

MEDICAL ONCOLOGIST STEPHEN B. STRUM, M.D., FACP

For those of you who subscribe to p2p@prostatepointers.org, you cannot help but having been amazed at the expertise, knowledge, and thorough explanation for recommended treatment provided to patients to discuss with their physician(s) by renowned Medical Oncologist Stephen B. Strum. We who subscribe to the prostatepointers prostate cancer support lists sponsored by our Us TOO Intl., Inc. Prostate Cancer Education and Support Network are truly blessed to have a Medical Oncologist of this stature and expertise available to address the serious side of dealing with prostate cancer, particularly recurring/advanced prostate cancer. This caring physician spends countless hours in reviewing the concerned postings from patients to the p2p (patient to physician) list seeking the counsel of "someone" with expertise to address their concerns. And who has always been there for several years providing this extremely valuable service and thorough explanation at absolutely no cost to we patients? Dr. Strum! His donated services over the years would have added up to millions of dollars were he to have charged the usual Medical Oncologist fee for such consultation. There is little doubt he has saved and prolonged countless lives through his recommendations. We would be hard-pressed to find another physician as willing to provide this valuable service to we prostate cancer patients at absolutely no cost. This caring physician deserves a special award for this extremely important service. Dr. Strum is regularly in my prayers for a continuing healthy existence, and I hope he is in yours.

Below is an example of his responses to patient concerns, and following that is contact information for this extremely knowledgeable Medical Oncologist who has specialized specifically in research and treatment of prostate cancer, and particularly recurring/advanced prostate cancer, since 1983.

Important comments to a patient and of interest to all prostate cancer patients from renowned Medical Oncologist Stephen B. Strum, specializing specifically in research and treatment of prostate cancer, and particularly recurring/advanced prostate cancer since 1983:

High PSA – Gleason Score 4+3=7 or above

1. Need for EXPERT pathology assessment
2. Use of other biomarkers when Gleason score is 8-10 and even if (4,3); these include CGA (Chromogranin A), CEA (Carcinoembryonic Antigen), NSE (Neuron Specific Enolase) and PAP (prostatic acid phosphatase)
3. Importance of evaluation of bone integrity imaging and biomarkers:

imaging via quantitative computerized tomography (QCT) bone density (not to be confused with bone scan) and use of biomarkers such as urine DpD (deoxypyridinoline) or urine N-telopeptides (uNTx) or serum Ntx or serum b-CTX (C-Terminal Telopeptide, b-Crosslaps). These are key markers of bone status and also correlate with probability of bone metastases and also tell you and your MD if the medications/other treatments employed to stop bone breakdown (resorption) are being effective.

4. Importance of more accurate staging tools such as Combindex for nodal staging and 18F-Fluoride PET/CT instead of routine bone scanning. Labs such as CTC (circulating tumor cells) also important.

Not doing anything to assess the extent of disease (stage) & to commence treatment based on pros and cons of all findings makes no sense to me. There is no other malignancy that I am aware of where we would watch the cancer grow. ADT (androgen deprivation therapy) is both an excellent modality to reduce PC volume and at the same time get a sense of aggressiveness (mutated or not) of the PC. If there is no drop in PSA to 0.05 or less, then the patient must be presumed to be at very high risk for PC associated mortality. See abstract below:

Scholz M, Lam R, Strum S, et al: Prostate cancer-specific survival and clinical progression-free survival in men with prostate cancer treated intermittently with testosterone inactivating pharmaceuticals. *Urology* 70:506-510, 2007. 17905106.

OBJECTIVES: More than 85% of men with prostate cancer die of other causes. An effective method is needed to distinguish fatal forms of prostate cancer from benign variants. **METHODS:** We performed a retrospective chart review from a medical oncology practice specializing in prostate cancer. All men with negative bone scans, prostate-specific antigen (PSA) level less than 100 ng/mL, adequate records for review, and who started taking testosterone inactivating pharmaceutical (TIP) agents before January 2000 were included in the study. Six factors were evaluated as potential predictors of prostate cancer-specific mortality: PSA nadir greater than 0.05 ng/mL while taking TIP, PSA doubling time of less than 12 months, Gleason score, stage, baseline PSA level greater than 20 ng/mL, and age. **RESULTS:**

The study criteria were met by 160 men. The median follow-up was 10 years. The median age, PSA level, PSA nadir, and PSA doubling time was 65.6 years, 9.6 ng/mL, 0.03 ng/mL, and 10 months, respectively.

