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NEWSLETTER

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♦ "MY HANDS DON'T HURT" ♦

Philip L. Brach, PhD, PE, FNSPE

INTRODUCTION

This article is about my renewed confrontation with prostate cancer. It is Part One of the continuing story about my second round of radiation treatment for prostate cancer. Some of you may remember the story of my first encounter with the disease (WRAMC Newsletter, May 2004). It was the end of the summer of 2001 and my critical numbers were a PSA of 14.7 and Gleason score of 7 or 8 (depending on who read the biopsy). I was accepted into a clinical trial at the National Institutes of Health (NIH) which included being vaccinated with the hope of developing a natural immunity to prostate cancer. As the vaccination protocol was experimental, I also received a full regimen of three-dimensional external beam radiation. But wait, what do my hands have to do with this? Well, on the Wednesday after Labor Day 2001, I was at a career fair at an elementary school in Northeast Washington when a young boy, maybe 5th grade, said "Mr., you are sick!" I said, "Yes, I am, but how can you tell?" He said "I can see it in your eyes." Well, my hands had been bothering me such that I had difficulty sleeping at night. So I made an appointment to see my family doctor. In a nutshell, when my blood tests came back, my PSA was 14.7! My doctor had me see a urologist. My biopsy resulted in a **Gleason score of 8, a T1C Prostate Cancer** (undetectable by DRE)**.** Well, hurting hands sort of fell into oblivion (that problem was solved later by over 2.7 million mg of Glucosamine ™ for arthritis).

CLINICAL TRIAL

With a confirmed diagnosis of prostate cancer, I saw a radiation oncologist. After a detailed discussion and explanation of his recommended therapy (external beam and seeds), I just happened to ask, was there anything on the "cutting edge" (no pun intended) for the treatment of prostate cancer? He said, yes, they were working on a vaccination for prostate cancer at NIH and was I interested? Of course I was; for me, there was nothing more comforting during this time of confusion, worry, and apprehension than the thought of participating in a clinical trial whose outcome might help others. If it would help me was not really important. After all, up to the moment of my diagnosis, I thought a DRE was the Director of Religious Education at church and a PSA was a Public Service Announcement! (Wouldn't it be nice if that were the case?)

At NIH I was evaluated to determine my eligibility for the vaccination study. After I passed all the qualifying tests, a computer program decided if I was to receive the vaccine or to be in a control group; this was not a blind study. I was selected for the vaccination group and prepared to start the protocol. **(Continued on page 8)**

♦ *INSIDE THIS ISSUE* ♦

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♦ FROM THE EDITOR'S DESK ♦

Attention WRAMC Us TOO Counselors! (See page 15) Readers have notified the editor that they have been unable to contact some of the men listed as counselors. Please review the telephone number and location shown for you. If it is incorrect, notify the editor of the change. Also, if you wish to discontinue service as a telephone counselor, please notify the editor.

♦ AUGUST SPEAKER'S REMARKS ♦

B.J. Reid Czarapata, RN-NP, Medical Faculty Associates, George Washington University Hospital, was our speaker on Wednesday, August 6, 2008. Her topic was "Managing Incontinence after Prostate Cancer." Her remarks are on page 8.

♦ MEETING SCHEDULE FOR NOVEMBER 5, 2008

Our speaker for November 5, 2008, is Ravi A. Madan, MD, Center for Cancer Research, National Cancer Institute. His topic is "Dealing with Osteoporosis after Prostate Cancer." This topic should be useful to every prostate cancer survivor, especially those men receiving androgen deprivation therapy. Join us on Wednesday, November 5, 2008, at 7 PM in Joel Auditorium. Your guests are always welcome.

PROSTATE - SPECIFIC ISSUES

PSA Screening Controversy Continues. Men who are 75 years or older should not be screened for prostate cancer, says the US Preventive Services Task Force (USPSTF). For these men, and others who have a life expectancy of 10 or fewer years, the incremental benefit from treating prostate cancer detected by screening is "small to none. Therefore, harm outweighs benefit."

This new advice is a significant change from the 2002 statement from the USPSTF which concluded there was insufficient evidence to recommend for or against routine PSA screening, but it did not stipulate any age. Now it recommends no screening for men who are 75 years or older and reiterates that the benefits of screening men younger than this remain unproven.

Instead, the USPSTF recommends that doctors discuss the potential benefits and known harms of PSA screening with male patients who are younger than 75 years. Men in this age group should be informed of the gaps in the evidence, and their personal preferences should guide the decision of whether or not to order the test.

Critics see the new age limit as arbitrary. It also fails to account for the significant number of very active men who are 75 years or older, who may have a life expectancy of more than 10 years. One observer noted that in practice, clinicians are often guided by their own experience with patients as much as they are by clinical guidelines, so this recommendation may influence but will not eliminate PSA screening in the older age group.

