

**Meet Medical Oncologist Stephen B. Strum, M.D., FACP**  
(from a presentation to [www.smartlifeforum.org](http://www.smartlifeforum.org) April 2008)

Dr. Strum has been a board-certified medical oncologist since 1975 and has specialized in the evaluation and treatment of prostate cancer since 1983. He has been elected as a member of the American Society of Clinical Oncology (ASCO), the American Urological Association (AUA) & ASTRO (the American Society for Therapeutic Radiology and Oncology).

He is a graduate of the University of Chicago School of Medicine. His preceptor was Elizabeth Kübler Ross. While in Chicago, Dr. Strum published many peer-reviewed articles on the pathology and natural history of Hodgkin's disease working with Henry Rappaport, MD, an international expert on lymphomas.

In 1983, he collaborated with Dr. Fernand Labrie of Laval University in Canada on the use of combined androgen blockade in the treatment of prostate cancer--six years prior to FDA approval of Eulexin (flutamide) and Lupron (leuprolide). As a result of this pioneering work, his entire oncology practice was soon focused solely on prostate cancer.

Dr. Strum has authored over 100 articles on topics such as androgen deprivation therapies, the side effects of PC therapy (the Androgen Deprivation Syndrome or ADS) and their correction, the intermittent use of androgen deprivation (IAD), high-dose ketoconazole (HDK), and the importance of the PSA nadir versus development of bone metastases. Dr. Strum focused early on the importance of risk assessment via the use of nomograms, algorithms & neural nets. It was Dr. Strum that termed the Partin data as the "Partin Tables" and emphasized the importance of using nomograms and neural nets to assess risk and more intelligently plan treatment strategy.

In addition to his focus on prostate cancer, Dr.

Strum has concentrated on supportive care measures to lessen the trauma of more difficult therapies such as chemo and therefore enhance the therapeutic index of anti-cancer modalities. He published one of the earlier clinical papers on the use of the venous access device (Port-A-Cath), has pioneered in the use of anti-emetics in the early 1980's, and has been a clinical investigator for many new anti-cancer therapies since the 1970's.

In 1996, 1997, 1999 and 2000, Dr. Strum planned and moderated four national prostate cancer conferences--directed primarily at the PC survivor and his partner. He has volunteered his services in many forums to counsel patients regarding their course of treatment. In October 1996, Dr. Strum cofounded the Prostate Cancer Research Institute (PCRI), and was the main contributor to its Web site ([www.pcri.org](http://www.pcri.org)) and chief-editor and contributor to the PCRI newsletter "Insights"—which was mailed to every urologist, medical oncologist & radiation oncologist certified in the USA.

Dr. Strum and co-author Donna Pogliano published "A Primer on Prostate Cancer, The Empowered Patient's Guide" in 2002. This book has received much praise from patients and physicians alike and has been the leading PC book for patients on [www.amazon.com](http://www.amazon.com). Dr. Strum is a sought-after lecturer, author and consultant. Above all, he is passionate in his care of and for patients with prostate cancer. Dr. Strum and his wife, Miwha, live in Ashland, Oregon.

### **Main Presentation**

Where "modern medicine" has gone wrong in its approach to healthcare is quite obvious to any keen observer of the human condition. We physicians are, at worst neither pre-emptive nor pro-active in how we assess and maintain health, but instead foolishly reactive in how we deal with ills affecting the body and mind. In essence, we practice military

medicine and put a bandage over our patient's wounds and a blindfold over our eyes. To add insult to injury, when we are reactive—and often late at that—we treat all patients as if they were chips off the same biological block.

Individualization of patient care as a logical reflection of our unique biology is the exception in medical practice and philosophy among so-called health professionals. Those crucial concepts that are foundational in all interactions with biological systems are given little heed or not recognized at all. Crucial philosophies that govern, to a great degree, the success of medical intervention at all phases of our journey through health, i.e. prevention, diagnosis, evaluation, treatment, supportive care and end-of-life services, have vaporized in the last few decades. Instead, the prevailing medical disposition is to look at the patient as a commodity, a source of revenue, a billing code, a procedure that earns incomes, and a means to an end that is unrelated to doing good but relates instead to greed and ego. Patient outcome as a priority has been replaced by physician income and/or ego.

When Abraham Lincoln was asked about his religious beliefs he replied: “When I do good, I feel good. When I do bad, I feel bad. That is my religion.” This too used to be a prevailing philosophy among physicians.

