High Grade Prostate Cancer

NAME/	AGE/74	SEX/Male	AREA/Australia

Visit 1: 30/9/2004

Case History Discussion

- Patient first visited me in 2001 for assistance and advice after diagnosed and treated for bowel cancer in 2000 (surgery – hepatic flexure removed); plus suffering from significant arthritic pain and stiffness (especially back & hips); prostate enlargement; lung congestion, mucous, catarrh; tiredness; and glaucoma of right eye.
- His recent prostate cancer diagnosis in August 2004, prompted him to come in for assistance.
- From 2001 until 2004, he was treated for all the above conditions, with reasonable progress except for arthritis and joint pain/ stiffness which troubled him quite a bit, plus occasional issues with lung congestion/mucous and tiredness.
- Enlargement of his prostate was fairly stable, a slight reduction in urinary flow/strength over 4 years, but PSA had increased steadily since the late 1990's.
- In 1998 his PSA was 0.9, 2000 it was 3.6, 2001 it was 6.3, 2002 it had reached 10, and by May 2004 had climbed to 30.8.
- At the appointment review, September 30, 2004, patient was quite well in general, especially since addition of extra remedies following his phone call in early September asking for extra assistance given the prostate cancer diagnosis – increased Zinc, Selenium, added Vitamin D, Colostrum, Bromelain, CoQ10.
- Energy was good except for occasional breathlessness on exertion; arthritis and stiffness reasonable but hips bothersome at times; lung congestion good with only occasional phlegm; glaucoma right eye stable.
- Prostate symptoms improved on extra Selenium, Zinc, Vitamin D, etc, mentioned that his flow had improved despite obstruction to the right ureter, plus now able to go for 4-5 hours at night without urinating, previously only able to last 2 hours before getting up.

Patient History

- Arthritis – extensive, spine, back, hips
- Bowel Cancer – in 2000 – hepatic flexure removed – fine since
- Glaucoma – especially R eye – pressure controlled
- Lung congestion/catarrh/mucous – started approx 2001
- BPH & associated symptoms
- Prostate Cancer – 09/2004

Pathology

1. Histopathology Report of Prostate Biopsy (30/8/2004)

* Note: all 21 biopsy cores show adenocarcinoma, grades 3 and 4, involving 90-100% of core volume, with focal perineural invasion seen in several cores.

Prostate Biopsy Synopsis

- Tumour type: Adenocarcinoma
- Composite Gleason score: 3+4=7
- Percent high grade (4/5) carcinoma: 30 to 40%
- Location: Bilateral
- Perineural infiltration: Present
- Vascular infiltration: Absent
- Capsular penetration: Not seen
- PIN (Prostatic Intraepithelial Neoplasia): Absent
- Intraduct carcinoma: Absent

Diagnosis: Prostate – Adenocarcinoma

2. CT Abdomen/Pelvis (10/9/2004)

• Prostate gland measures 4.4 x 4.5cm. No obvious prostatic mass is identified. Bladder is not optimally distended, and slightly thick-walled.

• No extra-prostatic extension identified. No significant para-aortic lymphadenopathy seen. 11 x 8mm retrocrural lymph node. Non-specific, non-enlarged, small mesenteric nodes noted on left.

• Liver fine except for 1.5cm cyst in right lobe, with 2 tiny cysts in segment 6.

• Lungs indicate 2 tiny pleural-based soft tissue nodular opacities in periphery of left and right lower lobes, non-specific.

• Both hip joints demonstrate severe degenerative change. Sclerotic lesion in the left ileum, but not clinically significant. Extensive multilevel degenerative changes in lumbar column, with compression fracture in L2.

3. Bone Scan (16/9/2004)

1. Overall appearance did not suggest metastatic bone disease.

2. Marked arthritic changes noted L5/S1 facet joints, more on left than right. Lesser degenerative changes noted throughout lumbar, thoracic & cervical vertebrae.

3. Marked arthritic changes at hips in most curious fashion; possibility of underlying metabolic disorder or osteoporosis should be considered. Slight arthritic changes elsewhere in knees, shoulders, elbows, wrists, hands.

4. Abnormal visualisation of right ureter with mildly dilated right kidney collecting system; appears to be an obstruction of the pelvic floor (possibly tumour obstruction to the ureter in the pelvis).

PSA Readings

	1998	2000	2001	2002	25/5/2004
Total PSA	0.9	3.6	6.3	10	30.8

Treatment Recommendations

1. Lifestyle & Dietary Changes

• Dietary habits were excellent and greatly improved over a number of years – high plant based diet, limited animal

protein and dairy products, very little sugar or junk food, no coffee or alcohol.

• Patient physically active for his age, but arthritis provided some limitations.

• Patient retired, but very active in gardening, bush regeneration, music and so on.

2. Supplement Programme

• Multivitamin – 1-2 capsules am Vitamin C Powder – 1 teaspoon daily

• Zinc (30mg) – 1 tablet bd Flaxseed Oil – 1 tablespoon daily

• Selenium – 400mcg Natural Vitamin E – 500IU

• Bromelain – 200mg bd CoQ10 – 100mg

• Colostrum and co-factors – 1 teaspoon bd Magnesium Chelate/Orotate/Aspartate – 100mg bd

• Green Drink – Green Barley, etc Herbal Prostate Formula – Saw Palmetto & Nettle Root – 3 daily

• Vitamin D, or Cod Liver Oil/Halibut Liver Oil Fish Oil – 1 capsule bd

For Other Health Conditions:

• Glucosamine/Chrondroitin for arthritis

• Slippery Elm, Psyllium, Probiotics, Digestive Enzyme Formula for managing bowels

• Bilberry, Lipoic Acid for glaucoma

• Iron, Folate, Vitamin B12 for low grade anaemia

3. Oncologist/Specialist Recommendations

• Hormonal therapy for palliative treatment of metastatic prostate cancer, to inhibit tumour growth:

• Lucrin – GnRH analogue – SCI daily - potent inhibitor of gonadotrophin production, resulting in suppression of steroidogenesis (suppressing LH, FSH, testosterone & dihydrotestosterone).

