

appraisals of the life of Jesus and its value for us today (Wilson, 1993; Polkinghorne, 1994).

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**Me Too: A Doctor Survives Prostate Cancer** by James Payne. Waco: WRS Publishing, 1995, 141 pp., \$11.95. ISBN 1567960863.

**How I Survived Prostate Cancer... and So Can You: A Guide for Diagnosing and Treating Prostate Cancer** by James Lewis. Westbury: Health Education Literary Publisher, 1994, 264 pp. \$18.95 (p). ISBN 1883257069.

**Prostate and Cancer: A Family Guide to Diagnosis, Treatment & Survival** by Sheldon Marks. Tucson: Fisher Books, 1995, 342 pp., \$14.95 (p). ISBN 1555610781.

**Prostate and Cancer: A Non-Surgical Perspective** by Kent Wallner. Canaan: SmartMedicine Press, 1996, 156 pp., \$15.95 (p). ISBN 0964899108.

**The Prostate Book: Sound Advice on Symptoms and Treatment** by Stephen N. Rous. New York: W.W. Norton, 1994, 287 pp., \$22.95 (c).

**A Patient's Guide to Prostate Cancer: An Expert's Successful Treatment Strategies and Options** by Marc Garnick. New York: NAL/Dutton (Plume Book), 1996, 276 pp., \$11.95 (p). ISBN 0452274559.

**The Prostate Cancer Answer Book: An Unbiased Guide to Treatment Choices** by Marion Morra and Eve Potts. New York: Avon Books, 263 pp., \$12.50 (p). ISBN 0380785641.

Frankly, blips in random number generators, unexplained output from white noise devices or barely detectable magnetic fields are, to use a fashionable colloquialism, not where it's at. A much richer vein of anomalous science may be found in the medical field with the true mother lode being prostate cancer. To use another metaphor, prostate cancer is a growth industry which has become a growth industry in books about prostate cancer; the above eight books are merely a sample of what can be found in libraries and book stores.

The boom in prostate cancer and its subsequent literature — unlike TB, AIDS or the Ebola virus — has nothing to do with any sudden epidemic that threatens the foundations of Western Civilization. The amazing rise in

detection rates and the consequent rise in treatment rates are due to the relatively new blood test, the PSA (Prostate Specific Antigen), and ultrasound-guided biopsies prescribed after an abnormal PSA. An earlier blood-test had been unreliable to the point of being useless while the familiar but often-dreaded DRE (digital rectum exam) was likewise too crude. Men who are completely asymptomatic suddenly find out that they have prostate cancer. In the era of the PSA, this is now so common that there is a new category just for them, T1C, which means that except for the PSA which generated the referral for the biopsy, these men would have been given a clean bill of health on a general physical.

An interesting issue is whether or not society is better off now that the PSA is so widely available. Obviously, for some men, early detection of prostate cancer plausibly leads to cure because if the cancer is not treated, cancer being cancer, eventually it will spread and the patient will die. However, prostate cancer is rather unique among cancers in that it is often very slow growing and many can die with it and not of it. In fact, autopsies of elderly men who die of other causes and who were never diagnosed as having prostate cancer, reveal that some 40% to 50% of them have prostate cancer and most not only never knew it but also never suffered any consequences from the cancer. And just as important, they never suffered the consequences of the treatment, which can be severe especially when one considers that the effects of the disease may never have arisen.

Compounding the dilemma of continually screening millions of men at \$50 to \$100 per PSA test is the notoriously high number of false positives and false negatives. The PSA, while specific to the prostate, is not specific to prostate cancer; as men grow older, the prostate tends to get larger and secretes more of what the PSA measures. The range of 0 to 4 is usually given as a normal PSA although even this is often age-adjusted so that normal for a young man might be 0 to 3.5 while for a much older person, the upper limit for normal might be 6.5. Prostate infection might markedly raise the PSA as might having the test done at a different laboratory which uses a different scale of measurement! Whether or not bike riding alters the PSA or whether or not the test should be done within 24 hours of an ejaculation is also debatable.