At present, the American Cancer Society and the American Urological Association recommend annual PSA screening as well as digital rectal examinations for men older than 50 years.

The screening controversy will persist until larger, longer-term studies are completed. Two large randomized clinical trials of PSA screening are currently underway. The European Randomized Study of Screening for Prostate Cancer (ERSPC) involves 190,000 men, while the prostate component of the US National Cancer Institute's Prostate, Lung, Colorectal, and Ovarian Cancer Screening Trial is being conducted in 76,705 men. (Source: *Ann Intern Med.* 2008;149:185-191, 192-199, via *Medscape Urology MedPlus*, August 5, 2008)

Prostate Cancer and Bone Fracture. A recent study at the Garvan Institute for Medical Research shows a link between prostate cancer and a higher risk of bone fracture. Garvan's Dubbo Osteoporosis Epidemiology Study suggests that men with prostate cancer face a 50% higher risk of fracture, which increases to nearly doubled risk if they are receiving treatment for the disease.

Nguyen, et al, studied 822 men for nearly 20 years. Of the 822 men, 43 subsequently developed prostate cancer. Twenty-two of the men received androgen deprivation therapy (ADT) and 21 did not. Compared to the men without prostate cancer, those with the disease showed a 50% increase in the risk of fracture. For those being treated with ADT, the risk increased approximately twofold. The researchers noted three important implications from the study: (1) most of the men who developed prostate cancer started out with a higher BMD (bone mineral density) than average; (2) developing prostate cancer clearly increased their risk of fracture, not withstanding their higher BMD at the outset of the study; (3) ADT treatment doubled their risk of fracture.

This study sends a clear message that men with prostate cancer should consider seeking evaluation for osteoporosis, particularly if they are being treated with ADT. In treating one disease, care must be taken not to increase the risk of another. (Source: *ScienceDaily*, May 16, 2008)

Prostate Radiation and Colon Cancer Risk.
A study by Bouchardy, et al., University of Geneva, Switzerland revealed an increased long-term risk of colon cancer after external radiation therapy for prostate cancer. The researchers acknowledge that the risk of a second cancer after irradiation is small; nevertheless, the relationship must be carefully monitored.

The study involved data on 1,134 men diagnosed with prostate cancer between 1980 and 1998 who survived for at least 5 years after diagnosis. Of these, 264 were treated with external radiotherapy. During follow-up through the end of 2003, 19 men developed colorectal cancer.

Compared to the general population, there was no increased risk of colorectal cancer among non-irradiated patients, but for irradiated patients, the risk was significantly increased for colon cancer, but not for rectal cancer. The elevated risk for colon cancer was more apparent in the 5- to 9-year period after diagnosis. (Source: *Int J Cancer* 2008;123:1141-1145, via Reuters Health Information, September 3, 2008)

Short-Term Mortality After Prostate Biopsy. Karakiewicz, et al., University of Montreal, report a small but significant increase in mortality within 120 days of transrectal ultrasound guided (TRUS) prostate biopsy. The authors caution that further studies are needed to verify this association and to uncover the mechanisms involved.

The study involved 22,175 patients who underwent prostate biopsy from 1989 to 2000. A control group included 1,778 similar men who did not undergo biopsy. The overall mortality-within-120 day in the biopsy group was higher than in the control group. Age, comorbidities, and number of biopsy procedures also affected mortality. Men younger than 61 years had a mortality rate of 0.2%, compared with 2.5% for men over 75 years. In men without comorbid disease, mortality was 0.7% versus 2.2% in men with multiple comorbidities. First-ever biopsy had a mortality rate of 1.4%, while subsequent biopsies were associated with a rate of 0.8% or less.

The findings particularly suggest that careful prescreening of older and less healthy men is warranted to determine if the benefits of biopsy outweigh the risks. Research has already shown that these men gain the smallest benefit from diagnosis of early prostate cancer. (Source: *Int J Cancer* 2008;123:647-652, via Reuters Health, September 2, 2008)

Sorry, Dear—I Don't Remember. All three erectile dysfunction drugs — Cialis, Levitra, and Viagra — now list rare reports of transient global amnesia on their labels. Transient global amnesia (TGA) is a brief bout of amnesia, lasting less than a day without causing other problems.

Levitra added TGA to its label earlier this year. And now, FDA records show that Cialis and Viagra will make similar additions to their labels. Those label changes don't amount to warnings or precautions. Instead, they will be listed in the "Post-Marketing" section of the drugs' labels.

There's no proof that any of the erectile dysfunction drugs cause TGA, which can happen for various reasons; it can even be triggered by sex.

