PRE AND POST TREATMENT CONSIDERATIONS

By Charles (Chuck) Maack – Prostate Cancer Activist and 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.

The following is info I usually provide to patients prior to making their treatment decision:

With the presence of Gleason Score 3+3/6 Active Surveillance may be your option choice, however, should you rather choose a treatment to hopefully remove or eradicate your cancer, or if your Gleason Score is 3+4/7 or higher, your prostate cancer should likely be treated rather than prolonging what I expect will be the inevitable. You want to find a physician, be that physician a Urologist or a Radiation Oncologist, who shows interest in your overall health to develop an appropriate baseline for treatment that includes not only the prostate cancer, but any other health issues that diagnostics might determine could impact on that treatment. The physician should know the health issues of the "whole man" first before determining what treatment choice would likely be most beneficial.

You have the time, and it would be prudent for you to more closely study the variety of treatment options available and make your own selection rather than be persuaded by a physician to follow his direction. Visit with surgeons who provide both open and robot assisted laparoscopic radical prostatectomy (open or robotic surgical removal of the prostate gland). Visit with more than one Radiation Oncologist to discuss if they administer not just Intensity Modulated Radiation Therapy (IMRT) but Image Guided Radiation Therapy (IGRT) as well. Possibly

there is a CyberKnife radiation facility in your area wherein this form of radiation can be administered five times over ten or so days with as complete radiation as IMRT/IGRT that takes several weeks (usually around 7 weeks of daily weekday administration). Possibly a Proton Beam Therapy (PBT) center is in your area, and is another reasonable form of radiation and hailed by many patients who have done so (but again keep in mind that radiation treatment with IMRT/IGRT or Proton Beam requires your presence daily, Monday through Friday, for between seven to eight weeks). Brachytherapy seed implant is another radiation option wherein seeds are implanted within the prostate gland in order to radiate any tumors from "within." This is a one-day procedure, so over and done with in short order. Another form of brachytherapy uses High Dose Radiation (HDR), again over and done with in short order. Some Radiation Oncologists administer both brachytherapy and external beam radiation to hit the cancer from different directions and include the gland periphery with the external beam radiation.

Advantages: Surgical removal of the gland, adjacent lymph nodes (and you should tell the surgeon that you want adjacent and pelvic lymph nodes removed for pathological review), and seminal vesicles provides the pathologist, physician, and you the best picture of whether or not the cancer has spread outside the gland into lymph nodes or seminal vesicles - the pathway to metastasis – or beyond surgical margins of the removed gland. If cancer is found in lymph nodes or just entering the seminal vesicles, or extended beyond gland margins, radiation may be recommended as a "salvage" external beam radiation therapy to hopefully eradicate the cancer in those lymph nodes and in the area of the removed seminal vesicles. If many lymph nodes and advance into the seminal vesicles is noted, more often than not androgen deprivation therapy (ADT) is recommended. More in that regard in the next paragraph.

So, the advantage of surgical removal is that you have radiation as a backup if the cancer is considered to hopefully not have yet migrated beyond any impacted lymph nodes or seminal vesicles. With radiation you have no idea if the radiation was successful in eradicating all cancer cells until you find your PSA is elevating and that elevation is not a "bounce" effect that sometimes occurs wherein the PSA starts to elevate, but then drops on down to an eventual nadir/lowest reading. If the PSA does not drop down and continues in elevation, then you would know that the radiation failed and the cancer has more than likely metastasized though still not showing up in imaging. The salvage therapy for brachytherapy seed implant or HDR would be external beam radiation. There is really no reasonable “salvage” treatment if external beam radiation shows failure. Cryotherapy/freezing is a possible, but I explain in the next paragraph why I don’t, personally, recommend

it. There are surgeons who will attempt surgical removal of the mess that remains in the prostatic bed post-radiation, but there are many other surgeons who remark that it is a very difficult form of surgery since what is left from radiation is more difficult to distinguish what to remove, and there can be complications. With continued elevation post radiation options the patient is then usually moved to androgen deprivation therapy to hopefully rein in the cancer, hopefully eradicate remaining cancer cells, or control and manage the cancer for hopefully many years.

