

PROSTATE CANCER COMMUNICATION

PROSTATE CANCER COMMUNICATION NEWSLETTER • VOLUME 22, NUMBER 4 • December 2006

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EDITORIAL

Seasons Greetings and Happy New Year to all of our members, advocates, friends and medical advisory board. We extend these greetings with a sincere wish for a significant improvement in the treatment of Prostate Cancer in 2007. We hope and pray for a break through this coming year. Miracles sometimes happen when we least expect them.

The latest news on the home front is that we have experienced a significant decrease in member contributions during the year 2006. It has been a very difficult year for all, especially here in Michigan, where we are ranked 49th in economic development. As a reminder, for the second time in the past 6 years we are asking all PAACT members to realize that even though this is a non-profit organization, the bottom line is that we **must** break even. Current YTD total revenue = \$115,921.49, total expenditures = \$144,565.91 resulting in a deficit of \$28,644.42. We cannot continue to spend more than our total revenue permits. We continue to run a very tight ship with limited options to cut costs, short of cutting quality or service. There are several options currently being explored at our end to help reduce the deficit. The first option is to eliminate the donation envelope that is presently enclosed with each publication, or only include it once a year, perhaps in the year end newsletter (December). The envelopes cost us approximately \$2,800.00 a year to purchase and approximately \$2,400.00 a year to have them inserted into the newsletter for a total cost of approximately \$5,200.00 yearly. The second option being considered is to downgrade our mailing classification from standard back to 3rd class where it was up until the December 2002 newsletter publication. If this takes place the following services that are now employed would no longer exist: 1) **Months 1 through 12:** newsletter forwarded to you at no charge, separate notice of new address provided to us for a fee of 75 cents, 2) **Months 12 through 18:** your newsletter is not forwarded to you, but returned to us with a new address provided for a fee of \$1.56 (we then correct your address and re-send it to you for the cost of a new newsletter and \$.87 postage), 3) **After month 18, or if undeliverable:** newsletter returned to us with no reason for non-delivery at a cost of \$1.56. This service alone cost us approximately \$1,500.00 this year not including December's charges which is usually our biggest month of the year for returns. In other words, if this takes

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place, all members who fail to notify us of a forwarding address will no longer receive a newsletter until returning to your prior address (heads up for snowbirds). Also, the U.S. postal service will discard any newsletters that are undeliverable at the address posted on the initial mailing. They will not notify PAACT, and they will not notify or forward the item to you. It is imperative for us to have the correct address of all members at all times. If we are not notified of any changes, we then continue mailing to an inactive address and sustain the cost of printing and postage, which is extensive. As you can see by looking at the charges listed above, even by PAACT enforcing these changes, we will still be far from breaking even without your help.

We must and do rely on our membership for consistent donations; we are here for you daily as many of you know. All past and present members make PAACT what it is today. If there are members that no longer have a use for the material and just discard it, please let us know and we will remove you from the mailing list. It is only through the generosity of members providing donations that we have been able to continue to subsidize the material being provided at a loss, or at no cost or obligation. For 22 years PAACT has been providing this service to all of

those in need with no financial obligation. In 1984 Lloyd Ney started this non-profit prostate cancer organization with a mere request of a \$50 voluntary donation if possible. Twenty two years later the message hasn't changed, Annual Membership Classifications; Patient.....\$50, Advocate.....\$50, Professional.....\$100, Donor.....\$500, Sponsor.....\$1000, Corporate.....\$1000, Other....., Include me as a member, though I currently cannot contribute.

The suggested donation of \$50 per year is asked for by those who are financially able so that we can continue to provide information to all members that cannot afford to offer a charitable donation. Every donation is always appreciated no matter how large or small. During our 22 years, costs have soared, membership continues to rise, and donations do not compensate for the expenses needed to operate this business. To continue to operate on a financial structure based on a 1984 economy, we are asking all of you who have never donated that are able, those of you who donate periodically, those that are in remission and may have chosen to no longer donate, to please reconsider for the sake of those that are still in need. Please remember that we are a 501 (c) (3) non-profit organization, therefore your donations are tax deductible. We can also receive donations through

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Articles authored by other than the editor may not fully reflect the views of the corporation but are printed with the understanding that the patient has the right to make his own interpretation of the efficacy of the information provided.

In an effort to conserve space and be able to insert as much material as possible in the newsletter, references from various articles are intentionally omitted. If you would like to obtain those references, please contact PAACT, we keep all of the original articles and the references used on file.

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United Way gift programs or from some employers that have matching gift programs available for non-profit charities. It was always Mr. Ney's desire to never refuse any person information regardless of their financial status. Without having a consistent steady income to operate, which comes from our members, further changes will undoubtedly have to occur.

Remember, this is your organization; the future of PAACT and the way it is going to operate and conduct business in the future is in your hands. Our mission is and always has been "Let's Conquer Cancer in OUR Lifetime." Now is the time for giving, what better way or opportunity to do so. Any changes that may or may not take place in the future will depend on the input of our membership during the upcoming quarter.

We wish all of you a safe, healthy, prosperous, and Happy New Year! We would also like to send a special holiday greeting and thanks to our superlative medical advisory board. It is because of their endless efforts and assistance that enable PAACT to continue to put out a great newsletter.

Vitamin D: More Than a Hormone – More Than a Calcium and Bone Thing

Donald L. Trump, MD, FACP
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We all "know" about vitamin D – it's the vitamin that prevents rickets (a childhood bone disease) and preserves bone density among postmenopausal women – and likely men on androgen deprivation for prostate cancer. But this article will briefly review the increasing recognition that vitamin D effects are multifaceted and involve many aspects of health.

Biology/Chemistry:

Vitamin D is a term used to describe a class of molecules – and it is misleading in several ways:

1. Vitamin D is really a *hormone*; a vitamin is a substance you must get in your diet – e.g. vitamin A, C, E, K, B.... But vitamin D is manufactured in the body – and that's the definition of a hormone.

Vitamin D is manufactured in a series of steps: first, light strikes the skin and induces the chemical change of a cholesterol molecule into a vitamin D molecule (vitamin D₃); in the liver and then in the kidney this molecule is further modified resulting in the most active vitamin D molecule, 1,25(OH)₂D₃ (calcitriol). Calcitriol is a prescription drug.

2. There are really more than 5 different vitamin D molecules: pre D₃, D₃, 25(OH) D₃ are each intermediate steps in the production of 1,25(OH)₂D₃ (calcitriol). 1,24,25(OH)₃D₃ is the major breakdown product of calcitriol and is largely inactive – but it is a "vitamin D." To make matters more confusing there is a plant derived form of vitamin D – vitamin D₂. D₂ is a "vitamin D" but probably not quite as active as D₃ – and not very important in human health and nutrition.

There are (3) important molecules to which you should pay attention:

a. D₃ (also called cholecalciferol): This is the form of vitamin D in nutritional and vitamin supplements. The government-defined recommended daily allowance (RDA) is 400 international units (400 IU). Vitamin supplements are available which contain 200 IU, 400 IU, 800 IU, 1000 IU, and 2000 IU.

b. 25(OH) D₃ (25 hydroxycholecalciferol): This is the form of vitamin D that is readily measurable in the blood and is the best measure of whether an individual has "enough" vitamin D in their body. The "normal" level of 25(OH) D₃ is 32 ng/mL – 100 ng/mL.

c. 1,25(OH)₂D₃ (calcitriol): This is the prescription drug form of vitamin D – the most potent D vitamin. Its main use is in individuals with either kidney failure or osteoporosis; the usual dose is 1-1.5 micrograms per day.

Normal Levels:

The "stores" of vitamin D in the body are reflected by the blood level of 25(OH) D₃. In the past 2 years the "normal" range has been broadened from 15-50 ng/mL to 32-100 ng/mL. Perhaps the best measure of what is optimal is that level which suppresses or reduces the normal biochemical reactions which are "upregulated" when vitamin D deficiency exists. Among the body's responses to low vitamin D levels

are an increase in the production of parathyroid hormone (PTH) and loss of bone density.

If blood 25(OH) D₃ levels are raised into the 32-100 ng/mL level, PTH levels decrease and loss of bone density improves in most individuals. Whether this level (32-100) reflects the optimal or ideal for any individual is not clear. It is clear that these levels of 25(OH) D₃ are completely safe.

It is interesting to consider that humans evolved in sub-Sahara Africa – a part of the world with a great deal of sunlight. Humans likely evolved with deeply pigmented skin – and pigment protects the skin from sun damage and minimizes the production of D₃ in the skin. As populations migrated out of sub-Sahara Africa lighter skin color evolved – in part, it could be argued, to increase the body's ability to make vitamin D. In less equatorial latitudes, those who made more vitamin D in their skin (i.e. had lighter skin) perhaps had an evolutionary advantage.

