

**WRAMC Us TOO, Inc.**  
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**NEWSLETTER**

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◆ **Dealing with Incontinence and Impotence: Your Mileage May Vary!** ◆  
by  
**Dave Karpinski**

When I got the call from my urologist on Halloween night in 2000 (as I was passing out candy), I was not terribly surprised. My latest prostate biopsy, taken a week or two before, showed cancer in seven of the ten cores. I was 57. The doctor suggested that I do some research about treatment options to decide how I wanted to deal with the cancer; he didn't ask me to come in to discuss options, perhaps not wanting to bias me toward surgery, but I was surprised that he didn't offer me more guidance. But that was OK with me because I was willing and able to surf the Internet, as I often did, to explore my options.

I wasn't surprised by the call because I had had two biopsies in the preceding eight years, both of which showed "pin" which I had understood to be pre-cancerous changes to cells in the prostate. No one advised me at the time to have regular biopsies based on those findings. Instead, each time it was my rising PSA that led to the biopsies.

I was working at a major medical center and I knew several people who had been diagnosed with prostate cancer and treated surgically by doctors in the Department of Urology. In fact, my former boss had his radical prostatectomy performed there and he recommended his surgeon to me without reservation. After deciding to go for the surgical option, I followed his advice and consulted his surgeon who agreed to perform the surgery. Shortly after New Year's Day of 2001, I checked into the hospital for my surgery.

The surgeon had prepared me for the possibility of some loss of urinary control (which often returns after a while) and some probability of temporary (or even permanent) loss of erectile function for which there were a number of ameliorating measures that could be taken. I told him I was not so concerned with the erectile function because my wife enjoyed clitoral massage more than intercourse (I count my blessings), but he assured me he would try to preserve the nerve bundles controlling erection during the surgery as much as seemed prudent based on where he found my cancer. I was more concerned about loss of urinary control, as I saw that severely affecting my quality of life. But cutting out all the cancer was, of course, the priority. The side effects, we could deal with.

The surgery went very well in spite of the existence of one very large cancer that had spread to the seminal vesicles. The pathology analysis after surgery confirmed clear margins around the cancerous tissue and the existence of nine separate cancers in my prostate (three of which were microscopic in size). Whatever the side effects of the surgery, I was totally relieved to have that unexpectedly large cancer, as well as all the others, removed from my body. It became clear to me that brachytherapy or external beam radiation therapy, both of which I had considered, might have been ineffective and missed that cancer in the seminal vesicles.  
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◆ FROM THE EDITOR'S DESK ◆

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Watch for a new format in the next issue (February 2008) of the newsletter. When the postal rates increased last May, standard first class mail cost rose just \$.02 from \$.39 to \$.41, but our newsletter mailing cost per copy jumped from \$.63 to \$.97, an increase of 54%! We mail about 1,900 copies per issue. As you may know, the newsletter is not a government publication. Funding the newsletter is the responsibility of our support group. It would be difficult to sustain our newsletter at that postal rate. In order to continue, we are considering certain steps to reduce publication and mailing costs.

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Dr. James R. R. Jezior, WRAMC Department of Urology, was our speaker on August 1, 2007. His topic was "Quest for Continence: Evaluation and Treatment of Post-Prostatectomy Incontinence." A summary of Dr. Jezior's remarks are presented on page 9.



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◆ PROGRAM ON WEDNESDAY, NOVEMBER 7, 2007

Dr. Steven Wilson, Radiation Oncologist, WRAMC Radiation Oncology Service, is our speaker for Wednesday, November 7, 2007. Dr. Wilson earned his medical degree at Tulane University and did his residency in radiation oncology at the University of California, Irvine, before entering military service in 1988. In addition to clinical practice, he is actively involved in prostate cancer research as the WRAMC principal investigator for two national prostate cancer research studies. He has been associated with the Center for Prostate Disease Research for 15 years. Dr. Wilson's topic is "Radiation Therapy for Prostate Cancer: How New Technology Benefits Prostate Cancer Patients." Join us at 7 PM on Wednesday, November 7, 2007, in Joel Auditorium. Plan now to attend and bring your spouse or a guest. They are always welcome.

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## PROSTATE - SPECIFIC ISSUES

### Tomato Diet Can't Guarantee Prostate Health.

Men who've been adding the tomato nutrient lycopene to their diets to cut their risk of prostate cancer may need to think again. According to a new study, lycopene does not appear to reduce the odds of prostate malignancy, findings that are in line with two other recent publications. Key, et al., at the University of Oxford, UK, say their large study does not support the hypothesis that consuming large amounts lycopene will reduce prostate cancer. The authors did find evidence to suggest that, once a cancer forms, high levels of lycopene may reduce by about 60 percent the risk of the tumor progressing to an advanced-stage prostate cancer. However, another recent study found no effect of lycopene whatsoever on prostate cancer risk, including the risk of advanced disease. Also, a review of lycopene's effect on cancer by the FDA likewise found no credible evidence to support an association between lycopene intake and a reduced risk of prostate, and other forms of cancer. (Source: *HealthDay News*, September 14, 2007)

### OK, So Lycopene is Out; What Next? Tangerines?

Yes! Tan, et al., at Leicester School of Pharmacy, UK, say that Salvestrol Q40, a compound contained in tangerine peel, may offer a new approach to uncovering a treatment for cancers such as breast, lung, prostate and ovarian cancer. But don't hold your breath. The researchers warn that many tests will be needed before reaching the clinical trial stage, which could take between five and seven years. (Source: Reuters Health News, September 12, 2007)

### External Beam Radiation and Brachytherapy Effective for High-Risk Prostate Cancer.

High tumor control rates over the long term are possible with external beam radiation followed by brachytherapy in high-risk prostate cancer patients, according to Dattoli, et al., Dattoli Cancer Center, Sarasota, Florida. The majority of the patients in this study had adverse features so that surgery would not have even been a treatment option. The researchers followed 119 intermediate-risk and 124 high-risk patients between 1996 and 1998. All but 39 of the patients

had at least one risk factor for extracapsular cancer extension. The patients received pelvic 3-dimensional conformal external beam radiation followed 2 to 4 weeks later by implantation of palladium-103 seeds. Extraprostatic seed placement was routinely performed, and generous brachytherapy margins were employed. The median non-failing patient follow-up period was 9.5 years. Overall, freedom from biochemical progression at 14 years was 87% in patients with intermediate-risk disease and 72% in those with high-risk disease.

