First reading of this sounded awful.

There is no excuse for what has happened. We have been warned; all of us. My carcass is my responsibility. I cannot blame the Physician for two things in particular; my part of the responsibility for myself; I cannot blame him for what nature dishes out.

The physician as a physician does bear some of the responsibility in that he is a primary care physician; opportunity was not lacking, I visited his office several times a year to have blood drawn. He knows or knew what to do; for him there is no excuse since he sets himself up as a family primary care physician, who is purportedly into preventative medicine. He checked the PSA (3.2) once without a DRE. He waited almost two years before a second PSA, and didn't perform a DRE until he saw the results of the PSA (5.8). His portfoilio increased in value during the same time period.

WELL - now we are sailing through the Islands. The Physician has shipped me off to a urologist with the admonition to the urologist that I am on Coumadin. The urologist, like the Heart Surgeon and the Cardiolgist doing the angiogram, began with conversation unrelated to their reason to be; rather was the conversation intended to relax the patient, and gain some human rapport; albeit exercise good bedside manner. At least the Neurosurgeon, who knifed my back twice, was matter of fact.

Anyway, now that I have been bedsided, I am prepared for the coup de grace.

My conversations with the urologist were not particularly encouraging. The slope was fairly steep for the time period (3.2 to 5.8 in 22 months). One would not guess hypertrophy. If there had not been a 'nodule' (physician P), or 'irregularity' (urologist) one might have speculated 'chronic infection' OR a tumor to account for the 'elevated' (physician P's nurse) PSA.

Now comes a few kickers. The urologist scheduled me for a ultrasound with biopsy.

Biopsy is dirty word for more than one reason, and not JUST because it involves the rectum. I must cease ingestion of Coumadin for a period of time to lower the 'Pro' time (not as in Pro Shop, [Shop talk for Professional]) but as in Prothrombin Time in order to allow for proper coagulation of blood that is anticipated will flow when the rectum, prostate, and intermediary tissue, and possible punctures of the urethra with a needle several times as the biopsying proceeds into the 'quadrants' of the affected Decrepitude (somewhere, there is a dangerous quadrant through which our ship must weather) .

I have 'gone off' the anticoagulant once before to accommodate the Neurosurgeon as he lumbar lamenectomied me. Cross out one success. The success relates to the fact, that, with time, two and one half years, one

may assume that few, if any platelets formed on the heart valve over the time period I was not ingesting the anti-coagulant. (Every blood test does indicate there is a level of lysed blood cells resulting from the shearing or mechanical action of the heart valve.) It would be difficult to know whether any platelets formed on the surface of the valve. Perhaps the (fluid dynamic) design allows a certain amount of discouragement of platelet formation for a short period of time. There are those who are allergic to anticoagulants who have been able to get by on aspirin equipped prosthetically with the St. Jude heart valve.

Now we aim for a second try at discontinuance. Only now the risk factor is multiplied by some unknown quanta. The risk of bacterial infection is much greater since the rectum et al are involved. If bacterial infection enters the blood stream, the St. Jude heart valve becomes a very susceptible and probable infection site (an unsafe harbor so to speak) which can lead to endocarditis. With no blood supply serving the artificial valve, bacteria could survive without exposure to all blood carrying 'antibiotics'. The bacteria would be able to multiply at random as was their wont; leading to a sunken craft?

Anyway with this latter consideration in mind, I questioned the prescribed prophylactic, believing it to be a routine formula for the biopsy procedure, and did not necessarily take into account the heart valve's susceptibility to harboring infections. So, here I am interfering with the 'tried an true' as I did when questioning the anesthesia used for the back surgery. Having had a first back surgery prior to the heart surgery I remembered the 'recovery' trauma, plus the depressed blood pressure; or perhaps the whole trauma was a resultant of the depressed blood pressure. Anyway I had requested different treatment for the second back surgery; receiving it as per request, with very different results (a much less traumatic recovery).

