Living Well with Prostate Cancer

Quality of life is a major concern of patients when they are choosing treatment for prostate cancer. Our prostate cancer panel led by Mike Scott is talking to Dr. Paul Schellhammer, a prostate cancer survivor himself, about treatment outcomes and post treatment quality of life, from his own experience as a patient and 40+ years of treating prostate cancer patients.

Full Transcript:

Priya: Good Evening and welcome to Curetalks. This is Priya Menon joining you from India on Cure talk on 124th episode. Today we are discussing – Living well with PROSTATE CANCER. Our Prostate cancer talks are conducted in association with the Prostate Cancer International and The Prostate Cancer foundation. My co-host for the show is Mike Scott. Mike is co-founder and president of Prostate cancer International – Prostate Cancer specific and not for profit, educational and informational organization based in Virginia. He is the former chairman of the board of National organization for rare disorder and is a board member of International Myeloma foundation. Joining Mike on the panel are Prostate Cancer advocate Paul Carpenter, Jan Manarite and Rick Davis. Dr. Paul Schellhammer is patient advocate for men diagnosed with Prostate Cancer. He has contributed to dozens of online groups and forums. He co-founded a Los Angeles support group for gay and bi-sexual men living with prostate cancer. He was diagnosed in 2007 with gleason 5 +4 disease. He has undergone 8 different treatment modalities so far, including surgery, radiation, chemotherapy, immunotherapy and ADPE.

Jan is widow caregiver, educator and advocate for 15 years currently vice president of Prostate cancer international. Jan's husband was diagnosed in 2000 with a PSA that was over 7000. He had bone metastasis almost everywhere including his skull. Jan began to advocate for him and read his medical records and ask for better questions. He lived for 13 years. Rick is a patient advocate and founder of Answer Cancer Foundation. Answer Cancer foundation diagnosed with locally advanced Prostate Cancer in 2007 and treated with radiation and hormone therapy. He speaks frequently on Prostate Cancer forums and planned patient navigation. Welcome to Cure Talks everyone. Thank you for finding time to be with us today.

Quality of life is a major concern of patients when they are choosing treatment for Prostate cancer. Today our Prostate cancer panel led by Mike Scott is talking to very distinguished expert Dr. Paul Schellhammer a Prostate cancer survivor himself also has over 40 years of experience of treating Prostate cancer patients. He has served as a professor at Eastern Virginia Medical School and has made many contributions to the field of urologic-oncology to research initiative. He has been published several times and serves on several editorial boards. He has also served as a President of the American Urology Association. Welcome to Cure talks Dr. Paul SchellHammer. It's a pleasure!

Dr. Paul SchellHammer: Thank you

Priya: In the coming hour we are going to discuss living well with prostate cancer and treatment outcomes and past treatment quality of life. We will be addressing questions from audience towards the end of the discussion. If you have a question for the doctor or the panel please email it to priya@trialx.com or post it on curetalks.com. You can also let us know by pressing 1 on your keypads and we will bring you on air to answer your questions. With that Mike I hand it over to you. You are on air

Mike: Thank you Priya. Sorry for interrupting you. Good evening Dr. Paul Schellhammer! How are you?

Dr. Paul Schellhammer: I' m well Mike Thank you.

Mike: What we would like to do is give you 15 minutes just to talk about your personal experience and trying to maintain your quality of life while you have been living with Prostate Cancer. What you really think works for the majority of men based on that experience and also on your own experience as physician in managing Patients as well. I am not too worried whether friend of mine is supported. I think what we need or every man needs to know is, what are the basic things they can do to maintain their quality of life from physical and psychological point of view, after they have been diagnosed with various forms of treatment?