Visit 2: 3/6/2005

Case Discussion

- Prostate symptoms were slightly improved despite the prostate enlargement and right ureter obstruction.
- Pre September 2004, he could only last about 2 hours without getting up at night, whereas able to last 3 hours most nights. His flow had improved and PSA remained stable at 32.9 (was 30.8, May 2004).
- General health was good, except for ongoing issues with stiffness and pain in both hips, especially the right hip.

Blood Pathology (25/5/2005)

PSA Readings

	1998	2000	2001	2002	25/5/2004	25/5/2005
Total PSA	0.9	3.6	6.3	10	30.8	32.9

Treatment Recommendations

1. Lifestyle & Dietary Changes

• Excellent dietary habits maintained

2. Supplement Programme (supplement programme changes*)

Continue guidelines as per visit 1 incorporating the following changes:

- Zinc (30mg)* – 3 tablets daily Selenium* – 300mcg
- Anti-inflammatory Formula* – 1 capsule bd Vegetable Enzyme Formula* – 1g bd
- Prostate Bladder Herbs* – Saw Palmetto, Nettle Root, Corn Silk, Uva Ursi, etc – 7.5ml bd

Visit 3: 25/3/2006

Case Discussion

- Overall prostate symptoms stable and slightly improved despite prostate enlargement and right ureter obstruction. His flow was slightly better, with nocturia improved to 3 to 3½ hours.
- General health and energy good except for the usual arthritis and joint stiffness.

Pathology

No testing done this visit

Treatment Recommendations

1. Lifestyle & Dietary Changes

• Dietary and lifestyle habits improving, but still occasional lapses.

2. Supplement Programme (supplement programme changes*)

Continue guidelines as per previous visit incorporating the following changes:

• CoQ10* – 100mg bd

For Other Health Conditions:

• Homeopathic preparation* for arthritis

June 2006 - Update

• Unfortunately, he suffered a urinary/urethra obstruction in June 2006, resulting in admittance to St Vincent's Hospital for TURP procedure.

Oncologist/Specialist Treatment

• Prostate cancer re-assessed by Urologist/Oncologists, with PSA only slightly increased at 35, but biopsies showed increased Gleason score of 9.

• He was given 5 weeks radiotherapy and placed on Androcur (anti-androgen for inoperable prostate carcinoma).

• After treatment completed, Androcur stopped and Zoladex implants (GnRH agonist for palliative treatment of

metastatic advanced prostate cancer) started. PSA reduced from 35 to 1.4.

Visit 4: 26/2/2007

Case Discussion

• Following TURP and 5 weeks radiotherapy in June 2006, plus androgen ablation therapy (Andorcur, followed by Zoladex), this visit was to update me on his progress since, plus to seek assistance with his programme.

• Due to the obstruction he had no option but to do the TURP, however wasn't so sure about the radiation, but given the Gleason score being 9, PSA 35, plus pressure from specialists he reluctantly decided to proceed with the therapy, despite understanding that radiation was not curative in his situation.

• As for the hormonal ablation therapy (Androcur followed by Zoladex), while reducing his PSA from 35 to 1.4, and recently 0.12, it has significantly affected his quality of life. His energy had dropped, and he suffered from slight hot flushes, plus was experiencing significant muscle and nerve issues (neuropathy & especially leg muscle weakness/tiredness, and reduced flexibility).

CASE BOOK: CASE 2

PSA Readings

	1998	2000	2001	2002	25/5/2004	25/5/2005	06/2006	08/2006	02/2007
Total PSA	0.9	3.6	6.3	10	30.8	32.9	35	1.4	0.12

Treatment Recommendations

1. Lifestyle & Dietary Changes

• Maintains healthy diet and lifestyle

2. Supplement Programme (supplement programme changes*)

Continue guidelines as per previous visit incorporating the following changes:

• Vitamin C Capsules* – 1 capsule bd (replaces Vitamin C powder)

• Magnesium Chelate/Orotate/Aspartate* (increase dosage 3 tablets daily or more re muscles)

• Anti-inflammatory Formula* – 1 capsule bd (increase dosage if required)

• Phospholipids* – 1 capsule bd (for nerves/neuropathy)

- Vitamin B12* – 1 tablet bd (for nerves/neuropathy)
- Prostate Bladder Herbs* – finish/stop

Visit 5: 14/12/2007

Case Discussion

- PSA remains stable and decreased further over the past 10 months, with readings of 0.12 (Feb 2007), 0.05 (Aug 2007) & 0.06 (Dec 2007). Patient maintains 3 monthly Zoladex injections.
- However, his general health is down, with reduced energy/tiredness, plus significant issues with his legs, muscles and joints.
- Muscle tiredness and decreased flexibility, in addition to lower back and hip pain/stiffness. Walking has now become a concern given the stiffness and pain, plus a low BMD test result.

- A recent chest infection/cough/mucous the past 6 weeks has further weakened him.

