

AN EXAMPLE OF MAINTAINING PROSTATE CANCER STATISTICS
by CHARLES C. MAACK – Prostate Cancer Advocate/Mentor

Prostate Cancer diagnosed November 1992 at age 59 with PSA 6.3ng/ml
RADICAL PROSTATECTOMY December 16, 1992 at Wesley Medical Center, Wichita, Kansas, by Urologist from the Urology Department of the Wichita Clinic..

Biopsy prior to surgery gave a Gleason score of 5. Pathology after surgery used 28 slides to review **101.2g(!)** prostate gland measuring 4.5cm anterior to posterior, 6.5cm transversely, and 4.7cm from distal to proximal surgical margins (**NOTE: In retrospect, this size gland should never be administered surgery or radiation without first reducing to at least 55g**). Slides determined Gleason score of 7 (3+4), pathological staging T3aNOMX which equates to T3a-extraprostatic extension (in my case, into fatty tissue) without seminal vesicle invasion, NO-no lymph node involvement, MX-unable to determine distant metastasis.

Three slides covering four lymph nodes found no carcinoma

Four slides covering seven other lymph nodes found no carcinoma

Slide of seminal vesicle found no carcinoma

Two slides covering sections of the vas deferens found no carcinoma

No urethral involvement was identified

However, the posterior and bilateral distal portions of the gland showed positive margin involvement into fatty tissue.

Both neurovascular bundles excised (Little wonder, see “note” above. It is unlikely neurovascular bundles can be saved when attempting to extract such an enlarged prostate!).

Following recovery from the surgery, from February to April of 1993 I received 37 treatments of **EXTERNAL BEAM RADIATION** at Wesley Medical Center Radiation Department five days a week. After the radiation treatments my PSA reading was 0.1ng/ml and subsequent bone and CT scans were negative.

For the next three years scans were negative and PSA reading remained less than 0.1ng/ml.

In April 1996 my PSA reading was 0.25ng/ml. By November 7, 1996 my PSA reading had risen to 0.81ng/ml. On November 20, 1996 began **ANDROGEN DEPRIVATION THERAPY (ADT2)** with a LUPRON injection every three months, accompanied by a daily 50mg CASODEX pill, for what was considered a total testosterone blockade (later learned it was not). After turning 65 in December 1997 and having to switch to Medicare

as my primary coverage and no military coverage except for those medications a military pharmacy had in it's formulary, I was no longer covered for the CASODEX pill and the military would not stock it or provide it to me because of it's expense. Fortunately, the HMO I signed up to provide me supplemental insurance for what Medicare did not pay said they would pay for this oral cancer medication. However, in late 1999 they said they had made a mistake, and would no longer pay for that medication. I then was able to get NILANDRON from Brooke Army Medical Center in San Antonio, TX and took that medication until late in 2000 when, though continuing Lupron (**ADT**), I discontinued taking any pill, so went from ADT2 to only ADT.

Earlier, on May 8, 2000, 3 years and 6 months with ADT2, I had a DEXA bone mineral density interpretation done to see if the androgen deprivation had effected that density. The result was Lumbar Spine: BMD 1-286, T Score 0.4, Z Score 0.1. Total Average Femur: BMD 0.984, T Score -0.8, Z Score -0.5. Interpretation of data: There was no evidence of osteopenia or osteoporosis.

Since by October 23, 2001 and five years of ADT2/ADT my PSA had not risen beyond 0.1ng/ml, I requested an ultra-sensitive 3rd generation PSA reading to get a more accurate marker of any PSA in my system. The result was a reading of 0.01ng/ml which, by several prostate cancer authorities, is considered in the range of "undetectable" PSA. I followed this having a testosterone serum reading done on November 6, 2001 to also get a marker for my current testosterone level . The result was a reading of 33 ng/dl, which is above what is considered the castration level of <20 ng/dl. This would indicate that I likely had/have an androgen dependent prostate cancer. (These tests should have been ordered by my physician five years ago after my first month of ADT2! It was only after my own research into procedures to be followed to ensure the ADT is working that I knew this should be necessary).

