

**PRIMUM NON NOCERE**

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*Bronner Handwerker, ND*

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Primum Non Nocere

# The Revolution in Prostate Cancer Management:

## Active surveillance and integrative medicine on the front line

**PHRANQ DOMINIC TAMBURRI, NMD**

This past year has been remarkable in both the changing perceptions of, and the recommendations in, the management of prostate cancer (CaP). Some presumed screening and treatment strategies have nearly collapsed under the weight of ever-increasing research and changing clinical perceptions. These factors challenge prostate specific antigen (tPSA) values, reflex biopsy, surgery, radiation and even the "dreaded" CaP hormone testosterone. In its place is a new flurry of promising yet mostly unrealized CaP genetic tests and new ways to use older screening tools. An especially radical change has been the new CaP therapeutic approach designated Active Surveillance (AS). Consequently, the salient role of the integrative ND is to sort through these changes, educate patients on their options and honor their choices.



Axial CT scan of an enlarged prostate

- This article will discuss how:
- Conceptions of CaP are changing in regard to its prevalence
  - Multiple new studies have discredited current screening methods and assumptions
  - These factors are having a profound influence on modern CaP treatment

- strategies, especially in the conventional model of AS
- Since AS is a principle of *Primum Non Nocere*, it should be incorporated prominently into naturopathic CaP management

*Continued on Page 4*

Vis Medicatrix Naturae

# Natural Treatments for Hemorrhoids

**NIRALA JACOBI, ND**

Hemorrhoids are a common condition, frequently overshadowed by more "glamorous" afflictions.

Most NDs have successful treatment plans for hemorrhoids, including many of the suggestions in this article. As part of a list of recommendations, I'd like to emphasize a simple thermal therapy device that has provided instant relief for countless patients.

Hemorrhoids are protrusions of the rectal vascular tissues and are classified into two categories: internal and external. Typically, external hemorrhoids are visible outside the anus, and internal hemorrhoids are non-visible protrusions above the anal sphincter. These are further graded based on severity of prolapse.

It is not surprising to most NDs that hemorrhoids are a common ailment of western countries. A dietary emphasis on low fiber and highly processed foods in countries such as the U.S., Australia and Great Britain promotes harder stools and can lead to an increase in straining and tearing of anal tissues.

If treated early enough, many cases of hemorrhoids respond well to natural treatments. Very advanced cases, however, often need surgical intervention.

**Causes**

Among the many factors that contribute to the development of hemorrhoids are those that cause a downward pressure onto the rectum. These include:

- Straining with bowel movements – often due to a diet low in fiber and water. Dry

stools are much more difficult to evacuate

- Pregnancy
- Chronic diarrhea
- Liver disease and functional liver congestion
- Genetic predisposition

**Symptoms**

- Rectal bleeding and itching
- Prolapse or protrusion of vascular tissue of anus
- Pain with or after defecation, although frank pain could signal other problems, such as a rectal abscess or anal fissure

**Treatment**

I often advise patients to start taking hemorrhoids seriously even if symptoms are still relatively minor. It can save years of pain and discomfort. Treatment focus for acute hemorrhoids is anti-inflammatory, tissue strengthening and stool softening.

Fiber assures regularity and a softer stool, preventing hard, irritating stools in the rectum. A bulky stool stimulates stretch receptors, increasing peristaltic ac-

*Continued on Page 6*

“To keep the body in good health is a duty, otherwise we shall not be able to keep our mind strong and clear”  
*Gautama the Buddha, 563 BC*

Continued from top of Page 1

**Growing Naturopathic and Allopathic Unity with AS**

I often present to divergent groups about better qualitative risk evaluations for CaP. I was honored this past year to be a key CaP presenter among conventional urologists by the Arizona Department of Health. An irony presented itself in that as I discussed an integrative model utilizing allopathic tests, the urologists discussed their allopathic model utilizing a new integrative approach. The conventional physicians were promoting what NDs have been practicing for years. Coming from different disciplines, we nonetheless each recognized how new research and social trends are forcing "reflex" surgery or radiation for CaP to be rethought in lieu of tracking the disease and involving patients more in their treatment. AS became the unifying term of the day.

Although the concept of treating surgically only as a last resort is not revolutionary to NDs, it is for the allopathic establishment. Consider a conventional doctor promoting AS, leaving the security of rote surgical procedures endorsed by the American Medical Association for less invasive measures. By promoting AS rather than surgery, physicians increase their liability by not removing the CaP, patient visits take more time and, without hospital procedures, reimbursement income lowers.