Dr. Paul Schellhammer: I would say that my situation is similar to some of the other panelists with regards to the therapy they received that include surgery, post-surgery radiation, subsequent radiation to metastatic sides of immune therapy, androgen deprivation therapy and I have not as of yet had those chemotherapy or radium 223 but just about every other androgen deprivation, manipulation available including internal estradiol, which I'll comment on in a moment but I would just start out by taking a couple of words that are very commonly used in the cancer community and I believe sometime not to insist on those words that are not entirely accurate or appropriate. One of them is War, we certainly are in a battle minded environment and culture what we got and not only the real wars of our country over the past 15 – 20 years but everything else seems to be a war whether it is sports or picnics or even interactions in politics, but for cancer we often talk about Patients more on the cancer and their battle on survivorship and I am looking specifically across Cancer which we all know can be a lethal disease but it's usually a disease that takes years and many years to reach that endpoint and if unfortunately it does so and it is my job to control almost there and patient's life expectancy is met by some other disease process. If one has a cordoned battle minded mentality day in and day out it becomes exhausting because it becomes energy depleting and the ability to get on with your life and live well with cancer – it is compromised by the attitudes that every day is a day of battle.

The other word is Cure and as a physician I am wary of using the word and using that concept early in my practice frequently and I have learned over the years both with regards to my own experience and experience from many patients that it is a evanescing term and it is one that every patient wishes to achieve whether by some chemical object, means or some surgical intervention. The reality is we really don't know the biology of malignancy well enough to say but yes indeed whatever we have done has killed every cancer cell and that we can get on with our life almost as it was before without any issues or problems. Another word is in Latin roots is 'curae' which means to 'Care for' so the idea of continuing care without the expectation of absolute cure has to be moderated and discussed in a way that is realistic and appropriate. I will bend on another word which is survivor, which again I feel the battle of the soldier who comes from a particular battle and who walks out intact is the survivor and it's reasonable to use the analogy for cancer for treatment but we know that survivor in the world of cancer is time related 3 years survivorship, 5 year survivorship and so forth. After all the therapy that I have thought about and participated in and discussed with physicians, I think the participant in the long run is more of an appropriate identifier for a patient who has had recurrence of disease, had to participate in the informed consent process and they are pursuing further therapies.

That comes to another issue of Clinical trials which I think can offer hope for patients but that aside they also are very time, labor and resource intensive and frequently if I were not a physician I would not have probably participated because the time away from work and profession would have been debilitating. Fortunately, as a physician I would call my staff when I was having my blood drawn my nurse it would make things a lot easier, but the idea that clinical trials are team effort and paramount. But team effort means that they facilitate everybody on the pain but specifically and most importantly the patient and I believe that our often-times are rules and regulations fall short.

To comment upon deprivation therapy, I call it a therapy that is described by a four letter word which is LOSS because there is a loss of energy of muscle mass, bone health, sexual function and health. It is debilitating long term of a back step in the vim vigor and vitality that you experience at a middle age aging male. I think the whole issue because it is not satisfactory chemotherapy is offering them underplay by physicians in the sense that yes within a thought of hormone therapy and it may be temporary and you have some issues but you buck through and the impact on the individual's life and their relationships with their significant others can be pretty debilitating and unrecognized. I really recommend patients of all damages of deprivation

therapy and manual for patients and their loved ones, recently published that, addresses most of the problems and gives solutions to them. They include not only dietary issues and exercise and put frank discussions and what they are playing at the field of new way of living and of re-negotiating marriage contracts in ways that were anticipated and something that needs more than just a “OK we are gonna start the therapy and manage your disease with mid term, short term or long term”

Mike: Let me just interject. I know you had threatened, but until you actually had hormone therapy yourself you really didn’t understand just how debilitating it could be for some men. Do you feel the average physician really understands that more now than they did?

Dr. Paul Schellhammer: I think more now than that they did but never to the point of really understanding it because if I tell them to the molecules in the body and the steroid molecule are bringing non-receptors in you and if not for you in the way coordinated responses that you would listen and taken for granted and enjoyed and now all of a sudden the circuit is shorted and what you previously were very comfortable with and now you are uncomfortable with and why you could perform at A,B or C level whether the sexual or physical endurance you are a different person. Yes, you can modify your lifestyle to accommodate or not something that is irretrievable or impossible though but it surely needs just a slight glance of the usual of intro that is given to patients before they start ADK. So, I think it’s an underserved educational process and unfortunately the amount of time it takes to do that education it is usually more than couple of 10 minutes sessions and that is why this manual if I write in the forward with even my experience I can appear someone adequately with just a couple of 10 minute sessions. This manual really helps explore to the core for the questions to the answers given with more background.

