

CHAPTER EIGHT WATCH AND WAIT

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The word cancer can be very frightening. When some hear it, they panic and want it out immediately. But a rash decision to have a rush treatment that is not necessary may cause more problems than the cancer. In many cases, the cancer may have taken several years to grow to the point where it was detectable. It won't hurt to wait for a while so that you can investigate all your options. It could be that you may never have to have a treatment.

If you are 50 years old, and in a room with two other men, one of you probably has cancer of some kind. One out of every two men will get cancer of some kind in his lifetime. About one out of every six men may have prostate cancer during their lifetime, but many prostate cancers are latent or indolent. If you look up the word indolent it will tell you that it derives from the Latin dolere, to feel pain, the prefix in- means not, so an indolent prostate cancer would not cause pain. Indolent also means lazy or inactive. These words describe many prostate cancers. There are millions of men who have these cancers and they will never be a problem. Whether they know it or not, these men are Waiting.

Unfortunately, we have no absolute way to determine which of the cancers are truly indolent and which ones may be dangerous enough to kill you. The rate of deaths due to prostate cancer was over 40,000 per year just a short time ago. Since the advent of the PSA test the mortality figures are coming down. The estimated figure for prostate cancer deaths in 2000 was 31,900. But an autopsy is not performed on many men who die. Some men die while not under the care of a doctor. Often the real cause of death is not known. So there may be more deaths from PCa than the official figures show.

Watching and Waiting may be the better option for many men. But those men who are blithely Waiting would be much better off if they were Watching closely while Waiting. One way to do this is to closely monitor the PSA.

The PSA test is one of the simplest and best markers that we have for any cancer. In most cases, the PSA will correlate fairly closely with the cancer activity. You should have a record of any PSA tests and the dates when checked. You can then check for any upward trend and the length of time between any rise. In most cases, the doubling of the PSA should be cause for concern, especially if it doubles in a short time. However, if you are 60 years old and your original PSA was 2.0 ng/ml, and it takes five years for it

to double to 4.0 ng/ml, you may not have to worry. If your PSA is 10 ng/ml or less maybe you should have a free-to-total PSA. If the free percentage is above 20%, then you probably do not have to worry. You may not even need to have a biopsy.

But if you are 60 years old and your beginning PSA or base PSA (bPSA) is 2.0 ng/ml and a year later it is 4.0 ng/ml, then you would have to be concerned. If the free PSA is less than 20%, then a biopsy probably should be done. But remember that the first rule when it comes to cancer is that there are no rules. We are all different and most cancers are as different as we are. So we have no absolute way to determine which cancers are just pussy cats and which are tigers.

Prostate cancer is not the only problem many men have. If you are at least 70 years old, there is a 70% chance that you have Benign Prostatic Hyperplasia or BPH. If you are 80 years old the chances of having BPH is 80% and 100% if you are 100 years old. Not many men die because of BPH, but it can severely disrupt one's Quality of Life. There are several drugs and treatments for this disease. Sometimes a man with BPH can just Watch and Wait.

You should also know that if you are 80 years old, you probably have some prostate cancer along with the BPH. But it may not cause any problems.

So, if you have been diagnosed with prostate cancer, depending on your age, your health, expected life span, your PSA and your Gleason score, you may choose to just "Watch and Wait" (WW). However, Watch and Wait does not mean that you should do nothing about your prostate cancer. W.J. Kenney, a man who appreciates humor, said that he came across this line on the internet regarding watchful waiting: "Ignoring prostate cancer is like trying to maintain eye contact while talking to Dolly Parton". Dr. Gerald Chodak, an advocate of this therapy, says that it should be called "Expectant Therapy". Others call it Watchful Progression. You should be aware that the natural history of prostate cancer is progression. For some, it may take a long time and they may die with their prostate cancer, not from it. Or they may get run over by a truck or die of some other cause before the cancer kills them. But left unchecked, it will progress. In some cancers that progression can be very slow and may take a long time. It may never cause a problem. Other prostate cancers may grow very fast and be very aggressive. Again, the first rule when it comes to cancer is that there are no rules.

You should expect that eventually you will have to take some action. You should keep a close check on your PSA and any other signs of cancer activity, and be prepared to take appropriate action. We have several tools that allow us to keep a wary eye on the cancer for any sign of undue

activity. We can then treat it accordingly. Our technology, tools and methods of diagnosis continues to improve.

There will come a day when we will be able to positively predict which tumors are the bad guys right from the beginning.

