

Book - Prostate Cancer Treatments – Chapter 1 –
“Too Many Radicals and Too Many Failures”

Prostate cancer is a disease that does not discriminate, wreaking havoc on the lives of young men, older men, wealthy men, poor men, wise men, leaders, followers, educated men, under-educated men, accomplished men, underachieving men, black men, white men, red men, brown men; men from all over the world. Regardless of their educational background, when it comes to prostate cancer, all men are equally ignorant. Make no mistake about it, prostate disease in general and prostate cancer specifically, is a disease for all ages. The disease has no boundaries, no conscience, and will strike most times with no warning other than an elevated PSA (prostate specific antigen). Your only defense is to be educated on the disease, get motivated and become proactive while optimally maintaining a PSA of less than 0.7 ng/ml. Many of those who fail to heed my warning will pay the ultimate price with their life. Many others will be spared but asked to endure a life of subtraction, losing the qualities of what makes being a man so special.

While prostate disease is the number one health risk that men face, prostate cancer is the most prolific organ cancer that men acquire in their lifetime as well as the second leading cause of cancer death. To state more specifically, one in five-six men will be diagnosed with prostate cancer in their lifetime while, if we live long enough, all men will get prostate cancer. Unfortunately, African-American men have a rate of prostate cancer that is twice their Caucasian counterparts. According to the American Cancer Society, an estimated 230,000 men will be diagnosed with prostate cancer this year while in excess of 30,000 men will die from the disease. This translates into a new case of prostate cancer diagnosed every three minutes while a man dies from prostate cancer every 16 minutes of every day, of every week, of every month, for every year. With the baby boomer generation aging into their 50s and 60s, the expectation is for 50,000 men to lose their life annually secondary to prostate cancer by the year 2020. While men in their 60s experience the news that prostate cancer has been detected most frequently, 30% of 30 year old men will acquire the disease only to have their lives spared initially as this renegade disease incubates for upwards of 15 or 20 years before the impact is realized with a rising PSA (prostate specific antigen) blood test enabling the diagnosis to be made in the majority of patients. When you decide to become motivated to learn more about this disease is your business; what you learn about the disease and how you treat the disease is my business and the heart and soul of this book.

Historically, radical prostatectomy (total prostate removal) has been the most common treatment offered and rendered when prostate cancer is diagnosed. The irony of treating the most prolific male cancer most frequently with radical prostatectomy is that the failure rate will be equally prolific. While prostate cancer is being detected earlier, there is no convincing data to suggest a survival advantage of radical prostatectomy over brachytherapy (seed therapy) with or without external beam radiation, external beam radiation alone, cryosurgery or a treatment strategy called chronic disease management (CDM). Only with Watchful Waiting (which I do not recommend) is there a slight survival benefit to radical prostatectomy. To put this in proper perspective, there is

significant data to suggest alternative therapies like CDM may make the better first choice when the inevitable happens and the disease comes calling. If 10 men with prostate cancer are lined up and evaluated, doctors cannot predict accurately who will be cured and who will fail regardless of who presents with the best disease characteristics. Equally unsettling is that all 10 men must receive the most aggressive and destructive treatment (radical prostatectomy) to yield a 60-70% success rate at 5 years regardless of the choice of Operating Physician or Medical Center selected for the surgery. 10 year data is another story of limited success and will never be as good as the number of successes at 5 years. In effect, regardless of our surgical skill, the outcome from major surgery is reduced to a guessing game where the outcome always remains in question. So why is radical prostatectomy performed so often? While this is a great question, the answer is very elusive. We hear phrases like, “that’s what I was trained to do”, “it’s the Gold Standard in prostate cancer treatment”, “it’s the only way that we can be sure that all of the cancer is gone”, and/or “this procedure gives you the best chance for cure”. When a patient asks a doctor for his best recommendation and all he performs is a radical prostatectomy, what do you expect him to say? Even if the doctor performs seed therapy, cryosurgery and radical prostatectomy but believes the radical approach is best for most patients, do not expect to hear a glowing endorsement for either of the other two choices? While doctors are supposed to be unbiased in their educational approach, it is difficult to remain completely unbiased when the meeting between doctor and patient may be the only meeting the doctor has to make an impact. Remember, treating prostate disease is a business too.

