New ways in diagnosis and therapy in prostatic cancer

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Ladies and gentlemen!

I am an urologist and have an academic career at the University Clinic in Düsseldorf behind me.

This included 15 years of performing operations, giving lectures, looking after students and performing scientific work myself having 8 doctorands.

Finally I was the Acting Director of the University Clinic in Düsseldorf.

I have always found oncological themes interesting.

My professional habilitation deals with "hormone receptors in renal carcinoma in humans".

This referred to the treatment in case of a positive hormone receptor level and metastases of renal carcinoma with progesterone.

This procedure is similar to that of mamma carcinoma today. The results of this research was shown to high receptor levels, so the treatment with clinovir has been given up.

As I was not entirely satisfied with general cancer treatment, I decided to go off in a new direction and have been working for the last 20 years in the field of complementary biology.

I have written books about complementary options, held many lectures and I am also represented on the Internet.

In this context I have also thought about new approaches to the diagnosis and therapy of prostatic carcinoma.

For example, my opinion that a biopsy is not always immediately necessary is also shared by other leading urologists.

General remarks on prostatic carcinoma:

School medicine has a variety of procedures available to treat prostatic carcinoma, e.g.

1 Radical prostatectomy

2 Radiation

3 Laser procedures

4 HIFU (high-focused ultrasound)

5 Chemotherapy

6 So-called "watchful waiting" or "active surveillance"

7 Hormone blockade

Radical prostatectomy

As far as this procedure is concerned, a complete cure is of course possible.

However, in about 35 to 60% of cases cancer can return. Either in the form of metastases or local recurrences.

Furthermore, the patient is threatened by urinary incontinence; faecal incontinence also occurs. Impotence, which almost always occurs. Impotence occurs always. Inspite of the so called nerve sparing operation where the dorsal nerve-bundle is not cut.

Radiation is often performed as an alternative to an operation.

I myself see many recurrences.

I often see several side effects concerning bladder and colon.

Once a patient had to receive an anus praeter due to a strong burning of the colon.

As far as lasers and HIFU are concerned, it is known that these are often only used to treat small benign prostates and in selected cases of prostatic carcinoma.

Chemotherapy, is used as ultima ratio so to speak, with little success in the treatment of metastasising prostatic carcinoma (e.g. Taxotere).

Concerning watchful waiting this option is chosen because it is not known what can be done at an early stage (e.g. direct shortwave warming of the prostate).

Hormone blockade is a tried and tested method. However, it should not be used too early, and it should it be interrupted, as otherwise there is a danger of hormone deafness..

There is a central, enzymatic and a receptor blockade.

By the way, I was one of the first in the world to analyse prostate tissue with respect to receptors in 1978/1979.

Complementary procedures, question of biopsy, radiological diagnosis

The possibility of modern radiological procedures gives us an alternative to immediate biopsy. If there is no palpation and no ultrasonic suspicion where we have to take biopsy, even a certain danger of spread is always given. Biopsy could not be replaced by MRT but we can approach diagnosis.

False negative findings also occur often because the focus is missed, but the PSA continues to rise.

Here I have to explain to you why magnetic resonance tomography can often be beneficial. While a biopsy only provides an analysis of various points in the tissue, an MRT allows an analysis over a large area of the malignant tumour with respect to the gland, capsule, seminal vesicles, fatty tissue and lymph nodes.

We can get an anatomic picture of the whole region.

Amongst other things, an MRT detects when lymph nodes have been invaded by a carcinoma by means of radiological criteria such as signal reductions or signal increases. This is also supplemented by a choline PET CT, where tumour masses show choline accumulation.

So an MRT can show suspicious points and localise them, as well as their extent. An MRT can therefore enable nexact.

The very important question is:

Is an operation in general possible or not. Can I cure the patient with an operation if the capsule shows a perforation.

If there is a perforation of the capsule and we think of micrometastase procedures, often there is a bigger spreading of tumorcells as even modern radiological methods are able to detect.

If for example the choline PET CT shows large retroperitoneal lymph nodes, no conventional procedure can help, but shortwave radiation can try it.

The MRT and the choline PET CT serve two questions:
1. pre-therapeutic situation analysis
2. post-therapeutic success control.
(e.g. after shortwave treatment, as explained below).

The therapy

1. Transurethral prostate warming

Via a treatment catheter with an intra-prostatic heat receiver, three-dimensional shortwave rays are transmitted into the prostate and its surroundings. About 34cm deep.

As a result it is possible to perform heat therapy in the early stages of a prostate tumour that has been detected by MRT, so that it is not necessary to wait until it gets worse (watchful waiting!). This can be readily applied to risk patients! The success of the therapy is objectified by means of an MRT control.

As long ago as 1932 E. Schliephake, the German doctor wrote a scientific work about shortwave therapy.

Also in cases of metastasising prostate carcinomas, where school medicine has no further options available, shortwave hyperthermia can be used to the patient's benefit.

What am I trying to tell you?

1. An immediate biopsy is not always necessary

2. Make use of the excellent diagnostic opportunities available in the form of MRT and choline PET CT

a) also to avoid unnecessary and ineffective ant to early operations

b) to check the possible therapeutic success of shortwave treatment.

3. This treatment also allows us to act at an early stage, where otherwise the course of action would be either to wait and see or perform a hasty operation. And it also gives us the opportunity to treat in high-risk and elderly patients.

4. It is possible to achieve therapeutic successes even if school medicine has used all options.

5. It may be possible to reduce the size of tumour masses to such an extent that they can then be subjected to radiation treatment, for example, where this was previously not possible.

6. Improving accuracy if a biopsy is required.

7. We have to think new about the indications of operation, radiation and at least equal chemotherapy.

8. We operate too much.

9. We have to think over the clinical value of new radiological methods and their consequences of doctors acting.

Thank you