Focal Therapy Options For Prostate Cancer Transcript

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Introduction to Dr. Scionti and focal therapy

Hello everyone. Welcome once again to another episode of the Prostate Cancer Summit. Today I have the great pleasure of introducing you, to my friend and really an expert in the field.

I call it Mount Rushmore. A focal therapy for prostate cancer. His name is Doctor Steve Scionti, who's the director and founder of the CRC Prostate Cancer Center.

Scionti Dr. Scionti He has worked, he was director of the focal therapy, department at urology at NYU, where I'm at. So that's where we met, about 15, 16 years ago.

I'm losing track of time here. And, he runs an excellent center in Sarasota, Florida, really focused 100% on prostate cancer, unique approaches to diagnosing prostate cancer.

And all things related to focal therapy, which is what we're going to talk about today, Dr. Steve Scionti Thank you, my friend, for being on this summit.

Well, gee, I was so excited when I heard about this project because, you know, you've taken a huge leadership role here, and I'm really honored to be part of it.

Steve, thank you so much. Before we get into physical therapy. You went to medical school years ago. We won't say how long that was. We'll keep that between you and I.

Then you went to medical school where, you know, most students have no idea where they want to focus. Focus? I boggle, it's Freudian slip, right? What what area in medicine. Then you go into urology.

Well, within urology you can go into, I don't know, 12 different directions. Whether it's urinary stones, you want it into prostate cancer. And then you said, well that's not good enough.

I want to go into focal therapies in prostate cancer, and I want to be the world and global expert in this area. Take me through that journey. Why? You know, that that's a great question.

I can go back and kind of look at my career now. And, you know, I always, you know, love, you know, dealing with disease because in most cases we had we, you know, we had patients that really did well from a cancer standpoint.

You know, prostate cancer is one of those cancers where, you know, most patients found early aren't going to have a long term survival. They're going to die of old age and not their prostate cancer.

And so it's a kind of a happy place to be, you know, in the, in the cancer world. But I, you know, I learned early on that the procedure which I spent, you know, many years learning how to do, at a high level, that is the radical prostatectomy and really is very proud because I thought I did a beautiful, beautiful operation.

It's a piece of art. What you guys did, what you did. I know you haven't pulled out a prostate in years, but even those that do now, it's like, wow, he's artistic.

It really is impressive. It was it was, it was, it was what I live for.

Career path into prostate cancer treatment

I mean, and, you know, I prided myself on just how meticulous I was with the surgery, but then something

happened, you know, I was in it, you know, I'd been in military medicine and and now into private practice and, you know, several years into practice and having done, having performed hundreds and hundreds of prostatectomy and I thought I was pretty darn good.

One day I had the opportunity to, perform a prostatectomy on someone who was a, you know, a friend, local in the area where I was, and, he was young, he was, in his late 40s, and my partner at the time, was an accomplished, very accomplished surgeon.

We did the prostatectomy, and it was literally one of these textbook operations. I mean, I could see the nerves beautifully. There was minimal blood loss.

The procedure was really fairly quick. And, you know, my partner said, you know, he said that was beautiful, Steve. That was a that was before the Robert. Steve.

Yes, I was before the robot. This is the this is our old fashioned, you know, radical retro pubic prostatectomy, the one that was popularized by Doctor Patrick Walsh and my, my teachers were all, you know, all, you know, students of Doctor Walsh.

Okay, so did this gorgeous, beautiful operation. There's only one problem. Man came back to me and it, you know, got his catheter out and he was wet. He came back a month later.

He was still wet. Two months later, he was still wet. When I say wet, I mean diaper wet. End of the year he was still wet. And we eventually had to, you know, do an operation, a place, something called an artificial urinary sphincter.

And that was, you know, and that and that, that did certainly, you know, help. But, you know, I asked myself, how does one do an anatomically perfect operation by the book nerves well visualized, beautiful, beautiful procedure and have a patient who's 48 years old and in a diaper.

And I want to tell you what I never forgot that, because that taught me that as good as we are at the surgery, we still don't. We still can't predict that patient that's going to have that terrible quality of life outcome.

And and, you know, we haven't even talked about the erectile sexual issues. Well, they're not going to get erections or care to have erections if they're cannot control their urination. Right.

