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A PROSTATE CANCER SUPPORT GROUP
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NEWSLETTER

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♦ LOOKING AHEAD ♦

The Walter Reed Army Medical Center (WRAMC) is the United States Army's flagship medical center serving more than 150,000 active and retired personnel from all branches of the military. In September 2005, the Base Realignment and Closure (BRAC) Commission voted to realign the Walter Reed Army Medical Center with the National Naval Medical Center in Bethesda, MD. Moving Walter Reed Army Medical Center will provide for a new and expanded facility being built at the National Naval Medical Center. The move will cost nearly $989 million, save the Pentagon over $300 million, streamline patient care, and provide state of the art medical treatment for all military servicemen and women in the area. In addition, a new, full service, 140-bed hospital is being built at Fort Belvoir, VA as part of the BRAC plan. As you can imagine, the merger at Bethesda is an immense task. All this is to reach fruition this September!

What does this mean for the WRAMC Prostate Cancer Support Group? We expect to maintain our organization, but no doubt our organization and operation will be affected by the merger, and perhaps as well as by the existence of the new major hospital facility at Fort Belvoir. We expect that there may be some temporary interruption of our regular meeting schedule and newsletter production during the relocation and consolidation process.

The merger at Bethesda will also be the occasion to consider the future of the newsletter in terms of its production and distribution. At present, the quarterly newsletter with a readership of approximately 2,200 is produced and distributed using costly conventional printing and mailing processes. We will consider conversion to a "virtual newsletter" that would be available on line at the web site of the WRAMC Center for Prostate Disease Research. This would result in practically a "no cost" newsletter, however, we realize it has implications for readers who are without access to the Internet.

♦ AGENT ORANGE STUDY SHOWS INCREASED PROSTATE CANCER RISK ♦

Vietnam veterans who were exposed to the defoliate Agent Orange are 49% more likely than nonexposed veterans to be diagnosed with prostate cancer according to results from one of the largest studies to date examining that association. Exposure to Agent Orange carried just as much risk as positive family history and even more risk than age. This is an especially important finding because Vietnam veterans are reaching the age when they would considered at highest risk of developing prostate cancer. Clinicians should be sensitive to this association when screening Vietnam veterans for prostate cancer.

Exposure to Agent Orange was also associated with younger age at diagnosis. Men found to have prostate cancer were roughly 5 years younger at diagnosis than men without exposure. The average age at diagnosis for men exposed to the defoliate was 61.4 years, compared with 66.1 years in unexposed men. (Source: Medscape Today, March 1, 2011)

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♦ FROM THE EDITOR'S DESK ♦

Where have we been? We did not publish the expected November 2010 and the February 2011 issues for two reasons. We had difficulty with one of the guest speaker's transcribed remarks which comprise the feature item of each newsletter, so it was not feasible to publish an abbreviated issue. Then a sudden death in my family was a factor in my inability to produce the missing issues.

♦ FEBRUARY SPEAKER'S REMARKS ♦

Our February program featured Dr. Leslie Cooper. Ph.D., Clinical Psychologist and Consultant to the WRAMC Center for Prostate Disease Research, whose topic was "Prostate Cancer and Romance: Intimacy After Therapy." A summary of Dr. Cooper's presentation begins on page 7.

♦ MEETING SCHEDULE FOR MAY 4, 2011 ♦

Recently published clinical trials have generated considerable interest in new treatment modalities for prostate cancer. This is your opportunity to learn about the latest developments affecting both newly-diagnosed men and men who were treated previously. Join us at 7:00 pm, Wednesday, May 4, 2011, at Joel Auditorium. Dr. Stephen Brassell presents "To Treat or Not to Treat? That is the Question," a discussion of recent ground-breaking clinical trials that could affect treatment decisions. Dr. Brassell is a urologic oncologist at WRAMC and Associate Director of its Center for Prostate Disease Research. He specializes in both open and robotic surgery, and his research interests include health-related quality of life issues and the impact of race and age on men with prostate cancer. Your family members and friends are always welcome.

