the People's Doctor
A MEDICAL NEWSLETTER FOR CONSUMERS
by Robert S. Mendelsohn, MD

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IN THIS ISSUE:

OF PROSTATES AND PRESIDENTS

The President's prostate surgery

By the time you read this, President Reagan seems to have made a good recovery from his prostate surgery.

However, operations performed on Presidents and their families often become quite popular among doctors and ordinary people, i.e., President Reagan's colonoscopy, Betty Ford's mastectomy. Therefore, let me alert you--whether you are considering prostate surgery or whether you have a close relative or friend who is thinking about this operation--to the darker side of prostate treatment, which is unlikely to reach public view.

On December 18, 1986, William Hines, chief of the Washington bureau of the Chicago Sun-Times, described President Reagan's impending prostate surgery, known as TUR (trans-urethral prostatic resection) as "minor" surgery. Hines wrote that this operation carries "a high degree of success, little pain afterward and few complications."

But if you want a second opinion, here's what Ralph C. Greene, M.D., professor of pathology at Northwestern University Medical School (where Nancy Reagan's father, Dr. Loyal Davis, served as professor) and author of "Medical Overkill" has to say:

"Trans-urethral resection (TUR) for removing the prostate is a major operation, probably the most formidable of invasive procedures. The prostate is chiseled out by an electrical wire loop and is removed in curved chips. Considerable bleeding occurs during the operation, which usually takes under an hour and may require transfusion if the procedure is prolonged. Because there is a continuous flow of fluid to wash out fragments and debris, water overload may occur with loss of salt, causing mental confusion, low blood pressure, heart failure, possible kidney damage and slow pulse. The fibrous capsule surrounding the prostate may be perforated, and with leakage of diluted urine into the surrounding tissue causing intense inflammation and infection.

"Less common are inflammations around the testicles (epididymitis) and after healing, contraction of the bladder neck, causing secondary obstruction and requiring further surgery. As with all other urethral invasions, infection may lead to bacteremia and inflammation of the heart valve (endocarditis), especially in debilitated patients....If the muscle or nerves of the bladder neck are injured [during surgery], there may be failure to retain urine (incontinence), but this is usually transient. The patient seeking relief from the urinary discomfort ["discomfort" was the word used to describe President Reagan's symptoms], urgency, frequency and dribbling may be disappointed that improvement is not complete. If the urinary opening is too narrow to admit the operating cystoscope,

it will have to be widened. After healing, urine may emerge as spray or in several streams."

Even the surgeon may be in danger from the operation. According to Dr. Greene, "The urologist is not exempt from injury. There have been a small but significant number of reports of electrical burns of the hands, face and scrotum of the surgeon due to defective grounding. This unexpected sudden shock can cause disruption of the procedure [I would certainly think so!] with damage to the patient."

The President's prostate surgery was done under spinal anesthesia. Possible complications of this type of anesthesia include ringing in the ears, a bitter taste in the mouth and, in overdoses, convulsions and cardiac arrest. Low blood pressure may develop due to blocking of nerves which control the diameter of blood vessels. This can lead to dilatation of those vessels, with ensuing loss of circulation to the brain with unconsciousness and death unless the condition is promptly corrected. Offsetting this downside of spinal anesthesia is the news that this form of anesthesia is preferred by most anesthesiologists when they themselves need surgery.

While Dr. Greene's book does not give the death rate from spinal anesthesia, the death rate from anesthesia in general is estimated at 1/815 major surgical cases.

The President also had his prostate gland biopsied for detection of possible malignancy. What were the chances that cancer cells would be found in the President's prostate? Dr. Elroy Kursh, professor of urology at Case Western Reserve University Medical School in Cleveland, Ohio, is quoted as saying that cancer cells are found in about 10 percent of operations for supposedly benign prostate enlargement.

Here are some other statistics that haven't appeared in the newspapers: Microscopic cancer cells are found in the prostate glands of 10 to 15 percent of men in their fifth decade of life and in as many as 60 percent of those in the eighth decade ("Harrison's Principles of Internal Medicine"). The President is 75 years old.

Why long-distance surgeons for President?

Just wondering. President Reagan's prostate surgery was performed at the Naval Medical Center in Bethesda, Maryland. However, the operation was not carried out by military doctors on the hospital staff. Instead, a team of civilian doctors from the Mayo Clinic came to Bethesda to do the operation. These physicians were chosen by Dr. Oliver Beahrs, an old friend and associate of the late Dr. Loyal Davis, stepfather of Nancy Reagan. Dr. Beahrs is a retired Mayo Clinic surgeon.

