Combining PARP+ PD-L1 inhibitors

Dr. Fatima Karzai is the Director of the Prostate Cancer Clinic for the Genitourinary Branch at the National Cancer Institute. She's keenly interested in developing novel strategies for harnessing the power of the immune system for hormonally driven cancers, particularly in advanced prostate cancer.

Prostatepedia spoke with her about a clinical trial she's running that combines PARP inhibitors and a class of immunotherapeutic agents called PD-L1 inhibitors in men with advanced prostate cancer.

Why did you become a doctor? What is it about medicine that keeps you interested?

Dr. Fatima Karzai: I decided to become a doctor at a very young age. I've always wanted to help people. When I was younger, I thought that being a doctor was the best way to do that. I really enjoy patient interactions, so that's why I'm a clinical researcher and I see patients on clinical trials. I find that it's the most rewarding experience to be able to interact with patients. It's always been a goal of mine to be able to help people in this manner. I think oncology was best suited for me to do so.

What are PARP inhibitors and PD-L1 inhibitors? How do they work, in which patients are they used, and how effective are they?

Dr. Karzai: PD-L1 inhibitors are members of a group of drugs called checkpoint inhibitors that have been developed for the treatment of cancer. PD-L1 is a protein that is present on the surface of cells. In cancer, PD-L1 on the tumor cells interacts with another protein on a person's white blood cells, which are immune cells that help fight cancer. This PD-L1 protein prevents the immune system from attacking the tumor cells. A PD-L1 inhibitor blocks that ability of the tumor cell to suppress our immune system, which can help our immune system kill cancer cells. They've been successful in certain cancer types like lung cancer and bladder cancer.

PARP inhibitors are a type of targeted therapy. We all have DNA in our bodies; when it becomes damaged, our bodies know how to repair it. Many things can cause DNA damage: exposure to UV light, radiation, or substances in the environment. There is an enzyme in cells called PARP. PARP helps repair DNA when it becomes damaged. By blocking PARP in cancer cells, we can keep cancer cells from repairing their damaged DNA, which causes them to die. PARP inhibitors work very well in a subset of patients whose tumors harbor something called “DNA damage repair mutations.” These mutations can occur in the tumor itself or it could be something that a patient is born with. PARP inhibitors were initially studied in ovarian cancer and breast cancer. We're starting to use them more in prostate cancer.

What is the rationale between combining the two agents for prostate cancer?

Dr. Karzai: We wanted to expand the use of PARP inhibitors. Like I mentioned before, right now they're used in patients with these specific mutations. We're trying to figure out if we're able to get this class of drugs to work in patients without these mutations if we combine them with another drug. Historically, PD-L1 inhibitors have not been that successful in prostate cancer, so we decided to put these two drugs together to see if there is any additive or synergistic mechanism that could help patients with advanced prostate cancer.
What have the studies revealed about the combination?
Dr. Karzai: We are still accruing to the study. We’ve looked in-depth at the first 17 patients and seen deep and prolonged responses in men with castrate-resistant prostate cancer with the combination, in men who have these germline or somatic DNA damage repair abnormalities. We’re now adding additional patients to the study to better define the activity and to help us evaluate the biology more.

You said you’re still looking for more patients?
Dr. Karzai: Correct.

Tell us a little bit more about eligibility criteria and who men can contact if they think they’re a fit.
Dr. Karzai: We are looking for patients with advanced prostate cancer—i.e. the prostate cancer has gone outside the prostate and is in either the soft tissue, organs, and/or bones. We would like to have these patients previously treated with either Zytiga (abiraterone) or Xtandi (enzalutamide). We think patients who have progressed on these two treatments might be more amenable to our combination. We allow previous chemotherapy, so if a patient has had Taxotere (docetaxel) or some other chemotherapy, they would be eligible. We are looking for patients who are still able to perform their activities of daily living and would be willing to participate in our trial and travel.

Some of our patients are local, but many come from across the United States. We even have some international patients.

You help defray the cost of travel for some of your clinical trial participants, don’t you?
Dr. Karzai: We do. Once a patient is on one of our protocols, then we reimburse flights in the United States. We also have a stipend for meals and hotels.

Any further thoughts on this particular combination or other combinations that you think may hold promise?
Dr. Karzai: Even though this type of immune therapy hasn’t been very successful thus far in prostate cancer, I still think that we need to do more studies and research to be able to find the subset of patients that it might work in. Immunotherapy is very exciting. We shouldn’t count it out in prostate cancer yet. The first vaccine that was FDA-approved in cancer was actually for prostate cancer. I think that the whole realm of immunotherapy is still open and could provide benefits for our patients. I am happy to see any patient for a consultation —those with newly diagnosed disease or those who are more advanced. We have clinical trials that span that spectrum.

Join us to read about more immunotherapy clinical trials for prostate cancer.

Tags: immunotherapy prostate cancer, PARP inhibitors PD-L1 inhibitors Combining PARP+ PD-L1 inhibitors
progressed in about 4 years. Became a patient of Dr. Myers who sent me to Dr. Bravo (Orlando, Fl.) and Dr. Dattoli for 45 sessions of targeted radiation later in 2013. Stayed on casodex for several years until Dr. Myers retired and assigned me to Dr. Berry at Duke Cancer. Dr. Berry prescribed Lupron and Zytiga and added Provenge in 2018. PSA currently undetectable in January 2019. I am 83 years of age and in excellent health except for the side-effects of medications.

