

DATTOLI CANCER FOUNDATION

Journey

FALL 2019

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Engineer, entrepreneur and pilot Kevin Chafee is soaring again, and sharing his Prostate Cancer experience with others. }



FROM THE EDITOR

Getting Away

As I write this, I am 10 days home after a wonderful vacation. Having worked full time all my life, I had never taken more than about 10 days off in a row before. This time I was gone for six glorious weeks.

My husband and I planned this trip for 10 months, kind of as a belated honeymoon. Having sweated away August 2018 in steamy South Florida, we made a pact to be somewhere else in August 2019. Our goal was to be relaxed and cool, with our Border Collie and 23-foot SeaRay. Through VRBO, we found a nice-looking lodge on the banks of Green Bay, in Door County, Wisconsin, in the unincorporated town of Gills Rock.

Although the trip would require some repairs on our boat and trailering it 1600 miles each way, we set off on August 5 with great excitement and arrived on August 9. The next four weeks were spent boating, hiking, resting, reading, eating, making friends and photographing the beautiful sur-

roundings. Of the four weeks, we only had about four rainy days that required staying in. Even watching the squalls move across the water was a beautiful sight, mesmerizing and entertaining.

Getting away really is a tonic. Everyone should try to do it as often as possible. Waking each morning with no agenda is a blessing. As hard as I tried to let go of stuff, it somehow remained in the corners of my mind. September was around the corner and that meant Prostate Cancer Awareness Month.

To address my long-standing commitment to educating the public about this disease, I wrote a quick "What you need to know" article and submitted it to the *Peninsula Pulse* weekly paper (circulation 18,200). I am delighted that it was published on September 5, a few days before we left for the long drive home. I'm always thinking about you guys and your partners, on your journey or mine. ❶

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Journey

FALL 2019

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Remembering Meg



ALEX STAFFORD

For many new patients, the sit-down and tour with Meg Brockett on their first day was a welcoming introduction to the philosophy of the Dattoli Cancer Center. After meeting with the clinical staff and enduring tests and examinations, the opportunity to relax and ask individual, personal questions about treatment – and beyond – was a calming time for anxious patients and family members.

Meg left Dattoli Cancer Center about two years ago, getting married and joining her husband in his business.

In May, we learned the distressing news that Meg was fighting ovarian cancer. In fact, she succumbed to the disease on May 14, 2019. She was just 49 years old.

It is difficult to imagine that someone so vibrant and full of life is gone.

Meg was from Severna Park, Maryland, the daughter of a prominent attorney. She is survived by a brother, Paul, and a sister, Catheryn, and her husband, Christopher D. Brantley.

For nearly a decade, Meg was an integral part of the Dattoli marketing department and assisted with Dattoli Cancer Foundation activities. She was instrumental in creating and updating the award-winning Dattoli Patient Handbook. Meg will be remembered for her sweet demeanor and warm personality. 📍



Prostate Gland Capsule: Fact or Fiction?

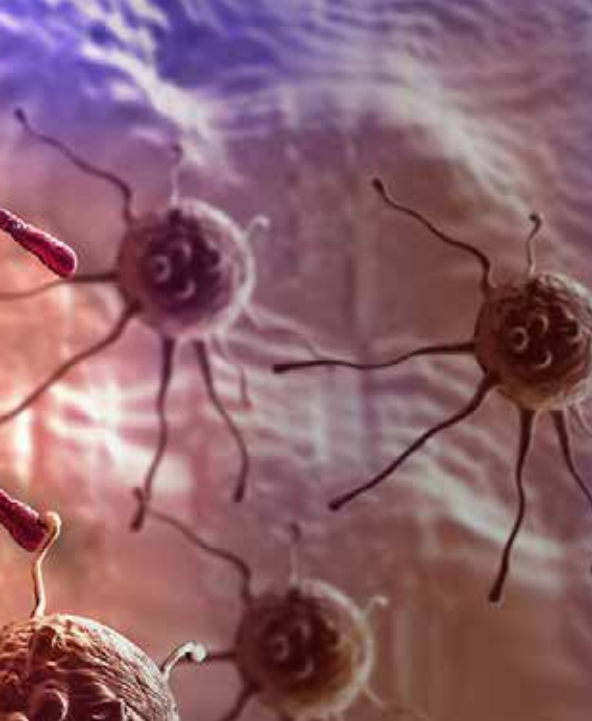
AMONG THE MANY MYSTERIES OF THE PROSTATE GLAND IS THE QUESTION OF WHERE IT BEGINS AND WHERE IT ENDS. FOR DECADES UROLOGISTS AND ONCOLOGISTS HAVE ESSENTIALLY ASSUMED THERE WAS A CAPSULE.