The researchers say that despite perceptions that brachytherapy is inappropriate for patients at higher risk for extracapsular cancer extension, their study strengthens the rationale that brachytherapy-based treatment may be a desirable modality for such patients. The researchers also say most patients were cured without suffering incontinence, while the vast majority has retained potency. In addition, no patient suffered bowel problems which lasted any longer than 1-2 months beyond their treatment. (Source: *Cancer* 2007; 110:551-555, via Reuters Health, August 27, 2007)

### New Study Backs Less Frequent Prostate Tests.

A Europe study suggests it doesn't hurt to wait a few years between prostate cancer screenings, but debate over the value of routine PSA screenings continues. High PSA levels can mean cancer or just an enlarged prostate; only a biopsy can tell. Moreover, prostate cancer usually is slow-growing and there's little way to predict which early-stage tumors will threaten life. Since treatment can cause incontinence or impotence, some experts hold that PSA testing may do more harm than good for some men. Researchers at Erasmus Medical Centre in Rotterdam tracked 4,200 Swedish men tested every two years, and 13,300 men tested every four years in The Netherlands. Over a decade, 13 percent of the men tested every two years were diagnosed with prostate cancer compared with 8 percent of men tested every four years. More frequent testing spotted more tumors overall, but didn't reduce diagnosis of aggressive tumors that formed between visits. Only a handful of those aggressive between-test cancers formed in each group. A

commentator said the study doesn't prove that four years between PSAs is safe, saying the Dutch men may have been healthier. A large U.S. study of PSA screening, due in 2009, may settle the question of how much benefit it really provides. (Source: *Associated Press*, August 28, 2007)

**The Barbershop, Black Men, and Prostate Cancer Risk.** For thousands of black American men, getting a haircut now means cutting their risk for prostate cancer, too. A new program has already enlisted 4,000 barbers nationwide to provide prostate cancer education and screening to minority men. Impetus for the program came from Virgil Simons, a black textile industry executive turned cancer crusader who was inspired by the 2004 movie *Barbershop* that highlighted a natural neighborhood gathering place for black men. Given the fact that American black males are at special risk for prostate cancer, Simons mobilized medical centers to have an educational outreach to barbershops, then provided them with information on screening and free care.

The program started with 300 barbers and last year, more than 100 medical centers across the United States participated. A number of barbershops in the program now have multimedia workstations that provide video clips, text-based material, PodCasts and Web content. (Source: *HealthDay News*, August 6, 2007)

**Zoledronic Acid Reduces Bone Damage in Prostate Cancer Patients.** Zoledronic acid given every 3 months reduces bone density loss and bone turnover in men with hormone-sensitive prostate cancer, according to Ryan, et al., Oregon Health & Science University, Portland. The researchers randomized 42 men with hormone-sensitive prostate cancer to zoledronic acid or placebo (given every 3 months). The investigators assessed the treatment affects on bone mineral density (BMD) of the spine and hip and on markers of bone turnover. Compared with the placebo group, men treated with zoledronic acid showed an annual increase in BMD of 4.2% at the femoral neck and 7.1% at the lumbar spine. Markers of bone turnover remained stable during the 12-month study in the placebo group, but they decreased significantly in the men treated with zoledronic acid. The researchers concluded that

bisphosphonates can prevent bone density loss in androgen-deprived prostate cancer, and biochemical markers of bone turnover may prove useful for monitoring therapy in the future. Adverse events were comparable in the placebo and zoledronic acid groups, however, the optimal dose and schedule of zoledronic acid have not been determined. (Source: *BJU Intl* 2007; 100:70-75, via Reuters Health, August 9, 2007)

**Cancer-Related Anxiety Influences Treatment Decisions.** A new study of men with prostate cancer says that stress and anxiety can affect treatment and encourage patients to request premature or unnecessary therapies. The results suggest there is substantial anxiety in at least some newly diagnosed men who might benefit from intervention to provide patient education and assistance with anxiety management. This is especially true of men choosing active surveillance (watchful waiting) as a treatment option. The research effort is related to continuing concern that screening for prostate cancer leads to men being diagnosed with early and non-life-threatening forms of prostate cancer. Many have cancers that would never cause symptoms if left untreated, and yet they receive curative therapy, resulting in treatment toxicities and likely no therapeutic benefit. So active surveillance is increasingly being promoted as an alternative.

The researchers state that men diagnosed with localized prostate cancer who select active surveillance instead of active treatment face a series of repeated PSA tests and other diagnostic procedures that can substantially raise the anxiety about their current and future health. Using a 3-item scale, the researchers measured cancer anxiety in 105 men patients who had localized disease and selected active surveillance. They calculated the rate of change in PSA with time and used the same formula to calculate the rate of change in cancer anxiety. The investigators found that PSA velocity and the cancer-anxiety change rate were significant independent predictors of treatment. (Source: *J Urol.* 2007; 178:826-832 via Medscape Medical News, September 5, 2007)

**U.S. Court Sees No Right to Unapproved Medicines.** A U.S. appeals court recently ruled that terminally ill patients do not have a constitutional right to experimental drugs not

approved by regulators. The Food and Drug Administration (FDA) requires a wide battery of research, ranging from animal and laboratory tests to advanced trials with people, before it will consider approving a new drug. Manufacturers say the process can take up to 10 years. Two advocacy groups have sued the FDA seeking greater access for dying patients to unapproved medicines that have cleared early safety tests, which usually include 20 to 80 people. The Abigail Alliance for Better Access to Developmental Drugs and the Washington Legal Foundation argued that patients have a constitutional right to try experimental drugs that have passed that hurdle, if they choose.

