Inside this Issue:

What the heck has been going on in my world

Dr. Bob's treatments & insights regarding prostate cancer

What is personalized medicine and why should you care?

From the president's desk

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Please note the following corrections to Dr. Bob’s Dec 2013 article (Volume 29, Number 4) “Dr. Bob’s Treatments and Insights Regarding Prostate Cancer”:

Begins the middle of 3rd Paragraph of article (Left most column page 3) should be replaced with:
Far too often, I consulted on prostate cancer patients who had a radical prostatectomy initially, but a few years later when their PSA’s rose, they were then often treated with radiation therapy; and when their PSA’s again rose, they were finally treated with hormone blockade. They were not cured with surgery and/or radiation therapy, but still had the side effects from “curative intent” local radical therapies. These side effects often included impotence, incontinence of urine, fecal soilage, urinary discomfort and many other problems.

Rightmost Column page 5 – Item Number 6), should be replaced with:
6. When prostate cancer patients are treated with intermittent androgen blockade (IAB), the time spent “on” hormone blockade is prolonged, while the time spent “off” hormone blockade shortens. This clearly demonstrates progression to CRPC.
I have been given the privilege and honor to write an article for my favorite prostate cancer organization - PAACT. My thanks to everyone for allowing this opportunity to write an article, as well as clarifying the same issue that Mark Twain so elegantly stated: "Recent reports of my demise (and allowing myself some poetic license - and/or my retirement) have been greatly exaggerated."

The only two minor difficulties for me are:

1. I did not make the actual commitment to write this paper until about 1 week before the deadline and…
2. Anyone who has seen any of my many DVD recorded lectures knows that I end up with at least 3 times more slides to show than is possible to review, but I know that most people realize that it takes several viewings to digest the information that I am trying to present and explain to prostate cancer patients and their families/friends/significant others. So my most difficult task is to provide a comprehensive overview of prostate cancer from my experience, insight, opinions, and (hopefully) wisdom; all as seen through the eyes of Dr. Bob and Compassionate Oncology Medical Group.

In 1991, I first began to challenge the conventional “alleged wisdoms” that governed the diagnosis and management of prostate cancer. I was distressed to observe a far too frequent pattern where following the diagnosis of prostate cancer, men were told that the “Gold Standard” of treatment was radical prostatectomy, although radical radiation therapy was often also advised instead of surgery. Far too often, I consulted on prostate cancer patients who had radical prostatectomy initially, but a few years later, their PSA’s rose with radiation therapy, and when their PSA’s again rose, they were given hormone blockade. They were not cured but this outcome did not protect them from the usual horrible and too often permanent complications like impotence, urinary incontinence, climacturia, fecal soilage, etc.

I soon discovered the term “Gold Standard” was self-proclaimed by urologists, and was a self-declared title rather than a beneficial treatment that was supported by conducting a prospective randomized study proving that radical prostatectomy is both a necessary and effective treatment for prostate cancer. Men who initially chose radiation therapy but subsequently had rising PSA’s were usually treated with hormone blockade since “salvage radical prostatectomy” after radiation therapy was fraught with enormous technical difficulties, permanent nasty complications, and the chances for permanent cure were miserably poor. Observing these results, I decided to skip surgery and/or radiation therapy, and instead treat prostate cancer patients with the same types of hormone blockade agent medicines that urologists and radiation therapists prescribed when their treatments failed to cure prostate cancer patients.

In 1992, I treated my first patient, Max K., without any local therapy. I developed, pioneered, named and was granted by the United States Patent and Trademark Office, my registered trademarks: Triple Hormone Blockade®, Triple Androgen Blockade®, and Finasteride Maintenance® therapy. Max’s PSA was 39; biopsy showed prostate cancer; and he received about 20 months of Triple Hormone Blockade®, followed by Proscar 5mg per day, so-called Finasteride Maintenance® therapy. All patients after Max were treated with 13 months of Triple Hormone Blockade® followed by Finasteride Maintenance® therapy until about 2004 when patients were given 1 Proscar (finasteride) plus 1 Avodart (dutasteride) a day. By the way, 19 years after diagnosis and treatment, Max had never required any additional hormone blockade or local treatment. When last contacted, he was in his 90’s with fully intact mental acuity. In September 1993, I treated my second Triple Hormone Blockade® patient, and with only 13 months Triple Hormone Blockade® followed by Finasteride Maintenance® therapy. He has never received any local treatment and continues to follow up with Compassionate Oncology Medical Group. He has never developed castrate resistant prostate cancer (CRPC); at times, he has been treated with High-Dose Testosterone Replacement Therapy, the Anti-Angiogenic Cocktail, and other medications. He is in his 80’s.