John Margaroni

Where is your clinic geographically located?

JJ

A prostate cancer survival guide by a patient and victim. Men Beware, the ugly truth. What doctors are not telling you about prostate cancer.

Updated January 30, 2019

In my opinion:

Per multiple experts: The testing and treatments for prostate cancer are often worse than the disease.

Follow the money!
The man that invented the PSA test, Dr. Richard Ablin now calls it: “The Great Prostate Mistake, Hoax and a Profit-Driven Public Health Disaster”.

Read the sad truth about prostate cancer outdated over testing and treatments, dangers, exploitation for profit by some predatory doctors. Prostate cancer dirty secrets, lies, exaggerations, deceptions and elder abuse. Healthcare is often about making money off others misfortune and is full of conflicts-of-interest. Many in healthcare don’t want to do the right thing.

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Warning: This document contains blunt content, adult subjects and may be offensive to some people. Discretion is advised.

Anyone may copy, distribute or post part or all of this document without bias or modifications. Get the hard facts about prostate cancer testing and treatment that no one will tell you about, even after it’s too late. Any man over 50, anyone concerned about cancer in general, possible dangers from clinical trials, injuries and deaths from medical mistakes, quality prescriptions at a huge discount from Canada, exploitation and elder abuse, HIPAA loopholes and privacy issues should read this document. Prostate cancer patients are often elderly, over treated, misinformed and exploited for profits by predatory doctors [1,9,10,25,27]. At times profit vs. QOL (quality of life). Low risk Gleason 6 (3+3) is a pseudo-cancer mislabeled as a cancer; it does not need detection or treatment [1,2,9]. Don’t let conventional testing and treatment, predatory doctors or lack of knowledge destroy your life. Prostate cancer studies and statistics are often flawed because they include Gleason 6 pseudo-cancer. Recommended reading, books: The Great Prostate Hoax by Richard Ablin MD and The Big Scare, The Business of
Facts per reliable sources:
1. Multiple studies have verified more harm and deaths caused by prostate cancer testing and treatment than from prostate cancer itself [1,9,10,22,23,27].
2. Extensively documented unnecessary testing and treatment of prostate cancer for profit or poor judgment by some doctors in the USA [1,5,9,10,25,27].
3. Medical mistakes are the third cause of deaths in the USA (over 251,000 deaths a year, over one million deaths in 4 years) more than suicide, firearms and motor vehicle accidents combined 13. Per a consumer magazine: Each year 8.8 million hospital patients suffer from preventable harm and 440,000 hospital patients die from medical errors and hospital-acquired infections.
4. About 1 man in 6 will be diagnosed with prostate cancer in his lifetime. 233,000 new cases per year in the USA.
5. 10% to 20% of nurses abuse drugs high as 24%
6. 1 million dangerous prostate blind biopsies are performed per year in the USA [5,11, 22,23].
7. 6.9% hospitalization within 30 days from a prostate blind biopsy complication 11.
8. About 1.3 to 3.5 deaths per 1,000 from prostate blind biopsies.
9. 0.5% died and 20.4% had one or more complications within 30 days of a radical prostatectomy 15. Prostatectomy related regret increases over time, 47% at 5 years after surgery 29.
10. A study of early-stage prostate cancer patients found no difference in surviving at 10 years whether men had surgery, radiation or monitoring (no treatment) 12.
11. Low-risk Gleason 3+3=6 “cancer” is often aggressively over treated [1,2,9].
12. Prostate cancer patients are at an increased risk for chronic fatigue, depression, suicide and heart attacks.
13. Depression in prostate cancer patients is about 27% and 22% at 5 years, for advanced prostate cancer patients depression is even higher 6. Men are more likely to take antidepressants after treatment. Suicides occurred 2.51 times more often in cancer patients. Men are often not screened for depression after treatment.
14. 75% of physicians in the world would refuse chemotherapy if they had cancer.
15. Breast cancer receives much more research funding, publicity than prostate cancer despite the similar number of victims.
16. The man that invented the PSA test, Dr. Richard Ablin also stated: “The medical community must confront reality and stop the inappropriate use of PSA screening. Doing so would save billions of dollars and rescue millions of men from unnecessary, debilitating treatments.” 1
17. When insurance payment reimbursement for ADT hormone therapy decreased so did the number of patients being prescribed ADT therapy [17,18].
18. By law, cancer reporting is mandatory for studies, research, etc. Loopholes often sanction privacy breaches. This can result in copying, distribution, downloading and viewing of patient files by numerous individuals without a patient’s knowledge or consent. Your privacy and confidentiality is often just an illusion.
19. Because of the unlimited potential for harm, the risk of overtreatment and the questionable benefits; for 2018 The US Preventive Services Task Force (USPSTF) is now recommending for PSA testing and screening: Men 55 to 69, letting men decide for themselves. For men over 70, no screening at all is recommended.
20. After prostate cancer treatment, ED estimates are deceptive because statistics are often quoted after the use of ED drugs. ED percentages are substantially higher without ED drugs. Similar deceptive tactics also apply to incontinence percentages.

The generally accurate humor and sarcasm is intended to entertain and educate while reading this possibly laborious text.