The 8-2 ruling by the full U.S. Court of Appeals for the District of Columbia reversed an earlier ruling by a divided three-judge appeals panel, which overturned a lower court decision to throw out the case. The majority opinion said "The FDA's policy of limiting access to investigational drugs is rationally related to the legitimate state interest of protecting patients, including the terminally ill, from potentially unsafe drugs with unknown therapeutic effects." The patients' rights groups intend to appeal the decision to the Supreme Court. (Source: Reuters Health Information, August 8, 2007)

**Efficacy of Sildenafil Wanes With Age in Older Men.** Sildenafil citrate is safe and effective for treating erectile dysfunction in men over 60 years old; however, response rates fall somewhat with increasing age. Mulhall, et al., Weill Medical College of Cornell University, investigated the efficacy of sildenafil in 167 men aged over 60 years. The response rate to sildenafil was significantly higher among men aged 60-69 years than among men aged 70-79 years and those aged 80 years and older, the authors report, but the erectile function score improved in all three groups with the use of sildenafil. Adverse effects were negligible in the three groups; they included headache in 18%, flushing and dyspepsia in 8% each, nasal congestion in 5%, and visual changes in 2%. The researchers concluded that the use of sildenafil citrate is safe and effective in elderly men with ED, with a minimal adverse events profile, comparable to the common side effects listed with the medication. (Source: *BJU Int* 2007; 100:117-121 via Reuters Health, August 3, 2007)

**Do Black Men Have More Aggressive Prostate Cancer?** A University of Minnesota study of prostate cancer tumors from Caucasian and African-American men has shown no evidence that the cancer is more aggressive in black men. Sinha et al., Minneapolis VA Medical Center, said the belief that black men's tumors are more aggressive is based on studies that failed to match patients properly and used only indirect means to measure tumor aggressiveness. The researchers selected preserved slices of tumors from 130 surgery patients. From these he was able to match 25 black and 25 white patients according to age, Gleason grade, clinical stage of the tumors and PSA levels before prostatectomy. The results showed that the ratios were not significantly different in tumors of black and white men. They concluded that invasiveness of prostate cancer is not race-dependent. They also stressed that their study results must be confirmed by more expansive studies. (Source: *Anticancer Research* September 21; vol. 27, issue 5A, pp. 3135-3142 via *Science Daily*, September 9, 2007)

**Can Changing Your Lifestyle Help Treat Prostate Cancer?** Up to 73% of men with prostate cancer take nonprescription supplements and smaller numbers use diet, exercise, or both in the hope of improving their outcomes. Most of these men also receive conventional therapy, but a few depend on lifestyle alone. The appeal of lifestyle therapy is obvious, but does it work? Research raises hope that it may have a beneficial impact, according to the July 2007 issue of *Harvard Men's Health Watch*. In a recent study, all of the 93 men who signed up for the trial had newly diagnosed low- to moderate-grade cancers that were localized to the prostate gland. Half were randomly assigned to a lifestyle program, and half got no advice on lifestyle changes. The program that researchers created included four elements: An ultra-low-fat vegan diet; supplements, including soy, fish oil, vitamins E and C, and selenium; an exercise program of walking 30 minutes six days a week; and stress reduction that included yoga-based stretching, breathing, and meditation for an hour a day. At the end of a year, a small but significant difference was evident. The average PSA in the intensive lifestyle group fell, whereas the average PSA in the untreated men rose. The participants in the lifestyle group also showed favorable cancer-

fighting changes in their blood. Much more research is needed before lifestyle therapy can be recommended clinically. Nevertheless, the Harvard Men's Health Watch notes that men with prostate cancer may choose not to wait until science catches up with their disease. And since the lifestyle program studied is good for general health, its elements will make a reasonable addition to any prostate cancer program. (Source: *Newswise*, June 28, 2007)

**Lumpectomy May Be Possible in Some Cases of Prostate Cancer.** Focal ablative therapy may be an effective and less invasive approach to treating some patients with clinically localized prostate cancer, according to Polascik, et al., Duke University Medical Center. Based upon pathology findings of men undergoing surgery for prostate cancer, the study suggests that 1 in 5 men have completely unilateral prostate cancers, and as such could potentially be candidates for unilateral ablation of the cancerous side of the prostate rather than whole-gland radiation or surgical removal. The researchers examined prostatectomy specimens from 1,184 men with organ-confined prostate cancer. In all, 227 (19.2%) had completely unilateral cancers, and 164 of them (72.2%) had tumor involvement of 5% or less. Only 14 (6.2%) had involvement beyond 15%. The researchers hold that in such patients, non-cancerous side of the prostate could be spared with the potential to better preserve quality of life, such as erectile function and urinary continence. They conclude that focal therapy for prostate cancer may become similar to breast-conserving lumpectomy in women for the treatment of breast cancer. (Source: *Cancer* 2007; 110:906-910 via Reuters Health Information, September 13, 2007)

**Androgen Deprivation Therapy in Prostate Cancer: 3 Years Should Remain Standard** Three years of androgen deprivation therapy (ADT) is currently the standard adjuvant treatment following external-beam radiation for prostate cancer, and Bolla, et al., Centre Hospitalier Regional de Grenoble, France, say it should remain the standard. The trial addressed the question of whether the period of adjuvant ADT after radiation for prostate cancer could be reduced from the standard 3 years to a shorter regimen of 6 months. The trial involved 970 men

with locally advanced prostate cancer (median age, 69 years) who had received external-beam radiation therapy (up to 70 Gy) and were then randomized to monotherapy with a luteinizing hormone-releasing hormone (LHRH) agonist for either 6 months or 3 years.