Pathology (13/08/07)

PSA Readings

	1998	2000	2001	2002	25/5/04	25/5/05	06/2006	08/2006	02/2007	13/8/07	6/12/07
Total PSA	0.9	3.6	6.3	10	30.8	32.9	35	1.4	0.12	0.05	0.06

2. Blood Pathology (13/8/07)

FBC – NR except red cell parameters/slight aneamia - RCC 4.16 L, HB borderline at 131

Iron studies slightly low

PSA 0.05

Biochem – NR (ALP – 105)

Vitamin D – 54 Low

Blood Pathology (6/12/07)

FBC – NR except red cell parameters/slight aneamia - RCC 4.22 L, HB 129 L

PSA – 0.06

CRP 3.5, Test 0.1 L, SHBG 56 H, FAI <0.4 L

Vitamin D – 79

Treatment Recommendations

1. Lifestyle & Dietary Changes

• Maintains healthy diet and lifestyle

2. Supplement Programme (supplement programme changes*)

Continue guidelines as per previous visit incorporating the following changes:

• Colostrum and co-factors* – 1 teaspoon daily

• Magnesium Chelate/Orotate/Aspartate* – 2-3 tablets daily or more re muscles

• Anti-inflammatory Formula* – 2 capsules bd (increase dosage if required)

• Calcium/Bone Matrix Formula* – 1-2 tablets daily

For Other Health Conditions:

• Chest Herbs*, Vitamins A & D, Vegetable Enzyme Formula,* Garlic and Goldenseal* for chest infection/cough

Visit 6: 7/2/2009

Case Discussion

• Patient generally feeling well with good energy.

• Due to ongoing issues with hips and walking, both hips were replaced (R Hip replaced June 2008 & L Hip replaced September 2008). Operation successful, now walking well and muscle strength returning.

• Prostate symptoms remain stable and unchanged, but the PSA is slowly starting to rise due to failing response to androgen ablation therapy (Zoladex).

• I discussed the reduced impact of hormone therapy (hormone refractory) over time and pointed out that in managing his cancer, the best way is to reduce the frequency of Zoladex (and other androgen ablation therapies), which lengthens the time that this therapy is helpful in extending its effectiveness.

CASE BOOK: CASE 2

PSA Readings

	25/5/04	25/5/05	06/ 2006	08/ 2006	02/ 2007	13/8/07	6/12/07	11/2/08	30/4/08	29/8/08	21/1/09
Total PSA	30.8	32.9	35	1.4	0.12	0.05	0.06	0.3	0.6	0.5	0.9

2. Blood Pathology (11/2/2008)

FBC – NR, CRP 1.3, PSA 0.3

Blood Pathology (30/4/2008)

FBC – NR, except RCC 4.22 L, CRP 1.3, PSA 0.6

Blood Pathology (29/8/2008)

FBC – all NR, Test 5.2 L; SHBG 60 H; FAI 8.7 L, PSA 0.5,

Blood Pathology (21/1/2009)

FBC all NR CRP, Gluc – all NR Biochem – NR except LD 256 H, ALP 106 Test 6.2 L, FSH 22.2 H, LH 18.8 H; FAI 12.4 L MSU: Leuc 30 H, RBC's 39 H PSA 0.9

Treatment Recommendations

1. Lifestyle & Dietary Changes

• Maintains healthy diet and lifestyle

2. Supplement Programme (supplement programme changes*)

Continue guidelines as per previous visit incorporating the following changes:

• Flaxseed Oil* – 1-2 tablespoons daily

• Magnesium Chelate/Orotate/Aspartate* 2-3 tablets daily or more re muscles

Visit 7: 25/2/2010

Case Discussion

• Patient generally well except some tiredness. However, PSA levels were steadily rising due to failure of androgen ablation therapy (Zoladex). PSA levels had moved from 0.9 in January 2009, 4.7 in June 2009, to 33 in February 2010.

Oncologist/Specialist Treatment

• Visited oncologist who performed bone scan, which was clear. Oncologist prescribed further Zoladex implants. Patient decided not to take due to lack of efficacy and reduced impact following up from my previous discussions about the hormone refractory effect that occurs if used continuously.

Pathology

PSA Readings

	25/5/04	25/5/05	06/ 2006	08/ 2006	02/ 2007	13/8/07	6/12/07	11/2/08	21/1/09	25/6/09	12/2/10
Total PSA	30.8	32.9	35	1.4	0.12	0.05	0.06	0.3	0.9	4.7	33

Blood Pathology (25/6/2009)

FBC, Gluc, Lipids, CRP 2.7 – all NR Biochem – NR except LD 263 H, GGT 55 H

Test 5.2 L PSA 4.7

Blood Pathology (12/2/2010)

FBC, Gluc, Lipids, CRP 1.6 – all NR Biochem – NR except LD 256 H, Tot Pro 63 L

Test 9.0 L PSA 33 H

Treatment Recommendations

1. Lifestyle & Dietary Changes

• Maintains healthy diet and lifestyle

2. Supplement Programme (supplement programme changes*)

Continue guidelines as per previous visit incorporating the following changes:

• Zinc* (30mg) – 1 tablet daily

• Selenium* – 200mcg

• Fish Oil* – 5ml daily

• Anti-inflammatory Formula* – 1 capsule bd

• Immune Modulating Formula* - 1 capsule bd

• Vitamin D* – 1,000IU – 1 capsule daily

Visit 8: 30/11/2010

Case Discussion

• PSA continued to increase from 33 in February 2010, to 54 in July 2010, and stabilising to 58 in Nov 2010.

• Patient decided to continue my suggestion of not taking further Zoladex implants at this point in time, as his PSA had leveled off over the past 4 months, plus he was feeling so much better in himself.

• Patient reported great improvements in energy, physical and muscle strength (had started weights for seniors which was very helpful), especially leg muscles, plus better walking and improved flexibility since stopping the androgen therapy.