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The Effect of Race and Rural Residence on Prostate Cancer Choice. Researchers at Emory University studied 516 men younger than 75 with incidence of prostate cancer in 33 counties in Southwest Georgia, a rural area with a population of 700,000 (40 percent African American). External beam radiation plus brachytherapy was the most common modality (31%) followed by external beam radiation alone (27%) and surgery (18%). Patients in this rural area were more likely to select external beam radiation versus surgery than men residing in the Atlanta urban area. Poor communication with their physician was reported by 13% of the patients, more so by African Americans. In both rural and urban areas Caucasians with prostate cancer had surgery more frequently than African Americans and the data suggested that this may be more attributable to income than race. Rural patients were also more likely to receive external beam radiation and less likely to receive brachytherapy alone or surgery. (Source: *Urology* 2011Mar:77(3):581-7 via UroToday (March 30, 2011)

Elderly Men and Unnecessary Prostate Cancer Screening. While large declines in prostate cancer metastases and death rates in the last 20 years coincide with widespread use of PSA-based screening, questions remain about its use. Data have been unclear about when men should be considered for PSA screening and when screening should stop. Eggener, et al., University of Chicago, studied PSA-based prostate cancer screening in the United States and found that many elderly men may be undergoing unnecessary prostate cancer screenings. Using data from surveys conducted in 2000 and 2005, the researchers report that nearly half of the men in their seventies underwent PSA screening in the past year – almost double the screening rate of men in their early fifties, who are more likely to benefit from early prostate cancer diagnosis and treatment. Further, men aged 85 and older were screened just as often as men in their early fifties. Because prostate cancer tends to be slow-growing, data show that many men – particularly those in their seventies and older – will die of other causes before prostate cancer becomes a problem that requires medical attention. The new findings underscore a long-standing concern that overuse of PSA screening and PSA-based treatment decisions may lead to unnecessary treatment of many older men, and potential complications such as incontinence, impotence and bowel dysfunction.

The researchers offered some possible explanations for the results, noting that screening rates may reflect how frequently men visit primary care physicians. Older men tend to have more health problems that require doctor visits. This may result in more frequent PSA testing than younger men, who see their doctors less. The study reinforces the notion that accurately determining life expectancy, taking into account such factors as age and co-existing medical conditions, is critical to screening and treatment decisions. (Source: Press Release; *Amer Soc of Clin Oncol*, March 28, 2011, via UroToday. com)

Factors Affecting Selection of Active Surveillance by Patients with Low-Risk Prostate Cancer. Soloway, et al., University of Miami, found that physician influence is the greatest contributor to a patient's decision to participate in active surveillance (AS) for prostate cancer. Among patients with very low-risk disease, only a minority of patients meeting eligibility criteria utilized AS. In this study, 185 AS patients were asked to assess the relative influence of 12 variables that might have contributed to their decision of whether or not to enroll in AS. These included: not wanting surgery, not wanting radiotherapy, other health issues, having a friend on AS who is happy with the choice, concern about ED, concern about incontinence, the physician thinking AS a reasonable choice, patient determined best choice, family support for AS, confidence that cure was still possible if the disease progressed while on AS, no anxiety about their prostate

cancer, and having a friend on AS who was not happy with the results. Median time enrolled in AS at the time of survey was 20.5 months. Among responses, the physician thinking AS a reasonable choice was most commonly ranked first, followed by feeling certain that cure was possible if the disease progressed, and patient derived conclusion that AS was best. Among side effects, 48% were most concerned about incontinence and 44% about ED. Having other health issues was the least ranked answer. The physicians who had made the initial diagnosis offered AS to only 36% of the 105 men, suggesting that it is uncommonly discussed with patients in this region and referral practice. (Source: Urotoday.com dated March 28, 2011)

Comparative Effectiveness of Robot-Assisted Laparoscopic Prostatectomy.