At a median 5.2-year follow-up, 100 of the 483 patients receiving 6-month therapy had died, compared with 73 of 487 patients on 3-year therapy. The 5-year overall survival rate was 80.6% for the shorter regimen compared with 85.3% for the longer regimen.

In addition, disease progression (mostly biochemical and/or bone progression) occurred in 159 of the 483 patients receiving 6-month therapy compared with 61/487 patients receiving 3-year treatment. The 5-year clinical progression-free survival rate was 68.9% with the shorter regimen compared with 81.8% on the longer regimen and the 5-year biochemical progression-free survival was 58.9% on the shorter regimen compared with 78.3% on the longer regimen.

An observer said the trial establishes the standard for patients with locally advanced prostate cancer. Some previous reports suggested that 6 months of hormonal treatment might be enough. However, this trial provides some solid evidence that longer androgen deprivation therapy is better. (Source: ASCO 43rd Annual Meeting: Abstract 5014; via Medscape Medical News, July 16, 2007)

**Finasteride and Sexual Function In Most Men.** Finasteride is an FDA-approved drug for the treatment of benign prostatic hyperplasia, but it is not yet FDA-approved for the prevention or reduction in risk for prostate cancer. Research at the Southwest Oncology Group says men and their physicians need not hesitate to use finasteride out of concern that it is likely to cause sexual dysfunction. The researchers surveyed more than 17,000 men 55 and older for seven years, and found that men given finasteride reported on average more dysfunction than did men given a placebo. But the effect was small and diminished over the seven years. Physicians usually warn that sexual dysfunction is a possibility when they discuss the drug with patients. These new results should lessen

concerns about a negative side effect associated with finasteride.

The study is an off-shoot of the Prostate Cancer Prevention Trial which found that finasteride, a drug which curbs the proliferation of prostate gland cells, is effective at preventing prostate cancer in men age 55 and older. The purpose of this latest study was to assess how many men in the Prostate Cancer Prevention Trial reported sexual dysfunction, and whether the problem decreased or increased over time. In earlier studies, some men taking finasteride reported decreased libido, impotence and other signs of diminished sexual function. But these studies were short-term and didn't try to assess the effects of age, other health factors, and individual variation. This new study suggests that finasteride will cause little or no sexual dysfunction for most men who decide to take it. (Source: *Science Daily*, July 19, 2007)

**Cancer Identified in One Third of Prostate Biopsies.** Welch, et al., Veterans Affairs Medical Center, White River Junction, VT, determined the outcomes of 10,429 prostate needle biopsies performed in men who were 65 years of age and older and Medicare patients. One third of prostate needle biopsies resulted in a diagnosis of cancer, US researchers report. It also showed that men not found to have cancer on initial biopsy often undergo repeat biopsies, which increases the odds of detecting cancer. The likelihood of detecting cancer was directly related to age, ranging from 26% for men in their late 60s to 41% for men aged 80 years and older. The odds of detecting cancer also rose as the number of biopsies increased: 50% of men were diagnosed after two biopsies, 62% after three biopsies, and 68% after four biopsies.

The study is likely to continue the debate about the “to screen or not to screen” issue. The researchers said that the utility of repeat biopsy warrants careful reassessment because the goal of screening is to reduce deaths from the disease and

not simply to find more cancer. They suggest that one approach to reducing overdiagnosis might be to restrict repeat biopsies to men whose PSA is rapidly rising or that reaches a threshold of 10 ng/ml. They acknowledge that some physicians might worry that a more conservative approach would miss lethal disease that could be cured by early therapy. Nevertheless, they say it is incumbent on those making such an argument to demonstrate that the benefits for the few exceed the harms of exposing so many to biopsy and treatment. (Source: *J Natl Cancer Inst* 2007; 99:1395-1400 via Reuters Health Information, September 20, 2007)

**Red Wine Touted Again, at Least for Mice!**

Researchers at the University of Alabama (Birmingham) report that nutrients in red wine may help reduce the risk of developing prostate cancer. They cite resveratrol, a plant compound found in red wine, that has evidenced anti-oxidant and anti-cancer properties. Male mice fed resveratrol in powdered form for seven months had the highest cancer-protection effect for reduction in their risk of more aggressive prostate cancer compared to mice that were not fed resveratrol. The researchers conclude that resveratrol consumption through red wine has powerful chemo-prevention properties, in addition to reported heart-health benefits. The bad news is that to equal the amounts of resveratrol fed to the mice, a person would have to consume one bottle of red wine per day! Cheers! (Source: *PhysOrgcom*, August 31, 2007, via the Us TOO Hotsheet, October 2007)

**The current issue of the WRAMC Us Too Newsletter and back issues are available on line at web site of the Center for Prostate Disease Research. Log on and go to [www.cpdrr.org/patient/newsletter.html](http://www.cpdrr.org/patient/newsletter.html).**

**(First person account, continued from page 1)**

After the standard amount of time with an indwelling catheter after the surgery, I moved to a condom catheter for a number of weeks because I continued to lose a fairly large amount of urine during the day. Fortunately, it was still cold out and my long pants covered the leg bag I wore during those weeks. Even with the catheter, my activities were not significantly affected, though I didn't try active athletics while I was on the catheter. A former colleague, who regularly ran ultra-marathons before his prostate surgery, ran his first marathon a month or two after surgery wearing a condom catheter without a bag – he just ran the tube out the back of his shorts and went dripping around the 50-mile course. He didn't say whether other runners were forced to stay well back from him!