Spokespersons for the manufacturers cited their procedures for monitoring and evaluating adverse effects of their products. To date, the data do not suggest a causal relationship between the use of these drugs and TGA. The manufacturers also noted that the drugs have been shown to be a safe and effective treatment for erectile dysfunction. (Source*: WebMD Health News*, August 26, 2008)

Transdermal Estrogen Patches and ADT. Langley, et al., Imperial College, London, say initial results confirm that transdermal estrogen patches can produce castrate levels of testosterone in men; therefore these patches show promise as a first-line androgen deprivation therapy (ADT) for men with prostate cancer. The early data from a multicenter phase II trial using patients with locally advanced or metastatic prostate cancer show that the Fem7 patch (Merck) substantially reduces testosterone levels. There are indications that transdermal estrogen delivery may reduce the risk of cardiovascular toxicity and osteoporosis seen with LHRH analogue approaches to androgen ablation.

The next step is a trial aimed at recruiting 200 subjects to compare estrogen patches and LHRH therapy.

To determine the suitability of the Fem7 patch, the researchers studied data on 13 patients given the Fem7 and who had at least 12 weeks of follow-up. All patients had a prostate specific antigen (PSA) response, and eight reached levels below 4 ng/mL.

The patches being used in the study deliver 100 mcg per day of estradiol. However, the investigators caution that day-to-day concentrations may differ between brands, and that pharmacokinetics may differ between men and women. Also, they emphasize the need to monitor hormonal response, toxicity and efficacy until more experience with estrogen patches is obtained.

The researchers conclude that (1) transdermal estrogen therapy is a novel and potentially cost-effective approach to androgen deprivation therapy; (2) large long-term studies are required to assess its effect on prostate cancer and side effect profile compared to LHRH therapy. (Source: *BJU Int* 2008;102:442-445, via Reuters Health Information, August 8, 2008)

Surgery versus Watchful Waiting. Bill-Axelson, et al., the University Hospital, Uppsala, Sweden, report that long-term study results confirm that radical prostatectomy reduces prostate cancer–specific mortality rates and the risk for distant metastases compared to "watchful waiting" in men with localized prostate cancer. The researchers from the Scandinavian Prostate Cancer Group-4 (SPCG-4) point out that, to date, this is the only randomized trial to have shown such a benefit for radical prostatectomy.

The study involved 695 men who were followed for a median of 10.8 years. Analysis of the data showed a relative reduction of 35% in deaths from prostate cancer, 35% in the risk for metastases, and 18% in overall mortality rates in favor of radical prostatectomy. Results are less certain for men older than 65 years or with limited life expectancy due to comorbidities.

However, it is unclear how applicable these results are to current prostate cancer patients in Western countries and especially in the United States, because men are now mostly diagnosed by screening for PSA. That was not the case for the men who took part in the SPCG-4 trial, which began in 1989 in Sweden. In that patient population, only 5% had their prostate cancer detected by PSA. The vast majority had palpable tumors. In addition, the control group was observed with watchful waiting, whereas current practice emphasizes "active surveillance," which could affect the outcomes.

On-going studies in the United States, the United Kingdom, and Canada are addressing the comparative efficacy of the several primary therapies. Nearing completion is the US Prostate Cancer Intervention Versus Observation Trial, which has also compared radical prostatectomy with watchful waiting, but expands on the SPCG-4 by including PSA-detected tumors and African American men. However, until the results of these other trials are available, the SPCG-4 provides the only evidence from a randomized trial for the benefits of a radical prostatectomy, the researchers emphasize. (Source: *J Natl Cancer Inst*. 2008;100:1-11, via *Medscape Urology MedPlus*, August 19, 2008)

Prostate Cancer and Obesity. Prostate cancer diagnosis tends to be delayed and complete surgical resection more difficult in obese men than in lean men according to Freedland, et al., Duke University Medical Center. The primary reason for the delay in diagnosis and poorer outcome is that PSA-based screening is biased against obese men due to lower PSA levels caused by hemodilution from a larger plasma volume.

The researchers tested this theory with 3,400 men by comparing outcomes of radical prostatectomy for PSA-detected cancers and those identified by digital rectal exam (DRE). A higher Body Mass Index (BMI) was significantly associated with high-grade disease, positive surgical margins, and biochemical progression. By contrast, obesity had no effect on the risk of progression for cancers detected by DRE. Accordingly, the researchers recommend lowering the PSA threshold for biopsy among obese men.

In a related analysis, the researchers studied the relationship between obesity and positive surgical margins after radical prostatectomy among 1,434. A higher BMI was associated with an increased incidence of positive surgical margins at all anatomical locations. Overall risk was 45% higher in mildly obese men and 128% higher in moderately and severely obese men relative to normal-weight men.