BY MICHAEL DATTOLI, MD,
WITH VIRGINIA CARNAHAN, APR, CPCR

Having worked with prostate cancer patients for nearly 30 years, I learned long ago that there is no true prostate capsule, and that many treatment failures – including radical prostatectomy, cryosurgery, HIFU, brachytherapy (as monotherapy) and many other modalities – result from the absence of a true capsule. In reality, the prostate is more akin to an egg without the shell or an orange without the peel.

Despite this, the presence of a capsule would certainly be helpful in describing the location of tumors and the extent of cancer, and in designing the treatment plan.

“The capsule” has been used as a sort of delineator of prostate cancer stage. Is the cancer contained in the capsule or has it “escaped the capsule”? This is an important piece of information, as it would determine whether any type focal therapy, especially radical prostatectomy, could adequately treat the disease, and how the radiation plan would be designed to reach cancerous tissue beyond the “capsule.” Cancer outside the capsule presents challenges to any chosen treatment protocol.



The American Urological Association (AUAnet.org) confirms: “The Prostate does not have a true capsule but an outer condensed fibromuscular band, which is an inseparable component of prostatic stroma. For convenience it is often referred to in the literature as prostate ‘capsule.’” Its absence is not even realized by most physicians. Even if there was a capsule, the fibromuscular stroma is absent at the prostate base (top of the gland) and prostate apex (bottom of the gland). These are the two most common areas where prostate cancer escapes.

As more physicians acknowledge this contrary finding, they are faced with finding new ways of describing diagnosed prostate cancers and devising accurate treatment plans. Where does one start and stop, either cutting or radiating? The word “capsule” must be eliminated from the prostate cancer language and be replaced with the more accurate “edge,” and if the tumor advances outside the gland, this would be appropriately labeled as “extraprostatic extension” (ePe) rather than extracapsular extension.

Younger men, age 40 to 60, are categorically told by scalpel-happy urologists, “You are young, so we need to just cut that cancer out.” Looking toward future years, the urologist wrongly implies that surgery will resolve their cancer problems and that these “young” men can go on to live cancer-free, care-free lives.

In fact, it is the polar opposite. Surgery, whether traditional open or robotic, that leaves cancer behind dooms the “young” patient to years of chasing the cancer cells which are left behind

But take a look at this, found on the “Teach Me Anatomy” website [emphasis added]:

“The prostate is commonly described as being the size of a walnut. Roughly two-thirds of the prostate is glandular in structure and the remaining third is fibromuscular. The gland itself is surrounded by a thin fibrous capsule of the prostate. This is not a real capsule; it rather resembles the thin connective tissue known as adventitia in the large blood vessels.”

Additionally, “The fibromuscular stroma” (or fourth zone for some) is situated anteriorly in the gland. It merges with the tissue of the urogenital diaphragm. This part of the gland is actually the result of interaction of the prostate gland budding around the urethra during prostate embryogenesis and the common horseshoe-like muscle precursor of the smooth and striated muscle that will eventually form the internal and external urethra sphincter.”

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Prostate Gland Capsule: Fact or Fiction?

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in the "prostate bed" (no surgery completely removes all prostate tissue), and they can leak out from the prostate bed and into the body via blood vessels and lymph nodes. We have seen countless numbers of men post-surgery, whose prostate cancer had escaped this way, presumably sometime before they underwent their operations.

We know from advanced scanning electron microscopy images that prostate cancer resembles the "Daddy Long-legs Spider," with a small body but very exaggerated, long microscopic legs (tentacles) that reach out through the edges of the prostate gland.

