Chapter One: Diagnosis To Decision: My Story

Michael H. Plumer, M.D.

 Distracted and a little embarrassed, I tried to ignore the little alarm light at the edge of my consciousness. My internist, a friend and colleague, was carefully examining my prostate with his gloved finger up my rectum. Just when I thought he was finished, he probed again. His finger slid slowly over the surface of my prostate.

 "I feel an irregularity here in the right lobe of the prostate, sort of a firm nodule. Probably nothing. I think I’d like you to see a urologist, though, just to be sure.” He withdrew, and I could hear him peeling the glove off, turning it inside out. The trash can lid clanged. “Go ahead and clean up.”

After I tossed the tissues in the trash, I pulled up my underwear and turned to face him. He was smiling. A good sign, I thought.

This would be a good time, he said, to check my Prostate Specific Antigen, or PSA. Though I was 55, I hadn't had this test before. Three years earlier, on my previous "annual" visit, he had acknowledged that some people recommended screening for prostate cancer with this test after age 50. But he felt it wasn’t necessary unless examination suggested a prostate problem. I'd been OK with that. I was trying to be a good patient, not a physician.

He didn’t seem worried, so I wasn't either. Having a lump in my prostate was interesting, but not alarming. I was sure there would be a reasonable explanation – maybe an old infection. It didn’t matter that I couldn't remember any infections. I wondered if my PSA would be up. Both normal prostate tissue and prostate cancer could produce PSA, so even an elevated PSA wouldn’t prove that I had cancer. But I wanted mine to be so low it would prove I *didn’t* have cancer. I thought a “normal” level (under 4) would do it. I was pretty ignorant for a doctor.

I hadn’t thought about prostate cancer since medical school 30 years before. I was an anesthesiologist, and now I spent most of my practice time providing pain relief and anesthesia care for women who were having babies. I had given anesthesia for an occasional prostate removal in the operating room, but except for that I didn't deal with prostate cancer at all. From medical school I remembered that prostate cancer was common in older men, and slow-growing. We'd been told many older men had undiagnosed prostate cancer on autopsy. The common saying was that most men would die *with* prostate cancer, but not *of* it.

Several days later my PSA returned. I was relieved to see it was only 3.45, well within the "normal" range. I didn't yet know about the relationship between prostate size and the amount of PSA produced, and had no idea a "normal" level might be too high for someone with a smaller prostate.

 Meantime, I made an appointment to see a urologist with whom I worked occasionally in the operating room. He seemed competent and sensible in that setting, so I was sure he’d dismiss this little nodule as insignificant.

 He reviewed my history quickly as we sat in his office, then did another rectal exam. Yes, he did feel that nodule as a hard little bump on the right. We should biopsy that. Set it up in a couple of days. Do a little bowel prep ahead of time with a Fleet's enema just to clean things out. Take an antibiotic to kill any bacteria introduced by pushing the biopsy needle into the prostate through the rectum. He'd use ultrasound to locate the prostate precisely and to see the nodule. As the ultrasound mapped the prostate, he said, he'd take a piece of tissue, a biopsy. Six times. Wouldn't be painful. Just a snap when the needle actually took the tissue core, then a bit of an ache right afterward.

 I asked how often he would expect to find a problem in situations like mine. Without hesitation, he said if he could feel a nodule he’d expect to find malignancy half the time. He didn't use the word cancer. I felt sorry for the people in the malignant half of the group. There were more of them than I thought. I had been imagining that most people would be like me. They’d have this little test and discover that everything was fine.

 Two days later I lay on my left side in the same office. I hadn't yet seen the urologist, but I waited naked under a paper drape, curled up with my backside to the door. This position requires some trust, I thought. I felt new empathy for women who sat with their backs toward me waiting for an epidural anesthetic. The door opened, and the urologist's big hand fell on my shoulder in greeting.

He went right to work. The ultrasound probe, which had apparently doubled in size as soon as I turned my back on it, produced an intense urge to poop it out. Breathe in and out. Don't push, don't push! How many times had I said that to patients nearing delivery? Did it sound as stupid to them as it did to me now?

The urologist said right away that he couldn't see any particular abnormality on the ultrasound. That might be good news. But he’d go ahead with the biopsies anyway, six of them.