The researchers emphasized that they did not detect a significant association between higher BMI and either extracapsular extension or seminal vesicle invasion. This suggests that the excess risk of positive surgical margins in obese men results from suboptimal technique rather than advanced disease. They explain that excess abdominal fat makes access to the prostate more complicated when resection is performed through a retropubic incision or by laparoscopy, whereas the larger prostate size in obese men makes removal more difficult through a perineal approach. (Source: *BJU Int* On Line, August 8, 2008, via Reuters Health Information, August 8, 2008)

Recurrence after Prostatectomy. Men with organ-confined prostate cancer and a Gleason score of 6 or less very rarely have local or biochemical recurrence of disease five years after prostatectomy, according to Hernandez, et al., the Johns Hopkins Medical Institutions, Baltimore.

In a study of 2,526 such patients, there were 13 cases (0.5%) of biochemical recurrence and five cases (0.2%) of local recurrence after a median of 5 years of follow-up. Furthermore, there were no cases of distant metastases and there were no prostate cancer-specific deaths. The five patients who had local disease recurrence underwent salvage radiotherapy with subsequently undetectable PSA levels.

The 5-, 10- and 15-year actuarial probabilities of local recurrence were 0.1%, 0.5% and 0.5%, respectively, and the corresponding probabilities of biochemical recurrence were 0.3%, 0.9% and 1.3%.

The researchers concluded that their study demonstrated that when prostate cancer is treated by the anatomic approach to radical prostatectomy with negative surgical margins and the tumor is organ-confined and lacks high-grade elements, it is effectively cured. (Source: *Urology* 2008;72:172-176, via Reuters Health Information, August 11, 2008)

Agent Orange and Prostate Cancer. A recent study by Chamie,, et al., University of California, Davis, and the VA Northern California Health Care System shows that Vietnam War veterans exposed to Agent Orange have greatly increased risks of prostate cancer and even greater risks of getting the most aggressive form of the disease as compared to those who were not exposed.

Although exposure to Agent Orange has long been the basis for VA compensation for Vietnam veterans subsequently diagnosed with prostate cancer, the scientific evidence was limited. This study is the largest study to date of Vietnam War veterans exposed to Agent Orange and the incidence of prostate cancer. It is also the first to reliably link the herbicide with this form of cancer by studying a large population of men in their 60s and the prostate-specific antigen (PSA) test to screen for the disease.

The researchers say that, unlike previous studies that were either too small or conducted on men who were too young, patients in the current study were entering their prime years for developing prostate cancer. There was also the added advantage that it was conducted entirely during the era of PSA screening, providing a powerful tool for early diagnosis and tracking of prostate cancer.

More than 13,000 Vietnam veterans enrolled in the VA Northern California Health Care System were stratified into two groups — exposed or not exposed to Agent Orange between 1962 and 1971. Based on medical evaluations conducted between 1998 and 2006, the study revealed that twice as many men exposed to Agent Orange were identified with prostate cancer. In addition, Agent Orange-exposed men were diagnosed two-and-a-half years younger and were nearly four times more likely to present with metastatic disease. Other prostate cancer risk factors — race, body-mass index and smoking — were not statistically different between the two groups.

The researchers conclude that the study clearly confirms that Agent Orange exposure during service in Vietnam is associated with a higher risk of prostate cancer later in life, and that men with Agent Orange exposure be given priority consideration for all the screening and diagnostic tools we have at our disposal in the hopes of early detection and treatment of this disease. (Source: Public Affairs Release, University of

California, Davis, Health System, August 5, 2008)

Hormone Therapy and Cognition. Jenkins, et al., University of Sussex, Brighton, UK, monitored the short-term effect of luteinizing-hormone releasing hormone (LHRH) agonist therapy on patients' memory, concentration and spatial skills. The results of the pilot study suggest that neoadjuvant hormone therapy for early prostate cancer has a modest short-term adverse impact on cognitive function.

Thirty-two patients with localized prostate cancer had cognitive assessments before the start of hormone therapy, at 3 months or on completing drug therapy but before radiotherapy, and 9 months later. Eighteen men with no prostate cancer were also given these cognitive tests. The results showed that for some men, performance was worse following treatment when testosterone levels were low, particularly their spatial skills. The effects were subtle rather than clinical, although a quarter of the men one year later still complained that their memory had deteriorated."

The researchers say that clinicians be aware that LHRH agonist therapy may cause subtle changes in cognition in this group of patients. These patients only received 3 months therapy whereas many patients receive longer term treatments. Given these findings and the increasing use of LHRH therapy, the researchers call for a larger prospective study of the possible side-effects of the treatment. (Source*: BJU Int* 2005;96:48-53, via Reuters Health Information, July 20, 2008)

ADT as a Primary Therapy. Primary androgen-deprivation therapy (ADT), used alone instead of surgery or radiation, does not improve survival, compared to conservative management, in the majority of elderly men with localized prostate cancer.

Yao, et al., Cancer Institute of New Jersey, New Brunswick, analyzed 19,271 men, aged 66 years or older, with clinical stage T1 or T2 prostate cancer. All the men were covered by Medicare and none received definitive local therapy; 7867 (41%) men received primary ADT, and the remainder was followed with conservative management.

