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NEWSLETTER

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◆ **TRENDS IN PROSTATE CANCER IN RECENT YEARS** ◆

PSA screening for prostate cancer as well as the incidence of early-stage prostate cancer have declined substantially since the United States Preventive Services Task Force (USPSTF) recommended against such screening, conclude two new studies. Both were published November 17, 2015, in the *Journal of the American Medical Association*.

"The incidence of prostate cancer is dropping, but this doesn't mean that the cancer is not there, it just means we're not finding it," says David Penson, MD, MPH, Vanderbilt University, Nashville, TN. There is reason to be worried about the two trends reported in these studies, he writes in an editorial accompanying the two studies.

Data From Recent Years

The USPSTF made its first recommendation to curb PSA screening in 2008 in men aged 75 years and older. In 2012, it broadened the recommendation to include all men, concluding that the benefits of PSA-based screening for prostate cancer did not outweigh the harms.

The first study, led by Ahmedin Jemal, DVM, PhD, the American Cancer Society, Atlanta, GA, shows that PSA screening rates decreased by 18% between 2010 and 2013 among men aged 50 years and older and that the incidence of early-stage prostate cancer also declined in this age group, going from 498 per 100,000 men in 2011 to 416 per 100,000 men in 2012.

The second study, led by Jesse D. Sammon, DO, from Brigham and Women's Hospital, Boston, MA, found that although the 2008 USPSTF recommendations against PSA screening in men aged 75 years and older were not linked to changes in screening, the 2012 recommendations were more successful in decreasing screening, particularly in men younger than 75 years. **(Continued on page 8)**

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◆ FROM THE EDITOR ◆

Do you know persons who would benefit from receiving this newsletter? Put them in contact with the editor as shown at the top, left, of this page. Also, we solicit your recommendations for topics for our quarterly meetings. Contact the editor with your suggestions.

◆ SPEAKER'S REMARKS - NOVEMBER 5, 2015 ◆

Our November program featured a presentation by Dr. Timothy J. Tausch, Department of Urology, Fort Belvoir Community Hospital and WRNMMC. His topic was "Prostate Cancer Survivorship: Urinary Incontinence After Treatment." Dr. Tausch also expanded his presentation to include Erectile Dysfunction. A summary of his remarks begins on page 10.

◆ MEETING SCHEDULE FOR FEBRUARY 4, 2016 ◆

Our speaker for 7:00 pm, Thursday, February 4, 2016, is Ms Nancy Tschiltz, Registered Dietician, within WRNMMC's Integrated Cardiac Health Project. Her timely topic is "Nutrition and Cancer." Please join us, and remember, your family and friends are also welcome.

(The presentation also may be viewed via video teleconference at the Fort Belvoir Community Hospital. Go to the Oaks Pavilion, 1st floor, Room 332, to participate.)

SEE THE BACK PAGE OF THIS NEWSLETTER FOR IMPORTANT INFORMATION ABOUT THIS MEETING.

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◆ PROSTATE-SPECIFIC ISSUES ◆

Low-Risk Prostate Cancer Often Not Monitored Closely. Most men with low-risk prostate cancer who choose "watchful waiting" (active surveillance) instead of aggressive treatment may not be followed as closely as they should be, a new study suggests. This puts them in danger of their cancer progressing or spreading undetected, the researchers warned.

"This is really an important finding, because before patients and their doctors decide to pursue active surveillance as a management option for prostate cancer, both the physician and patient should agree on a follow-up schedule to closely monitor the cancer," according to Chamie, et al. at University of California, Los Angeles, in a university news release.

The study included almost 38,000 men who were diagnosed with prostate cancer between 2004 and 2007, and followed through 2009. Of the approximately 3,600 men who chose active surveillance instead of aggressive treatment such as surgery and radiation, only 4.5 percent received proper monitoring.

"What was most surprising was that patients who underwent aggressive treatment for their prostate cancer were more likely to receive routine lab testing and visits with their doctor than those not receiving aggressive treatment, "In other words, those likely cured through aggressive treatment were followed more closely than patients whose cancers were left untreated," the researchers said.

Recommended monitoring includes prostate-specific antigen (PSA) tests, physical exams, and at least one additional prostate biopsy within two years, according to Chamie. "Many researchers have been advocating for active surveillance for men with low-risk disease, however, this study suggests that before advising patients to pursue active surveillance for their prostate cancers, doctors should be certain that they are committed to closely monitoring the cancers with a repeat biopsy, PSA testing and physical exams."