Who Should Adopt WW?

Dr. Israel Barken and Ralph Valle make frequent posts to the Internet Prostate Problems Mailing List (PPML). (Instructions on how to join this list are given later in this chapter and also in the Resources Chapter).

Below are a couple of notes they posted to the PPML.

From Dr. Barken:

<Many in the medical establishment feel that a patient may adopt WW if one or more of these four points are fulfilled:

1. Age above 70; 2. Significant medical problems; 3. Low volume and low grade tumor; 4. Diploid tumor. These points are the conclusion of an article reviewing 8 studies of watchful waiting. My personal view is that no patient has to fit perfectly to the rules. The key is for the patient to feel comfortable with what he is doing. Quality of life may be more important to patients than statistical likelihood of surviving a certain number of years. Watchful Waiting is a bad term. Watchful Doing is a much better term. Patients can do a lot before submitting to any primary treatment- Good nutrition, good exercise and good mental attitude are very important. Whatever he does, the patient has to feel comfortable while monitoring his situation. Take care, Israel Barken, MD>

Ralph Valle replied:

<So true, people should be able to be comfortable with monitoring, but sadly, so many who could fit the mold of WW, get scared when they get the news, and too many doctors don't suggest, or explain, WW as a potential methodology when they fit the profile you mentioned.

We have seen many posts by men who have gone through so much that suggests regret because of precipitous action. Those of us who have been on the PPML for several months are aware that many men are in fact doing something other than just sitting and waiting and watching the cancer cells multiply. Some are changing their life styles, changing to low fat diets, eating soy products, taking saw palmetto, adopting high fiber diets, taking antioxidants, engaging in exercise, meditation, stress reduction, etc. Ralph>

There are several men who are ideal candidates for WW. None of us like to think about the end, but eventually it will come to all of us. Trying to predict how much time we have left is no fun but it should be part of any treatment decision. If you are 80 years old, you probably won't live another 25 years.

But it is quite possible that you will live another 10 years. If you are diagnosed with prostate cancer, you probably should not consider having a radical prostatectomy. But we are all different. A member of a local support group had a radical prostatectomy at age 83. He expects to live for another 20 years. For most men at this age the major surgery may be quite traumatic. If you are an older person, you may die from some other disease before the prostate cancer kills you.

On the other hand, if you are 50 years old, normally you should expect to live for another 25 to 30 years. However, depending on your diagnostic stage, your PSA, your Gleason Score and your general health, your cancer could kill you within two to ten years. But if you are a 50 year old man, with a low PSA, a low Gleason Score, and otherwise in good health, then you may be a good candidate for watchful waiting.

Some of the advantages of watchful waiting include its initial freedom from side effects of harsh treatments. It may also be inexpensive since you will not be paying for drugs and treatments.

Watchful waiting may be best for those who are too old or too ill to withstand the rigors of treatment. It may be difficult to face reality, but if a man's life expectancy is fairly short, a radical treatment may not be worthwhile.

Don't Rush to Treatment

There is no need to panic if you have just been diagnosed. It may have taken 10 or more years for your cancer to have become significant enough to be detected. So it won't hurt to wait just a while longer. Before making a decision for any treatment, whether watchful waiting, surgery, radiation or any other modality, learn all you can about your disease first. Remember that your doctor may be very busy and may not have time to study your charts and tests. You should get copies of all your tests and records. Don't be put off if the doctor or hospital refuses to give them to you. Your records belong to you. You should study them. Always remember that it is your body, your disease, your life and your decision as to which treatments to choose.

Graph Your Trends

A very important tool is to make sure that you have several PSA readings so that you can look for a trend. Many men use graph paper to plot the activity of their PSA. The PSA will correlate fairly closely to the activity of the cancer. Some men use their computer and a spreadsheet program such as Lotus, Quattro or Excel to plot their PSA and other tests. All doctors and hospitals should use this type of record keeping. Most doctors have to wade through a large manila folder full of the patient's history and visit records. A spreadsheet program could show the doctor all of your tests, drugs and trends immediately. Eventually, this will happen.

John Fistere is a computer programming whiz. He has written a program called MultiGraph that will construct a graph for you showing the trends of your disease. All you have to do is send him a digest of your history by e-mail. It's a free service of the Prostate Cancer Research and Education Foundation (PCREF). Send a message to John at JFistere@email.msn.com for instructions. John has contributed a whole lot to the fight against prostate cancer.