I'm not keen on Cryotherapy (freezing of the prostate) because of the almost certain result of impotence, though not necessarily incontinence. Focal Cryotherapy is also available to only freeze that area of the gland considered to have tumor presence, but again, my concern would be that microscopic PC cells may have migrated to other parts of the gland but not yet developed sufficiently to show up in biopsy or imaging, and if so, the focal freezing would not have eradicated all the cancer.

So, those are your primary options, and if you have the time, you should seek out such facilities and the physicians who administer them to simply "discuss" the option and get a feel for both the physician's demeanor (whether he/she appears to care about you as a patient or sees you as "just another patient"), just how many of the procedure he/she has administered and how often (for surgical removal, you want the physician to have performed well over 250 of either open or robotic, and you want him/her to be doing so on a regular/weekly basis).

For radiation, you want to also ask the Radiation Oncologist how often he/she performs the procedure and also ask him/her about the qualifications/expertise of his/her team that ends up doing the actual IMRT, IGRT, or Proton Beam radiation (every Radiation Oncologist has a team that consists of experienced Radiation Therapists, Radiation Oncology Nurses, Medical Physicists, and Medical Dosimetrists (most patients have no idea that this team is involved in making certain the radiation to be administered is at appropriate dose and targeting).

Keep in mind that to married couples or those with partners, that prostate cancer is a "couple's disease." The emotional impact hits just as hard on the partner as it does on the patient. If possible, the spouse or partner should accompany you on all visits with the doctor regarding prostate cancer to ask their own questions as well as to absorb what the doctor is saying...somewhat a second ear/brain that will remember what you, the patient, may have missed. And as a couple's disease, it is important that you both openly communicate with each other how you feel, what you are experiencing in your mind, so that you both somewhat look after each

other's emotions and concerns. With either surgical removal or radiation, you will experience erectile dysfunction (ED). For some that may be a brief period of weeks to a few months, for others it can extend into a year or more. You can help enhance earlier recovery by beginning NOW taking a PDE5 inhibitor (Viagra, Levitra, or Cialis - your choice) at least every-other day and continuing to do so following whatever treatment option you end up with. The reason is that these medications provide oxygenation to penile tissue as well as arterial blood flow necessary to rehabilitation and return of natural erections. Often, health insurers, if providing oral medications, will only cover a handful of PDE5 inhibitors, so if this is the case, or if you want to save money, you can go to www.alldaychemist.com, a firm in India that likely is the manufacturer for the medications sold here in the U.S., and click on the word "all U.S. brands" that will open a webpage with a long listing of medications available. Scroll down to Suhagra for Viagra/Sildenafil or to Vardenafil for Levitra and click on either to open another webpage with the products, their cost (much less than in the U.S.) and ordering details. Though they also carry Cialis/Tadalafil, they do not ship to patients ordering in the U.S., though they do ship to addresses in Canada. If Cialis/Tadalafil is your choice, go to www.mysecuretabs.com for this product at more cost than from alldaychemist, but much lesser cost than purchasing in the U.S..

If, following whichever treatment, you do not experience the beginning of return of natural erection by 4 to 6 weeks post-treatment, it is then time to consider being prescribed by your urologist bimix or trimix (best to start with bimix) penile injection that also serves to provide oxygenation and arterial blood flow to penile tissue, and near guarantees a good erection. If you want more info in this regard, get back with me and I'll send you further explanation of the procedure.

It is also important to begin NOW kegel exercises. This will help to strengthen your pubococcygeus muscle and consequently the urinary sphincter muscles. This muscle is located between the pubic bone to the tail bone. This, too, should begin now and continue until you know any incontinence issues from surgery or radiation have been remedied by this exercise. Open the following to explain this procedure: http://tinyurl.com/6ng8o6t

Hope this gets you off on the right path, and as you will note below, I am "Always as close as the other end of your computer to help address any prostate cancer concerns."