The researchers concluded that primary androgen-deprivation therapy does not appear to be a good alternative to surgery or radiation; outcomes appear to be no better than conservative management or watchful waiting. They also note that primary ADT has become an increasingly popular option for localized prostate cancer, especially among older men, and is used in place of surgery, radiation, or conservative management. However, the popularity of this option is not backed up by data; this is not a standard treatment approach, nor is it sanctioned by any major groups or guidelines, they point out.

Furthermore, ADT has significant adverse effects and is costly, the researchers say. Previous studies have suggested a 10% to 50% increase in the risk for fracture, diabetes, coronary heart disease, myocardial infarction, and sudden cardiac death; a 500% increase in the risk for gynecomastia and hot flashes; and a 267% increase in the risk for impotence. In the United States, ADT cost $1.2 billion in 2003 and was the second-highest Medicare Part B drug expenditure. (Source: *JAMA*. 2008;300:173-181,via Medscape, July 11,2008)

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(A summary of a presentation to the WRAMC Us TOO Chapter on August 6, 2008)

INTRODUCTION

Why do men who have had primary treatment for prostate cancer have a higher risk of urinary incontinence? The answer is obvious and well-known to those of you here tonight. The primary therapies for prostate cancer - surgery, radiotherapy, and cryotherapy - involve delicate procedures affecting the urinary process. Despite the improvements in technique and technology over the years, the primary therapies will affect patient continence to some degree. Various studies citing the incontinence rates associated with the prostate cancer therapies may cite better or worse incontinence outcomes, but few men will be unaffected by their treatment. (Note: Ms. Czarapata then displayed and explained a slide showing the anatomical relationships of the male urinary system and its relationship to the prostate gland.)

Let's define our topic at the outset. Urinary incontinence is a condition in which involuntary loss of urine is a social or hygienic problem and it is objectively demonstrable.

All types of incontinence involve the pressure in the bladder becoming greater than the closing pressure of the urethra. We prefer to help men deal with urinary incontinence by the least invasive process, and that's where I come in. Tonight I want to discuss urinary incontinence as treated by the nurse practitioner who employs various techniques to help men overcome urinary incontinence or at least manage its effect on their lives.

EVALUATING THE PATIENT

When a patient comes in and says he is leaking, I don't take anything for granted. For example, I take a thorough history to help assess the cause of the patient's condition. He is often surprised by the detail I seek. He is probably thinking, "Why is she asking me all these questions," that to him seem unrelated to his problem. For example, the patient who underwent a radical prostatectomy often assumes his incontinence is related solely to his surgery. Perhaps it is, but I simply can't rely on his assumption. There are other systemic conditions that, if not the immediate cause, could be aggravating factors.

These are the other factors I take into consideration in my evaluation of the patient: other genito-urinary complaints; sexual problems; gastrointestinal complaints; back pain; lower extremities; appetite; sleep habits; bowel function; mobility and dexterity; recent life style changes; environmental issues; and social factors.

On examination, I'm going to evaluate anal sphincter tone. Is the sphincter in good shape? Is there evidence of retained stool that might be irritating the bladder? There are two reflexes called the "anal wink" and the bulbocavernosus reflex that show whether the nerves to the bladder coordinating the voiding function are working. They create the possibility that one can detect a "need to go" and thereby control it.

We also perform a bladder scan using an ultrasound machine to detect urinary retention in the bladder. Urinary retention is often

found in men who had a radical prostatectomy. The reconnection of the bladder and urethra after removal of the prostate can result in scar tissue, restricting urine flow. If this is the case, there are urologic procedures to correct the condition.

STRESS URINARY INCONTINENCE

Let' start with stress urinary incontinence. It is the most common type of incontinence. Urinary leakage occurs with increased abdominal pressure. A cough, a sneeze, rising from a chair, bending over, picking up heavy objects—all these activities will likely result in leakage for persons with stress urinary incontinence. In dealing with stress urinary incontinence, we focus on the development of the lower pelvic musculature. The key here is the Kegel exercise, correctly performed. Too often I see varying descriptions of the Kegel, so it's no wonder that some men become confused and disillusioned with the results—so they quit doing them! Here is my practical description of the correct Kegel. Just imagine that last night your wife found a new recipe for baked beans. She used it, and the results were so good that you had three servings. Now you are sitting among friends and the accumulated gas is about to wreak havoc on the social environment! Of course, you are going to try and hold back the gas. To do so, you squeeze the anus to retain the gas. Hold it for about one second and then relax. There, you have done a Kegel correctly!

