ADVANCED PROSTATE CANCER ON DIAGNOSIS OR BEING MOVED TO ANDROGEN DEPRIVATION THERAPY AS YOUR PRIMARY TREATMENT AND PRESCRIBED ONLY AN LHRH AGONIST OR ANTAGONIST?

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DISCLAIMER: Please recognize that I am not a Medical Doctor. I have been an avid student researching and studying prostate cancer as a survivor and continuing patient since 1992. I have dedicated my retirement years to continued research and study in order to serve as an advocate for prostate cancer awareness, and, from a activist patient's viewpoint, to voluntarily help patients, caregivers, and others interested develop an understanding of prostate cancer, its treatment options, and the treatment of the side effects that often accompany treatment. There is absolutely no charge for my mentoring – I provide this free service as one who has been there and hoping to make your journey one with better understanding and knowledge than was available to me when I was diagnosed so many years ago. Readers of this paper must understand that the comments or recommendations I make are not intended to be the procedure to blindly follow; rather, they are to be reviewed as my opinion, then used for further personal research, study, and subsequent discussion with the medical professional/physician providing your prostate cancer care.

I am surprised that any physician would prescribe only an LHRH agonist or antagonist as primary treatment for anyone with an obvious advanced and aggressive prostate cancer diagnosed at higher grade Gleason Scores at the onset, or when moving a patient's treatment to androgen deprivation therapy as their continuing primary treatment.

You should be treated as aggressively as your cancer is trying to be aggressive.

I am a STRONG proponent of triple-hormonal blockade and the reasoning is explained in these two papers: http://tinyurl.com/3ulagd2 and http://tinyurl.com/74bkzam.

Right now, all an LHRH agonist or antagonist is doing is shutting down testosterone produced by the pituitary/LH/Leydig Cell/testicular route; it is having no effect on testosterone metabolized from androgen precursors produced by the adrenal glands. It is certainly recognized that the amount of testosterone produced by the adrenal glands is nowhere near the volume otherwise produced by the testicular route, but it is a sufficient source of testosterone to still provide fuel to cancer cell growth and proliferation (dividing/multiplying). Without an

antiandrogen to hopefully block all the multitude of androgen receptors on cancer cells, that testosterone has (and currently has) open access into the nucleus of cancer cells. With that access the testosterone comes in contact with 5Alpha Reductase (5AR) isoenzymes in the nucleus of the cancer cells and is converted to dihydrotestosterone/DHT. DHT is a five times more powerful stimulant to prostate cancer cell growth. Obviously, an antiandrogen should be prescribed to block androgen receptors. And a safeguard in the event there are faulty androgen receptors wherein testosterone still gains access - and certainly if an antiandrogen is not prescribed in the first place or shows failure - the 5AR "inhibitor" dutasteride/Avodart should be prescribed. This is all explained in the foregoing references. Every patient has the right to insist being prescribed not only antiandrogen as long as that antiandrogen remains effective, and a 5AR inhibitor. Both are ethical medications for advanced or recurring prostate cancer.

The problem that has been occurring for too long is that physicians are not taking the personal time to research and study medications like 5AR inhibitors to understand their role in the management of advanced or recurring prostate cancer. It amazes me that they can remark that they are “saving other medications in the event their current prescription fails.” If those “other medications” are expected to provide any effectiveness in the future, they should certainly be part of initial protocol to shut down continued cancer development with the hope that at least some number of cancer cells experience apoptosis/cell death. You can read for yourself in my paper referred to above "The Importance of 5Alpha Reductase (5AR) Inhibitors" to recognize by the many reference papers therein of this importance.

More supportive papers to my opinion can be studied by going to these papers published by the Prostate Cancer Research Institute (PCRI) in Los Angeles, California http://pcri.org/pcri-papers/ then scrolling down to "Systemic Therapies" and reviewing any or all papers following that subject line to include "Androgen Deprivation Therapy, "Secondary Hormonal Therapy and Androgen Resistance," "Androgen Independent PC," "High Risk Prostate Cancer," and "Novel Therapies." These are papers written by top physicians specializing in the treatment of prostate cancer, and in this case, advanced or recurring prostate cancer.

Educate yourself to help insure your own long-time survival. The more you empower yourself with knowledge the more physicians will realize that "this patient knows his stuff" and will more likely be willing to consider your own preferences in your treatment and why.

Further considerations for those men initially diagnosed with advanced, high grade and aggressive prostate cancer, and particularly if metastases has already occurred, can be reviewed here: http://tinyurl.com/3s76t6x