claims, there is a definite need to help patients identify mis-information and understand why certain claims are dubious/false. We propose a regular series of joint communications that identify the latest misinformation in prostate cancer, and cancer in general, and explain why the claims are not valid. This would complement existing work by others, including Macmillan's digital nurse system and The Wellcome Trust-Shift partnership focused on investigating health information on social media and the impact of inaccurate stories.
3. Mentorship and peer support – it was clear from speaking to members of the support groups that, in the lead up to treatment, there is a lack of information around the side effects and the impact on an individual's quality of life. We proposed to create a facilitated mentorship and peer support system for those men that have recently been diagnosed to be able to speak with other men that have lived experience of prostate cancer treatment and care before they undergo treatment themselves. Many men only find out about support groups in their area after treatment, rather than after diagnosis, so it is important for men to be able to connect, with and learn from the experiences of others that have been where they are and know what they are going through at the earliest possible stage. There is also the added challenges of transport and mobility needs that can place strain on a man's relationships with family and friends. A peer mentor could help alleviate some of this by driving/accompanying men to ongoing appointments.
4. A decision-making toolkit – prostate cancer treatment and care should not be regarded as "one-size-fits-all". What might work for one man, may not work for another. At the moment, men have limited agency in the decision making treatment process. We propose creating a decision making toolkit that would follow a patient journey through each possible treatment pathway and provide men a clear idea of the potential impact of each. This would not be about recommending a particular pathway, but rather providing men with a tool that empowers them to understand the options available to them and have an informed opinion on the pathway to follow.

As a research charity, we acknowledge that we do not have the expertise nor the infrastructure to deliver upon all of these activities, particularly with regards to the mentorship and peer support. We are therefore looking for partners with whom we can start to develop a project that meets the needs of men with prostate cancer.



Contact Information

Tel: 07548 033930
 E Mail elpcsginfo@virginmedia.com

From Left to Right Hazel Goulding (Treasurer) Leon D Wright (IT Admin) Stuart Marshall (Secretary) Steve Laird (Vice Chairman) Dave Riley (Chairman)

We are a group of local people who know about prostate cancer. We are a friendly organisation dedicated to offering support to men who have had or who are experiencing the effects of this potentially life threatening disease.

The East Lanc's Prostate Cancer Support Group offers a place for free exchange of information and help for local men and their supporters (family and friends) who may be affected by this increasingly common form of male cancer.

At each meeting we strive to be a happy, supportive and upbeat group of people; encouraging open discussion on what can be a very difficult and perhaps for some an embarrassing subject. We have lively, informative, interactive, sharing and above all supportive meetings.



Jeff Stewart

The entertainment for the Christmas Knees up is a singer / songwriter from the East Lancashire mill town of Colne.

Delivering comic songs and stories with a good dollop of nostalgia.

Sponsors