Robot-assisted laparoscopic radical prostatectomy (RALP) has gained widespread acceptance in the treatment of prostate cancer. While it increasingly is becoming the surgical approach of choice in many medical centers, limited data exist directly comparing it to radical retropubic prostatectomy (RRP). Researchers at the Department of Urology, University of Minnesota, examined the evidence comparing RALP to RRP. The outcomes evaluated were arranged into perioperative, oncologic, and functional outcomes. Overall, RALP was associated with lower blood loss, lower transfusion rates, reduced length of hospital stay, and higher cost when compared to RRP. Definitive conclusions regarding complications and oncologic and functional outcomes are not yet possible, and will require longer-term follow-up and well-designed randomized controlled trials. (Source: *Curr Urol Rept*, March 2, 2011 via Urotoday, March 28, 2011)

Prostate Cancer Spending Growth Among Medicare Beneficiaries.

According to researchers at the University of Michigan, prostate cancer is one of the most expensive diseases to treat, in part secondary to its chronic nature. It outpaces spending for cancer in general at nearly $7 billion per year. The researchers evaluated whether the increased spending for prostate cancer is due to the utilization of more expensive options (such as LHRH agonists instead of orchiectomy) or whether physicians are using more of all prostate cancer services. They performed a study assessing trends in Medicare spending among patients with prostate cancer to measure the extent to which spending growth is a result of selective usage of higher-priced services (price) vs. greater overall usage (quantity). They identified 111,711 patients.

The study evaluated the frequency and nature of prostate cancer care and the per capita expenditures for each year. They found that Medicare expenditures for the first 2 years after diagnosis increased by 20.2%, from $8,933 to $10,734. Per capita payments for inpatient care declined by 57% from $3,499 to $1,504, however, per capita expenditures for physician services increased by 82.8% from $3,317 to $6.062. Per capita spending for hospital outpatient care increased by 62.2% from $1,847 to $2,996. This suggests that the per capita Medicare payments for prostate cancer appear to be increasingly dedicated to physician services and outpatient facilities. The services that were most accountable for spending growth included androgen deprivation therapy, radiotherapy, and chemotherapy. The cost of androgen deprivation therapy doubled from $988 per capita in 1992 to $1,891 per capita in 2003. Usage, not price changes, was the primary mechanism underlying the observed growth, accounting for 59% for ADT and 76% for IMRT. (Source: *Urology* 2011 February;77(2):326-31)

Overview of Management of Radiation Failures in Prostate Cancer. There are a variety of salvage therapies for failure after radiation therapy, the most commonly utilized one is androgen deprivation therapy, used in over 90% of cases, according to CaPSURE data. Local treatment failures can be stratified as; “focal” due to inadequate dose, “margin failure,” “cold spot failure” due to “marginal miss,” or “diffuse failure.” A comparison of cryotherapy versus salvage prostatectomy published by Pisters, et al., reported three-fold improved cancer outcome with surgery.

Pisters concluded that salvage prostatectomy is underutilized and should be considered in carefully selected patients. Salvage

brachytherapy under MRI guidance found that at four years, grade 3-4 toxicity was 30% and 13% required a colostomy. Outcomes were worse when there was a short time period between RT and the salvage brachytherapy. Roach, et al., concluded that with careful patient selection, patients could have reasonable outcomes in the salvage setting. (Source: Presentation; 2011 GU Symposium, February 17-19, 2011)

Managing a Rising PSA After a Negative Biopsy. Researchers at Glickman Urological Institute, Cleveland Clinic, observe that the prostate biopsy remains one of the most commonly performed urologic office procedures. A significant percentage of men with a negative result may have unrecognized disease. Inadequate biopsy strategies or findings of high-grade prostatic intraepithelial neoplasia increase this likelihood. The term "negative biopsy" may be misleading. Traditional sextant biopsy is inaccurate and extended- or saturation-biopsy protocols may miss small cancers. A rising PSA after a negative prostate biopsy may indicate undiagnosed cancer. Magnetic resonance imaging (MRI) and template-guided biopsy have been proposed as diagnostic adjuncts, but have met with limited acceptance in this setting. In the presence of a rising PSA after a negative biopsy, a low threshold for repeat biopsy should be considered. Saturation biopsy increases cancer detection, especially in patients with more than two prior biopsies. Adjuncts to improve cancer detection, such as administration of 5-α-reductase inhibitors and MRI, also are promising. (Source: *Curr Urol Rept* , 2011 February 23, 2011, via UroToday, March 21, 2011)