In a survey of more than 500 Urologists (reported in JAMA 283: 3217-3222, 2000), the question was asked of Urologic Surgeons; what approach should be taken with a 65 year old male with a newly diagnosed prostate cancer associated with a Gleason score 7 and a PSA (prostate specific antigen) of less than 10.0 ng/ml? For those unfamiliar with the meaning of Gleason score, I refer you to the glossary and/or the pathology section for a review. For those more familiar with the term, a Gleason score of 7 (a moderate to poorly differentiated cell type) is commonly encountered in approximately 30-35% of the cases of prostate cancer. Relevant to the questionnaire and to the surprise of no one, a traditional Urology line of thought was followed by 90% of the Urologists polled, who would have recommended a radical prostatectomy for this patient. While this opinion from a surgeon may come as no surprise, there is minimal documentation to support the strength of such an opinion. In an effort to establish diversity of opinion, noting that doctors would only recommend what was best for the patient; Radiation Oncologists were asked their recommendation for the same patient with the same cancer characteristics. Can we expect Radiation Oncologists to be more objective than the surgeon? No, not really, as the majority of Radiation Oncologists followed their residency training manual and recommended brachytherapy (radiation seed implantation) or external beam radiation and/or a combination of both. Patients, therefore, who seek these professional opinions, must be mindful that it may be difficult to get an unbiased opinion from a physician who is biased to how he was trained and how he practices. It is often said and bears restating; **“If all you have is a hammer, it is amazing how everything begins to look like a nail”**. I am not trying to be overly critical but this is the perception that we are giving. If you can’t get a straight answer from your doctor; then

who do you trust - who do you believe? In this imperfect world, the burden for an improved understanding of the disease and its various treatments, unfortunately, becomes the responsibility of an undereducated patient. This doesn't seem quite fair as little has been done to diminish the anxiety the patient experiences when the diagnosis is made.

Based on a likely rush to judgment that is commonly experienced when the diagnosis of prostate cancer is made, patients are encouraged to become increasingly aware of the peril and consequences associated with prostate disease treatment prior to the event; not after the event.

Taking the time to study your options is supported by research performed at Johns Hopkins Medical Center. What they demonstrated is that while the diagnosis of prostate cancer must be taken seriously, a delay in treatment of months or even years may not change the course of the disease and the outcome. While this will likely depend on the specific characteristics of disease identified in a given patient, the news is nonetheless, heartening as the task to understand the disease and the various options is significant and will take a concerted effort and ample time by all who choose to be well versed.

This book will, therefore, serve many worried men and families as an objective resource that must be carefully understood before the decision is made on how the disease process of prostate cancer is handled. While it is critical to determine the extent of disease in order to select the best treatment strategy, it is equally important to realize that few of us understand the futility of this diagnostic process based on our current imaging tools and random biopsies. It is for this reason that I am very excited about Magnetic Resonance Imaging Spectroscopy (MRIS) discussed later in this book. To state further, MRIS, performed with a 3.0 Tesla magnet may well be the best diagnostic modality for prostate cancer that will insure the most accurate decision making based on clarity of image quality giving us the greatest chance for ultimate success. This scan, which I call the "Ultimate Prostate Scan", will provide precision prostate cancer localization allowing us to validate whether the tumor is truly organ confined or not. In other words, the MRIS scan, using a 3.0 Tesla magnet for excellence in focal disease localization and spectroscopy should represent the most integral baseline diagnostic scan validating any decision that is made relevant to how to treat the disease.

Conservatively speaking, while our prospective study data evaluates the benefit of diet and nutrition versus prostate cancer, it also supports the concept of allowing men the opportunity to live with prostate cancer much like patients would live with Diabetes or Arthritis rather than undergo organ removal or radiation. If men decide later to attempt to cure the disease, their chance of success should not have been diminished by the delay. In other words, time is an ally that allows us to avoid a rush to judgment. Quite frankly, by delaying a choice of definitive decision making, anxiety is reduced, as the advantages and disadvantages of every therapy becomes better known. Better stated, you cannot accept the consequences of your decision until you fully understand the lifestyle you have to accept when the choice is made. The key to the success of our research treatment protocol relates to the ability to suppress and/or resolve the signs and symptoms of inflammation (non-bacterial prostatitis) through a dietary supplement as validated by an improvement of white blood cells associated with the prostate secretion. While diet plays a role, the

