

## **APPROPRIATE ANDROGEN DEPRIVATION THERAPY FOR ADVANCED AND RECURRING PROSTATE CANCER**

by Charles (Chuck) Maack – Prostate Cancer Activist/Mentor

**DISCLAIMER:** Please recognize that I am not a Medical Doctor. I have been an avid student researching and studying prostate cancer as a survivor and continuing patient since 1992. I have dedicated my retirement years to continued research and study in order to serve as an advocate for prostate cancer awareness, and, from a activist patient's viewpoint, to voluntarily help patients, caregivers, and others interested develop an understanding of prostate cancer, its treatment options, and the treatment of the side effects that often accompany treatment. There is absolutely no charge for my mentoring – I provide this free service as one who has been there and hoping to make your journey one with better understanding and knowledge than was available to me when I was diagnosed so many years ago. Readers of this paper must understand that the comments or recommendations I make are not intended to be the procedure to blindly follow; rather, they are to be reviewed as my opinion, then used for further personal research, study, and subsequent discussion with the medical professional/physician providing your prostate cancer care.

I have always maintained that despite androgen deprivation with, for example, LHRH agonists or GnRH antagonists as monotherapy or in company with antiandrogens, or with antiandrogens as monotherapy, that androgen receptors (AR) are not entirely blocked from testosterone/androgen that might still be produced, albeit minimal, via testicular Leydig cell production, or certainly still being produced via the adrenal glands. And with this recognition, the importance of 5Alpha Reductase (5AR) inhibition by dutasteride/Avodart (more effective) or finasteride/Proscar is evident to prevent conversion of testosterone/androgen to the more powerful stimulant to prostate cancer cell growth, dihydrotestosterone (DHT). And when we realize that with LHRH or GnRH monotherapy androgen receptors are not restricted from the activity of 5AR by antiandrogen blockade, the importance of 5AR inhibition is even more evident. Thus, the importance of triple androgen/hormonal blockade when treating advanced or recurring prostate cancer.

Should the LHRH agonist/antiandrogen/5AR inhibitor treatment fail, I would expect that the antiandrogen would be withdrawn and HDK/HC would be the next

line of defense if not yet experiencing metastases – or if already experiencing metastases, abiraterone acetate/Zytiga or enzalutamide/Xtandi should be prescribed, since metastases is a pre-requisite for prescribing either of these medications prior to chemotherapy.

For those patients who at diagnosis are already known to have advanced, high grade prostate cancer that has metastasized, a direct move to a series of chemotherapy with docetaxel/Taxotere 75mg/m<sup>2</sup> every three weeks for six cycles has been recommended to begin within four months of starting androgen deprivation therapy, with the patient then returned to continued androgen deprivation therapy medications following the chemotherapy series. This procedure sequence has been found to extend survival compared to moving directly to androgen deprivation therapy medications and waiting for them to fail before moving to chemotherapy.