For prophylaxis, I have requested from the primary care physician some determination that properly accounts the heart valve. So I have acquired a formulation; that is, I have interfered. Now I'll need to ask for discussion with the urologist as preliminary to any procedure. The formulation is recommended by the AHA according to the cardiologist who was consulted. SOOOOO, what next? The wise-cracking 'insensitive' primary care physician claimed it didn't take an Albert Einstein to figure out that a biopsy of cancerous tissue ran the risk of liberating cancerous cells into the blood stream (small comforts for the diseased dinosaur).

Everybody gets to make a buck on the deal. Finally the undertaker. One supposes there are those who would waive the costs if the patient expires; but don't count on it. NEXT!

After reading all the available layman's data provided by the Harvard Health Letter (six years accumulation), and my concerns re: the heart

stuff, I asked for another consultation with the urologist, Charline in attendance.

It seemed after all the discussion that the next step was indeed the biopsy. Assuming a dangerous quadrant, the questions centered around strategy for getting through the maelstrom.

The urologist's 'empirical', first approximation, fell into the B stage, seemingly 'early-enough' stage, which could be treated by surgically removing the offending decrepitude. Whether this is prejudice has yet to be learned. The question will be asked after the results of the biopsy.

Surgery may create new problems for the ship. A leaking bilge, and limp sails. The limp sails might yea or nay depend upon the skill of the surgeon, about whose expertise he will necessarily field that question? Are you the best there is? Like the Harvard Prostate Lit has suggested, inquire after the surgeon's batting average.

Thar is no garantee that the removal of the gland will get it all. Thar may already be some cells in the lymph system, or some local tissue may have been invaded. They will not really know, so I am gathering from this particular urologist, until they get some new PSAs following surgery.

The urologist's 'prejudice' seemed not to favor radiation as a treatment of the primary decrepitude, believing the evidence shows that radiation doesn't get it all. However this needs to be discussed some more since certain radiation procedures are not conducted even within the State of Oregon; 'seeding', for example. Virginia Mason was raised by the urologist.

Is a discussion with an oncologist a step that should be taken?

The surgeon mentioned a man who had had the prostate surgically removed some 17 years previous, and after that time period has shown an elevated PSA. Question: At what Stage was the prostate removed? The search is underway to discover the incipient Island. I do believe the 17 year example was mentioned to indicate the upper end of a survival curve; that is if you were to be given fifteen years survival in the cancer world, you got yourself a pretty good deal.

Following ultrasound and biopsy (8 pops). Inconclusive from ultrasound; stones brightly showing, perhaps some calcification; other 'grey' areas to be exposed for what they are through biopsy. Gland normal in size. If biopsy shows positive, then a bone scan is in order, maybe to discover if what's what is to be found elsewhere. The Doc is going out of town, so his assistant Kelley will field the biopsy and arrange the bone scan and, if scan is to be done in big claustrophobic machine, she will need to arrange for some Xanex, the anxiety blanket.

Then when the doc returns we talk, and talk, and talk, presumably.

Meanwhile antibiotics and a return to coumadin, then a 'pro' time check or two, and a return to normal maybe until the next onslaught.

Beware the Ides of March.

Today will be the day I learn I tested Positive. (Having been Negative most of my life.) This CHANGE will represent Mutha Nature's way of tidying up the place; attempting to get rid of the cynic.

The truck is loaded for Lasqueti; another Positive step. Maybe a trip before something else is done. Leave the truck there, returning by bus maybe.

Anyway, off antibiotics, and back on rat poison. 11:03 A.M. Positive. The Big "C"

NEXT:

Oh, Yeah!, there is a bone scan scheduled for the 17th, early A.

M.. Both physicians out of town. No information.

So the battle for information begins.

Charline says it is cruel to keep me in the dark. That's the medical profession; the patient needs to operate with a crowbar.

Anyway: Adenocarcinoma (glandular carcinoma) Gleason Scale of 6 (3 + 3) moderately aggressive malignancy; moderate dedifferentiation..

Talked to pathologist re: above. His comment was the appearance and Gleason score was in the usual range of values he sees when examining prostate cancers, saying he seldom sees a 2 or seldom sees a 10. Talked to another urologist in the absence of the first and the primary care physician (both out of town). He wasn't much help; and neither Charline nor I felt comfortable with him. He did mention that the Walsh surgical procedure was overrated. He said also I was lucky to have had the thing diagnosed as early as I had, in defense of the primary care physician.