Pathology

CASE BOOK: CASE 2

PSA Readings

	25/5/04	25/5/05	06/ 2006	08/ 2006	02/ 2007	13/8/07	6/12/07	25/6/09	12/2/10	19/7/10	23/11/10
Total PSA	30.8	32.9	35	1.4	0.12	0.05	0.06	4.7	33	54	58.4

Blood Pathology (19/7/2010)

FBC, Gluc, CRP 2.1- All NR

Test 10.3; Free Test 13.9 L; SHBG 61 H;

ALP stable at 85

PSA 54 H

Blood Pathology (23/11/2010)

Test 6.0 L

PSA 58.4 H

Treatment Recommendations

1. Lifestyle & Dietary Changes

• Maintains healthy diet and lifestyle

2. Supplement Programme (supplement programme changes*)

Continue guidelines as per previous visit incorporating the following changes:

• Immune Modulating Formula* - increase to 2 capsules bd

Visit 9: 16/4/2011

Case Discussion

• Overall feeling well, no major symptoms from prostate cancer except for the occasional mild ache in groin, urinary flow very good.

• However PSA was increasing, from 58.4 in November 2010, to 87.1. Unfortunately, he had not been doing the full dosage of important remedies like the Immune Modulating Formula (only 1 capsule bd), so the results were better than expected given the reduced nutrient levels.

• I encouraged him to increase the dosage of the Immune Modulating Formula and Vitamin D given the rising PSA.

Pathology

PSA Readings

	25/5/04	25/5/05	06/ 2006	08/ 2006	02/ 2007	13/8/07	6/12/07	25/6/09	12/2/10	19/7/10	23/11/10	03/3/11
Total PSA	30.8	32.9	35	1.4	0.12	0.05	0.06	4.7	33	54	58.4	87.1

Blood Pathology (30/3/2011)

Biochem: ALP 100, GGT 43 H

PSA 87.1 H

Treatment Recommendations

1. Lifestyle & Dietary Changes

• Maintains healthy diet and lifestyle

2. Supplement Programme (supplement programme changes*)

Continue guidelines as per previous visit incorporating the following changes:

• Vitamin D* – 1,000IU – 2 capsules bd

Visit 10: 23/9/2011 & 30/9/2011

Case Discussion

- Unfortunately, while lifting a heavy box of music, visual disturbance occurred and he was unable to see in his upper right visual field. Opthalmologist consulted and referred to RNSH for confirmation of possible minor stroke. CT, Angiogram and MRI brain scanning confirmed left occipital lobe stroke. Spent one week in RNSH hospital from the 15/9/2011, discharged 21/9/2011, during which all his stroke related symptoms completely resolved. He refused medications (Ramapril & Lipitor) except for Aspirin on discharge.
- In hospital extensive sclerotic lesions prominent in his vertebral bodies of the axial skeleton were also investigated, given the known PC history and elevated PSA (174) and ALP (272). CT scan (and chest x-ray) showed prominent lymphadenopathy in mediastinum and lower L para-aortic region; liver cysts; presumed mesenteric cyst R lower abdomen; plus segmental collapse of R lower lobe of lung and effusion. Bilateral

dilation of renal collecting systems was also noted. Reviewed by oncologist, who suggested that the lung effusion unlikely to be PC but could be lymphoma, and the mediastinal LN could possibly be PC origin. Bone metastasis from PC the most likely diagnosis for the sclerotic skeletal lesions given the history and pathology, with bone scan recommended for confirmation.

- Patient visited me for advice and recommendations on the 23rd of September. He was confused as to what to do and very much against too much medical intervention or excess medications. He was concerned that the vision in his R eye had not really improved, plus the collapsed R lung/effusion was bothering him with mucous and breathing issues. He was also experiencing a lot of stiffness in his neck and shoulders, was very tired and fatigued, plus concerned about the rising PSA, ALP over the past month.
- My suggestion was to deal with the two most pressing problems first; add additional treatment for brain support and stroke prevention, plus try and improve R lung collapse/fluid/mucous condition. Appropriate nutrients were added for both conditions, with extra Anti-inflammatory Formula, Magnesium, Phospholipids, Adenosine & Cerebrum Compound added for his brain, and Expectoration Herbs added for the lungs. I suggested reviewing the above issues in the next week, whereas the PSA/PC issues could be checked in a few weeks when things are more settled. I suggested referral from his GP to appropriate specialists for monitoring brain and eyes (Neurologist & Opthalomologist), and if the lung condition worsens to go to hospital ED.
- 30th September phone consultation: no significant change in eyesight or vision, but he was feeling better with improvement in R lung symptoms, but still well below par. I suggested he may need more assistance on these issues, so follow through on my previous advice should things not improve significantly over the next few weeks.

Pathology

PSA Readings

	25/5/05	06/ 2006	08/ 2006	02/ 2007	13/8/07	6/12/07	25/6/09	12/2/10	19/7/10	23/11/10	03/3/11	19/9/11
Total PSA	32.9	35	1.4	0.12	0.05	0.06	4.7	33	54	58.4	87.1	174

Discharge Referral/Summary RNSH (15/9/2011- 22/9/2011)

Left occipital lobe infarct diagnosed and confirmed. Visual changes and unable to see upper R visual field after lifting a heavy music box, plus some headaches over the past 6 weeks.

Blood Pathology (19/9/2011)

Albumen 31 L

Alk Phos 272 H

Lymph 0.9 L

PSA 174

Blood Pathology (21/9/2011)

Lymph 0.6 L

Re Occipital Lobe Infarct:

1. CT- Angiogram brain (15/9/2011) – Visual field defect R upper quadrantanopia. Acute/subacute infarct of L occipital lobe, with no abnormalities of intra or extra cranial arteries; plus sclerotic lesions throughout vertebral bodies.

2. MRI brain (19/9/2011) – Acute infarction of medial L occipital lobe on background of chronic white matter ischaemia; no haemorrhagic transformation.

3. TTE – normal heart chambers, no thrombus & no PFO, minimal tricuspid regurgitation, pulmonary artery pressure normal (40mmhg).