Epidemiology/Population Studies:

There are many studies which indicate that there may be an inverse relationship between environmental light exposure (i.e. latitude), estimated blood vitamin D level as well as measured blood vitamin D level and the frequency of and death rate from many cancers. Prostate, breast, lung, colorectal and pancreatic cancer are all cancers that may have a causative and prognostic link to vitamin D – the lower the vitamin D level, the higher the risk of cancer and cancer death.

Basic Science:

There has been considerable research which has greatly expanded our knowledge of how 1,25D₃ is produced, transported to cells all over the body, enters cells and induces changes in cellular activity and function. Among the things 1,25D₃ induces in cells are reduced cell movement, reduced cell division, increased cellular maturation and differentiation. The multitude of 1,25D₃ effects all seem to happen through the binding of 1,25D₃ (vitamin D) to the vitamin D receptor (VDR).

When 1,25D₃ and VDR associate, this complex binds to another protein (RXR) and this complex sits on special locations on DNA in the cells chromosomes and causes the activity or blocks the activity of many genes. These and these changes in gene activity re-

sult in a huge number of vitamin D associated biologic activities. Without VDR, none of these 1,25D₃ effects occur.

As a way to understand what 1,25D₃ does, scientists have been able to develop a so-called vitamin D receptor knock out mouse (VDR KO mouse). Using molecular techniques it has been possible to “make a mouse” that has no VDR and therefore, 1,25D₃ has no way of influencing cell growth and integrity. Studying what happens to such mice provides important information about what 1,25D₃ does. The following table lists the abnormalities that afflict the VDR KO mouse:

1. low blood calcium
2. weak bones (“rickets”)
3. hairless skin
4. abnormal muscle development
5. high blood pressure
6. abnormal heart muscle development
7. increased susceptibility to infection
8. increased susceptibility to blood clot formation

It is likely that this is an incomplete list of “diseases” the VDR KO mouse has; studies of this mouse are just beginning. This list and further studies on this mouse emphasize the wide range of vitamin D effects and suggests that there may be many human disorders that could be influenced by vitamin D.

Clinical Implications:

1. Vitamin D Deficiency: There are several studies which indicate that many people have lower than ideal vitamin D levels. Thomas and colleagues described > 250 patients admitted to the Massachusetts General Hospital. 57% of those patients had abnormally low levels of 25(OH) D₃ – and in 1998 abnormally low was defined as < 15 ng/mL! We have recently looked at 25(OH) D₃ levels in more than 200 prostate and colorectal cancer patients; 70% of patients had 25(OH) D₃ levels < 32 ng/mL. As expected African Americans had lower levels than Caucasians, levels were lower in the late winter and early spring and patients with more advanced disease had lower levels. There is very limited information on the frequency of Vitamin D deficiency among men with prostate cancer – or individuals with any form of cancer; however, the information available suggests vitamin D deficiency or insufficiency (lower levels

than are ideal) is common.

There is little information about the impact of cholecalciferol (D₃) replacement on cancer. We have begun careful studies of replacement which we hope will clarify how often replacement is needed and what is the optimal replacement dose.

2. Role of vitamin D administration:

a) Osteoporosis - There are data that vitamin D replacement (~400-800 IU D₃) + calcium supplementation (1200-1500 ng) reduces the rate of development of osteoporosis in post menopausal women.

b) Cancer Prevention - Calcium + vitamin D supplementation have been studied as a preventive for colon polyps and colon cancer. While the largest study completed failed to show benefit of this treatment it seems likely that this result was confounded by the inordinately low dose used (400 IU/d).

c) Prostate Cancer Treatment - There were several studies in the 1970's & 1980's using calcitriol in patients with leukemia and myelodysplastic syndromes (diseases of bone marrow failure). These studies were uniformly negative. However, it is the view of our research group that this might well be because inadequate doses of calcitriol were given. Many investigators have argued that calcitriol-induced hypercalcemia is such a problem that vitamin D analogues which do not cause hypercalcemia must be developed. Two investigative groups (Trump & Johnson at Roswell Park Cancer Institute and Beer & colleagues at Oregon Health Science Center) have argued that very high dose calcitriol can be administered if an intermittent schedule is employed. While 1-2 mg calcitriol every day for 30-60 days results in unacceptable calcium increases in blood and urine in up to 50% of individuals, Beer and colleagues have given up to 2.4 mcg/kg (168 mg for a 150 lb man) weekly without any toxicity; we (Trump & Johnson) have given 38 mcg daily x 3 days (114 mcg total weekly dose) by mouth and 196 mcg intravenously weekly without consistent or limiting calcium changes. We have chosen to evaluate intravenous calcitriol because the commercially available oral caplets are inadequate for high dose oral use - they are prepared only as 0.5 mg caplets and at doses > 20 mg the entry of calcitriol into the blood stream from the intestine is erratic and limited. A new company, Novocea Pharmaceuticals, has reformulated calcitriol into 15 mg and 45 mg caplets and have achieved de-

pendable absorption and intriguing clinical trials results. (see below)

Vieth, et al., Gross, et al., and Trump et al. have each shown that D₃ or calcitriol (alone or with dexamethasone) reduces PSA in either androgen dependent or independent prostate cancer. Because of problems with the available oral formulation at high dose further work with calcitriol has been limited. We are currently completing a study of intravenous calcitriol (77 mg IV weekly) + dexamethasone 4 mg daily x 2 each week in androgen independent prostate cancer.

At the present time the available formulation of calcitriol limit what can be achieved with that agent. However, available data suggest that all men with prostate cancer should measure their 25(OH) D₃ level and take enough supplementation to assure blood levels in the normal range. Since it takes 8-12 weeks for a steady state level of 25(OH) D₃ to be achieved, D₃ supplementation should be adjusted no more often than every 3 months, guided by blood levels of 25(OH) D₃.

Calcitriol + Chemotherapy:

There are numerous scientific studies which show that a high dose of calcitriol enhances the anticancer effects of many types of chemotherapy. Several studies have shown that calcitriol + several chemotherapy agents are safe. Beer and colleagues found a surprisingly high (88%) PSA response rate following weekly docetaxel (Taxotere) + calcitriol (0.5 mg/kg). Based on this small study, Novocea conducted a phase III study of docetaxel + calcitriol vs. docetaxel + placebo. While the dramatic PSA response rate seen earlier was not replicated, the survival of calcitriol treated patients was significantly better than placebo patients and the toxicity associated with therapy was less. Especially striking was the apparent reduction in blood clots and other vascular events (stroke, heart attack) in the calcitriol group. These data are particularly intriguing in view of studies in the VDR KO mouse and other systems suggesting vitamin D deficiency may encourage blood clots. Novocea is currently conducting a 1000 pt trial seeking to confirm or refute the results seen in the initial, smaller trial.

Punch Line:

Vitamin D is very likely to have much broader health effects than bone and calcium changes. Vitamin D deficiency is common - due to life style and envi-

ronmental light exposure considerations; we recommend that all prostate cancer patients ask their doctors to measure their 25(OH) D₃ levels and oversee supplementation to assure blood levels are at least in the normal range. Vitamin D supplementation merits continued study as a potential cancer preventive and treatment approach.

High dose vitamin D (calcitriol) is a very effective agent in the laboratory and clinical results are encouraging. We suspect that high dose vitamin D will find a role in prostate cancer treatment.

Vitamin D is not a vitamin, it's a hormone and we believe it is a hormone important in cancer treatment.

LAC-PAACT ¹UPDATE

Gregory H. Teufel, Esq., Chairman²

We are still looking for volunteers to help in the fight for approval for off-label use of chemo's for prostate cancer. The issue of off-label use of chemo's for prostate cancer is a very complex one because the use of these chemo's has primarily been in phase II trials. Hence, it is very difficult to provide peer-reviewed articles that insurance companies require for "proof of efficacy." It is extremely frustrating and depressing to see off-label use of other drugs allowed and not chemo's that have shown some efficacy for prostate cancer in the smaller trials. If this sounds like an issue that would interest you and you want to help, please contact Greg Teufel.

In the most recent LAC-PAACT Update, we reported that our newest member of LACPAACT, Dorothy Varon of Robinson Donovan, P.C. in Massachusetts was representing a prostate cancer victim regarding robotic laparoscopy denied coverage as experimental. We are happy to report success with the matter. Health New England agreed to cover the procedure

¹ LAC-PAACT is PAACT's legal advisory committee. Despite the name of the committee, for various reasons, we generally cannot give you legal advice or act as your personal attorney. Please do not consider anything in this article as legal advice. If you want legal advice, I encourage you to consult a lawyer in your state, so that your specific situation and local laws can be considered.