I usually have my patients perform the Kegel for ten repetitions-three times a day (thirty times). We recommend you start and hold the squeeze for one or two seconds, then you work up until you can hold the squeeze for ten seconds and relax it for ten seconds. The goal is to over-exercise the muscles to bulk them up so they can better control urine flow. (As an aside, when I gave my description of a correct Kegel to a group of urologists, one of them said in jest," Why would you want to hold back the gas?" I responded that only a man would fail to do so!)

URGE URINARY INCONTINENCE

Urge urinary incontinence is a sudden need to urinate. You leak because your bladder pressure increases due to the contraction of the bladder. The bladder is twitchy or simply contracts and its pressure exceeds the closing pressure of the urethra. Patients with normal sphincter function can often hold back the urine spurt, but if the sphincter is damaged as a result of your primary therapy for prostate cancer, then look out! But if you employ the Kegel technique we just practiced, that will often turn off the urge to urinate. When you sense that urge, relax the abdomen (don't tighten it as many men do) and do three little squeezes. That should do, and here's why--there is coordination between the bladder and the sphincter so that as the bladder contracts, the sphincter muscles open allowing the urine to come out. But if you sense the bladder contracting and you squeeze the sphincter muscles, the bladder relaxes. That is the process essential to resisting urge incontinence.

Now is the time to tell you my pet peeve. Some urologists tell their patients to perform the Kegel exercise by starting and stopping the urine stream. That is wrong! You do not want to do the Kegel exercise that way because it fouls up the natural coordination between the bladder and the sphincter muscles.

OTHER KINDS OF INCONTINENCE

Mixed incontinence is some combination of stress incontinence and urge incontinence. The majority of patients probably fall in this category. **Overflow incontinence** is often associated with urine retention caused by scarring at the bladder-urethra reconnection that I mentioned earlier. Your bladder keeps topping off, making you leak small-volume voids periodically. Occasionally there can be a completed emptying of the bladder during sleep. **Functional incontinence** is not due to urinary tract problems. Rather, it is a situation wherein otherwise continent persons with mobility difficulties or other physical conditions have difficulty coping with the need to urinate.

DEALING WITH INCONTINENCE

The whole process is determined by how much damage has been done to the bladder neck and your sphincter muscles during prostate cancer therapy. The first step is to develop a preliminary individualized continence program involving timed voiding, habit training, prompted voiding, and bowel training.

The treatment process has several aspects: **Kegel Exercises** properly performed. We used to recommend 300 Kegels a day, but no more. If you over-exercise your pelvic floor muscles, you cause muscle fatigue that could actually worsen incontinence. So we recommend three sets of ten. **Obturator Internus Exercises**. These two exercises affect the pelvic sling. One exercise involves placing a ball between the knees while seated. The knees are then pressed together for five seconds for several iterations. Then a related exercise involves wrapping an exercise stretch band around your legs while you try to spread your knees. **Timed voiding** means exactly what it says. The patient keeps a schedule of when he voids, picks "half way" times, and makes an effort to urinate at that interval, relying on Kegels, as necessary, to meet the scheduled time objective. The idea is to urinate "by the clock" without turning your life upside down in the process. **Biofeedback and Electrical Stimulation** are well-known procedures, the "big guns," so to speak. (Ms. Czarapata displayed and discussed a slide demonstrating biofeedback.) Electrical stimulators applied to the pelvic floor muscle give it a boost to increase the effort to contract. They may also dull the urge to urinate if it is overactive.

Medications like Detrol® and Ditropan® help quiet down the bladder. This reduces urinary urgency and may reduce leakage caused by coughing or sneezing. When these treatment processes are inadequate, the patient and his physician may resort to more invasive procedures, such as **Collagen injections** or the implantation of an **Artificial sphincter**. Collagen injections may work for some men, but overall, they have not been the success we would hope for. On the other hand, the artificial sphincter has had good success in helping many men cope with incontinence.

BLADDER IRRITANTS

Bladder irritants stimulate the bladder to contract. These irritants are well known: caffeine in coffee, chocolate, aspartame, citrus products, alcohol, constipation, and any urinary tract infection or inflammation. I can tell patients about these bladder irritants, but they must commit to dealing with them in any program to reduce or cure incontinence.

BLADDER TRAINING

Coping with incontinence requires bladder training. Its components are a bladder diary, fluid management, urge control, and bowel training. I have already discussed urge control when we described the Kegel exercise. So let's move on to the others. The bladder diary keeps track of when the person urinates and when leakage occurs.

I recommend the person try timed voiding, that is, an attempt to urinate every hour whether he needs to or not; then try to stay dry in between times. If this is doable, I may increase the target time to an hour and a quarter.

Some persons restrict fluid intake in order to reduce leakage. This could lead to over-concentrated urine in the bladder which will only exacerbate bladder irritation. Fluid management helps to ensure that fluid intake is adequate to the body's needs.