• All L occipital lobe infarct symptoms resolved.

Re Sclerotic Lesions of Vertebral Bodies:

1. PSA elevated at 174 & ALP elevated at 272

2. CT Chest/Abdomen/Pelvis (20/9/2011) – Showed extensive sclerotic bony lesions and multiple small sclerotic lesions throughout axial skeleton, prominent lymphadenopathy in mediastinum and lower L para-aortic region. Liver cysts, presumed mesenteric cyst R lower abdomen, segmental collapse of R lower lobe of lung and effusion. Bilateral dilation of renal collecting systems is also noted. Reviewed by oncologist, suggested effusion unlikely to be PC but could be lymphoma, and that mediastinal LN could possibly be PC origin.

Re Lung Collapse

1. Chest XR (15/9/2011) – Prominent R hilar vascular markings, small pleural effusions noted, collapse of medial R lung base is present.

2. CT – findings above confirm collapse of R lower lobe of lung and effusion.

• Patient refused further investigations and suggested medications except for aspirin 100mg and was discharged.

Treatment Recommendations

1. Lifestyle & Dietary Changes

• Maintains healthy diet and lifestyle

2. Supplement Programme (supplement programme changes*)

Continue guidelines as per previous visit incorporating the following changes:

- Magnesium Chelate/Orotate/Aspartate* – increase to 2 tablets bd, or tds
- Anti-inflammatory Formula* – increase to 2 capsules bd

For Other Health Conditions:

- Anti-inflammatory Formula*, Magnesium Chelate/Orotate/Aspartate*, Phospholipids*, Adenosine* & Cerebrum Compositum* for Stroke/CVA Prevention
- Lung Expectorant Herbs* (Elecampane, White Horehound, Pleurisy Root, Mullein, etc) for lung collapse/effusion/mucous

Visit 11: 16/12/2011 & 19/12/2011

Case Discussion

- Patient visited following a 2½ week stint in the SAN hospital.
- CT scanning of chest, abdomen and pelvis confirmed extensive metastatic disease of spine, scapula, ribs and pelvis, plus highly suspicious for bronchoalveolar carcinoma (enlarged mediastinal lymphadenopathy, nodular opacities & masses in the R lobe) of the R lung.
- CT Pulmonary Angiogram revealed presence of low grade pulmonary emboli, plus an increase in the size of pleural effusions since the previous study in September.
- CT Brain indicated old infarcts L frontal & L occipital lobes. Chest x-rays revealed extensive opacities in R and middle lung lobes (infection? lymphangitis?) with small effusions bilaterally, widespread bony metastasis, with consolidation R prehilar region and mass R lung base highly suggestive of carcinoma.
- In summary, diagnostics were fairly conclusive for the metastatic bone progression of his prostate cancer, with low grade pulmonary emboli & pleural effusions, plus possible lung cancer.
- PSA had also increased to 290 and the ALP to 574, with his oncologist recommending Zoladex implant as treatment, but was most pessimistic about the situation and prognosis. He went ahead with the Zoladex on this occasion.
- While in the SAN, lungs were drained with 1.5 litres removed from R lung and 900ml from L lung. Blood clots in lungs were treated with Clexane injections.
- His heart was also checked, and while reasonably normal for age, Coversyl was prescribed.
- Since drainage of pleural effusions his cough and chest symptoms had improved, but he still felt very weak, tired and run down.
- His blood tests revealed borderline anaemia, lymphopaenia, inflammation (CRP), abnormally high PSA & ALP (re metastatic PC), and abnormal LFT's and low protein (albumen).

Updated Programme/Approach

- Overall, prognosis very poor from a SO perspective, plus on presentation he was in very poor shape, and having seen many hundreds of cancer cases, unless his general condition could be turned around then he would die fairly soon.
- Given the situation, it was essential that a more aggressive programme was suggested and implemented.
- Lack of financial resources had limited his ability at times to do all the recommendations and quality formulas, but as there was considerable deterioration in his general health, plus a worsening cancer situation, I suggested it was time to be more focused on key remedies and immunotherapy to turn things around.
- The new programme would focus on the main and essential remedies, with more emphasis on the Immune

Modulating Formula, Anti-inflammatory Formula, and RBAC.

- His new programme, not only included increased Immune Modulating Formula, Anti-inflammatory Formula, RBAC, but also increased dosages of Vitamin D, Zinc, Magnesium, Vegetable Enzyme Formula, Vitamin C capsules, Bone Support Formula, plus increased immune support to complement the RBAC, namely Beta 1,3/1,6 Glucan Shiitake Mushroom Complex and Immune Herbs, in addition to continuation of Lung Expectoration herbs and addition of Rice Protein Powder.

Pathology

PSA Readings

	25/5/05	06/ 2006	08/ 2006	02/ 2007	6/12/07	25/6/09	12/2/10	19/7/10	23/11/10	03/3/11	19/9/11	15/11/11
Total PSA	32.9	35	1.4	0.12	0.06	4.7	33	54	58.4	87.1	174	290

SAN Hospital Testing & Summary (15/11/2011 - 25/11/2011)

Blood Pathology (15/11/2011)

ALP 574 H; GGT 67 H; LD 511 H Test 8.0 L PSA 290

Blood Pathology (24/11/2011)

CRP 15.0 H RCC 3.9 L; Lymph 0.7 L Albumen 32 L ALP 567 H; LD 482 H

Blood Pathology (25/11/2011)

CRP 11.9 H RCC 3.8 L; Lymph 0.8 L Albumen 27 L ALP 519 H; LD 425 H

CT Chest, Abdomen, Pelvis (15/11/2011)

Lymphadenopathy: Numerous enlarged mediastinal lymph nodes:

Anterior mediastinum: 29 x 16mm Pretracheal: 21 x 21mm Left pretracheal bones on 23 x 16mm

Metastatic Disease:

• Extensive sclerotic metastasis of whole vertebral column, bony pelvis as well as ribs and scapula.