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The PSA will reflect to a great extent your cancer activity and should be monitored closely. This doesn't mean that you should be getting a PSA test every other day. Dr. E. David Crawford says that some men become "PSA junkies" who may shop around and get several PSAs, hoping to find a lab that returns a test that suits them. Depending on your diagnosis, stage, Gleason and other factors, you may not need a PSA more often than once every six months. Of course if it appears that your PSA is rising fast, then it should be done more often.

You should know your clinical stage and your Gleason score and know their significance. Knowing these numbers, you should consult the Partin and Narayan Tables in Chapter Six and determine the predictions.

Learning What You Need to Know

Before you can make a good decision about any treatment you must be informed. We are talking about your life and how much longer you may live. How much longer you live may depend on the decisions you make. There are several good books on prostate cancer. Read them and learn. If you have a computer, log onto the various websites and learn. A couple of the better sites are the Prostate Problems Help List (PHML) and the Prostate Problems Mailing List (PPML). These sites are actually E-Mail sites. There are several hundred patients and relatives who post questions, problems and answers on these lists every day. A great many of the posts are from Individuals who have had all of the various treatments. Their first hand experiences can help you enormously. If you are going to have a treatment, what better way to find out what to expect than from someone who has had that treatment? Several doctors monitor the PHML and the PPML and answer questions. They usually point out that their answers and advice cannot take the place of a face-to-face consultation with your doctor. The subscriptions to PHML and PPML are free. All you need is a computer and a modem.

Of course you will need to access the PHML and PPML through an Internet Service Provider (ISP) such as AOL, Prodigy, Compuserve, or any of the hundreds of providers now available. The ISP services may cost about \$20 or more per month. Many have local access telephone numbers, otherwise you may have to pay a telephone toll for time spent on the internet. To subscribe to the PPML and PHML use your E-Mail that is usually supplied by your IPS. When you log on to send a message a form will usually come up with space for address, subject and message. Send e-mail to:
listserv@listserv.acor.org
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Another excellent web site is www.prostatepointers.org. Once you get to this site, you will see several places of interest. If you click on Medicine, you will find several articles about prostate cancer. The ProstatePointers Website is maintained by Professor Gary Huckabay, a young man with advanced prostate cancer. He puts in many long hours maintaining the website. He is also very active in the National Prostate Cancer Coalition (NPCC). If you don't have a computer, you should think about getting one. At one time, computers were very expensive. But most everyone can afford them now.

Some Disadvantages of Watch and Wait

There are thousands of men who are doing very well on watch and wait. We don't want to frighten you, but there are some downsides to watch and wait. One problem is that some men may become complacent and not worry about their disease. They may have a false sense of security because they feel good. They may forget that prostate cancer usually has no early symptoms. They may also wait too long before seeking treatment. There is usually a window of opportunity when curative treatment can be initiated. Once the cancer has escaped the prostate, it is incurable. However, it is still treatable.

Another disadvantage is that we can only know the clinical stage of the cancer, which may not be the true stage. The patient may think he has an indolent cancer when in fact it may be a fairly dangerous beast. The patient may have read or heard of some of the Swedish and other studies that seem to prove that prostate cancer is something that needs no treatment. Many magazines and newspapers reported the studies with large headlines.

Many people were led to believe that prostate cancer can be ignored. Many of the studies have been proven to have been flawed, but there have been no headlines and few magazine stories to refute the original reports.

After the discovery of PSA, it was soon recognized what a fantastic tool it was. We can now detect very early prostate cancer with a simple blood test. Several hospitals and urologist organizations began setting up free or almost free screening tests for prostate cancer. Many people objected to these screening tests. They claimed that most prostate cancers were slow growing and harmless. They claimed that if a man was told that he had cancer, even if it was harmless, then it would cause stress and worry. It might even cause the man to panic and have unnecessary surgery or other treatment. Below are some discussions and examples of these items.

Waiting Too Long

One of the early advocates of watchful waiting was Dr. Willet F. Whitmore of the Memorial Sloan-Kettering Cancer Center. He was one of the pioneers in brachytherapy. This was before we had ultrasound so they made an incision then placed the radioactive seeds by hand. They were not too successful.

Dr. Whitmore and Dr. Jewett developed the A B C D staging system for prostate cancer. Dr. Whitmore coined the phrase "Is cure necessary for those in whom it is possible and is cure possible in those for whom it is necessary?"

Here is another quote from Dr. Whitmore:

"Many more men die with prostate cancer than of it. Growing old is invariably fatal. Prostate cancer is only sometimes so."