Urologists often take advantage of the term "capsule," as most cancers of the prostate begin on the edge (peripheral zone – PZ) and extend microscopically into tissues outside the prostate (ePe). Microscopic findings are not seen on mpMRI, PET scans or CT scans, so the urologist tells the unknowing patient that the cancer is "contained." Meanwhile, the urologists' referred radiologists are often complicit in this deception by never uttering the words "extra-capsular extension" or "prostate capsule."

Consider this, comparing prostate to breast cancer: When a woman is found to have a cancer the size of a BB, her surgeon will excise as much surrounding tissue as possible, at times even removing the entire breast. When a pea-sized tumor is found in the colon, typically 18 inches or more of bowel is removed. Bottom line is that a significant swath of cancer-free tissue is typically excised with every other malignancy, except for the brain (and other rare sites),

to ensure complete removal. If a tumor cannot be removed with a swath of normal tissue, then post-op radiation is immediately arranged for most other cancers, but rarely the prostate.

Additionally, cancer surgery should be "bloodless," otherwise the cancer cells coming with circulating blood, allowing them to disseminate throughout the body, leading to bone metastases and/or lymph node spread.

For decades we have heard nightmarish stories of patients who went to the hospital for cancer surgeries and later reported that "as soon as the air reached the cancer, it exploded throughout the body." This old-timers' evaluation was actually the experience of cancer cells gaining access to the normal blood circulation and escaping through the blood stream, and not the exposure to oxygen.

The prostate gland is so vascular and entangled by so many vessels that it is impossible to make its removal a "bloodless" operation. The prostate is literally wedged between many critical structures – e.g., the bladder, rectum, neurovascular bundles (NVB), urogenital diagram, etc. – so there can be no successful attempt to remove a swath around the prostate, as is the case with so many other cancer operations.

In prostate surgery, the gland is simply "shucked out" and as a matter of necessity the internal sphincter of the bladder is severed, frequently leading to incontinence issues and the potential need for life-long use of diapers. The more fortunate surgical patients will only have to deal with varying degrees

“The post-surgery patients that we see every week in our practice are often anxious, depressed and angry that their surgery did not eliminate their prostate cancer, as was initially promised by their urologists. They now face additional treatment to locate, track and then treat the cancer in places outside the gland.”

- Michael Dattoli, MD

of stress incontinence. Also, the NVB is typically severed, leaving the man with permanent erectile dysfunction.

Most important, however, is that without a true capsule to define the surgical field, active cancer is likely to be left behind by unknowing urologists, leaving these patients to require post-operative radiation therapy when the PSA rises and compounding side effects. Without post-operative treatment, the patient is doomed to experience local recurrence (or more accurately persistence) or metastases to lymph nodes and bones for many years, and eventually succumb to the disease.

Bear in mind that when radiation alone is utilized to treat prostate cancer, every effort is made to avoid the bladder and rectum. After surgical removal, however, the bladder and rectum fall down into the cavity where the prostate once resided (the prostate fossa or bed), making it impossible to spare these critical organs when delivering adjuvant (follow-up) radiation. So much for what the surgeon typically tells a man: "If you have radiation first, we will have a very difficult if not impossible time removing the prostate if cancer

returns." The reverse scenario (surgery first before radiation) is far worse. The truth of the matter is that when a man with intermediate or high risk features (Gleason of 7 or higher; PSA of 10 or higher) undergoes appropriately designed and delivered radiation therapy to the intact prostate, the potential that the cancer has already "breached the capsule" is always considered and accounted for in the treatment plan.

The same intermediate and high risk surgical candidates, depending on the skill level and philosophy of the urological surgeon, often only have the identified tumor removed, leaving prostate tissue behind that either is cancerous or that could become cancerous down the road, as well as microscopic disease already outside the gland.

The post-surgery patients that we see every week in our practice are often anxious, depressed and angry that their surgery did not eliminate their prostate cancer, as was initially promised by their urologists. They now face additional treatment to locate, track and then treat the cancer in places outside the gland.

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What's In a Name?