High-intensity Focused Ultrasound (HIFU): A Single Center Experience. High-intensity focused ultrasound (HIFU) is a minimally invasive treatment based on thermal ablation of tissues which are warmed up to 85 degrees C in the focal area. Clinical studies have shown this treatment modality to be safe and effective in the management of localized prostate cancer as well as of local recurrences after radical prostatectomy or radiotherapy. Di Venere Hospital, Bari, Italy, recently reported its experience over an eight-year period with 171 patients who had no previous treatment for prostate cancer. The patients, aged 44 to 86 years (mean 74.7), underwent 197 HIFU treatments; 22 patients needed a second treatment as the first was incomplete or because of recurrence. At a mean follow-up of 67.9 months, biochemical success rate (PSA constantly less than 0.5 ng/ml) was obtained in 84.2% of low and intermediate risk patients and in 43.1% of high risk patients. Post-treatment biopsies (6 months after treatment) revealed no residual tumor in 93.4% of low or intermediate risk patients and in 63.1% of high risk patients.

Radical prostatectomy remains the "gold standard" for localised prostate cancer. However, HIFU seems to be a promising alternative and less invasive treatment modality with an encouraging success rate, at least in the short-term, in patients with low and medium risk of progression. (Source: *Arch Ital Uro-lAndrol*; 2010 December;82(4):253-5, via UroToday, March 21, 2011)

Neoadjuvant Hormonal Therapy Preceding Radical Prostatectomy. The effect of neoadjuvant hormonal therapy (NHT) on radical retropubic prostatectomy (RRP) for prostate cancer is various and remains a controversy for urologists. Researchers at the Chungnam National University's School of Medicine, Daejeon, Korea, conducted a comparative study to evaluate whether NHT before RRP is indicated and beneficial in the aspects of postoperative complications, positive surgical margin, and biochemical recurrence.

Sixty-nine men were scheduled for RRP for clinically localized and locally advanced prostate cancer and were divided into two groups. Group 1 was treated with RRP only, and Group 2 underwent RRP with preoperative NHT. They were evaluated for clinical and surgical parameters, the positive margin rate in surgical specimens, and the biochemical recurrence rate. There were no statistical differences in age, body mass index (BMI), preoperative biopsy Gleason score, initial PSA levels, International Prostate Symptom Score (IPSS), or quality of life (QoL) between the two groups. The researchers found no differ-

ences in the transfusion rate, mean catheterization time, or positive margin rate. However, the mean operative time was significantly higher in the RRP with preoperative NHT group than in the other group. There was no significant difference in biochemical recurrence or positive surgical margins.

The researchers said that the results suggest there were no clinical benefits to the administration of NHT before RRP from the viewpoint of biochemical recurrence. (Source: *Korean J Urol* 2011 January ;52(1):18-23, via UroToday, March 21, 2011)

High Intensity Focused Ultrasound: Ready for Prime Time? High Intensity Focused Ultrasound (HIFU) is often aggressively promoted as a less invasive, conveniently performed procedure with fewer side effects than surgery or radiation therapy, while achieving excellent prostate cancer control. Stanley Brosman, MD, reviewed the clinical evidence to conclude that it does not support the claims for HIFU. Compared to radical prostatectomy, external beam radiation, and brachytherapy, HIFU is clearly more convenient and less invasive. Regarding side effects, the evidence is less persuasive. A Canadian study found that common complications included impotence (44%), urinary tract infection (7.5%), urethral stricture (12.3%), incontinence (8.1%), as well as other urinary problems. It is difficult to assess HIFU's cancer control compared to other treatment modalities because the requisite studies simply have not been done. The bottom line is that HIFU remains an "investigational therapy" until well-designed clinical trials are completed and reported. (Source: *PCRI Insights*, March 2011, Volume 14, Number 1: page 19)