concept will become obvious once you have reviewed the dietary and nutritional sections in this book. Relevant to the prospective study, 23 patients with known prostate cancer had been evaluated over an average time frame of 38.5 months. 20 out of 23 patients noted a marked improvement or decrease in their PSA (the recognized marker of disease activity) of 58%. This is truly remarkable and quite frankly has never been seen before in this large of a study group. While I am pleased with the outcome, I am not surprised as I have experienced significant improvement in countless patients over the years. To state further, this concept has not been studied adequately, heretofore, as it has never received priority funding. It is my hope that visionary philanthropists, who support and understand my beliefs, will come together to provide the capitol expenditure that will validate the research that I have done as well as promote a prostate cancer prevention trial. The Prospective Study, touched on above, will be described in its entirety later in this book.

Let's take a look at a typical clinical case that allows us to better understand the present state of prostate cancer treatment and the associated angst that comes with the diagnosis. Jon Freda, a 54 year old Caucasian male, was diagnosed with prostate cancer with a Gleason score of 6 (3+3) associated with a PSA of 4.2 ng/ml. A Gleason 6 prostate cancer designation comprises the most common cancer cell type identified, as well as recognized, as the cancer type that predicts the most favorable clinical outcome. This is the group of patients that Pat Walsh, M.D. and the team at Johns Hopkins and other major centers of excellence use to show their respective level of confidence in their outcome data, to validate their treatment choice of radical prostatectomy for prostate cancer. This is also the group of cancers that many experts believe are over treated. In other words, many men in this category would do equally well with a radical prostatectomy (assuming cure) or with a more conservative approach like chronic disease management (reference the Prospective Diet & Nutritional Study) or active surveillance if offered. It is for this reason that word needs to be promulgated throughout the world that CDM is a viable alternative to radical prostatectomy or radiation when this category of cancer is diagnosed.

Based on Jon's relative youth and fear of impending death from a, presumably, less than predictable disease, the patient agreed to a radical prostatectomy at the urging of his family and surgeon. Now 6 years later the patient's PSA (prostate specific antigen) is rising consistent with treatment failure. A progressive rise in PSA following any attempt to cure signals the failure of the operation or radiation to cure the disease. This is also called biochemical failure or disease relapse. A rise in PSA despite the removal of the prostate tells you that the disease had escaped the prostate while looking to find a new source of nourishment in your lymph nodes or bones (or both). It is estimated that the range of disease recurrence following radical prostatectomy or radiation is 30-40% and possibly as high as 40-60% by 7-10 years (fn). The earlier the rise in PSA following surgery or radiation and/or the failure to nadir the PSA to less than 0.5 ng/ml suggests that the disease is more aggressive and was likely systemic at the time when the disease was thought to be localized or confined to the prostate. Unfortunately this information does not help us after the fact except to predict a troubled and probable aggressive clinical course that will likely hasten our demise. The only way to have avoided this misstep is to have avoided the surgery that you thought would get rid of the disease in the

first place. Confused? Join the millions, who like you, are going to learn first hand from this book and the experiences of others. Minimally the failure of Jon Freda to be cured calls into question the ability to cure anyone with certainty and should slow the march of the ignorant or educationally challenged to the operating room door.

Our data suggests the failure to cure a patient when radical prostatectomy or radiation is performed, bodes poorly for the patient. Specifically, according to Anthony D'Amico and colleagues, when the PSA doubling time (the time it takes for the PSA number to double) is less than 3 months following radical prostatectomy or radiation, the patient has a 20 times increased chance of dying from prostate cancer within 6-10 years. Importantly, our clinical research concurs showing the clinical course observed for the patient who isn't cured by radical prostatectomy or radiation will be a much more aggressive battle to fight than the individual who chose the more conservative treatment concept associated with a strategic chronic disease management protocol, whereby, the patient learns to live with the disease. Examples will be provided through out this book that will make this point very clear.