²Gregory H. Teufel, Esq. is a partner in the Litigation Department of Schnader Harrison Segal & Lewis LLP's Pittsburgh office. The views expressed are those of Mr. Teufel personally and not of the firm.

as non-experimental up to the amount they would have paid had the prostate cancer victim done it in-network. Attorney Varon had hoped to get the insurer to cover the entire expense, but in the end her clients were quite relieved to get at least some coverage. She expressed their thanks for our assistance with the matter.

We received a disturbing report of denial of coverage as experimental for proton beam therapy as a treatment for prostate cancer. We passed on information to help in the fight for coverage in that case and will keep you updated as we hear about the progress of that dispute.

We also had a report of a denial of coverage for 150 mg of Casodex. Initially, the VA had approved the prescription and filled it, but cancelled it without warning. The prostate cancer victim's insurer under his Medicare drug plan (Humana) would not cover more than 100mg, forcing the prostate cancer victim to pick up the cost for the remaining dosage at \$50/pill. We passed on some information to help in this fight for coverage and will keep you updated as we hear about the progress of that dispute.

We also recently did some research into who owns pathology slides, in answer to an inquiry from a prostate cancer victim. They wanted to get a second opinion and did not want to get a second biopsy but rather wanted access to the slides from the first biopsy, and ran into a problem when the pathology lab in Maui would not release the original slides, but would make new cuts, for a fee, and send them to another pathologist. Basically the research indicated that doctors usually wind up "owning" the slides, depending on the circumstances and the applicable laws, but that does not settle the issue. Patients should have the right to have another doctor view the slides, even if the doctor (or pathology lab) owns them, just as a patient has the right to have another doctor review medical records, even though doctors generally "own" medical records. If any others are interested in the results of this research, or if anyone has any useful thoughts or research they may want to provide to assist with evaluating this issue, please contact Greg Teufel. Once we determine the extent of patients' rights, we may need to consider advocating legislative change and addressing the practical questions of how to economically enforce those patient rights.

We want to keep you aware that the LAC-PAACT is here to help you. We are particularly helpful in addressing insurance and Medicare coverage issues related to advanced cancer treatments. Please do not hesitate to contact us regarding any coverage or other legal issues related to advanced cancer treatments. We want to help and need your help in identifying the areas of greatest need.

We are also always seeking volunteers to help with LAC-PAACT activities. Even if you are not a lawyer, you can volunteer if you are inclined to help with law related issues. Also, if you know any lawyers that would be sympathetic to our cause, please make us aware of them and them aware of LAC-PAACT. Just contact Greg Teufel regarding volunteer opportunities with LAC-PAACT.

If you have been denied coverage for an advanced cancer treatment, be sure to let us know and we will see if there is anything we can do to help.

Contact LAC-PAACT

If you have any questions or comments, or any suggestions about how LAC-PAACT can best serve your needs, please do not hesitate to contact me. The preferred method to contact me is via email at gteufel@schnader.com. You can also call me at work at (412) 577-5289, home (412) 421-7123, or on my cell phone (412) 596-6316, or send me a letter at Schnader Harrison Segal & Lewis LLP, Suite 2700, Fifth Avenue Place, 120 Fifth Ave., Pittsburgh, PA 15222 or a fax at (412) 765-3858. Please note that requests for the LAC-PAACT kit should be addressed to PAACT. Contact information for PAACT is on page 2 of this Newsletter. Please remember that this article is not legal advice and I cannot generally give you legal advice or become your personal attorney.

WHAT THE HECK HAS BEEN GOING ON IN MY WORLD-PART 13 (oops that is an unlucky number so lets call it part 13.5)!!!

Mark A. Moyad, M.D., M.P.H.

Let me see if I get this straight. I have been going to Michigan football games since I was 5 years old, now I am 41 years old, and we have never seen anything like this in my lifetime?! What am I talking about here; well at the time of this PAACT writing Michi-

gan is ranked second in the country and Ohio State is ranked number 1 and both teams are undefeated! Holy Macaroni (I could have used another word here but my mom reads this newsletter and my wife is Italian)! Earlier this year Michigan embarrassed Notre Dame at their own stadium and beat them senseless by over 25 points!! Where is "Rudy" when you need him? Ouch!!! So, what is my prediction for the Michigan and Ohio State game this year?! No comment...if Michigan wins I will rub it in, if they lose I have already thought of plenty of excuses.

77) DHEA (the pro-hormone supplement) in small doses or testosterone in small doses, in a small number of patients, over a long period of time (2 years) seems safe, but does not seem to do much for older men and women except help with minimal weight loss and minimal bone changes. Perhaps higher doses are needed or perhaps more research is needed to establish safety or perhaps all of this stuff is worthless.

The search for pills, creams and a variety of other medicines that can slow the aging process is a very profitable industry, (this is the understatement of the year). Currently, in the U.S., there are several books that promote bio-identical ("natural") hormone therapy for men and women to improve energy, increase sexual health or just become super all-night or all-day lovers, slow the aging clock, and apparently improve a variety of other areas in their life. In fact, I am waiting for some company to claim that if you take an anti-aging supplement it will also make breakfast for you in the morning. It is real easy to place the blame of aging on hormone in the body that decrease as we age. For example, growth hormone decreases by more than 10% every 10 years as individuals get older, but finding a strong study that really supports the use of growth hormones for anti-aging purposes is difficult, despite what some "experts" selling their product claim in an advertisement.

Another easy hormone target are the primary female hormone (estrogen) and the primary male hormone (testosterone). Estrogen levels drop quickly after menopause in women, and testosterone levels drop more slowly in men, as they get older. Another hormone, DHEA (also known as "dehydroepiandrosterone") or DHEA-S, comes from the adrenal glands which sit on top of the kidneys. DHEA can eventually be converted into a variety of hormones including testosterone and estrogen. It is also true that

DHEA levels decrease after the age of 30, and by the time a woman or man hits the age of 60 their DHEA levels have dropped more than 50%. So, DHEA is often sold as a replacement hormone in women and men to reduce all sorts of problems.

Commercials that sell these hormones come from a variety of places and make some claims that aging causes changes such as:

- Increase in fat, especially belly fat
- Decrease in bone mineral density and increased risk of a fracture
- Reduction in muscle, and a loss of strength
- Reduced quality of life, including your sex life
- Mental health issues
- Cardiovascular disease
- Cancer...blah, blah, blah...

However, there is an old saying in medicine “Are you the culprit or a bystander” or “association does not mean causation.” In other words, spring does not occur every year because winter ended, there are actual scientific reasons for the specific changes in seasons of the year. Just because thousands or even several hormones decrease in the body with time, does not mean that replacing any of them reverses aging. In fact, it could mean that disrupting the aging process could accelerate aging. This is a possibility that is not mentioned enough in the anti-aging movement, perhaps because it is a big business movement for some practitioners. Researchers learned in the Women’s Health Initiative (WHI) that increased amounts of certain hormones (estrogen and progesterone) after menopause actually increased the risk of cardiovascular disease and cancer. Some anti-aging experts claimed that this was due to the use of non-natural hormones, but in reality the findings were a surprise for many researchers including myself. We need to be careful playing “Monday, Tuesday, Wednesday, or whatever day morning quarterbacks.” It is real easy to explain away findings or place blame on why something did not work after the fact. However, I find it seems to be more difficult to be honest at the time for some so called “health experts.” My favorite example is vitamin E supplements, and general health. After 2 decades, one of the best selling vitamin E supplements has lost its appeal because numerous studies have not shown much of a benefit for this type of vitamin E for most health conditions. Rather than some health experts claiming to be wrong on this specific issue, and admitting that this

was a surprise or unexpected finding, it seems that some are now claiming that researchers did not use the right type of vitamin E and this is part of the overall problem. Researchers apparently need to use a more “natural” vitamin E supplement to change health. The problem is that the natural vitamin E supplements do not have much, if any, real research into any long-term health benefits. So, rather than claiming that there is no clear cut answer yet on vitamin E, some health experts would rather appear that they are never wrong than do the right thing for patients ethically and morally. This is the danger of preventive medicine, and every year this arrogance is probably responsible for more undocumented injuries, illnesses, and deaths than one could imagine in medicine. So, how about offering 3 answers in medicine – “yes, no, or I have no idea yet if this does or does not work - not because I am an idiot but because there is no research on this subject of any real value.” This brings the readers back to the issue of the anti-aging movement and medicine. Rather than telling patients that adding hormones back into your body as one ages has unknown effects right now, it seems more important to make a variety of unsubstantiated claims. The reality is that adding hormones back even in small doses may help, hinder, or have no impact until it is studied. Patients need to realize that some of the anti-aging claims depend on personal experience to support the promotion of the product. For example, the claim that it helped this particular person should be good enough; forget the large and objective studies. This is simply ridiculous - if someone lives to be 100 years old and smoked and drank alcohol every day and was obese, this does not mean I would advocate this type of lifestyle. This is why I really enjoyed reviewing this latest study from the New England Journal of Medicine that interestingly enough, received little to no media attention after it was published recently, and I wonder why?!