Over the years, we have published our Triple Hormone Blockade® and Testosterone Replacement Therapy results in various peer reviewed medical journals and presented such findings at national and international conferences.

Some of my favorite quotes that I originated include:

1. Everyone is entitled to their own opinion…their own WRONG opinion.
2. The best form of local therapy is “Systemic Therapy”. (I have almost never recommended radical prostatectomy,
radiation therapy, HIFU or any form of local therapy. Instead I advise 13 months Triple Hormone Blockade® followed by Finasteride Maintenance® therapy for men who present with low or intermediate risk disease. For more information, refer to my papers on our website (specifically “THB UPDATE: THE DEMISE OF THE (FOOL’S) GOLD STANDARD; THE RISE OF THE “PLATINUM AND DIAMOND STANDARD”), and to my lectures available on DVD. All papers that I have written may be downloaded for free on our website: www.compassionateoncology.org. You may request a free DVD copy of my lectures online on our website or by calling our office at (310) 229-3555 (only pay for S&H at $5/DVD).

3. The WORST method of hormone blockade is CAB – Continuous Androgen Blockade. A BETTER method of hormone blockade is IAB – intermittent Androgen Blockade, but this merely delays the development of CRPC. The BEST method of hormone blockade is Triple Hormone Blockade®/Leibowitz Protocol.

Some of “Dr. Bob’s Pearls” of wisdom and/or opinion:

✓ The longer you are OFF hormone blockade, the much longer you will live.

✓ In my opinion, your survival does not become threatened until or unless you develop a rising PSA while on hormone blockade (which implies having a castrate level of testosterone). This is the definition of castrate resistant prostate cancer (CRPC).

✓ If we can find ways to postpone, or even better, avoid the need to go back on hormone blockade, then this treatment is prolonging your life.

✓ You cannot develop CRPC unless someone puts you back on hormone blockade.

✓ Every month that you are on hormone blockade, brings you one month closer to developing CRPC. Every month that you survive with a normal testosterone or preferably a supra physiologic level of testosterone, is in my very strong opinion, an extra month added to your survival – it does not subtract from your life span.

I was grateful that by subspecializing in prostate cancer beginning in 1992, and by only accepting prostate cancer patients to my practice by 1998, I was able to make my Triple Hormone Blockade® contributions. My beliefs about intermittent hormone blockade satisfied my desire to make the type of meaningful contributions to help prostate cancer patients learn about new treatment options that were not only effective, but were also non-invasive and that offered a marked improvement in a prostate cancer patient’s quality of life. Our therapies are much more tolerable and are associated with much lower risks of permanent toxicities than prior alleged “Gold Standards.” This is why I decided to name my Triple Hormone Blockade® treatment protocol the “Platinum and Diamond Standard.”

I was further blessed and guided by God to develop extremely effective treatment protocols for treating different stages of prostate cancer. We are proud that all of our treatment protocols are individualized based on each patient’s tolerance and responses to our therapies, unlike the inflexible institutional protocols.

My “Three-Pronged approach” for treating high risk, recurrent and/or metastatic prostate cancer consists of an alternate 3 drug hormone blockade; 12 or 15 doses of extremely well-tolerated, low-dose, weekly Taxotere/Emcyt/Carboplatin (T/E/C) chemotherapy, 3 weeks on, 1 week off. This T/E/C part of the protocol is extraordinarily well tolerated with virtually no nausea or vomiting; about 6 out of 7 men have little to no hair loss, while only about 1 out of 7 men have some noticeable hair thinning, which is essentially always reversible. We have a volunteer list of over 70 (and growing) men who have agreed to speak to prospective patients and/or their significant others to describe their experiences with whichever Compassionate Oncology protocols they were treated with, and to answer any questions and concerns that you might have. Simply call our office at 310-229-3555 to request a copy of our “Volunteer List.”

The third arm of my Three-Pronged attack is my “Anti-Angiogenic Cocktail” (AAC). For more information, please download my paper on this subject from our website, and call our office to request my lectures available on DVD’s #7, #8, and/or #9 where I discuss AAC and present some typical patient responses to it.

I first began treating patients with the anti-angiogenic drug, thalidomide, in 1998, shortly after it first received FDA approval to treat a form of leprosy. Over the past 15 years, I often tried to add other types of anti-cancer agents such as other anti-angiogenic drugs including alpha interferon and a metronomic dosing schedule of very low-dose oral Cytoxan chemotherapy, which metastatic breast cancer studies demonstrated that some women whose disease progressed on the standard once-every-3-week high-dose intravenous Cytoxan, responded to the daily oral low-dose schedule. It was generally accepted that this benefit was due to an anti-angiogenic effect against cells that formed blood vessels to bring oxygen and “food” to cancer cells. It is known that cancer is not able to grow larger than 2mm unless it can attract its own blood supply.