The bone scan didn't seem to show anything out of the norm, according to the reading pathologist, however the big black blob in there area of the bladder may have masked a whole bunch of stuff.

Obtained a copy of the Prostate Book, written by a Stephen Rous, a Urological surgeon. It amplified what I have been learning from other publications, those found in the Harvard News Letters, and Prostate Diseases published by the H. Med School (which included the reference to the Rous Book); and another titled Prostate Cancer by Zeneca Pharm. (printed on recycled paper).

Soooooo! What is next? A trip to the coast with Charline for the weekend.

Then on Tuesday (21 Mc)at 4 P.M. a meeting with the returning (first) Urologist.

What to discuss? Lymph nodes, to be consistent with the philosophy behind obtaining the bone scan? Laproscopy?

Laproscopy in conjunction with prostate removal?
Radiation? Should I be talking to a highly skilled radiologist?
Is there one in this neck of the woods?
There are no avowed seeders in the State of Oregon. ?????

Nice enough weekend by the ocean. Boxed motels are not my cup of tea; and sharing the beach with 'idiots' doesn't brew well either. Sooooo! But long walks on sandy beaches; not entirely a Coney Island experience. We brought home pretty rocks and fossilized scallops. And we drove an entirely new route on our return. Not much talk about the prost(r)ate. I'm sure the getaway cheered Charline.

Would like to take big truck loaded to the Island before doing anything with carcass; and would like to check out the boat as well.

I deem these actions important for one kind of mental health. One's body assumes too much dominance; a very narrow theater of 'operation'.

On the Marquee: "Assailing The Decrepitudes"

It was the story of the knife. The story of meat-cutting. Albeit life-extension. But despite what the cardiologist declared re: body parts in twenty years, no plastic prostate. A tale with a gruesome aspect. One might mistake stumbling around with the knife as courage.

Gruesome for obvious reasons; not courage, as much as buying into the argument with fear. Despair; hmmm!

Of course one sets his sights beyond; its part of the unfinished business of life. Let that be a lesson to yuh; keep your accounts up to date, otherwise you could leave this planet in arrears. One might promise certain things in order to clear the hurdles.

Germane to the uplifting story.

What price life? We get to ask questions like that nowadays, even when life seems on par with the peso. When you are nobody, they have all they can do to feign indulgence. One is privileged at that.

How it must have been with inexplicable pains, and tiredness, and perhaps diminished stream flow, and painful ejaculations; finally expiring from something like pneumonia. In the old days nobody knew. Nowadays they speculate that testosterone gets it going, and that animal fats (red meat) get the testosterone going; and it happens to a helluva lot of old farts who survive other maladies. Like me for instance, who was supposed to have croaked around about now from the diseased heart valve(s) etc.; artificialized, only to have lived for this, the second move in the final chess game. Decrepitudes. Mardi.

Talk with the Urologist/Surgeon.

Before doing so, the old back surgeon appeared in the urologist's environs. We recognized each other shaking hands. I told him the back was doing fine.

The talk with the urologist seemed to indicate a GO very soon. A few questions to be answered re: blood collection and anticoagulant tactics. whether one can collect spare blood with anticoagulant suspended therein. And how many times to go through anticoagulant discontinuance. The cardiologists and the cardiovascular surgeons are advising against too long a discontinuance, claiming, e.g. that three weeks would be too long. Presumably, if only the surgery is involved, there might be another approx. eight day period of no ingestion. But if the blood collection becomes involved in this discontinuance it gets tricky, since the blood can only be kept in storage for approx. four weeks. The urologist would like two units at least, drawn five days apart approx. Following that scenario I would be off the anticoagulant for approx. four days before the draw, and another 5 waiting for the second draw, then need to return to anticoagulation, only to go off again for the surgery all within the timeframe of the life of the blood. Sounds tricky.

