Show Introduction and Prostate Cancer Focus

Good evening, good evening and welcome to another edition of Wellness Watch here on the African American Wellness Project and blackdoctor.org. Of course, I am one of your hosts.

and we have a wonderful, wonderful show scheduled for you tonight. We're gonna call tonight the Prostate Chronicles because tonight it's all about prostate cancer.

And we had one of the nation's top experts, Dr. Mack Roach with us tonight, again, he was one our first guests when we started this program a long, long time ago and had to bring him back so we could talk about prostrate cancer here in Black Men's Health Month.

We are excited to have him. And of course, you know, we always have our usual hijinks and we've got something that special consideration for you tonight.

We have a prize. Got a gift for your at the end of the show. So you got to stick with us to the ends of this show to find out what that gift is and how you can qualify to receive that gets from your friends right here at Wellness Watch.

Again, big show tonight. We're all about prostate cancer. So sit back, get your pen and pad ready because we're going to give you some useful information that you can take with you to get prostate or your husband's prostate, or you're uncle's or father's, your son's.

Whatever man you have in your life get their prostate. active and together and healthy, which is the most important thing so they can become their own best advocate.

So sit back, relax, put your seatbelt on. We have a big show tonight and I'm going to bring in the man of the hour, as you know, Dr. Michael Lenore. Thank you very much for introducing me and introducing our special guest.

I think we're really fortunate to have one of the world's experts in prostate cancer. You know, it's not often we have a world expert. We have city expert, state expert and sometimes we a national expert but here we Dr.

Matt Roach is the professor of racial oncology, former chairman of that department. He is world respected for his work and he's an expert in all types of prostate cancer, certainly localized prostate cancers.

But what I like most about Dr Roaches, he has devoted himself not only to academic excellence at UCSF, by the University of California San Francisco. But also he's devoted himself to increasing health equity for men with prostate cancer.

And he has attuned his research and he is attune his dialogues and his articles in that direction as well as certainly the academic strength that he brings to the table.

So let's welcome Dr. Roach into our program and let us get started with what's usually a very interesting hour I think those of you who had prostate cancer, concerned about it, need to know about, it should stick with us through this hour.

There's gonna be some serious stuff here. So welcome Dr. Roach to our program. Thank you for the invitation. I'm honored to be able to, be involved. You know, one of the things that I like about discussing things with you is that there are a lot of myths about prostate.

cancer. you've probably heard them all.

Myths, Risk, and PSA Basics

What are some of, the myths of our prostate, cancer that turn out not to Well, we actually don't know as much about why people get prostate cancer in the first place as most people think.

I mean, most say, well, you know, I'm vegetarian. Well you can be vegetarian and still get prostrate cancer. We do know that if you're a man and you live long enough and people look carefully at your prostate, if your prostates biopsied when you were in your 70s or 80s, it's likely that you can have small amounts of prostate cancer in there.

Some people are confused as though all prostate cancers are the same and that some people believe that we cannot distinguish the aggressive form from the non-aggressive form.

And that's not true, actually. The grade of the tumor that is the appearance of cancer under the microscope gives us a tremendous amount of information about the likelihood that this prostate is important, is meaningful.

Gleason, there was a pathologist. Pathologists are people that look under a microscope and decide, Is this cancer or not? And there a was pathologists whose name was Gleson.

And Glesson came up with a grading system that allows us to call low grade, intermediate grade and high grade. The difference is, if you get a high grade prostate cancer, your chances of dying are 10 times greater than if your have a low grade cancer.

And if have the low-grade cancer and you're diagnosed at age 75 or something like that, you might not need to be treated at all and still do quite well.

On the other hand, If you are 75 and have most aggressive form of prostate and don't have any other life threatening illnesses, then you probably would benefit from treatment.

You know, I've been looking at some articles recently. There's always this notion that African-American men have a worse form of prostate cancer and have worse outcomes because of that.

I was in some studies from the VA, large studies, that suggested that if you have two men, one black, and one white, starting with the same level of cancer, you treat them the Same, not only do African Americans do just as well, but often they do better.

That's a recent observation. It turns out that 20 years, actually 30 years ago, when I first started doing this, everybody said prostate cancer is inherently more aggressive than black men.

And this dogma was being taught to everybody. But I was looking at the data and I go, wait a minute, just because you can't blame the victim for the problem.

So the fact is that that the studies that suggested that black men did worse were studies where they did not control for the quality of care, they didn't control the stage, the grade, insurance status, other health conditions.

And so what's happened is that more recently, as some of us have complained, no, this is not true, and been able to publish papers that show that race is important.

What's important is what is the stage? What is it the grade? what does the PSA and what's the quality of treatment? Those are things that are important.

And black men, the best way, so when we look at data, there's population-based data where you just say, how many men got diagnosed with prostate cancer in the United States?