Finally I moved to urinary pads (Depend Guards for Men) after a month or two and was able to get by with one pad per day. In spite of faithful efforts over six months to strengthen my urinary sphincter muscles using Kegel exercises, I have never been able to get by without a urinary pad, even after six years. It is a bit of a bother but it does not restrict my activities in any respect. Within four months of the surgery, I resumed regularly riding my bicycle the 20 miles to and from work and my wife and I resumed our tandem bike riding on the weekends. Now that I am retired, I play tennis two or three times a week, jog and ride a bicycle for hours at a time. When I am very active or standing for a long time during the day, I find it important to carry a spare pad with me, as I have saturated the pad on more than one occasion. But that is a very minor and infrequent bother.

Erections are a different matter. I have tried Viagra to no avail. Apparently it was not possible during my surgery to preserve the nerve bundles because of the extent of my cancer. I never asked the surgeon after the surgery whether he tried to preserve them or not, but I suspect that it wasn't possible. I tried the Caverject injections. They worked, but not only did the injection sting going in, the erection was painful. It took me a while to realize that the operation effectively shortened my penis by more than an inch and, with the same amount of erectile tissue still there, it may have been overstretching everything. Anyway, it was not pleasant and completely interfered with any attempt at orgasm. Since my wife, as I mentioned earlier, was not particularly turned on by vaginal intercourse, it became a non-issue for me.

One particularly helpful doctor friend, however, strongly recommended a special vibrator to be used in our sexual play, one which would provide far more effective clitoral stimulation for my wife and which I might find enjoyable as well. It has made our sex life much more enjoyable. I especially recommend it to anyone wanting to find alternatives to conventional sexual intercourse when those erectile aids aren't doing the job. **(See the Editor's note, below.)**

I have been disappointed in the quality of my orgasms since the surgery. I don't remember whether they were immediately affected after the surgery, but in spite of a lot of desire and sexual interest, the orgasms I have these days are almost not worth going after. That is not to say I don't thoroughly enjoy sex with my wife and the feeling of that vibrator; it's reminding me of times, however, early in our marriage when she was pre-orgasmic but still enjoyed sex. It's disappointing but not tragic. Dying would have been tragic!

Bottom line: I have continuing problems with incontinence and potency, but neither is significantly affecting my quality of life. I'm having a grand time in retirement.

**(Editor's note:** Any reader interested in more information about the product described by the author may contact Mr. Karpinski at 619-819-8594 or [davekarpinski@yahoo.com](mailto:davekarpinski@yahoo.com).)



**QUEST FOR CONTINENCE:  
EVALUATION AND TREATMENT OF POST-PROSTATECTOMY INCONTINENCE**

**Dr. James R. Jezior**  
**Department of Urology, Walter Reed Army Medical Center**

(A summary of a presentation to the WRAMC Us TOO Chapter on August 1, 2007)

### INTRODUCTION

At the outset, I want to talk about some considerations before prostatectomy, particularly as they affect urinary symptoms. Increased screening for prostate cancer has enabled us to detect the disease much earlier than in the past. An article by Maureen O'Rourke at the University of North Carolina looked at what newly diagnosed men with prostate cancer face as they consider the treatment options available to them. Some men decide in the blink of an eye, so to speak, filtering large amounts of information into a few salient facts, getting "the big picture." Others employ a more analytical process by collecting data and applying critical thinking. You may have been screened annually for several years, but never really thought much about prostate cancer until the fateful day when screening led to a biopsy and the results were positive for the disease. Now you are likely to be bombarded with information of varying quality from multiple sources—from your urologist, from the Internet, books and pamphlets from libraries and clinics, family, friends, and support groups. Spouses are actively involved in most patient decisions although wives will often underestimate the influence that they have in the decision. Then the patient applies his personal values to the assembled data. For instance, some may select a form of radiotherapy because they think it lessens the pain and discomfort. Similarly, men may select surgery because they want a "cure." When researchers at the University of Colorado asked men how they evaluated the effectiveness of the various therapies, the men cited "improved chances of survival and non-progression," as you might expect. But just as important, it seems, was "preservation of quality of life." The chance of serious side effects is the major factor in quality of life considerations. The common side effects are urinary incontinence, impotence, urinary urgency/frequency, fecal incontinence, and rectal pain. Some of these are more likely in patients who select radiation therapy; others are more likely in patients who select surgery. Yet, when

we try to analyze the outcomes of the various treatment modalities, we find there are other factors that influence outcome, such as where the treatment is performed, the skill of the provider, and the patient's physical and mental characteristics.

### INCONTINENCE

Now let's focus on incontinence. Why is it so difficult to get data about urinary incontinence after prostate cancer therapy? It's not just the selected prostate cancer treatment that affects the variability of the outcomes. As I just mentioned, some of it is due to the condition of the patient. Age is an important variable. The incidence of lower urinary tract symptoms tracks closely with age. Benign prostatic hyperplasia, overall health, medications taken for other conditions, bladder function, sphincter function, and prior surgeries are some of the other pre-therapy conditions affecting post-therapy outcomes. For example, patients with diabetes or a herniated lumbar disc might have decreased bladder function. Prior surgery such as transurethral resection of the prostate is another example. In short, the patient brings other considerations to the table after they have been diagnosed with this disease.

If you look at what happens to men as they age, by the time they reach their sixties, the prime risk years for diagnosis of prostate cancer, about one-third of them will have pre-existing urinary symptoms. Even 15% of men in their forties will complain about some kind of voiding problem.