Asked why the President chose an outside medical team instead of his White House physician who is a urologist, or the military doctors he has relied on in the past, Mrs. Reagan replied that she has known the Mayo doctors since she was a little girl.

But credible as these explanations may be, certain questions arise. Why did that surgical team travel to the patient instead of vice versa? Wouldn't the Mayo surgeons have preferred operating on their home turf? And if they were to travel, why to that Bethesda Hospital which recently has been the scene of a well-publicized medical scandal? Why didn't the Mayo surgeons travel instead from the frozen Minnesota tundra to the warmth and sunshine of Palm Springs (which certainly has its share of hospitals) where the President vacationed over New Year's Day?

The President's surgery was successful, and my concern is moot. But I still wonder...

Q

I am an 87-year-old man whose general health has not been so good for some time now. Among other things, my family doctor found that I have inflammation of the prostate. Because I have a weak heart, surgery is not being considered.

The doctor arranged for me to have some blood tests at a lab. The result of the acid phosphatase test worried me considerably because cancer of the prostate has occurred in another member of my family. The doctor tells me, "The result of the acid phosphatase test is normal," and off he goes to the next patient.

Yet I know that a blood test I had taken three weeks ago showed acid phosphatase as 2.3 while a blood test taken almost exactly one year ago registered it as 1.2. In other words, the acid phosphatase count is double what it was last year.

The doctor brushes away the higher count by saying it is not important and that the number is within the normal range. He says the difference between the two tests may lie in their being given at the different laboratories. Frankly, I find that difficult to accept.

Can you give me some much-needed guidance? I feel very weak and tired.--W.F.

A

Acid phosphatase levels

Now that you have learned a little about the serum acid phosphatase test, let me teach you a little more.

Acid phosphatase, an enzyme found primarily in the prostate gland, may be tested by examination of the blood, urine, prostatic secretions, or direct needle aspiration of the prostate. The normal blood values in men (measured in King-Armstrong units) range from 0 to 5. So your doctor was correct in telling you that both your results fall into the normal range and that one of the reasons for the discrepancy may be the difference in laboratories. However, this is not the only reason for different laboratory values in the same patient. The secretion of acid phosphatase into the bloodstream is controlled by the male sex hormone, testosterone, and both these substances may normally vary from time to time in the same patient. Even if all tests for this enzyme were performed in the same laboratory, a certain degree of laboratory error is always present. These are just some of the reasons why laboratory tests must not be taken at face value.

If your doctor gives you just a little information about your tests (such as in your case, the numerical values), further questions are likely to be raised in your mind. The doctor then has a responsibility to give you further information that will allay your fears.

Acid phosphatase levels are elevated in about two-thirds of patients with metastatic prostatic cancer. Therefore, this test may be used to help identify and monitor these spreading cancers. A slight to moderate elevation also may be seen in benign (non-cancerous) enlargement of the prostate and in other diseases, including multiple myeloma, Gaucher's disease (a disorder of lipid metabolism leading to enlargement of the spleen, etc.), Paget's disease (thickening and softening of the bones), pneumonia, and hepatitis. Acid phosphatase also has medical-legal importance. As Edward R. Pinckney, M.D., points out in "The Patient's Guide to Medical Tests" (Facts on File, $7.95), in cases of suspected rape, the vaginal fluid may be tested for this enzyme to prove that sexual intercourse took place. A woman who has been raped may not show a positive sperm test, but she will usually show a positive acid phosphatase test.

Atromid-S, a drug designed to reduce elevated serum lipid (cholesterol and other fats) levels, may elevate the serum acid phosphatase levels. You also should note whether your blood was taken for that test before or after the doctor examined you because the very act of

rectal examination of the prostate and/or prostatic massage can raise serum acid phosphatase levels.

You probably now know more about acid phosphatase than you ever wanted to know, but perhaps this information will help you in future discussions with your doctor about whether you should ever have another such test.

Q My husband has been taking Mandelamine for more than a year to treat a urinary infection caused by an enlarged prostate gland. The doctor says he either must take the drug for the rest of his life or he must have prostate surgery. Someone suggested to us that a zinc supplement might help an enlarged prostate. Would chiropractic adjustment be of any value? What are the side effects of Mandelamine?--E.G.