The findings were reported in the December 1, 2015, issue of the journal *Cancer*. (Source: University of California, Los Angeles, news release, Dec. 1, 2015, via HealthDay News, December 4, 2015)

Surgery May Beat Radiation for Men With Early Stage Prostate Cancer. A Canadian analysis of 19 studies suggests surgery has an edge in survival, but experts say each case may be different. Men with prostate cancer that is still confined to the organ are more likely to survive if they have surgery rather than radiation therapy, this new Canadian study suggests.

This type of "localized" prostate cancer is the most common form of the disease, accounting for about 80 percent of cases, according to Nam, et al., Odette Cancer Centre, Sunnybrook Research Institute, Toronto.

The most common treatments for localized prostate cancer are surgery and radiation therapy, but which works best to keep the disease at bay? To find out, Nam's team looked over data from 19 studies that included a total of nearly 119,000 men with localized prostate cancer.

Findings from 15 of the studies showed that those who received radiation therapy were twice as likely to die from prostate cancer as those who had surgery. Findings from 10 of the studies also showed that men who had radiation therapy were 50 percent more likely to die sooner

of any cause, compared to those who had surgery. The results of the analysis were published December 14, 2015, in the journal *European Urology*.

The researchers concluded that past studies that compared the success rates of surgery or radiation have been confusing because of their methods, but this new study evaluated all the good-quality data comparing surgery and radiotherapy, and the results are pretty conclusive; in general, surgery results in better mortality rates than radiotherapy."

But prostate cancer treatment is never a one-size-fits-all matter, the researchers added. "There are times when radiotherapy may be more appropriate than surgery, so it is important that a patient discusses treatment options with his clinician," Nam said. He believes that "the important thing about this research is that it gives physicians and patients additional information to consider when making the decision about how to treat localized prostate cancer."

Two U.S. experts came to somewhat different conclusions about the results. "The results of this study point not only to the efficacy of surgery as a principal mode of treatment and first line of defense against prostate cancer, but also as a way to extend the life of men affected by prostate cancer," said Dr. David Samadi, Lenox Hill Hospital in New York City.

He said that surgical removal of the prostate "is the only option which removes the entire prostate, and therefore allows for more accurate staging and grading [of the tumor]. This means your doctor can create a better long-term plan of care for each individual patient. And Samadi stressed that "radiation is still possible as a secondary treatment after surgery. So patients have yet another way of combating their cancer if necessary."

But another expert had some reservations about the study. Dr. Jonathan Haas, chief of radiation oncology at Winthrop-University Hospital in Mineola, N.Y., said that the Canadian review may not have accounted for recent improvements in radiation treatment that could boost outcomes for patients.

According to Haas, what's needed to answer the surgery-versus-radiation question is a "prospective randomized trial using state-of-the-art medicine."

"Only then can the best conclusion be made," he said. "Patients with this disease have many options including radiation, surgery, and possibly even surveillance. Only by individualizing a treatment plan for an individual patient with their specific information can the best outcomes be obtained." (Source: Winthrop-University Hospital, Mineola, N.Y.; *European Urology*, news release, December 14, 2015 via HealthDay News, December 15, 2015)

Physical and Psychosocial Side Effects of Brachytherapy. Brachytherapy (BT) plays an important role in cancer treatment. Like any other medical therapy, it may induce side effects whose recognition can affect the patient's quality of life. Therefore, the present study evaluated the frequency and severity of physical and psychosocial adverse effects of BT.

Seventy patients undergoing high-dose-rate (HDR) BT or low-dose-rate (LDR) of head and neck, breast, and prostate cancers were interviewed face-to-face at the end of their course of treatment. Interviews concerned the occurrence of 35 physical (dermatological, gastroenterological, neurological, ocular, pulmonological, and urological) and 10 psychosocial side effects of BT. A high percentage of patients reported that BT decreased their life satisfaction (54.3%),

and their sense of security (41.4%), and self-esteem (34.3%). The highest frequency of gastroenterological and urological symptoms was reported by prostate cancer patients. Cigarette smoking increased the frequency of nausea, dyschezia (constipation), and weight loss. Overweight patients were characterized by an increased rate of urinary incontinence and dyschezia, as well as more pronounced decrease of self-esteem and sense of security following BT treatment.

These findings are not only highly relevant to the way patients can be prepared for the therapy but also have a bearing on ways to minimize the number and severity of BT side effects. (Source: *Journal of Contemporary Brachytherapy*. October 13, 2015 [Epub])

Evaluating a Support Group Program for PCa Survivors. Prostate cancer survivors in Alaska and elsewhere have unmet support needs. The Men's Prostate Cancer Survivorship Retreat, or "men's retreat," was developed targeting Alaska Native and non-Native men who were survivors of prostate cancer. The program brought together survivors in a supportive environment to discuss and share their experiences.