### TREATMENT OPTIONS

No doubt you are all familiar with the basic treatment options—watchful waiting, radiation therapy (external beam and brachytherapy), and radical prostatectomy. A study at MD Anderson Cancer Center looked at the urinary outcomes in about 1,000 men with localized disease treated by radical prostatectomy, external beam radiation, or

brachytherapy, compared to a control group. They used a health-related quality of life questionnaire to measure a variety of urinary symptoms. Typical questions involved the frequency of leakage, evidence of blood in the urine, and pain during urination. In this chart that shows selected outcome; the higher the number, the better the reported quality of life. For example, the control group's (men without cancer) mean score for urinary incontinence was 92.2. The mean score for the RP group was 80.0; for the external beam group--85.5; and for brachytherapy--78.0.

## **PROSTATECTOMY AND INCONTINENCE**

Now we move on to our primary topic tonight—the prostatectomy and incontinence. Most of the current treatment strategies for significant incontinence after radical prostatectomy are surgical. This is an anatomic diagram of the prostate and bladder. Here is the bladder, and the prostate sits right below it. The groups of muscles here make up our continence mechanisms or sphincter mechanisms. Some muscles you control, others you do not. These tissues here make up your volitional external sphincter and the fibers here make up your involuntary sphincter or bladder neck. As you can see, both muscle groups are affected by surgery to remove the prostate. The surgical process of a prostatectomy requires surgery up to the external sphincter at the apex of the prostate and “teasing” of the bladder at its base.

### **RISK FACTORS**

What are the risk factors for leaking urine after a radical prostatectomy? They include age, existing medical problems, cancer stage, surgical technique, preoperative continence, urethral length, prior radiation, and a prior TURP. The older the patient, the more likely he will be incontinent after surgery. Certain medical problems (e.g., Parkinson's disease, diabetes, multiple sclerosis, spinal injuries) can impair bladder function and increase the post-operative risk of incontinence. The cancer stage itself is also a factor, though we are not sure why. Perhaps it is because the cancer stage dictates a more aggressive surgical approach. As for surgical techniques, we are uncertain whether the nerve-

sparing techniques now used to preserve erections will also enhance post-surgery continence. Nevertheless, the meticulous surgical techniques that we have learned from nerve sparing probably have helped our continence rates overall. We have also observed that if the bladder neck can be preserved when separating the prostate from the bladder, continence rates are improved. Of course, nerve sparing and bladder neck preservation must be weighed against the chance that cancer may be left behind. Now if you had continence problems before surgery, your chances of incontinence afterwards are higher. As regards to urethral length, preservation of any part of the urethral structure probably will help continence. So we try to pull or “tease out” as much of the urethra as possible from the apex of the prostate itself. If you had radiation prior to surgery, your chance of incontinence is higher; the same is true if you had surgery in the form of a transurethral resection of the prostate (TURP).

### **CONTINENCE RATES**

Patients often express interest in the surgeon's continence rate, and rightly so. But comparisons of surgeons' rates are difficult because of the varying definitions of continence. Let's look at the common definitions of continence. One is “total control without any pads or leakage.” The second definition is “no pad, but with a few drops of leakage.” Finally, the third definition is “one pad or less per day.” If you review the literature, probably the third definition is the most prevalent one for continence after primary therapy. OK, but that's from the doctor's perspective! If you are the one walking around with the pad, you may not share the doctor's viewpoint! Frankly, nowadays pads are so good that you can leak some urine without much disruption of your daily activities. So the “one pad a day or less” definition of continence may not please everyone, but it has become an acceptable standard. A series of studies of continence have shown that about 50% of men are completely dry after radical prostatectomy, and 90% use one pad or less a day. I see these outcomes in my own clinical practice. You can compare your own experience with this prevalent definition to see whether you agree with it.

## TYPES OF INCONTINENCE

There are several types of incontinence. The most common type is stress incontinence. If you stand suddenly, cough, sneeze, or pick up something off the floor, urine spurts out. It tends to be a small volume of urine and directly related to that movement or activity; however, if your sphincter is badly damaged, you might have a lot of leakage, so that description of stress incontinence fades a bit because you tend to leak all the time. Still, most persons with stress incontinence will have some control and leak small volumes.

Urge incontinence is a sudden need to urinate associated with a loss of urine. Patients with normal sphincter function can often hold back that urine despite the strong urge to urinate. This tends to be in a larger volume. When your bladder contracts, it can expel its entire contents.

Overflow incontinence occurs when the bladder doesn't empty completely. This may be due to the reconnection of the urethra to the bladder neck, resulting in a circumferential scar. The scar has a tendency to contract over time and that can narrow the passage. That narrowing effect can be as high as 20%. Our experience at WRAMC is about 5%. Surgeons vary with respect to the urethral size they create during surgery. Our experience has been that some narrowing may actually convey continence to some men. There is a fine line between how much scarring may cause residual urine and how much it helps incontinence.

Then there is the mixed category of incontinence. Probably the majority of patients fall in this last group. They have some combination of the conditions for the types mentioned above.

### EVALUATING INCONTINENCE

About 90% of men who have incontinence after prostatectomy will have it because their urinary sphincters do not function as well after the procedure. The other 10% will have leakage because their bladder wants to contract when they don't want it to. About a third of the patients will have a combination of those two. And less than 5% will have leakage due to the scarring effect at the reconnection site of the urethra and the bladder neck.

The next order of business is to pinpoint, as best we can, the type of incontinence affecting the patient. We put them through a variety of tests to determine the type of incontinence. In the past we used to assume it was the stress type and we were usually right. Now we are able to be more precise and offer different treatment approaches depending on the type of incontinence. We take a detailed history, conduct a physical examination, and order a urinalysis to make sure there is no infection involved. We like to check the patient immediately after he has emptied his bladder. Those patients with scarring at the reconnection of the urethra and bladder neck don't empty their bladders well; the retention of urine is a sign that needs to be investigated. We may also use an endoscopic camera to look into the bladder to verify that there are no other abnormalities in the bladder. The last test is the urodynamic test or UDT that is a form of neurologic testing of the bladder. This slide shows the urodynamic setup. The UDT measures pressures throughout a complete filling and emptying cycle of the bladder using water infused through the catheter. A bladder scanner can be used to evaluate patients who might be retaining urine. It uses ultrasound to measure urine volumes in the bladder sparing the need to place a catheter.