"I WANT A NEW DRUG – ONE THAT WON'T MAKE ME SICK ONE THAT WON'T MAKE ME CRASH MY CAR – OR MAKE FEEL THREE FEET THICK. I WANT A NEW DRUG – ONE THAT WON'T HURT MY HEAD – ONE THAT WON'T MAKE MY MOUTH TOO DRY – OR MAKE MY EYES TOO RED!"

CHRISTOPHER JOHN HAYES; HUEY LEWIS

BY GINYA CARNAHAN, APR, CPRC

When 1980s pop icon Huey Lewis wrote those lyrics, I don't think he was thinking about Otezla[®] or Vraylar[®]. Or Amovig[®], Qbrexza[®] or Biktarvy[®].

Have you ever wondered where these crazy names come from and what they mean, if anything? I did a little digging to satisfy my own curiosity.

A *Popular Science* article from 2013, authored by Rebecca Boyle, pretty much sets the stage for this investigation with this introduction: "Say it with me: Xeljanz. OK, at least try and say it with me. *Shell-jance? Zell-johns? Ghel-yahns?* Who knows. It is an arthritis drug, and I have no idea how to pronounce it, but one thing is definitely clear: It could be worth billions to its maker, Pfizer. (That name you probably know how to say)." It turns out that Xeljanz is a made-up word, made up to be more memorable (and marketable) than the drug's generic name: tofacitinib citrate, or its totally unpronounceable chemical name, containing a long string of characters numbers and symbols.

As it turns out, drugs have three names. The chemical name comes first and many of those drugs never make it to market even after decades of research. Once a

drug has passed all the tests to prove it is viable and useful, and not too dangerous, the Food and Drug Administration will give its stamp of approval. At that point naming the drug becomes the task of a very specialized marketing whiz.

This is serious business. According to the FDA, mis-prescribed drugs are the most common error in health care, and thousands of people die this way every year. New generic drug names must meet the standards set by the World Health Organization's International Nonproprietary Names (INN) and the United States Adopted Names Council for Pharmaceuticals (ANC-P). All brand names must be approved by the FDA.

Here is an example of how this works. For instance, take the common drug Prozac[®]. It has a second generic name, fluoxetine, indicating the active ingredient in the drug. In addition to Prozac[®], another manufacturer offers fluoxetine in a formula called Serafem[®]. Either of these registered trade names for fluoxetine



is much easier to say than the drug's chemical name *(RS)-N-methyl-3-phenyl-3-[4-(trifluoromethyl)phenoxy]propan-1-amine*.

Drugs cannot be named just anything – such as “Cure-me” or “Ache-no-more.” Here are some of the stipulations in naming of drugs:

1. Prefixes that imply better, newer or more effective; prefixes that evoke the name of the sponsor, dosage form, duration of action or rate of drug release should not be used.
2. Prefixes that refer to an anatomical connotation or medical condition are not acceptable.
3. Certain letters or sets of letters also are not allowed at the beginning of new generic names. These include me, str, x or z. (*I would have to contest this rule – what about the aforementioned Xeljanz? And what about Zolof?*)

Every generic name will have two parts. The last half of the name is the same for all drugs in a particular class. Take, for instance, the family of cholesterol-lowering drugs. They all end in “vastatin.” Lipitor® (brand name), atorvastatin (generic name); Zocor® (brand name), simvastatin (generic name); Crestor® (brand) rosuvastatin (generic).



Other easily recognizable class suffixes include:

- oxetine – antidepressants, such as fluoxetine (Prozac®)
- sartin – blood pressure lowering, such as losartan (Cozaar®)
- afil – erectile dysfunction, such as sildenafil (Viagra®)
- coxib – anti-inflammatory, pain relievers such as celecoxib (Celebrex®)
- dronate – prevents calcium loss, such as alendronate (Fosamax®)
- formin – one class of diabetes drugs, such as metformin (Glucophage®)
- vir – for antivirals such as anti-flu drug zanamivir (Relenza®).

These suffixes usually come from the full chemical name, but sometimes they combine several syllables, such as *mab* from monoclonal antibodies.

When it comes to the prefix part of the drug name, you can mostly use your imagination, as long as it conforms to the USANC's rules. Branding the drug with a memorable name is, as I said, serious business. You will want the public to remember it and ask for it.