I now had transferred from my urologist to an oncologist at the Cancer Center of Kansas (CCK) (telephone 316-262-4667) who agreed with my reasoning that it was time to "test the waters." **WATCHFUL WAITING:** I discontinued androgen deprivation therapy (last injection August 2001). He directed that in view of the necessity to now keep a very close check on my level of PSA, I monitor my PSA and testosterone levels monthly. Should my PSA begin to rise, I should return to androgen deprivation Lupron injections and, if necessary CASODEX.

12/17/01 Normal PSA test <0.1 ng/mL, Testosterone 37 ng/dL

01/14/02 Normal PSA test <0.1 Testosterone 38
02/11/02 3rd Gen. PSA test 0.01 Testosterone 52
03/11/02 Normal PSA test <0.1 Testosterone 30
04/15/02 Normal PSA test <0.1 Testosterone 45
05/13/02 Normal PSA test <0.1 Testosterone 24

The 5/13/02 PSA test was supposed to be a 3rd Generation test but lab failed to realize that. I decided at this time I will just get quarterly 3rd Generation PSA tests until such time that I see any change in the readings.

05/21/02 3rd Gen PSA test 0.04ng/ml (figured this may be a miss-reading)

06/10/02 Another DEXA Bone Mineral Density test. Result: Compatible with normal bone density at each site examined (T-scores all above -1.0 – No evidence of osteoporosis).

08/20/02 3rd Gen. PSA test <0.01ng/ml Testosterone 122ng/dl (**Please note: Having been kept on Lupron continuously for 5 years, this was the highest level my testosterone ever returned. If a patient's PSA level maintains at <0.05ng/ml and testosterone level near or below 20ng/dl for at least one year, the patient should be taken off LHRH agonists and antiandrogens as intermittent therapy to give one's testosterone level a chance to return to near normal. Keeping a patient on continuous LHRH agonist for more than two years will likely result in little return of testosterone.**)

08/21/02 Bone Scan: No evidence of metastatic disease.

11/08/02 was supposed to be 3rd Generation but came back as a normal reading of <0.1ng/ml Testosterone 98ng/dl

AS OF DECEMBER 16, 2002, IT HAS BEEN TEN YEARS SINCE INITIAL RADICAL PROSTATECTOMY.

02/04/03 3rd Gen. PSA test 0.01ng/ml Testosterone 89ng/dl

04/29/03 3rd Gen. PSA test 0.02 Testosterone 95

06/12/03 3rd Gen. PSA test 0.04 No testosterone result

With this increase to 0.04ng/ml my oncologist wanted to resume Lupron. I requested we wait another two months.

08/05/03 3rd Gen. PSA test 0.05ng/ml Testosterone 88ng/dl

Oncologist agrees that we wait for more significant progression before recommending return to any treatment.

11/06/03 3rd Gen. PSA test 0.13ng/ml Testosterone 87ng/dl

RETURN TO ANDROGEN DEPRIVATION THERAPY (ADT)

(I saw this as a ten-fold rise and at the time thought it better to return to androgen deprivation therapy)

11/18/03 began two weeks of Casodex 50mg w/Proscar 5mg to prevent a biochemical flare before returning to Lupron. (With Congress enacting the law that retired military members and their dependents are entitled to military insurance coverage for life (Tricare-for-Life), I became covered for all medications, thus Casodex, Proscar, Avodart, etc. would now be covered by Tricare-for-Life.)

12/04/03 began Lupron 4-month injection and discontinued the Casodex and Proscar.

12/5/03 after reading a presentation by Dr. Charles “Snuffy” Myers, a nationally recognized oncologist specializing in prostate cancer treatment, I added 10mg Lycopene, a powerful antioxidant that causes prostate cancer cells to self-destruct, and 1000mg Fish Oil (Omega-3 fatty acid), a very powerful factor for general health as well as having a major impact on the evolution of prostate cancer

AS OF DECEMBER 16, 2003, IT HAS BEEN ELEVEN YEARS SINCE INITIAL RADICAL PROSTATECTOMY.