Follow the money $: The CEO’s of some cancer charities make well over $400,000 annually.
A surgeon is financially responsible for operating expenses, a large staff or an oncologist is also responsible for a lease on multimillions of dollars in radiation treatment equipment. Do you think they would be more or less honest about the benefits and hazards of treatment when recommending treatment? Do you think the profit margin would compromise some doctor’s ethics?

What is the purpose in over testing and treating cancer that often will not spread (testing and treatment frequently cause lower quality of life, ED, incontinence, depression, fatigue, etc) if it was not extremely profitable? Prostate cancer testing and treatment may do more harm than good. Potential for harm and the questionable benefit, for 2018 The US Preventive Services Task Force (USPSTF) is now recommending men decide for themselves. For men over 70, no screening at all is recommended.

Cancer patients are often elderly and exploited for profit. The treatments offered have horrible side effects. Prostate cancer is often slow growing and of low risk and can just be monitored. Often no treatment is the best treatment.

Numerous experts, studies and investigations, documentation, etc. Getting a treatment recommendation from a doctor who profits from the treatment is sometimes a mistake. [1,9,10,17,18,25] https://urologyweb.com/why-most-prostate-cancers-and-treatments-are-fake/

A 12 or 18 core blind biopsy, holey prostate! One million dangerous prostate blind biopsies are performed in the USA each year and they are often sent to a urologist for a blind biopsy. Cost in the USA is at least $3 billion annually. Men should be told about other options; percent free PSA test, 4Kscore test, PCA3 test or an MRI, 3D color-Doppler test before eliminating the need for a risky and invasive blind biopsy. Men with a high PSA tests result are often sent to a urologist for a blind biopsy. This technology is 30 years old. Blind prostate biopsy cost in the USA is at least $3 billion annually. Biopsies can cause urinary problems, 6.9% hospitalization within 30 days from a complication [5,11,22,23]. There is also debate that a biopsy may spread cancer because of needle tracking. A blind biopsy is degrading and can also increase PSA reading for several weeks or months, further frightening men into unnecessary treatment. Blind biopsies are almost never performed on other organs. One prestigious hospital biopsy information states “Notice that your semen has a red or rust-colored tint caused by a small amount of blood in your semen”. Another well-known hospital states “Blood, either red or reddish brown, may also be in your ejaculate.” These statements can be an extreme exaggeration (mostly lies). Biopsy a man’s semen can turn into a jet black goo.

Bone scan scam: Prostate cancer patients are often sent for a bone scan. About a 13% chance of having a false positive and only 3 men in 1,000 have bone cancer who have a bone scan. Bone scans may sometimes be unnecessary in low-risk prostate cancer patients.

Low-risk cancer patients or patients with short lifespan are often sent for aggressive treatment by some doctors when monitoring is often a better option: overtreatment is one SBRT radiation clinical trial. Treated with a huge dose (50Gy total, 5 fractions) of radiation resulting in disastrous long-term side effect for some of these men. The typical SBRT dose is 35 to 36.25 Gy, 5 fractions. A large percentage of prostate cancer patients in this clinical trial had low-risk prostate cancer and may not have required any treatment. Clinical trials may (or may not) be hazardous to patients: the intent is not necessarily to help or cure patients. Given a treatment that will harm them (as in the above example) or given a placebo in place of treatment or needed treatment is withheld, the patient may be deceived or harmed. Investigate
before you participate in any clinical trial. You may not be available to you after the clinical trial is over. If the trial is for a drug, you will not be told if you are getting a drug or a placebo until after the trial is over.

Your privacy and confidentiality is often just an illusion. Under the HIPAA law, all access to your records is allegedly by a “Need to know” basis only. This is a lie. Cancer reporting is mandated by law. All patient (cancer and non-cancer patients) can have files duplicated (downloaded) numerous times by multiple databases. HIPAA has numerous loopholes and exceptions. Even excluding violations, HIPAA will often not protect your privacy.

Prostate cancer patients are asked to fill out a series of EPIC questionnaires or other forms. The EPIC questionnaire asks several intimate details about patient’s sex life, urinary and bowel function. By a prostate cancer patient completing an EPIC questionnaire, he may be able to assist his doctor, nurse, office workers or multiple databases track his progress or decline. By refusing to fill out these forms and supplying relevant information only, he can help ensure his privacy and ensure he does not unknowingly become part of a study, survey or have his information forwarded to multiple databases. Most of the time a patient has no idea who has access to medical records or why the records are being looked at. Probably everyone that works in a medical office or building has access to the records, except you (often you, the patient may have limited or no access without a formal request). Often a patient is not allowed to touch, handle or look at their own records. File access may include non-medical employees, office workers, bookkeepers, janitors, insurance companies, college or high school interns as young as 14. This may include other facilities, trial, drug companies, students, government Health Information Exchange (HIE) or servers. Dozens, sometimes even hundreds or thousands or more people may have access (Surveillance, Epidemiology and End Results) and its contractors, partners, institutions, etc are linked to major databases like SEER or state cancer registries and its contractors, partners, institutions, etc to determine “end results” for researchers, studies, drug company clinical trial offers, etc. Almost anyone could have access to your records. SEER and cancer registries are just some of many databases. Servers, both government and private are sharing information.