DHEA was given for 2 years at a dose of 75 mg per day in men and 50 mg per day in women. These researchers decided to look at the impact of this hormone on the body, physical performance, insulin and other factors compared to a placebo. There were a total of 87 men (29 received DHEA, 27 received testosterone, and 31 received placebo) in this study and 57 women (27 received DHEA and 30 received placebo), and the average age of the participants ranged from 66 to 70 years. Men and women in this study were just slightly overweight with a Body Mass In-

dex (BMI) of 26 to 27.

Women that had low levels of DHEA (median value of 0.4 mcg/ml or 1.1 nmol/l), and men with low levels of DHEA (median value of 0.7 mcg/ml or 1.9 nmol/l) had their levels increased by approximately 3.5 mcg/ml or 9.5 nmol/l after taking DHEA. This is a 500% increase in blood levels of this hormone in some of the patients! This current study showed that quality of life did not change on DHEA, but perhaps a larger study would have provided more clarity in this area. There were no changes in oxygen intake (a measure of metabolism change), muscle strength, or insulin.

Another part of the study enrolled older men with a total testosterone level that is considered low (below the 15th percentile) and gave a transdermal testosterone patch (5 mg per day) enough to raise testosterone levels from an average of 357 ng/dl (12 nmol/l) at the beginning of the study to 461 ng/dl (16 nmol/l), and their bioavailable (amount of free testosterone in the blood and the amount bound to a protein known as “albumin” in the blood) testosterone level increased by about 30.4 ng/dl (1.1 nmol/l). There were no significant health changes (positive or negative) in these men, and this study and the researchers raised the question of whether testosterone replacement should be given to men that are aging at a normal pace. No changes occurred in quality of life with testosterone, and there were no significant side effects (no change in prostate volume, PSA, liver tests, electrolyte levels, or hemoglobin).

However, personally I was concerned that the DHEA group experienced an unhealthy drop in HDL or “good” cholesterol, which was a significant 5-point reduction in women, and an almost significant 3-point reduction in men during the study. No such HDL drop occurred in the testosterone-receiving group of men during the study. Men receiving testosterone had a slight reduction in fat tissue, and bone mineral density increased at the hip area in men on DHEA and testosterone. In women, DHEA increased bone mineral density only in the area of the wrist, but not at other sites. So again, this study leaves open the possibility of testing higher doses of DHEA and testosterone but safety will ultimately also be an issue.

The results overall were disappointing, but were not necessarily different than some other large studies. Several studies using a dosage of 50 mg of DHEA have found a variety of isolated benefits, but no over-

all impact with this hormone. For example, one study found benefits only in women (age 60 to 79 years) and an increase in sexual desire or libido, but no body changes or muscle changes. Some studies report increases in bone mineral density, but the changes have been small and inconsistent. Interestingly, these bone changes are only about half of what can be achieved with estrogen or taking a bone drug (bisphosphonate).

A loophole in U.S. legislation has allowed DHEA to be regarded not as a drug, but as a dietary supplement. However, DHEA was never approved as a drug by the Food and Drug Administration (FDA), but rather, its status was altered from drug to dietary supplement under the Dietary Supplement Health and Education Act (DSHEA) of 1994. Any company that sells a dietary supplement may not make claims that their products “prevent, treat, cure, mitigate, or diagnose” any disease unless proven by research and supported by the FDA. However, a number of companies do not seem to follow this rule, and make false and misleading claims about a variety of supplements including DHEA. What is even more concerning at times is that the FDA cannot police many of these companies, but also cannot ensure that what is advertised on the label of a supplement is actually in the bottle. For example, one study of DHEA supplements found that of the commercially available DHEA preparations tested, they contained anywhere from 0 to 150% of the actual amount stated on the commercial package. This is and should be completely unacceptable.

DHEA is not well-understood in the human body in terms of its overall significance to health. In fact, some animals do not even produce DHEA, for example rodents. However, other hormones that come from the adrenal gland such as cortisol and aldosterone do have important physiologic functions. Some researchers believe that DHEA is not really that important, because men for example make enough testosterone and do not need the small contribution from DHEA from the adrenal gland. If there is a problem with the adrenal gland and it simply does not produce enough DHEA, then in this situation some experts believe DHEA supplementation makes sense. However, this is also controversial.

Bottom Line

I always like to say that if a medication or supplement does not come with a catch or a side effect then over the short-term it is probably ineffective or worthless. In other words, if it is 2 AM in the morning and an infomercial comes on TV and claims the product is “all natural with absolutely no side effects” then in my opinion there is absolutely no active ingredient in the product. Taking low-dose DHEA supplements in older men and women for about 23 months increased the blood levels of DHEA to normal-to-high of that usually found in a young individual, and it slightly increased the blood level of testosterone and estrogen in women, and just increased estrogen levels in men. Low-dose testosterone replacement in men significantly increased the levels of both total and bio-available testosterone in these men. DHEA in men and women, or low-dose testosterone in men did not seem to have much overall benefit or harm, including no change in PSA or prostate volume for men. DHEA did reduce levels of HDL or “good cholesterol” which I find concerning, but testosterone did not cause harmful cholesterol changes. Neither DHEA nor testosterone impacted insulin levels, physical performance, or quality of life. Higher doses of DHEA and/or testosterone need to be studied, but in the meantime, reversing the signs of aging with hormones has little to no evidence, and even if it is possible to reverse aging with high doses of some hormones this will come with a catch. Either way, let’s keep the B.S. out of medicine and in the barn and let honesty rule the day. You may remove my soapbox now!

78) Grapefruit and possibly other fruit juices may impact the metabolism of some of your prescription drugs. Always check with the pharmacist and other health care professionals for the latest and greatest information.

Grapefruit juice (I really enjoy drinking this stuff especially when I am sitting on a beach in Florida contemplating my early retirement where I will yell out loud at the grocery store when they are out of my favorite bread, hair color or fiber tablets, fight with and make up with my wife a lot (if you know what I mean here...), complain about the government, go to dinner at 3:30 PM for the early bird special, talk about my bowel movements to anyone that can hear me within 10 to 20 feet of the restaurant table, and use the words “the world is going to hell in a hand basket” after watching the nightly news on a daily basis) and other fruit type juices have the temporary

ability to stop an enzyme from working in the intestine and liver that is usually involved in the metabolism of certain drugs. It can take as little as 4-6 ounces of grapefruit juice or eating 1 regular size grapefruit, and the impact can last for as long as 3-7 days. This impact means that the concentration of the drug can run quite high (higher than normal over a long period of time) and this could result in no, minor, or major side effects (depends on the drug, dose, and person). However, even though grapefruit juice gets a lot of attention, there are other products that should also be mentioned that have this ability to increase prescription drug concentrations. For example, seville oranges, tangelos, limes, and even marmalades made from grapefruit peel may be an issue. It also turns out that recently pomegranate juice has been found to potentially have this same effect (but this needs more research and is getting more research at some places like Johns Hopkins...). In the meantime, we will discuss pomegranate juice in a future issue and in the journal Seminars in Preventive and Alternative Medicine that I will shamelessly promote at the end of my column in this newsletter. Hey, I like pomegranate juice, but everything in life has to come with a catch! At least it is getting some research.

So, ALWAYS ASK THE PHARMACIST ABOUT THE LATEST INTERACTIONS OF YOUR MEDICATIONS WITH FRUIT JUICES. Not all prescription drugs have this problem, but some of the more common ones might surprise you and they include:

- Antidepressants (such as Zoloft®...)
- Benzodiazepines for anxiety... (such as Valium®, Halcion®, ...)
- Calcium channel blockers for high blood pressure (such as Norvasc®...)
- Cholesterol lowering drugs (such as Lipitor®, Zocor®, ...)
- Erectile dysfunction drugs (such as Viagra®...)
- Estrogen
- Extended release tablets

Some of the dietary supplements and herbal products have not been tested so always inquire about any pill you’re taking and possible interactions with fruit juices. This column may scare some of you, but it shouldn’t because the purpose of it is to show you that knowing a lot about any pill you take is simply smart, and pharmacists and other health care profes-

sionals are NERDS (this is a compliment - I am a nerd also) just like doctors, nurses, physician assistants... and they know all about this drug interaction stuff. So, PLEASE TALK TO YOUR PHARMACIST ABOUT THIS WACKY AND WILD STUFF and see you at the next nerd convention or in the town of nerdville because I am the mayor.