Of the 160 men, 39 died of prostate cancer. Death from prostate cancer was far more common (78% versus 11%) and accelerated (median of 4 years versus 7 years) for men with a PSA nadir greater than 0.05 ng/mL than for those with a

lower nadir. Multivariate Cox regression analysis indicated that the hazard ratio for prostate cancer-specific mortality in men with a PSA nadir greater than 0.05 ng/mL was 11.6 (P <0.0001). The hazard ratio for men with a PSA doubling time of less than 12 months was 2.9 (P = 0.04). Gleason score, stage, baseline PSA level greater than 20 ng/mL, and age were not statistically significant. CONCLUSIONS: Of the factors studied, the PSA nadir while taking a TIP was the best predictor of prostate cancer-specific mortality.

Regarding Incontinence and sparing of neurovascular bundles with surgery:

Occurrence of incontinence is hugely reflective of skill/experience of the urologist. Before this was understood by me, 50% of my patients having RP had gross incontinence. Immediately upon recognizing this "SKILL" factor, not one single patient in the ensuing 20+ years was incontinent after an RP. Also, the success rate of nerve sparing is clearly associated with similar surgical skills. All men are not created equal. They may have equal opportunities but definitely there is an artistry that is both inherited and developed. This might help you regarding realizing that the equation for success in anything has a lot to do with the skill of those involved in your care.

1. Proper assessment of the Patient
2. Proper treatment of the Patient
3. Choice of an Artist
4. Involvement and will to live of the Patient

The above are some of the key ingredients to a successful outcome. In the best of worlds, the above would be pre-empted by Prevention of Illness.

Regarding reaching ADT goals:

Key issues with failure to reach an undetectable nadir on ADT is:

1. Was testosterone deprivation achieved? It should be minimally 32 ng/dl or less.
2. Was testosterone assay used an accurate one at low levels of testosterone? Only the LC/MS/MS assay is accurate at low levels (< 50 ng/dl).
3. Was ADT comprehensive? Only use of ADT3 or ADT4 addresses issues of blocking AR (androgen receptor) and blocking DHT production by virtue of blocking 5AR (5-alpha reductase) using dutasteride (Avodart) or finasteride (Proscar).

Regarding moving to chemotherapy:

I have used high dose Taxotere (docetaxel) and high dose Taxol (paclitaxel) and then used lower, weekly dose therapy with either agent. I then went back again to the higher dose every 3 week regimen. There is no way that men with PC tolerate the every 3 week higher dose regimen well in contrast to even elderly frail men handling the weekly regimen. Moreover, I can combine the lower dose weekly regimen with other agents for synergy and still have good tolerance to the therapy.

Regarding a rising PSA while on ADT:

You should definitely NOT have been continued on Casodex in the face of a rising PSA (assuming testosterone level < 20 ng/ml or < 0.69 nM/L in the UK) since you might have an ARM (androgen receptor mutation) due to Casodex. Now you should definitely go abruptly off Casodex.

Regarding nausea while on chemotherapy treatment:

One of the best agents to resolve nausea is Kytril (granisetron) which now comes in not only tablet but also 5-day patch as well as i.v. form.

To learn more from this renowned Medical Oncologist who has specialized specifically in research and treatment of prostate cancer since 1983 regarding the treatment of our insidious disease, recommend subscribing to:

Physician To Patient

The purpose of the p2p mailing list is to provide the prostate cancer patient or other interested parties with information from physicians about the treatment of prostate cancer. This is a moderated list without the high volume normally associated with mailing lists or the frequent off-topic questions. To subscribe, go to:

<http://www.prostatepointers.org/mailman/listinfo/p2p>

IMPORTANT:

Every message sent to p2p must contain a Prostate Cancer Digest.

Instructions for preparing your digest are in the first issue of PCRI Insights, which you can get in .pdf format here:

<http://www.prostate-cancer.org/resource/insights.html>

The same instructions are also available as a webpage:

<http://www.prostatepointers.org/p2p/pcd.html>

Contact information for Dr. Strum if interested in his counsel:

Stephen B. Strum, Ashland, Oregon, Contact Miwha Strum at miwha@sbstgrum.com or call her at 541-201-0219 to arrange consultation