I will just explain the estrogen equation, which is estrogen really got a bad name as in all medication because it is associated with cardiovascular and thromboembolic events. It was however more successful in the control of cancer than the estimated or the other surgical castration cancer. It is just that the benefit was overwhelmed by the cardiovascular morbidity and mortality. Well now we have a way of delivering estrogen transdermally which obviates the cardiovascular side effects just because the estrogen does not travel through the passed through the liver which causes all the upset in the coagulation profile and it has so many other advantages amongst them bone health preservation, hot flush reduction and some stimulation of sexual interest that men don’t understand and mostly people don’t understand that men have a certain amount of estrogen as a result of having testosterone you eliminate testosterone and estrogen and you do in a private unit. Estrogen at least gives you a little bit of adequation back in control of your cancer. There is a large clinical trial going on in the UK of comparing transdermal estrogen to LHRH analog injections as they come up with early quality of life issues and bone health issues that they were estrogen. It will be important to see how it stands out with regards to disease control as well.

Mike: I just want to ask you one question, and then I will hand over to Jan. You talked a little bit about supplements and your experience of using them. I remember you jokingly telling me once that you certainly tried pomegranate juice. There are obviously a lot of men that try supplements and I keep getting curious to hear your take on what is useful, what isn’t even if it is not actually physiologically effective but it must be feeling good to do something?

Dr. Paul Schellhammer: Well! The whole supplement issue has become very complicated not only because of absence of good trials but the question of how much the supplement has in its formula what it says it has on its bottle. I mean the one faith now and I have the most faith in is vitamin D because most of us as we age and our vitamin D get deficient as I do monitor vitamin D a couple of times a year and with my patients and my own as well. It is 35-60 level instead of a 10-20 level. I do take to merit which is confusing as to inflammatory abilities so I think it is a double win may be for my joint problems as well. All the things go with celebrex and aspirin I’ve had some benefits almost every medicare age male in pharmacy profile because of the cardiac benefits out of it.

An interesting trial that sounds like male can get it that show the benefit which got exceed in reduction so I had to take 500mg of American ginseng a day. The things that I used to take like the pomegranate juice, I

stopped it as it got a lot of sugar in it. They did some good trials to UCLA but I don't think as average as it should have and so that was my supplement with Vitamin D with cumin and the ginseng. I do take omega3 500mg every day for its cardiac benefits and maybe its heart benefits and again most to them through a medicare agent. Maybe some benefit from Statin in reducing prostate cancer growth. I think a very interesting progress metformin is being tested in the clinical trials now and both with regards to easing the metabolic syndrome tendencies with ADT and also potentially with some anti cancer effects as well. But then again after a while you have to cut down on a number of course intake so you can eat lighter.

Mike: Ok Thank you Dr. Paul Schellhammer. I am gonna hand over to Jan and ask her to moderate the rest of the session. I am sure she would have questions for her as well or from the other panelists. I'm sorry I'm gonna run. Thank you so much for your time and I'll be talking to you soon.

Dr. Paul Schellhammer: Sounds good

Jane: Thanks Mike. Hi Dr. Schellhammer, I always really appreciate your inputs and thoughts and your experience so we're really happy you're here. I wanna definitely give Paul Carpenter and Rick Davis sometime to comment and ask questions but I wanna back track first for just a little bit. One thing that is important to me you actually mentioned this in your articles so it was important, I wanna give some thought to using common words that our listeners will understand and I wanna back track to transdermal estrogen and mention it that would be in simple terms estrogen patches to people listening would you say it that way?

Dr Paul Schellhammer: Yes

Jan: Ok! Androgen deprivation even now a lot of men know that to be hormone therapy is real telling us just hormone therapy. Another term mentioned was LHRH analog so that would probably be hormone therapy lupron.

Dr. Paul Schellhammer: Lupron, Eligard, any one of them, are all hormone therapy injections, yes.

Jan: ok! Going forward just help the people listening because in my mind they are all listening, wondering and referring to something that they are doing or they are on so I would like to put the words a little bit. I would like to give Rick a chance to come and ask a couple of questions if that's ok? I think he also has a pamphlet which he would like to make reference to, if that's alright?