What about a low PSA? Well, if you have prostate cancer and your PSA is low, that is perhaps the worst case because the cancer cells are so unlike normal prostate cells that they are unable to secrete the antigen. Nevertheless, the typical case is a high PSA which results in the need for monitoring over time along with biopsies which can only rule in prostate cancer but cannot rule it out because the guidance mechanism is such that the tumor may be missed by the biopsy needle.

Once a pathologist determines there is a malignancy, the patient's next step depends on his knowledge and the information forthcoming from his urologist. That is where science fades out and luck along with tenacity in the form of a computer comes in. As validated by my own experience and the Internet

e-mail postings I've seen emanating from many others, the urologist is likely to recommend a bone scan to rule out metastasis and then if the bone scan is negative, strongly suggest that as soon as possible a radical prostatectomy (RP) be done because an RP is the "gold standard." External-beam radiation (XBRT), if mentioned at all, is likely to be denigrated by the urologist as not having as good a long-term track record as RP and besides, he (and more than likely it is a he) will say that if the RP fails, radiation can follow as a so-called salvage treatment while the reverse order — radiation followed by surgery — is extremely difficult.

Most of the above advice is at best self-serving and, as I and others have discovered, most probably very much in error. Urologists are surgeons who have spent many years honing their skills and it is only natural that they believe in surgery as a cure. Look carefully at the second sentence of the third paragraph where the word "plausibly" appears. It turns out that, even when the surgery is undertaken because there is no evidence of metastasis and the pathology exam indicates that the cancer is confined to the prostate gland, the patient may still not be cured because some micro cells exist undetected elsewhere in the body; after months or years, the PSA, which should have remained at zero, starts to rise indicating that the cure did not take place.

The curative rate of RP is much lower than I have just indicated because of understaging of the cancer. A relatively large percentage of men go into surgery believing that they are candidates for a "cure" only to find out that the pathology exam performed at surgery indicates that the cancer has escaped the capsule or is in the seminal vesicles or is in the surrounding lymph nodes and the entire operation has to be aborted.

Radiologists protest the assertion of the urologists that surgery is preferable to radiation. Patients who are too feeble or too old to undergo the rigors of surgery receive XBRT and this difference in parent populations between the two techniques vitiates any comparison. Furthermore, no truly large randomized, double-blind experiment comparing surgery with any other modality — including doing nothing but monitoring, otherwise known as watchful waiting (WW) — has ever been undertaken. Some effort is underway in this regard but the long incubation period and the lack of immediate symptoms act to inhibit such efforts. Not to mention the resistance of the surgeons who consider it criminal to doubt the efficacy of their profession. European medical practice is far less aggressive than its American counterpart and hence, observational — that is, non-experimental — studies emanating from Europe tend to indicate that watchful waiting was equally good as surgery; the reaction from my first urologist was entirely typical: he called the European attitude "malpractice."

America is too proactive a country to adopt the attitude of watchful waiting. The prostate Listserve which I am on bears witness to this remark. As soon as WW is mentioned as a legitimate form of treatment, the members of the Listserve who are prostate-cancer victims go predictably bananas using analogies

to the necessity of guns in a world replete with criminals, or the need for weapons in face of a threat from a foreign power. The few WW adherents in the Internet audience are slammed every time they suggest that all too frequently more harm than good is done to the quality of life of someone who is experiencing no symptoms whatever at the present but who will likely be incontinent for at least a few months, impotent for perhaps a lot longer and maybe for life even though the aggressive procedure has a relatively high probability of failure anyway.

However, there is now a bigger European danger to surgery and to XBRT although at this moment few would identify it as European and most would say it is from Washington, the State not the District of Columbia. In the early 1980s, a Danish doctor, H. Holm, modified an earlier technique known as "brachytherapy" or the implantation of radioactive seeds (SI) directly into the prostate; previous implantation of seeds was done during surgery and so to speak, freehand. Holm's idea of ultrasound guidance for the placing of the radioactive seeds via needles was picked up by Dr. Blasko at Seattle's Northwest Tumor Institute where it was greatly improved technically. Blasko and his team have trained many others in this technique and within the last two years I have seen a phenomenal growth in the brachytherapy industry.