Other AAC drugs we tried to include are the second generation thalidomide, Revlimid (also known as an IMiDs drug); finasteride (Proscar); dutasteride (Avodart); bisphosphonates (Aredia, Zometa); anti-osteoclasts such as denosumab (Xgeva, Prolia); we tried Avastin; Celebrex; and
also targeted drugs like Sutent, Nexavar, Herceptin, Leukine; and over the counter agents like shark cartilage, reservatrol, artemisinin, and many other miscellaneous agents.

For the past many years, our AAC consisted of Leukine (GM-CSF) 5 to 7 nights per week of usual doses of 150—250 mcg per night; Revlimid 5mg alternating with thalidomide 50 mg – never more than 1 Revlimid or 1 thalidomide a day – a combined total of not more than 7 capsules per week. We also use an injectable anticoagulation, LMWH (low-molecular-weight heparin) in full dose (not prophylactic dose), but often we substitute Arixtra. We use Celebrex 200mg once a day with food (probably provides some AAC benefit); and usually 1 Proscar and 1 Avodart as well.

The AAC agents, Leukine, Revlimid and thalidomide, are not forms of hormone blockade; are not chemotherapy; and they actually enhance and strengthen your immune system!! Isn’t this exactly the type of treatment that you have been searching for? Additionally, if these medications control your PSA, you delay or could prevent the need to go back on hormone blockade.

If there is one description that my critics most often use to describe my prostate cancer treatments – these would include: maverick; loose cannon; idiot; too controversial; dangerous; crazy; has never had any successes treating any patient with any of his protocols etc., etc., etc.

Beginning in approximately 2000, I decided to try to prove or disprove what every “Prostate Cancer Expert” had always been taught and accepted as an absolute certainty:

a. “Giving testosterone (T) to someone with prostate cancer is like pouring gasoline on a fire.”
b. “It is contra-indicated to ever give T to any patient with a history of prostate cancer.

I refer the reader to my posted papers on our website on high-dose Testosterone Replacement Therapy (TRT) and a number of my lectures on DVD on this subject.

If allowed, I plan to return to this subject in much greater detail in the next PAACT issue.

Let me mention a few things:

1. Can hormone blockade alone cure prostate cancer? This cure must be proven, not just presumed. If you answered “no,” then Dr. Bob begs to differ and will present proof in the next issue.
2. It is often stated that a “normal” T level is 300 to about 1000. Our target T range for our prostate cancer patients on high dose TRT is 1800-3000.
3. It is the RULE, not the exception, that when high-dose TRT is stopped, PSA’s fall rapidly and dramatically.
4. The majority of our TRT patients are on maintenance AAC.
5. Many of our patients, who have metastatic CRPC when they first consult with us, are candidates for high-dose TRT, but we first treat and control their systemic disease before starting them on high-dose TRT.
6. When prostate cancer patients are treated with intermittent androgen blockade (IAB), each cycle “on” hormone blockade lengthens survival, while each cycle “off” hormone blockade shortens survival. This clearly demonstrates progression to CRPC.
7. Similar to the above pattern, many patients on high-dose TRT are able to have cycles on TRT alternating with cycles of hormone blockade. Unlike IAB patients, we have many high-dose TRT patients whose subsequent TRT cycles are often much longer than preceding cycles on TRT.
8. One of the earliest pioneers in lab studies on IAB, Dr. Nick Bruchovsky, and I discussed the significance of some of his experiments, and he explained his belief to me that testosterone replacement preferentially stimulated hormone sensitive cells to regrow at the expense of hormone resistant cells.
9. I have heard from a number of people that they believe prostate cancer is not caused by testosterone, but rather they are certain it is caused by estrogen, and more specifically, by estradiol. In the next issue, Dr. Bob will offer evidence in the form of case histories that might contradict the “estradiol school of thought.”

Dr. Shahrooz Eshaghian and I work closely together, to not only provide emerging state-of-the-art prostate cancer diagnosis and treatment, but also to continue to provide innovative treatment protocols that are years ahead of other prostate cancer therapies. Finally, as our name implies, we provide our care in a compassionate environment – in fact, our patients often give us the compliment that they feel like they are a part of our family. We have opened our practice and are now accepting new patients.

Until the next PAACT issue, as always,

Be happy, Be well, Live long and prosper,
Dr. Bob, Dr. Eshaghian, and our Compassionate Oncology staff

P.S. Happy Hanukkah, Merry Christmas, and have a Happy HEALTHY New Year and Year of the Horse.

* Triple Hormone Blockade, Triple Androgen Blockade, and Finasteride Maintenance are the registered trademarks of Robert L. Leibowitz, M.D.