Despite the proven effectiveness of support groups for improving quality of life for cancer patients, men typically do not participate in formal support groups. This descriptive study was conducted to explore the needs of Alaska Native and non-Native prostate cancer survivors and assess satisfaction and acceptability of a men's cancer survivorship retreat in Alaska.

Prostate cancer survivors who attended men's retreats during 2009-2013 were asked to complete a retreat application and post-retreat evaluation. Comments regarding social support, helpful and valuable aspects of the retreat including overall satisfaction were reported.

The study concluded that a men's retreat with activities that engage men can be successful for prostate cancer survivors. Many men returned for successive retreats. After the retreat, 97% of the participants said they would continue with support activities. The men's retreat provides a valued opportunity for men to interact with other survivors and access information from health professionals. The results from this study highlight a successful model for social support and resources specific to male prostate cancer survivors. (Source: *International Journal of Circumpolar Health*, November 25, 2015 - e-published)

A prospective cohort study of treatment decision-making for prostate cancer following participation in a multidisciplinary clinic. Patients diagnosed with prostate cancer (PCa) are presented with several treatment options of similar efficacy but varying side effects. Understanding how and why patients make their treatment decisions, as well as the effect of treatment choice on long-term outcomes, is critical to ensuring effective, patient-centered care.

This study examined treatment decision-making in a racially diverse, equal-access, contemporary cohort of patients with PCa counseled on treatment options at a multidisciplinary clinic.

A prospective study was initiated at the Walter Reed National Military Medical Center (formerly Walter Reed Army Medical Center) in 2006. Newly diagnosed patients with PCa were enrolled before attending a multidisciplinary clinic. Patients completed surveys pre-clinic and post-clinic to assess treatment preferences, reasons for treatment choice, and decisional regret.

As of January 2014, 925 patients with PCa enrolled in this study. Surgery (54%), external radiation (20%), and active surveillance (12%) were the most common primary treatments for patients with low- and intermediate-risk PCa, whereas patients with high-risk PCa chose surgery (34%) or external radiation with neoadjuvant hormones (57%). Treatment choice differed by age at diagnosis, race, comorbidity status, and calendar year in both univariable and multivariable analyses. Patients preferred to play an active role in the decision-making process and cited doctors at the clinic as the most helpful source of treatment-related information. Almost all patients reported satisfaction with their decision.

This is one of the first prospective cohort studies to examine treatment decision-making in an equal-access, multidisciplinary clinic setting. Studies of this cohort would aid in understanding and improving the PCa decision-making process. (Source: Uro Today, December 15, 2015 - Epub ahead of print)

Very long-term survival patterns of young patients treated with RP for high-risk prostate cancer. In patients with a long life expectancy with high-risk (HR) prostate cancer (PCa), the chance to die from PCa is not negligible and may change significantly according to the time elapsed from surgery. A study evaluated long-term survival patterns in young patients treated with radical prostatectomy (RP) for high-risk prostate cancer.

Within a cohort, 600 young patients (≤ 59 years) treated with RP between 1987 and 2012 for high risk prostate cancer (defined as at least one of the following adverse characteristics: prostate specific antigen > 20 , cT3 or higher, biopsy Gleason sum 8-10) were identified. Statistical techniques assessed cancer-specific mortality (CSM) and other cause mortality (OCM) rates at 10, 15, and 20 years after RP. The same analyses were performed to assess the 5-year probability of CSM and OCM in patients who survived 5, 10, and 15 years after RP.

The 10-, 15- and 20-year CSM and OCM rates were 11.6% and 5.5% vs. 15.5% and 13.5% vs. 18.4% and 19.3%, respectively. The 5-year probability of CSM and OCM rates among patients who survived at 5, 10, and 15 years after RP, were 6.4% and 2.7% vs. 4.6% and 9.6% vs. 4.2% and 8.2%, respectively. Year of surgery, pathological stage, Gleason score, surgical margin status and lymph node invasion were the major determinants of CSM.

The study concluded that very long-term cancer control in young high-risk patients after RP is highly satisfactory. The probability of dying from PCa in young patients is the leading cause of death during the first 10 years of survivorship after RP. Thereafter, mortality not related to PCa became the main cause of death. Consequently, surgery should be considered among young patients with high-risk disease and strict PCa follow-up should be enforced during the first 10 years of survivorship after RP. (Source: Uro Today, December 16, 2015 - Epub)

The impact of interdisciplinary team meetings on patient assessment, management and outcomes in oncology settings. Conducting regular multidisciplinary team (MDT) meetings requires significant investment of time and finances. It is thus important to assess the empirical benefits of such practice. A systematic review was conducted to evaluate the literature regarding the impact of MDT meetings on patient assessment, management and outcomes in oncology settings. Relevant studies were identified by database searches. Studies were included if they assessed measurable outcomes, and used a comparison group and/or a pre- and post-test design. Twenty-seven articles met inclusion criteria.