Health information may be shared by millions of entities and servers all over the USA and sometimes the world. Records may be packaged with others and offered for sale, often happens on “the dark web”. If a doctor, patient, insurance company, pharmacy or lab is involved in a criminal or civil case; medical records may become public or court or law enforcement records. Financial and medical Identity theft is also a problem, often expensive and difficult to correct. Hacking and Ransomware is also a growing problem. Your records can be accessed by anyone (trainees, volunteers, college or high school interns as young as 14) “for training purposes” or any other reason, all without your knowledge or consent. They can also read records about your prostate problems, your wife’s hemorrhoids and your daughter’s yeast infections and all files for any patient, all within the HIPAA guidelines. Would you like to have a 16 year old high school student intern that perhaps lives in your neighborhood or attends your member’s medical records and person watch major surgeries. These people do not have to be employed by the facility or have a background check. All patients should avoid supplying unnecessary information whenever possible. Supply relevant information only when filling out forms. This is a growing problem and is often financially devastating. Medical forms can be a good source of information for thieves. A pharmacy benefit manager (PBM) can track your prescriptions. Drug companies use major databases to solicit people for clinical trials and product. Even without violations, records can be accessed by multiple people and appear in multiple databases. Sometimes medical phone calls are recorded.

Dignity and privacy, especially if it is in conflict with training, research, studies, profit or other objectives. If you are a celebrity or you (neighbor, acquaintance, co-workers or probably) want to have a look at your record on this subject, “Snooping into medical
Mandatory privacy breaches: Months after my cancer treatments ended I started receiving disturbing advertisements and clinical trial offers in the form of postcards and letters. I learned: 1. By law cancer reporting is mandatory. 2. By law, your cancer records cannot be deleted or sealed and are often not protected. 3. HIPAA has numerous exceptions and loopholes. 4. Anyone with a reason can apply for access to all cancer records in the database. Multiple names with unknown backgrounds can be submitted by one person. 5. Researchers, students and others can have immediate access to your records, however if you want a copy you will be required to fill out forms and verify your identity. 6. Cancer Registry WebPages will tell you “Your information is safe” and “your information is de-identified” and how very important your privacy is to them. This is all lies. Clinical trial offers will indicate otherwise. The only deterrent a patient can try is submitting a formal opt-out request for clinical trials to his or her state cancer registry. However, this may only give partial confidentiality. The responsibility will be left to the patient to submit the request; the patient will not be informed or contacted otherwise.

A patient’s dignity (or lack of dignity): Prostate cancer testing and treatment is stressful, degrading, demoralizing and embarrassing. Per one study 80% of men with ED never talk to their doctors or seek treatment because of these reasons. After his surgery, one patient stated his prostate and his dignity were both removed and discarded. EPIC questionnaires can be counterproductive impacting a patient’s dignity, privacy and confidentiality. The term “strictly confidential” can be misleading. His “strictly confidential” EPIC questionnaire was only read by every female office staff member who ogle him. He stated that he became very uncomfortable and discontinued his appointments. Many women prefer or only employ female staff. Over half of men will only see female doctors. Almost all gynecologists will employ only female staff. Per some studies, a significant percentage of men will feel uncomfortable or will completely avoid medical care if a female doctor, nurse or staff member provided it for prostate problems, incontinence, ED, etc. EPIC questionnaires can lead to awkward conversations, unasked questions, deafening silence, and canceled appointments. Some men would prefer illness, no treatment and sometimes even death over embarrassment. Some men are more likely to seek or accept medical care for personal health issues if the staff (point of contact) is male. Yet modern medicine still insists on using the same old flawed traditions and procedures. http://drlinda-md.com/2016/11/men-patients-forced-man-medical-setting/

Becoming radioactive: LDR Brachytherapy procedure implants about 60 to 125 radioactive seeds in the prostate, sometimes resulting in urinary problems. The patient will literally become radioactive for months and up to one or two years. The patient may set off radiation alarm at airports, seaports and border checkpoints. They will also be required to use a condom initially, have no close contact with pregnant women, infants, children and young pets for months or longer. Occasionally he may even eject dangerous radioactive seeds during sexual activity or urination. The patient will become like a walking Chernobyl, having radioactive scrap metal and emitting hazardous radiation from his crotch. Anesthesia and a catheter will also be required. Brachytherapy has a probability of ED and other sexual dysfunctions.

ADT Hormone therapy, big profits and devastating side effects: ADT Hormone injections are a common and expensive treatment. Men are prescribed ADT hormone therapy, AKA chemical castration as an additional or only treatment. ADT therapy is sometimes overprescribed for profit, per some studies. Hormone therapy is often very expensive (Profitable for doctors if provided at the doctor’s office). It can have horrible, strange and devastating side effects; feminization, hot
flashes, fatigue, weight gain, metabolic cognitive issues, the penis could shrink breasts. This treatment can have nume- stated that ADT therapy turned him into sometimes actually castrated (orchiect. Studies (Medicare and financial) have profit (depending on Insurance payout reimbursement for ADT decreased so [17,18]. Per Wikipedia: “in patients with has demonstrated no survival advantage and bone loss. Even so, 80% of Ameri- prostate cancer.” Overtreatment with A avoidable.