But you know, I never forgot that, you know, because that procedure destroyed that gentleman's quality of life. And that was I remember the, the date that was 1999, and I was at the American Urologic Association meeting, shortly thereafter.

And and I went there, said, you know, there's got to be something else. There's got to be another way we can deal with this disease. And at that point, you know, I began, I got very interested in cryotherapy or crouse surgery, and that's for anyone that's freezing the prostate.

Now, in those days in 1999, we didn't have MRI. We didn't really know where the cancer was. But when I began to learn about cryotherapy, I became very, very clear to me that, you know, by protecting the urethra, by keeping it warm, then in protecting the external sphincter, by monitoring temperatures, incontinence could be a very rare event.

And in fact, that that's that's been the case. So I began a prostate cryotherapy program in 1999. And that was well before anyone thought that these were reasonable things to do.

You know, but my patients were telling me they were doing extremely well at the time. Steve. Cryotherapy was full gland, not focal at the time was it was full gland or we started to do we began very quickly to move into hemi cryotherapy or half the prostate.

But in those days, the way we got there was with a trans perineal saturation biopsy. So we go to the operating

room, we put a lot of needles through the perineum into the prostate.

I remember doing 70, 80, 90 samples in those days. Right. Again, we didn't have a way to see the prostate. We had no MRI. So this is ultrasound guided, which really means here's the prostate.

You don't know where you're going with it. You have an idea where the prostate is and you just keep poking away. And if you get taken, yeah, 80 steps.

If you could take enough samples through a grid and map that out on a piece of graph paper, which is what we did. And the cancer is all just on one side of the graph paper.

Okay. That's a Hemi, that's a Hemi cryotherapy. And it's freezing one out. And those guys did fantastic. They did fantastic. The problem was, is that, you know, how many patients really want 80 biopsies done to their prostate.

And, and you know, that was that was a technology that, you know, that approach made great sense. And patients did incredibly well from a cancer standpoint.

In fact, in those days, we were showing 90% of men maintaining good erections and no incontinence in those initial patients. That data was published by my friend Doctor Gary Owen.

Many years, many, many years. You see the father of cryotherapy in the US at least, or no, he's one of the earliest innovators. Yeah. And, you know, cryotherapy goes back to the 1960s.

Right? Right. Not very. But that got me onto a pathway where I began to realize, you know, if we could treat a portion of the prostate, we can really markedly change the, the, the, the consequences, you know, from total radical whole gland therapies, that is the incontinence and the erectile dysfunction and oncological.

The patients were doing great. But the way we had to get there was this massive, you know, biopsy. Well Haifa came along in 2005. I was introduced to that.

And it was high through its high intensity frequency ultrasound, high intensity focused ultrasound, and very you know, I came across that again at an American Urologic Association meeting.

From radical surgery to cryotherapy

And here we talking about now, Steve, this is 2005 okay. 2005. It's this new thing called Haifa. Right. They were using it in Europe and I was kind of skeptical, but, you know, I met a friend of mine who, was a another crowd surgeon.

He said, you know, I've, I'm working with the university in Dominican Republic. We're doing some treating some patients. Why don't you come down to the Dominican Republic and look at what we're doing?

So, you know, they're playing get out and look at this and I'll tell say it was very primitive. But what I saw was a very noninvasive way to put energy anywhere we want into the prostate.

And again, we didn't have MRI. We couldn't target things very well. These are the early days. Yeah. But I saw even at that point that the ability to target energy to a region of the prostate was very much, something that this high powered technology could do.

Well, I began to develop that program really at the end of 2005, early 2006. And in those days, because we still did not have FDA approval for high intensity focused ultrasound, I had to get a medical license in different countries.

I was fully licensed as a physician in the country. Bermuda. I had a medical license in the Cayman Islands. I had a medical license in the Bahamas. And so I'd see my patients in my, in my Mexico practice, our way to go to Mexico.

So I would see my patients in my local practice. And instead of going down the street to the, to the medical center, we got on airplanes and we went to these foreign countries.

Now, as crazy as that sounds, you know, it allowed me to really get, really get me on the early stage of development of these technology because I had an idea where I wanted things to go.

I knew we needed better imaging. I knew we needed better diagnostics. And and I knew that a targeted approach in which we don't destroy the whole prostate was going to, was going to give us a much better outcome.