Cost Implications of Adopting New Technologies. Intensity-modulated radiation therapy (IMRT) and laparoscopic or robotic minimally invasive radical prostatectomy (MIRP) are costlier alternatives to three-dimensional conformal radiation therapy (3D-CRT) and open radical prostatectomy for treating prostate cancer. In this study, a research team formed by several major institutions assessed trends in the utilization IMRT and MIRP and their impact on national health care spending. They determined treatment patterns for 45,636 men age ≥ 65 years who received definitive surgery or radiation for localized prostate cancer diagnosed from 2002 to 2005.

The mean incremental cost of IMRT versus 3D-CRT was $10,986; of brachytherapy plus IMRT versus brachytherapy plus 3D-CRT was $10,789; of MIRP versus open RP was $293. Extrapolating these figures to the total US population results in excess spending of $282 million for IMRT, $59 million for brachytherapy plus IMRT, and $4 million for MIRP, compared to less costly alternatives for men diagnosed in 2005. In short, costlier prostate cancer therapies were rapidly and widely adopted, resulting in additional national spending of more than $350 million among men diagnosed in 2005 and suggesting the need for comparative effectiveness research to weigh costs against benefits. (Source: *J Clin Oncol*. 2011 March 14-an Epub prior to printing, via UroToday, April 6, 2011)

Treatment Regret After Prostatectomy. Issues such as physical and psychological distress impact the quality of life of patients after a radical prostatectomy. Researchers at I-Shou University, Taiwan, Republic of China, sought to understand the regret that patients reported following a prostatectomy and to identify the influencing factors. Patients who had a diagnosis of prostate cancer and who underwent a prostatectomy between 2004 and 2010 participated. A total of 100 patients participated and 31% of them voiced regret that they chose a prostatectomy. Factors causing regret were: not understanding the treatment and its potential complications, adverse sexual effects, age, and adverse bowel effects. The researchers conclude that urologists and urological nurses should carefully portray the risks and benefits of the prostatectomy during preoperative counselling to minimize patient regret and maximize patient satisfaction. (Source: *Cancer Nurs.* 2011 January 15; Epub in advance of printing; via Urotoday February 22, 2011)

♦ PROSTATE CANCER AND ROMANCE – INTIMACY AFTER TREATMENT ♦

by

DR. LESLIE COOPER

(A summary of a presentation to the WRAMC Prostate Cancer Support Group on February 2, 2011)

INTRODUCTION

Thank you very much for inviting me back. I welcome the opportunity to be with you again. When I last spoke, the subject was "Why Talking is Important and Why Sucking it up Doesn't Work." When I was asked to speak again I noted that it would be in February, the Month of Romance with Valentine's Day, so I thought I would talk about prostate cancer and romance. As I prepared I consulted the available research and the literature so as not to rely solely on my own opinions.

In reviewing the appropriate research I was struck by the frequency of such terms as "spousal communication and intimacy" and I thought "well, what a perfect follow-up to my previous presentation." I decided to look at " intimacy after treatment." And I became curious about what made you decide to attend tonight's lecture. Was it the title that was intriguing? Did you think I would be discussing sexual intimacy? Well, the code of ethics of the American Psychological Association stipulates that we cannot discuss matters beyond the scope of our practice. So I will not be talking about sexual intimacy or sexual dysfunction from the points of view of a medical doctor or a sex therapist.

ROMANCE AND INTIMACY

Is there anyone here tonight who doubts the proposition that communication does indeed affect intimacy? I thought not. After all, you cannot read another person's mind, so good communication is bound to enhance intimacy. So let's take a look at this whole idea of romance. The dictionary definition says "romance" is love, especially romantic love, idealized for its purity or beauty. This slide portrays a young couple and their pose is right off the cover of a pulp romance novel or magazine. Now look at this slide defining "intimacy." Note the generational shift from the previous slide - an older couple in a loving, albeit less passionate embrace.

"Intimacy" is defined as a process whereby a person expresses important self-relevant feelings and information to another, and as a result of the other's response, comes to believe that he/she is understood, validated and cared for.