Returning to the case of Jon Freda; again, a gentleman who could have lived with this disease very easily, there were issues other than a rising PSA following the failed attempt at cure with radical prostatectomy. Ever since the operation, this patient has been a sexual cripple; meaning that he cannot achieve adequate erections despite the use erectile stimulating drugs like Viagra (the little blue pill) or Caverject. He also complains of urinary leakage but this would be manageable if only the operation was a success. What is sad is that this patient should have been cured as his disease characteristics could not have been more favorable; suggesting that anything short of cure is a significant failure. This case history establishes very clearly why a more conservative approach may have been the better first choice. Unfortunately, Jon had never been told that he could live a long and prosperous life with the prostate remaining untouched using a chronic disease management protocol. Had this happened Jon would not have been the first patient discussed in this chapter.

While hind site is 20/20, this is the reason, nonetheless, that patients must become increasingly aware that radical prostatectomy is not what it is made out to be. There are no guarantees even when you hear...the treatment represented gives you your best chance at cure. Improved awareness and understanding of the topic is the only defense that will allow the patient to comprehend the options discussed; but more importantly, to walk away and rethink what has been discussed absent the emotion of the moment. While our patient Jon Freda paid the ultimate sacrifice, in my opinion, for an unnecessary chance at success, I believe he would have been willing to live with quality of life limiting side effects of impotency and incontinence had the cure been achieved. At this junction in Jon's life, he is now facing off with the next set of questions that will require intelligent decisions related to how the disease will now be managed. His choice at this point is to consider radiation or chronic disease management (active surveillance). Radiation, replete with its own set of side effects, including rectal bleeding and radiation cystitis, is also likely to worsen his already limited potency as well as worsen his ability to control his bladder. A much more reasonable approach would be the use of a CDM (chronic

disease management) or active surveillance protocol. At this point, his cancer will respond very favorably to hormone manipulation via anti-androgens (Flutamide, Casodex or Nilutamide) given intermittently. While his PSA is just beginning to rise from the nadir of 0.2 ng/ml, no one knows that the disease will not stabilize when conservative measures are employed as no two cancers are alike. Besides, earlier treatment with an LHRH-analog or anti-androgen at a lower PSA number will hasten the onset of hormone refractivity, a well known consequence of hormonal manipulation. Furthermore, I would not discount the role of diet and nutrition to assist holding the cancer in check by extending the doubling time of the PSA rise. When the PSA reaches a higher and more definable number, I would use various products or formulas associated with various mechanisms of action versus the disease process in an effort to enhance a successful outcome, thereby, prolong life. Remember, while there is no clear decision choice, there are also no tests that can tell us with certainty where the cancer is located or whether the cancer will respond to conservative measures; now that radical prostatectomy has failed to be the treatment to cure the disease. At this point, I will assist Jon regardless of the choice he makes and do all I can to foster his success, including the application of a CDM protocol in the event radiation is chosen and fails. It is not as important why this clinical scenario happened with Jon, but rather, how can we prevent this from happening to other men, like: Paul, Jack, Scott, Brad, Mike, Steve, Bill, Dave, Harry and all other male members of the human race!

Carl Lackey's case history and clinical experience is equally riveting for even the most learned or savvy prostate cancer patient! A 60 year old former All-American hockey defenseman at Michigan State University, who now resides in Green Bay, Wisconsin, Carl learned he had prostate cancer when his PSA reached 8.2 ng/ml in October, 2004. The year prior, his PSA was 3.9 ng/ml. It is unfortunate but when he asked if there was anything that could be done to try to lower the PSA, he was told by the doctor it was still in the normal range and not to be concerned. A 12 core biopsy, performed based on the 8.2 ng/ml PSA, yielded a Gleason 4+4 cancer in 3 out of 6 biopsies on the left side and a cancer precursor cell type, High Grade PIN (prostatic intraepithelial neoplasia), on the right side. His biopsy stage was T2b meaning that significant disease (cancer) was located in more than one area on the left side of his prostate. Following the biopsy, the PSA value reached a high of 13.0 ng/ml. Given the poorly differentiated cancer cell type, he went about the process of trying to determine the best way to defeat the disease. 3 Urologists representing 3 different Urology practices had recommended that a radical prostatectomy was his only chance to survive the disease. One urologist went so far as to state; if he did not have the radical surgery, he would be dead within 1 year. Concerned for his well being and quite frankly scared beyond belief, Carl had decided hastily that surgery seemed like the only option. He had completed his pre-op evaluation and had received the hospital wrist band identifying him to all hospital personnel. At home, his wife Sandy was feverishly looking for other options as she did not feel good about the choice that the man of her life had made. Several days prior to his early morning arrival at the hospital for the expected surgical procedure, Carl's life changed. Sandy had come across my website, www.TheProstateCenter.com and placed a toll free call to the clinic. While I can't recall if it was that day or the next day, I had a chance to talk to the man with the disease about his treatment and what, if any, was his expectation from the