"One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient." -Sir Francis Weld Peabody to Harvard medical students in 1917. When each of us enters a healthcare crisis, we have a unique opportunity to regain perspective, and to evolve in our sense of things that are really important. Our journey in life is really a search, a yearning for love and connection. From a purely medical standpoint, a health crisis is a call to awareness that we have lost balance in our lives,

microscopically and macroscopically. Balance and communication at a cellular level truly reflects health. At a personal level it reflects love and on a global level it reflects peace.

We Homo Sapiens are supposed to be sentient beings. This is especially true for those of us privileged to become involved with others who are at a crossroads in their life. Dr. Strum says, “in my years of medicine, I find it impossible to be a real doctor if I am not cognizant of foundational principles that tie the practice of medicine into a profession which is both an admixture of art and science, saturated in the love of the patient and a passion to fix the patient’s ills.”

What are these biological concepts that should be part and parcel of the everyday care of people, or for that matter for all biological living systems?

This is a first attempt to define core principles that have led him to a higher plain of medical care and rewarded him with professional interactions with patients that reflect what real medicine is all about.

What he presents below is a distillation of his experiences as a physician involved in cancer medicine since 1963. He welcomes suggestions to add or modify what is being presented. Lastly, he says, please realize that there is considerable overlap of various principles throughout the medical genealogy of prevention-diagnosis-evaluation-treatment-supportive care and end-of-life services.

## **General Philosophies**

**Teamwork or strength in unity:** The physician and patient connection, in its proper form and execution, exemplifies the most immediate and intimate relationship save that of a mother and her newborn child. The patient is the primary recipient insofar as the output of this physician—patient relationship. Family members should be included as well as other involved members of the medical

team. In today's world of medicine the strength of this unity has been eradicated due to greed and ego. The patient is regarded more and more as a commodity. This transgression of the medical contract denigrates the physician's role. The oldest profession has now become the oldest "profession".

**Empowerment:** The patient and significant family members, as well as close friends, should look at a life threatening illness as a way to bring relationships closer than ever before. At the same time it is a powerful teaching lesson that enables the person and parties at risk to understand how to solve problems through self-educational processes. The importance of the **medical record**: obtaining copies of all consults, hospitalizations, labs, pathology, operative reports, treatments, and imaging studies; as well as understanding the importance of **how to process this information over time** is crucial to the evolvement of medical care in this century. Universal health care will become a universal mess unless we learn to organize our tasks and the information associated with these tasks. He will bring a copy of The Medical Record to the meeting to show you a prototype of this approach.

**Utilization of technological approaches** relating to information gathering: PubMed (<http://www.ncbi.nlm.nih.gov/entrez/query.fcgi>) and Quosa ([www.quosa.com](http://www.quosa.com)) are two outstanding examples along with Google, and other information retrieval sites. Sharing of information among groups of patients with the same illness could facilitate the learning process greatly. These groups could interact with physicians & become a powerful team to fulfill the goals of the patient-family-physician team. This has been initiated and we are calling such groups of empowered patients MMPs or "mini-Manhattan projects".

## Prevention

**Use history:** The genetic history of parents & siblings is a valuable means to understand where the Achilles' heel(s) of the patient may be. Special focus can then be applied to prevent repeating history. An example would be a family history of PC and the use of Avodart in male relatives to decrease the incidence of PC.

**Patient context as a key ingredient of risk assessment.** The occupation of the patient, his environmental exposures and his lifestyle all provide insight about ways to prevent illness. We learned that Agent Orange exposure is associated with a higher risk for PC. Such patients should be surveilled differently as well as told to incorporate various diet and lifestyle changes to reduce the risk of PC.

**Use the experience of others:** Existing medical literature on boron, selenium, lycopene, strawberries (ideally, organic) all indicate we can lower incidence of PC or occurrence of aggressive PC if there is adequate intake of these products. Use information about that which appears to be effective.

**Pro-active Integrative Management (PIM):** This is a term superior to active surveillance since it emphasizes the integrative nature of health and the need to be pro-active in our management of health issues. He will share the PIM form that is helpful to understand your medical baseline in areas of health that commonly affect humankind. Ideally, such an approach should be initiated at age 25 when we are at our theoretical peak of health.

## Diagnosis

**Validation**, e.g. key biologic inputs such as pathology at diagnosis of RP (radical prostatectomy; surgical removal of the prostate gland). Since so much literature on diagnosis, risk assessment and prognosis is based on items such as the Gleason score, this key input must be validated by sending the pathology material for expert review. Local pathologists reading PC material must be validated by periodic testing to assure that their ability to diagnose and grade PC is comparable to that of an expert like Jon Epstein, David Bostwick, Helmut Bonkhoff and others internationally recognized in their field. This same applies to all aspects of medicine.