• No hepatic metastases. 21 x 15mm liver segment 8, likely a liver cyst.

• Within R middle & R lower lobe of lung there are partly confluent nodular opacities with bronchocentric increased density and areas of adjacent groundglass density. A more discrete mass in the R middle lobe (max dimension 20mm) is noted as well as a subpleural mass medially in the apical segment of the R lower lobe measuring approximately 24 x 25mm. There is moderately sized R sided pleural effusion and a slightly smaller L sided pleural effusion. No lung lesions noted on the L side.

Other Findings:

Bilateral pleural effusions. 21mm diameter cystic structure noted anterior to the IVC at the level of pelvic inlet, possibly a mesenteric cyst.

Conclusion:

Extensive sclerotic metastatic disease. The presence of mediastinal pathological adenopathy in the absence of intraperitoneal or retroperitoneal lymphadenopathy would be unusual for prostate cancer. The appearance of the abnormality in the right lung could relate to bronchoalveolar cell carcinoma and is atypical for metastatic disease. The lung findings have progressed since the previous exam (compared to CT 20/9/2011).

CT Pulmonary Angiogram (24/11/2011)

• The study is positive for the presence of pulmonary emboli although the load of emboli is fairly low.

• Pleural effusions have increased in size since the prior study.

• Again noted is pathologic lymphadenopathy and multifocal areas of diffuse and confluent opacity in the right lung largely unchanged compared to the most recent CT study.

CT Brain (24/11/2011)

Left lobe – old infarct L frontal lobe Further old infarct - medial L occipital lobe

Chest X-Ray (24/11/2011)

Extensive opacities R & middle lobes. Infection? Lymphangitis?

L base – small effusions bilaterally Widespread bony metastases

Chest X-Ray (29/11/2011)

Persistent widespread air space consolidation R middle and lower lobes in R hilar region.

Consolidation R prehilar region and mass R lung base highly suggestive of carcinoma.

Echocardiogram (25/11/ 2011)

Heart fairly normal. Mild ????

Treatment Recommendations

1. Lifestyle & Dietary Changes

• Maintains healthy diet and lifestyle

2. Supplement Programme (supplement programme changes*)

Continue guidelines as per previous visit incorporating the following changes:

• Vitamin C capsules* – 1-3 capsules bd Zinc (30mg)* – 1 tablet bd

• Magnesium Chelate/Orotate/Aspartate* – increase to 2 tablets bd Anti-inflammatory Formula* – increase to 2 capsules bd

• Vegetable Enzyme Formula* – 1g 4 times daily Immune Modulating Formula* – increase to 2 capsules bd

• Vitamin D* – 2 capsules bd RBAC*– 1 sachet bd

• Rice Protein Powder* – 1-2 scoops bd Immune Tonic* & Lung Herbs* – 5ml bd of both

• Beta 1,3/1,6 Glucan Shiitake Mushroom Complex* – 2 teaspoons bd

For Other Health Conditions: Lung Expectorant Herbs* for lung collapse/effusion/mucous congestion

Update & Phone Consultation: 12/2/2012

Case Discussion

- Due to unresolved swollen ankle at the end of December, he presented at the SAN hospital ED for assessment.
- Ultrasound of leg revealed no DVT, chest x-ray showed small bilateral pleural effusions. He was advised to continue Clexane to resolve lung clots, wear compression stockings, and that the swelling in his ankle was most likely related to lymphatic oedema from secondary lymphatic obstruction due to metastatic cancer.
- Reviewing his blood tests, they revealed borderline anaemia, lymphapaenia, inflammation (CRP), abnormally high ALP (re metastatic PC), and abnormal LFT's and reduced renal function (creatinine), plus low protein (albumen).
- Overall the PC/Bone metastases situation had improved with reduction in his ALP.
- Although he felt a lot better in his general wellbeing, he was still experiencing breathing difficulties and SOB.
- As he was improving, I advised to continue current treatment programme, but to keep a close eye on his breathing and SOB, and if this deteriorates to visit ED of the SAN.

Pathology

PSA Readings

	25/5/05	06/ 2006	08/ 2006	02/ 2007	6/12/07	25/6/09	12/2/10	19/7/10	23/11/10	03/3/11	19/9/11	15/11/11
Total PSA	32.9	35	1.4	0.12	0.06	4.7	33	54	58.4	87.1	174	290

SAN Hospital Testing (29/12/2011)

Blood Pathology (29/12/2011)

CRP 9.8 H RCC 3.7 L; Hb 122 L; RDW 15.7 H; Lymph 0.6 L Albumen 33 L ALP 426 H; GGT 77 H Creatinine 58 L

Chest X-Ray (29/12/2011)

Small bilateral pleural effusions

Ultrasound

Legs (No DVT found)

Treatment Recommendations

1. Lifestyle & Dietary Changes

• Maintains healthy diet and lifestyle

2. Supplement Programme

Continue guidelines as per last visit

Update & Phone Consultation: 4/4/2012 & 5/4/12

Case Discussion

- Patient had lungs re checked with a CT Pulmonary Angiogram on the 22/3/2012, which was compared with previous examination 24/11/2011.
- The scan showed complete resolution of previous pulmonary emboli and near complete resolution of the L pleural effusion, but little change in the large R pleural effusion.
- However, the overall situation of the R lung had significantly improved with marked reduction in septal thickening and basal predominance, plus normalisation of previous marked lymphadenopathy.
- Overall, a marked improvement in his lung situation. He was still on Clexane and advised to continue given the general lung situation.
- PC/Bone metastases situation had also improved with reduction in PSA from 290 to 8.48 & ALP from 574 to 192. Blood tests also revealed improvement in anaemia, LFT's, renal function (creatinine 58 to 60) & low protein (low albumin 33 to 38) due to the reduced lymph oedema.
- Although he felt a lot better in his general wellbeing, the concern was still the sensation of fluid in the R lung, with breathing difficulty and shortness of breath, so R lung was drained at the hospital visit.
- As he was improving, I advised continuing the current treatment programme, but doubling the lung drainage/expectorant herbs.
- Overall, an excellent change and very good outcome to the previous dire situation. Given he was very close to death in December, a remarkable turnaround.