The reasons for the growth are simple. Urologists can no longer say that SI hasn't proved itself because now there is seven years, worth of data from Seattle and pushing over five from other centers. My claim that "Urologists can no longer say" does not mean that the average urologist will recommend SI; in fact, more than likely, the average urologist will refer to the failures of the pre-Holm freehand method and either be unaware of Blasko entirely or still insist that 15 years of SI is needed or that Blasko was selective in the patients and dealt only with those whose cancer was indolent.

There is one fact that no one will dispute about SI. Its morbidity and mortality rates are far, far lower than RP or XBRT. There is virtually no incontinence and a much lower rate of impotence. RP requires 5 to 7 days in a hospital with another two weeks of a very uncomfortable catheter. SI is done on an outpatient basis or an overnight. And SI costs less than either RP or XBRT.

That last sentence needs some explaining and like everything connected with money and medicine, it all depends. What one pays for any of these procedures depends entirely on what deals one's insurer has cut with the hospital or the practitioner. My personal experience is illuminating and illustrative. After over a year and one half since my diagnosis and a subsequent accumulation of many pounds of information, I attempted to have my SI done locally even though it was not very frequently performed here. My HMO would pay for everything. Unfortunately, my gland was too large for the equipment; in addition, the local people were changing their protocol such that I would need to undergo six months of hormone therapy to reduce the size of the gland and I would need an XBRT topping in addition to the SI. I balked at what I considered unnecessary treatment with too many side effects: hormones produce a

loss of libido and hot flashes while the XBRT could lead to its own complications. Instead, I decided to choose my out-of-network option, and have the SI done without hormones and without XBRT at one of the Blasko-trained centers where the procedure was performed very frequently. I litigated with my HMO claiming that because the treatment of SI only was not available locally, I should be reimbursed for the \$3,000 maximum out-of-pocket expense; I lost even though by avoiding hormones and XBRT I saved the HMO money no matter how much of a discount the HMO had arranged locally. This was to no avail. Insurers want gate-keeping control of the purse and will fight with everything they've got; in my case, the HMO brought in five people to defend their case, including their chief statistician in case I mumbled something obscene such as standard deviation.

Two other conventional treatments for prostate cancer exist, although one of them is deemed experimental and most probably won't be covered by insurance. Cryotherapy, the freezing of the gland, makes good sense for those who are not willing or able to undergo surgery or radiation of any form. It has the distinct advantage that if it fails, it can be repeated unlike surgery or radiation. One disadvantage in addition to a relatively high likelihood of impotence is that the people pushing it have a vested financial interest in the device for doing the freezing. It is also new enough that there is little data accumulated regarding its efficacy.

A well-established treatment for prostate cancer which has escaped the gland is hormones. Unfortunately, eventually the hormone-resistant cancer cells start to thrive after the hormone-sensitive cancer cells are killed and the patient gets progressively worse. The time period for which the hormones are providing good results is very variable from patient to patient; months for some, many years for others and is rather unpredictable. Although hormone therapy has been around for many years, it is only recently that it is being recommended early on in conjunction with RP, XBRT and SI. The chief recommender is an organization known as Patient Advocates for Advanced Cancer Treatments (PAACT) which is but one of the increasingly many patient-advocate groups in this age of desk-top publishing, the Internet and the World Wide Web. PAACT is very critical of the medical profession in general and stresses the need for the patient to take control of the decision making and not let that be left up to the first medical doctor who is the bearer of the bad news.

In order to take control, a lot of reading of the literature is in order. No one book suffices and frankly, some of the books have bad advice and/or bad prose. Rous' book was first written in 1988 and is out of date completely even though the claim is that it was revised in 1992 and 1994; it is very much a urologist's out-of-date book. Payne's book has no index and is especially disappointing given that he is both a prostate-cancer victim and a medical doctor. He seems to be surprised at every turn of events despite his being a general

surgeon. Impotence is very much on his mind and his RP does result in that and a urethral stricture as well.