Bowel training is important because constipation is a bladder irritant. The idea is to have a bowel movement when you can expect it daily. I usually recommend that persons with constipation drink 8oz. of hot water first thing in the morning, then insert a glycerin suppository (non-laxative) to stimulate a bowel movement. Of course, foods

high in fiber are very useful. Within fifteen minutes of finishing breakfast, the person should use the bathroom to try and have a bowel movement without straining. If it is not accomplished after fifteen minutes, then try later. The idea is to regularize bowel movements to avoid constipation. Abdominal massage is also useful to stimulate peristalsis.

NOCTURIA

Nocturia is the frequent need to get up during the night to urinate. My experience is that patients who have had a radical prostatectomy aren't affected too much by nocturia. Instead, they tend to lay there asleep and don't leak throughout the night. Polyuria, the daily passing of large amounts of urine, is another condition we must consider. There are probably underlying systemic problems, such as diabetes II, that need to be evaluated. Polyuria also affects our ability to concentrate our urine output. The urine output of younger persons is very concentrated and this is good. But as we age, our urine output is less concentrated because the kidneys become less efficient over time. Then there is the mobilization of stored fluid. Here's how it works. When you have been up all day and on the go, you have stored a lot of fluid in your lower extremities. When you lay down in bed, that fluid all gets back into your system while you are sleeping. To overcome this condition and its effect on the bladder, I encourage patients to do some reclining for about an hour before retiring with the feet elevated to the level of the heart. You do that for about an hour, then sit up vertically or walk around, then urinate before getting in bed. This should help reduce the need to void during the night. Nocturia may also be associated with obstructive sleep apnea. So if you find that you are putting out a lot of urine during the night compared to your daytime volume, then a sleep apnea study may be indicated.

Sometimes there are accidents on the way rushing to the bathroom. This is related to the functional incontinence I mentioned earlier. So make sure there is a lighted path towards the bathroom and no loose rugs that you can trip over on the way.

CONCLUSION

One final point. There are all sorts of diapers and pads available to deal with incontinence. Some men even improvise methods to collect urine leakage. I recently became aware of a new product called BioDerm®. It attaches to the very tip of the penis and channels urine into a soft collection chamber that holds about eight ounces. This device is for someone who is leaking constantly. Properly used, BioDerm® reportedly needs to be changed every three days. In closing, here are some Words of Wisdom for the incontinent--**SQUEEZE BEFORE YOU SNEEZE**! Now I'm open for your questions.

QUESTIONS AND ANSWERS

Question: Do you have hand-outs of your presentation?

Answer: No, but a summary of it will be included in the November issue of the WRAMC Prostate Cancer Support Group newsletter.

Question: I had collagen injections for my incontinence, but the effect wore off after a few months. Subsequent treatments were also unsuccessful. I'm still looking for an effective alternative.

Answer: Unfortunately, your experience with collagen is all too typical. Collagen is injected into the bladder neck. It causes the tissues to enlarge and squeeze together to reduce leakage. Over time, the collagen begins to be absorbed, and when it is, it takes up less room, so it becomes progressively ineffective. The virtue of collagen is that it is a relatively easy-to-do outpatient procedure that can be repeated. You may wish to consider the implantation of an artificial sphincter. Many men have found it very effective. Another surgical procedure is the male sling that is placed under the urethra to create pressure on it. You should consult with your urologist to learn if these surgical procedures are appropriate for you

Question: I understand the importance of doing the Kegels correctly and regularly. How long must a man perform them before they can be declared successful?

Answer: Normally you achieve maximum rehabilitation of a muscle at four months of regular exercise, but many men will note some improvement at the outset. Then usually after about a month or two, we see more substantial improvement. If we don't see improvement by four months, we need to consider another alternative. I actually had one patient call me after hearing my presentation to say he went from 14 pads to one pad per day. So, all of you have the possibility of improved continence just by listening to me! (Laughter)

Question: What about the man who is very active, regular jogging, for example? Leakage control while exercising is my biggest problem.

Speaker: This situation affects both men and women. When jogging, or performing some other type of exercise, you are increasing the pressure in your bladder that exceeds the urethra closure pressure. You may want to consider wearing a condom catheter during your scheduled exercise period.

Question: A friend of mine had a urinary incontinence problem after surgery that lasted almost a year before it cleared up on its own. I imagine that Kegel exercises would probably have helped help clear it up sooner.

Answer: You are absolutely right. Many men experience a natural resumption of continence as the pelvic muscles and tissues heal over time. That is why urologists

prefer to wait twelve months or so after primary therapy before addressing a patient's incontinence issues. On the other hand, most men don't want to wait a year to see if natural processes will solve their incontinence problems. They want them solved NOW! The regular and correct performance of the Kegel exercise can speed up those natural healing processes. That's the name of the game!

Question: So if a man had a radical prostatectomy six or seven months ago, and he is not satisfied with his progression toward continence, is it too late to begin or resume Kegel exercises?