79) Vytorin® or ezetimibe (Zetia®) is a good option in individuals that want to lower their cholesterol levels, but are having trouble taking a cholesterol-lowering medication (also known as a “statin”).

Zetia® is a prescription drug that comes in a once a day 10 mg pill that can be combined with any statin drug or can simply be taken by itself as an individual pill. It works by blocking the absorption of dietary cholesterol in the gut, so this cholesterol never goes into the blood or to the liver. What happens if cholesterol does not reach the liver? The liver responds to this situation by creating more receptors in the liver itself for low-density lipoprotein (LDL, also known as “bad cholesterol”). More receptors for LDL means that more “bad” cholesterol can park in these receptors and these LDL’s are taken out of the bloodstream, into the liver, and this lowers the blood levels of LDL. Zetia® also blocks the absorption of some plant cholesterol and not just egg, meat, and shellfish (like shrimp) cholesterol. These plant cholesterol (also known as “phytosterols”) are healthy in general and also may block other food sources of other cholesterol, but some people that absorb too much plant cholesterol also can have an increase in their blood cholesterol levels. Other plant cholesterol types known as “phytosterols” are not impacted as much by the drug Zetia®. The important point here is that plant sterols and plant stanols by themselves can reduce cholesterol by occupying the limited amount of space available for unhealthy food sources of cholesterol to be eventually absorbed in the gut, which would then go to the bloodstream.

Only foods from animals have real “cholesterol” that may be generally harmful if one gets too much of it. The brain has the largest amount of cholesterol, while liver, and other organ meats also have high amounts-even muscle tissue contains moderate amounts. Egg yolks have high amounts of cholesterol (200 to 250 mg per egg), but the egg white does not contain any cholesterol. Breast milk has moderate amounts,

which demonstrates the importance of cholesterol at certain points of human development. Dairy items also have cholesterol, which are generally found in the butterfat portion of dairy. So, dairy, meats, fish (salmon has 50-75 milligrams per 3 ounce portion), and shellfish are the primary sources of cholesterol. Some heart healthy diets support the idea that individuals should not get more than 300 mg a day of dietary cholesterol (from meat, eggs, and shellfish). Let’s get back to the story of Zetia®.

When Zetia® is taken it can undergo a fairly quick breakdown in the intestinal wall and liver. However, the overall half-life of the drug, after one takes it, is about 22 hours, which means patients only need to take 1 pill a day. This drug has no effect on the activity of the drug metabolism enzymes (such as P-450 or N-acetyltransferase). It has little to no interaction problems with most drugs such as blood thinners, oral contraceptives, and antacid or acid suppressive agents. However, one type of cholesterol lowering drug known as “cholestyramine” may reduce the plasma concentration of this drug by as much as 50%. Age, sex, kidney, and liver function do not show differences, in general, of how the drug is metabolized. In other words, this drug can be safe in a lot of individuals. One clinical trial of almost 400 patients demonstrated how different doses of zetia® can reduce LDL or “bad” cholesterol. The percentage reductions in LDL with the various doses of Zetia® were as follows:

- 0.25 mg Zetia®=12.7% LDL reduction
- 1 mg Zetia® =14.7% LDL reduction
- 5 mg Zetia® =15.8% reduction
- 10 mg Zetia® =19.4% reduction

So, this is why the dosage of Zetia® chosen for prescription was 10 mg a day because it reduces LDL cholesterol by itself by about 20%. Again, this drug can be combined with all types of other cholesterol lowering medications such as statins and fibrates (such as the drug “Tricor®”). In fact, when Zocor® the statin drug is combined with zetia® in one pill this is known as the drug “Vytorin®.” This drug has allowed some individuals to also lower the amount of statin drug they take so they may have a lower number of side effects.

Another potential benefit of Zetia® besides about a 20% lowering of LDL, is the slight increases (2-5%)

one may get in HDL or “good cholesterol” and a possible small reduction in triglycerides (2-5%) or “fat” in the blood. Also, because it is not extensively metabolized by the liver and body, it is unusual to have muscle or liver problems from taking this drug, but the catch of course is the fact that zetia® can not lower cholesterol better than any moderate to high-dose statin when compared head to head. However, again keep in mind that this drug can work complementary to a statin because they work at different sites in the human body.

So, who qualifies for Zetia®? The following types of individual’s should ask their doctor about Zetia®:

- individuals that do not do well on statins by themselves
- individuals that continue to have a high LDL despite the dosage of statin used
- individuals that simply cannot reach their LDL goal with diet and lifestyle alone

A small number of individuals have a rare inherited disorder known as “sitosterolemia,” which results in a reduced excretion of plant sterols (or plant cholesterol such as sitosterol, campesterol...). Patients with this disorder can do very well taking zetia®.

The bottom line is that as researchers are beginning to learn of the importance of having a low cholesterol to reduce the risk or even progression of a variety of diseases, including prostate cancer, so Zetia® is simply another of many options that can help people reach their cholesterol goals.

80) The not just for prostate cancer patients part of the column (similar to the above article). Everyone reading this column should read about this latest eye health trial. The National Institutes of Health (NIH) is launching a new dietary supplement clinical trial for potentially preventing the progression of age-related macular degeneration (AMD) using fish oil. Are you a candidate to participate?

Here is an exciting new clinical trial being paid for by the government (your tax payer dollars). Almost 100 clinical centers are participating and currently attempting to enroll about 4000 patients ages 50 to 85 that have age-related macular degeneration (AMD), which is the leading cause of blindness in the elderly in the U.S. The NIH is funding this study to see if a combination of vitamins, minerals, and fish oil can

slow the movement or progression of vision loss from AMD, which is the number 1 reason for vision loss in the U.S. for individuals over the age of 60 years.

This new study is called the “Age-Related Eye Disease Study 2 (AREDS2)” and will attempt to add to the knowledge of what was learned in the Age-Related Eye Disease Study (AREDS) that was completed five years ago and changed the way macular degeneration is treated in the U.S. The AREDS study found that a pill with a combination of vitamins and minerals (vitamin C & E, beta-carotene, copper, and zinc) reduced the actual risk of progression to advanced AMD by 25%, and reduced the risk of moderate vision loss by 19%. This trial changed the way eye doctors now treat the dry form or most common form of AMD. In fact, the original pill formulation used in AREDS could save more than 300,000 people from vision loss over the next 5 years if it is used in individuals with the dry form of AMD.

AREDS2 will use the pill from the original study, but will also add lutein and zeaxanthin, which are plant-derived yellow pigments that get concentrated in the macula of the eye, which is the small area responsible for central vision (see straight ahead) near the center of the retina. AREDS2 will also use the omega-3 fatty acids EPA and DHA in the pill formulation. Observational studies, but not large clinical trials have demonstrated that lutein, zeaxanthin, and omega-3 fatty acids may protect the eyes from vision loss, but a large clinical trial is needed to support these initial findings.

AMD simply causes injury or damages the macula of the eye, and as the disease advances it begins to blur the central vision of the patient so that they can really only see well peripherally. However, there are two forms of AMD, the wet and dry form. Dry AMD is by far the most common form of AMD and it is usually slow and partially treated by the antioxidants found to be effective in the AREDS trial from 5 years ago. Dry AMD occurs when the light-sensitive cells in the macula begin to slowly break down. Wet AMD is also a major and even bigger concern because it is more severe and advanced than the dry form and results in a rapid loss of central vision unless the disease is treated. It is also important to know that untreated dry AMD can actually become

wet AMD, and that is why more effective treatments for all forms of AMD are needed now.

The best candidates for this clinical trial are patients at a high risk for advanced AMD that may lose their vision. So, AREDS is looking for patients with AMD in both eyes or advanced AMD in one eye. Patients must be available for once a year eye examinations for at least 5 years. For a list of study sites, eligibility requirements, and any other information on this trial please call 1-877-AREDS-80 (1-877-273-3780) or go to: <http://www.nei.nih.gov/AREDS2> to review the clinical trial sites near you over the web.

It is also important to mention to prostate cancer patients that you should not take an eye health supplement with high-doses of zinc unless given a good reason why by the eye doctor. High-dose zinc (100 mg or more) from preliminary studies has not been healthy overall or even prostate healthy. It seems that men taking eye health supplements should limit their supplemental zinc intake to about 20 mg/day (similar to that found in a cheap multivitamin) due to side effects with cancer medications and other issues we have discussed in the past issues of this newsletter. Again, it is always better to be “safe than sorry” or “less is more” or “everything in moderation” or “that guy looked more nervous than a long tailed cat in a room full of rocking chairs” (oops - sorry that saying has nothing to do with zinc at all).