**About AS**

There are two instigators for the AS movement. First is a new conceptualization of CaP *in vivo* where CaP in most cases can be left alone but monitored. Second involves recent studies that are finally declaring

traditional CaP screening and monitoring tools as ineffectual and that question even the long-term efficacy of surgery and radiation treatments. Together, these two realizations have undermined the conventional model and illuminated AS as a viable treatment strategy. It may not yet be promoted to patients, but it is a prevailing topic among urologists.

Criteria for AS will depend on each physician's experience and the amount of risk he or she and the patient feel comfortable taking. AS could include patients with either undiagnosed suspect CaP without biopsy or a diagnosed CaP of Gleason 7 (3+4) or less. Other criteria may include no tPSA velocity over 2.0ng/ml/yr or over 0.75ng/ml/yr consecutively over two to three years, and tPSA values capped at 8-12ng/ml. One condition for some allopathic AS physicians is submitting to mandatory yearly biopsies to track progression. The naturopathic AS program could follow all of these guidelines or perhaps substitute annual transrectal ultrasound of the prostate with color doppler imaging, PSA dynamics and genetic marker testing in lieu of annual biopsies. The goal for any variant of AS is to responsibly monitor CaP patients for elevated risk for metastatic disease while they decide on or undergo their preferred treatment. AS is a powerful strategy when both longevity and quality of life issues surface for patients. If metastasis risk elevates, then patients must be informed, advised of perhaps more invasive options and yield informed consent if such treatments are denied.

Of further note, "Active Surveillance" is a doubly appropriate term for naturopathic

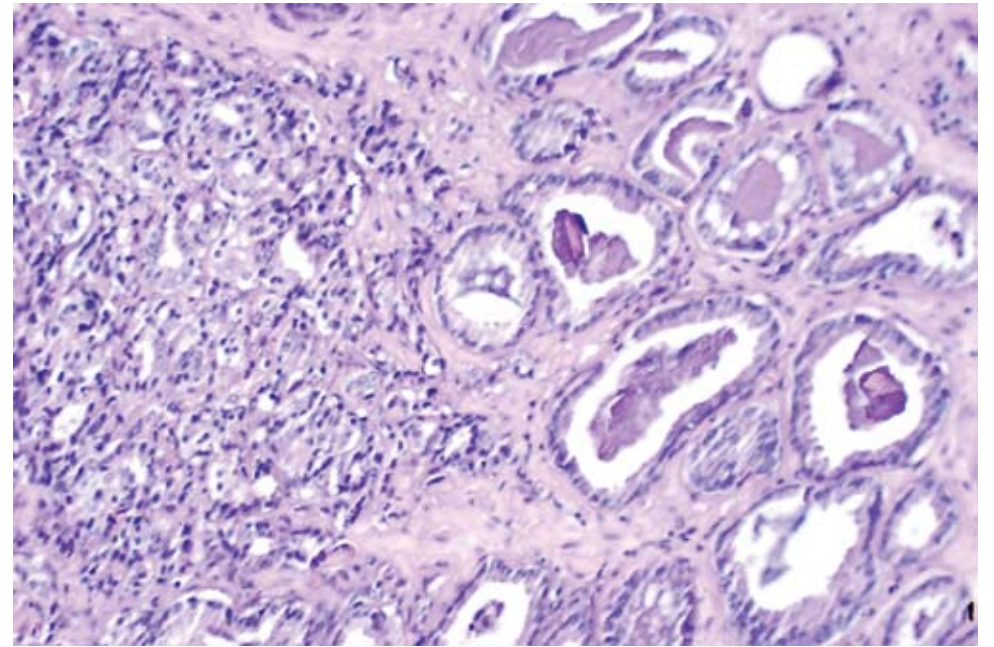
patients. For example, if a conventional patient denies standard CaP treatment (e.g., surgery), then he is typically labeled as "Watchful Waiting" (WW). This moniker, however, only labels the patient who simply returns home to undergo surgery when the tPSA "gets bad enough." This label fails to describe proactive, educated naturopathic patients engaged in their healing through botanicals, fasting, exercise, meditation and other means. So although AS technically

refers to the manner of follow-up by the physician for CaP patients, it can dually describe the treatment strategy undertaken by the integrative patient.