And you come up with a big number, let's say 300,000. How many of them were black and you come up with another how many are more white and come over the number?

And then you say what was the 10-year survival? He said aha the white men have a better survival well the White men had less diabetes less hypertension They're less likely to get killed by police.

I mean, there's all kinds of stuff that adds up to what mortality is due to. So the bottom line is though, but if you focus on the prostate cancer and you control for the quality of care and the stage in greater disease, black men do at least as well as white men for prostate cancers.

We're talking to Dr. Mac Roach, a world's expert in prostate cancer. If you've got questions about prostate answer, you're not gonna be able to talk to a worlds expert very often.

So we want you to to other people, share this, call, do whatever you have to do. Because we can get every question that we need answered from Dr. Roach.

One of the couple things that are going on now that seem to be different. A lot of African American men, they said this, a lot more concerned about how the diagnosis was made.

Didn't often bother, the PSA didn't bother with the digital rectal examination. Seemed to be an intrusion for a lot of men and maybe threatened some. But now I understand that you don't use, that that's not as important anymore as it used to.

And that the Digital Rectal doesn't give you as much information as you thought you needed. It's true. What's really brought this to the forefront is the pandemic.

So most of the patients that I see now, I've seen them on a Zoom consult initially. So I didn't examine. In fact, haven't examined the prostate in a long time because the patient gets referred to me after they have a biopsy.

The pathologist is called the greater the tumor. The patient has had an MRI of their prostate, which shows me the distribution disease in their prostate.

And I'm talking to the patient on Zoom. Then based on all the medical information, the PSA, Gleason score, imaging, and so forth, there really is no need for me to do a rectal exam.

I have to admit, I don't miss it. You know, my wife used to ask me, so how was your day today? Well, you know how you say, well, I had a few new patients and you don't have to use this finger anymore to, but it's not that big a deal.

The other thing is that if you look at men who are diagnosed with prostate cancer, 75% don' have anything you can feel anyway. So if your PSA is elevated, And because of the elevated blood test, the PSA stands for Prostate Specific Antigen.

It's a blood for prostate cancer. The normal is up to four. If it's over four, and if you're a young guy, really young, in your 50s, even three might be a bit high.

So if you do a biopsy on the patient and you diagnose cancer and then you'd do an exam, 75% of the time you go I don't really feel anything and sometimes people say they feel something but then one doctor says I feel this one and the other one says, I fell this.

So there's inter observer variability. It's not a real reliable thing. If you do do a rectal exam and you feel a big mass on the prostate then that means locally advanced disease and that does give us useful information but that's in a small percentage of patients and usually the MRI is going to show it much better than the finger can.

Now, you know, a lot of people have been talking about the PSA and what that means. First of all, there's a PSI, high PSAs always mean you have prostate cancer.

That's the first thing. I think the second thing is when should you start getting a PCA? And finally, my third question

is the American Cancer Society said that men over 70 probably really don't need to get one.

How do you respond to those three questions? Well, I'll be 68 this year. And I can tell you that I'm gonna be getting the, if I, Lord willing, I will be gettin' my PSA checked at age 70. I think that the problem is that there are men who die at 60 because of comorbidity, diabetes, heart disease, kidney failure, stroke, whatever.

So the age is really not as important as the physical condition. My father's 91. So if I'm going to live as long as he has, then why would I go 20 years without being screened and so forth?

Screening, Biopsy, and Active Surveillance

So I disagree completely that the age should be, the cutoff should 70. It depends on the health of the patient that should dictate that. That's the easiest one to answer.

The PSA elevation, if you consider the normal as 4.0, If you biopsy people that have a PSA between 4 and 10, only about 25% of them will have positive biopsies.

You can have an elevated PS because of an enlarged prostate. An elevated because an infection. You know, some people ride a bicycle and they have the kind of seat where they ride and hit the prostate.

You can inflame the prostatitis in just inflammation of the process. So infection, prostititis, trauma, those things can happen. And some have enlarged prostate, so the normal prostate is about walnut size, about 20 cc and feels like the soft part of your palm.

But by age 65, the prostate is about twice that size on average, more of like 40 cc's. But there are people that will walk in the door with a prostate that's 150 cc's.

And the normal prostate also makes PSA. So if you have an elevated PSa, it could be because you had a really big prostate. If you a small prostate and your PS is elevated, its more worrisome because cancer tends to make more PS than normal prostate.

But normal prostate can make PS as well. So it doesn't always mean cancer, but it does mean that it should be looked at if your PSA is elevated in your otherwise health.

Now, one of the things that here again we just touched on is the American Cancer Society's opinion about the PSa over the age of 70. I know you say you're going to get yours.

How do you rebut their conclusion that too much is done when the PSA is a elevated and older patients? Well, there's several parts to it. One is that they recommend that, they assume some of the guidelines, the American Cancer Society used to support screening strongly.