Bottom Line:

There is a new clinical trial being sponsored by the National Eye Institute (NEI), which is a part of the NIH. It is called the “AREDS2” and will include a pill made of lutein, zeaxanthin, and omega-3 fatty acids to attempt to slow the progression of macular degeneration if you have been diagnosed with this disease. If you are interested in signing up for this wonderful clinical trial where most items will be provided free of cost including eye exams and supplements, please call 1-877-AREDS-80 (1-877-273-3780) or go to: <http://www.nei.nih.gov/AREDS2> to review the clinical trial sites near you over the web.

I hope everyone has a wonderful holiday filled with low-calorie punch, high-fiber cereal, Canadian beer, snow, roasted soy nuts, cheap flaxseed, and omega-3 fatty acid shakes.

Mark, where is that shameless promotion you prom-

ised to deliver earlier in the column? Don't worry- here it is for your viewing pleasure.

I am the editor of a patient and health care professional medical journal by Elsevier called “Seminars in Preventive and Alternative Medicine” and it is now also offered online and will include regular medical updates for subscribers. If you go to the web-site of Elsevier publications (www.elsevier.com or call 1-800-654-2452) you can order the same medical journal that the health professionals can use that updates the latest on diet, supplements, and drugs... for cardiac disease, different cancers, and anything else that is happening in preventive and alternative medicine. It is far cheaper to do a 2-year subscription now than a 1-year subscription. This is almost the end of shameless promotion number 322, but seriously, for some patients the medical journal should be a good source of objective education. If you find that it is too expensive, we actually made it one of the cheapest medical journals ever offered by the company. If you still cannot afford it please contact PAACT because we are attempting to get them some free copies of some articles.

THAT IS ALL - GO BLUE---PLEASE JUST WIN THE NATIONAL TITLE FOR ME AND I WILL BUY BEER (limit 1 two ounce beer per individual and maximum number of total beers I will purchase from this promise is 6, and no light beer is allowed) FOR EVERYONE OF THE RIGHT AGE THAT PRETENDS TO BE A MICHIGAN FAN WHEN I SEE THEM AT A LOCAL MEETING OR TALK!

High Dose Testosterone Replacement Therapy (TRT) and Prostate Cancer (CaP) Part II

By Robert L. Leibowitz, M.D.
Compassionate Oncology Medical Group
310-229-3555

In 1941, Huggins and Hodges reported that removing the testicles in men with metastatic prostate cancer resulted in a remission for more than 80% of them. Unfortunately remissions only lasted an average of about 18 months.

Since removing testosterone (T) initially controlled metastatic CaP, it was most logical to assume that giving T to a man with CaP would be like pouring gasoline on a fire. This is what 99.9% + of all doctors believe. The package inserts for all TRT products state that “testosterone is contraindicated for all men with CaP.” This implies that T will markedly stimulate CaP cells to grow, spread and hasten death.

Because of space limitations in this PAACT edition, readers are urged to log onto our website <http://www.compassionateoncology.org> where you will find papers I have written on Testosterone Replacement Therapy along with the medical references that support my beliefs, insights and opinions (“Testosterone Replacement Therapy”, “High-Dose Testosterone Replacement Therapy” and “Testosterone Levels and Prostate Cancer – The higher, the better?”). This paper and all of my papers may be downloaded at no charge from our website under Publications. I urge everyone to please read the full text on TRT before trying to determine if you could ever consider TRT.

I cannot overemphasize that this paper should not be brought to your doctor along with a request for a testosterone prescription. Testosterone is contraindicated in men with prostate cancer. It has caused the death of some patients (fortunately, no one in my practice); permanent paralysis, increased bone pain, and new metastases. In my opinion, the only indication for using T in a patient with prostate cancer is for quality of life issues. We require comprehensive consultation on all patients who are considering therapy with T including a discussion of all risks/benefits/alternatives and informed consent. Very frequent monitoring of laboratory results is mandatory – varying from once each week to once each month. In addition, frequent visits and follow-up scans are required.

For more information, you can call his office and request a copy of a patient volunteer contact list (over 40 volunteers) at 310-229-3555.

* None of the above should be construed as medical advice or consultation, and anything discussed in this paper is meant for information only. All medical treatments, consultations, decisions and recommendations can only be made by the patient and his/her treating physician.

Legend to Abbreviations:

A/G = Aminoglutethimide
A.A. = African American
AAC = Antiangiogenic Cocktail
BID = Twice a Day
C = Casodex
C.T. = Cat Scan
CAB = Continuous Androgen Blockade
CaP = Cancer of the Prostate
COMG = Compassionate Oncology Medical Group
D/C = Discontinued
DRE = Digital Rectal Exam
DT = Doubling Time
EBL = Estimated Blood Loss

ECE = Extracapsular Extension
F = Flutamide
gl = Gleason Score
JHH = John's Hopkins Hospital
KC = Ketoconazole
L = Lupron
Lt. = Left
mets = Metastasis
mg/day = Milligrams Per Day
nl = Normal
P = Proscar
PAP = Prostatic Acid Phosphatase
PNI = Perineural Invasion
Pos. = Positive

PSA = Prostate Specific Antigen
PSADT = Prostate Specific Antigen Doubling Time
R.P. = Radical Prostatectomy
R.t. = Right
R.T. = Radiotherapy
Rx = Treat
SV = Seminal Vesicle
T = Testosterone
TAB@ = Triple Androgen Blockade
T/E/C = Taxotere/Emcyt/Carboplatin
THB@ = Triple Hormone Blockade
TRT = Testosterone Replacement Therapy
y/o = years old
Z = Zoladex

I would like to acknowledge the continued help of Joanna Tai, my office manager, in the preparation of these reports and the associated TRT manuscript.

TRT CASE REPORTS

1. John H.

11/03 – 61 years old; PSA 3346; gl. 4+4/8 @ JHH; 22 lb. weight loss, severe bone pain. He was referred to the Hospice Service at his HMO. He was told to get his affairs in order because it was unlikely that he would survive more than a few months.

Treated with 13 months Triple Hormone Blockade®, 15 doses Taxotere/Emcyt/Carboplatin chemotherapy, and antiangiogenic cocktail.

1/05 – stopped hormone blockade, continue cocktail and add high dose testosterone.

	3/05	6/05	7/05	8/4/05	8/18/05	11/05	12/05	1/06	4/06
T	1612	1640	3703	3831	5488	3546	1644	1873	2255
PSA	0.128	0.163	0.372	0.453	0.454	0.360	0.420	0.360	0.330

	5/06	6/06	7/06	8/06	10/06
T	4036	2324	1247	2246	> 1500
PSA	0.380	0.628	0.501	0.513	0.590

2/1/2006 – Bone scan @ St. John’s Hospital, Santa Monica, CA, compared to 8/18/05, showed interval improvement – meaning less cancer.

2. Stuart B.

12/95 – 52 years old; gl 3+3/6 at JHH; PSA 7.3

5 mos. 2 drug hormone blockade; 12 mos. Triple Hormone Blockade®, then proscar alone.

7/03 – started high dose testosterone; later added in some antiangiogenic cocktail

	9/03	11/03	1/04	3/04	5/04	7/04 (note1)	9/04	11/04	1/05
T	1498	1545	1539	2062	1043	3678	1540	2674	1214
PSA	8.11	5.7	7.1	5.6	8.35	7.32	8.66	8.59	7

	3/05	4/05	6/05	8/05	11/05	12/05 (note 2)	1/06	2/06 (note 3)	3/06
T	1286	2237	1232	2068	1427	1474	2212	3181	2791
PSA	7.12	6.4	7.57	9.19	9.01	11.1	11.5	9.25	6.92

	4/06	5/06	6/06
T	2059	1599	1863
PSA	7.8	7.62	6.99

6/06 – died of natural causes. Dr. Bob told coroner the clinical history and coroner did special studies looking for any prostate cancer cells in the prostate. Instead of making only one slide of prostate tissue, the pathologist made 1 mm thin sections through the entire gland. This is the same way that a Radical Prostatectomy specimen is examined and evaluated. He also made multiple slides of the spinal bones where prostate cancer cells preferentially spread. In spite of all of this, NO PROSTATE CANCER CELLS were found anywhere in his body. Cause of death was heart attack.

3. John C.

1/03 – 78 years old; PSA 12; gl 4+4/8 (JHH) 9 of 9 cores involved; normal DRE

Treated with 13 mos. Triple Hormone Blockade®, including 3 Casodex per day through 3/04, then Proscar 5 mg once a day, so called Finasteride Maintenance® Therapy.