Major surgery, major side effects: In m Nerve-sparing Robotic prostatectomy i standard”) and having fewer side effec surgery can result in a faster initial rec libido, Long-term risk of incontinence, f and have a shorter penis, etc is about surgery are at about a 22% chance of required. 0.5% died and 20.4% had on prostatectomy 15. Patients can have u option, per some studies. The ED rates A published study found that prostatec years after surgery 29. Men are often li https://urologyweb.com/robotic-prostate https://urologyweb.com/prostate-surge Patients should not be naive: Medical one million deaths in 4 years) 13. Medi and motor vehicle accidents combined mistakes. If you are having surgery or someone qualified or knowledgeable n and technicians can be profit motivated mistakes, and be apathetic or rushed. int or for profit. 10% to 20% (up to 2 Hospital staff often work 12 hour shifts fatigue. Medical staff sometimes gossi of My Emergency Room) and use othe many patients in a relatively short amo typical). This may be a disadvantage to be compromised. The staff usually get outstanding care. I personally know or other medical staff that I would consider lazy or apathetic, sarcastic or abusive, people did not have a name tag and st. One of my neighbors is a mentally ill tr dangerous. I am now sure modern me sometimes victimizes the naive patient leading cause of deaths in the USA. I r preventable and sometimes intentional hide behind anonymity, do patients irre his or her first name. TV, movies and s caregivers; however the healthcare pr incompetent workers as other occupati however this may not protect us from ti fired: 1. Prescription drug abuse (becau use drugs). 2. Too many mistakes. 3. 4 No proper licenses 5. Abuse of patient
can just find another job, without any repercussions. QOL (quality of life) may be secondary or an absent goal in treatment. A career in the medical field can present opportunities for drug addicts, the profit motivated, sadists, misogynist, misandrist (man or boy haters), sociopaths, psychopath, voyerist, perverts, and occasionally rapists and serial killers. Patients in nursing homes are most vulnerable to abuse. Employee screening is often deficient. Sometimes overtreatment for profit or to prevent an unlikely death or metastization from low-risk cancer n treatment. Many men may not be prepared for or have unrealistic expectations about the outcome, physical and psychological impact of testing and treatment. Depression in prostate cancer patients is common, 27% and 22% at 5 years, 6 and for advanced prostate cancer patient's depression is even higher. an increased risk of suicide. The use of antidepressants increase after prostate cancer treatment.

Men are seldom screened for anxiety and depression after treatment. Suicides occurred 2.51 times more often in prostate cancer patients. The risk of chronic or permanent fatigue (that can result in depression and suicide) is almost always understated if disclosed at all to patients. The risk of chronic fatigue is about 25% to 60%. a high risk of fatigue.

Conventional prostate cancer testing and treatment. Quackery, butchery and Frankenstein medicine? Castration, ADT hormone therapy, cryotherapy, surgery, chemotherapy are emotionally brutal, traumatic and disturbing. primitive and almost beyond belief in today's world of advanced technology. It seems all of the best treatments for prostate cancer have not been approved and some are only available outside the USA. Newer treatments like Neutron capture therapy, CBD and TH ablation (laser, IRE Therapy) and orphan drugs (dichloroacetate, etc) should be approved and used when appropriate. It often takes years or decades for new treatments to be approved. no profit is to be made as in orphan drugs, limited to selective MRI guided sample some studies vitamin D3 may prevent prostate cancer testing and treatment in prostate cancer patients. Look for IRE, Laser or focal Ablation and no blind biopsies. Some studies list one location as a reference: https://urologyweb.com/

Prostate Radiotherapy (EBRT-external beam radiation therapy) for cancer treatment. technology consists of Proton, IMRT, SBRT, IGRT, VMAT, TrueBeam, Cyberknife, etc. newer, faster, more accurate and easier to set up radiation equipment is of much benefit for doctors, staff and a good selling point to patients. equipment. Radiotherapy can cause high orgasm intensity and multiple forms of sexual dysfunction from newer equipment. Radiotherapy can cause high long-term side effects, especially fatigue. The treatment plan: Gy dose and fractions, margins, testicular dose, constraints and age of radiotherapy equipment to ensure excessive radiation exposure treatment is not given that can result in additional side effects. Patients should be aware that pelvic shaving, permanent tattoo markers, fiducial marker (small seeds) are sometimes placed in the prostate, MRI, CT scan, photographs, catheters and other procedures may or may not be required. Radiotherapy can also occasionally result in secondary cancers and damage to "organs at risk" (organs close to the prostate). Some of the studies on proton therapy and ED are biased because they only include men under 60 years old. Radiation has a high probability of sexual dysfunction and fatigue, just as high with the newer equipment. ED rates estimated at 35% to 75% or higher, 93% at 15 years. Sometimes radiation can also cause bowel and urinary problems. A 5 day SBRT radiation treatment is now commonly available with about the same results and side effects as a 9 week radiation treatment. 44% decreased orgasm intensity and multiple forms of sexual dysfunction. Some studies include men under 60 years old. Radia
influenced by his or her financial obligations when deciding to recommend over testing and treatment.

Fried nuts, two: Prostate radiotherapy can sometimes result in a 5% to 30% or more temporary or permanent drop in testosterone levels, excluding hormone therapy. This drop is determined by the testicular radiation dose (treatment equipment and planning) [19,20]. A below normal drop in testosterone can result in fatigue, depression, sexual dysfunction and other symptoms. Always ask for a printout of testicle dose and constraints for prostate radiotherapy to ensure your testicles are not over-radiated, also include the CT scan exposures. With radiotherapy robotic arm equipment and the testicles included in the treatment field can result in a major drop in testosterone. If you are being treated with robotic arm radiotherapy equipmen demand “Testicular Avoidance (TA) beam arrangements”. Have your testosterone levels tested before and months after EBRT prostate treatment.