There was limited evidence for improved survival outcomes of patients discussed at MDT meetings. Between 4% and 45% of patients discussed at MDT meetings experienced changes in diagnostic reports following the meeting. Patients discussed at MDT meetings were more likely to receive more accurate and complete pre-operative staging, and neo-adjuvant/adjuvant treatment. Quality of studies was affected by selection bias and the use of historical cohorts impacted study quality.

The study concluded that MDT meetings do impact upon patient assessment and management practices. However, there was little evidence indicating that MDT meetings resulted in improvements in clinical outcomes. Future research should assess the impact of MDT meetings on patient satisfaction and quality of life, as well as, rates of cross-referral between disciplines. (Source: Cancer treatment reviews Uro Today, November 24, 2015 - Epub ahead of print)

Repeating PSA Test in Select Patients Can Mitigate Controversial Issues in Prostate Cancer Screening. Canadian researchers show that repeating PSA tests in select patients can reduce the number of biopsies.

The prostate-specific antigen (PSA) test is used to screen for prostate cancer; however, some task forces advocate abandoning its use because it leads to unnecessary biopsies. Now, a Canadian study shows that a repeat PSA test in patients with abnormal findings can dramatically reduce the number of unnecessary biopsies.

In this study, Breau, MD, and Lavallée, MD, at The Ottawa Hospital and the University of Ottawa-Canada, et al., investigated what impact a prompt, repeat PSA test would have on the number of men referred for biopsy. Their study involved 1,268 men undergoing prostate cancer screening.

The researchers said that a high PSA level is associated with a greater risk of prostate cancer, and PSA screening can help detect cancer at an earlier, more treatable stage. However, fluctuations in PSA levels can be caused by infections, physical activity, and laboratory error. To accommodate this variation, the researchers implemented a protocol in which all abnormal (high) PSA test results prompted a repeat test before referring the patient for a biopsy. "We had a hunch that this would reduce unnecessary biopsies, and our study shows that our suspicion was correct," the researchers said.

They reviewed the medical records of 1,268 men evaluated between 2008 and 2013 and whose PSA test results were high. In 25% of the men, results of the second PSA test were normal. Only 28% of the men with conflicting test results underwent a biopsy compared with 62% of men whose test results were abnormal in 2 tests. This represents a 55% reduction in biopsies.

Furthermore, only 3% of men with conflicting test results who underwent biopsy received a cancer diagnosis within the year, compared with 19% of men with two abnormal test results. This suggests that the second test result is important.

"It is clear that any man with an abnormal PSA test should have this test repeated before a decision to biopsy," they concluded.

Some doctors and patients may worry about missing a significant cancer diagnosis if they forgo biopsy after conflicting test results. But this study shows this is very unlikely. The PSA test is just one factor considered when making the decision to proceed to biopsy, which always

involves the patient in the decision making and can be revisited if risk factors change.

"Our study has important implications for patients and the health care system. Prostate biopsies can be uncomfortable and inconvenient for patients, and in rare cases, they can lead to infections, so we only want to do these if they are really necessary. Prostate biopsies are also expensive for the health care system, said the researchers. (Approximate costs are \$30 for a PSA test but \$880 for a prostate biopsy.) (Source: *Mayo Clinic Proceedings*, doi:10.1016/j.mayocp.2015.07.030)

Adverse Events With Androgen Deprivation Therapy in Patients With Metastatic Prostate Cancer. Intermittent androgen deprivation therapy (ADT) did not reduce long-term health-related events in patients with metastatic prostate cancer when compared with continuous ADT, according to a study published online in *JAMA Oncology*.

In this study, investigators sought to compare the long-term events such as cardiovascular and endocrine events between patients who had received intermittent or continuous ADT. Patients were determined to have had an adverse health event based on whether they had any hospital claim or at least 2 physician or outpatient claims 30 days apart for: ischemic and thrombotic events, endocrine events, sexual dysfunction, dementia, and depression.

A total of 1,134 patients with metastatic prostate cancer were randomly assigned to receive continuous or intermittent ADT. Median age was 71.3 years and the most common long-term events were hypercholesterolemia (31%) and osteoporosis (19%)

Results showed that 10-year cumulative incidence of ischemic and thrombotic events was higher for those in the intermittent arm: 33% vs 24% for those in the continuous arm.