Rick Davis: Hi Good Evening or Good Afternoon everybody I guess few of you are on the West coast and everybody else is on the East coast. I myself went through 28 months of hormone therapy and it was started before my treatment and then it continued for a couple of years or more after I was finished and it was an experience. I stopped by to say that and I don't think that's what exactly what I expected and it became obvious to me very quickly that I was had not been prepared one iota for as to what to expect from hormone therapy. Now, working with hormone therapy is that it is a systematic treatment and the reason that it is to prescribe it is because it addresses the rest of the body trying to prevent the cancer from spreading other than the specific area where you had treatment. If you had surgery or you've had radiation and there is a suspicion of cancer might have gone beyond that then you have some sort of systemic therapy. In many cancers chemotherapy is used.

Jan: Can I take just a minute. Can you define systemic Chemo just in case people don't know? I have a full definition I use which is systemic which treats your whole system from head to toe. I think by pill or injection.

Rick Davis: Lots of cancers use chemotherapy. I think we are moving closer in Prostate cancer to introducing chemotherapy earlier but at this point in time is very rarely used when you are first diagnosed and unless you have metastatic disease meaning you have seen cancer well outside the prostate usually somewhere in the bones or possibly in visceral or soft tissue organs like lungs for example or liver. Most of the time chemotherapy is not introduced early and that's not the case as many of you will know and in other diseases of cancer like for example breast cancer. I think of hormone therapy as a slow drip chemotherapy.

Chemotherapy is usually over in a 3 months, 4 months or sometimes 6 months. For a lot of men who have to do for a long term hormone therapy say a couple of years or longer the effect is cumulative. By the time you are 24 months out you have most of the same symptoms than people who have had chemotherapy experience. Just one of the clarifications for those of you who are on hormone therapy that doesn't always mean that you are on androgen deprivation therapy and there is more than one type of hormone therapy and some men don't necessarily do androgen deprivation therapy then they use what is called an anti androgen so we have to be little careful in how we use the term hormone therapy and androgen deprivation therapy. The side effects aren't always exactly the same but they are similar. Now what I realize was, I am being prepared, and it became evident I was treated that was UCSF as least my radiation was a UCFS and I had the opportunity to sit with the chiefs of both the urology and radiation oncology department. You don't do the job preparing them but they going home and tell you, they say, we agree. I said what can we do about it? UCSF happens to have a series of pamphlets for which a patient are oriented and we prepare the pamphlet written from a patient's perspective where they find the medical staff. That pamphlet is one of the better short guides to introduce men to what to expect from hormone therapy and it's available online. If you Google UCSF hormone therapy pamphlet you will find the URL is a little long. There are other very good written materials Mark shows his chapter in Invasion of the Prostate cancer and Invasion of the Prostate hormone therapy is good. There are couple of other books Richard… forgot his last name. In a nutshell that is my experience and some of the things I have been doing. I just don't think men in the long term are hormone therapy of women are supported and I think it's an area where medical community needs to make vast improvement before just saying to a man that we are going to give you a an Lupron agonist or antagonist or LHRH or so.

Jan: Would you say that one of the challenges to living well with Prostate cancer is simply helping men understand hormone therapy before they make their choice and coping them to deal with the side effects better?

Rick Davis: Yes! I would definitely say that if you know what to expect then you can deal with it much better. I can give you a very good example of depression. Lot of times men become depressed and they think that they are depressed because they have cancer and they think it is the reason but they don't understand this that the lack of estrogen changes their brain chemistry. And therefore, their reasons why they need to take antidepressants to replace those brain chemicals that are not being producing are better for not doing that. Now I am not saying that social aspect and the worry doesn't contribute to the depression but it's much easier for a man to accept that he has to take an antidepressant if he understands that it's the side effect of another drug that he is taking rather than if he thinks that social effects of his getting cancer.

Jan: I would add that some prescriptions for depression may offer help to other side effects including having pleasures, Dr. Schellhammer do you want to comment on that?

