

Recurring Prostate Cancer

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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.

Info to use with recurrence of prostate cancer post surgical removal of the prostate gland or post radiation to the prostate gland:

The pathology report post-surgery of Gleason Score 4+3/7 or higher (or even at initial biopsy) is the first “red flag” indicator of the possibility of metastasis having already occurred. At that point in time blood serum levels of PAP, CGA, CEA, and NSE should be checked to identify the possibility of metastasis as well as aggressiveness of the cancer. See <http://tinyurl.com/cbdw5lc> .

Recurrence obviously means cancer cell activity continues somewhere within the system. With the surgical removal of the prostate gland – that should mean the source of PSA production has been removed – one's PSA level should likely be less than 0.03ng/ml. If Radiotherapy was the initial procedure of treatment, papers report that a PSA lowering to 0.2ng/ml is expected. If Cyrotherapy is the form of initial treatment, a PSA of 0.5ng/ml is expected. If salvage radiation follows surgical removal, it would still be expected that a final PSA result should be <0.03ng/ml as expected with the surgical removal of the prostate gland in the first place. With recurring cancer, it is important to aggressively and effectively treat the cancer to hopefully eradicate remaining cancer cells, or at least rein in

continued progression that will hopefully result in years of management to control that progression.

Prolactin level should be checked, since if over 5ng/ml it should be treated with cabergoline/Dostinex to bring it below 5ng/ml and preferably below 3.0ng/ml. The reasoning for this is explained here: <http://tinyurl.com/7w5omeo>.

Also recommend blood serum 25-hydroxy Vitamin D level be checked to determine if deficient in this important Vitamin to overall health. Though 32ng/ml is considered the low end of a range up to 100ng/ml, it is preferred to have one's level at least up to 50ng/ml and preferably for prostate cancer patients, within a range of 65ng/ml to 90ng/ml. Reasoning and what to do about it explained here: <http://tinyurl.com/748cx5c>.

Since with possible metastasis one may also be experiencing the beginning of osteopenia or osteoporosis, bone mineral density (BMD) should be determined with either Quantitative Computerized Tomography (QCT) (preferred) or Dual-Energy X-ray Absorptiometry (DEXA) imaging. Bone resorption can also be checked with a Ppyrilinks-D Dpd deoxypyridinole urine test. Foregoing explained here: <http://tinyurl.com/7ewmovu>

In any event, more often when prostate cancer has recurred the prescribing of a bisphosphonate, with Zometa having been the most prescribed in the past, is recommended to help counter cancer tumor effect on bone as well as play a role in apoptosis of some cancer cells. More recently the medication Xgeva/denosumab is heralded as an improvement over Zometa, and an advantage of this new medication, as well, is that it is a subcutaneous 120mg injection every 30 days compared to having to sit through an infusion of Zometa. Important to be aware when prescribed either of these medications is to have all dental work completed prior to administration of these medications since once on them the patient is to NOT have any dental work such as extractions, root canals, or other dental issues that would impact the jawbone. This is explained here: <http://tinyurl.com/3m78ymg>.

Since many men diagnosed with prostate cancer may also be experiencing bone issues of osteopenia or osteoporosis, it is a good idea to consider adding an effective bone supplement formulated for that purpose. I highly recommend looking into this formula development by Medical Oncologist Stephen B. Strum, M.D., FACP, a specialist specifically in research and treatment of recurring and

advanced prostate cancer since 1983, that includes those supplements important among which also explained in this paper: <http://tinyurl.com/ovnhbj5>

In my opinion it would be ridiculous to hold off more aggressive treatment until PSA reached any level beyond 2.0ng/ml. That “wait” could permit recurring cancer to already be running rampant and metastasis becoming symptomatic.

ADT should be seriously considered and my preference would be triple hormonal blockade (aka ADT3) with an LHRH agonist (Lupron, Eligard, Trelstar, Zoladex) or the GnRH antagonist Firmagon/degarelix; the antiandrogen bicalutamide (the generic of Casodex); and the 5AR inhibitor dutasteride/Avodart. The reason and their different purposes are explained here: <http://tinyurl.com/3ulagd2>. Supporting information in this regard are provided in these two papers: <http://tinyurl.com/3dxq43u> and <http://tinyurl.com/3gfd23r>. And since there are side effects that might be experienced, an explanation and remedies are explained here: <http://tinyurl.com/3p9pl3p>.

The following is a controversial subject but included for awareness to be discussed with one’s Radiation Oncologist if concerned:

If salvage radiation is being considered as the result of failed surgical removal of the prostate gland, the following two paragraphs, according to Medical Oncologist Charles E. “Snuffy” Myers, also well known as an expert specialist specifically in research and treatment of recurring or advanced prostate cancer.

His concern is the effect radiation therapy has on the Immune System CD4 T-helper cells/lymphocytes. It appears from a video presentation he made in this regard that external beam radiation to the entire prostatic bed and its periphery to include adjacent lymph nodes and entry to seminal vesicles can have a very damaging effect on these CD4 T-helper cells, some of the most important cells in our immune system protecting us from viral infections; helping other cells fight bacterial and fungal infections; producing antibodies; fighting cancers; and coordinating the activities of other cells in the immune system. I am not aware whether brachytherapy requires this same concern.

Dr. Myers discussed radiation to oligometastatic prostate cancer wherein cancer may have spread to 5 or less lymph nodes or 5 or less bone locations. Targeted radiation to these specific locations (rather than wide spread radiation) apparently would have a lesser effect on CD4 T-helper cells in the

path of such radiation and thus be of less concern. But even with this remark, Dr. Myers feels that even such targeted radiation requires much more research, study, trials, and current Radiation Oncologists performing follow-up testing as to whether the number of CD4 T-helper cells have been sufficiently diminished to have affected the immune system.

In my opinion, rather than see this as an absolute for concern, I more agree with Dr. Myers as noted in this last paragraph: ...such targeted radiation requires much more research, study, and trials... as well as... Radiation Oncologists performing follow up testing as to whether the number of CD4 T-helper cells have been sufficiently diminished to have affected the immune system. We would hope with such follow-up testing of CD4 T-helper cells and reporting of Radiation Oncologists of the results of that testing a consensus of opinion would be determined whether or not this should be a concern.

Take the time to read the material referred herein. Read it several times to help understand the importance of the considerations identified. This “empowers” the patient with sufficient knowledge to not just “do what the doctor orders,” but rather be an involved partner to discuss with reasonable understanding what should be appropriate future treatment.

If interested in my prostate cancer, advocacy, and mentoring background, please visit my website www.theprostateadvocate.com and also click on the menu word “Observations” to access over 230 papers regarding prostate cancer, its treatment, and treatment of the side effects that too often accompany most any treatment option.