Chemotherapy can be extremely toxic and sometimes deadly: women (who are being offered chemotherapy should be particularly cautious. The effectiveness of the specific chemo drug being used on the exact cancer type being treated, chemotherapy can often be more toxic to the patient than to the cancer. Chemotherapy may be extremely expensive, profitable for some doctors (if dispensed by the doctor and not by a third party) and can be misused or overused, often for profit. The “chemotherapy concession”: A doctor may purchase a quantity of chemo drugs for $10,000 and charge a patient $20,000. The doctor can also receive a percent kickback from the drug company for prescribing the drug. This is a well documented and common practice. The world would refuse chemotherapy if they had cancer and chemotherapy may have a high failure rate.

One Michigan oncologist who committed fraud and gave $35 million in needless chemotherapy (for profit) to patients, some who did not even have cancer is now in jail for 45 years. He was running his own in-house pharmacy. The state regulatory agency initially cleared him of any wrongdoing (a cover-up).

Drugs are considered a biohazard. Long-term care for side effects is often lacking, exploitive or ineffective. PSA testing for years. Long-term side effects often consist of fatigue, bowel or urinary problems, sexual dysfunction, depression, isolation and sometimes suicide. Often treatments for long-term side effects are embarrassing, degrading, unavailable, nonexistent, costly, not effective, not offered and other ED products, catheters, pads and additional treatments and surgeries for side effects (chemical castration) are sometimes required.

Men, aging, exploitation and elder abuse: The elderly are the ideal victims for profiteers, scammers, sadists, etc. If any man lives long enough it is very likely he will have a prostate problem, low testosterone or some form of sexual dysfunction. In my opinion, modern medicine often has been exploitive, abusive and has provided substandard care for older men in general due to all of the explanation given in this text. Americans need improvement and they are sometimes viewed as being subhuman and exploitable by various groups and individuals. One patient after recovering from a brain injury testified that he was repeatedly abused, slapped and hit, forced to drink boiling hot tea by multiple caregivers and sexually assaulted by one female caregiver.

One patient after recovering from a brain injury testified that he was repeatedly abused, slapped and hit, forced to drink boiling hot tea by multiple caregivers and sexually assaulted by one female caregiver.

Make sure you have an estate trust, etc 24.
Avoid the drug company rip off. No more exploitation! No bathtub included: Almost all conventional prostate cancer treatments usually result in a high percentage of erectile dysfunction. Often claims of prompt effective treatment for ED or other side effects if they occur after treatment are often misleading. After treatment, ED estimates are deceptive because rates are given after the use of ED drugs. Without ED drugs, ED rates are about double. Statistics for ED percentages from treatment are usually quoted after treatment with Viagra or other ED drugs, therefore most statistics are very misleading. ED rated at 5 years may be as high as 50% to 80% or higher for most treatments. For ED drugs like Levitra, Cialis, Viagra and Muse are deliberately kept very expensive by drug companies, about $11 to $60 per 1 pill free bathtub featured in its advertisements for Cialis. The cost of 30 5Mg Cialis is usually well over $330 and the cost of an inexpensive bathtub is about $200. Generic PDE5I ED drugs in Canada and other parts of the world sell for about $0.50 to $2 a pill. Some ED drugs should have already become available in a generic in the USA form for about $1 a pill. Have been developed however they have not been approved for use in the USA and they may never be approved. Men are also exploited by counterfeit mail order ED drug sales. ED treatments can also be embarrassing, not offered, not practical, expensive/not covered by insurance. 80% of men will not seek treatment because of these reasons.

For cryotherapy, ED rates are extremely high. ED drugs like Levitra, Cialis, Viagra and Muse are deliberately kept very expensive by drug companies, about $11 to $60 per 1 pill. Viagra is the cost of a $11 to $60 pill for a free bathtub featured in its advertisements for Cialis. The cost of 30 5Mg Cialis is usually well over $330 and the cost of an inexpensive bathtub is about $200. Generic PDE5I ED drugs in Canada and other parts of the world sell for about $0.50 to $2 a pill. Some ED drugs should have already become available in a generic in the USA form for about $1 a pill. Have been developed however they have not been approved for use in the USA and they may never be approved. Men are also exploited by counterfeit mail order ED drug sales. ED treatments can also be embarrassing, not offered, not practical, expensive/not covered by insurance. 80% of men will not seek treatment because of these reasons.

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incontinent, fatigued, sterile, exploited, devastated, demoralized, depressed, sometimes castrated, Increased use of antidepressants, complications, sometimes financially harmful, sometimes literally dead. Some men can suffer from post-traumatic stress disorder (PTSD) after treatment. Loss of libido, suicidal, stressed, left with complications, sometimes financially harmed or ruined, sometimes radiated or radioactive. And sometimes literally dead. Some men can suffer from post-traumatic stress disorder (PTSD) after treatment. Loss of libido estimated at about 45% or higher, excluding hormone therapy.