Pathology

PSA Readings

	06/ 2006	08/ 2006	02/ 2007	6/12/07	25/6/09	12/2/10	19/7/10	23/11/10	03/3/11	19/9/11	15/11/11	14/4/12
Total PSA	35	1.4	0.12	0.06	4.7	33	54	58.4	87.1	174	290	8.48

Blood Pathology (14/4/2012)

RCC 4.2 L; Hb 131 NR; Hct 0.39 L; Lymph 0.6 L

Albumen 38 NR

ALP 192 H; GGT 48 H

PSA 8.48

SAN Hospital Testing (22/3/2012)

CT Pulmonary Angiogram (22/3/2012)

• Comparison made with previous study of 24/11/2011.

• No residual pulmonary arterial defects suggestive of thromboembolic disease can be identified.

• Near complete resolution of the L pleural effusion. The moderate to large R pleural effusion is unchanged in volume.

• Perihilar soft tissue density and peribronchial thickening, intra-and intralobular septal thickening involving the R lung with basal predominance have markedly decreased in extent (? treated lymphangitis).

• Diffuse sclerotic metastatic disease is noted throughout the imaged bones.

• Conclusion: resolution of the previous pulmonary emboli.

Treatment Recommendations

1. Lifestyle & Dietary Changes

• Maintains healthy diet and lifestyle

2. Supplement Programme (supplement programme changes*)

Continue guidelines as per previous visit incorporating the following changes:

• Immune Tonic & Lung Herbs* – 5ml bd of Immune Herb & 10ml bd of Lung Herb

For Other Health Conditions:

• Lung Expectorant Herbs* for lung collapse/effusion/mucous congestion – 10 ml bd

Visit 12: 1/6/2012 & Update: 30/7/2012

Case Discussion

- Patient's lungs and shortness of breath improved further with extra Lung Herbs and R lung drainage in April.
- Patient continued Clexane given concerns about emboli and blood clotting.
- Energy was also markedly improved as well.
- Patient visited Oncologist for assessment of his PC.
- The Oncologist was most surprised by dramatic turnaround in not only his general health (as he never expected him to be alive), but the significant decrease in his PSA from 290 in Nov 2011 to 8.48 in April 2012. He attributed most of this change to the Zoladex, which he assumed had been done in both Nov 2011 and Feb 2012.
- However, patient had not done the Feb injection, so most of the dramatic reduction can only be attributed to the addition of increased immune support namely RBAC, Beta 1,3/1,6 Glucan Shitake Mushroom Complex, Immune Herbs, plus increased dosages of key remedies especially Immune Modulating Formula, and Anti-infalmmatory Formula, Vitamin D, Zinc, Magnesium, and other supporting remedies like Vegetable Enzyme Formula, Vitamin C capsules, Bone Support Formula, Rice Protein Powder, etc.
- It was decided to continue the reduced Zoladex frequency to 6 monthly intervals, so he did the May injection as programmed.

- Blood testing in July revealed further reduction in PSA to 3.55 (NR), ALP also returned to normal range, being 101, plus chemistry now in normal range. Except for slightly low RBC & WBC counts (iron dosage was increased), blood profile had improved considerably.
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Pathology

PSA Readings

	06/ 2006	02/ 2007	25/6/09	12/2/10	19/7/10	23/11/10	03/3/11	19/9/11	15/11/11	12/2/10	14/4/12	24/7/12
Total PSA	35	0.12	4.7	33	54	58.4	87.1	174	290	33	8.48	3.55

Blood Pathology (24/7/2012)

Albumen 42 NR

ALP 101 NR; GGT & LFT's/Chemistry all NR

PSA 3.55 NR

Treatment Recommendations

1. Lifestyle & Dietary Changes

• Maintains healthy diet and lifestyle

2. Supplement Programme (supplement programme changes*)

Continue guidelines as per previous visit incorporating the following changes:

For Other Health Conditions:

• Iron, Folate, Vitamin B12 for low grade anaemia* - increased dosage due to anaemia

• Lung Expectorant Herbs* for lung collapse/effusion/mucous congestion – 10ml bd

Update & Phone Consultation: 25/8/12, 6/10/12, 1/11/12 & 18/12/12

Case Discussion

- Patient suffering from blood in the urine from early August, which had stopped by the time he spoke to me on 25th August. Urinary herbs prescribed as an interim measure until he saw the urologist in September.
- Urologist performed a cystoscopy in mid September to determine cause of the bleeding.
- Examination revealed that bleeding was due to radiation damage to bladder wall some 8yrs earlier, plus aggravation from the blood thinners (Clexane) taken since Dec 2011 (which he stopped in August when the bleeding started).
- Following the procedure, bleeding returned, but much worse than before and would not stop. A catheter was inserted for a week, but after its removal, he had several blockages of the urethra, by clots, over the following 2 weeks, necessitating several return visits to hospital.
- As the bleeding would not stop, the urologist booked him into hospital to have a 2% Formalin injection into the bladder, which was scheduled for October 10th.