3/04 – Started T; later added in some antiangiogenic cocktail

	4/04	5/04	6/04	7/04	8/04	10/04	11/04	2/05	4/05
T	600	878	2247	1163	1455	2487	2400	2022	2914
PSA	0.018	0.200	0.313	0.644	0.835	1.400	1.320	1.990	3.170

	8/05	9/05	11/05	12/05	1/5/06	1/27/06	3/06	4/06	6/06
T	1536	1218	1451	4224	2516	4856	4538	4825	2236
PSA	2.800	3.100	3.500	4.810	4.670	4.240	3.780	3.100	3.290

	7/06	8/06	10/06
T	1993	1393	3173
PSA	3.630	3.860	2.960

4. Gene B.

01/02 – 62 years old; PSA 20.8; PAP 1.8; gl. 3+4/7; 3 out of 6 cores
02/02 – Zoladex + 1 Casodex per day for 2 mos., then Zoladex for 10 more months
03/02 – R.T. (7400 cGy)
05/02 – PSA < 0.1
05/03 – Finasteride Maintenance® started
06/28/04 – Consult with Dr. Bob – PSA .003, T 20, although off hormone blockade since 1/03
Up to 35 hot flashes per day
06/29/04 – TRT started, later some antiangiogenic cocktail added

	7/04	8/04	10/6/04	11/04	12/04	1/05	3/3/05	3/15/05	4/05
T	1015	975	2181	2452	2146	2114	1433	2040	1714
PSA	0.030	0.050	0.168	0.250	0.232	0.240	0.370	0.430	0.330

	6/05	7/05	8/05	9/05	11/05	12/05	1/06	3/06	4/06
T	3469	3265	3101	2705	5247	3485	3100	3231	2894
PSA	0.320	0.260	0.298	0.220	0.290	0.320	0.220	0.290	0.290

	7/06	8/06	10/06
T	1811	2155	2346
PSA	0.346	0.260	0.216

5. Bob L.

12/99 – 46 years old; PSA 8.6; gl. 3+3/6 in 3 out of 6 cores
Clinical Stage T2a by DRE
09/00 – PSA 6.93; started 13 months Triple Hormone Blockade® including 3 Casodex per day, then Proscar 5 mg per day (Finasteride Maintenance® therapy).
PSA < 0.05 after about 4 mos. hormone blockade
11/02 – Started T

	5/03	8/03	2/04	8/04	11/04	12/04	3/05	6/05	8/05
T	1428	3200	1109	1521	1547	2482	1071	2249	> 1600
PSA	2.860	1.170	1.610	1.780	2.240	1.990	2.280	2.920	2.220

	9/05	10/05	11/05	12/05	2/06	3/06	5/06	6/06	8/06	10/06
T	1297	1545	1164	3389	4241	2981	2082	1243	> 1644	1681
PSA	2.960	2.930	3.700	2.710	3.340	2.890	2.900	3.160	2.630	3.080

6. Malcolm M.

9/98 – 58 years old; AA; T1c 1 out of 6 cores; gl 3+3/6 (JHH)
1/99 COMG – PSA 5.11, T – 237
13 months Triple Hormone Blockade®, including 3 Casodex per day through 2/1/00
8/02 – PSA 1.37, T 341, Start TRT #1

	11/02	2/03	6/03	10/03	12/03	3/04	5/04	7/04	10/04
T	542	762	564	546	661	1070	1295	1983	1591
PSA	1.820	1.810	2.150	2.990	2.170	2.880	2.070	3.640	3.700

	1/05	3/05	4/05	5/05	6/05	8/05	D/C TRT	9/19/05	9/28/05
T	1307	1312	1322	1363	1544	1069	D/C TRT	123	256
PSA	3.050	4.250	4.660	4.600	6.670	7.550	D/C TRT	3.100	3.390

	11/05	12/8/05	12/22/05	12/25/05	1/06	2/06	3/6/06	3/27/06	4/06
T	271	254	447	Start TRT #2	970	1855	997	1834	2057

PSA	1.710	1.880	2.370	Start TRT #2	3.120	3.750	6.910	5.570	6.600
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	5/1/06	5/11/06	5/19/06	5/30/06	6/15/06	6/29/06	7/06	8/06
T	1956	1325	3209	1118	855	537	949	1218
PSA	9.430	7.200	10.200	9.660	4.700	1.970	2.490	2.820

7. Bob S.

11/92 – 72 years old; PSA 6.1; gl. 4+3/7; 6 out of 6 cores; 20-80%
 Lt. Iliac and obturator nodes; rib mets and L-3
 11/30/92 – Lupron + 6 Flutamide per day
 1996 – bone scan – normal
 1/97 – CT scans – no nodes
 3/97 – COMG; had been on CAB for 4 years and 4 months; PSA < 0.05, T-16
 Discontinued hormone blockade and start Finasteride Maintenance® therapy
 9/98 – PSA 0.04, T 46; TRT until 2/99
 9/02 – Restart TRT

	12/02	3/03	6/03	10/03	5/04	8/04	10/04	2/05	6/1/05
T	955	1476	> 1600	1310	2001	2390	1796	> 1600	> 1600
PSA	0.235	0.422	0.585	0.535	0.672	0.852	1.130	2.350	1.940

	8/05	9/21/05	9/05	9/28/05	10/05	11/05	12/05	3/06	7/06	8/06
T	4128	3675	Stop T	260	127	118	64	42	< 20	< 20
PSA	4.390	5.180	Stop T	3.170	1.840	0.243	0.091	0.015	< .003	< .003

Scans in 2005 – no mets.
 Was on T for 3.5 years and when he stopped T, his PSA fell to unmeasurable.

8. Dr. R.F.

6/04 – 59 years old; PSA 7.6; DRE found locally advanced disease
 gl. 4+4/8; 9 out of 10 cores involved
 8/04 – lymph node dissection at UCLA – 5 nodes contained prostate cancer and unable to remove hard mass of metastatic cancer so no R.P.
 8/23/04 – Treated with 12 doses weekly Taxotere and daily Emcyt.
 12/04 – consult with Dr. Bob and was started on 13 mos. Triple Hormone Blockade®; 9 doses Taxotere/Emcyt/Carboplatin chemotherapy and antiangiogenic cocktail; Received local R.T.
 4/05 to 6/05 – 6120 Gy.
 1/06 Started T and continued AAC

	1/06	3/8/06	3/24/06	4/06	5/06	6/15/06	6/30/06	7/06	8/06	10/06
T	1472	2183	4630	1184	2248	2789	2199	2349	2336	3879
PSA	< 0.1	0.210	0.198	0.110	0.110	0.147	0.154	0.145	0.144	0.167

6/06 – no mets on scans

9. Ron L.

7/95 – 49 years old; PSA 5.2; T1c; 1 of 4 cores; gl 3+3/6
 Normal DRE
 Flutamide alone for 4 weeks, then over the next 11 mos., received 9 4-week doses of Lupron; 1 of the doses was given almost 3 weeks late
 1/97 – Saw Dr. Bob – was off Lupron for 5 mos. and T was 382 confirming no Lupron present; PSA 3.4
 Was treated with Triple Hormone Blockade®, including Casodex per day though 2/98; then Proscar alone.
 3/03 - Started T.

	12/02	5/03	9/03	1/04	4/04	8/04	12/04	4/05	7/05	11/05
T	351	1164	1105	1195	1800	2388	1454	1908	2365	1570
PSA	2.770	2.170	2.510	3.350	3.030	3.500	3.400	3.210	3.910	4.140

	3/06	6/06	9/06
T	1842	1616	2586
PSA	5.590	5.070	4.680

Feels great; feels like he is 30 years old!

10. John L.

9/97 – 57 years old; PSA 48; locally advanced; gl 4+3/7; 5 out of 6 cores (JHH); Bone scan multiple bone mets.
 4/98 – left posterior pelvic pain, buttock and groin pain
 1st cycle hormone blockade: Lupron plus Flutamide for 3 mos.; then Lupron plus 1 Casodex for 11 mos.
 6/99 – Consult with Dr. Bob – stop HB; start 1 Proscar per day; PSA 0.07
 10/99 – PSA 4.29; T236
 1/00 – PSA 11; T 400
 6/01 – PSA 21
 8/01 – PSA 39; T 263; start cycle #2 hormone blockade for 9 mos. through 5/02, and start cycle #1 Taxotere/Emcyt/Carboplatin chemotherapy (8/01 to 1/02)
 5/02 – Start TRT cycle #1
 12/02 – PSA 19; stop T after 7 mos.
 2/03 – PSA 20; T 363; Start cycle #3 hormone blockade, for only 4 mos. through 6/03
 6/03 – PSA 0.1; Start cycle #2 T, lasting until 12/03
 12/03 – PSA 33; Start hormone blockade cycle #4, lasting until 10/04
 10/04 – PSA 0.4; Start TRT cycle #3
 1/05 – PSA 27; Stop T; start #5 cycle hormone blockade
 2/05 – Start cycle #2 chemotherapy (12 doses), through 8/05
 6/05 – PSA 0.03
 3/06 – Stop HB; Start cycle #4 T