The authors concluded that older men who received intermittent ADT had no reduction in bone, endocrine, or cognitive events and an increased incidence of ischemic and thrombotic events. (Source: *JAMA Oncology* doi: 10.1001/jamaoncol.2015.4655)

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(Trends in Prostate Cancer - Continued from page 1)

Dr Sammon, who is also with the Henry Ford Health System, in Detroit, MI, and his group found that in 2010, 23% of men aged 50 to 54 years underwent PSA screening, compared with 18% in 2013. A similar decline in PSA screening was seen in men aged 60 to 64, which went from 45% to 35%.

Has the Pendulum Swung Too Far?

In the editorial, Dr Penson acknowledges that physicians have been "overly aggressive" in prostate cancer screening and treatment over the past 20 years, but he notes "the pendulum may be swinging back the other way." "The USPSTF recommendations have had a profound impact on the way we diagnose prostate cancer in the United States, and I'm not sure this is a good thing," Dr Penson told *Medscape Medical News*. "These studies show that primary care providers are taking the recommendations against screening to heart. The incidence of

prostate cancer screening has dropped, and the incidence of prostate cancer is dropping, but this doesn't mean that the cancer is not there, it just means we're not finding it. We have to rethink the way we approach the problem of diagnosing prostate cancer. Right now, it's an all-or-nothing approach," he said.

Urologists Are Getting the Message

"Urology has to take a look in the mirror," Dr Penson continued. "We've overscreened, and we've overdetected, and we've overtreated, but things are changing. Even before the USPSTF recommendations, we were starting to see a lot more active surveillance, and we were becoming more selective in whom we screen. So we were very aggressive in one direction, and now the USPSTF has gotten very aggressive in the other direction. We have to meet somewhere in the middle. Too much screening is bad, but no screening is just as bad. We have to screen and treat smarter. A good place to start is with screening men known to be at high risk, such as those with a strong family history of prostate cancer and African American men. Also at high risk are men in their 40s who have high PSA levels. These men are at high risk of dying from prostate cancer," Dr Penson said.

"It may be possible to quantify baseline risk for high-risk prostate cancer. A study from Sweden found that a single PSA measurement of greater than 1.6 µg/L in men aged 45 to 49 years was associated with a 5.14% greater risk of dying of prostate cancer within 25 years of testing," he said. "Maybe the way to go is to have a single initial screening test at a certain age, and if the number is very low, screen infrequently or not at all, but if the number is higher, screen frequently, because that man is at higher risk for disease," he added.

There Will Be Deaths

Stopping PSA screening altogether will avoid the impotence and incontinence and other adverse effects from the various treatments for prostate cancer, but it will come at a cost. More men will die from prostate cancer..

In the European Randomized Study of Screening for Prostate Cancer, the investigators estimated that 27 prostate cancer cases were needed to be detected in the screening group to prevent one cancer death. Looking at the effect of the USPSTF recommendations, where Jemal, et al., estimate that around 33,000 fewer cases were detected in 2012, all you need to do is divide 33,000 by 27 and you see that roughly 1,200 men who otherwise would have had their cancer detected and treated are not going to and are going to die of their disease. That's a 'back of the envelope' calculation and is obviously based on a lot of assumptions, but I am not sure it's entirely wrong," he said.

"There are costs on both sides of the equation, but we cannot take the extreme approach advocated by the USPSTF to stop screening in everyone," Dr Penson said.

"We know that about a third of the cases picked up on PSA screening would never have caused problems, so of those 33,000 cases that declined, 10,000 did not need to be picked up, but 23,000 did. We're not doing anyone any favors by simply burying our heads in the sand and pretending that this is not something to be worried about. It is a very simplistic

of dealing with a very difficult problem, pretending it's not there. To me, that's really worrying. I'm very disturbed by this," he said.

Even more worrying is the recent step by the Centers for Medicare and Medicaid Services (CMS), which is considering not only refusing to pay for prostate cancer screening because the USPSTF has designated such screening a category D but also penalizing physicians who do order PSA-based screening over a preset level, Dr Penson said.