The biopsies themselves didn't hurt much. I heard the snap of the needle, and then a wave of pain like a bowel cramp, which cleared quickly. Another patient said later this was how he thought it might feel to have a BB gun shot up his rectum. That captured the sound and then the wave of sensation, but it painted a more frightening picture than I experienced. I felt more like the fellow who said his biopsy bothered him less than having his blood drawn. "Of course," he added, "they didn't draw blood six times in a row with a broomstick up my ass."

 As soon as the biopsy was done, I wanted to know the results. This usually took several days, but Memorial Day weekend was coming up. It looked as though it might be more than a week before I’d learn results. That was too long. I knew I was OK, but I needed to have it confirmed sooner than that.

 So I gratefully embraced one of the perks of being in medicine. I called the pathologist who would be reading the biopsies. We'd had some contact on the hospital's medical executive committee, and he understood my anxiety. Of course I wouldn't need to wait. As soon as the specimens came, he'd read mine and call me. I didn’t give much thought to the other people who wouldn’t hear results until after the weekend.

 The next morning I was working on the obstetric floor when I got a page from the pathology office. My hand shook a little as I dialed the number. I was still pretty certain I'd hear that everything was fine and I could have my life back...

 "Mike, I don't have good news. I see cancer in two of the biopsy specimens. It's all Gleason 3, so the score is 6. I do see some perineural invasion in the specimen." He paused. "I'm really sorry to have to tell you all this."

I had already done enough reading to know that a Gleason score of 6 meant the cancer was in the middle between well-behaved normal cells and wildly uncontrolled cancer cells which had lost all their identifying characteristics. This was definitely real cancer, but it wasn’t as bad as it could have been. Perineural invasion meant the pathologist could see cancer creeping in around the nerves in the biopsy specimen, maybe already looking for ways to get out of the prostate and spread around the body.

 I didn't move from the chair. I must have dialed the phone again, because I was talking to Barb, my wife, and crying and telling her it was cancer. I didn’t say it, but I knew now I would die early. I'd have to undergo bloody surgery. It wouldn't really cure the cancer, but it would leave me impotent and in diapers. My sexual interest would dwindle along with my appeal. My fantasy of retiring and moving from California to the Northwest was going down in flames. I might just as well stay in California and die.

 I paged for help. I needed someone from the anesthesia group to take over for me right now. I suddenly couldn't face making life-or-death decisions for other people, or even being pleasant. One of my partners answered almost at once. Yes, he'd be right in. I could hardly keep my voice steady on the phone, and I sat crying half an hour later when he came into the call room.

 The urologist who had done the biopsy called right after the pathologist. He'd made time in his schedule to talk at the end of that same day, so Barb and I found ourselves sitting together in his office just after four. We sat on straight-back chairs facing him across his big desk. He leaned back in his chair, fingertips together, looking serious.

 I’d already brushed up on the easily accessible literature, and knew now that one man in every six would be having this sort of conversation with a urologist at some point in his life. In fact, I had already calculated that I was one of 500 men having this conversation on this very day. The American Cancer Society said 180,000 new cases of prostate cancer would be identified every year, and 30,000 men would die of it. Right at that point those other guys didn’t matter. I felt very alone.

My urologist was clear in his opinion that a radical prostatectomy was the best treatment for a man of my age with disease at my stage. Removing the entire prostate gave the best chance of removing all the cancer. He acknowledged that some predictable problems might follow prostatectomy. I might be incontinent, unable to stop the flow of urine. I was quite likely to be impotent, unable to get an erection.

Most surgeons removed the nerves necessary for erection when they removed the prostate. Dr. Patrick Walsh, chairman of urology at Johns Hopkins, didn't think that was necessary. He had developed a "nerve-sparing" technique of prostatectomy. He claimed that his technique of leaving the neurovascular bundles intact left patients more likely to have erections but no less likely to be cured. I was interested.

My urologist was quite frank. He didn't do the "nerve-sparing" technique, and he didn't think anybody else in town did it well. Ninety percent of his own patients, he said, were impotent after the operation. He obviously expected that I'd shop around for a surgeon, and didn't expect to do the operation himself. I asked him what he'd do if this were his prostate. He thought for a minute and then said, "I'd go to Hopkins."

 I had worked under Dr. Walsh 30 years earlier, when he was the chief resident in urology at UCLA and I was a surgery intern. I remembered him as focused and competent, a meticulous surgeon. He had spent the last 30 years making a name for himself as a prostate surgeon, and I had followed his career.