surgery. After a brief factual and straightforward discussion, Carl cut the hospital wrist band from his arm and scheduled an appointment at my clinic in Sarasota, Florida. In our conversation, I had said nothing that would diminish his hope for a successful outcome, although, I had informed him that while radical prostatectomy may have provided his greatest percent chance for cure, as represented by his 3 urologic consults, **no one informed him, the percent chance of cure was only 15%**. In other words, 85% of all prostate cancer represented by Gleason Scores of 8,9, or 10 have disease recurrence within 5 years. He was incredibly disappointed that no one had discussed the literature based facts on the historical, surgical futility associated with this cancer grade, but rather, opted for a leap of faith to save his life. No one had allowed Carl and Sandy the opportunity to understand that what they were about to do, made little sense and was obviously the wrong approach based on well documented statistics and therefore, should have been out of the question as an option.

By making the commitment to see me in the clinic, Carl and Sandy had become a member of my extended family. During the 3 hour plus clinical evaluation and interview process, I reviewed viable options including the option of allowing Carl to live with the disease through a protocol of chronic disease management. Minimally, this option would buy us some time while not burning a bridge; allowing us to be more aggressive later if an option presented itself that made sense when the risk-reward discussion took place. My clinical experience allowed me to share other patient success stories using the CDM concept. Together we created and accepted a treatment strategy that was intended to minimally stabilize the cancer disease process. I made it very clear that we were in this together and I was as close as a telephone call. He could count on me as a brother as I was confident we could make a difference. Based on his heightened disease status and dangerous Gleason Score, I elected to start him on a CDM protocol that included various mechanisms of action to suppress the disease or make it less aggressive or even dormant. Without going into a lot of detail here, he was placed on a patented prostatitis formula called, Peenuts®. This is a synergistic blend of vitamins, minerals, herbs, and amino acids that has shown the unique ability to resolve the signs and symptoms of prostatitis. This was an important step as prostatitis has been shown to evolve into prostate cancer by many research experts including the American Association of Cancer Research (AACR) and David Bostwick, M.D., world renowned Pathologist. Carl was also started on Avodart at 0.5 mg daily to decrease the conversion of Testosterone to Dihydrotestosterone (DHT) as well as promote an anti-angiogenic component (decreases new blood vessel formation) while reducing the size of the prostate. He knew full well that the PSA would be decreased by some number less than half based on the presence of benign prostatic hyperplasia cells and cancer cells. I was also cognizant of the benefit demonstrated by the Prostate Cancer Prevention Trial (PCPT) where this class of drug (Avodart or Proscar) was associated with a decreased incidence of prostate cancer by 25% when compared to placebo. While I had no data to show specific benefit versus prostate cancer with this drug, I did not want the cancer to be exposed to DHT, the more desirable form of the cancer growth promoting male hormone. Vitamin D3 (the active form of Vitamin D) was added for its benefit in decreasing prostate cancer cell proliferation. (fn) Additionally, Omega 3 fatty acids were added to enhance the Omega 6: Omega 3 fatty acid ratio, thereby, enhancing heart health and a possible mechanism