"The CMS website is asking for comments. This is going to have a much bigger effect on primary care providers and urologists. They are going to look at providers' electronic medical records, and if they screen above a certain proportion of patients, they will be considered to be a poor-quality provider. Of course, physicians need to have a personal discussion with their patients about whether screening is the right thing to do, but this is going to kill that," he said. (Source: *JAMA* 2015;314:2054-2961, 2077-2079)

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◆ PROSTATE CANCER SURVIVORSHIP: MALE URINARY INCONTINENCE ◆
by
Timothy J. Tausch, MD
WRNMMC and Fort Belvoir Community Hospital

(A summary of a presentation to the WRNMMC Prostate Cancer Support Group, November 5, 2015)

I am pleased to be with you this evening to discuss the important topic of male incontinence after treatment for prostate cancer. I will also be discussing erectile dysfunction later in the presentation.

INTRODUCTION

This slide shows the anatomical relationships of the male urinary system. The bladder stores the urine that exits the body through the urethra, facilitated by the sphincter muscles which contract and relax to control the urine flow. Now let's distinguish between incontinence and over active bladder. The former is any involuntary loss of urine. The latter is symptoms of urgent urination with or without actual urination, usually with frequent urination both during the day and at night.

INCONTINENCE

There are three types of incontinence: **(1)** stress urinary incontinence, the involuntary leakage on effort or exertion, sneezing, and coughing; **(2)** urge incontinence, leakage preceded or accompanied by an overwhelming need to urinate; and **(3)** mixed incontinence, leakage associated with urgency and effort, exertion, sneezing and coughing. Incontinence is caused by prostate cancer surgery, pelvic trauma or surgery, and conditions such as diabetes, multiple sclerosis, Parkinson's disease, or stroke.

Incontinence needs to be treated because it can cause: **mental distress** (feeling dirty and less confident; fear of odor and discovery; feelings of depression and negative views about health); **social restrictions** (some limited travel and social involvement; problems with lifting heavy objects and wearing certain clothing); **inconveniences** (extra laundry and expense; skin irritation). Worldwide, over 43 million men are affected by stress, urge, and mixed incontinence, including 3.4 million men (17%) in the U.S ages 60+ who suffer from incontinence. Rates of incontinence range 2.5% to 69% after prostate cancer surgery.

MANAGEMENT AND TREATMENT OPTIONS FOR URINARY INCONTINENCE

Behavioral modifications and medication (limit fluid Intake; avoid bladder irritants such as caffeine and alcohol; do pelvic floor exercises- "kegels"). Drugs to treat overactive bladder are sometimes used to treat stress incontinence "off label", i.e., they are not specifically approved for stress incontinence.

Absorbent products are disposable or reusable pads or garments worn on the body or placed on furniture to absorb urine. They include diapers, inserts or liners and pads. Side effects may include skin irritation, leakage, movement, odor and indiscreet situations

Penile clamps can be effective in some cases. Placed around the penis, they apply pressure to the urethra to prevent or limit the involuntary loss of urine. Side effects could include scarring, pain, and skin and tissue irritation.

Penile catheters may be either external or internal. The external mode incorporates a condom that fits over the penis and attached to a tube that collects urine. The internal mode is inserted into the penis, remaining continuously in place allowing the urine to drain into a collection bag. The patient remains in control of the process, but the possibility of urinary tract infection, irritation of the penis due to friction, and urethral blockage.

Bulking agents such as collagen and silicone are injected into urethral tissue to increase tissue bulk. It is a minimally invasive surgical procedure for stress incontinence. Success rates have ranged from 17% to 69%. The substance injections must be repeated periodically because their effectiveness deteriorates over time.

SURGICAL TREATMENT OPTIONS FOR URINARY INCONTINENCE

1. ADVANCE® Male Sling System is a small, synthetic sling designed to treat male stress urinary incontinence. The sling supports the urethra and is designed to restore normal bladder control. In effect, it serves as a "hammock" during physical activity. *Advance®* has success rates ranging from 54.6% to 90.6% in six clinical studies involving 35 or more patients. In one study of 42 patients, 94.3% would recommend the procedure to a friend.

Potential side effects include pain and inflammation, bleeding and irritation at the wound site, and urethral or tissue erosion.. *Advance®* is not for men with urinary tract infections; blood coagulation disorders; comprised immune systems; any other condition that would compromise healing; renal insufficiency; and urinary tract obstruction. It is recommended that a six-month period of non-invasive treatment (e.g., behavior modification, bladder exercises, bio-feedback before a sling implant is considered for men with stress incontinence.

2. AMS 800® Urinary Control System

The AMS 800® Urinary Control System is considered to be the "gold standard" for treatment of incontinence. It is an artificial urinary sphincter designed to restore the natural process of urinary control. It is comprised of three components: a urethral cuff, a pressure regulating balloon, and a control pump.

The AMS 800® works like this: The urethral cuff wraps around the urethra and, upon inflation, it keeps the urethra closed, retaining the urine within the bladder; squeezing the control pump deflates the cuff, opening the urethra, allowing urine to exit the body.