Why not radiation then? Because the belief is they (the radiologists) would not get it all, and the morbidity could be so great that it might preclude any necessary surgery. The urologist claims the tumor too large for effective radiation treatment. It is his conviction also that the tumor is confined to the prostate, not involving the lymph nodes, hence not advising laparoscopy. Called: Zeroing In, In short, there can be no watchful waiting. There can only be the hope that what the urologist says contains some reasonable degree of competent judgment.

Sinking in, the decrepitude!

No problem with drawing anti-coagulated blood since they do a citric acid base anticoagulation anyway; and since it for my use only.

Trying to save a little time, I had attempted to get the blood bank to draw a unit of blood in anticipation of the 'forthcoming' surgery. No can do without a prescription from the physician. The physician is not available; if he had been available, he would need to schedule the surgery before the prescription would be issued. He can only schedule surgery through the hospital which has allotted 'blocks' of time to physicians who do not participate in its own health-care management plans. Jesus Fucking Christ of the Sacred Heart.

April 3. We have been to the Boat, Island, etc.. It is where we belong. Like scurrying ants we rode the concrete ribbon to and fro.

Closed Hard entities behind the wheels. UGLY. We are aggressors upon each other; UGLY.

We are occupiers. We not only feed upon the planet; we feed upon each other, as do the other parasites feed upon us.

These are brutal facts. There are so many of us, we have become valueless; almost like junked automobiles that fill our lives; rusted, dented, abandoned, tipped over, parts cannibalized; forlorn. Then crushed, with an angry finality. Recycled, Resurrected, Reborn; from Rust unto Rust.

This morning, a protein breakfast in preparation for the first unit of blood to drawn this A.M.

What to do next? Feel the need to talk more to the 'professionals', but feel only bitterly inclined to talk to family physician. The prostate within has become a monster within; it has decided to become a thing in itself; fuck the remainder; isn't that like life as we know it? Rapacious and greedy. Not content to be what it is. It must become separate, and it must colonize; to what great purpose? It takes the ship with it.

Some of this chatter belongs in Planning My Exit, but what the hell. Its all water from the same dam. And you have heard it all before.

While at the boat I encountered a fellow who advised shark's cartilage as a remedy for tumors, the 'theory' being that shark's cartilage would gravitate to (preferentially find a suitable home in) tumors; that said cartilage, itself requiring no blood supply, would eventually deprive the tumor of vessels. Far Out Man. He spoke of something else as well, that sounded like Saw Palmatto. He is also a believer in prophylactic EDTA treatment (chelation) to stave off things like Alzheimer's. His scientific background seems sort of like mine, although I do have a cautionary innate sense about homeo/naturopathic well-wishing. He said he would mail me some literature; we'll see (Charline sees him as a snake oil salesman). In some ways it is only marginally different than surgeons believing in surgery and radiologists believing in radiation. You have to be sick and marginally desperate in order to enter into these encounters with staving off the Decrepitudes (deceptitudes).

I do believe in the inevitability of the Decrepitudes (take your pick). Ponce de Leon, notwithstanding. And physicians notwithstanding.

Someone handed Charline a vial of Genesis Juice (organically grown). Well-meaning spirituality (pulverized rabbit's foot). Charline told me I had to drink it 'right away' after carrying it around in her knapsack for several hours. Just before retiring did not seem the appropriate time, so I declined the 'highway to heaven'. I placed it in the refrigerator, and found half of it consumed over night. Charline is gathering some spirituality for the coming onslaught.

I called the therapeutic radiologists who won't talk to me without a referral (shitheads!). Anyway their office personnel 'referred' me to the 'information bureau' dealing with oncological problems, who will provide

some information, but also encouraged me to call one eight hundred four cancer, who also offered information plus another eight hundred phone number dealing with support groups. The second proved to be an answering machine. We already know there is a waiting line at the pearly gates (1 800 7HEAVEN).

Mother goes to a physician to have a cancerous growth removed from her neck. Not to worry; an office visit. Her primary care physician (same as mine) had told her not to be concerned about the growth; my guess is he figured she had more serious problems, like HBP, an arthritic back, and OLD AGE (93). Anyway she persisted in HER concern (it was ours as well) until she finally got a REFERRAL. What can you say? 'Doctors' have trouble sometimes even getting their billings correct. Whereas the guy who runs the upstairs always supplies a supplicant with a PAID IN FULL.