After testing and treatment your life may be very different. Prostate cancer patients can be elderly and exploited for profit [1,5,9,10,25]. Ineffective, expensive, not offered, degrading, demoralizing, lacking or nonexistent. Cancer patients are often not told about chronic fatigue, depression, loss of libido and the true risk of side effects are often understated.

Your medical records can be viewed by several people and downloaded to multiple servers. Modern medicine often fails, victimizes and exploits prostate cancer patients. Often few good choices exist for treatment.

Often few good choices exist for treatment. After your conventional prostate cancer testing and treatment your conventional prostate cancer testing and treatment choice can be elderly and exploited for profit. High-risk prostate cancer and does not have advanced age he may need treatment. He should look into other newer treatments if available. Also, he should try and avoid hormone therapy if possible because of the multiple side effects especially if the cancer is organ-confined. If laser or other newer treatments are not available a 5 day SBRT radiation treatment may be considered (In my opinion SBRT could be the least worst of the bad choices, still a poor option). SBRT seems to be fast, least invasive. ED and fatigue is still a high long-term risk. Radiation with hormone therapy has a very higher risk of ED and long-term fatigue.

My story (my dilemma): I went to see my doctor for a checkup. He had 16-year-old girl and a 17-year-old boy high school interns that reside in the neighborhood looking over patient records (with full access to all records) working in his office for the summer. Privacy and confidentiality issue/violation. His longtime medical assistant was going through a nasty divorce and it seem to be affecting her performance and my care. My doctor referred me out to his urologist friend because of a high PSA test. He used old and dangerous testing technology (18 core blind biopsies), his nurse seemed to have a mental defect exhibiting arrogant, rude, strange and abusive behavior and was intent on inflicting psychological and possibly physical harm to me.

His nurse was no longer employed at his office and no person in that office would refer to her employment or her existence. I now believe this nurse was under the influence of drugs because of drug abuse is common among nurses (easy access to drugs). I was diagnosed with prostate cancer by Dr. “A”. I was given a book by Dr. “A” (see the paragraph below “the book with no happy ending”) I refused Dr. “A” surgery and hormone therapy recommendation because of the imminent side effects and his unprofessional (arrogant, rude, strange, sarcastic and abusive) nurse behavior, so Dr. “A” referred me to Dr “T”.

Insurance network; however, his office manager stated she was willing to work with my insurance, offered me a doctor consultation and would accept any insurance payment as a full payment. When I arrived in his office the waiting room was empty and Dr. “T” had a large staff. Dr. “T” used older conventional technology (old equipment, 9-week radiotherapy), offered me overtreatment, hormone therapy, bone scan (unnecessary procedures and testes). One week after my consultation with Dr. “T” I received an $850 bill, in conflict with what was agreed upon with his office manager.

After a recommendation from an acquaintance, I called clinic “O” and met with the nurse. She offered me treatments with a verbal guarantee of “no side effects from the SBRT radiation”. However, this nurse could not answer any of my basic questions lacked any credibility and sounded like an unscrupulous used car salesmen. Most of these office visits caused me multiple problems with office workers processing paperwork for tests, insurance forms and billing, etc. Two of these doctors recommended unnecessary hormone therapy ADT (overtreatment) for my organ-confined cancer. After I absolutely and utterly refused hormone therapy, both doctors admitted it probably would not help me in my final outcome because of the computer estimate run on me with my organ-confined cancer. Having no newer treatments (laser, etc) available to me at that
time, I decided on SBRT treatment with Dr. "K", he could answer my questions and had new equipment. Before my treatment could start I was referred to "W" lab for an MRI. The trainee assisting and it took over 3 hours to complete my MRI. I examined the MRI report, I found it had my name and some other patient's history information. I wasted 2 stressful days verifying it was the correct MRI of me and not some other prostate patients MRI before my treatment could start.

I had a relatively fast and noninvasive treatment (SBRT), resulting in several months of fatigue, a large PSA bounce 18 months later. I still have ongoing problems obtaining PSA lab request forms from my radiologist's office. I feel this entire ordeal aged me and I'm not sure what the future will bring? I also no longer trust modern medicine, doctors, nurses, etc. It seems to be more of a gamble than a science. I have wasted hundreds of hours and thousands of dollars. I feel modern medicine has violated my confidentiality, abused and failed me (and others) due to the lack of guidelines and also approved obsolete technology, better unapproved treatments, exploitation, greed, apathy and incompetence. Hindsight is 20/20. If I could do it over again, I would also consider no PSA testing and treatment or traveling for newer treatments from a competent provider. Two doctors recommendations and received unnecessary hormone therapy in addition to the radiotherapy my quality of life (QOL) would have been severely impacted for years or permanently and could possibly have resulted in my early death.

"First, do no harm", unless you can make a lot of money and get away with it: A number of medical staff I came into contact with seemed intent on doing me harm. I was physically assaulted and verbally abused by his sadistic nurse. Clinic "O" nurse attempted to misinform and deceive me about the treatment outcome of "SBRT treatment with no long-term side effects". I observed several medical facilities do not require workers to wear name tags and when asked for a name most will give a first name only; this may also be a factor in healthcare workers not acting in an ethical manner. It seems that this prostate cancer nightmare maze was intended to be demoralizing and be of maximum physical, psychological and financial harm. Also to be of questionable benefit and to be of utmost profit for doctors.

