My Prostate Cancer Story
By Richard C. Richards

My name is Richard C. Richards. I am a 74-year-old Professor of Philosophy Emeritus, and live in a suburb of San Diego, California. I received treatment for prostate cancer from Radiotherapy Clinics of Georgia (RCOG) in 2000. They have changed their name recently to the Radiotherapy Centers of Georgia. The treatment involved brachytherapy followed by conformal beam radiation. This is a brief account of the events which led up to the treatment, the treatment itself, and subsequent events.

For several years in the late 1990s, my PSA had been steadily rising. A Kaiser Permanente urologist and I had been watching it for a year or two, and it began to rise faster in early 2000, to around 8 from around 6. A biopsy at that time showed cancer in three lobs. The staging, etc., has now escaped my memory. Another PSA test in mid 2000 showed it was 10.

I consulted with two different urologists and a radiation oncologist from Kaiser, read a number of books, which in retrospect were years behind in presenting available options, talked with my younger brother who had had a radical prostatectomy the previous year, and initially found very little objective evidence about the efficacy of any treatment, though opinions were plentiful.

From I local newspaper I heard about the Informed Prostate Cancer Support Group (IPCSG) and attended a meeting. I found a wealth of information from the members, who had among them probably experienced about every treatment modality known to man. I found a healthy interest in evaluating older treatments and a curiosity about newer possibilities. I also found a healthy skepticism with regard to any one kind of treatment. Several members gave me their phone numbers and invited me to call if I had additional questions. I called two, and got more information and opinions. This group is obviously not on the payroll of any doctor or organization. The main invited speaker that day, a radiation oncologist, was very helpful and answered some of my questions from the floor.

All this encouraged me to keep investigating, with an increased awareness of the wide range of options available to me.

I'm a percentages guy. I plan my life on the basis of what probably will happen. So I wanted to go with the type of treatment that had the best chance of curing my cancer.

My wife and I went on the Internet, and she found the website of RCOG, Radiotherapy Clinics of Georgia, located in Atlanta. They had a large statistical base (nearly 8,000 patients treated at that point). They published a series of cure rates for various PSA numbers and Gleason scores. They not only said they could often cure the cancer, but that there would be fewer negative side effects, such as damage to bowel, bladder, or erectile dysfunction. Their statistics supported that claim. People can lie with statistics, but RCOG's foundation was thorough and impressive. They kept a large statistical base to

evaluate the efficacy of their treatment. At that point the statistics covered the eight years since they had begun their present modality of treatment. Since I have taught courses in logic and scientific method, I had a pretty good idea about what to look for.

Given my PSA and Gleason score, their statistics indicated that the probability I could be cured, based on their database, was around 75%. If I had contacted them earlier, the probability would have been as high as 90%. The 75% beat the best figures of the few urologists who kept statistics, or the new treatments such as cryotherapy or hormone blockage, by a whole lot. Or at least it beat the figures of the very few clinics which bothered to keep statistics on their patients. Statistics from anyone but RCOG were very hard to locate, and none of them were as impressive as those of RCOG. RCOG uses the toughest criterion for a cure that anyone uses: statistical zero PSA for 10 years. This is the same criterion that urologists use for radical prostatectomy. Most radiation oncologists use a less rigorous criterion. Some practitioners seem to have no criteria for a cure at all.

We made the arrangements, and in November of 2000 I was in Atlanta. By then my PSA was 15. There are slow growing forms of prostate cancer. Mine was not acting like it was one of them.

A two-pronged treatment modality is not cheap. Medicare covered the major part of the expense, and I was fortunate to stay at the American Cancer Society's Hope Lodge for the majority of the seven weeks I was there for treatment. I figure money saved by not getting my best chances for a cure would look pretty silly if the cancer came back.

RCOG impressed me by treating the whole person. Not only were there weekly personal consultations with the physician to whom I was assigned, but on Monday nights during my treatment there were meetings open to everyone being treated at that time, at which one of the RCOG physicians would answer any and all questions. We were also fed a vegetarian meal, courtesy of RCOG, and gently told the advantages of at least cutting down on red meat, high fat foods, and adding more healthy food to our daily intake. They suggested but did not push a vegetarian diet.

We were also told what they would expect with regard to what we would be feeling, both physically and psychologically, as the treatment progressed. I like the approach of telling us what we could expect.

In November of 2000 I went to Atlanta for the first part of the treatment, which consisted of brachytherapy. It was explained to me that RCOG believes that brachytherapy should be done first so that maximum radiation can be concentrated on the prostate. Over 100 radioactive iodine seeds were placed in my prostate under general anesthetic, by remote sensing techniques, so that the

seeds could be evenly placed in all parts of my prostate. These seeds serve as a guide for the conformal beam radiation treatment following, and also to maximize the amount of radiation applied to the prostate during the treatment since they are in place when the conformal beam radiation starts.