## TREATING INCONTINENCE

There is a wide range of treatments for incontinence. Many of you are familiar with biofeedback and pelvic floor exercises (Kegel exercises) to improve the musculature of the pelvic floor. As for biofeedback, there is some evidence that if you start it early you return to continence after prostatectomy more quickly than those patients that don't. But by the end of twelve months, there appears to be little difference between those patients that went through an aggressive course and those that didn't. Surprisingly, the outcomes for patients relying on instructional hand-outs were no different than those patients who used complex biofeedback techniques.

We also use a variety of oral medications for incontinence. Most of these are actually for urge incontinence. Medicines like Detrol® or

Ditropan® are used to quiet the bladder down. This reduces urinary urgency and may reduce leakage in a small number of patients when they cough or sneeze. Sudafed can be used to “tighten” the bladder neck. It does the opposite of medicines that we give to help men urinate better if the prostate is enlarged. Unfortunately, it can speed up your heart rate and using it chronically has not been all that beneficial.

There are more invasive treatments to settle down the overactive bladder (the less frequent reason for leakage after prostatectomy). We are now using botulinum toxin (Botox) that people use to smooth their facial wrinkles. We are injecting it into the bladder. We also put in electrical stimulators in the sacrum and buttock to “confuse” the bladder so the patient doesn’t feel like they have to go all the time.

For most patients with stress-related incontinence, we usually consider a variety of surgical treatments. Collagen has been around for some time and I suspect persons here tonight have been treated with it. Collagen is a bovine product processed into a paste-like substance that flows through a needle. A camera helps direct it right around the opening between the bladder and the urethral sphincter. Collagen has turned out to be less durable than we would like. Your body eventually breaks it down, so what initially looked like a great result doesn’t look so occlusive later. It takes about four sets of injections to maximize the treatment. Most patients will report early success, followed by recurrent leakage. Others, however, report sufficient benefit to make it a treatment option. If

it works for you--great--because it is a minimally invasive procedure. Success is unlikely in men who have a lot of scarring at the reconnection of the bladder neck and the urethra. Similarly, patients radiated after prostatectomy don’t do well with collagen. Finally, men with severe incontinence or with low leak point pressures are not great candidates for the procedure.

Having had success in dealing with female incontinence using a sling technique, efforts were made to adapt it for male incontinence using the InVance System produced by AMS. The surgical technique uses a perineal approach to emplace a sling of synthetic mesh under the urethra to create

pressure. Small screws are placed into the pubic bone to secure the sling in place. The trick to success is setting the pressure adequately. Here at WRAMC, we use a urodynamic machine to help us. The perineal surgery is well tolerated. Of course, there are some risks. Urethral erosion may occur if the pressure is excessive; infection is also a possibility; and the procedure may simply be ineffective for some men.

How effective is the sling procedure? Well, here is one study. In a group of 64 patients, half were completely incontinent; the other half required an average of 4.7 pads per day before the procedure. After 22 months of follow-up, 36 of the 64 became dry; 5 became significantly dry; 27% required a revision of the procedure; 6% had erosion of the urethra; and 3% had infection. So the InVance sling is a treatment option for some patients. Like any other surgical procedures, it has its pluses and minuses.

Things may be looking up in the area of male slings! Last year AMS introduced its AdVance sling. The sling is made of artificial material. In this case, it is polypropylene which has been used for many years as a suture that can remain within the body. The sling is wrapped around the bones of the pubic arch. Instead of drilling anchors into it, we actually go behind it and around the urethra. We get about 3cm more push on the urethra by going behind the bone to elevate the urethra. The sling is held in place by the patient’s own tissue and the serrated edges of the mesh sling.

So what are the outcomes for AdVance? We are not sure because there have been no authoritative peer-reviewed studies completed. AdVance was only approved by the FDA in July 2006. An abstract presented at the recent AUA convention described a study of 28 incontinent men; 15 had moderate incontinence and 13 had severe incontinence. Most of the patients had prostatectomies. After treatment, 24 out of the 28 required one pad or less per day; and 17 of the 24 were dry. The group’s average pad usage dropped from 5.6 pads per day to 0.6 pads per day. We don’t know the long-term complications of AdVance yet, if any. It’s not as easy to place as the prior AMS sling. And I would guess it is not as easy to remove, if necessary. My own experience with AdVance involved ten patients,

nine of whom were post-prostatectomy. I used five pads or greater to define “severe incontinence.” Their average pad use was 4 pads per day. After treatment, one was dry, 5 improved to 1 pad per day, and 3 had no change in pad use. I did not measure the actual volume of leakage, but I am starting to do so in order to get a better understanding of our results. Again, the AdVance sling is a treatment option, but it not likely to be the “home run” we hoped for in those with severe leaking.