Dr. Whitmore was stricken with prostate cancer himself. He chose to watch and wait. He later died of prostate cancer. Shortly before he died, it was reported that he said he regretted the fact that he had waited too long before actively treating his disease.

There is definitely a window of opportunity for cure. We have several tools that can help recognize that window. But none of them are absolute.

Watchful Waiting Studies

A study that was done in Sweden, and some that were done in this country, seemed to prove that a person could live as long with prostate cancer, with no treatment at all, as those who had every type of treatment known. So why not avoid the pain and expense of surgery that may leave you incontinent and impotent? Why not avoid the morbidity, the loss of quality of life (QOL), and possibly even loss of life, due to the painful treatments?

You must be aware that not all studies are perfect. Almost every urologist in this country has pointed out that the Swedish study was flawed in several ways. The patients in the study were older patients and they were only followed for a short time. Most of the patients had a low grade cancer. Several writers have ignored the flaws in the study. Magazines and newspapers have published several articles based on this study. These articles have convinced many that prostate cancer is something that is innocuous and harmless, a toothless lion. They completely ignore the fact that a large number of men needlessly die from it each year.

In the U.S. during 1996, one man died from prostate cancer every 12 minutes or 41,400 during that year. We are making a bit of progress. In the year 2000 about 32,000 will die from prostate cancer. Every man who died from prostate cancer had a small cancer at one time that was curable.

Here is part of a post by Ralph Valle regarding the Johansson study: (Note: Cancer grades are mentioned several times in this post. Cancer grades are assigned to combinations of the Gleason score. Grade I is well differentiated cells, and includes Gleason score 2, 3 and 4; Grade II includes Gleason score 5, 6 and 7 which are those cancers that are moderately differentiated; Grade III includes Gleason 8,9 and 10 and includes cancers that are poorly differentiated. Remember that a well differentiated cell looks like a normal cell.)

The overall age for the Johansson study was 72 years at diagnosis. Is that representative of the mean age at diagnosis today? No it is not. The study of 223 men consisted of 47.5% (106) men with *T01 or T0d* stages and 52.5% (117) men with Stage T1-T2. Grade I cancer was present in 66.3% (148), Grade II in 29.5% (66) and Grade III in 4.0% (9) of the men in this study. Is that representative of the stages and grades of cancer discovered at diagnosis? No it is not.

The study is representative of early stage prostate cancer diagnosed at a fairly advanced age (mean age at diagnosis was 72 years). In this study, of the 223 men, 76 or 34.0% had progression. There were 64 men, or 28.7%, who had hormonal manipulation but were nevertheless counted in the overall survival figures. Local progression was defined as tumor growth through the capsule as detected by DRE. We all know the inefficiency of DRE by itself to establish progression. The study only investigates death with autopsy in 32 (26%) of the 124 patients that died during the study and claims that death by prostate cancer occurred in only 19 (8.5%) of those patients.

From the same set of data and the results of the Johansson study I conclude that conservative management of prostate cancer in older men with early stage prostate cancer is a viable option that must be

considered. To correlate the study with younger men or ignore higher cancer grades is in error and it can cause younger men or those with advanced cancer to decide for a course of action that can significantly increase their risk of dying from the disease.

Below are some tabulated results comparing deferred treatment with radical prostatectomy. These figures are taken from a paper by M. Menon et al: Should we treat localized prostate cancer? An Opinion. Urology. 46: 607-616, 1995

	Deferred Treatment	RP
Total patients	586	2395
Mean age (yr/range)	72 (67-76)	62 (59-63)
Mean follow-up (yr)	6.9	6.7
Grade 3 cancer (%)	7	16
10-yr crude survival (%)	33	83
10-yr disease-specific surv.(%)	83	93
10-yr metastasis-free surv.(%)	69	82
Death due to intercurr. dis.(%)	50	10
Death from PCa at 10 yrs(%)	17	7

Please note that in this tabulation the RP cohort includes almost 10 times more men with Grade 3 cancer than in the DT cohort and in spite of that the RP results are better in every single category.

Now, I am not advocating RP for everyone. Far from it. Just trying to point out that we can use numbers from different studies and demonstrate different results.”

In the post above, Ralph listed stages T01 and T0d that I had not heard of. I thought it might be an error so I sent him an e-mail. He answered:

Hi Aubrey,

No, it is not an error, but a subclassification created by Johansson et al. T01 means that there is less than 25% cancer of the total specimen collected by TURP. T0d means more than 25% cancer in the specimen.