The same primary care physician has more or less dismissed three other growths that have occurred on my carcass, one he characterized as a lipidoma (?), another as a cyst of sorts that has shown some enlargement with time (he showed me his); and another is a blotch of brown, like a big freckle that seems to grow larger.

You would think an old cynical sourpuss like me would be glad to get it over with. FOREVER?!!!!? Despite what you would think, you cannot be a cynical old sourpuss without a little palpitation.

I took mother to a dermatologist to have a basal-cell carcinoma removed, one growth upon her neck that had been there almost too long, after many inquiries about it through her 'family' primary care physician (same as ours) which worried her and bothered us enough to insist she have it examined; finally a home care nurse gave her such a bad time she herself insisted that it get looked at. It proved malignant.

Well, things are heating up. I've decided to expand my knowledge intake; to break out of one box for at least a few days. Which means surgery will be postponed. I have visited the cardiologist; I will have an echo/treadmill/cardiogram done; I will visit the urologist, I will visit the Oregon Health Sciences University Radiation Oncologist, I will visit the Northwest Tumor Institute for a Seed Implant Consultation, and the Virginia Mason Cancer Clinic Urologist for further consultation. Then perhaps somewhere along the line a cryogenic surgery consultation, and an oncological summit.

I have received a pile of literature from the National Cancer Institute. Along with the Harvard Health Letter and their Prostate Disease Booklet, The Rous Prostate Book, the PAACT supported Lewis Book on How I Survived Prostate Cancer and so can you. No where in this literature have I found it advised to put a gun to one's head. At the same time I have not found an easy way out of this dilemma. One book suggested making out a last will and testament.

And I said to Charline "so much for penis envy". 'A big price to pay for a hose'.

I did attend my first prostate support group; a 'meaningful' experience.

I did meet with a fellow who had received a seed implant; PSA 13, Gleason 4. Both lobes. Good candidate for seed. His PSA rose initially, then fell to the original level, he is awaiting the next reading; and the remainder of the story (Sept 94, diagnosed; Dec. 94, implant; April 95, waiting). Age 61 when diagnosed. He has had another kind of cancer (some kind of malignant lipidoma) which was treated with radiation, then surgery. He has had two knee joint replacement surgeries.

I did talk with a fellow long distance Seattle, re: radiation; diagnosed in '87 4.4 PSA, Gleason 5.5 - 6, non-palpable tumors, but did retrospectively note less stream flow before treatment [followed eventually by 'like when I was 20'] which could mean his tumors, though not palpable might have been pressing more internally against the urethra); external radiation (did not ask which type; hope to talk with him some more), 38 treatments; he talked of radiation side-effects which seemed to be considerable, falling within the range of those experienced by others radiated for PC. Enormous fatigue following radiation lasting 2 to three months. Age 58 when diagnosed. Now 66, seems convinced he is cured with 'flat' PSAs. Progressive impotence, various bowel problems, one requiring medication. Other probably unrelated health problems (heart arrhythmia).

There are many prophets in this business. One guy profits and the other guy looses. Cut your loses. Prophets and loses.

That is to say, the cardiologist this AM pronounced me with good valve, sound heart, with the usual risks of discontinuing the rat poison for the duration of a surgery (you know RADICAL prostatectomy) that kind of gets you in the tummy. He said admonishingly the risk is worth it to get the PROPER Treatment ..er.. of the prostate problem; meaning, as a St. John The Baptist, that the urologist/surgeon we have all come to know is the 'proper' treatment.

I rapped with a very nice fellow yesterday who had had interstitial implants (brachytherapy). (same fellow as above). 90 I-125 seeds (not Interstate 125 grass seed, but hot Iodine). Its his baby, he is still dealing with the hopefully short-term effects of a burning sensation during urination. He is happy with his potency. There were those at the Prostate Anonymous meeting who SWORE (not SNORE)by the Hormoannn treatments. I haven't read the cryo prophets yet, but they are there. Summation. MAN! There's money in a cure. Golf Afterwards.