The next fun challenge is creating a television, radio and print advertising campaign to market the drug. Untold millions of dollars go into this work. Do you recall the grandfather who “huffs and puffs” because of his COPD (chronic obstructive pulmonary disease)? Or the poor, sad woman who sees itchy spores coming out of the sweater in the store window? And the happy-go-lucky guy who is mowing his grass in a circle with a spring in his step? If you do, those ads are memorable. But do you remember the specific product?

That is the question! ❶

The Knowledge Navigator



KEVIN CHAFFEE THOUGHT HE'D BE GROUNDED BY HIS PROSTATE CANCER, BUT NOW HE'S SOARING AGAIN, AND SHARING HIS EXPERIENCE WITH OTHERS.

The oldest of five brothers, Kevin Chaffee was born and raised in Batesville, Indiana, a typical Midwestern town of 6,500 people. The town was built in the 1850s as a stop along the railway from Cincinnati to Indianapolis; the railroad still runs through downtown Batesville.

Kevin's father was an elementary school teacher, and his mother had her hands full with five active boys at home. To this day, his 85-year-old mother prepares lunch daily for any of her boys (and their families) who stop in. This is a tightknit family, held together by love and their strong Catholic faith.

After graduating from the Rose-Hulman Institute of Technology with a degree in Civil/Environmental Engineering, Kevin began a career in water treatment plant design and management, working in nearby places such as Gary and Indianapolis, Indiana. In 1985, he returned to his hometown and in 1989 formed his own company, now called Earthtek Environmental. Kevin and his staff now design and build water treatment plants throughout the USA and in a few foreign countries.

A Lucky Chance

One weekend when Kevin was 44 years old, he was out shopping with his wife for a new kitchen table, when he spotted an advertisement for a free PSA screening offered at the local hospital. (Funny the details you remember from a sentinel event in your life.) Although there had never been any cancer in his family, he thought it was a good idea to get checked. His PSA came back at 3.6. The staff at the event explained the results,

and since it was under 4, encouraged him to just get it checked again in 5 years.

In the meantime, Kevin (who had earned a pilot's license several years earlier) was looking for a new plane to use in his growing business. The specific model he sought was a Cessna Turbo 182 Retractable Gear. He saw an ad for a nice used one in Florida. Kevin and his son traveled to Sarasota to check it out. The plane was owned by a prostate cancer survivor and associate of Dr. Michael Dattoli, who casually invited him in for a tour of the Dattoli Cancer Center. Interesting, he thought, but the plane was his real focus and concern. After negotiating the purchase of the plane, almost as an afterthought, the plane's owner presented Kevin with a copy of his book, *Prostate Cancer: A Survivor's Guide*, "just in case" he might need it one day.

Fast-forward four years. Now age 48, Kevin scheduled a physician's office visit for a general, overall health check-up. This time, during the digital rectal exam, the doctor noted a lump on his prostate gland and promptly referred him to a doctor in Indianapolis for a biopsy. The results of the 12-core biopsy were 11 positive cores, with cores containing up to 95% cancerous involvement and a Gleason score of 7. This was not good. He was offered surgery and hormones... "until they stopped working."

Kevin felt like he had been sucker-punched in the gut.

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Dealing with The Diagnosis

Back at home Kevin shared the news with Pam, the woman he had met in college and to whom he had been married since 1982. Pam was a homemaker and a teacher. Their young family consisted of a son and three daughters. His mind raced with impossible thoughts. He was just approaching his prime. This couldn't be right!

Somewhere in this desperation, Kevin remembered the book he had been given...just in case. He pulled it from his bookcase and began to read. Out of the darkness, a light began to shine!


Like hundreds of other fortunate men who had learned about the Dattoli Cancer Center after being diagnosed,

Kevin put in a phone call to the good doctor and had his records sent down.

And like many others, he was amazed that he received a return call from Dr. Dattoli immediately. It was a long phone conversation as the doctor reviewed his biopsy findings and explained how the Dattoli treatment protocol would approach his "high volume, aggressive" disease. Kevin cleared his calendar and made the first appointment available to travel to Sarasota for a complete evaluation.

