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PSA Rising While on Routine ADT, No Metastasis Evident; should Chemotherapy with Docetaxel/Taxotere be Added? (Apparently NOT!)

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Compiled by Charles (Chuck) Maack - Continuing Prostate Cancer Patient Since 1992, Advocate, Activist, Volunteer Mentor since 1996 to men diagnosed with Prostate Cancer and their Caregivers locally and online Worldwide.

Adding chemotherapy with docetaxel/Taxotere to ADT when ADT alone resulted in continued PSA rise, DID NOT improve results for those men for whom metastasis was not evident. In fact, with this chemotherapy addition those men experienced grade 3 or 4 hematologic toxic effects of neutropenia (60 of 125 patients [48.0%]), febrile neutropenia (10 [8.0%]), and thrombocytopenia (4 [3.0%]). Thus, in view of these side effects with the addition of chemotherapy with docetaxel to ADT, patients should discuss with their treating physician why this addition would be warranted if metastasis has not yet been evident (Link 1).

While on the usual ADT protocol of a GnRH agonist or antagonist and likely accompanied by an antiandrogen (bicalutamide, flutamide, or nilutamide), the usual ADT protocol, and your PSA is rising, and there is no evidence of metastasis (non-metastatic castration-resistant prostate cancer (nmCRPC), first have your Prolactin level determined (reasoning (Link 2). Next determine if your testosterone (T) level and your dihydrotestosterone (DHT) level are elevated. If so, then the addition of the 5Alpha Reductase (5AR) inhibitor dutasteride/Avodart could be considered to add to your current ADT to prevent testosterone (T) conversion to DHT (the more powerful stimulant to prostate cancer cell growth and proliferation) when T comes in contact with 5AR. Additionally, to be considered, and recently approved by the FDA for nmCRPC to add to your current ADT, is enzalutamide/Xtandi, a much more powerful medication than the usual antiandrogen, to block any T or DHT access to 5AR and/or the multitude of androgen receptors on cancer cells. Another for consideration recently approved by the FDA is apalutamide/Erleada to add to the ADT, since this is also a "next step" medication for nmCRPC pre-chemotherapy prostate cancer. On the near horizon will likely be darolutamide/ODM-201, on the verge of approval by the FDA, for pre-chemotherapy nmCRPC.

What would likely be yet another medication preferred, but unfortunately only approved by the FDA for pre-chemotherapy metastasis evident castration-resistant prostate cancer (mCRPC), would be abiraterone acetate/Zytiga to shut down the three locations of T production (testicular, adrenal glands, and that which cancer cells can produce within themselves). Additionally, enzalutamide/Xtandi has been found in the ARCHES study to be effective to accompany ADT for patients showing evidence of castration-resistant, metastatic, but still hormone-sensitive prostate cancer (Link 3).

Please Note: Medications involved in Androgen Deprivation Therapy (ADT) are known to increase cardiovascular risk. Thus, It is Important

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that prior to prescribing any form of ADT medication the patient's other health issues, that would include already present cardiovascular issues, are determined. As noted here (Link 4).

"Androgen deprivation therapy (ADT) has been the mainstay of treatment for advanced prostate cancer for decades and has been shown to control disease and improve symptoms. In addition, for men with high-risk localized or locally advanced prostate cancer, short-course ADT in combination with radiotherapy improves survival. There is evidence that ADT increases cardiovascular risk, particularly in men with preexisting cardiovascular disease. This increased risk may apply even with short-course ADT. In an individual patient, the benefits of ADT should be balanced against the risk, and patients who require ADT should have risk factors for cardiovascular disease optimized. There is some evidence to suggest that more contemporary methods of delivering ADT may reduce cardiovascular risk."