So between 2005 and 2015, when I got FDA approved, I'd already done nearly 1000 procedures outside of the United States. And during that journey, I learned a tremendous amount about how to improve the technology, did a lot of work with the manufacturers and the software people.

I came up to NYU, and this is where you and I had an opportunity to work together and meet, and that was, that was early in 2009. And that was where the real revolution, I think, in prostate cancer, in imaging was really starting to occur.

We really that was when we started to understand the power of MRI in terms of finding prostate cancer and telling us where the cancer lived, because before that we didn't know.

And NYU was one of the universities that really took an early lead under the direction of, you know, some of my great colleagues there, Doctor Laporte, Doctor Tunisia, you know, tremendous, tremendous, you know, innovators in how they thought about this and began to really get expertise in the, in the ability to read MRI, understand how to use it.

We were very much involved, at NYU in using the, fusion biopsy technology, which was and it was, you know, we use Artemis, which is one of the machines out there.

And I still use that to this day to do my targeted fusion biopsies. But I got the I got the idea after a year or two, I said, you know, we're we're diagnosing all our patients now with MRI based fusion, targeted biopsy.

But now we're going to clinics either using cryotherapy or using high fu. And we're still treating to the entire prostate or maybe just half the prostate, because we still didn't know how to marry together.

The information from the MRI into our treatment platform. And so I remember I remember this very clearly was 2010. I was up in New York. I called the the CEO of the AI company, and he was a really forward thinking, gentleman.

And it had and understood a lot about imaging. And I said, why aren't we using MRI images and fusion to, guide our hypercube? And he goes, well, that's a great idea. I never thought of it.

So I got involved and got the companies together, and within a year we had a working software program where we were able to marry together MRI to ultrasound fusion, that is, use the MRI image.

Get that that image of the MRI into the into the hyphae technology. And now see where the tumor was and direct sound energy focus sound energy to the tumor did the same thing with cryo several years later.

So today, you know, as a because we we had that background, I saw that evolution from the whole gland to half using tremendous amount of MRI. My experience up in New York now, today, I mean, a standard of anyone who's does focal therapy is using the MRI image to design and guide to treatment.

And every every vocal therapy procedure today uses that concept. But what drove that was that that patient who was wet and there was no good reason for it, and it was that quest to find, honestly, to find a better way.

I never wanted to see that happen to anybody again. So that implies, of course, that focal therapies for prostate

cancer, have very low, adverse event profile, particularly as it relates to urinary dysfunction and perhaps erections.

That kind of reverse engineer this a little bit. What are the side effects for focal therapy. You could be general for now. We're going to dive deeper in a little bit.

Yeah. So there's nothing we do in medicine that's got zero side effects. No one's ever invented that. And so you know, a lot of the side effects are very, you know, they're, they're just related to the short term effects of the procedure.

So there's, you know, the some irritation from, you know, having a case of high food, for example, there's an ultrasound probe in the rectum. So there may be some, you know, irritation of hemorrhoids and, you know, local irritation.

There's going to be a catheter, in the penis for, you know, for anywhere from three days and sometimes even 5 or 7 days or sometimes longer if there's more treatment necessary.

So there's a period of what's called urinary retention that requires a catheter. Now, if there's a catheter in place, there's always a risk of getting a urinary infection.

So there's a short term things you know, in all my years of doing this with all these technologies, I will tell you, I've never had a patient with an injury to their rectum, ever.

And so one of the concerns about, any of these techniques years ago is that they had a side effect called the rectal fistula can occur. And that's a disastrous problem where there's a connection between the rattle Canal and the urinary tract.

And so that's, that's a that's really a fecal matter coming out of the urinary tract. And urine. Urine two nights. Exactly both ways. And you're right.

Exactly right. And you know, I fortunately, you know, I've never you know, that's never I've never had to deal with that. But the the short term side effects that are really retention, urinary infection, the irritation from the procedure.

And certainly, you know, anyone it says I've never had a patient with Ed, that there's nothing that good. But I will tell you, it's real. I mean, you know, a well done focal therapy procedure, I think it's it's fair to say that greater than 90% of patients today will resume a very similar quality of erectile function that they had.

You know, they'll get back to their baseline. And that's I think that's real.

MRI-guided focal therapy and treatment planning

So if their baseline is not pretty good, it's not going to get better. It's not going to fix it. Yeah. Right. Right. But you know but if they're if, if, if a man is very functional he'll get back to 90% of men will get back to that level of function. Now the one thing that people don't talk about is orgasmic or ejaculatory function.