A *Non-surgical prostate remedies*

Mandelamine, an old and respected drug, is one of my favorite treatments for urinary tract infections. The only adverse reactions listed in the prescribing information are gastrointestinal disturbances and generalized skin rash. However, even Mandelamine, if taken at higher-than-recommended dosages, may itself cause difficulty or pain on urination. So you are absolutely justified in questioning any doctor who tells a patient he will have to take a drug for the rest of his life. Even Mandelamine's relative safety does not relieve a patient of his responsibility for finding out how he can safely stop using it.

Zinc, recommended by doctors and nutritionists for prostate conditions, certainly deserves your husband's investigation. While most chiropractors will not claim they can specifically help a prostate gland, chiropractic manipulation, through its effect generally on the body, has provided relief for many patients.

Once your husband's prostatic obstruction has been relieved, the urinary tract infection should clear up by itself.

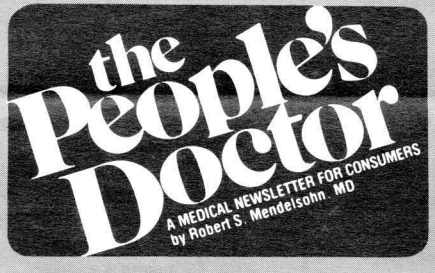
Q Most men my age (68) face this problem: Prostate trouble--reduced ability to urinate, waking several times during the night to empty the bladder, etc.

I've read about several operations to relieve the condition, but that may be difficult for me because I have had pulmonary emboli (about five years ago) and a history of less serious blood clots. I take 60 milligrams of Coumadin per week, am tested every few weeks and try to keep my prothombin time at 21 or 22 seconds. I love to golf and walk.

The doctors have found nothing abnormal other than an enlarged prostate. They imply that any operation to remedy that would be very bloody, and without the Coumadin, I am subject to clots. I appreciate the courageous stand you often take against certain long-accepted medical practices. Any suggestions?--J.A.

A Ask your doctor whether he is familiar with the nutritional approaches that often relieve prostatic symptoms without surgery. These include zinc supplementation or eating zinc-rich foods such as brewer's yeast, nuts, molasses, eggs, rice, bran, onions, chicken, peas, beans, lentils, wheat germ and beef liver.

Q After bladder surgery six months ago, it was discovered that I have prostate cancer in its earliest stage. My doctor put me on five mg. stilbestrol once a day. At first, I was upset about the side effects, but then I decided it was better than the other types of therapy. At the end of six months, a scan showed no spread of cancer to any other part of the body.



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I am in my early fifties. Because I am impressed by the way your answers to questions don't follow the rank and file, I want to know if you think I would benefit from a second opinion at a clinic, university hospital, or whatever. What do you think about the kind of treatment I'm getting--my doctor says I'll have to stay on these pills for the rest of my life.--J.J.

A

Stilbestrol treatment

I'm not surprised you were upset about the side effects of that female sex hormone which include impotence and loss of sexual vigor, especially since you're only in your early fifties and your doctor gloomily predicts you will have to stay on stilbestrol for the rest of your life.

Of course you should get a second opinion. You might begin in your home state of Ohio where Cleveland Clinic's famed George Crile, M.D., has stated that cancer of the prostate can be demonstrated microscopically in the prostate of a third of all men beyond the age of 50.

Q

I wrote you several months ago because I had prostate cancer and my doctor was treating me with stilbestrol. I was unhappy with the side effects of the drug. You suggested I get in touch with Dr. George Crile at the Cleveland Clinic. Since he treats only woman patients, his secretary referred me to another doctor at the clinic. This doctor took a needle biopsy and a body scan, said everything was negative, and suggested I discontinue the stilbestrol and come back in four months for another biopsy.

I cannot tell you how happy I am. Before I had written to you, I had gotten down on my knees and prayed to God for guidance. I read Dr. Sattilaro's article, "An M.D. Who Conquered His Cancer," as well as Dr. W. D. Kelley's book, "One Answer to Cancer." I changed my diet and took vitamins, protein and enzymes. Thank you for being a part of all this and for pointing me in the right direction.--J.J.

A

When I publish my list of the 100 best doctors in the U.S., the names of George Crile, Anthony Sattilaro (whose cure from a macrobiotic diet was reported in the Saturday Evening Post) and William Kelley will certainly be included, and I congratulate you for taking full advantage of the best parts of their advice.

Your letter led me to muse on the benefits of adverse reactions from drugs. Had you not suffered the common effects of female sex hormones on male patients, you would have had little motivation to seek help. As a result of your search, you have now regained your health and even though you do not mention it specifically, I am sure you have regained your virility as well.