2/15/04 From an Email from Dr. Stephen B. Strum, another nationally recognized oncologist who specializes only in prostate cancer to a patient recommending Lycopene at 15mg twice daily, I increased my intake to that level this date.

2/27/04 **PSA <0.01ng/ml, Testosterone 26ng/dl.**

Since testosterone has not yet reached “castrate” level of <20ng/dl,

3/2/04 added Casodex 50mg daily.

3/25/04 At appointment with oncologist discussed the Casodex addition and my interest in adding dutasteride (Avodart) to bring down testosterone level to <20ng/dl. Oncologist reasoned that since Lupron alone has returned my PSA to virtually undetectable <0.01ng/ml and brought my testosterone down to 26ng/dl his preference would be to keep Casodex in reserve in the event my PSA were to begin a rise, and Avodart as well unless we determine that the testosterone is also not maintaining its current low level. He agreed with my preference for 84-day Lupron rather than 112-day Lupron.

3/25/04 **ADT.** Received 84-day Lupron injection (but continued Casodex 50mg one per day on my own, **ADT2**, while typing up my reasoning why I would prefer to be attacking any PC still present with full three-level blockade (ADT3) rather than *waiting* for some change to occur. ADT only buys time, ADT3 attacks PC cells and can kill them (apoptosis) or cause them to remain dormant for many years).

4/10/04 **ADT3**. Oncologist acquiesced to my preference to continue Casodex and add Avodart 0.5mg one per day to my regimen.
(During a presentation at our Us TOO meeting , a noted physician indicated that Avodart remains working in the system for more than two days, therefore it could be taken every other day and remain effective)
5/27/04 3rd Gen. **PSA <0.01ng/ml, Testosterone 23ng/dl.**
6/10/04 Received 84-day Lupron injection. Continuing **ADT3**.
8/24/03 **Testosterone 22ng/dl** – Lab lost blood sample for 3rd Gen PSA test.
8/25/04 Another DEXA Scan – No evidence of osteoporosis - all areas normal with all T-scores above -1.0, in fact for Lumbar Spine 5% improvement since 2002 scan and 3% improvement since 2000 scan; Right Femoral Neck 2 % improvement since 2002 scan and 1% improvement since 2000 scan; Left Femoral Neck 5% improvement since 2002 scan and 9% improvement since 2000 scan. (As a several year patient on ADT, I find this very questionable!)
9/2/04 Provided another blood sample for 3rd Gen. PSA test. Received 84-day Lupron Injection. Continuing **ADT3**.
9/7/04 Result of 9/2/04 test 3rd Gen. **PSA <0.01ng/ml.**
11/15/04 **PSA <0.01ng/ml, Testosterone 38ng/dl.**
11/23/04 Received 112-day Lupron injection because neither the Cancer Center of Kansas nor Via Christi St. Francis Hospital had 84-day Lupron in stock.

AS OF DECEMBER 16, 2004, IT HAS BEEN TWELVE YEARS SINCE INITIAL RADICAL PROSTATECTOMY.

1/26/05 Recognizing that the DEXA scan received and noted herein on 8/25/04 appears suspect since it is hard to imagine an “improvement” in bone density after being on androgen deprivation therapy for over eight years, a Pylilinks-D (Deoxypyridinoline – Dpd) urine test was administered as another measure to determine if excessive bone resorption or breakdown is occurring. This test measures a fragment of the bone matrix that is excreted in urine. Per Dr. Strum, a normal reading of Dpd/Creatinine ratio is considered <5.4nmol/mmol, within a range from 2.3 to 7.4 nmol/mmol. **Today’s test result of 9.4nmol/mmol is significantly high!** This supports my opinion that the DEXA scan has falsely read either arthritic changes in the lumbar spine and hip, curvature of the lumbar spine, and/or vascular calcifications in either spine or hip area as bone density, thus under-stating the degree of bone loss. (Note to readers: In that a DEXA scan can provide false readings, a QCT BMD (Quantitative Computerized Tomography Bone

Mineral Densitometry) scan should be the choice of testing if available in your area.)