The AMS 800® has been well-received. In one study of 50 patients, 90% reported satisfaction; 96% would recommend the AMS® implantation to a friend; and 92% would have it placed again. Another study of 34 patients reported that 59%-90% used 0-1 pad per day after the procedure. As for potential side effects, some pain, infection and tissue erosion are possibilities.

The AMS 800® is not recommended for persons with low manual dexterity; an irreversible blocked lower urinary tract; permanent bladder dysfunction or instability; and a known allergy or sensitivity to certain medications.

SUMMARY. Incontinence is a common problem that is amenable to treatment. Some treatments are more effective than others, so prospective candidates need to be thoroughly evaluated for suitability. Surgical treatment options offer proven, long-term options.

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(AT THE CONCLUSION OF HIS PRESENTATION ON INCONTINENCE, DR. TAUSCH PRESENTED SLIDES AND PROVIDED SOME OBSERVATIONS ABOUT ERECTILE DYSFUNCTION)

WHAT IS ERECTILE DYSFUNCTION (ED)?

INTRODUCTION

ED is the persistent inability to achieve or maintain an erection firm enough to have sexual intercourse. If you are coping with it, don't feel like the "Lone Ranger!" Approximately 20% of American men 20 years of age and older are affected by it to some degree! That amounts to approximately 30 million American men! Its causes range from vascular issues, diabetes, medications, pelvic surgery-radiation or trauma, neurological causes, and endocrine problems.

ED RESTORATION TREATMENT OPTIONS

Oral Prescription Medications

No doubt most of you are familiar with the several drugs - Viagra, Cialis, and Levitra. In general, they are found to be effective in approximately 70-80% of cases. They work in response to sexual stimulation, and are usually taken within one hour before anticipated sexual activity and they remain effective for up to four hours (36 hours for Cialis).

These oral medications should not be taken more than once a day. The efficacy of some oral medications can be affected by certain foods. Common side effects include headache, facial flushing, stuffy nose, upset stomach, and dizziness.

Caveats. The oral medications should not be taken by men who are prescribed with nitrates. If alpha-blockers have been prescribed for other health conditions, your alpha-blocker therapy should be stabilized before using an oral ED medication. Similarly, these medications should be avoided if sex is inadvisable due to cardiovascular conditions, as well as men who have had any heart problems, stroke or blood pressure issues, or liver or kidney problems.

The Vacuum Erection Device (VED)

Again, most of you are familiar with the VED shown in this slide. It is non-invasive, drug-free, and cost-effective and many men find it to be a satisfactory alternative to other ED treatments. Its side effects include bruised blood vessels, penile discomfort and numbness, delayed ejaculation and erection cool to the touch.

Urethral Suppository (MUSE®)

MUSE® is a urethral suppository employing a plastic device to insert a pellet of the drug alprostadil into the urethra which dissolves to enhance blood flow to the penis. No needles or injections are involved, and an erection results within 10-15 minutes. Some reported side effects include penile pain, urethral burning sensation, urethral bleeding/spotting, lowered blood pressure, and dizziness.

Intracavernosal Injection Therapy

Caverject® is a widely used and effective delivery system used to inject the drug alprostadil directly into the corpora cavernosa of the penis resulting in an erection within 5-20 minutes. It, too, has potential side effects such as penile pain, prolonged erection, scar tissue at injection sites, and blood collection under the skin at the injection sites.

Penile Implants

Penile implants provide an option for men whose experience with other therapies has been unsatisfactory. It is a surgical procedure that has been available for over thirty years with more than 300,000 reported implants to date. It has high patient and partner satisfaction rates and recommendations from users.

As seen in this slide, it is a three-piece inflatable implant that is entirely contained within the body. The device inflates to provide rigidity, and then is deflated for concealment. Once activated, the erection is maintained as long as desired. The expansion is in both girth and length. Typically, the implant does not interfere with ejaculation or orgasm.

The potential side effects are: Natural or spontaneous erections will be impossible, as well as other interventional treatment options; in the event of infection, the implant may have to be removed; the penis may become shorter, curved, or scarred; the implant may have mechanical failures; and pain.

There are risks involved and not all patients are candidates for a penile implant. As is the case with any treatment for ED, discuss the risks and benefits of implants with your doctor.

The Prosthetic Urologist

Not every urologist is a prosthetic urologist. A prosthetic urologist can offer the complete spectrum of treatment options, but only such a urologist has the training and experience in implant procedures.