 Two days later I called Johns Hopkins hoping to talk to someone in Dr. Walsh’s office. In a few minutes I found myself talking to Dr. Walsh himself. I explained our former connection and my current situation. Yes, he said, he'd be happy to see me for a consultation. At his request I called his secretary for an appointment. The first opening was almost a month away, in June. I took it.

 For the next few days it seemed that the rest of my life had gone completely off its tracks. Nothing in the future seemed to matter. I couldn't even see a future.

I had been planning to leave that weekend to attend the annual meeting of the obstetric anesthesia society. I'd been president of this society, had hosted two of its meetings, and had produced its newsletter for six years. I felt deep connections to these people, and had looked forward to this meeting for months.

Suddenly I was no longer part of that world. Those people were all still living their lives, and I wouldn't get to live mine. I quietly slid my unused airline tickets into a desk drawer and stayed home.

 I’d been planning to retire from the private practice of obstetric anesthesia in two months and move from California to Washington. That was why I was having the physical exam in the first place, as sort of a last contact with my current physician. Although I loved being an obstetric anesthesiologist, I had never liked being up all night. It seemed that each sleepless night brought me closer to death. When a younger cousin died unexpectedly, I saw the handwriting on the wall. We put our California house on the market, bought a house in Washington, and looked forward to a new life on Puget Sound, teaching and writing and building wooden boats.

Now this was all wrong. I couldn't imagine moving away from the love and support of friends and co-workers in California. We'd have to stay put, at least until after I'd had some sort of treatment. We’d just have to cancel the sale of our California house and put the Washington house back on the market.

 I wrote a long letter to the nice couple buying our house. I explained the sudden decline in my health, and asked that they release us from the agreement to sell the house. They wrote that they were so terribly sorry to hear of my cancer, and of course they wished the best for me. Nevertheless, if we didn’t get out of their house immediately, they'd take legal action.

 I couldn’t face another struggle. Days passed, and the initial panic began to recede. We found that moving to the Northwest began to seem like a good idea again. We already had a house there, right on the water. Set among old-growth cedar trees looking out across Agate Passage toward Bainbridge Island, it seemed a perfect, healing place to be. We'd wanted to go there because I'd felt alive there once. So why not just go? I wouldn’t be having medical care in Sacramento, anyway. I'd be going out of town for that.

 In my journal during this time, I wrote about my fear that I’d lose sexual function, and about my dismay that we weren’t doing something about this, like having as much sex as possible before it was no longer possible. I wrote that Barb seemed to be doing quite a bit of suffering as the cancer patient’s wife, and I was irritated that the poor cancer patient himself seemed to risk being pushed out of the warm spotlight of sympathy. Still, I wrote, “I’m having a honeymoon with my cancer. No disability yet, no pain, no loss, no expense, no treatment. Lots of love and sympathy. I’m getting the benefits and not yet paying any of the price …”

 I decided at the beginning that I wouldn't keep secrets about what was happening to me. I'd be completely open, even with the kids. That was easy with Barb. She was also a physician, so I didn't have to explain basics. She helped digest medical information, and she really listened when I talked.

My older kids were the first to know, after Barb. Douglas, 26, a graduate student living in New York with David, his partner, responded quickly to my e-mail. He'd already searched the internet, and knew that his own risk was increased if I had prostate cancer. He joked that he'd better eat his fruits and vegetables and find a doctor with small fingers, and offered to go wig shopping with me. Jonathan, 23, was still in town, so we talked first on the phone, then in person. He brought his firefighter’s calm and his rib-cracking affectionate hugs. Katherine, 20, didn't respond at first to my e-mail. It took a while to break the silence that had settled years earlier when her mother and I divorced.

I wrote my parents, my sisters, and a few close out-of-town friends. All were encouraging and supportive. Nobody appeared to be wringing hands or hanging crepe.

 We told Erica, 9, and Elliott, 6, as much as they wanted to know. I explained that the doctors had found cancer in my prostate gland. That required a little anatomy lesson to get the prostate into the picture. I said although cancer sounded pretty scary, mine had been discovered early. My chances of having it treated and cured were very good. I hadn't yet made a decision about treatment. I'd probably be away at least a short time for any treatment I chose. But then I'd be home. I expected to be OK. I told them I would answer any question, any time. I never wanted them to think something bad might be happening that I wouldn't tell them about. At first, there were questions every day, but within a few months the cancer seemed to have disappeared into the background for them.