I have been one of the worst events that has happened to me in my lifetime. Also, seeking testing and treatment is one of the biggest mistakes I have ever made. I feel modern medicine for not protecting patients from predatory doctors, substandard technology and a lack of regulations that would protect patients.

If I could do it over again, I would have saved thousands of dollars, time, had no side effects, no paperwork, more confidentiality, privacy and less abuse. I could have received better advice? I could have received a nice amulet or a good luck charm to protect against sorcery and magic (conventional prostate testing and treatment) and evil medicine men and witches (predatory doctors, incompetent staff). My (lack of a good) treatment choice: Because castration (orchiectomy), ADT therapy (chemical castration), prostatectomy, Chemotherapy, LDR Brachytherapy and blind biopsies are what I consider quackery, butchery strange, bizarre, brutal, twisted, degrading or a perverted nightmare I would avoid all of them. Unfortunately, I was deceived into having a 18 core blind biopsy. I do not believe other conventional treatments like radiotherapy are good or great choices either, just not as horrific. The choice I made was a 5 day SBRT radiotherapy. It had drawbacks and side effects, about the same as a 9 week EBRT radiotherapy. I also had no newer treatment options available to me.
would also consider either no PSA test and treatment or traveling for newer treatments from a competent provider if practical and available. Receiving conventional testing and treatment is often worse than the disease. Substandard providers. 3 years later I greatly accelerated my ageing (through radiation and was also a financial burden). Studies my intermediate Gleason 7, 4+3 about a 50% chance of a treatment failure was originally quoted at 85% before my testing and treatment is mostly smoke. Dr. Richard Ablin now calls it “the Great Health Disaster”1. When asked: “How away from doctors and don’t take anything they prescribed. I now believe this advice to be mostly true.

The Book with no happy ending: In my opinion, my doctor gave me a book written by a female. It generally contained conventional hazardous prostate cancer testing and treatments with multiple side effects. No mention of harm from a blind biopsy or focal ablation treatments (new testing and treatment) in this book. This book also contained potentially harmful misinformation. It seemed subjective, had some incorrect, demeaning and demoralizing content. I am not sure if this book was intended to cause anxiety, to devalue and misinform men to accept conventional testing and treatment without question? They could just rename all books like this one, “The DANGERS and TRAGEDY of Conventional prostate cancer testing and treatment”. Always protect yourself: Conventional prostate cancer testing and treatment is hazardous. A patient should be extremely skeptical of exaggerated claims about minimal long-term side effects from conventional treatments or blind biopsies, exaggerated cure rates or the need for immediate treatment. Bring someone educated or astute with you to your consultations and appointments. Inquire about newer testing if you have prostate cancer. Always ask for a second or third opinion if you are being offered treatment with low-risk prostate cancer or have a short lifespan. Learn about all your treatment options, testing and side effects. Under the HIPAA law, you are entitled to a copy of all your medical records and bills. Always ask what is the “biochemical recurrence” (AKA rising PSA or treatment failure) rate for well beyond 5 years. 5 years is not a magic number. Get a 10 or 15 year cure estimate. For help contact a good prostate cancer support group without a conflict of interest. A wise man once told me “you need to learn to think like your doctors (nurses or other providers).” What are the motives of your providers? A medical holocaust: Multiple studies have verified more deaths and harm caused by prostate cancer testing and treatment than from prostate cancer itself. Leading cause of deaths in the USA, over 251,000 deaths a year or over one million four thousand (1,004,000 deaths in 4 years.
accidents combined 13. Per a consumer magazine: Each year 8.8 million hospital patients suffer from preventable harm and 440,000 hospital patients die from medical errors and hospital-acquired infections. Per the FDA, 106,000 deaths per year (Over one million people in 10 years) from prescription drugs. I personally know of 2 patients killed by medical mistakes, one got hepatitis from a colonoscopy and the other death from an upset ER nurse forcing a tube down his throat causing lethal damage.

No national guidelines: A prostate cancer patients “bill of rights” is needed to be created and enforced because of the extensive and documented abuses of prostate cancer patients: 1. Blind biopsies should be banned. 2. Full mandatory industry standard disclosure needs to be created for tests and treatment to include realistic risk factors and all side effects listed. 3. Newer testing and treatments need to be created and approved. 4. Mandatory aftercare needs to be available. 5. Mandatory confidentiality need to be standardized and enforced in addition to the deficient HIPAA laws. 6. Mandatory drug testing for employees with access to control substances. 7. A truthful and accurate educational book or PDF needs to be created and distributed to all high PSA and prostate cancer patients. 8. All health care workers need to be screen and no adolescent under 18 years old should have contact with patients or records. It is unlikely any of the above recommendations will be implemented unless prostate cancer affected a larger percent of the population or enough prominent people are affected.

Prostate cancer patients must protect themselves as the only alternative!

Clarification: This document has angered and upset some people for various reasons; some prostate cancer support group members, advocates and others are trying to spread the truth and others are attempting to suppress the truth. If you do not have a short lifespan and have metastatic, advanced, intermediate or high-risk prostate cancer you may need treatment. The intent of this document is not to imply all doctors are dishonest or to condemn all medical providers. The intent is to educate men of the consequences and dangers that may await them so they can take appropriate action and to inform patients of real world, typical or worst case scenarios. Also to obtain the best testing and treatments available. I created this document after I was extensively abused, lied to, provided substandard care and had my privacy and confidentiality violated.

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