And then over a period of time, There were a number of studies that suggested that some men did not benefit from treatment. So the American Cancer Society became concerned about over-treatment, about people that were being treated that didn't benefit from the treatment.

And so if you do the statistics, if take a population of 1,000 men that are age 70 and you look at whether or not you can show that they live longer because you check a PSA and then diagnose and treat them for prostate cancer, it's difficult to prove that the live long.

But the reason that they're against it is because they are concerned about the fact that a lot of men that have an elevated PSA get a biopsy and get treated and don't need treatment.

Well, we don' really do that much anymore. Most of the men I see now that has a mildly elevated PSA that shows that their grade of tumor is low, like a 3 plus 3, We put them on active surveillance.

Most of those men don't get treated. So you have to look at the risk benefit ratio. In the past, in the distant past like 20 years ago, we treated everybody.

And the benefits were low and the risks were high because of the side effects of treatment. But now that we put those patients on active surveillance and we recommend treatment mostly on men that have either intermediate or high grade tumors, there the benefit are much greater than the risk.

The risk benefit ratio favors treatment, so those men need to be treated. So it really just depends on how you look at the circumstances in terms of whether or not people should have a, I mean, you shouldn't do, if a patient is in a nursing home, with oxygen on and they have Alzheimer's, no, shouldn' do a PSA on that patient even if they're 60. But if the patient's 70 and is good health, and their PSA is elevated, then they should be dealt with appropriately.

And if the grade of the tumor is low, they can probably do active surveillance and be followed. If they have a high grade tumor and they're likely to have 10 year or 20 year life expectancy, than they shouldn't be treated aggressively.

One of the things that happens after you get the positive PSA is this whole issue of biopsy. One the reasons that I just kind of stopped getting PSAs and I didn't want a bunch of unnecessary biopsies.

What have we done in the last 10 years or so to make this bioplasty situation a little more tolerable? Well, there's some blood tests that can be done that break down.

For example, you can look at the free versus the total PSA. So it turns out that if you have a large percentage of free PS, then that suggests that PS elevation might be more from benign prosthetic hypertrophy.

There's other blood test that do that can give you a little bit more of an idea about the likelihood of whether there's cancer there. One simple thing is the PSA density.

So if you take the PSA level and you look at the size of the prostate, I mentioned this before, that people that have a really, really big prostate can have higher PSAs.

So if you have a patient that has a PSA, which is 4.1, 4.2, just over four, but their prostate is 150 CCs or 100 CCS, then you'd have lower index of suspicion that they actually have cancer in that prostate.

And the patients who have smaller gland, if the PSAs elevated, you're more worried. Somebody just shot me a question about whether the whether immunotherapy has a role, is it a viable option for prostate cancer?

And in fact, There are studies that have shown randomized trials that has shown that in the setting of metastatic disease, immune therapy can be used to treat prostate cancer for people where the cancer has metasticized.

So there's a company called Dendrion. I have no stock in a the company, no conflicts. It's the form of immune, therapy which can work against prostate cancers.

Also, The other thing is that it's possible, one of the most interesting questions of all is why is prostate cancer more common in black men? No one knows the answer to that.

My working hypothesis is it is due to chronic stress from racism. So I think that chronic stress, there's evidence that, chronic, stress can affect the immune system.

There's some studies I could show you. And I, think, that if anybody has chronic stresses, black men in America, and I'd think there are studies in animals, studies, in humans showing.

In animals people wonder, well, how do you stress an animal? How do, you know that an, animal is stressed? Well, they've taken mice. and put them in containers, these plastic containers where they can run up and down in the container.

And what they do is they take one group of mice and they close the containers down so that the mouse cannot run and up down. When you do that, there are biochemical changes which are stress, flight or fright type things.

The adrenal androgens, the stress receptors and so forth start firing off.

Treatment Options and Quality of Life

And if you infect those animals with viruses or you implant those animal with cancers, they're more likely to grow. So stress as a physiologic phenomenon can be measured.

And I think it's due partly to chronic immune suppression. At the one end, in the very advanced cases, you can use immunotherapy to treat metastatic spread prostate cancer resistant to conventional treatment.

And at the other end, it might have something to do with why we have a higher risk of prostate cancers. The other interesting observation with that study using that compound called Provenge is that the black men did better than the white men.

So with immunotherapy, the black men had a better response, had better survival than the white men. And I think that's because the prostate cancer that black man have had is more related to stress due to immune suppression.

When you treat them with the immunotherapy, that may work more effectively. One of the things that I thing people need to make some correlation to and that we continuously call attention to and the African American Wellness Project.

As you know, when you see profiling the police of African-American men, I think medicine profiles black men, too. And so some of the outcomes that black man have is because they're profiled, they are not treated the same, and they don't get the information.