Dr. Matthew Roe, a Professor of Medicine at Duke University's Clinical Research Institute (DCRI), the Faculty Director of the Global Outcomes Commercial MegaTrials program, and the Director of their Fellowship Program, remarks: "If a patient who has advanced prostate cancer and known cardiovascular disease is being considered for androgen deprivation therapy, it is important that he speak with his cardiologist. (Presumably, both a cardiologist or cardiovascular specialist and a urologist or oncologist would treat him.) He needs to ensure that all the providers have a discussion about what the best and safest treatment would be before therapy begins. Obviously, this trial (the Pronounce trial regarding which is safer for patients with cardiovascular issues, the GnRH agonist Lupron or antagonist Firmagon (or neither?) (Link 5) is not completed yet so we don't have any answers. In the meantime, it is certainly in the patient's best interest to ensure that his providers are communicating and trying to jointly determine the right approach."

Disclaimer: Please recognize that I am not a Medical Doctor. Rather, I do consider myself a medical detective. I have been an avid student researching and studying prostate cancer as a survivor and continuing patient since 1992. I have dedicated my retirement years to continued deep research and study in order to serve as an advocate for prostate cancer awareness, and, from an activist patient's viewpoint, as a mentor to voluntarily help patients, caregivers, and others interested develop an understanding of this insidious men's disease, its treatment options, and the treatment of the side effects that often accompany treatment. There is absolutely no charge for my mentoring – I provide this free service as one who has been there and hoping to make their journey one with better understanding and knowledge than was available to me when I was diagnosed so many years ago. Importantly, readers of medical information I may provide are provided this "disclaimer" to make certain they understand that the comments or recommendations I make are not intended to be the procedure to blindly follow; rather, they are to be reviewed as my opinion, then used for further personal research, study, and subsequent discussion with the medical professional/physician providing their prostate cancer care.

Charles (Chuck) Maack - Continuing Prostate Cancer Patient Since 1992, Advocate, Activist, Volunteer Mentor since 1996 to men diagnosed with Prostate Cancer and their Caregivers locally and on-line Worldwide.

A mentor should be someone who offers courtesy, professionalism, respect, wisdom, knowledge, and support to help you achieve your goals; would that I succeed.

My reason for my research, and reporting same, is in my effort to insure "no harm," or at least "no more harm than absolutely necessary" occurs with the patients for whom I mentor.

My intent as a mentor is as an advocate to the patient as well as to assist the treating physician in explaining to patients the treatment strategy being recommended, but the patient telling me they did not understand. I attempt to determine what they 'heard' their physician explain but didn't understand; determine the status of the patient from their physicians explanation and lab/pathology reports the patient should have in his own records; explain reasoning for the treatment being recommended; depending on the patients status, explaining the various options appropriate for that status and why they should be considered in the event that had not already been explained by their physician; and provide this support in layman's language for easier understanding. I then recommend they further research that I provided and if they have further questions/concern to return to their treating physician and have them addressed. With all patients and their caregivers who contact me, I remark that I am "Always as close as the other end of your computer to help address any prostate cancer concerns."

Recipient 2008 Us TOO Intl., Inc., Prostate Education & Support Network 1st "Edward C. Kaps Hope Award"

Recipient 2012 Prostate Cancer Research Institute (PCRI) "Harry Pinchot Award"

Recipient 2016 Us TOO Intl., Inc. Certificate for 20 Years Dedication/Inspiration

Personal interview 2009: (Link 6) and scroll down to "*Let's Talk About Prostate Cancer …* with *Chuck Maack***.**" - please note that in that interview when I meant to be talking about antiandrogens, I mistakenly used the word "Lupron."

Author of several Journal articles regarding Prostate Cancer.

References

1. Link 1: https://www.ascopost.com/News/59778
2. Link 2: https://tinyurl.com/7w5omeo
3. Link 3: https://tinyurl.com/y6splelu
4. Link 4: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4516188/
5. Link 5: https://tinyurl.com/yxnw5kb6
6. Link 6: https://pcainternational.org/activities/lets-talk-about-prostate-cancer-series-b/

Note: The above links are submitted by author, if you need more information please click on the links.

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