Getting Down to Business

At his June 2008 appointment, Dattoli's partner Dr. Richard Sorace welcomed him. "I'll never forget what he said to me," Kevin recalls. "We'll treat you in the gland and treat your lymph nodes,



“I was able to have a little office right there and keep up with my business while under treatment – but I sure missed Pam and the kids.”

- Kevin Chaffee

MARK LYONS

since it is apparent that several are involved. Your disease could be anywhere.” This scared Kevin. He was quickly put on hormones to stabilize the advancing disease. When his PSA fell appropriately, Kevin returned to Sarasota in September to begin radiation treatment.

At that time the Chaffee family had a “fifth wheel” travel trailer, which Kevin brought with him for the 6-week treatment period. “I was able to have a little office right there and keep up with my business while under treatment – but I sure missed Pam and the kids,” he remembers. His family had come down with him to set up the trailer, but they had to return to Batesville after he was settled, since Pam was teaching and the kids were in school.

“I’ll never forget how totally alone I felt as they drove away in a pouring rain storm. We were all crying.” He promised to keep busy and active. The daily radiation sessions were a piece of cake, after which Kevin would work out at the local YMCA.

Kevin took full advantage of all the Cancer Center had to offer, attending the weekly “Beamers” programs and hanging out in the lobby to chat with other patients. He made several good friends with whom he stays in contact to this day.

His last radiation treatment was scheduled on the day before his youngest daughter’s birthday; he was

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determined to be there, and he surprised the family by walking in the door just as the celebration was starting.

Tough Decisions

After his diagnosis, Kevin made the tough decision to sell the plane, anticipating losing his FAA pilot's license medical clearance following a cancer diagnosis. He would just focus on staying healthy, building his business and supporting his family. He settled back into his activities, including playing adult baseball, attending church and volunteering in the Batesville community.

One evening at a Catholic Men's Conference, he was asked to share his experience with prostate cancer. It was this event that inspired Kevin to openly seek opportunities to educate other men about the disease and the treatment that saved his life. He visited the Us TOO Prostate Cancer Information Group in Cincinnati and quickly found an outlet for his first-hand knowledge of the disease.

The group meets twice a month; its members have dubbed Kevin the "Knowledge Navigator," as he would diligently research each member's questions and provide educational presentations. Kevin even had Dr. Dattoli sharing his wisdom and answering questions via Skype at several packed educational sessions.

The Role as Counselor

In the 10 years since his treatment, Kevin has "counseled" dozens of men who were experiencing the same shock

and fear that he had felt when diagnosed. Many of these men have taken his advice and traveled to Sarasota for treatment at the Dattoli Cancer Center. Sometimes, the group members even joke about Kevin being on the payroll for the Center!

Looking back on his prostate cancer journey to survival, Kevin recalls, "God has kept me alive for a reason." He is intent on making his life meaningful by helping others. Not only is he active in the prostate cancer counseling arena, he was also elected to the Batesville Common Council in 2012 and now serves as its president. He remains faithful to the Catholic Men's group, and he is a mentor to his son and daughters.

Kevin is grateful for the unusual path that brought him to Dattoli Cancer Center. Today he calls his health "perfect," in every way: emotionally, mentally, spiritually and physically whole and happy. Cured and clear of his cancer, he has restored his FAA license and bought another plane – quite similar to the one that he believes saved his life.

"It gives me chills to think that I might never have known about the Dattoli Center if I hadn't bought that plane," Kevin concludes. "It is a place that treats you like a member of the family. These are people who are the best at what they do and who really care." 📍

“Just the facts, man.”