**Changing Perceptions of Cancer**

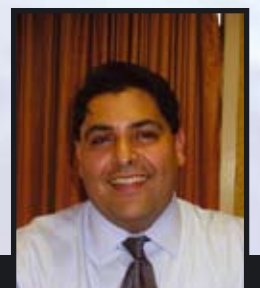
Although cancer is never desired, its role and purpose is slowly changing in some minds. For example, the further research unravels the inter-workings of how cancer

An irony presented itself in that as I discussed an integrative model utilizing allopathic tests, the urologists discussed their allopathic model utilizing a new integrative approach



Histological slide (at 300x) showing prostate cancer. On the right is a somewhat normal Gleason value of 3 (out of 5) with moderately differentiated cancer. On the left is less normal tissue with a Gleason value of 4 (out of 5) that is highly undifferentiated. Image/Otis Brawley

**NEUROTRANSMITTERS and BRAIN Seminar**



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functions, the more astounding and bewildering it appears. As the sheer number of specific, almost intelligent, biochemical strategies are uncovered, the more one may perceive cancer as a unique life form to itself rather than a simple mutated "mistake." In addition, from a public health standpoint, leading representatives of the "cancer establishments," like the public National Cancer Institute (NCI) and non-profit American Cancer Society (ACS), are slowly and subtly shifting focus. They are changing from the simplistic "war on cancer" promoted 30 years ago to developing better strategies of prevention and quality living with the disease.

### CaP Biopsy Considerations

Not all CaP is created equal. Some (the minority, in fact) are aggressive cancers that if not stopped or removed can quickly become metastatic and fatal. High genetic risk or Gleason scores above seven certainly apply. This also includes biopsies where multiple cores are positive, with the majority of each core CaP. However, most CaP on biopsy is of the *indolent*, non-aggressive form. Indolent CaP tends to be "lazy," with a low Gleason score of six, maybe seven, and where only a small percentage of perhaps 1/12 cores is CaP positive. Indolent CaP is often stereotyped as the form where "the patient will live 20 years and probably pass away from something else." Although there is obviously a strong disparity between these two CaP presentations, allopathy nonetheless traditionally treats both scenarios with the same, often disproportionate, treatment options.

Utilizing abnormal screening tests (tPSA), biopsies are positive for CaP in only 25% of men. Even if 25% of the negative biopsies are false negatives or found positive on repeat biopsy, with so many negative biopsies following screening, what may actually be triggering the CaP concern? In most cases of simple elevated tPSA, prostatitis (and often BPH) is the culprit. Consider further that if the tPSA is often elevated from non-CaP causes when biopsies are negative, could it also be true even when positive for CaP? If this is true, even part of the time, then this might suggest that biopsies are systematically done primarily in response to a prostatitis where coincidentally, in 25% of the cases, "capturing" occurs – perhaps by accident – of some random CaP cells of the indolent variety. If this scenario proves true, then urologists in many cases understandably may have been tracking and treating the wrong pathology. When a CaP is found on biopsy, no matter how indolent, general fears and stigmas often step in that instigate surgical "treatments" for a cancer that perhaps may not be a mortal threat. Whereas studies suggest that cancer cells are common to everyone, indolent CaP appears so common in even large, low-risk, young male studies that perhaps we will one day recognize some CaP varieties as almost "natural." The primary objective, however, for both the practitioner and the patient when considering AS is in recognizing which CaP variation is present, followed by awareness that all cancer has mortality risks.

### CaP Screening Studies that Shook the Establishment

Two important studies in particular have ignited the urology field recently. The first is from the *British Medical Journal* (Lu-Yao et al., 2002). The researchers studied the efficacy of CaP screening, such as tPSA and digital rectal exam (DRE), between two

patient populations in Chicago and Seattle over an eleven-year period. They concluded that the study did not support the hypothesis that the intensity of DRE/PSA screening and treatment with surgery or radiation was related to the reduction in prostate cancer mortality seen in the two regions.

The second study was the most incendiary and was published in the *American Journal of Preventive Medicine (AJPM)*; (Lim and Sherin, 2008). It reviewed the efficacy of DRE and PSA for CaP screening found in medical literature prior to July 2007. It was concluded that there is insufficient evidence to recommend routine prostate cancer screening with tPSA testing and DRE. Rather, they recommended that clinicians have an annual discussion with patients about the potential risks and benefits of prostate cancer screening and the limitations of the evidence currently available. Several other organizations have adopted a similar position, including the American Academy of Family Physicians, U.S. Preventive Services Task Force and the American College of Physicians.