The key word involved in this CANCER business is survival.

CURE is a word that must be used reservedly, or perhaps, not at all.

The first referral should be to an oncologist - period - not to the specialist hawking his wares; i.e. re: prostate CANCER; a

surgeon/urologist; a radiologist/urologist; an implant radiologist/urologist; a cryogenic/urologist; a hormonal urologist/oncologist; or combinations thereof; and/or a urological oncologist, wherein all of the above may perceive themselves as oncologists.

Survival is the key word; for how long? Remission is another of those words that may find coterminous comfort with survival.

Survival is measured in terms of time; months to years.

Palliate, Palliative; other words.

Yesterday, I told the referring physician, whom I have seen for the first time since his belated DRE, that he ought not disregard a 3.2 PSA in a sixty year old; i.e., lump it into a 'normal' for PSA values. Our discussions during our visit bears this out in philosophical terms; and mathematical terms. While initially he made the error of lumping statistically, his philosophy during the discussion emerged differently; i.e., he claimed each case (patient) was individual. He ignored his own philosophy as well as my health in this matter. He did want to rely on the statistical thing as a defense; his defense did not become an issue in our discussion, because we both somehow realize 'crying over split milk' leads to other things that the issue at hand. Besides I require a physician to obtain prescriptions, to order blood tests, and perhaps to render the end, etc., since the whole medico/insurance world is a protectionistic interwoven thing that prohibits those whom it serves from entering it upon their own behalf (as an equal partner - they pay lip service to this sort of thing while at the same time petitioning legislatures to pass laws protecting themselves from lack of disclosure - to wit. Oregon Revised Statue 677.097). Clarification: I should have insisted upon entering it in my own behalf as pertains to requesting the PSA/DRE as per recommended time interval (by the protectionistic society that deals with these matters).

Question: Why in hell do we require doctors? Because they have access to hospitals and insurance?

Remember the Oregonian article re: the butcher, the baker and the iceman; the surgeon, the radiologist and the cryogenics man.

All these professionals give the feeling they have either a proprietary interest or disinterest in my welfare. In Oregon they take the Statute seriously; let the patient beg. Information belongs to THEM.

April 12 PSA 5.1. I'm not fooled into believing that something is going away. What is marginally comforting in the reading is the fact that it is not some large increase over the 5.8 of two months ago. I should have the DNA ploidy analysis by this afternoon to take with me to the next step. Result: DIPLOID with low SPF. The judgment of the same pathologist who gauged the Gleason at 3 + 3 = 6 "In General, DNA aneuploid tumors with a High

S - Phase Fraction are associated with a more aggressive clinical course than DNA diploid tumors, and those with a low SPF." "The determinations are semiquantitative when obtained from a paraffin block" (in which the biopsied 'spreads' were preserved). What might one assume from that indirect analysis?

We saw the sawbones (first urologist) again. He is now scheduled for surgery into End April. So, if we elect surgery, most likely we would fall into May. First blood collection supposedly good for 42 days (from April 3) as red blood cells. He said he had a tough hide when we said we were gathering second opinions; and he said he would still consider him as our urologist.

April 13 Harper Pearse OHSU; most gentile, informative, generally unbiased. Most likeable; good for me. Volunteered a DRE, finding the prostate size normal, also feeling the irregularity, not alarmingly. Given what information we supplied (PSAs, Gleason, Ploidy, Bone Scan), he felt we were good candidates for any of the treatments now available. Often he is treating people who have gone beyond the stage into which ours falls. He might be inclined to favor the prostatectomy, perhaps with lymph node examination, although his prediction, like McDuffie, would be no lymph node involvement. The prognosis of surgery is good, which, if it failed over time, could be followed by hormone therapy and selective radiation therapy. If radiation were used, and failed, perhaps only hormone therapy could follow. Seed implantation would also seem to be feasible, with perhaps some external radiation. If only seed was used, and failed??? A matter to be probed further. Obviously, hormone could follow, or perhaps selective external radiation. Cryosurgery was left in the air as an option for the lack of enough survival, and morbidity data. In short any procedure is most likely tailored for the individual, given any and all other considerations.