versus prostate cancer. The modified Mediterranean Diet was the diet of choice (rationale for this diet will be discussed comprehensively in the diet section). The last integral piece of the treatment strategy was the use of Casodex (Bicalutamide), a non-steroidal anti-androgen, used at 150 mg per day, similar to the dose effectively used in Europe. I have had tremendous experience using Casodex at the aforementioned dose as a monotherapy. This represents a higher dose than that typically used in the United States but is quite safe and effective when used intermittently. Specifically, the anti-androgen blocks the prostate cancer cell receptor, thereby, inhibiting the growth of cancer. To state this differently, Testosterone, which remains normal to high in this treatment scenario, is preferentially blocked from its usual action of attaching to the cell receptor in the presence of the anti-androgen. The concept is analogous or similar to what you would expect to see when you put plastic child safety caps on an electrical outlet. No matter how hard you try to connect the cord of a lamp (as example) to the source of electricity, you can't do it. Thusly, Casodex blocks the interaction of DHT with the cell receptor and promotes cell death preferentially over cell growth.

While there are a few side effects from the use of Casodex, as a monotherapy, including but not limited to a transient elevation in liver enzymes, mild breast tenderness or swelling, and the potential for diarrhea, the side effect profile is acceptable for the anticipated short duration of usage. The side effect profile, nonetheless, can be avoided using additional medications or supplements that would minimize and/or eliminate these concerns. Using this approach, we were able to avoid an LHRH-analog (Luteinizing Hormone Releasing Hormone), thereby, by-passing chemical castration associated with its host of undesirable side effects including but not limited to: lethargy, increased fasting blood sugars secondary to decreased insulin resistance, muscle wasting, hypercholesterolemia, anemia, bone loss, hot flashes, cognitive changes, depression, mood swings, and weight gain. When used as a monotherapy, intermittently, disease specific anti-androgen therapy has a tremendous lifestyle advantage when compared to the more traditional monotherapy of an LHRH-analog alone or in combination with an anti-androgen (combined androgen blockade).

The decision was made to use the anti-androgen intermittently between PSA action points of 10.0 ng/ml and 1.0 ng/ml. 10.0 ng/ml or higher would mark the point where Casodex would begin and 1.0 ng/ml or lower would mark the point where the Casodex is discontinued. Carl remained on the protocol for 17 months in total. The Casodex was used only for the first two months, dropping the PSA (the marker of disease activity) from 13.0 ng/ml to 0.3 ng/ml. In effect, Carl had been off of Casodex for 15 months, while his PSA had remained stable at 1.7 ng/ml. This response represents a truly remarkable turn of events for a very bad cancer, possibly never recorded before in the annals of medicine. In his yearly follow-up appointment to the clinic, Carl's white blood cell count associated with the expressed prostatic secretion had gone from TNTC (too numerous too count) down to 45 white blood cells when reviewed under 400X (microscopically). This represented a 91% decrease in the inflammatory response; a process that promotes prostate cancer evolution, while mitigated by the patented prostate nutritional formula, Peenuts®. His urinary symptoms had improved from 10.5 to 1.5 in

the same time frame representing an improvement in symptoms of 86%; again, attributed to the same nutritional formula.

In his follow up, rather than discussing his demise or worse yet, death, as predicted by his previous Urologist, the three of us celebrated a measure of victory versus an unpredictable and potentially deadly disease. We had demonstrated the success of chronic disease management in a very difficult case presentation. While I believe this case represents one of the more spectacular responses of prostate cancer to chronic disease management, highlighting Casodex as a monotherapy, we should not diminish the impact of key nutrients and medications as outlined previously. While I am sure I will hear from my colleagues that this case is “too good to be true”, I always welcome calls from any of my critics. More importantly Carl and Sandy would be happy to share their joyous experience with those who care to contact them. Maybe some day, Carl and Sandy will be able to tell their story on a bigger stage, thereby, bringing more than just hope to the hundreds of thousands of men who face the uncertainty of prostate cancer everyday. Now, with the disease suppressed, the Lackeys decided to take another step; in effect, to take a calculated risk to get rid of the disease once and for all, by undergoing High Intensity Focused Ultrasound (HIFU) at a site outside of the USA under my supervision. HIFU is still under FDA scrutiny and therefore not offered on US soil as of June, 2006. Carl’s progress will be monitored by a spectral analysis of his prostate, using the 3.0 Tesla magnet from General Electric to validate an absence of disease without the need for additional biopsies to confirm. I refer you to the section on Magnetic Resonance Imaging Spectroscopy (MRIS) for an improved understanding of this technique, as well as rationale, for why prostate biopsies may soon be a technique of the past as the procedure of choice commonly used to confirm treatment success.