In response to the *AJPM* position statement, the National Comprehensive Cancer Network (NCCN) retorted with its own *Prostate Cancer Early Detection* guideline,

which acknowledges the latter study but found it misleading in that proper screening may still be accomplished if various PSA-based adjunctive parameters are used. These new adjunctive parameters are CaP markers and diagnostic indicators that were detailed in last year's *NDNR* article, *Prostate Cancer Risk Assessment: A Qualitative Approach* (Sept. 2007). They include advanced CaP assessment tools such as the American Urological Association Symptom Score and Transrectal Ultrasound of the Prostate with Color Doppler in addition to PSA dynamics such as tPSA, percent free PSA (%fPSA), PSA density (PSAd) and PSA velocity (PSAv). An exciting CaP assessment indicator, independent of PSA, is the new urinary Prostate Cancer Antigen 3 molecular gene test (PCA3).

### A Disquieting Concern

With current mounting economic concerns, in particular for insurance companies and hospitals, these new studies may inadvertently promote decreased testing and insurance reimbursement for even the most preliminary CaP test. Let it be clear that PSA and DRE are not useless; they are still an integral part of a more comprehensive approach necessary for both advanced CaP screening and AS.

### The Future is Genetics

Dramatic shifts from PSA testing toward genetic tests for CaP are occurring. Besides the technological advances in identifying single nucleotide polymorphisms (SNPs), the further push for these molecular tests abound to create a quick, reliable and quantitative CaP marker unlike the tPSA. Current candidates include serine peptidase inhibitor, Kazal type 1 (SPINK1);

Focus 5 Prostate Cancer Risk Test; a variant rs1571801 in DAB2IP gene associated with aggressive prostate cancer (Hsieh et al., 2007); the immune molecule B7-H3 marker (Roth TJ et al., 2007); two variants of chromosome 8q24 associated with increased risk of CaP and the 8-allele (DG85737).

However, since gene tests such as these, besides the PCA3, are not yet available, the indecisive CaP assessments from currently faulty PSA readings are presently being overcome by increased biopsies.

### Anxiety and AS

One last study addressed a concern regarding psychological stress when a patient does not follow up immediately with conventional treatment and opts instead for an AS approach. The *British Journal of Urology International* (Burnet et al., 2007) demonstrated that AS was *not* associated with greater psychological distress (depression or anxiety) than more immediate treatments for CaP. Today's integrative physician stands at a nexus regarding proper clinical and treatment decisions for the CaP patient. While recognizing that many CaP patients may be candidates for an AS program to avoid conventional treatments, such a program should not rely on simply PSA and DRE monitoring. Due

... Indolent CaP appears so common in even large, low-risk, young male studies that perhaps we will one day recognize some CaP varieties as almost "natural"

to the current sundry opinions and CaP interpretations, the physician must triangulate numerous assessment tools in conjunction with a well-informed, consenting and compliant patient. Lastly, however, the ND has a paramount responsibility to alternatively recognize early when the odds for an indolent CaP are not in a patient's favor and serious adenocarcinoma is a concern. This recognition of CaP variants and subsequent treatment options will assure patients that, regardless of their ultimate treatment path, they shall be endowed empowerment over their health, the transcendent factor in wellness and healing. ▾

**Phranq D. Tamburri, NMD** graduated from SCNM in 2001 and served as chief resident until 2003. He has since earned recognition as a national authority in the field of prostate cancer assessment, diagnosis and treatment utilizing an integrative naturopathic and allopathic perspective. He is a contributing author to the upcoming *Foundations of Naturopathic Medicine* textbook. Pertinent experience and training was earned under Bernard Gburek, MD (Mayo Clinic-trained urologist) and nationally recognized Tom Kruzel, ND. Currently, Dr. Tamburri sits as the first ND board member of the Southwest Prostate Cancer Awareness Foundation and is professor of clinical urology at SCNM. His current successful practice, Prostate Second Opinions at Naturopathic Family Care in Arizona, sees a primarily international patient clientele. Contact him at PhranqNMD@Gmail.com.

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Volume 4 Issue 11 | November 2008

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Our printer utilizes wind-power

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Annual subscriptions (12 issues) are available to other health-care providers and NDs outside of North America: US \$72; Canada & Mexico \$97USD; Europe and Overseas \$122USD

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