And and so oftentimes it's never talked about because with the prostatectomy that can't be protected. Even with Rady most radiation patients are going to lose that function.

Okay. But if we can treat a tumor and it's not in the vicinity or what are called the ejaculatory ducks in a relatively small amount of the prostate is treated, most of those men are going to maintain normal orgasmic sexual function.

Now, if the tumor is in areas near the ejaculatory ducts that that part will go away. So that's a possible side of it. But that's related to tumor location, you know, where do you have to put the treatment of the previous deer in those ducts that's going to harm them?

In terms of incontinence, that's really a that's really a bright story here because the risk is really, really low. And

when I say really low in my patients, it's it literally is a 1 in 100 risk.

Wow. You know, that's a lot. It's because we're not treating near we're not treating the urethra and we're protecting the urethra. It's not it's not really rocket science, so to speak, but it's understanding.

You know who's a good patient to select, right. And who is not. In other words, if there's a tumor surrounding the urethra, we're not going to do very well with focal therapy.

Right. It's a tumor. Location becomes important. But I think it's fair to say is the quality of life what drives focal therapy? Is it the quality of life is absolutely better.

Always, always. So we're going to dive a little bit deeper. How is the, the control of the cancer. And, and if you were to define focal therapy. Right.

So in cryo for example, focal therapy unless things have changed is I last heard means half of the prostate is frozen. Right. So you would think that it implies literally just getting the cancer cell itself.

So break that break that down for us with the different technology, break down the different technologies that you do and what does focal therapy, what does focal mean in this?

In this case you have focal. It's a confusing word because some people thinks it means a little tiny spot. And we're going to spot weld one little part in the prostate with whatever treatment we're going to freeze one little spot.

We're going to put high food in one spot and cook one spot. We're going to laser one spot or use Tulsa, which is another ultrasound technology for one spot.

No, I think that's a miss. That's a misconception. Focal therapy to me means, you know, targeted a targeted treatment that preserves, a portion of the prostate that's safe to preserve.

Now, that might be a half of the prostate, or it might be a quarter of the prostate is preserved. It might be 30% of the prostate that's preserved. But it's it depends upon tumor.

And again this goes back to diagnostics. It depends on tumor location and what part of the prostate can safely be preserved from a cancer standpoint. That's that's a critical assessment that that I need to make when I see a patient and consider a subtotal or a more, I call it more of a precision based ablation.

Okay. Now it's really it's really technology agnostic. And what I mean by that is it doesn't matter whether I use hot or cold to create the, the tissue destruction or whether I'm using ultrasound or laser or ice is the energy source, in different portions of the prostate, those energies will have different advantages.

It's all, you know, the debris control, the cancer, control the temperatures are going to be different, different parts of the prostate. So tumor location is really important.

Tumor location is really important. You know, the concept though is really simple. If you think about as you break this down, you've got some abnormal cancerous tissue within a prostate gland.

And we have to understand where that is. Okay. Once we understand where that is, what's the most efficient and effective way to deliver energy to that targeted tissue?

Is it from an ultrasound beam that comes from the rectum and focuses on it, or is it from a probe? It's in the penis like Tulsa trans urethral ultrasound and goes from the center on out.

Or is it putting the needle through the perineum with the freezing probe or laser fiber? And the if the which tool is chosen really depends upon who depends upon where that tumors of the tumor is at the very top of the prostate, far away from the rectum, and a sound being coming from the rectum on up won't work very well.

On the other hand, I've got a tumor right down what's called the posterior area within, you know, a centimeter and a half from an ultrasound probe. And the rectum is going to be perfect for that because a sound energy can get there very effectively, very nicely.

So it's really about understanding where the cancer is, how much the prostate needs to be treated, and what tool are you going to use to deliver treatment to that area. So is so when we break that down, all focal therapies, consist of a specific type of energy, different energies for a focal area of the tumor.

But you're taking that tumor plus some degree it, outside of that tumor. Is that right? Yeah. It's as I said, we don't want to spot. Well, just, you know, with just one little spot because we will fail if we do that.

We know research has showed us that, you know, the field, the area around that tumor is also affected. So think about this. It's not just one house in a neighborhood.