 Once my appointment with Dr. Walsh was secured, I had almost a month of breathing space. I still needed to know a lot more about other treatment choices. I began to spend all my spare time on the internet. The official websites of cancer societies were too generic to be useful, but several other websites dealt specifically with prostate cancer. The best of these were run by individuals whose own experiences with prostate cancer had inspired a commitment to providing information for others. I followed every link from these sites. Then I ran searches for prostate cancer and followed those links. Eventually, the information began to overlap and repeat itself.

I looked at websites run by individuals and groups touting particular treatments. These were a new idea for me, as they would have been for many doctors my age. I would once have dismissed them as advertising or self-promotion, as indeed they are. But I was delighted to see how much information the best of them presented.

I found two limitations on the value of internet information. First, nobody certifies the information on the internet. A bald-faced lie looks the same on the screen as time-tested "truth." I didn't consider information seriously until it had been reviewed by peers (other experts) and published for all to see. I wanted treatments that had been around long enough for meaningful data to have been published in peer-reviewed publications, "real" medical journals.

Here I encountered the second limitation. The web didn't usually have the full text of journal articles. Most literature on the web is available as abstracts, short summaries of research papers. These briefly describe the research and give the conclusions. Some abstracts, like the personal ads in newspapers, convey an optimistic view of the real situation. Here I began to appreciate my medical education. I went to the medical library at UC Davis to examine the original articles. I found that sometimes the unequivocal-sounding conclusions in abstracts weren't supported by the weak research in the papers.

Surrounded by piles of articles from dozens of journals, I was reminded that all peer-reviewed literature isn't equal. Some journals are tough, some easy. Tough journals require good scientific principles, rigorous data analysis, and conclusions that fit the data. Easy journals publish many pieces rejected by tougher journals. Some articles were worthless. There was no way even to know what the researchers had observed, much less evaluate the way they analyzed their information and reached their conclusions.

 I read about every treatment I could find -- prostatectomy, radioactive seed implants, external beam radiation, cryosurgery, proton beam radiation, high density radiation treatment, androgen deprivation, castration, chemotherapy. Then one morning after I'd been doing this for several weeks, I realized I'd started my search for a treatment without asking even the most basic question. I was trying to compare survival statistics among different treatments, but I hadn't even asked would happen if prostate cancer weren't treated at all.

 So I read more about "watchful waiting." And I encountered the controversy over screening. Many family practitioners and internists seemed to be arguing that we can't tell which cancers will spread all over the body and which will lie indolently into old age. Moreover, we can't be sure any particular treatment is really capable of "curing" prostate cancer or extending life. The treatments themselves produce misery and disability and a great deal of medical cost, they argue, so why look for the cancer early? How do we know we're not simply taking a group of men who would have done well for years and exposing them to the disabling effects of surgery, radiation, and drugs without making any useful difference in the length of their lives? My own internist had held this view. That’s why I hadn’t had a PSA drawn at age 50.

 Amid this confusion I began to see that one of the most important issues in successful treatment is whether the cancer has already escaped the prostate and extended into the body before treatment begins. Several researchers have looked at this question. The “Partin tables”, prepared by Dr. Partin from Johns Hopkins, make it possible to predict from PSA value, clinical stage, and Gleason score the probability that cancer will have extended outside the prostate capsule.

Looking at the Partin tables, I could see that even at my early stage, things were worse than I thought. There was at least a 35% chance my cancer had already extended through the capsule. I thought this made prostate surgery less likely to be successful. I thought I'd need to find a way to treat not only the prostate, but also the area around it (the prostate fossa).

It was hard for me to keep in mind that these numbers described probabilities of either/or outcomes. When I was teaching, I used to remind anesthesiology residents that a mortality rate of one percent didn't mean everybody was one percent dead. It meant that one patient was completely dead and 99 others got off scot free. Same here. Partin's numbers didn't mean I was already 35% cancer-riddled. They meant that I had a 35% chance of drawing the short straw and finding tumor outside of my prostate at prostatectomy. On the other hand, they also meant I had a 65% chance of finding that my tumor was completely “organ-confined”, not yet outside the prostate.