	3/1/06	6/06	7/06	8/22/06	8/29/06	9/7/06	9/19/06	9/25/06	10/06
T		1250	846	1415	4569	849	1002	1348	1046
PSA	0.008	18.600	31.000	39.500	26.000	8.530	6.340	4.260	4.700

11. Dr. Bob P.

11/98 – 53 years old; PSA 22.5; DRE locally advanced; gl 4+5/9, 3 out of 6 cores involved
 12/98 – started Lupron and 1 Casodex for 8 months
 R.T. 7000 cGy 3/99 to 5/99
 7/01 – PSA 0.3; 7/04 PSA 0.7; 2/05 PSA 1.2
 4/19/05 – PSA 1.7, consult with Dr. Bob, PSA doubling time 7 mos.
 Cycle #2 Hormone Blockade; 9 mos. of 3-drug HB but avoided anti-androgens along with 15 doses Taxotere/Emcyt/Carboplatin chemotherapy and Dr. Bob’s prostate cancer antiangiogenic cocktail (AAC)
 2/1/06 – Stopped HB, continue AAC and add high dose T

	3/06	4/06	5/06	6/06	7/06	8/06	9/06
T	< 2160	3650	2707	1437	1079	2155	< 2160
PSA	0.110	0.230	0.290	0.300	0.380	0.400	0.500

12. Richard W.

2/95 – 52 years old; pain in low back, legs, buttocks, and pelvis; PSA 2378; PAP 51.8; gl 4+4/8 all cores; marked locally advanced disease
 Bone scan – multiple bone mets; CT chest showed too numerous to count mets in both lungs up to 1.5 cm in diameter
 Start cycle #1 Triple Hormone Blockade®, lasted for 13 mos.
 3/96 – PSA 0
 8/97 – PSA 24; start cycle #2 hormone blockade, lasted for 11 mos.; start cycle #1 chemotherapy with 16 doses Taxotere/Emcyt/carboplatin
 10/00 – PSA 42; start cycle #3 hormone blockade, lasted for 11 mos.; start cycle #2 chemotherapy with 18 doses Taxotere/Emcyt/Carboplatin
 1/02 – antiangiogenic cocktail
 6/02 – start cycle #1 T, lasted for 10 mos. through 4/03 (PSA 15, T 500)
 7/03 – PSA 65; start cycle #4 hormone blockade, lasted for 13 mos.; start cycle #3 10 doses chemotherapy (PSA 0.06)
 8/04 – Start cycle #2 T, lasted 5 mos. until 1/05 (PSA 49)
 1/05 – Start cycle #5 hormone blockade, lasted until 2/06 (PSA.05)

	3/06	4/06/06	4/18/06	5/06	6/12/06	6/22/06	7/06	8/06	9/06	10/5/06
T	1324	1690	1222	2288	1356	4100	2319	3293	8000	5882
PSA	1.360	4.580	5.950	3.980	4.900	3.160	2.300	2.310	1.160	4.500

10/20/06

T	2313
PSA	3,940

Lloyd Ney - Founder of PAACT

*Patient and member inquiries about PAACT's founder, Lloyd Ney, prompted us to print this article. Lloyd passed away in August 1998 and since then many thousands of PC patients and advocates have been added to the PAACT database. Most of them did not know Lloyd or have the opportunity to converse with him. The following is from Dr. Strum's eulogy tribute to Lloyd, which expresses so eloquently the question **who was Lloyd Ney.***

“We are here today to show our respect, our admiration, and our love for Lloyd Ney. Let me share with you some recollections and my understanding of Lloyd's inner self. Lloyd was diagnosed with prostate cancer in January of 1984. He received radiation therapy in February and March of that year. Eight months later Lloyd had back pain due to metastatic prostate cancer involving the thoracic spine, sacrum, and left ribs. He was informed that his prognosis was terminal and to get his affairs together. Lloyd being Lloyd, found this unacceptable. He researched the literature on prostate cancer and came upon the pioneering work of Fernand Labrie in Quebec, Canada. Dr. Labrie's work had not been accepted at that time in the United States and was not to be endorsed until 5 years later. Lloyd went to Canada and was started on combination hormone blockade. When Lloyd realized he was not going to die, he dedicated whatever years he had left to help other men with prostate cancer. The six month prognosis Lloyd was given turned into 14 years. Lloyd's credo became what John Donne wrote about in 1623 in the poem No Man Is An Island. Let me paraphrase this:

**No man is an island unto himself; each man is part of the continent.
Any man's death diminishes me, because I am involved in Mankind.**

And Lloyd immersed himself in helping his fellow man. He worked out of his basement, 7 days a week, 20 hours a day directing confused, frightened men and their loved ones – their wives, girlfriends, and children. Lloyd put himself at the bottom of his priority list; he epitomized self-sacrifice.

An anonymous author from the Holocaust said: He, who saves one soul, saves the world.

And this was Lloyd's prime directive – his mission. Lloyd was a missionary as well as a visionary. He did not want to lose one fellow man. Lloyd was a one-man powerhouse. As stubborn as a mule, set in his ways, willing to lock horns with anyone, anywhere and anytime. This was the outer crust of Lloyd Ney – tough, irascible. But inside of this crust was the soft bread, the uniqueness of Lloyd Ney. I have not met a man so dedicated in his efforts to help others to the exclusion of himself. Lloyd established Patient Advocates for Advanced Cancer Treatments (PAACT). He worked doggedly at putting out the PAACT newsletter, and made a real effort to get cryosurgery on its feet. He is responsible for referring many patients into the capable hands of Fernand Labrie, Fred Lee, Duke Bahn, Bob Badalament, Snuffy Myers, Roy Berger, Israel Barken, Bob Leibowitz, Others who I forgot to mention, and also to me.

So, Lloyd was the mother hen, the caregiver for so many people – directly and indirectly.

Ralph Waldo Emerson said in his poem entitled: “A Few Words on Success”

To leave the world a bit better, whether by a healthy child, a garden patch or a redeemed social condition;

To know even one life has breathed easier because you lived. This is to have succeeded.

Lloyd has helped so many men. He has helped the men with prostate cancer but also, all those in the life sphere of these men as well: mothers, fathers, sisters, brothers, wives, children, grandchildren, friends, and business

associates – all over the world. Conservatively, Lloyd has touched the lives of millions. What a measure of a man's success.

Lloyd lit many candles. He is so much responsible to initiating and furthering the **empowerment movement** of the man with prostate cancer. A movement that is a paradigm for men and women working together to solve problems – it is a model for evolution of the spirit. Lloyd constantly **challenged the medical establishment**. He painfully listened to the horror stories of bad treatment of men with prostate cancer – hour after hour, day after day. This angered him, and often soured him on the medical professionals involved with prostate cancer. It led him to the concept of a **Consumer's Union of Men** with Prostate Cancer that would report on wonderful doctors and medical centers, but also on the terrible doctors. Lloyd challenged the FDA and wanted the prostate cancer movement to **fast-track drugs** and treatments for men with prostate cancer the way the AIDS patients have done for themselves. He inspired the formation of the legal arm of PAACT called LAC-PAACT.

There is a quote from the famous Rabbi Hillel that goes something like this: **If I am only for myself, what am I. But, if I am not for myself, who will be for me?**

Lloyd was hardly for himself. Lloyd would have perished years ago if it were not for the love and caring of his wife, Jan Ney. Jan was the perfect mate for Lloyd. For every strand of DNA, there is a second strand that reinforces the structure and integrity of the other strand. So it is with Lloyd and Jan. Lloyd never would have succeeded without Jan. The praises in the past and in the present to Lloyd Ney are equally bestowed upon Jan Ney. As I have told Jan many times, she is one of the angels that are easily identified on this earthly plain.

Lastly, I wish to say the following. It seems like a long time ago, but at the same time, just like yesterday, that a bunch of us met with Lloyd to discuss and write the tenets or basic concepts of PAACT. These appeared in the PCR or prostate cancer report. These concepts are: **choices, cooperation, concentration of effort, communication, compassion, centers of excellence, charity.**

A number of these concepts are now part of the reality for the man and his family with prostate cancer thanks to Lloyd.”

***Editor's Note:** Mr. Ney had received letters of commendation from Mayor John Logie, Governor John Engler, Senator Carl Levin, Rep. Vernon J. Ehlers, President Clinton, Drs. Duke Bahn and Fred Lee of Crittenton Hospital, National Prostate Cancer Coalition, American Cancer Society & U.C.I. Medical Center, Strathmore's Who's Who and the Advanced Prostate Cancer Support Group of San Diego.*

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