Here is a portion of another Swedish study by Dr. Gunnar Aus et al. It was published in the 1995 Aug. issue of the Journal of Urology.

Abstract:

PURPOSE:

We investigate the long-term outcome of patients with prostate cancer treated with noncurative intent.

MATERIALS AND METHODS:

All 514 prostate cancer patients who died between 1988 and 1991 and who underwent either deferred or immediate hormonal treatment were followed from diagnosis until death.

RESULTS:

In all patients with stage M0 (M0 is without metastases) disease at diagnosis the ultimate cancer mortality rate was 50%. Among the 65 patients who survived at least 10 years the mortality rate due to prostate cancer was 63%.

CONCLUSIONS:

Mortality in patients with stage M0 prostate cancer was surprisingly high when follow up exceeded 10 years.”

Most of those men in the Swedish study spent many of their last months in a hospital in great pain and suffering. The cost of their treatments was very expensive.

Conservative Treatments

With some radical treatments there is a diminishing of quality of life. But newer treatments, procedures and technologies are being developed such as cryosurgery and various types of radiation such as 3D Conformal External Beam radiation, Proton Beam radiation and seed implants. These newer treatments can save your life and may have very little effect on diminishing your quality of life. Even if a treatment diminishes your quality of life, it is still better than not being alive.

There are some studies ongoing that are using high dose antiandrogens as a chemoprevention and treatment. Theoretically, the antiandrogens such as Flutamide, Casodex or Nilutamide are synthetic drugs that appear to the cancer cells to be real androgens. These drugs can attach to the androgen receptors of the cancer cells, then when the real androgen comes along, the cell is already satisfied. The real androgen is thus blocked. Without the real androgens, the cell will starve and die. The cells also need testosterone in the form of dihydrotestosterone (DHT). An enzyme, 5alpha-reductase, is needed to convert testosterone to DHT. Proscar is an inhibitor of 5alpha-reductase. The prostate cancer cells must have the DHT in order to survive.

Some men are taking 150mg/day of casodex and 5mg of proscar. We don't have any long term data, but most seem to be doing well. The high dose antiandrogens have very few side effects. However breast enlargement or gynecomastia is almost universal. Many men have a small dose of radiation to their breasts which prevents the enlargement.

One large disadvantage of the LHRH agonists such as Lupron or Zoladex is that these drugs eliminate the production of testosterone. Without testosterone, there is no libido. Without testosterone, there is also loss of muscle mass, there is

fatigue and osteoporosis or bone loss. The high dose casodex or flutamide does not affect the production of testosterone but they help prevent it from being utilized by the cancer cells.

If you can determine that your prostate cancer is slow growing, you can easily monitor it. New methods of treatment are being developed every day. New research is very promising. If you can hold off long enough, perhaps the “magic bullet” will be discovered before you have to have a radical treatment.

Causes of Death

Many of the advocates of watch and wait often make the statement that “many men die with prostate cancer, not from it”. That was quite true a few years ago when more men were dying of heart disease, lung cancer and other diseases. They died of these other causes before the prostate cancer had a chance to kill them. Fewer men are dying from those diseases now. We are now living long enough for the prostate cancer to catch up to us.

Dr. Jean deKernion is chief Urologist at UCLA. In a presentation to our UCLA support group, he said that there are some third world countries that have a very low death rate from prostate cancer. One of the reasons is that the average man only lives to about 40 years old in those countries. Who knows how many may have died from prostate cancer had they lived as long as we are living?

We know that many cancers seem to cause little harm unless they invade or choke off a vital organ. But we also know that if there is a large number of cancer cells, they may produce several toxic substances. We know that some of these substances may cause loss of appetite, cachexia, malnutrition and wasting away. So even if it has not metastasized, a large tumor burden may cause problems.

Chemoprevention

For the last ten years, co-author Dr. E. David Crawford has organized an International Prostate Cancer Update Conference. A special addition to one of his Conferences addressed the Progress and Prospects for Chemoprevention of Prostate Cancer. He had several renowned speakers such as Drs. Fernand Labrie, David Bostwick, Charles Boone, Brian Henderson, Gary Kelloff and several others. Their presented data shows that prostate cancer can be avoided in many cases. One of the better treatments of all is to prevent prostate cancer. Chemoprevention of prostate cancer means using drugs such as the antiandrogens, antioxidants, use of vitamins and minerals, diet, exercise and good common sense health practices.

We haven't found the magic bullet yet, but we are getting closer.