**Quality** of technical equipment, e.g. QCT vs. DEXA; MRI 1.5T vs. 3.0T; TRUSP with or without color Doppler. We cannot base our assessment of a patient's status on technology that leads us astray. DEXA is one of the worst offenders. Here we have a conflict of interest since many physicians have DEXA scanners in their offices as an income generator leading to this technology pre-empting the use of more accurate assessment of bone mineral density using quantitative computerized tomography (QCT).

**Skill** in interpretation of imaging studies, e.g. ultrasound, MRI, CT, nuclear medicine imaging such as bone scan, PET/CT scans. We need reporting that is objective that measures pathologic lesions and cites them as index lesions to be followed. We should not allow "weasel" reports that reflect the CYA approach of many radiologists. The joke that is painfully true in reality is that the official plant of the radiologist is the "hedge".

## Evaluation

Establish a **baseline** before starting treatment. Obtain key biomarkers and perform the important exams upon which assessment of status depend upon.

Utilize **history** in the form of algorithms, neural nets to prognosticate on diagnosis, stage and response to treatment, e.g. Partin, Kattan, Prostate Calculator ([www.prostatecalculator.org](http://www.prostatecalculator.org))

**Variability in skills** of health practitioners in physical diagnosis, e.g. DRE

Utilizing the full extent of **laboratory analysis** to establish diagnosis, assess status insofar as extent or stage of disease (PSAV, PSADT), provide response indicator to treatment (nadir, PSA halving time).

**Objectification** of results—past and present—with measurements and comparison of key endpoints in medical reports. Note the specific index lesions on a bone scan or MRI, etc and compare side-by-side imaging media with specific measurements in a table format for ease in evaluating patient's response to a particular treatment.

## Treatment

**Context** of the patient: Don't consider an RP in a patient with Alzheimer's disease and a PSA of 85. Know the internal medicine issues that will point to one treatment versus another, e.g. LUTS.

**Status begets Strategy.** Know the overall status of the patient by utilizing all the tools mentioned above and below to determine the patient's

biological reality since the treatment decision depends on this.

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**Selection of an artist:** Especially for technically difficult issues such as RP, brachytherapy, cryosurgery.

Use **Biologic End Points (BEPs)** to assess therapeutic efficacy, e.g. (25OH) D-3 levels, Ketoconazole blood levels, EFA profiles, NMR lipoprofile.

## Supportive Care

Maximize **Therapeutic Index (TI):** Patient Benefits ÷ by Adverse Effects.

Understand importance of **drug interactions** for both synergy and toxicity, especially in light of TI. The uniqueness of the patient's biology is often forgotten despite 100,000 deaths per year in the USA from drug toxicity (adverse effects of medications , JAMA, 2000;284:483-485).

Utilize **pharmacologic multitasking** where one drug or supplement may perform multiple functions. This decreases healthcare costs, minimizes drug interactions, simplifies patient's life and supports the concept of integrative biology. Examples include use of angiotensin receptor blocker to control hypertension and at same time have anti-PC value. Quinazoline alpha blockers improve lower urinary tract symptoms (LUTS) and at same time induce PC apoptosis.

**End of Life Services** (these concepts are applicable all throughout the patients course of illness)

**Understand the patient's status completely.**

Know when all reasonable measures have been exhausted to prolong quantity & quality of life, and be honest with patient & family when that time approaches. However, **do not** categorize the patient as “terminal” when the patient is untreated or has not had the benefit of being evaluated by a physician that may be aware of one or more “secondary” treatments that have not been used and that may extend life in a significant fashion or improve the quality of life of the patient. I have seen many patients who were told they had 6 months to live only to be alive and free of disease 10 years later. Some of these patients have outlived the doctor making that fatalistic prognosis.

**Make no false or egoistic pronouncements about survival.** Remember that MD does not equate with medical deity but should relate to medical detective. No where in the course of another’s life should a physician make a pronouncement that a patient has “x” number of years to live based on statistical studies that negate individual variations in patient and in the ability or creativity of the treating physician. To do so is to implant a negative thought form that can psychologically devastate the patient. Moreover, new treatments evolve over a period of months to years and prognoses may dramatically change.

**Advise the family to express their love.** Instruct family & friends that during these end times the most important exchanges with the patient involve sharing joyful times and expressing thoughts of love. The caring physician informs the family not to focus on medical issues if the battle with PC or another life-threatening illness has been lost. Instead, tell them to speak from your heart & soul since they may not get a chance to say the words they want to speak.

Inform family & friends to **record conversations** with loved ones since this is most commonly regretted by those who have not done so.

**Be generous with analgesia.** Do not allow the patient to suffer with poorly controlled pain or complications of terminal illness. Address these issues with tender loving care.