Dr. Paul Schellhammer: – I think what Rick said was right on in the sense of the preparation, expectation, side effect profile, depression with the change in the body and it always gets bigger and you just don't feel like you are healthy any more. A lot of things that just change the body and we have included in our clinic now, just in the past month when patients are given that script and they go for physical therapy because I might say to them to increase your activity, go to the gym, walk, etc, – those are all kind of admonitions you will hear for every disease process pretty well, but they are quickly forgotten. So we are now insisting that they really get a program with a good clinical trial over there to support for mental health and physical health but they ward off the side effects of Hormone therapy or I should not say ward off as much as minimize the side effects.

Jan: So, as a physician you can actually write a script for physical therapy which is a little more concrete and suggesting they go to the gym. Define that medicare in general tends to pay for that, is it hard to get coverage for?

Dr. Paul Schellhammer: Fortunately, We have a physical therapy department and practice emphasizing surgical advancements for both men and women after their surgery. They have valued the insurance field

and medicare does reimburse and many other third party carries allows too.

Jan: I wanted to ask Paul Carpenter and give him a chance to come in.

Paul Carpenter: Basically I would willingly endorse what both Rick and Dr. Schell Hammer said. Is that Shell hammer?

Dr.Paul Schellhammer: You are right SchellHammer.

Paul Carpenter: Thank you. Rick, I would be interested in seeing the pamphlet for myself. I came up with a five point thing for men who were going to be facing androgen deprivation therapy and it includes what you mentioned about it also. Often overlooked is referral for fraternity counseling for men who might be interested in hiring for children. Not a single doctor I met where during my lead up to treatment even thought of that. That is one and the other is baseline bone density test to find out how much the bone is crumbling for a year or got to be a 5 years, if you are older for 5 years. And other of my points is a referral to the nutritionist because the body is going to process things specially carbohydrates very differently on ADT and to be prepared on ADT in advance and then to watch how things change. Metformin could play a role and some people will develop diabetes. So, to be aware of these things, I would be interested in seeing that pamphlet maybe offering some suggestions for supplementing it.

Jan: One thing I can do after this call for all of our listeners and we would probably have several 100, is to put a link to Rick's pamphlet and Paul.

Paul Carpenter: I get that yeah.

Dr. Paul Schellhammer: Androgen Deprivation therapy by Richard Wassersug also.

Rick Davis: Thank you. That was the name I was looking for. Thank you.

Jan: That's a book or is that a pamphlet?

Dr. Paul Schellhammer: It's a book of 115 pages on Amazon for $10.95.

Mike: Richard Wassersug has been one of the survivor and he's been on Androgen therapy for some time.

Jan: Make those two resources available on Curetalks.com and put them on the comment or unless Priya has another way to do that so that people can access that. It is not only important to clarify their problems but also to give solutions.

Paul Carpenter: Right

Rick Davis: I would like to comment on what Paul said. I was forced enough to get on all of the referrals but he mentioned and I think we incorporated them into the pamphlet. By the way my pamphlet is on UCSF and I did the first draft but I'm no longer involved and I think they are redrafting it right now. One of the things that was really missing is this actually goes back to what Dr. Schellhammer said is that there was no exercise consult and I was at that time and I am still I am an athlete, a lifelong athlete. There was no help for me and I knew I was going to have problems once I went on hormone therapy. Now, for many men they know they need to exercise for many different reasons which Dr. Schellhammer mentioned and we have to get them to start exercising whether you have been on exercising or know how it is going to affect you or you need to start exercising. I thought for myself why is there no consult for exercise? And one of the programs that we have established that you see that flourishes is an exercise consult program for cancer. It started because of Prostate cancer and it is now available for any cancer. Anybody who goes to UCSF can avail themselves the free consult and the purpose of that consult is not to tell them what exercise to do but to connect them to exercise programs and to encourage them to exercise and to seek compliance and out of that came an

organization called Medicit.org which tries to extend that program to other institutions.

Jan: Dr. Schellhammer could you just give us a short list of the benefits of exercise for men on hormone therapy or with prostate cancer.