Q

About three months ago, while he was doing a routine examination, our g.p.-family doctor found a nodule on my prostate gland. I was referred to a local surgeon in the field of urology who, after examination, advised a biopsy procedure involving entry via the scrotum.

After discussing this matter with my family and a trusted acquaintance, I decided to get another opinion. The third doctor, also a urologist, suggested I postpone the biopsy and surgery in lieu of a further examination about four months later.

As a reader who concurs with many of your views, I would appreciate your opinion and advice regarding my options. I am 71 years old and am otherwise in excellent health. I work fulltime.--E.D.

A

When is surgery justified?

You now have received two opposing opinions on the management of prostatic tumors, one of the most confused fields in modern medicine. I hope you recognize that your search for truth is just beginning.

Go back to that surgeon who wants to cut and ask him for published documented studies (not just verbal information) that will justify his recommendation for a biopsy and that will inform you of the risks of such intervention. Go back to the conservative (at-least-for-the-moment) doctor and ask him for published documented studies (not just verbal reports) that will give you the risks if you do not have surgery. Ask both doctors about the evidence that more than half of all men your age carry cells in their prostate gland that, on microscopic examination, appear malignant.

Next, go back to your g.p. whom you know better and who should know you better than either urologist. Ask him to give you an independent opinion rather than deferring to the surgical specialists, one of whom wants to operate now and one who may well decide to operate four months from now. Tell your g.p. you do not want the decision to operate made by anyone with a vested interest in performing surgery. Tell your g.p. you want him to assume the burden of responsibility in helping you reach a decision, and you will use the surgeon only as a technician to carry out the g.p.'s recommendation.

Ask your g.p. for access to his medical books and journals, and look up the diagnosis and treatment of prostate tumors. See whether the two of you don't end up agreeing with me that prostate tumors are one of the most over-treated conditions in modern medicine.

Q

I am a 75-year-old man whose doctor says he has prostatic cancer. He says the therapy may leave me impotent. I'm afraid of losing my nature. What should I do?--W.W.

A

Many older men are threatened with mutilating operations, including castration, and dangerous forms of hormonal therapy if the doctor discovers cancer cells inside their prostate glands. Recently, two such patients consulted me before consenting to undergo such radical procedures. As is my method with most such patients, I pulled a few medical textbooks off my shelf and shared the sections on cancer of the protate with these patients and their relatives.

Most medical texts begin with incidence figures on the disease. For example, "Harrison's Principles of Internal Medicine," one of the major reference textbooks, tells us in the very first paragraph on prostatic cancer that 15 to 20 percent of all men between 40 and 50 years of age show microscopic evidence of prostatic cancer at autopsy. This figure increases to 60 percent for men between ages 70 to 80. The next sentence in the textbook is the important one: "Less than one-sixth (of cancers), however, become clinically apparent prior to death, the remainder being latent carcinomas." In other words, in five out of six men who show evidence of prostatic cancer under microscope, those cancer cells never behave like real cancer. The patient has no symptoms of prostatic cancer. The cancer cells don't spread anywhere. The cancer doesn't kill the patient.

Now that you have these facts at your fingertips, ask your doctor the following questions:

1) Do I fall in the one-sixth of patients who develop real prostatic cancer, or do I fall in the five-sixths who only have cells that look like cancer but don't act like cancer?

2) If you can't answer my question, why should I submit to your treatment?

3) Why didn't you tell me about these statistics before you took the biopsy?

4) Would you recommend modern treatment (radical prostatectomy, orchiectomy--the medical term for castration, estrogen therapy, corticosteroids, removal of the adrenal glands, removal of part of the pituitary gland, supervoltage radiation, injection of radioactive substances) for all men in whom the microscope reveals prostatic cancer cells?

Armed with this information and these kinds of questions (which I try to provide to every patient of mine), you and your surgeon now will have plenty to discuss.

Potpourri

Beware new abortion pill!

A new abortion pill, known only as RU486, has been developed by French scientists. While little is known about this highly-publicized "major advance," you may be interested in the fallout surrounding this announcement.

Dr. Gilbert Schaison and his Parisian colleagues tell us that RU486 is a reasonable alternative to surgical abortion "which carries the risks of anesthesia, surgical complications, infertility and psychological problems." They also contrast RU486 to the widely-used "morning-after pill," whose estrogenic hormones "can cause a variety of side effects, including severe vomiting."