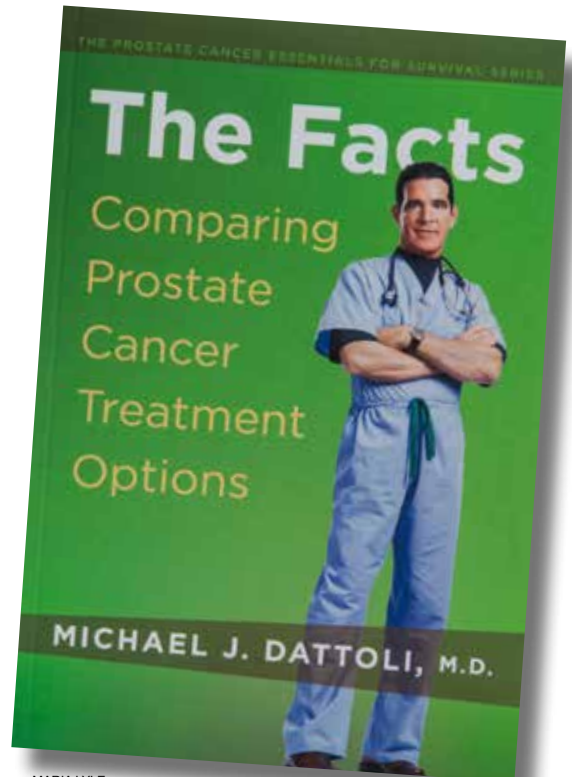
When Sergeant Joe Friday of “Dragnet” fame said, “Just the facts, ma’am,” we knew it was time to cut through the garbage and get down to the nitty-gritty.

A decade or more ago, we realized that the information about prostate cancer treatment options was horribly confusing, inaccurate and difficult to compare. We decided to try to gather descriptions and data, and to put unbiased information about all major, mainstream treatments into a document that newly-diagnosed patients could use as a guide. What a task!

So, harking back to that iconic black-and-white TV show and Jack Webb, badge number 719, we decided to call this document *The Facts*. You may have seen a copy of this chart along the way.

Through the years, as new treatments evolved, we revised the chart until it became so content dense that it would no longer fit into a chart format. Nor could anyone read it without a magnifying glass.

Today we have transferred the information into booklet form, with a page dedicated to each of the treatment options with a brief description, pros



MARIA LYLE

and cons, published results, and some reference citations; it’s easier to read but requires flipping pages to make comparisons.

The Facts is now available through Amazon or by request from our office, along with the other booklets in the *Prostate Cancer Essentials for Survival Series*. ❶

DCF and Myriad Genetics Offer Screening That Can Personalize Treatment

Myrriad Genetics and Dattoli Cancer Foundation teamed up on September 28, in recognition of Prostate Cancer Awareness Month, to offer an important genetic screening test for prostate cancer patients who meet certain criteria.

Myriad, a testing company based in Salt Lake City, Utah, has created a simple saliva or blood test that can predict risk of eight different cancers, including prostate, breast, uterine, colon, ovarian, pancreatic, melanoma and gastric. The test examines 35 genes

for evidence of predictive anomalies. Patients must have developed metastatic prostate cancer, or have prostate cancer with a significant family history of other cancers.

Data from the test is useful in personalizing the patient's ongoing treatment, as well as alerting family members of their increased risk of developing certain cancers. This knowledge can signal the need for early screening to detect disease, and to make lifestyle changes to potentially reduce or eliminate risk. ❶

Prostate Gland Capsule: Fact or Fiction?

CONTINUED FROM PAGE 7

The challenge for any treatment protocol is assuring that all suspect tissue is removed (or sufficiently irradiated) to conquer the disease. Again, without a capsule, it is very difficult to know where to stop treatment. After surgery, even a low PSA recurrence (e.g. $0.1 > 0.5$) is often associated with spread to the lymph nodes and bones, since the cancer often mutates significantly so that it doesn't even resemble prostate cancer cells, and therefore is not able to express PSA.

With radiation's ability to be "sculpted" and aimed to pinpoint targets, it is possible to shape the radiation beam in innumerable ways to reach the cancerous tissue within and outside the gland, while avoiding those important structures

so closely aligned in the pelvic bed. This key benefit of radiation is often denied to post-operative patients because the original structure of the gland and its neighbors has been destroyed by the removal of prostate tissue.

It would be much simpler for both the urologist and the radiologist if there was definable capsule. Given the fact that there isn't, in my opinion radiation clearly offers the best opportunity to halt the cancer in its tracks, at any age, wherever it may be found, and the first time. Our published results, and numerous results published elsewhere, repeatedly verify this. ❶