How much do you think that contributes to some that have poor outcomes than African-American men have with prostate cancer? Well, part of reason that I said that racism has something to do with it, when you say There's a famous principle in medicine called Occam's razor.

Occams razor is a belief that you shouldn't, if a person has symptoms of something, let's say they have a cough and they and they have an abnormal chest X-ray.

And they an have abnormal blood test that looks like pneumonia. You shouldn't say, well, they got lung cancer. They got, you know, I mean, all these symptoms could be explained by one diagnosis.

So when we look at African-American men, African American men have more hypertension, more diabetes, more likely to get put in jail, more like to give kidney failure, and across the board, black people are 50% more than likely die of cancer than white people.

So the question is, is there a unifying theme or explanation that can explain all of those things? And we know what explains police shooting black men, unarmed black man, it's racism in America.

And there are studies that show within People that have Medicare, that had heart disease, they don't get the same treatment in hospitals, the psychiatric patients don' get treated with the Same medication.

When it comes to being operated on, we don get operated by the thesame people. Even with The same insurance, We don"t get The Same treatment. So if you're looking for a unifying explanation, it's racism in America that can explain all of these different observations.

And it is clear in medicine that we don't get the same treatment. All right. And like I said, we do have that basic principle that underlies chronic diseases by the African-American Wellness Project.

We have a piece on our website called This Is How We Do It of questions that people can ask when they go in. So they have some basic frame of reference to deal with the system.

But before we get distracted by that, let's talk now about the advances in treatment. for men with prostate cancer. There's so many options once you get the information that is sometimes very confusing for for a man to make that decision.

In your experience, what are the thought processes that go into your patients when they try to decide what kind of treatment to give with So most men, and this is true of cancer across the board, when a person's diagnosed with cancer, most people just assume I need to get an operation.

Right? That's the first thing, cut it out. Right. So, and it seems like it makes a lot of sense to just remove the cancer. And it's true in breast cancer and when my mother was diagnosed with breast cancers, she was like, so I said, So mom, what are you going to do?

She said what do you mean? What am I going? Don't have my breast removed. I was, like mom you don't need to have your breast remove. You can have the lump removed and then you can get radiation and you keep your breasts.

Yeah, and she finally figured out what I did for a living, right? So most men when they get diagnosed, when a man is diagnosed with prostate cancer, a biopsy is required to make the diagnosis for localized disease.

And the biopsies are performed by urologists and urologists get paid to cut people's prostates out. So it's sort of like if you're gonna buy a new car and you go to the BMW dealership.

You know you about to undate the whole urology specialty. That's not my problem. So the bottom line, so if go a BMW dealer ship and go, you know, I'm not talking about all urologists, the typical uologist will say, well I really recommend, you could have surgery or you can have radiation.

I think for you, if the patient's healthy and say 65 ish, most surgeons will say, I really think surgery is the better way to go. The problem is they don't have data to support that.

And so, you know, everybody has a right to their own opinion, but not their facts. The fact is we have a randomized trial called a PROTECT trial, like it was done in the UK.

They randomized men to observation, radical prostatectomy, or radiation. And at 10 years, surgery and radiation equally reduced the likelihood that the cancer had metastasized, But the quality of life was better in men who got radiation, And so, you know, so from my perspective, surgery is a good option for people that want to be operated on.

But, interestingly enough, African-American men are more likely to pick radiation over surgery. And part of the reason is, number one, when you look at the risk and the benefits, Surgery is associated with a higher risk of erectile dysfunction.

And black men- For people who don't know what that is? Erectile dysfunction. I told a patient once that surgery was associated with a higher instance of erectile disfunction.

And he was looking at me, erectiles dysfunction, what is that? And then after I explained to him, he said, you mean no action on the Jackson? And I was like, yeah, that's what I'm talking about.

And then the other thing is that surgery is associated with a higher risk of incontinence, meaning the urine is leaking, you have to have a catheter or you wear pads.

You know, or you have dribbling like I have some things you say, no, my continents is good, except if I cough or if i lift something heavy, then I leave.

I said, okay, well, fine, you know. But the bottom line is that black men are more likely to say well doc, if the survival rates are about the same and one of them has a better chance of a keep sexual function and I'm not going to be incontinent, why do I want to get operated on?

You know, I'll debate any surgeon on the planet Earth to have that conversation. The fact is this, surgeons like to believe that the gold standard for prostate cancer is radical prostatectomy, cut the prostate out, the goal standard.

This is what the standard is and everything else is secondary. I would argue that radiation should be, somebody wrote, women are watching this. How can we play a role?

The elevator no longer goes up. Well, that's another conversation. We'll try to get back to that, okay? But the bottom line is that sexual dysfunction, when you have treatment, is treatable.