- Patient was not happy about having the procedure, so contacted me for assistance, and postponed the procedure to allow the herbs, nutrients and natural healing time to work.
- Increased dosages prescribed of Anti-inflammatory Formula (3 capsules tds), Vitamin C capsules (3 capsules tds), Zinc (3 tablets daily), plus some new Urinary Herbs, which he began on 8th October.
- Within a few days bladder symptoms had dramatically improved, with no bleeding or clots since starting the herbs. He contacted me again on the 1st November, confirming that the bladder was excellent with no symptoms present.
- I spoke to him again on the 18th December to update the bladder situation and assess his recent blood tests. His bladder was fine with normal flow and no bleeding since early October, so it was decided to discontinue the herbs.
- His blood tests were also very good, with PSA stable at 3.63, chemistry normal (ALP 98), and slight anaemia (Hb 129, HCT 0.39, RCC 4.2) and & lymphocytes at 0.9.
- He also reported not doing the scheduled Zoladex injections (scheduled for August & November) until the blood results were in.
- Given his PSA was remarkably stable at 3.63 & ALP at 98, and as he was feeling quite well, it was decided to postpone the Zoladex until next year and reassess after next round of blood tests. The only treatment change to his programme was to increase his iron blood building formula.

PSA Readings

	06/ 2006	02/ 2007	12/2/10	19/7/10	23/11/10	03/3/11	19/9/11	15/11/11	12/2/10	14/4/12	24/7/12	10/12/12
Total PSA	35	0.12	33	54	58.4	87.1	174	290	33	8.48	3.55	3.63

Blood Pathology (10/12/2012)

RCC 4.2 L; Hb 129 L; WBC NR; Lymph 0.9 L

Albumen 41 NR

ALP 98 NR; GGT & LFT's/Chemistry all NR

PSA 3.63 NR

Treatment Recommendations

1. Lifestyle & Dietary Changes

• Maintains healthy diet and lifestyle

2. Supplement Programme (supplement programme changes*)

Continue guidelines as per previous visit incorporating the following changes:

For Other Health Conditions:

• Iron, Folate, Vitamin B12 for low grade anaemia* – Increased dosage due to anaemia

• Lung Expectorant Herbs for lung collapse/effusion/mucous congestion* – 5-10ml bd

• Re Haematuria: Urinary Herbs* – 7.5ml tds or bd

• Increase Anti-inflammatory Formula* to – 3 capsules tds

• Increase Vitamin C* to – 3 capsules tds

• Increase Zinc* – 3 tablets daily

Update & Phone Consultation: 9/2/2013

Case Discussion

- Patient called in for review of his blood tests and discussion following yesterday's oncologist visit on the 8th February.
- Feeling well except for slight shortness of breath and lung sensation. Recent blood tests revealed PSA had increased to 8.87 and ALP to 115, with slight anaemia (RCC 4.0, Hb 129, Plat 133).
- No Zoladex injections since May 2012 (missed Aug 12, Nov 12, Feb 13), so perhaps given the increases in PSA/ALP plus SOB it was decided to do Zoladex over the next couple of months.
- Increased his Iron again, as he perpetually has an issue with low Iron, eats little meat, and has bone metastases.

PSA Readings

	06/ 2006	02/ 2007	12/2/10	23/11/10	03/3/11	19/9/11	15/11/11	12/2/10	14/4/12	24/7/12	10/12/12	9/2/13
Total PSA	35	0.12	33	58.4	87.1	174	290	33	8.48	3.55	3.63	8.87

Blood Pathology (9/2/2013)

RCC 4.0 L; Hb 129 L; WBC NR; Lymph 0.8 L; Plat 133 L

Albumen 42 NR

ALP 115 NR; GGT & LFT's/Chemistry all NR

PSA 8.87

Treatment Recommendations

1. Lifestyle & Dietary Changes

Maintains healthy diet and lifestyle

2. Supplement Programme

- RBAC – 1 sachet bd
- Multivitamin – 1-2 capsules am
- Vitamin C – 1-3 capsules bd
- Zinc (30mg) – 1 tablet bd
- Flaxseed Oil – 1-2 tablespoons daily

- Selenium – 200mcg daily
- Natural Vitamin E – 500IU daily
- CoQ10 – 100mg bd
- Colostrum and co-factors – 1 teaspoon daily
- Magnesium Chelate/Orotate/Aspartate – increase to 2 tablets bd
- Green Drink – Green Barley, etc
- Cod Liver Oil (Vitamin D) – 5ml daily
- Fish Oil – 5ml daily
- Anti-inflammatory Formula – increase to 2 capsules bd
- Vegetable Enzyme Formula – 1g 4 times daily
- Vitamin B12 – 1 tablet bd
- Calcium/Bone Matrix Formula – 1-2 tablets daily
- Immune Modulating Formula – increase to 2 capsules bd
- Vitamin D – 2 capsules bd
- Beta 1,3/1,6 Glucan Shiitake Mushroom Complex – 2 teaspoons bd
- Rice Protein Powder – 1-2 scoops bd
- Immune Tonic & Lung Herbs – 5ml bd of Immune Herbs & 10ml bd of Lung Herbs

For Other Health Conditions:

- Glucosamine/Chrondroitin for arthritis
- Slippery Elm, Psyllium, Probiotics, Vegetable Enzyme Formula for managing bowels
- Bilberry, Lipoic Acid for glaucoma
- Iron, Folate, Vitamin B12 for low grade anaemia* – increased dosage due to anaemia
- Anti-inflammatory Formula, Magnesium Chelate/Orotate/Aspartate, Phospholipids for stroke/CVA prevention
- Lung Expectorant Herbs for lung collapse/effusion/mucous congestion* – 5-10ml bd
- Re Haematuria: Urinary Herbs* – stopped Feb 2012