It's always nice to see the truth come out about existing medical treatments, even though it's too bad it usually takes a new treatment to stimulate doctors into telling the truth. Or at least, part of the truth. The full truth about RU486, a steroid that interferes with the hormone progesterone, has yet to surface. As more information about this new "breakthrough" emerges, I will keep you informed.

Meanwhile, American women are receiving some degree of protection from government agencies and insurance companies. The head of Planned Parenthood, Dr. Louise Tyrer, says she doubts the drug ever will become legally available in the United States because of regulatory obstacles and because of problems drug companies face trying to get insurance for such products. That doesn't surprise me.

You can be sure the insurance industry is going to ask plenty of questions about RU486 before assuming liability that could end up (as in the case of the late unlamented IUD) in financial catastrophe. Every woman who contemplates taking such a drug should ask at least as many questions as the insurance companies will ask. The prospect of millions of women aborting themselves monthly is the stuff of which insurance company nightmares are made.

Any woman who is tempted to obtain RU486 illegally should remember thalidomide. That popular drug for morning sickness, which caused thousands of cases of severe congenital malformations, never was approved for sale in the U.S. by the Food and Drug Administration. The only U.S. women who delivered armless children because they took thalidomide were those who obtained the drug illegally.

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Another View

by Marian Tompson

When Patient X's urologist recommended he enter the hospital in six weeks for surgery to remove his enlarged prostate, he decided it was time for a second opinion. So he came to Chicago to consult with Keith Block, M.D., an Evanston physician whose practice is based on the premise that medical treatment should progress through stages, beginning with the most appropriate and least invasive techniques and then progressively to interventions that are clearly called for by virtue of careful monitoring.

Dr. Block put the patient on a regimen that included a therapeutic diet which eliminated meat, milk products, chemicalized foods and caffeine. The diet stressed cereal grains, land and sea vegetables, beans, seeds, fruits and fish. The patient was given special training and techniques for managing stress, and he was provided with a carefully designed regimen for improving his physical fitness through aerobic competency.

Six weeks later, when his hometown urologist examined Patient X, he was shocked to find that the patient's prostate had shrunk. "Whatever you've been doing, keep on doing it," he wisely advised. It's been six years since that examination and Patient X, who works six days a week with an energy that belies his 78 years, has yet to face the surgeon's knife.

Patient Y, on the other hand, had a more serious problem: He had cancer of the prostate which had spread into his bones. This patient already had undergone a bilateral orchiectomy (castration) in an unsuccessful effort to stem the spread of the disease when he visited Dr. Block for the first time. Chemotherapy had made him violently ill, and he was on the verge of taking his own life. After four weeks on a regimen that included a very specific high fiber, low fat, high complex carbohydrate diet which was tailor-made for his individual clinical needs, his pain reduced. One year later, bone scans showed that the bone cancer had cleared up completely.

Dr. Block has treated a group of patients with cancer of the prostate who have done unusually well. But when a patient does not respond satisfactorily or has a recurrence, Dr. Block usually recommends a treatment developed by Ferdinand Labrie, a Canadian endocrinologist who has done impressive research on the adrenal steroid precursors put out by the adrenal gland. Labrie's work at the Foundation for Prostate Cancer, Laval University Medical Center, Sainte Fay (Quebec), seems to demonstrate that by using a combined treatment with an androgen blocking medication at the same time a chemical or surgical orchiectomy is done, a dramatic number of patients have a sustained remission. When the androgen blocking medication is given after the orchiectomy has already been done, the remission rate is reduced to one-third.

"While I like to have patients avoid unnecessary or potentially damaging treatments, when it becomes essential, combining both regimens has shown some very positive results," says Dr. Block. "Prostate disease is a lifestyle-induced disorder of which diet is a major cause. In populations where the ingestion of animal fat and animal protein are reduced, one sees much less cancer of the prostate. By cutting fat out of our diets we are also removing a potentially harmful hormonal effect from animal foods.

"In addition we should not overlook the effects of stress. Besides disturbing one's physiology and one's immune functioning, stress may be a factor in enhancing a possible recurrence after a patient has been disease-free. In my own clinical care, I retrain and equip patients with specific tools to assist them in coping more effectively with the day-to-day tensions they experience."

When does Dr. Block feel prostatic surgery is justified? "Only when a patient's particular circumstances dictate it." There is little point in exposing patients to pain and generalized suffering for minimal results. It is the responsibility of the good clinician to recognize the significance of alternative approaches and, without automatically reaching for the easier invasive alternative, to apply those profoundly valuable techniques that produce a combination of maximum health with minimum risk!