What are the key issues here? That there is an open sharing of thoughts and feelings; that one person shows that he/she cares about what the other is thinking or feeling; that they understand; that they validate their partners. This is what intimacy is all about. For a negative example, when a woman comes home eager to tell her spouse about the details of her day and he continues to watch the re-run of yesterday's NFL game, well, that speaks loudly, doesn't it, that he is not interested. That doesn't convey intimacy. Of course not!

PROSTATE CANCER AND INTIMACY

Manhood is not dependent solely on hormones, but on a lifetime of being male. But does being a male mean that real men don't cry and don't talk about their feelings? Do you think it matters that many of you have a military background? How do you personally think about revealing your feelings? It is very much a generational thing, younger men today are more apt to be able to talk about their feelings, more apt to display their feelings than most of us older people. This is a very important development.

When we talk about intimacy, when we talk about relationships, when we talk about cancer or other life-changing events, much of our reaction has to do with our age, our generation. If you are younger, single and have prostate cancer, it is a very different situation than if you are older and married. And then there is the cultural issue. In some cultures one doesn't talk about illness, and much less cancer. As we talk to night, remember the issues of age, generation, culture, ethnicity, and religious persuasion. We must avoid sweeping generalizations about psy-

chological issues involved in dealing with prostate cancer.

Prostate cancer is the most common site of cancer in men in the United States. It is not uncommon for men who are diagnosed with prostate cancer to experience anxiety and distress at some point in dealing with the disease. This is also true for women diagnosed with breast or ovarian cancer. Many newly diagnosed men often answer my "how are you doing" question with such comments as "fine, no problem, or no concerns." Recall that age is an important factor that conditions a person's reaction to diagnosis. Quality of life issues differ between men of different cultures and ethnicities, and religious communities. For example, we know that strong ties to a religious community lowers stress because it displays a sense of community, a sense of belonging, a sense that we are not alone.

COMMON QUESTIONS ABOUT SEXUAL FUNCTIONING AND PROSTATE CANCER

Have you ever asked yourself some of these questions? If left untreated, will my prostate cancer affect my sexual functioning? If I have treatment will it affect my sexual functioning and for how long? Could having sex make the cancer worse? Could having sex with my partner adversely affect my partner? (No, but it is actually a very common question). Can I have sex while undergoing treatment?

There is a significant amount of individuality about how the available treatments will affect sexual functioning, so there is no comprehensive answer. It would be nice if there were a pat answer, but there isn't. As you may know, the Internet is loaded with information on these questions, but the Internet advice doesn't have your specific name attached to it!. So be careful about applying generalized information, however reasonable it seems, to yourself.

QUESTIONS ABOUT YOUR RELATIONSHIP

Again, ask yourself if these questions have ever preoccupied you. How did your relationship start all those years ago. Is your relationship different since the prostate cancer? If you are not in a relationship now, why not? If you are in a relationship, how satisfied are you with it? How is your sex life since the cancer? The same or different? What do you like or dislike about your sex life? What does your partner think about your sex life or perhaps the absence of it? And most important of all, how do you know how your partner feels? Does your partner actually tell you, or is it because you both have been together so long that you assume you understand how your partner feels? What kinds of problems have you and your partner faced recently? Are they the same or different since you were diagnosed with and treated for prostate cancer? What is your main method of coping with these problems? What is your partner's/spouse's main method of coping with these problems? When was the relationship closest and most satisfying? When was it the most distant and blaming?

Before your diagnosis you probably did not think about many of these questions. You just were intimate in whatever form intimacy took. Now things are different and communication is the key to handling these questions. Many of us get involved in a relationship when we are younger, but when a relationship develops when we are older, we are just happy to be involved so we don't ask these questions. We just ignore them because we are on automatic pilot, so to speak. We have our partner, so we just get on with our day. But then we have a life-changing event such as a diagnosis of prostate cancer that triggers these questions.