I had no way of knowing whether I was in the "good" group or the "bad" group. I had one chance in three of waking up after prostatectomy and discovering I had lost my bet, and prostatectomy hadn't removed all the cancer. On the other hand, the odds were 2:1 that I'd be a winner and be told that prostatectomy had removed all the cancer. How could I know ahead of time? And how was I supposed to pick which side effects and complications I most wanted to risk? In the end I'd have to balance an educated guess about success against another educated guess about complications. Any choice would be simply a “best guess”.

 I wanted nothing to do with new treatments that had no track records. Prostate cancer generally does its damage so slowly that any new treatment looks good for a while. Not many men die, and not many get dramatically sicker. You'd see the same thing with no treatment at all, at least for a while. It takes years to tell whether a treatment is really effective.

The only treatments with long track records were radical prostatectomy, external beam radiation, and radioactive seed implantation. But their track records were hard to compare. They'd been running different races at different tracks under different rules.

 Radical prostatectomy has been called the "gold standard." That doesn't mean it's perfect. It means only that there's enough information about the outcomes of radical prostatectomy to compare other techniques to prostatectomy. But that's not easy.

Surgeons insist that success means both prostate and cancer are gone, so PSA is undetectable. Many radiotherapists, on the other hand, have been content to declare victory if PSA is still present, but no longer rising. That seemed like having the exterminator call his treatment successful as long as he couldn't count more cockroaches on your kitchen floor than he saw before he started his treatment. I didn't find that consoling. I wanted no cockroaches crunching under my bare feet. Not now, and not ever again.

Success meant whatever a group wanted it to mean. Groups didn't all evaluate their results in the same way. In cockroach terms, some exterminators would treat only clean kitchens with a few roaches to keep their statistics good-looking. Others examined their kitchens only once or twice right after treatment, and didn't follow up for the long times necessary. Still others seemed to lose track of which kitchens they'd treated, and couldn't give information about the kitchens that were "lost to followup."

 One radiotherapy clinic in Georgia kept showing up in my searches. Dr. Frank Critz ran what had been a small private clinic in Decatur, near Atlanta. He had been carefully following patients for years, and had published several papers with his results. His clinic group specialized in radioactive seed implantation followed by 3-D conformal external beam radiation. They called this approach “prostRcision®”, for excision of the prostate by radiation. This struck me as completely hokey, since doctors don’t usually invent brand names for medical techniques. Still, they seemed like a serious group, so I was willing to suspend judgement on the name.

Virtually all patients there received both seeds and external beam radiation. All of the treatments were administered in facilities run by the group in the Atlanta area. Nobody got sent home with a "radiation prescription". After some initial bad experience with "home town" radiation, the group now insisted on taking responsibility for every phase of the treatment.

 Their approach was a little rigid, but I thought it made sense as a way to deal with the chance that tumor had extended outside the prostate capsule. I really liked their attention to detail. I knew from personal experience that medicine is an art, and I wanted doctors who understood themselves as artists. These people produced encouraging numbers. Their approach looked as though it might give me the same chance of being disease-free at ten years as a radical prostatectomy. The risk of impotence seemed lower, and the risk of incontinence was negligible.

I wanted to talk to these guys. I'd be flying right through Atlanta on the way to see Dr. Walsh in Baltimore, so I called the clinic to see whether I could see Dr. Critz or Dr. Hamilton Williams, one of his partners. Dr. Williams had time, so I was booked to see him on June 22. We'd fly a day early so we could stop over.

But we almost didn't make the stopover. Our Delta flight was cancelled at the last minute when the plane manifested a mechanical problem. It looked as though we’d have to fly straight to Baltimore the next day and skip Atlanta. As I stood meekly in line to change our tickets, Barb strode off to the America West counter. In minutes she waved me over. We could still make it to Atlanta by way of Phoenix. We'd arrive after midnight, but our clinic appointment wasn't until 1 pm the next day. We were on track again.

 The next day we arrived at the clinic well ahead of time. White letters on red brick proclaimed this the Radiotherapy Clinics of Georgia. A small sign on the side of the building said "All Deliveries in Rear". Maybe somebody here had a sense of humor. We settled down in the busy reception area to fill out the requisite paperwork and wait. Men came and went for their radiation therapy appointments, and one or two other new patients sat off to the sides of the room. None of the men looked sick.

Although the clinic staff were very friendly and attentive, we weren’t shown to a room. Finally, we began to understand there'd been a mistake in the schedule. We’d been set up to see Dr. Williams at the same time he was addressing a class, with a full schedule of other patients afterwards. We waited almost three hours to see him, but when he sat down in the room with us, he was all ours. We had time to learn about each other.