2/1/05 **PSA <0.01ng/ml, Testosterone Free Direct reading of .8pg/ml of a normal range 6.6-18.1pg/ml** (When taking lab sample, clerk erroneously checked Testosterone , Free, rather than Testosterone, Serum)

2/15/05 Oncologist agreed that a bisphosphonate should be included in my medications and prescribed Fosamax 70mg, 1 per week, take with 6-8 oz. water same day of week first thing upon arising while empty stomach, no other meds or food for thirty minutes, and remain up and active after taking.

3/15/05 will be the final date of expected effectiveness of the Lupron injection received on 11/23/04. **ACTIVE OBJECTIFIED**

SURVEILLANCE: Having maintained a PSA of <0.01ng/ml for the past full year with ADT3, this will also be the commencement date of my second off-phase from ADT (Intermittent Androgen Deprivation – IAD) but this time maintaining with Avodart following the manner of the trial and results of Dr. Strum described in “A Primer on Prostate Cancer,” pages 144-149. I ceased intake of Casodex on 2/15/05. According to Dr. Strum, the concept behind using Intermittent Androgen Deprivation (IAD) is based on at least the following:

1. The finding of sufficient adverse effects (fatigue, muscle loss, hot flashes) from AD (androgen deprivation) to warrant giving the patient a “holiday.”
2. The belief that a testosterone surge has pro-apoptotic (cell killing) effects against the PC cell population (if there is residual active PC).
3. The ability of a normal testosterone milieu to stop the bone loss and release of bone-derived growth factors that are known stimulants for PC growth.
4. In men with intact neurovascular bundles, potency is usually recaptured in the off phase of IAD

5/10/05 **PSA <0.01ng/ml, Testosterone 23ng/dl.** In ADT off-phase (IAD) maintaining with Avodart 0.5mg one in the evening.

5/31/05 MRI of the Lumbar Spine with and without contrast. Wichita Open MRI. Findings: The sagittal imaging shows no evidence of compression fracture or evidence of altered signal from the marrow of the vertebral bodies. The transverse series does show some moderate stenosis at the L3-4 level secondary to disk bulging as well as some ligamentous and bony hypertrophic change. More moderate to severe stenosis is at the L4-5 level secondary to ligamentous and bony hypertrophic change. The AP dimension of the dura at the L4-5 level measures about 9mm. I do not see any evidence to suggest metastasis or evidence to suggest any abnormal enhancement.

Impression: There is moderate to severe stenosis most marked at the L4-5 level secondary to ligamentous and bony hypertrophic change with the AP diameter of the dural sac here measuring about 9mm. I do not see any metastatic disease or compression fractures.

8/9/05 PSA <0.01ng/ml, Testosterone 45ng/dl. Continuing in IAD off phase but maintaining with 0.5mg Avodart daily.

10/4/05 Pyrilinks-D (Deoxyypyridinoline-Dpd) lab result **6.4 nmol/mmol**. A significant reduction from 1/26/05 9.4 nmol/mmol reading as an obvious improvement result from the administration of Fosomax 70mg one per week begun 2/15/05. Normal range is 2.3-7.4 nmol/mmol but hope to reach preferred level 5.4 nmol/mmol recommended by Dr. Stephen Strum.

11/7/05 PSA <0.01ng/ml, Testosterone 51ng/dl. Continuing in IAD off phase but maintaining with 0.5mg Avodart daily.

AS OF DECEMBER 16, 2005, IT HAS BEEN THIRTEEN YEARS SINCE INITIAL RADICAL PROSTATECTOMY.

02/06/06 PSA <0.01ng/ml, Testosterone still 51ng/dl. Continuing in IAD off phase but maintaining with 0.5mg Avodart daily.

4/11/06 Pyrilinks-D result 4.9 nmol/mmol. Fosamax doing its job!

05/10/06 PSA <0.01ng/ml (CCK failed to get T level). Continuing in IAD off phase but maintaining with 0.5mg Avodart daily.