Dr. Paul SchellHammer: Well! The first is the tendency to develop the subtle, what we call the metabolic process called insulin resistance or metabolic syndrome. By implying to that you don't have to be diabetic or suffering from consequences. And it has debilitating effects on a number of systems of cardiovascular or musculoskeletal. Exercise has been very effective to halt or reverse that gradual disability that associates with ADT from a mental psychological cancer point of endorphins which are the kind of feel good products of exercise which help with depression. They help in balance of bone prevention and all exercise just remarkably easy in the sense that it is available to everyone pursuing it rigorously and faithfully but it is great mental, physical remedy or preventive measure for the consequences of cancer diagnosis in treatment that you are receiving for cancer.

Jan: Even if I do small amounts of exercise?

Dr.Paul Schellhammer: Yes and many things or some things that more than just come in a couple of life of everyday and you are going to reach every other day and put it down on your schedule, just like you put other things down, like you need to do of going to the store, go to the whatever… it has to be a focused event to accomplish it adequately.

Jan: One of the simple points have been that multiple benefits for little time spent and almost no downside unless you are doing some kind of rigorous exercise maybe was not healthy for you.

Rick Davis: It should be a combination of both weight resistance and aerobic exercise. The aerobic exercise just so that you can manage your weight and the resistance exercise for your bone health.

Paul Carpenter: I would like to add to that something frequently overlooked. It is the form of exercise gives a man a sense of purpose and mastery and the fun. They can make up for all the medical benefits as well and in regaining the lost sense of self that ADT sometimes bring about.

Jan: Even perhaps a patient could be encouraged to ask his doctor for a script or an order to physical therapy. The worst he can say is NO but they can always ask.

Rick Davis: Yeah but physical therapy really isn't the same thing and physical therapists often times are not equipped to give you exercises to change your lifestyle and they are more focused on the addressing specific issue.

Jan: I don't want to go too far with that because I think we are hearing Dr. SchellHammer he's been saying he has been using with success in his clinic. There might be some fine lines there but….

Dr.Paul Schellhammer: The intent is for the help of the ADT patient.

Jan: I know different things work for different people and that perspective can be really helpful and you can't force people on doing things that they are just not going to do and can't use too many should and guilt them into it. Meeting a person for that and figuring out something that works for them can be really helpful.

Rick Davis: One suggestion I have is that people seek exercise trainer that has a qualification in cancer training. Those people are out there for example American Institute of medicine has classes and certifications. If you are thinking of bringing exercise into your everyday regime try and find a trainer that specializes in cancer training.

Jan: That's helpful. We have about 3-4 minutes left and if you don't mind I would like to go back to the

estrogen real quickly Dr. SchellHammer. I find especially interesting because I know men who have a rising PSA and a hormone therapy are looking for new ideas and new treatments and my husband personally responded very well to taking estrogen by pill form which was DES with coumadin which was a blood thinner. In addition to that estrogen was also part of the trial for xofigo. It was part of the data that xofigo got the FDA approval it on the label which was mentioned estrogen. I also think it's interesting but I also think it can be Rick to use to figure out the right questions with your doctor but it often gets overlooked.

Dr. Paul Schellhammer: I think right now there is a new clinical trial that really states loudly that cardiovascular component had all the concerns in the past is nullified by hard data and it can been difficult for physicians to depend on clinical estradiol or estrogen patch. It said that it was hard initially to convince the physicians back in the 60s and 70s that cardiovascular events were significant and they should stop using oral estrogen. Now its 180 degree polar opposite problem but the conviction is so strong that it takes some doing. I've been on estrogen now for 8 years and I think I had to go off it after clinical trials in fact couple of clinical trials which said I could not be on estrogen and I can clearly tell you that I felt worse when I did and then I felt better than I assumed it. Everybody will but it is systematic and I would say self recall.

Jan: It is and it is not worthy. So you have been on estrogen patches just to clear it for people listening, is it correct?

Dr. Paul SchellHammer: Yes

Jan: Maybe that's part of your living well that's gives you better quality of life?

Dr. Paul SchellHammer: I think it has, yes

Jan: I think that's really interesting. I need to turn back over to Priya we are about 6.45 and so that she can take questions by email and by phone from listeners. I think we are just about there.