It's a bad neighborhood. That needs it needs to be treated right. Or if the an analogy I'll use with my patients oftentimes is think about your beautiful lawn, your grass in your yard.

You may have, you know, a region, you know, where there's a patch of crabgrass. And so if you're going to kill the crabgrass, you know, you're not you're going to you're going to you're going to treat a much wider area than just where you see the crabgrass.

Right, right. And that's and we know that from research. Right? We know from research studies that if an MRI shows an area of abnormality, there is a much larger area than what the MRI shows where the cells are abnormal.

In fact, Doctor Asia and his team at NYU showed that well over ten years ago. Okay. And so we know that we have to add what's called a margin, which is we have to in a halo, an area penumbra, a halo, a region around the tumor and treat that region as opposed to treating that one little tiny spot.

And that has led to some very nice oncologic or cancer control results. You know, the group from the University College of London now has a series of, focal hyphae, patients now that are out around ten years and they show that 87% of patients have been able to avoid radical therapies using focal therapy, which means that 13% of patients progressed to needing something more significant.

That's pretty darn good. Yeah, that's a good number. That's pretty darn good. So I think, you know, the lessons we've learned over the years is that we we need to understand where the tumor is, how to get energy to it, and to build in a sufficient safety zone or margin around that tumor and, and learn how to do that in a way that critical, important structures can be safely preserved.

So you mentioned three type focal therapies. One is called Tulsa which is it's similar. Is ultrasound treatment similar to Haifa except that it goes through the penis.

High food, high intensity focal high food ultrasound is is is late in the day here, Steve. Long day, just like you. We were talking before. Long date.

It was for both of us. So that's through the rectal area. So it sounds like to me with, if we were to compare Tulsa to Haifa, they're both just. The energy source is the same, but they're able to get to different parts of the prostate better.

Right. So depending you said location is, well, well, this location is a little bit closer to the urethra. That's probably probably better for Tulsa. Touch approach if it's closer to the rectum.

Well maybe Haifa is depending on that location. Is that right. Yeah. So example I did I did a Haifa procedure today on a gentleman. And if you think about the face of a clock, his tumor was down at 5:00.

So that's posterior close to the rectum.

Side effects, strictures, and patient selection

Well seen tumor. Easy for him to get to tomorrow morning. First case, 8:00 tomorrow morning. I've got a gentleman who's got a tumor that is at the top of the prostate.

It goes from 11:00 across 12:00 over to 1:00, the anterior prostate. So the top prostate. I can't get a high beam up there. Right. The ultrasound probe in the rectum or.

Excuse me, in the in the urethra. Sending sounded you right up to that area. And of course Tulsa is done in an MRI suite. So there's real time MRI imaging and MRI control.

But that's a perfect procedure for that location. So it's not about one technique or one technology being a better technology. It's about what is the right tool to, you know, for the, you know, for the mission.

Right. And that it truly to depend upon, you know, a really good three dimensional understanding about where where that tumor lives in the prostate, where's the cancerous target live and how are you going to get there?

You know, it's like a good mechanic in a lot of ways, you know, whereas talking to one of my technicians, they we were joking about this a little bit.

He said, you know, he said, my dad used to have, one wrench in a, in an old rusty vice grip, and he tried to fix everything with that. All right. Right.

He said, you know, he ended up stripping an awful lot of bolts. He said, you know, he said, this guy loves to make things in loves. He says his, I've got this, you know, I've got this great tool kit.

I've got every size wrench you can imagine and, you know, and it's it's really in a lot of ways you need the right. You need the right tool for the job.

Right. And a skilled vocal therapist really needs to have some mastery of these different, these, these different modalities, these different tools, and understand how to use them and when to use going to what situation to use them.

And so that's, that's what I've really spent, you know, the last 20 years trying to figure out. So then creo is the other type of approach. And then that's freezing when who's the right candidate for cryo.

That's not the right candidate for Tulsa or Haifa okay. Great. Great. So first first second procedure to morning. What this morning was a focal cryotherapy.

This was an older gentleman. He had an interior tumor up around 10 or 11:00. But he had a lot of calcium deposits in his prostate. Now calcium deposits will block the passage of sound waves.

Okay. So I could not use an ultrasound technique. I could not use Haifa or Tulsa in this gentleman. In his case I was able to use MRI fusion like we do with everyone else.

