Day 2,745 — Conversation With the R.O.

May 17, 2018 By Daniel Zeller

When I was in 7th grade, I had to give a presentation on my science project, an erupting volcano, and I was so anxious about the presentation that I became physically ill and erupted myself. Not pretty. While I didn't get physically ill today, the feeling was almost the same as I waited to see the radiation oncologist. It's silly, I know. But it was very real.

In a nutshell, his recommendation was to start salvage radiation therapy.

The R.O. is a Navy captain medical officer, and we spent nearly forty-five minutes going over my case (which I truly appreciated). He took control of the conversation from the outset, explaining the options and consequences of each. I could tell that he had given this little presentation once or twice before. Once we got through that, we did have a real conversation. Some key points:

- He disagreed with the notion that the increasing PSA is from residual benign prostate tissue left behind.
- He was confident that the cancer would be in the prostate bed based on my numbers and statistics.
- He talked about the differing definitions of biochemical recurrence, saying that the American Urological Association (AUA) and American Society for Radiation Oncology (ASTRO) use the 0.2 ng/ml threshold, but the National Comprehensive Cancer Network (NCCN) defines recurrence as a detectable PSA with two consecutive increases. My case meets the NCCN definition.
- Continued surveillance is a viable option for me given my numbers and PSA doubling time.
- We talked about the short and long-term side effects of radiation therapy: urinary control, sexual function and bowel control. His estimate the probability of long-term quality of life-impacting side effects in any of the three areas to be in the "single digits."
- He reminded me of selection bias when talking to other patients or bloggers about their side

effect experiences. Yes, their experiences are very real, but for each person in an online forum, there are many others outside the forum who are leading productive, acceptable lives.

- If we were to do salvage radiation therapy now with my PSA under 0.2 ng/ml, he put the probability of me having no evidence of disease five years from now at seventy-five percent. If we wait until my PSA is above 0.2 ng/ml, that number decreases.
- Newer scanning technologies weren't likely to pick up anything at my current PSA levels, yet he was open to the idea of them if it gave me peace of mind.
- With my numbers, there is no reason to radiate the pelvic lymph nodes or use androgen deprivation therapy (ADT).
- He was open to waiting until the August PSA results to see what they revealed before making a decision.

It was a good conversation, but I'm sorry to say that I don't know that there was a lot of new information for me there that would tip the scale either way. The doctor wasn't pushy in one direction or the other, saying that it was equally reasonable for me to continue surveillance or for me to begin salvage radiation therapy. The choice is mine. About the only thing he was adamant about was not starting ADT, and I'm in perfect agreement with him on that.

I did learn one really interesting thing, however. The reason that the VA Medical Center referred me to Naval Medical Center San Diego has to do with geology. Apparently VA Medical Center San Diego (La Jolla) was built sufficiently close to a geological fault line that they couldn't build a radiation "bunker" that would be safe in the event of an earthquake.

What's next for me? A ton of thinking, reflecting, and reevaluating.

Enough for now. I'm spent.

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