7/25/06 Pyrilinks-D result 5.0 nmol/mmol. Fosamax continuing doing its job.

8/15/06 PSA 0.02ng/ml (???, will check this again in November!), Testosterone 45ng/dl. Continuing IAD but maintaining with 0.5mg Avodart daily.

11/13/06 PSA 0.04ng/ml (Oops...maybe getting nasty again...will keep monitoring for awhile). T 53ng/dl. 25-hydroxy Vitamin D3 25.5ng/ml (extremely deficient in Vitamin D3! Will increase Vitamin D3 intake to 7200IU daily to try to reach preferred 65ng/ml).

AS OF DECEMBER 16, 2006, IT HAS BEEN FOURTEEN YEARS SINCE INITIAL RADICAL PROSTATECTOMY.

1/10/07 5a-Dihydrotestosterone (DHT) 2.9mg/dl. 25-hydroxy Vitamin D3 38.5ng/ml (Vitamin D3 movin' on up!)

2/13/07 PSA 0.07ng/ml (More oops....if it doesn't level off before reaching 2.0ng/ml I'll return to Lupron and Casodex added to my continuing Avodart) T has dropped to 39ng/dl.

5/8/07 PSA 0.08ng/ml (Ahha! Very small increase! At this rate, could be another couple years before a return to Lupron and Casodex). T back up to 59ng/dl but obviously not going to go higher. As a recurring PC patient, I have no intention to attempt T replacement therapy. 25-hydroxy Vitamin D3 41.6ng/ml so increasing at slow rate. Will increase Vitamin D3 supplement by another 1800 IU to a total daily intake of 9200 IU to see if that will provide a more significant increase.

5/22/07 Ppyrilinks-D result 5.1nmol/mmol. Still below Dr. Strum's preferred 5.4nmol/mmol. Fosamax continue to do its job.

7/8/07 Ppyrilinks-D result 4.9nmol/mmol.

7/31/07 PSA 0.11ng/ml (Hmmm! This is what is meant by Active Objectified Surveillance (AOS)!). T went way up (if you can call an 18ng/dl rise from previous steady levels of any value!) to 71ng/dl – yippee? 25-hydroxy Vitamin D3 level 51ng/ml (still goin' up!).

Parathyroid hormone level 8pg/ml. Calcium serum level 9.6mg/dl.

10/30/07 PSA 0.17ng/ml (still sneaking up), T 48ng/dl so dropped back down, 25-hydroxy Vitamin D3 level 60.8ng/ml so will probably cut current 9000 IU daily intake to 5000 IU and see how things look in three months.

10/31/07 Experiencing lower back pain, so had MRI this date. Result: Spinal stenosis at L4-L5 due to combination of degenerative disc, ligamentous and bony disease. No evidence of nerve root encroachment. Remainder of lumbar spine unremarkable and no sign of any acute bony abnormality or of metastatic disease.

AS OF DECEMBER 16, 2007, IT HAS BEEN FIFTEEN YEARS SINCE INITIAL RADICAL PROSTATECTOMY.

2/5/08 PSA 0.29ng/ml (continuing rise), T68ng/dl (whoopie!?).

5/6/08 PSA 0.37ng/ml (continuing rise but NOTE: The PSA is only a 0.08 rise in past three months and a 0.29 rise in the past year), T45ng/dl (back down), Vitamin D3 92.4ng/ml (so time to cut back to 4000 IU total daily to see if maintains 65ng/ml – my chosen plateau).

8/12/08 PSA 0.47ng/ml (continuing slow rise). T57ng/dl (gone forever, sigh). Erroneous lab report stated 25-hydroxy Vitamin D level as 38ng/ml. With previous report 3 months prior at 92.4ng/ml, re-tested for both 25-hydroxy and 1,25 dihydroxy Vitamin D levels. Result: 25-hydroxy Vitamin D 60.7ng/ml, 1,25 dihydroxy Vitamin D 50.7pg/ml. Since I would prefer my 25-hydroxy level at 65ng/ml, will add another 1000 IU Vitamin D supplement to the 4000 IU I had dropped to after

having jumped to 92.4ng/ml while taking in a total 9000 IU daily, to see if a total daily intake of 5000 IU will maintain

8/24/08 Colonoscopy. Significant diverticulosis, otherwise nothing unusual.

