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(Revised)

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### THE WILL ROGERS PHENOMENON

Will Rogers quipped -- "in the 1930's, there was a mass migration of people from Oklahoma to California. As a result, the average I.Q. of both states.....increased."

If you were a school teacher in California and used a new textbook as these new students flooded your school, you might conclude that the new textbooks were causing the I.Q.'s to increase, when the improved results were a result of smarter pupils (Okies).

In medicine we call this "stage migration."

Over the years, as we begin to figure out new prognostic factors, we can weed out those patients who will not do so well. We then look at our early results with some new treatment and believe the improved results are because of a better treatment. But we must remember what Will Rogers cautioned -- the improved results may not be from better treatments but from more carefully screened applicants.

If our prostate cancer population is not screened, the results of treatment don't look so good.

So then our next protocol requires entering patients who have lower PSA's and lower Gleason scores in order to qualify for the new "improved" treatment. For the first few years, it looks like we are curing a higher percentage of patients when, in fact, all we have done is eliminate the early failures by requiring lower PSA's and Gleason scores before we allow them on this new protocol.

In the October *Journal of Urology*, I note that the best results for radiation treatment are in those men whose initial PSA's were less than 2. Hardly surprising. The lower the PSA and the lower the Gleason score before treatment, the longer it will take before your PSA rises after treatment. The cure rates will not be higher (I predict), but the failures will be postponed and not

## WILL ROGERS PHENOMENON

### Page 2

identified as failures for a few extra years.

For men considering radical prostatectomy, the same issue points out that a pretreatment PSA of less than 4 shows very promising (early) results, especially if the Gleason score is also low (6 or less). Hardly surprising. The higher the PSA and the higher the Gleason score, the earlier men recur following radical prostatectomy or radical radiation. What these studies are doing is finding the men who have the least amount of disease to start with; these are the men who would take the longest to have a rising PSA.

Is cure necessary in these men? Almost for sure not, as pointed out by Dr. Willett Whitmore, whose early insight says it all:

Is cure necessary for men in whom it is possible; and is cure possible for men in whom it is necessary? As you know, Dr. Whitmore had a radical prostatectomy and later died of metastatic prostate cancer.

Ironic or predictable?

When you choose to treat PSA's of less than 4-6, and Gleason scores of 6 or less, and if your average follow up is only three or four years, your results are going to look great. Not because of the treatment, I caution, but because of "The Will Rogers Phenomenon."

I do believe it is possible to cure most of these tiny, 0.5 cm tumor volumes. But it is not necessary. This man would die with prostate cancer, not from prostate cancer. These men almost certainly have biologically indolent disease that would never spread, and the local treatment would be unnecessary, but would still result in the nasty side effects with which we are all too familiar, including urinary incontinence, erectile dysfunction and, for some, fecal incontinence.

I will start to believe local treatments alone work when the definition of failure is a measurable PSA using a methodology that detects PSA down to .07 or less; and when you check PSA's every three months looking for failure, not once a year, and when your average follow up is closer to ten years. Then I will start believing that local

**WILL ROGERS PHENOMENON**

**Page 3**

treatments alone work. Not until then, Will, Rogers, not until then.

And, as always --

Be happy,

Be well,

Live long and prosper,

**BOB LEIBOWITZ, M.D., AKA DR. BOB**