After the brachytherapy, I returned to San Diego for two weeks, then returned to Atlanta for seven weeks of conformal beam radiation. I began to experience some uncertainty regarding my urinary continence. I kept a Kleenex in my shorts. This took care of any slight leakage that had started. This leakage stopped a few weeks after all treatment was completed.

RCOG physicians said that use of a conformal beam radiation therapy minimized damage to surrounding tissue, including bowel and bladder. Their statistics supported their contention.

RCOG believes that this sequence of treatment is the most effective, though they have data only on this method. The sequencing of the two forms of treatment is based on their belief that doubling the radiation during the early phases of treatment is the most effective treatment. It makes good sense to me. Why wait until after the radiation is complete to set the seeds? Better to have seeds and radiation working together. Clinics in which the seeds are introduced into the prostate after the radiation have a high rate of complications and damage to surrounding body parts, from the research I have seen.

RCOG's philosophy seems to be that they will treat for the next to worst-case scenario with every patient. That scenario involves the possibility that the cancer has left the prostate and is still in the surrounding tissue. So they radiate the general prostate area for two weeks. The worst-case scenario is that the cancer has spread out of the pelvic area into the whole body. At that point radiation is not going to help much.

My radiation went on for seven weeks, with the shape of the conformal beam being changed each week to match the changes in my prostate as it reacted to the strong radiation being applied very specifically to it from both the seeds and the beam. During this period I experienced some feelings of fatigue and tended to fall asleep in the afternoon. I kept an active program of walking in the early afternoon, prior to the naps. Radiation was given to me at the same time each week day morning at the clinic. I consulted weekly with the radiation oncologist to whom I was assigned, and he was thorough and open to any question I had.

I was told several times that I would leave RCOG after treatment with as much erectile function as I had when I came. I did. Semen volume and color began to change soon after the end of treatment, and I eventually had little ejaculate. Since I have no plans for parenthood, this is no loss. Erectile function began to diminish somewhat several months after I finished treatment. Whether this is due to the treatment, or increasing age, is anyone's guess.

I left RCOG in early 2001. Soon any temporary urinary leakage had resolved itself. A slight loosening of my bowels toward the end of the conformal beam radiation lingered on for months, but was never bothersome. It corrected itself in time.

Erectile ability has continued to diminish somewhat in the nearly ten years that have passed since I left Atlanta. At my age I had been led to believe I would experience diminishing erectile ability no matter what I did, radiation or no radiation. My wife and I still have a satisfactory sex life, with penetration, aided by Levitra. Viagra gave me distorted color vision, some dizziness, and periods of sweating. Levitra does not.

From RCOG and other sources I learned that the cure rate for radical prostatectomy is around 50% unless done by the finest surgeons, in which case it can approach 80%, but with a higher rate of complications. The cure rate of most forms of radiation is around 50%, but brachytherapy by itself has a somewhat higher rate of cure. Some other treatment modalities are still gathering data, but their statistical bases are meager at this point.

The thinking of the people at RCOG is that we need the brachytherapy to concentrate radiation in the prostate and to provide an outline of the prostate for the subsequent conformal beam. Conformal beam radiation augments this radiation and also treats the margins and the areas immediately around the prostate to deal with any cancer that might be escaping, an area many other treatment modalities neglect. The truth of these assumptions seems to be verified by RCOG's high cure rate, higher than for any other treatment modality, and supported by a very large data bank of past patients.

RCOG figures indicate that the PSA of the patient should be down to near statistical zero within five years of the treatment, since prostate cells die slowly. Six months after treatment my PSA was around 5. It dropped by a point or less each six months, except for a spike around 30 months out. RCOG's database indicated this was not unusual, and they had informed me about what they call "PSA Bounce," which is a temporary rise in PSA for a few months. They have published papers on the subject. It was reassuring to know that in all probability I was merely experiencing PSA bounce.

My PSA was a bit slow to drop. Their database indicated this was not unusual, and would not affect the cure rate. This was reassuring. My PSA approached statistical zero before four years from the termination of treatment, and it has been there ever since. Because a few cases of zero PSA have shown a rise in PSA after five years, RCOG does not believe they can declare a probable cure until 10 years after termination of treatment, but at this point there is a very high probability that I will be cured, though they say that the PSA must remain at statistical zero for the rest of the patient's life for a cure to be certain.

Knowing what I know, would I be treated by RCOG if I were to do it all over? In a heartbeat I would.

What were the most useful items in my search for a cure? Certainly the concern and advice of the men at IPCSG was very important. The Internet gave a wealth of information, almost too much to digest, but with persistence my wife and I sorted it all out. Am I still a member of IPCSG? Of course. Perhaps my experience can be useful to others, and I am learning about other therapies that I can use in the unlikely chance I still have prostate cancer.