The first thing he learned was that we were freezing. The air-conditioned clinic had the ambiance of a meat locker. After almost three hours on the hook, Barb was clearly losing her battle against hypothermia. Dr. Williams looked at her summery attire and her clacking teeth, and excused himself for a moment. He returned with his suit jacket, which he draped over Barb's shoulders. Barb huddled gratefully inside.

Dr. Williams took a careful history, and then gave me the most complete physical examination I'd had since medical school. To my surprise, he said he didn't feel a distinct prostate nodule on his exam. Was I already healing myself by good thoughts, I wondered?

 He said my cancer was ideally suited for the approach his clinic would take. Treatment would occur in two stages. In the first stage, I'd have the radioactive seeds implanted in the prostate. Though a relatively minor surgical procedure, it would be done in a hospital under a general anesthetic. They'd place at least 20 long needles into the prostate through my perineum, the area between my scrotum and my anus, then insert the seeds through these needles. I'd need to spend a couple days in Atlanta getting ready for the operation, and at least a day afterward before I could go home.

Three weeks after the implant, I'd come back to Atlanta for six or seven weeks of conformal external beam radiation. Much of this radiation would be delivered through a cutout in a lead block that would have exactly the shape of my prostate. This would shield other delicate tissues from the radiation.

Dr. Williams thought I had a 90% chance of being disease-free at 10 years, and at least a 70% chance of avoiding impotence. Incontinence was extremely unlikely, as was serious rectal injury. Urinary irritation was common, as well as some bowel irritability. He’d be happy to undertake my treatment if that was what I wanted after examining my options.

I asked why it seemed so hard for proponents of one treatment to be objective about other treatments. He laughed and said the biggest impediment to keeping an open mind about other treatments is money. Prostate cancer treatment is big business. Nobody wants to admit somebody else's therapy is better, or even equivalent. Doctors worry that talking objectively will encourage patients to go elsewhere. No patients, no money.

As Barb and I fretted through rush-hour traffic to the airport, we compared impressions. We agreed that Dr. Williams seemed to be one of those physicians whose practice is designed to serve patients, rather than use patients to build the physician’s reputation or fortune. It seemed that our experience mattered to him, that he was a man we could trust.

In Baltimore the next morning I prepared myself for the cold impersonality of a legendary medical center, but Johns Hopkins was a pleasant surprise. The Hopkins shuttle picked us up right outside the entrance of our downtown Baltimore hotel. At the hospital I watched residents and medical students stride past, looking intent, as I filled out papers and gave blood. I was acutely aware that I wasn't here as part of their world. I belonged to the larger crowd that eddied along the admissions counter and then swirled upward aboard the escalator. My bright-orange official Johns Hopkins card and my new sheaf of papers were my tickets to the urology clinic. Barb and I were shown to a sunlit consulting room to await Dr. Walsh.

 At length he strode in unaccompanied and introduced himself. He had aged a little in our 30 years apart, and I was surprised that he didn’t seem as big as I remembered him. It was clear that he didn't remember me, but he acknowledged our UCLA connection. Interns had been poorly treated at UCLA, he said. Already we agreed on something.

After a few minutes of conversation, he picked up the biopsy slides I'd brought with me and left the room to examine them. Just as I began to wonder if he’d left us for good, he came back and took a bit more history. Then suddenly he stood up and left the room without explanation. He did this several times.

Although Barb had introduced herself as a physician, he didn’t speak directly to her unless she asked a question. When he spoke to her he was curt, as though annoyed by her intrusion. This seemed discourteous, but later I realized I might have been doing the same thing in my own practice. I often focused on an obstetric patient and didn't try to include her husband because he wasn't the "real" patient.

Dr. Walsh's cursory physical examination consisted primarily of a vigorous digital rectal examination as I lay submissively spread-eagled over the end of the exam table, arms wrapped around the table. As he examined me, he spoke of the benefits of having patients assume this position, as though I would incorporate it into my own practice when I got home.

 Finally we sat to talk. He'd looked at my slides, and he agreed my Gleason score was approximately accurate. He wasn't worried about whether my tumor was invading the prostate capsule. He didn't think that would interfere with my prospects for cure by radical prostatectomy. He dismissed my worry about perineural invasion, saying it was just a sign the tumor was moving toward the outside of the prostate. He thought my chance of being cured by prostatectomy was upwards of 87%. I'd have an 80-90% chance of retaining my ability to have an erection. At 18 months, I'd have a seven percent chance of needing a pad to absorb occasional urinary dribbling. I'd have a two percent chance of needing more than one pad per day.