The Artificial Urinary Sphincter (AUS) is considered the gold standard for treating incontinence. It is the most invasive of the continence procedures that we do because it entails placing a mechanical device in the body. Here is what it looks like. The device has a small cuff that wraps around the urethra. A reservoir that holds fluid is surgically placed in a space next to the bladder. At rest, the cuff is filled with fluid that crimps the urethra. A small pump is placed in the scrotum to allow the patient to transfer fluid from the cuff to the reservoir. After urination, the device automatically refills the cuff to restore continence. The results are good—an 80-85% success rate (0/1 pad per day); 50% were free from revision for at least 5 years; and 75% had a functioning AUS at 10-15 year follow-up. The results are better than the other available treatments at this time. The artificial sphincter is a mechanical device, and like all such devices, has a propensity for mechanical problems over time. The longer you have it in place, the more likely you are going to need a revision of it. As noted above, after five years about half the men needed a revision of their AUS. I tell my patients that if a revision is required, it tends not to be as aggressive a procedure as the first placement of the AUS. This might be a reasonable price to pay for being dry. On the other hand, at 15 years, 75% of the patients that have them still have one that’s in and working. They may have had it revised, but they still prefer an AUS to other alternatives. The most common reason for revision is atrophy of the urethra over time. What was a nice, tight-fitting cuff is no longer that, and incontinence may resume. Actually, mechanical failure is less of a problem; probably less than 10% of men have a revision for that reason. Infection also is fairly uncommon these days, about 3-5%. There are several techniques to accomplish needed

revisions. They include the emplacement of a smaller cuff or a double cuff, as well as a technique developed at Duke Medical Center that incorporates tissue from the adjacent structures to “bulk up” the urethra.

## CONCLUSION

In conclusion, preservation of continence after prostatectomy is an important quality of life consideration. There is a wide range of treatments available to deal with incontinence should it occur. The name of the game is to identify and apply the most appropriate technique to deal with the degree and type of incontinence

## QUESTIONS AND ANSWERS

**Question.** I read recently about a group of urologists who practice the robotic technique. They have apparently developed a technique where they take excess tissue to reconstruct some of the musculature affecting incontinence. They claim some very remarkable results such as men becoming dry almost immediately.

**Answer.** I don’t have experience with it. I believe they are using the pelvic side walls to resupport the urethra. We did something very similar with the open RP procedure. We took some muscle from the rectal muscle to enhance the musculature of the urethra (a form of sling), but it showed no real benefit. It should be noted that many early studies appear promising with good data, but later lose some effectiveness as a wider range of patients are treated by a variety of physicians. Currently, some studies report that the robotically-assisted RPs have better continence rates compared to the open procedure. Other studies have come to the opposite conclusion. My personal recommendation for men considering treatment options is to consider the experience of the surgeon, whatever technique is employed. Surgeons who have done five hundred procedures will likely have better results than those who have done twenty. This principle is applicable across all the different surgical techniques. It is also my observation that most technical innovations are not truly revolutionary. They simply become another tool or option for us to use.

**Question.** You briefly mentioned rectal incontinence. I assume any person that has this just sort of lives with it.

**Answer.** The first thing to do is to improve upon the patient's bowel habits in general. The idea is to improve the consistency of the stool using appropriate fiber in the diet. Research in artificial and surgical methods to improve fecal soiling are ongoing. One such device is an artificial sphincter that is wrapped around the rectum. Unfortunately, it doesn't work all that well at this time and has high complication rates. So the first order of business is to improve the consistency of the stool and avoid medications that may worsen it. Earlier radiation techniques used to radiate the entire pelvis, adversely affecting the rectum and the bladder. The current conformal radiation method

have significantly improved rectal problems. When I counsel my patients about treatment options and side effects, I say surgery may have a higher rate of incontinence, but it is easier to treat. Patients with complications from radiation may be fewer in number, but complications such as rectal incontinence, are much more difficult to treat.

**Question.** I have a question regarding the artificial sphincter. For erectile dysfunction there is also a pump. Can you actually have both of those devices? Is there room for them both?

**Answer.** Yes. Both the artificial sphincter and the penile implant can be accommodated within the scrotum at the same time. **You just have to remember to pump the right one at the right time.**



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(As November 1, 2007)

(These persons are willing to share their experiences with you. Feel free to call them.)

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| Robert Gerard    | Carlisle, PA     | (717) 243-3331 |                        |
| Ray Glass        | Rockville, MD    | (301) 460-4208 |                        |
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| Ron Gabriel     | Bethesda, MD      | (301) 654-7155 | (Brachytherapy)                         |
| Irv Hylton      | Woodstock, VA     | (540) 459-5561 | (Brachytherapy)                         |
| Harvey Kramer   | Silver Spring, MD | (301) 585-8080 | (Brachytherapy)                         |
| Bill Melton     | Rockville, MD     | (301) 460-4677 | (External Beam Radiation)               |
| Oliver E. Vroom | Crofton, MD       | (410) 721-2728 | (Proton Radiation)                      |
| John Waller     | Yorktown, VA      | (757) 865-8732 | (Brachytherapy)                         |
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**INCONTINENCE**

|           |               |                |  |
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**OTHER THERAPIES/MULTIPLE THERAPIES**

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| Arthur E. Clough | Kerryville, TX  | (210) 896-8826 | (Surgery and Radiation)                        |
| S.L. Guille      | Sumerduck, VA   | (540) 439-8066 | (Surgery, Radiation, Hormonal)                 |
| Richard Leber    | Chapel Hill, NC | (919) 942-3181 | (Surgery, Radiation, Hormonal)                 |
| Charles Preble   | Annandale, VA   | (703) 560-8852 | (Cryosurgery, Hormonal, Intermittent Hormonal) |
| Emerson Price    | Absecon, NJ     | (609) 652-7315 | (Hormonal, Radiation, Cryosurgery)             |
| S.L. Ross        | Alexandria, VA  | (703) 360-3310 | (Brachytherapy, Radiation, Hormonal)           |
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**OFFICIAL BUSINESS**

◆ **MEETING ANNOUNCEMENT** ◆

**WEDNESDAY, NOVEMBER 7, 2007 AT 7 PM**

**JOEL AUDITORIUM (SECOND FLOOR)  
WALTER REED ARMY MEDICAL CENTER**

◆ **SPEAKER** ◆

**LTC STEVEN WILSON, MC  
Radiation Oncology Service  
Walter Reed Army Medical Center**

◆ **TOPIC** ◆

**Radiation Therapy for Prostate Cancer:  
How New Technology Benefits Prostate Cancer Patients**