11/11/08 PSA 0.66ng/ml (+0.19), T 27.0ng/dl, Vitamin D 37.2ng/ml(!). This is surprising, and indicates I may as well up my daily Vitamin D intake to 8600 IU to get the level back in the 60ng/ml-75ng/ml range. This may have again been an erroneous lab result, however, since we didn't retest, I'll continue my increase to 8600 IU then see result in February 2009. If back up in the over 90ng/ml range, we will know this was an erroneous lab results and I'll cut back again to around 4600 to 5600 IU daily.

AS OF DECEMBER 16, 2008, IT HAS BEEN SIXTEEN YEARS SINCE INITIAL RADICAL PROSTATECTOMY.

02/10/09 PSA 1.05NG/ML (+0.39 – larger rise and time to consider return to ADT3 – will check PSA again in six weeks rather than three months), T was not checked and PSA rise despite castrate T of concern, 25-hydroxy Vitamin D 100ng/ml (top of normal range, which supports that lab reports on both 8/12/08 and 11/11/08 reporting 25-hydroxy Vitamin D levels as 38ng/ml and 37.2ng/ml were in error and likely reporting 1,25 dihydroxy levels but stating as 25-hydroxy levels. Had the lab not erred, I would have reduced my Vitamin D intake last August. I have now backed down to 4600 IU daily. All other important blood levels are within normal ranges.

04/07/09 PSA dropped down to 0.87ng/ml – a reduction of 0.18ng/ml - GREAT!

5/20/09 MORE GOOD NEWS: PSA dropped down to 0.81ng/ml. 25-hydroxy Vitamin D dropped down to preferred level 72ng/ml. T only 50ng/dl.

9/01/09 Oops, PSA now up to 1.16ng/ml! T still hovering around “castrate” level at 53ng/dl. 25-hydroxyVitamin D 76.6ng/ml. Discussed PSA levels with Medical Oncologist Charles “Snuffy” Myers while at PCRI National Conference on Prostate Cancer in L.A., and he suggested giving Rapamycin 1mg e/o day a try to see if PSA stabilized.

Rapamycin is a mTOR pathway inhibitor that in low dosage has no side effects but slows aging and reduces hormone resistance. Will wait for December PSA result to determine adding this medication to my “mix.”

12/02/09 Well, PSA 1.31ng/ml so still elevating. Beginning Rapamycin 1mg e/o day to see what occurs over next three months. Testosterone is only 12ng/dl, so when do return to ADT once reaching a PSA level of 2.0ng/ml, I'll likely forego a return to Lupron since there is no need, and will go with bicalutamide at 150mg daily to add to my continuing dutasteride/Avodart 0.5mg daily. My 25-hydroxy Vitamin D3 level is holding at 79.2ng/ml with 4600 IU daily.

AS OF DECEMBER 16, 2009, IT HAS BEEN 17 YEARS SINCE INITIAL RADICAL PROSTATECTOMY

As prescription requirements or my choice of medications or supplemental vitamins, I currently take the following (Exception: No Lupron and No Casodex when noting in these statistics that I am on an off-phase from ADT):

PRESCRIPTION MEDICATIONS:

(CURRENTLY IN OFF-PHASE THIS MED)

@LUPRON/LUTEINIZING HORMONE-RELEASING HORMONE

(LHRH agonist (112-day lasting injection) forces the pituitary to over-stimulate the Leydig cells in the testicles to “wear them out” or to reduce the ability of the messenger to stimulate those cells; the messenger is LH or Luteinizing Hormone-Releasing Hormone of the hypothalamus. The end product is a diminution of Leydig cell testosterone (T). This is better known as Androgen Deprivation Therapy (ADT), chemical castration, for prostate cancer control. Though historically termed ADT, it would be better termed TRT, since it is, in reality, Testosterone Reducing Therapy)