I'd have the operation under a spinal anesthetic, he said. After four days in the hospital, I could go home on the plane with a urinary catheter in place. My urologist at home could take it out in three weeks. I'd never need to return to Baltimore to see him, but he'd require that I send him periodic PSA values. This would continue, he said with a faint smile, until his obituary appeared in the New York Times.

By the way, he added, I was too fat for him to do his best operation. He handed me a yellow sheet of paper describing how I could lose 30 pounds in two months, and told me he'd schedule me in two months so I could do that. I agreed I was too fat at 240 pounds on a 6'2" frame, but I wondered whether obesity was the only issue. Was he keeping the operating schedule light for a summer vacation? I didn't ask.

He stood, shook my hand, and said if I decided to have him do the operation, I could just call his secretary to get on the schedule. Once scheduled, I'd need to make arrangements right away to start donating my own blood and shipping it to Baltimore for the operation. He turned and was gone.

 Barb was silent as we rode down in the elevator. As we waited for the shuttle outside, she suddenly turned to me and said, "I do *not* want that man to put his hands on you ever again." She was quick to add that if I decided he was the right guy to do the treatment, she'd honor my choice and support me fully. I admitted that I hadn't felt much of a personal connection, either. But it was less an issue for me. I thought Pat Walsh was the best at what he did; he apparently agreed.

 I came home undecided. I drew up a decision table, contrasting prostatectomy with seeds and radiation. I listed every decision element I could think of, from estimated chance of being disease-free at ten years to the attractiveness of the city in which treatment would occur. I thought both approaches had about the same chance of "cure", and about the same risk of impotence. Incontinence was primarily a surgical risk. Expense was about equal. Pain and misery would be greater at first with the prostatectomy, but approximately equal at six months. Time away from home was much greater with seeds and radiation in Georgia than with prostatectomy. Barb's enthusiasm for surgery was lower, as was mine. The surgeon was less likeable than the radiotherapist. I liked Baltimore more than Atlanta, but I wouldn't be spending much time there if I had surgery.

 So I simply made no decision. I didn't start the crash diet for surgery. I didn't call Georgia. And I didn't look at any other options. I was stuck, unwilling to commit to treatment. In the meantime, life didn't stop. The moving van was still coming on July 14.

On the morning of July 6, the Radiotherapy Clinic called me at home. Had I made a decision about my treatment? Did I have any further questions? I heard myself saying I'd like to go ahead and schedule myself for a radioactive seed implant. Their first opening was in early August. I liked that time, but was disappointed that Dr. Williams wouldn't be available for the implant that day. Who would? Dr. Critz. I thought having the founder of the clinic and originator of the technique do my implant sounded pretty good. So I was committed, corralled by a "tickler" file. I felt no regret, had no second thoughts. I felt only relief that the period of indecision was over.

A week later I worked my last night shift as an obstetric anesthesiologist. I hugged a few people goodbye, emptied the contents of my locker into a cardboard box, and walked out into the already-hot morning of my new life. I was about to leave my practice, my professional identity, my income, my community, my home, and some of my family for a new life in Washington, in a community where I was completely unknown. And almost as soon as I arrived there, I'd begin treatment for my cancer in Georgia, away from my family.

I looked forward to living on the water in Washington, and to being retired from practice. I was filled with anticipation, not dread. I didn't grasp the extent of the change we were taking on, and I had no way to be sure what lay ahead with cancer treatment. Months later, I would recall a scoring system that gave stress points for major life events, and would wonder whether I'd pushed my score off the top of the chart this year.

 The moving van left Sacramento late on Friday, July 14. By the following Tuesday, it was in Washington, ready to be unloaded. Barb and I arrived at the empty house on Sunday evening, alone. The kids had flown to Hawaii to be with Barb’s ex, and wouldn’t be back until after my implant. So for two weeks we'd have the new house to ourselves.

At dusk on that first Sunday night, I looked out the kitchen window toward the east and saw an orange glow begin to spread over Bainbridge Island. Concerned, I called Barb. Was there a fire on the Island? We watched as the glow filled the sky behind the trees. Suddenly a full moon edged above the trees into its own low-watt version of a sunrise. We sat on the back steps sharing yesterday’s leftover chicken sandwich from the RV refrigerator as we watched the long path of reflected moonlight spread slowly across Agate Pass. This would be a magic place.