Korda's book has been very widely read because of his prominent position as editor-in-chief of Simon and Schuster. But like Payne, he seems woefully uninformed and childish in his concern about the possibility of impotence; again, there is no index. Unlike Payne, Korda has lots of money behind him and he can afford to explore around to find the most famous medical doctors including the most famous of them all, Patrick Walsh of Johns Hopkins. Walsh is the inventor of the so-called "nerve sparing" operation. Until Walsh discovered back in the 1980s that the nerves for an erection are on the outside of the prostate and therefore, severing them could be avoided, impotence was always the result of RP. Walsh is invariably quoted and cited in any article having to do with prostate cancer and he is considered the god in the field. Unless, of course, you believe that his success rate is due to his very careful selection of candidates who are likely to be young, otherwise healthy, have small tumors and are potent before the operation. Urologists who don't train at Hopkins tend to view Walsh with a great deal of statistical suspicion; those who trained at Hopkins tend to idolize him.

Korda's opinion is very strange. From what Korda has written, the care and advice he received at Hopkins was terrible. He still is unable to have an erection and many complications resulted which could have been avoided, yet he still seems to believe that selecting a Walsh RP was a wise choice. Korda is a relatively wealthy man so money was no object but few of us can afford helicopters from Hopkins to home as he did.

The book that was the most useful to me was the one by Lewis because it arrived at the time I was about to make my decision. The 1994 publication date means that the book did not contain the latest statistics on SI but was very detailed as to the procedure and why it should be considered along with any of the others. Lewis is an African-American, a group that has a much higher incidence of prostate cancer than whites do. He chose XBRT and by all indications is doing very well. His book was sent to me courtesy of PAACT and in many ways reflects PAACT's view of things but happily, without PAACT's oft-times unnecessary bombastic pronouncements. Of all the survivor books, Lewis' is the best and the one the patient should get first even if it is two-years old in this fast-changing field. To show how fast things are changing, during the time I have composed this review, the SI world was reeling because it was announced that Blasko was severing his connections with NWT and would be moving to another part of Seattle to join the University of Washington to launch an academic career. The consternation has to do with litigation between Blasko and what would be his former associates over who owns the data. The implication is that the public will be denied further post-treatment information regarding how well SI is doing while the lawyers fight over ownership.

Wallner is very highly thought of by the people on my Listserve. He is a radiation oncologist and thus doesn't suffer from the same biases as urologists. His book is short and the type is large yet he seems to cover all the bases. This is a good book to own. The other two books by medical doctors, Garnick and Marks, are longer and certainly worth reading, especially Garnick's. In fact, the issue of length of a book on prostate cancer is not without interest. Some men such as myself have an insatiable appetite for reading the literature while others are far more likely to trust any authority figure in a white jacket. The former group can suffer from "analysis paralysis" while the latter group can repent at leisure for a decision based on faith. For those of us hooked on the subject of prostate cancer, **Garnick's** is the best read.

The book by Morra and Potts is rather dry but it is exceptional in that it is written by two (non-medical) people who will never get the disease because they are women. The Listserve which I have referred to has an increasing number of women members but understandably they are in the minority. And sometimes they object vigorously to the more infantile sexual comments made by prostate-cancer victims who have too much bandwidth at their disposal. The clutter — chit chat about dogs, God, soy protein, quality of erections, saw palmetto and shark cartilage — has become so acute that I routinely delete most of the messages before reading them. If I go away from my computer for an extended period, my mailer gets swamped with childish messages by men who have too much time on their hands and an overactive modem.

Unsubscribing to the Listserve is easy but I hesitate to take that step inasmuch as the course of the disease is unpredictable as are the medical (and statistical) advances in treatment and prevention; my fellow victims, despite their immaturity, are a valuable resource for conventional and anomalous results delivered several times daily. It would be difficult to find another area of human endeavor where such a vast quantity of personally-relevant and contradictory scientific information arrives so effortlessly.

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**Expedientes Insolitos: El Fenomeno OVNI y los Archivos de Defensa** by Vicente Juan Ballester Olmos. Madrid, Spain: Temas'de hoy, 1995.

Having known Vicente-Juan for many years I continue to marvel at his long-standing personal dedication to high quality UFO research and his prolific writing for the benefit of others. He has produced four major and excellently written books about UFOs and, unfortunately for English speaking people, all are in Spanish so far. Nevertheless, his research is first rate and his selection of topics is both interesting and valuable. This is no less true for his latest