I was able to see the tumor in place. Two crown needles through the perineum, through that patch of skin and the perineum directly into the prostate. Used some temperature sensors to carefully monitor my temperatures, and create, an area of ice around that tumor.

Again, using the MRI images that we had previously done to guide that. Again, MRI fusion. So so again, it's it's you know, he wasn't ideal for any ultrasound technique because the sinuses would have been blocked by little tiny stones or calcium deposits, which are fairly common.

I think as many as probably 25 or 30% of men will have calcium deposits in their prostate as they get older. It's not a disease. It's not a problem. But if you're trying to put sound waves through stones, it doesn't work very well.

Right? Right. Fascinating. So, Steve, you know, this particular summit, there's going to be a lot of people watching and a lot of the folks that are watching, they're looking for a different way out of the box thinking, they're looking for a natural approach.

There's nothing that I know in the conventional medical world that sounds more natural than vocal therapy for prostate cancer is like, wow, I can have my broccoli and eat it too.

You already mentioned that there are no things. There is no such thing. There's no such thing as medical treatment that doesn't have side effects. I have not seen a side effect and anyone with vocal therapy in about ten years.

So the urinary continent rate, is high and the incontinence rate is very low. Erections seem like, you know, they have they go back to their baseline strictures are probably the one thing that, I've seen that most of you guys, the experts in focal therapy, are concerned about.

I haven't seen one of those in about ten years. Where are we with urinary? What's a urinary stricture? How does it affect a patient? And where are we as it relates to stricture and focal therapies?

You know that's a great question because, you know, that's a problem that I realized we had to figure out during those days outside of the U. S that ten years of, you know, those thousand procedures out of the US.

I learned very quickly that if we have a treatment that puts a lot of energy on the urethra and doesn't protect the urethra, that energy will cause damage to the urethra, which could result in a scar of the urinary channel or urethra.

A stricture is a scar that blocks the channel. If the channel gets scarred too much, it narrows down. And if the channel gets too narrow, a man can't pass urine through the narrow channel.

And that requires a surgical procedure to fix it. And so in the early days of cryotherapy, before the warming catheter was invented, strictures, and you were going back to the early to mid 1990s if you froze the urethra with no protection, a stricture was common.

And that was disastrous. In the early days of high fu, the entire prostate, including the urethra, was subjected to very high temperatures. Well, if you cook the urethra at 90°C or 180°F, you're going to get a crispy, cratered urethra, and it's going to scar up and it's going to cause a stricture.

So the whole concept of focal therapy is that you don't treat the urethra right. Once there, one structure we're never going to treat with focal therapy is the urethra.

We're going to protect it. And depending on what technique we're going to protect in different ways, if we're using freezing or cryo, we're going to keep the urethra hot or warm.

If we're using hyphae, which is heat, we're going to keep the urethra cool. If we're using Tulsa, which is ultrasound, which is heat, we're going to keep the urethra cool.

I'm now doing trans perineal focal laser ablation. We're using a cooling catheter to keep the urethra cool. But this goes back to tumor location. If you've got a cancer that's wrapped around the urethra, then there's no way to put energy there.

And not not cook the urethra. That's a patient that's not going to be a focal therapy candidate. So again, it's understanding who is the ideal patient that can get that maximum benefit to treat the cancer.

And not cause these some of these terrible problems that we saw years ago. And that's all about understanding tumor location. Understand where the energy's going and how to protect these important structures.

So I will tell you that I have not dealt with the stricture in years and years. And it's because we've learned these lessons. Yeah. And, you know, not you know, it's something when I teach a lot of the courses, it's something I just, I

just harp on this because, you know, if if we're going to take a man and caused that kind of problem, we may have.

Well, just taken his prostate out. Right. That leads me to my next question. Who's not a candidate for vocal therapies where they do and need their prostate to be removed?

That I don't think you're saying or even or implementing or insinuating that prostatectomy are, you know, not needed. So who are those men that are that need a prostatectomy?

Well, I think no, I think that's a great question. I mean, if I were the way I look at this is if we look at the spectrum of prostate cancer, one end of the spectrum, we've got very small amounts of cancer.

They're very slow growing cancers. These are our Gleason score six are what we call our grade Group one cancers. There's 1 or 2 or maybe three biopsy spot if they're tiny areas.

It's, in a especially the man's a little older. That's one spectrum of prostate cancer that men will probably never, ever have a problem with this prostate cancer.

