LHRH/GnRH agonists/antagonists and low testosterone concern
Opinion of Charles (Chuck) Maack – Prostate Cancer Advocate/Activist

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.

Regarding LHRH/GnRH agonists/antagonists effect on patients with heart and/or diabetic issues as well as those susceptible to stroke because of the lowering of testosterone (T):

With the FDA now requiring labeling on the package material of LHRH/GnRH agonists/antagonists regarding the effect of low testosterone on patients with heart and/or diabetic issues as well as those susceptible to stroke, the physician has now been alerted and now has a responsibility to thoroughly check and determine other health issues his/her patient may be experiencing, and not just prescribe LHRH/GnRH agonists, antagonists, or for that matter, Transdermal Estradiol patches or gels, without doing so. The physician additionally has the responsibility to discuss what these drugs and the lowering of testosterone might - not necessarily will - have on that patient with heart, diabetes, and possible stroke health issues. Since the patient is unlikely to have access to view the containers in which these drugs are provided the physician in order to be able to read these warnings, the onus becomes even more so on the physician. In effect, this makes the physician the responsible party if that physician has not first run appropriate tests to rule out heart issues, diabetes, or patients with issues that could lead to a stroke. On the

other hand, if the physician has performed due diligence, I would doubt a case could be made against that physician for malpractice.

Back to the patient who has any of these health issues that could be affected by the lowering of testosterone by these drugs: If another physician is treating the patient for any of these issues, it behooves the now treating Urologist, Radiation Oncologist, or Medical Oncologist, who is anticipating prescribing these drugs to, in addition to discussing with the patient, also making personal contact with that other physician or physicians as co-partners to determine the degree of likelihood that the drugs will be dangerous to the patient, or to work together with close attention to the patient with appropriate diagnostic monitoring to pull the drug if having an adverse effect.

The unfortunate concern is that the patient who has failed the usual RP, RLRP, RT, or Cryotherapy now becomes "between a rock and a hard place" to decide with his physician(s) alternatives to rein in his recurring disease. Since current methods all appear to have an effect on heart issues and diabetes, it becomes imperative for the drug to be administered in likely only monthly dosages, with very special close attention and monitoring to recognize early on any adverse effect on the other health issue(s) so that the drug can be withdrawn.

Since the known androgen/hormonal deprivation drugs to shut down testosterone can have an adverse effect on these patients with other health issues, I expect they will continue to be administered, but now in lower dosage/shorter time-frame with much closer attention to patient monitoring and diagnostic results.

I recognize that sequential androgen blockade (SAB) without an LHRH/GnRH agonist/antagonist but with an antiandrogen can be prescribed. This option serves to block androgen receptors from testosterone access to the cancer cell nucleus and contact with 5Alpha Reductase enzymes where it can be converted to the more powerful stimulant to prostate cancer cell growth, dihydrotestosterone (DHT). Should this option be employed, rather than the antiandrogen as monotherapy, it is my opinion that a 5AR inhibitor of either dutasteride/Avodart (preferred) or finasteride/Proscar should be prescribed to accompany the antiandrogen in order to prevent T conversion to DHT should any testosterone gain access via faulty androgen receptors. In any event, it has been my observation over several years of monitoring prostate cancer support lists that SAB has a short lived effectiveness of only a year or two before androgen receptor mutation and antiandrogen failure.