How we think about relationships and the partners involved can help us cope with life-changing events. When you think about the kinds of communications challenges that we have, it is very difficult to start talking about our own personal feelings, fears and concerns. With cancer we may see ourselves, our bodies, and our relationships differently, hence the challenge to confront these questions.

LET'S LOOK AT SOME OF THE DATA

Initial communication is often difficult, but if you keep at it, it will get easier over time. A significant proportion of prostate cancer patients (something on the order of 20-38 per cent) report psychological distress. Naturally, their relationships and the accompanying intimacy are likely to be stressed as well. When I refer to intimacy it is within the context of its definition as

we discussed at the outset. I am talking about relationship intimacy, not necessarily sexual intimacy. How patients and their partners cope with cancer-related stresses may impact the "normalcy" in their relationship. Each relationship has its own little bubble of normalcy, i.e., a set of rituals, a sort ebb and flow of daily events that defines the relationship. We health care providers often focus on the patient and the partner as separate entities, instead of the couple as a unit in dealing with chronic, long-term disease such as prostate cancer. Cancer and other chronic, long-term illnesses affect the relationship and the affected couple needs to adjust accordingly.

Studies have shown that a higher quality marital relationship, a relationship that has a degree of openness, caring, trust, and reciprocity predicts a lower level of patient distress across the projectory of the illness from the diagnosis to its culmination.

As I organized this presentation I knew that it would be hard to separate relationship intimacy from sexual intimacy. The former involves communication, sharing, closeness, the willingness to discuss our fears and concerns. As persons start to talk about matters that make them feel vulnerable, they may feel that they are now different to our spouse or partner, and become concerned about whether the spouse or partners will care for them as in the past.

Now I want to talk about what happens when we begin to confront matters and issues that are very close and dear to us. A member of the audience just mentioned the sexual challenges resulting from his treatment, and how they have caused him to be withdrawn in his communication with his partner. There is mutual communication when you can talk frankly about these matters. But there is also mutual avoidance. This is not just true of prostate cancer; I see it with many of my cancer patients and their families. The problem is that patient who has cancer doesn't want to talk about his/her concerns, worries, or fears and the partner doesn't want to talk about them either. Patients are usually more willing to disclose than their spouses are. This leads to the phenomenon termed "patient demand-partner withdrawal" in which the person with the cancer does want talk openly, but too often the partner will withdraw often saying something to the effect that "everything is going to be fine" or that " it doesn't really matter." Whether it is mutual avoidance or patient demand-partner withdrawal, the outcome is likely to be reduced intimacy and increased stress.

In my previous lecture, I mentioned that women are social beings who thrive on relationships and mutual support. Men tend to be problem solvers who say "tell me the problem I will solve it", while women say "I am going to talk to my friends about this." If women are denied social interaction and men are blocked from problem-solving, there is likely to be more distress. So you can imagine what happens here. The degree to which one or both partners avoid talking about cancer-related concerns can increase or decrease relationship closeness, and more importantly increase stress. When there is an increase in stress or distress, our bodies are affected. Do we know with absolute certainty that our bodies are affected? No, it is complicated matter. But the idea is that we are social animals and we are hard-wired to seek support. So it may be that the perception of collaboration or joint coping with the disease reduces emotional distress and ultimately increases a feeling of closeness and intimacy. Remember, when I talk about intimacy, I really mean the sense of closeness, healing and support without downplaying for a moment the sexual aspect.

When a couple begins a relationship, they tend to develop certain communications patterns that develop over the years, and they seldom stop to question whether that pattern of communication is still working for them now that they must confront life-changing events such as cancer. Something like a cancer diagnosis should make them stop to evaluate how are they talking with each other. There are ways to learn how to communicate more effectively. And there are persons like me, social workers, others at the Center for Prostate Disease Research who can be effective in helping evaluate our communications patterns with those we love.

Relationship-compromising behavior such as holding back concerns, actively avoiding cancer-related discussions and one partner pressuring the other to talk while the other withdraws can reduce relationship closeness.. And if you think about it, it makes sense. Holding back has been related to greater psychological distress, and

mutual avoidance (where the couple simply doesn't talk about an issue) has been associated with lower-quality marital relationship. When you feel that you lack support and are going it alone, what you need is a good immune system in order to deal with the resultant stress. But the only way you can get the support you need is to reach out for it and make it welcome in your life.