Summary

ED is a common problem, but there are several treatment options providing a satisfying solution. ED can be a life-changing event for many men and their partners. If ED is an issue for you, talk to your partner, then consult with your doctor about treatment options that may be able to enhance your quality of life.

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(THESE PERSONS ARE WILLING TO SHARE THEIR EXPERIENCES WITH YOU. FEEL FREE TO CALL THEM.)

SURGERY

Tom Assenmacher	Kinsvale, VA	(804) 472-3853	
Jack Beaver	Falls Church, VA	(703) 533-0274	1998 (Open RP)
Rob Calhoun	Annapolis, MD	(410) 293-6635	2011 (Robotic Surgery)
Gil Cohen	Baltimore, MD	(410) 367-9141	
Richard Dorwaldt	San Antonio, TX	(210) 310-3250	(Robotic Surgery)
Michael Gelb	Hyattsville, MD	(240) 475-2825	(Robotic Surgery)
Robert Gerard	Carlisle, PA	(717) 243-3331	
Tony Giancola	Washington, DC	(202) 723-1859	2008 (Radical Prostatectomy)
Ray Glass	Rockville, MD	(301) 460-4208	
Monroe Hatch	Clifton, VA	(703) 323-1038	
Tom Hansen	Bellevue, WA	(425) 883-4808	1998 (Robotic Surgery)
Bill Johnston	Berryville, VA	(540) 955-4169	
Dennis Kern	San Francisco, CA	(415) 876-0524	
Sergio Nino	Dale City, VA	(703) 590-7452	
Ed Postell	Collegeville, PA	(610) 420-6765	(Robotic Surgery)
George Savitske	Hellertown, PA	(703) 304-3081	2000 (Open RP)
Artie Shelton, MD	Olney, MD	(301) 523-4312	
Jay Tisserand	Carlisle, PA	(717) 243-3950	

PROSTATE CANCER AND SEXUAL FUNCTION

James Padgett	Silver Spring, MD	(301) 622-0869
George Savitske	Hellertown, PA	(703) 304-3081

RADIATION

Leroy Beimel	Glen Burnie, MD	(410) 761-4476	1987 (External Beam Radiation)
Bob Bubel	Grand Junction, CO	(970) 263-4974	2010 (Proton Beam Radiation)
Harvey Kramer	Silver Spring, MD	(301) 585-8080	1998 ((Brachytherapy)
Joseph Rosenberg	Kensington, MD	(301) 495-9821	2009 (Brachytherapy)
Barry Walrath	McLean, VA	(571) 969-8269	2001 (Brachytherapy)

WATCHFUL WAITING

Tom Baxter	Haymarket, VA	(703) 753-8583	Active Surveillance
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SPOUSE SUPPORT

Renate Bubel	Fairfax, VA	(703) 280-5765
Karen Collins	Mechanicsburg, PA	(717-766-6464
Betty Kramer	Silver Spring, MD	(301) 585-8080
Ellen Rosenberg	Kensington, MD	(301) 495-9821
Nancy Wallrath	McLean, VA	(703) 915-8108

OTHER THERAPIES/MULTIPLE THERAPIES

Howard Bubel	Fairfax, VA	(703) 280-5765	1995,1996 (Hormonal, Cryosurgery, Sexual Function)
Arthur E. Clough	Kerryville, TX	(830) 896-8826	1993 (Surgery and Radiation)
Pete Collins	Mechanicsburg, PA	(717) 766-6464	2007, 2009 (Surgery, Radiation, Hormonal)

◆ MEETING ANNOUNCEMENT ◆

THURSDAY, FEBRUARY 4, 2016

7:00 - 8:30 PM

AMERICA BUILDING (BLDG 19, 2D FLOOR) ROOM 2525
(DIRECTLY ABOVE THE LAB/PHARMACY)

WALTER REED NATIONAL MILITARY MEDICAL CENTER

◆ SPEAKER ◆

NANCY TSCHILTZ, REGISTERED DIETICIAN
INTEGRATED CARDIAC HEALTH PROGRAM, WRNMMC

TOPIC

"NUTRITION AND CANCER"

Gate/Parking: If you enter the base through South Gate (Gate 2) off Rockville Pike/Wisconsin Avenue, take the first right (Palmer Road South). On your left will be the Emergency Room. Continue to follow signs to the America Building and the America parking garage.

Security: A military ID card is required to get on base. Persons without a military-related ID card who are attending the meeting are required to register in advance in order to gain entry. To register, contact the CPDR front desk at 301-319-2900 at least four business days prior to Thursday, February 4, 2016, to arrange entry. Have a photo ID card ready when arriving at the gate.