Radiation can affect sexual function as well, but it doesn't affect it as badly as surgery does, and it's treat able drugs. Just because somebody asked a question, I'll digress for a minute.

It's hard to get it off my mind when a woman asks a questions like that. So when I was a resident at Stanford many years ago, was doing follow-up on a patient that had been treated about 10 years before.

And I always told, ask the patient how is sexual functioning? So I asked the patients, Mr. Jones, how's your sexual function now? He says, well, about five years after radiation, my sexual function, it went away.

Now, of course, with the surgery, a lot of those people, the sexual functions goes away immediately after the operation. But with radiation this guy said, you know, five year later, he went a ways.

He said so then I got an implant. We said my wife used to have one orgasm, now she has three. I was like, oh, OK. It's like that. OK, fine. So the next patient I saw came in.

without surprise day cancer. Yeah, well, I'm just sharing with you some anecdotal experiences. So the next patient comes in, and he was looking really depressed.

And I asked him, so how is everything? He says, oh, OK. I said, how's your sexual function? And he's like, it's terrible. You know, you know I had this other patient.

He told me he had an implant. My wife used to have one of her guys, but now she has three. Can I talk to him?

Lifestyle, Sexual Health, and Diet

So I called the guy up and said, okay, for this guy to talk to you, he said sure. But there are other options. There are drugs like Viagra that can work in some people.

People can, there're injectables that could work. So the, you know, and the implants come in, they come different types of implants. Just some implants that are semi-rigid.

The less expensive ones are just kind of there, but there's more expensive once they have a butt. you push that button and the thing goes up and it stays up until you put it down.

So, I don't know, but you have to adapt to the situation. Now let me ask you now, it's not simple, even if you choose… When should a will be screened for this type of cancer?

You asked that question and so did Lauren. Most people recommend that is the AUA and the American Care Society, they tend to recommend screening around age 50 for the average person.

They talk about white people, right? People that have risk factors like African-American, people tend recommend like five years early or sometime early.

I recommend a baseline at 35. That's when I got my first PSA. You know, I wrote a proposal over 20 years ago to study PSAs specifically in African-American men.

And I submitted a grant and the NCI, the National Cancer Institute said, no, we don't wanna screen black men, We don' want to screen nobody. White men were getting screened.

Black men weren't getting the screen. I had this theory that if you follow people, you start off with a baseline, and you then check it every few years that you could look for trends.

And there's data from Kaiser that shows clearly that people who have very low PSAs don't need to be screened regularly. They can be screening every now and then because if they're gonna get prostate cancer, that PSA starts to come up at an earlier time point.

Family history is important. That does increase your risk of prostate cancers. especially if you have siblings, brothers, father, that sort of thing. But even if on your mother's side, some of these things are inherited in some genes that are similar to genes involved in breast cancer and other kinds of cancers.

So you need to know your family history. It is important. A lot of times people didn't talk about this stuff back in the day. So here's a couple questions that we look together.

A lot of men think once they get prostate cancer, it's like a death sentence. That's one question. And there's so many options now in radiation. Could you explain the differences between a few of those and how you make a decision about when to use what?

Right, so I talked about the fact that we have low-grade tumors, intermediate- grade tumors and high-graded tumors. And for low grade tumor, it is not a death sentence.

In fact, for none of them is a dead sentence If you wait until it's widely metastasized, you will not be cured, okay? But we even cure people with high grade tumours with the appropriate treatment.

Now, the type of treatment It's sort of like, if you commit a crime, the fact is that, you know, If you can get a parking ticket and then you just have to pay or write a little check, or you could commit felony and you might have do some time in jail, whatever.

The type of treatment depends on how aggressive, how advanced the prostate cancer is. So there are some patients that have very advanced prostate cancer that I recommend they stay on medication for years.

And they get aggressive radiation, not only to the prostate, but to lymph nodes as well. Then I have patients who have sort of intermediate prostate cancers where I recommended they stayed on medications only for four months with radiation.

And then I have some patients that I treat who have less aggressive disease, so I recommend only radiation to the prostate, no drugs at all. And we have a high cure rate.

So the cure rates are high for all three types of treatment, but we give more treatment for more aggressive diseases, less treatment from less-aggressive disease and less treatments for earlier-grade and earlier stage disease.

Dr. Roach, we've got a question here from the audience. And this is one from Cynthia. She says, as a man, if he's over 65 and has a great sexual appetite, like two times per week, is it likely they can have prostate cancer?

Does prostate persist less in sex? Actually, that's a good question. There are a couple of studies that show that Regular consistent orgasms may reduce your risk of developing prostate cancer.

So sexual activity may actually lower your risks. There's some studies that suggest that if a man has about 20

orgasm a month, it doesn't mean that they have to be having intercourse.

but they have about 20 orgasms a month. There are a couple of studies that suggest it may lower your risk of prostate cancer. There's also… Was that increase your risk of heart attacks and strokes?