A RELATIONSHIP INTIMACY MODEL

This slide shows an interesting Relationship Intimacy Model of Couple Adaptation to Cancer. A relationship is "relationship enhancing" when there is reciprocal self-disclosure, partner responsiveness, and relationship engagement. The couple relationship is strong enough to weather the storm that a life-changing event such as a diagnosis of prostate cancer diagnosis can produce. But a relationship is "relationship compromising" when there is avoidance of discussion, criticism, and a demand-withdraw atmosphere. This condition limits adaptation to the life-changing event. Again, and this is very important, we are talking here about intimacy in its broadest sense and how the lack of such intimacy can affect one's overall health and emotional well-being.

CAN ROMANCE SURVIVE AND THRIVE?

Well, yes! But you have to work at it! Some experts suggest that over time romance fades and eventually evolves into a companionate, friendship-like love. According to this theory, the idealized romantic love/passionate sex type of desire (as defined and portrayed on my first slide) lasts about two years, but romance can survive and thrive if evolves into an intimacy that is characterized by reciprocity, closeness, sharing, coping, trust. I knew when I put this together it would be a controversial presentation, but it would trigger some useful insights. But I was willing to risk it because sometimes it helps to stir the pot a bit.

QUESTION: How can I tell if I am depressed? And I am hesitant about medications.

ANSWER: Depression isn't just about prolonged sadness or suicidal tendencies. Depression may appear as an irritable disposition where things easily get on your nerves, where you are quick to anger, where there is a sense of restlessness and a lack of patience, or an urge to withdraw into social isolation. There are many shadings to depression and often the person is unaware that he/she is depressed. Be aware of the professional resources available to you, such as you have here at Walter Reed and seek them. Sometimes an anti-depressant actually can smooth out the edges and rebalance the brain, so to speak, making you more open to listening, feeling, and thinking. But it doesn't change you per se; you are not a different person.

QUESTION: It's still not easy to discuss with others the issues associated with prostate cancer.

ANSWER: I often find myself asking patients if they have told their partner of their concerns. It is question of being aware and recognizing what pattern the communication is taking between you and your partner. What you are avoiding and why? Where you are pushing for answers to find that the other person is withdrawing It is very important to understand this. Often times when I see new cancer patients, they will say that they don't need my services because they have an understanding spouse, a circle of friends, their church, etc. But later I will get a phone call saying they would like to talk to me. When push came to shove, it turned out that they couldn't bring themselves to confide in their spouse or friends. Or they got the frequent spousal response of "don't worry, it doesn't matter." Or friends will ask "how are you doing?" but it is clear that they really don't want to know. So there is a certain loneliness to having these life-changing conditions. It takes a lot of courage and bravery to start to share your thoughts and feelings, but it is worth the effort.

THE WRAMC PROSTATE CANCER SUPPORT GROUP'S NEWSLETTER IS AVAILABLE ON THE WEB SITE OF WRAMC'S CENTER FOR PROSTATE DISEASE RESEARCH. THE CURRENT ISSUE AND BACK ISSUES MAY BE ACCESSED BY GOING TO WWW.CPDR.ORG/PATIENT/USTOO/NEWSLETTER.HTML.

♦ WRAMC US TOO COUNSELORS ♦ (As of May 1, 2011)

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

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♦ MEETING ANNOUNCEMENT ♦

WEDNESDAY, MAY 4, 2011
7 PM

JOEL AUDITORIUM (SECOND FLOOR)
MAIN HOSPITAL BUILDING, WRAMC

♦ SPEAKER ♦

STEPHEN BRASSELL, MD

Associate Director, Center for Prostate Disease Research, WRAMC

♦ TOPIC ♦

"To Treat or Not to Treat? That is the Question"
(Ground-breaking Clinical Trials Affecting Treatment Decisions)