(CURRENTLY IN OFF-PHASE THIS MED)

#CASODEX/BICALUTAMIDE 50mg 1 at night. (An anti-androgen that blocks the androgen receptors and prevents natural androgens from stimulating cancer cell growth - ADT2)

#AVODART/DUTASTERIDE 0.5mg at night (5-alpha reductase (5-AR) inhibitor that blocks both Type I and Type II enzymes in prostate cancer cells from converting testosterone (T) to ten times more potent metabolite dihydrotestosterone (DHT) that profoundly stimulates cancer cell growth. Avodart/dutasteride also serves to cause prostate cancer cell apoptosis and

inhibit cell proliferation. ADT3 Androgen Deprivation Therapy for prostate cancer control when all three foregoing medications are taken.

+**FOSAMAX/ALENDRONATE SODIUM** 70mg in morning once a week and on same day (Sunday) every week (as a bisphosphonate to stop bone mineral loss and bone resorption that can result from androgen deprivation therapy (ADT). Also considered to inhibit osteonecrosis of the jaw).

(CURRENTLY OFF THIS MED UNTIL REQUIRED TO RETURN TO ADT)

#**RAPAMYCIN** 1mg every-other morning. mTOR pathway inhibitor to reduce hormone resistance.

+**FOSINIPRIL/MONOPRIL** 10 mg at night (ACE Inhibitor/diabetes aid)

+**ZOCOR/SIMVASTATIN** 40 mg at night (to reduce cholesterol)

+**PRILOSEC/OMEPRAZOLE** 20 mg in morning (to prevent gastric reflux/heartburn)

+**ADVAIR/FLUTICASONE PROPIONATE** 250 mcg **&**

SALMETEROL 50 mcg inhalation powder 1 inhalation in morning, 1 at night (to keep clear from bronchial & lung congestion)

+**GLIPIZIDE** 5 mg in morning, 5mg in evening (to control glucose serum level)

#**ZYRTEC/CETIRIZINE**) 10mg in morning (for allergy control)

#**MOBIC/MELOXICAM** 7.5mg in morning daily (to relieve signs and symptoms of osteo-arthritis and rheumatoid arthritis).

SUPPLEMENTS/VITAMINS:

***CALCIUM CITRATE** 945mg **W/VITAMIN D3** 600 IU at night (Sam's Club Members Mark) (to counter loss of bone density that could otherwise be caused by ADT)

***VITAMIN D3** 4000 IU in morning that by adding daily the Calcium/Vitamin D combination **TOTALS 4600 IU DAILY** (to maintain 25-hydroxy Vitamin D level within 60ng/ml to 75ng/ml range for prostate health; blood pressure regulation; heart attack, stroke, heart failure reduction; and helps reduce inflammation)

***COENZYME (COQ-10)** 200mg one capsule in morning for general health

***FISH OIL/OMEGA-3 FATTY ACIDS** **4000 IU** daily (2000 IU in morning, 2000 IU at night - as antioxidant reduces risk of recurrent prostate cancer as well as powerful factor for general health.)

***POMEGRANATE EXTRACT** 750mg (three 250mg capsules in morning) Pomegranate has substances, such as polyphenols, that have anti-oxidant, anti-viral, and anti-tumor activity. Pomegranate may also be helpful in maintaining healthy cholesterol and triglyceride levels, and a

recent study indicates pomegranate has compounds that play a role in osteoarthritis and prostate health

***VITAMIN C** 1000mg tablet in morning; Men with higher vitamin C intake appear less likely to develop gout, a painful type of arthritis.

***IBUPROPHEN** 200mg two in morning for arthritic discomfort

***ACETAMINOPHEN PM** 500mg at bedtime to aid sleep.

@ Administered in oncologist's office

+ McConnell AFB Pharmacy

Express Scripts 1-877-283-3858 physician-to-pharmacist number

*Over-the-counter