Priya: Thank you Jan. Listeners if you have questions for Dr. Schellhammer or any of our panelists please press 1 on your key pads and we can bring you on air to ask your question. Dr. SchellHammer I think I got it right this time. We have been receiving questions during the course of discussion and I'll just read them out to you. Maybe you can give quick answers. First one is a bit long, the person says, I was treated with hormone with external beam therapy and I finished radiation treatment on Feb 27th, 2017 and I am still on hormones. My question is I recently had a CAT scan and it shows two areas of concern within my lungs. I have enlarged lymph nodes in the AB window and a 1 cm lymph node in the right hela. None were visible on the previous CAT scan six months ago. Could this be related to the prostate cancer so soon after treatment?

Dr. Paul Schellhammer.: What is your PSA level and if PSA level is low and undetectable, it is highly unlikely to be Prostate cancer. Even if I say your PSA is detectable, it is unusual as an early finding and as a solitary finding about involvement of the bones or abdominal lymph nodes or the fact that you have a high lymph node or pulmonary nodule then it would really raise my suspicion for another kind of cancer and it probably or could be one cancer. That would be your eye of focus not 5 or 6 but a biopsy of dependency of that nodule.

Priya: Thank you Doctor. The next question is what is the importance of PSA doubling time and why is this important indicator?

Dr. Paul Schellhammer: The PSA is reduced by prostate cancer cells and the doubling time is in the volume often of the prostate cancer and it affects the ability to grow. If you have a rapidly growing cancer the PSA doubling time could be shorter so in reverse if you have a very short PSA doubling time by that I mean less than 3-6 months it means that the cancer is actively surviving and proliferating as opposed to PSA doubling time of 18-24 months then it says the cancer is growing but at a very very slow pace.

Priya: Thank you doctor. There is someone who wants to ask about diet in prostate cancer and how far

alcohol consumption is allowed?

Jan: What they eat? I think we covered supplements but we did not talk about diet.

Dr. Paul Schellhammer: It should be healthy diet.

Paul Carpenter: Could you please expand on that, could it be red meat, diminish carb, no sugar…. What exactly do you mean is a healthy diet?

Dr. Paul Schellhammer: Well balanced calories, reasonable diet, 1800-2200 calories a day, that is mostly vegetable protein, not your favorite chicken, not fried, good delivery of protein, less red meat – not total abstinence. Those are issues that are brought up in maintaining a healthy weight, your BMI which is the measurement of height and weight or even 22-23 range and to say you are not overweight and moderately thin or significantly obese.

Rick Davis: I'd like to add just a couple of things on diet. First of all a lot of men when they go on hormone therapy know if this one thing they are hungry. Men don't think much about it but they just tend to grab what's in their hand and a lot of times it is not healthy on what they snack on. The fact is that hunger is really a reflection of metabolism slowing down as a result of having a testosterone in the body. One of the body things that really suggest is have a good supply of carrots, celery or piece of cucumber or something that is healthy to snack on that will fill you up and does not give you calories and realize that the hunger is just another effect of commencing hormone therapy. That is not applicable for everybody because hormone therapy affects each man differently. The other thing I wanted to mention is that there is also a very good UCFS nutrition pamphlet, diet and nutrition pamphlet it's also called UCSF diet and nutrition in prostate cancer and maybe we can try and get that and I'll send the link for that to Jan and we can get that posted as well.

Jan: Sure, Priya do you have another question?

Priya: We are just waiting for more questions. In the meantime Paul you have quite a few and maybe you could go ahead with them.

Paul Carpenter: There is one segment which we have not addressed so far. Those are the people who have a low position score or considered lower risk and they are also trying to decide what to do and they also are living with cancer and without being in a position myself I often would point out that a person could live for 30 years, 50 years whatever, whether with the deletion 6 plus 6 or 3 plus 3 and the active surveillance should always be considered an option with a very low risk category. I wonder what do you have to say about that Dr. Schellhammer?

Dr.Paul Schellhammer: Well! I agree in totality to what you have just stated and to emphasize the situation more significantly to state that literally 70% of men over the age of 75 or 80 and 50% over the age of 60 and if you examine their prostate in careful cross section you will find elements of cancer in fact body system done on 35 years old men do have cancer at that age so we can say that prostate cancer when in small or low gleason score is something that is almost possible of ageing and that it can be observed, not ignored but observed through examination and through PSA section. Now, sometimes the MRI imaging to ensure the patient's progression to some dangerous point is not approved.