No, probably lowers your risks of a heart attack and stroke. But the thing about it is that… I think sugar does that. I was just trying to… And there are some patients who will present with erectile dysfunction.

And it can be a manifestation of heart disease because all your blood vessels in your body are under the same exposure of risk factors for heart diseases.

So some men when they develop erectile dysfunction, that is they have trouble getting erections and they'll come in for a workup and there'll be diagnostic prostate cancer because the blood supply to the penis is compromised just as the supply of the heart is compromise.

So if a man develops sexual dysfunction he might actually have a risk for prostate cancer and heart disease, and the heart diseases may be more likely to kill him.

So you should, so if a man has sexual dysfunction, it should be worked up because it might mean that it may save him from having a heart attack. And also in men who have advanced prostate, cancer locally advanced, It is possible for the cancer to affect the nerves that affect sexual function.

I got a question here about and just on the other side because I know there's been a lot of myths and I remember watching my aunt for every meal cut my uncle a plate full of tomatoes because she had heard about lycopene being something that will help reduce his risk of prostate cancer.

Are there any foods or anything dietary that we can eat that's natural that could reduce our risk of prostate cancer, or is it still like a lottery that you either get it or you don't?

So for some of these factors, you can find some studies that say yes and some study that says no. But the lycopenes that the studies supported, we're talking about cooked tomatoes, not raw tomatoes like you put in the salad.

So you're taking about like pasta sauce. And so the problem with that data, in part, is that the Mediterranean diet is associated with a lower risk of prostate cancer.

And that's also associated, with drinking a little red wine, it's associated a different lifestyle. So there are other factors that may be in play. But it certainly doesn't hurt you to have lycopenes.

I like lyopenes, whether they affect my prostate risk or not. But the association is not with fresh tomatoes that you cut and put on a salad. It's with the cooked tomatoes.

Okay. We're kind of running out of time, Dr. Roach. One final question. What do you see in terms of the future of diagnosis and treatment of prostate cancer?

What's on the horizon that you as a radiation oncologist can do diagnostically or anybody can to therapeutically say 10 years from now that we're not doing now?

Well, the genetics of cancer are much better understood now than they were before. So it turns out that there are molecular patterns that can be identified in cancers that may point you to using certain specific kinds of drugs that you can combine with radiation or you might be able to use some of them without radiation.

For example, I had a patient who had radical prostatectomy, cancer was cut out, the cancer came back, I radiated him.

Future Diagnostics and Personalized Therapy

The cancer had metastasized and he failed every other treatment and his PSA, you know, normal one is less than four, his PSA was 700 and looked like he was about to die.

He was really looking bad. And then we ordered the test to look at the molecular characteristics of his tumor. And he had something called microsatellite instability.

Microsatellites instability is a measure that correlates with a suppressed immune response. So it turns out that the cancer was blocking his body's immune responses to kill the cancers.

He was given a medication called pembrolizumab, which is an antibody that blocks the area where the cancer was suppressed in the immune system. And his PSA dropped basically to zero and all of his metastatic disease disappeared.

The last time I saw him walking down the street, he looked completely normal and we had dinner with him and his wife. That's a remarkable change And the unique thing about this is that this applies to all kinds of cancers.

So that's one dramatic example, but there are other drugs for other people who don't have microsatellite instability. There are also some biomarkers that predict who will benefit from hormonal therapy in conjunction with radiation.

For example, you know Superman, if you wanna hurt Superman you expose him to green kryptonite, that makes Superman weak. When we wanna weaken prostate cancer, we take away the male hormone testosterone.

And it turns out that some people benefit from that a lot and some don't, but we have new information about who benefits more and who benefit less. Then we imaging agents like PSMA, prostate specific membrane antigen, which is we use for PET scanning that can identify very small deposits of cancer very early.

And we're now able to zap individual metastatic foci of cancel and in some cases prolong survival because of the ability to diagnose those things. So there are all kinds of things that are being studied and are very promising as we sit here today.

I wondered, Mr. Dean, you have any more questions for Dr. Roach before we conclude our interview? No, I'm always, and I've been very, very quiet because I got such a rich family history on both sides of prostate cancer.

I'm always listening and I becoming, you know, I being a little selfish. I get to sit at the catbird seat and get some great information. And so I think the audience is also reflecting that here.

You know Cynthia is talking about that as well. So I, think, ultimately, Dr. Rose, what I hear you say is that a couple of things, and that's why I put it on the screen.

We have a family history, you should start probably getting screening. A black man with family issues should probably start getting screened around 35 in terms of getting that PSA.

you should know what you're missing. And that's a Mac Roach recommendation. That's not the American Urologic or the AA or American Cancer Society, right?