Answer: Absolutely not! Start or resume now. The regular and correct performance of Kegel exercises can only help the healing process. The saying that "The Lord helps those who help themselves" certainly applies in this situation.

("My Hands Don't Hurt" – Cont. from page 1)

I will never forget my first day. It was September 11, 2001. Yes, that's right, 9-11! I had received my first vaccination at the National Cancer Institute at the National Naval Medical Center in Bethesda and was on my way to drop my wife off at her work (she accompanied me every day, I needed a lot of moral support) and in the car we heard the news of a plane striking one of the towers of the World Trade Center. A tragic "accident," I thought at that moment, because I remembered as a kid when a plane ran into the Empire State Building (my Dad was the city engineer who went to survey the accident scene). So I dropped my wife off at the Vatican Embassy and went to my employment at the University of the District of Columbia. Upon arriving I sought out a TV to see the latest news on the plane crash. I was just in time to hear that a sec-

ond plane had hit the second tower and another had struck the Pentagon. No longer an accident! I was very young when Pearl Harbor happened, but I am sure the horror of such an attack lived in the minds of my parents as 9-11 remains in mine. Prostate cancer was no longer on my mind.

Eight months later I had completed my external beam radiation and a series of eight vaccinations. As a result, my PSA was undetectable. My PSA was monitored every 3 months, than twice a year, and finally once a year. My PSA remained undetectable. I felt very good each time I got the results of my PSA to learn it was undetectable. The days before the blood test and hours after waiting for the results were apprehensive. You have to experience it to understand as I'm sure many of you do.

(Now, let's skip forward five years to August 2007.)

IT'S BACK!

This is a brief narrative of my second confrontation with prostate cancer beginning in August 2007. My annual PSA results arrive—**IT IS DETECTABLE**. Maybe it is an anomaly, maybe the test is in error, Oh S—T; well, I knew it might (could) not last forever! The doctors at NIH said "let's see what happens; we will take another test."

So a month later my PSA has gone up; by November it is doubling about every 2 to 3 weeks. What happens now—you would expect that I am used to this scenario, old stuff, like falling off a log. Well, it is not. Apprehension reigns again.

There are a couple of clinical trials I might fit into. First, one requires that they take a biopsy of the prostate to see if by some chance cancer has survived the initial radia-

tion therapy. I have the biopsy--no cancer. A second trial requires that I have a certain level of testosterone. No luck, I don't.

Next a pelvic scan, a brain scan, a bone scan and some tests I don't even remember. I met with a urologist, an immunologist, and an oncologist. Somewhere in all of this a single node of prostate cancer is discovered. It is just outside of the field of my original radiation treatment. Surgery is considered, but it is deemed too risky. Maybe hormone therapy alone--I don't particularly like this alternative. Finally, radiation of the newly-detected mode is a possibility. Now, it's May 2008 and all the options have been fully considered; I start 25 days of external beam radiation (at the same time I have started hormone treat-ment--3 month shots of Lupron). September 2008—good news! My PSA is back to undetectable. My fingers crossed!

PHOTO THERAPY

During my first go-around with prostate cancer I took photos of virtually everyone I encountered. Those directly associated with my care as well as those with an ancillary association and even those with no real connection at all (see article in USTOO Newsletter, May 2004). I have continued this "Photo Therapy" the second time around. Part 2 of this article will include charts, graphs and photos of a "Sojourn with Prostate Cancer."

Cancer is a terrible disease; for men prostate cancer is the most common. If caught early, it is treatable and most important livable. For me, and I am sure for most of the men that attend the WRAMC US TOO meetings or read this newsletter, the many folk who make up the support group contribute significantly to the physical and mental health of those of us with prostate cancer. The many people at NIH and the NNMC that helped me through this endeavor will always be in my prayers.

ADDENDUM

There are many exciting clinical trials going on at NIH with the potential to significantly impact the devastation of this disease as well as many others. But the sad thing is that progress on these clinical trials is too often delayed because of a lack of volunteers. I became a volunteer because it was extremely comforting to know that maybe—yes, only maybe—it might help others. Maybe is good enough for me, I hope some of those who read this article may find it good enough for them.

THE CURRENT ISSUE OF THE WRAMC US TOO NEWSLETTER AND BACK ISSUES ARE AVAILABLE ON LINE AT THE WEB SITE OF THE CENTER FOR PROSTATE DISEASE RESEARCH AT WWW.CPDR.ORG/PATIENT/USTOO/NEWSLETTER.HTML.

♦ WRAMC US TOO COUNSELORS ♦ (As of October 10, 2008)

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

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7 PM

JOEL AUDITORIUM (SECOND FLOOR)
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♦ SPEAKER ♦

RAVI A. MADAN, MD
Center for Cancer Research
National Cancer Institute

♦ TOPIC ♦

"Dealing with Osteoporosis after Prostate Cancer"