Tried to get more information regarding the Laval U., Labrie data regarding hormone therapy. So far not much data in that area. I called Laval only to get first an answering machine in French, then to get a regular person in French after which I inquired after the English version only to get another speaking English with a French accent telling me that the place was closed (Good Friday [I don’t know what's good about it] until Tuesday [after Easter Monday]).

Also attended another support group meeting in Springfield whereupon some of the same faces appeared as from the previous groupie at Sacred Heart. This gathering was reserved for a demonstration and accompanying so-saying of an accupuncturist. Some additional talk of Essiac-Tea and sharks cartilage.

Used Sacred Hearts onco-line computerized filing of prostate info; papers etc. One paper indicated that doubling times of tumors may be slower than some PSA values indicate. Another paper seemed pessimistic about the overall field; perhaps not as pessimistic as with other cancerous growths, but not as hopeful as some of the interpreters of current data. Obtained permission from the family phys. to use Physicians Library where I would hope to read all the important papers for myself.

This morning, Easter, Charline and I discussed the immune system while drinking our sunny morning oblations in bed. I ask all the tough questions, while Charline reads from the Cell Biology tome. Of course I had to ask what happened to all those cells liberated during Biopsy, without trying in any way to emulate Albert Einstein.

The other day when conversing briefly with Ney of PAACT, we got on hormone therapy, and the idea of debulking all tumors with hormone regardless of stage. He was inclined to believe that vested interests and stupidity was preventing the end user, the patient, from access to things that would help him. I asked him how does one get access to the information. He said you get the good oats by going to the head of the horse. Most likely he was referring to the Labrie group. The Truth is out there somewhere being carefully manipulated. He is a strong believer in finding a good oncologist. Second very strong opinion on that subject. However, oncologists will not agree on a common approach. The END is always achievable without anyone's help.

We are all stuck in going to the health people, even the health food stores, or faith healers. We are essentially helpless.

If I want to obtain a piece of my health record I have to sign a release form. Its theirs, whoever they are; the only way I can get it is to wait for them to dig it out and then I have to sign. Even the simplest blood test. An old anesthesia record that resides in some hospital's medical records will take three weeks to obtain, after I sign a release form. Its all a control game. In order to get at information in the hospital library, I need to obtain a prescription from a physician. The local urologist did allow me to carry some of my records to another physician without the extra falderal (as it should be). But next week I hope to be able to consult with my former cardiologist in order to bring myself up to date with a talking cardiologist; with a cardiologist it doesn't take a month to see. In order to converse with me meaningfully we will need to re-transfer my records from his replacement during his absences. Involved, and maddening; A CONTROL GAME !!!

At least in the Cancer Care Center I was able to sit down to the CD ROM computer to access the ONCO-Disc, where I am able to obtain

abstracts of relevant papers, many from foreign journals that would not be in the library in any case. The fellow who is the overseer of the CCC always greets me in a friendly manner.

April 18, John Blasko, the seed man. Told it like it is or was; thinks I am a candidate for his specialty. Followed on the 19th by Roy Carrea, a Urologist who had had a rad. pros. two years earlier. He says everybody has good five year survival statistics in the prostate game. He thought I might be a candidate for death by other means when it came to considering the ten year survival game given my current heart condition, the fact that my father and my grandfather both died of heart failure. He wasn't advising me, but leaning heavily in the rad. pros. direction he said he was confident I would make the right decision.

Nobody is talking hormones. Returned home feeling strongly inclined toward seed implants or brachytherapy or instititial implants; i.e. 103Pd.

I must return to Seattle on the 25th for a visualization imaging of the prostate, i.e., volume study, preliminary to the implant, done by ultrasound. Then the estimate of time for implants is Earliest, early June; May is booked.

I do not want to sit around waiting, so I might as well go to the Island for a month to do something constructive.

Mouth to mouth reconstructivization.

Its not over until it is over.

It is what it is.

Jimmie The Greek sets the odds on the Big C