I'll tell you, yeah. Cancer society says 50, but that for general market, mainly white. For white men who don't have a family history. Exactly. So I'm talking about black men with a history, Dr.

Roaches say, probably should start getting your baseline at 35. Another thing that I think all men, because if you ask me, Uh right now, I probably wouldn't know what my PSA level that's something that you should know just as like, you know, like you shouldn't.

Your blood pressure, your blood sugar. Absolutely. You should. Don't trust those doctors because I have patients

say, well, my doctor said my PSA was okay.

Well, the doctor might think it's okay for you, but it might not be okay Right. So know your number. Know your PSA level. I'm trying to give it to, because there's a lot of women that are watching, so they can give to their sons and their husbands and whatnot.

Say, honey, what's your PSA level? If he can't tell you, then he needs to go find out. He needs a call. If his had his physical recently, he could call and say, hey doc, where was my PSLA level, or a lots of them is online.

You can probably pull it up online and get your whatever labs they ran as your last physical. Another thing that I heard today was you don't need to stop getting PSAs done unless there's some specific situations about your care level and things of that nature.

But if you're still relatively healthy and you are 65, 70, 75, you should continue to get PSA tests done because that could affect your health. Additionally, we should do things to reduce stress.

As a black man in America, I don't know if we can fully eliminate stress, but there should be things that you could do to reduced the stress levels of your life, because that could have a negative influence on your prostate long term, just having elevated stress loads all the time, and then having healthier a more plant-based diet.

Exercise probably reduces your risk of getting prostate cancer too. Obesity increases your risks across the board of cancer, including prostate cancers.

So obesity is a bad thing and exercise is good thing. So we got a question that says, how can people reach you? But it sounds like you're the next step.

They've got to go through steps one and two, and then you are step three. Anybody can Google me. If you Google, you can find me online. I'm not hiding anywhere.

At the University of California, San Francisco. You can my email anywhere Okay. Well, thank you so much, Dr. Rhodes. It's a pleasure and honor. We have to do this again.

And one time we should just talk about radiation. Everything you want to know about, radiation for prostate cancer. We operate with the principal. We've got a question at the door before you leave.

Are PSA testing a part of regular exam or does it need to be requested? Well, it varies by practitioner. Some doctors routinely do it and some doctors, there's at Kaiser after age 70, they routinely stop doing it.

So if you're a Kaiser patient and you over 70 and your in good health, you have to ask for it. But if your younger than that, I would just ask.

COVID Update and Vaccine Discussion

Don't even just tell them I want a PSA. And then don't assume that you would need to be treated if it's a little bit elevated. No, but you'd have ask it for.

Some doctors just do it routinely. Yeah. And also I would add to that is that that's what we were talking about earlier in terms of knowing your family history.

When you fill out that form, fill it out completely. Don't skip over that family, history part, because that will send that part send signals to the doctors of what type of labs they're going to run.

So if you don't put, I've got a family's history of prostate cancer, or if, you know, know if. You've. Got a. Family history or prostate. Cancer, then they may or may not.

It'll be in that doctor's hands and say, Oh, well, They don't have a family history, so we might not run that test. And so you've got to take it out of there.

You're a black man, you're at risk. We do have on the American Wireless Project site something that we call, this is how we do it, questions to ask your doctor when you have prostate cancer.

So we want to thank you, we're going to a short break and then we'll be back to kind of do a COVID update. Thank you. I understand the hesitancy and the resistance that some folk may have to taking the COVID-19 vaccine.

You absolutely have a right to feel hesitant. But COVID is real. And I know from first-hand experience, I had it. I wouldn't wish COVID on anyone. Not fully recovered, but I don't want to ever be that sick again.

You and all the people that you love are at risk from COVID-19 infection. So please get vaccinated for yourselves, your family, and your community. Thank you.

You know, that was a very powerful message. But before we go and talk about what's happening with COVID now, I want to share with the audience I did have prostate cancer.

And I had to go through some of the very same things we talked about with Dr. Roach. He obviously has a great deal of knowledge about a lot of things.

I would say that the PSA was important. I would say that finding the right doctor was important, getting the treatment was, and doing the follow-up was.

I don't want anybody sending me a relatively minor, not minor but any cancer is significant, but I was effectively treated and for all intents and purposes right now.

At this moment, everything is going well. So we really want to have him back so he can expand his discussion. This is an interesting week, Mr. Dean, for COVID.

Certainly this variant, this Delta variant is on the horizon. A lot of people are dying who don't. Most of the deaths from coronavirus now are non-vaccinated people.

Yes. We still want to always say talk about it and suggest to people that they do consider the information that's out there about vaccination and the dangers of not being vaccinated.

And that's pretty much all we wanna say. We don't wanna keep- Can I just say one thing about the coronavirus and vaccinations and rates and deaths and hospitalizations that people are seeing going down?