Paul Carpenter: I think that is valuable address. I did have another question. I once joked to my doctor that success is measured by how many people died by something other than prostate cancer. It is in fact a reality to some extent. Prostate oncologist should keep in mind that some treatments that prevent or postpone death from prostate cancer can actually lead to death from other causes. I want you to comment on how you work with patients to find the balance of decreasing risk of death from one cause and increasing risk from other causes.

Dr.Paul Schellhammer: That's a good question. There is always a risk of death ratio with any therapy or any intervention that's delivered. To put it very accurately maybe there is no such thing is pre launched. If you are going to be suggested for surgery it is very safe but can have complications and can have very small incidences mortality. You have to balance the benefits of those interventions. The problem is the only way. It can help with radiation.

Paul Carpenter: How can you help patients determine the balance because most of the patients are not well equipped to figure out half a percent of chance to going for a stable treatment?

Dr.Paul Schellhammer: Unfortunately physicians who are somewhat ill-equipped say- Mr.Jones you have these many diseases, you have, cardiac stent your life expectancy is 10 years and we know of cancer of lifetime approaches problem of 10 years is virtually nil, zero but 1%. It could be that you could have to go through certain commodity sales and look at live tables and too often, I am guilty of this myself, to come up with an estimate that is supposed to be more precise estimate. I think we will be obliged to be more critical with regards to making a statement to live from for the other things like you have now certainly outplayed in prostate cancer risks and we can treat you with low risk. The risk certainly favors no treatment.

Jan: We just have few minutes left, Priya do you get any new questions in?

Priya: Yeah there is one question, Dr. What are the diagnostic measurements used to stop ADT after an appropriate course?

Dr.Paul Schellhammer: Moving target that has changed in the past 10 years initially in deprivation of hormone therapy is given, radiation therapy for 36 months, and 36 months is a long time and the question was, it that necessary? Then it was effective against 24 months and then it was 18 months. Then there were aspects of how big or expensive was the cancer. Locally to make those modifications and sometimes there were little advances in 6 months. Your question is an excellent one but it cannot be answered without a defined number and requires other pieces of information to bring it to the core. To give you some black and white, if you have the high gleason score and a significant on digital examination on the outset probably 36 months is still the projected time for but I think so less of radiation therapy is reasonable.

Jan: We have just a couple of minutes and Priya I know you are gonna close us out. I'd like to just reiterate a couple of things if that's ok. One is that we will past the link of the pamphlet to the UCSF and the title of the book by Richard Walter. Both of these resources can help men dealing with hormone therapy and hormone therapy side effects. 2 is that this is a private one, we are going to do two sessions with the same title called 'Living well with Prostate Cancer' in the bottom of the month on May 30th and there will be a part 2 with Dr. Schell Hammer. We really appreciate him giving us his time today. The third thing I just want to say is that Dr. SchellHammer wrote about a lot of things in a recent paper regarding his experience including his own frustration on fear sometimes but the one thing he certainly said is that he talked about how even when you go through these things the human psyche turns resilient. I don't know it just resonates with me because I know it's been part of our story so I appreciate that statement.

Dr. Schellhammer.: The way it could be available with patients, I don't know if it is possible

Jan: Yes absolutely.

Dr. Paul Schellhammer: It is perfectly fine with me

Jan: Ok even that could be put on the website. That's terrific!! Thank you

Priya: Thank you Jan, Thank you Dr. SchellHammer it was a pleasure listening to you. Paul, Jan and Rick thank you so much for your participation and thanks specially for taking over for Mike today. This talk is available on Cure Talks website and as Jan mentioned we have Dr. SchellHammer back with us on May 30th at 6pm to continue talking about 'Living well with Prostate Cancer'. You can RSVP for the same on

curetalks.com and also please do join us for a talk on ‘Precision Medicine targeted cancer treatment with Genomic Testing’ on May 10th at 6pm. Please visit curetalks.com for details of all upcoming talks. Thank you very much. Have a great day everyone.