So when the diagnosis of prostate cancer is made in your case, what will you do? Will you try to live with the disease or do you have to remove the cancer at any cost? Is your goal a cure and if so, is this realistic? While I never want to deprive you of hope, false hope and unrealistic expectations is unfair to you, the patient, who so desperately wants to succeed. If cure is possible, what are the chances of success? Is it worth the risk when your chance of success is less than 50%? If cure is impossible, what is the best strategy to ensure the best outcome? This is not as simple as applying a radical prostatectomy or radiation to a cancer but rather lies in a multi-factorial approach that may include a radical prostatectomy or radiation but only if the odds of success are overwhelmingly in your favor and you are willing to take the risk. Based on the inability to predict success predictably versus prostate cancer suggests that we should take our time and consider all options including CDM before the commitment is made to proceed. Get a second and a third opinion! If you act on impulse and make the incorrect choice, you will have, what will appear to be, a lifetime to lament the error in judgment.

William Fair, M.D., former Chairman of the Departments of Urology and Surgery at the esteemed Memorial Sloan-Kettering Cancer Center was so frustrated with his inability to predict a successful outcome with radical prostatectomy or radiation for prostate cancer patients that he stated in a now famous speech from 2000; **“Based on everything we know about prostate cancer, I am not sure that it should not be treated as a chronic**

disease”. While I am not saying that radical prostatectomy is obsolete yet, I am saying that if we continue to apply the same therapy to every patient without an improved understanding for treatment success as well as limiting the procedure to only those who best qualify, the future of radical prostatectomy will be doomed based on the public’s perception suggesting a lack of physician understanding of the disease, greed and/or inappropriate dogma tied to a disease we know too little about. What Bill Fair may truly have been seeking was a moratorium on radical prostatectomy and radiation therapy until he and other research experts could figure out the natural history of the disease, thereby, selecting patients for a treatment based on a sound strategy as opposed to “one size fits all”. There is rarely a doctor among us who will share Dr. Fair’s commentary with his newly diagnosed prostate cancer patients, much less, investigate valid conservative options as appropriate care. These conservative, yet effective, options will be addressed in chapters on minimally invasive treatment like cryosurgery and high intensity focused ultrasound (HIFU) later in this book.

For men with PSA levels of greater than 1.0 ng/ml, it is not too premature to begin to think about the educational process as you will learn later in this book that 20-30% of all prostate cancers are in the range of 1.0-4.0 ng/ml. If you wait, you could face the same tough decisions that faced Jon Freda who never knew he had another option or you can think ahead and begin planning your strategy as if you had the disease and have the success of Carl Lackey. Will you be a willing participant when a biopsy is recommended when the PSA exceeds 4.0 ng/ml (20-30% of biopsies are positive in this range) or will you reach out to an improved technology like that available at the Diagnostic Center for Disease in Sarasota for a confirmational MRIS first, noting that more biopsies are negative than positive? Random biopsies should be discouraged based on the sampling bias as well as the relatively low risk of prostate cancer on any given prostate biopsy procedure; not to mention the risk of spreading cancer cells (if present) beyond the prostate. Will what you have read thus far stimulate you to be proactive and try to avoid an inevitable disease by controlling prostatitis with a patented, scientifically proven, prostatitis formula called Peenuts® or are you content to be reactive and take your chances that the disease won’t come your way? Whatever your personality, whatever your choice, I am dedicated to making a difference with you when the time comes. If cancer is inevitable, I want your case to be predictably successful giving you the opportunity to continue to take from life all that is yours. The remaining chapters in this book are instructional and will make you think. What makes this book different from other prostate books is that I will not pretend to be the expert in every facet of prostate cancer. For this reason, I have brought together national, if not world experts who are prepared to present the facts in a fair and balanced format as well as respond to tough questions where they may not have the answer. For these and other reasons, I encourage you to use this book as a learning tool, as a reference and as a guide to keep you health conscious while protecting your prostate and your heart. It has taken me years to do my research and years to write this book, so please take your time to read it carefully and absorb it so that you are equipped to face the battle, should the disease present itself.