And so I think the unvaccinated people taking this as a sign of, I don' need to get vaccinated and what the problem with that is that when you collect data, What's happening is all the vaccinated people are getting dumped into that same bucket.

And so that's why you see that sharp decline on all those graphs. If you pull all of the vaccinating people out of that data, the number of deaths, death rates have not gone down, hospitalizations haven't gone And the number of people getting contracting COVID has not gone down.

What has gone is they're dumping the 150 million people that are fully vaccinated into that data and it's causing an effect on it. Unvaccinated people are still at the same risk as they were before people started getting vaccinated.

So you have to make sure that you're really cognizant of that and don't just get seduced by, oh, it's going down. I don' need to get vaccinated, that is untrue.

so I have get that off my chest. We got to thank some people who went to that day and say, Oh, I didn't need it. It's it going away and said, no, Now, I reinforce that.

If you look at polio vaccine, always mention this. Polio vaccines been around for 50 years. The last case of polial was this year. And so consequently, this virus is going to be around, for a very long time.

What Mr. Dean is saying is absolutely correct. is that if you get infected with the coronavirus, you have the same risk of going to the hospital, same risks of dying.

In fact, most of the people that are dying are those people who are unvaccinated. in addition, there's something called a long haul. That means for people will get affected with coronavirus.

A lot of them have heart disease, lung disease. and pulmonary disease, I mean, and brain disease. And so consequently, it's not insignificant. Plus, as you see now every day, businesses are not letting people come back to work.

In hospitals, entertainment venues, in major financial groups, you have to be vaccinated or then you're gonna be terminated. But I don't think that should be a major part of your own personal decision.

but I think we do have say, look at these statistics really carefully, read them every week, look at the dangers that these variants pose for you, and then make a decision.

Before we… Yeah, I think we also have to mention the Delta variant because that's the variant right now. And so, Cynthia, to your family members under the age of 45, talk about this.

Dr. Lenore just mentioned it in terms of long haulers. Additionally, we had an insurance rep, a medical chief medical officer that does reviews for insurance, one of the things you're gonna have to start putting on your medical records is even if you survive COVID, is you gonna to have list COVID as a pre-existing condition.

And so when you go into your doctor's office, if your short of breath, you have headaches, things of that nature, and then you put COVID it can't be ruled out as the cause of this particular disease.

Additionally, If you start trying to get life insurance for you and your spouse, and you list, hey, I'm a survivor of COVID. COVID is showing over long terms, still studies are being done, but it's showing to have an effect on your life.

expectancy. And so therefore, your insurance premiums might be higher to get the same amount of coverage because they're saying somebody that has even if they've survived COVID, they are going to have potentially more medical problems to deal with going forward.

So therefore they will be more of a burden on the insurance company. They will utilize their policy more more frequently and more often than somebody that didn't have COVID.

And so therefore they're going to charge you at a higher rate. So those are the things you have to consider, not just the fact that you're afraid of the vaccine.

We understand vaccine hesitancy and fears about that, but you also have consider what it means to even, even if you survive COVID, what does that mean for your life going forward?

Closing Remarks and Giveaway

So yeah, I think each week we'll try to do some COVID updates. We've been talking about the wellness project and we're about to make a few changes. Are we going to change our time to a 730 time on the east and program for the west?

And also each way we are going give away something to people who remember two or three things about interviews that we have. We always appreciate if you would tell us what you want to hear what subjects you Want to talk to us you?

Want us to to? Talk to you about you. Want? To get that information But each week we want you to join us as a regular member of the watching one of The welcome Of the wellness watch family and tell your friends about it and share not only our our Facebook project, but also share our podcast.

We have a podcast called Black Doctors Speak, and it repeats some of the information that we've shown here. So I'd like to thank Dr. Rhodes for joining us.

I would like thank Mr. Dean for always being good about what we're doing. Well, I know you're about to hit the lot, But for this week, can we give the book to Cynthia?

Cynthia, if you would, please. Reach out to the African-American Wellness Project or reach out directly to me at blackdoctor.org. Cynthia, you stay with us.

You ask a question. We want to thank you for that. Make sure you share this program. So, Cynthia send us your contact information and we will get that book out.

We're going to send you the book, Focus on Your Health, How to Construct Your Own Health System, with something that we at the African American Wellness Project have as our major focus.

The book is called Focus On Your health. It has everything that you need to construct your own health care system. We'll get that out to you, Cynthia, and each week we're gonna give away at least a book and often some other opportunities for you.

So thank everybody for joining us. Thank you, Mignon, for all the production that you've done today. I think it's been exceptional in terms of how we were able to move this along.

But most of all, I'd like to thank everyone who joined us for the Wellness Watch. Remember, health is your biggest asset. We'll talk in the next week.