This house was the best vacation rental we’d ever found, but it wasn’t a rental. We owned it. The van came after two days, so we agreed to spend part of each day unpacking like responsible adults. But the rest of the time we let ourselves be free. We took our kayaks out onto the water from our own beach and explored the edges of the Sound, fascinated by jellyfish and sea stars and salt water. We sat on a bench in Poulsbo’s downtown park and watched the sunset over the marina. We watched the sunrise through the bedroom’s four east-facing windows. We learned that the gentle dawn at 4:00 was followed by the insistent glare of sunlight off the water by 5:30. Nights were short, days long, as though the universe was encouraging us not to spend these last days of normalcy asleep.

I knew that when we came back from Atlanta, the kids would be coming back from Hawaii at the same time. My son Jonathan would be coming up from California. Our quiet time together would be over. We’d all be together again, with guests. And I would be uncomfortable from the implant, changed forever in some way.

 I was to have my seed implant on Thursday, August 4. I'd fly from Seattle to Atlanta on Monday. Tuesday I'd meet the doctors and be evaluated pre-operatively. Wednesday I'd clean out my bowels and wait nervously for Thursday. I'd have the operation Thursday morning. By Thursday afternoon I'd be back in my hotel room. I'd have a catheter in my bladder to ensure the prostate didn't swell up after the operation and make it so I couldn't pee. Friday morning I'd go back to the clinic and they'd take the catheter out. If I could pee, then I could go home.

 The operation itself would take only an hour, but it would require a week to fly there, have the operation, and come home. Three weeks later, at the end of August, I’d return to Atlanta for external beam radiation. This would take six or seven weeks. Since the radiation was administered only during the week, I could come home on weekends if I felt the cost and hassle of air travel were worth it.

 I thought at the time that cancer was changing my life. But that wasn't quite right. It wasn't cancer itself. It was the meaning I gave to the word cancer that changed my life. I made "cancer" mean I was going to be destroyed by something inside of me, and I took action in response to that meaning.

 I have never experienced my cancer. What happened is that someone told me they could feel a small hard lump in my prostate, in a place where I couldn't even reach in and feel it myself. A lump is just a lump. It means nothing.

 But then someone else told me that the lump was cancer. Now a *cancer* in my prostate, that meant something. It meant death. Early death. Horrible, painful death. It meant illness and disability and maybe burned bowels and a dribbling bladder and no more sex. It meant that something growing within me would consume me and leave me withered and destroyed and dead.

I was afraid, deeply afraid. But I didn’t talk then about this primitive fear, even to acknowledge it. I talked like a physician, about outcomes and probabilities and years of disease-free survival. The primitive fear was there even before I could get that doctor-thinking machinery started. And it stayed there, under the noise of the thinking machinery -- the fear I would be destroyed.

I created an imaginary future from my worst imaginings. My fear of cancer was fear of an imaginary future. Until the day of diagnosis, my life had been fine. But now I was afraid my life would become this imaginary life I feared.

I wanted to make the imaginary future go away. I believed there were practitioners who could destroy this cancer that I couldn't even feel. If they could do that, they could spare me this grim, dark future.

I was perfectly willing to bargain. I knew destroying the cancer would mean destroying some part of my body. But in my fear I was ready to begin throwing nonessential parts overboard if that would save me. I knew this would permanently change or even abolish some functions I liked.

 I had not always understood this. Although I had worked in operating rooms all of my professional life, first as a surgical intern and then as an anesthesiologist, I had not undergone a major operation myself until I was 39. I had undergone a partial thyroidectomy for a benign tumor, and I had been amazed to discover afterwards that the thyroidectomy incision had disrupted some nerves *that would not grow back*! I now had a permanent numb area "downwind" of the incision. For the first time I understood that operating on the body is not comparable to maintaining a factory-fresh machine. Each intrusion into the body produces some permanent loss of function, however minor.

But I was more afraid of the imaginary future with cancer than of the predictable "collateral damage". I weighed each of the approaches to destruction carefully, and made a deliberate choice to destroy part of my body and accept the losses in hopes of avoiding an imaginary future with cancer.

In that same situation, I'd probably have the same response again.

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