That's a that's a gentleman. Today we're always going to recommend surveillance. And in an ideal lifestyle modification if, if they're if they'll accept that that's that's ideal.

Now the other extreme is the patient that comes in and his prostate literally is loaded with high Gleason score cancer. Right. He's they've got seven, eight, nine, ten, 12 biopsies positive.

The Gleason score is eight nine and the whole prostate is involved. The capsule might be involved. Those men need a much more radical approach. They need they need in sports term.

They need the full court press. Right. That's right, I can I've got it that that patient cannot be treated with a minimal procedure. But fortunately that's that's not the majority of patients we see today because of early diagnostics.

We generally don't see a lot of those patients. But if they come in, I had a gentleman that came in to see me a couple of weeks ago. He wanted a high for procedure in the worst way.

He had a Gleason nine cancer. There were multiple areas involved, both sides of the prostate. It was very close to the urethra, and he was 58 years old.

I said, you know, I can't I can't offer you a focal therapy because it will fail.

Who is and is not a candidate for focal therapy

Right? I said, you know, even though you don't want to hear this, my advice to you is you need a robotic prostatectomy or an open by an expert level surgeon.

And if there's a positive margin, you may need radiation or more therapy beyond that. But your best statistical chance of long term survival is a much more aggressive approach.

It's surgery, possibly followed by radiation because he's got really bad disease that's multifocal all over the prostate. High grade. So that's an extreme example.

But let me let me let me that. You see those patients all the time. Let me ask you a provocative question. This is a 58 year old man. That man with 1 or 2 lesions that you know are Gleason nine, close to the urethra.

You're probably going to say to him, well, is it Gleason nine? And for the listening audience, a Gleason, the Gleason score is is a histological grading system.

The higher the number, the more of the possibility of the cancer being aggressive. So it goes really from 6 to 10

and nine is very aggressive. So he has a Gleason nine 1 or 2 let's say lesions Gleason night.

And you're saying no, Mr. Brown, Mr. So-and-so, I don't think he's saying, look, I know my risk. A cancer is a cancer. I did a PSA, I did a Pet scan, I MRI, everything is showing that I have everything encapsulated.

There's nothing else I want to work with. Doctor, go and do aggressive lifestyle interventions to create a microenvironment that's hostile to cancer cells.

But I need these tumors to be taken out. A tumor is a tumor. I don't care if it's a Gleason nine, a Gleason ten. What's the answer in that scenario? Well, you know, so then so now we're going to go to the, the you know, really the more personalized, more, individualized approach.

You know, I think we're obligated to tell the patients what the science says, right? You know, we're obligated to tell them, hey, the literature and our guidelines say that.

Listen, by knowing in no uncertain terms, you know, you should be looking at radical therapy. That's what the book says. That's what our guidelines say.

Is statistically in terms of what's published, that your best chance of long term outcome. So you gotta you gotta be honest with people. Right. But let's take that patient that's got a Gleason and say that it's not say it's in an area where I can safely get a lot of energy to without causing a problem. Right.

No calcium in there. And it's an area I can get to. Yeah, it's within reach of the energy. Right. And I and I can get there, and I'm not going to destroy the urethra.

I'm not going to destroy the other critical structures. What I consider with all those disclosures. Right. Treating that patient and exactly to the program you described.

Yeah, I wouldn't say no. I think we have to be honest with people and say, listen, there's a good chance you're going to need more treatment. I don't think I'm going to carry with one thing alone.

Right. But can I destroy that area of tumor? Yeah, I think I can reliably destroy. But we know statistically it's likely to develop other areas. We will probably not going to be done with that.

But I think you brought up an excellent point. If you're going to do that and he's going to go on and he's not going to be not going to be willing to follow carefully.

And I think the lifestyle modification is critical here. I think it's absolutely critical because if we go back and ask the question and again, I'm going to I'm going to be speculative here, right?

I can't prove what I'm going to tell you, but you probably agree with me that Gleason nine cancer developed for some particular reason in that man's body.

There is a series of inflammatory markers, inflammatory factors that spurred the development of the. There's likely been there's been probably DNA damage that's occurred, and a host of toxins that probably played a role.

There's that that Gleason nine. And unless it's one of these rare patients that had a true inherited you know, inherited mutation from mom or dad that occurred in his life because of the exposures his body is seen to the environment.

So if we can't change his body's make up an environment, if we can't change the toxins, it's, it's going to happen again. Right. And so that's my you know, so I think you've hit on a really important point because you know Steve you know I love science I really do got I read 5 or 6 papers a day right.

I can't get enough. The more scientific papers I read, the more I realize that science cannot tell you everything or

cannot give you all the answers. Everything cannot be studied.

And there comes a point where you got to think outside the box. And then when you start applying the different elements of natural living and natural lifestyle, environmental, outside and inside the body, exercise the importance of very prescriptive, you know, targeted careful supplementation, diet modifications do that.

Treat the the area outside of the tumor. You treat my tumor. I treat my microenvironment outside the box thinking, yep, I know there's no studies on this.

I'll take my chances. Why not? You know, I think you bring up a good point and it's all about, you know, it's all about patient education and and really being honest with people.

Right. But yeah, I would, I would, I would not turn a patient down like that if I could get energy to the target and, and if they're willing to work on the other side of this, because if they go back to the standard, you know, hot dog and cheeseburger diet, you know, Terry lifestyle and things like that.

Yeah. Then we're then, you know, then we're going to be right back in the same situation. We're not going to change anything. Yeah. So, but it's, it's fascinating because, you know, I think this is one of the areas in prostate cancer I think is a good model for it, where, you know, taking your expertise and and then my expertise and putting them together.

Right, I think is it's more, it's, it's more than just one and one equals two. It's, it's it's very synergistic and it's. Yeah, it's a multiplier effect.

And no one's really studied it really that. Well. Yeah. I mean, we have, we have, you know, you've seen the studies that look at, you know, laboratory studies and do suggest that these a lot of these toxins can create, create tumors and cultures and in mice and so forth.

I'm waiting for that, that, that prospective randomized control trial in humans showing that if we change the micro environment, we change cancer. I'm not sure we're going to see that.

Well, I tell you, there is there is gut, prostate, connection talk and cross link and. Sure. So, I think we have enough science that shows this a there's something there.

There's something there. Be what do you lose? You lose nothing. You only gain. You don't really lose much. The side effects are favorable. Your overall health is better. You're right.

And but but certainly things like exercise and certain diets. Our friend Stacy Loeb has published excellent papers on, you know, diets and prostate cancer.

Prospective studies. I think when you combine everything multimodal approach the patient, you know, I call it, you know, you become a prostate cancer thriver not a survivor.

You know, that that's a that's a phenomenal way to think about it. It really is because I think it's exactly right, you know, because we have to go back to their core question.

I mean, patients ask me all the time, why did I get prostate cancer? Why me? You know, my dad didn't have it. My granddad didn't have it. So why? I'm 55 years old.

Why do I have this? You know, and you know, we still have a hard time answering that question. Although I think you. I think you and I and, you know, I think we probably are getting at what some of those reasons are, you know.

Yeah. So, this has been great as always. Very nice to see you. Very nice to have these conversations with you. We we talk shop almost every single time we see each other.

We don't get enough. We're. So we're both so passionate about our work in prostate cancer. So once again, thank you for what you do, what you do for patients and educating the rest of us.

You do what what patients would say you do God's work. So thank you so much. Final words. And and how can people get in touch with you? Well, listen, I think the the world is changing here.

Technology is our is our friend here. Right. And I would say to any of our prostate cancer patients out there, if you're dealing with this disease, you know, look around, look at what your options are, look at and understand that, you know, that there's a lot of ways to treat your prostate cancer.

It's not you don't need to give up your quality of life. You know, in most cases. So, you know, I'm easy to find. I'm at the City Prostate center.com, that's all.

One word city prostate center.com. It's the best way to find me. I've got a lot of stuff out there on YouTube. I've got videos that talk about how we do things.

I've got a YouTube channel at Dr. Deoxygenated, Doctor City. But, for men, just take your time. Don't panic. When you get the diagnosis, do your research, talk to a lot of different people and find out what's the best balance for you.

And I think that's the best advice I can give anybody. Thank you. Thank you. Steve, thank you so much. I really appreciate your time here. Just been an honor.

Thank you. All right, everyone, thank you so much for tuning in to the Prostate Cancer Summit. We'll see you next time at our next phenomenal session and interview with another expert. Talk to you soon.