

**WRNMMC Us TOO, Inc.**  
**A PROSTATE CANCER SUPPORT GROUP**  
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**WALTER REED NATIONAL MILITARY MEDICAL CENTER**  
**NEWSLETTER**

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**◆ FACE-TO-FACE VERSUS ON-LINE SUPPORT GROUPS ◆**

As social media are evolving rapidly on-line support groups are becoming increasingly important for patients. The aim of this study was to compare the users of traditional face-to-face support groups and on-line support groups.

We performed a cross-sectional comparison study of all regional face-to-face support groups and the largest on-line support group in Germany. The survey covered socio-demographic and disease-related information, decision-making habits, psychological aspects, and quality of life.

The study analyzed the complete data of 955 patients visiting face-to-face support groups and 686 patients using on-line support groups. Patients using on-line support groups were 6 years younger (65.3 vs. 71.5 years), had higher education levels (47 vs. 21%), and had higher income. Patients using on-line support groups reported a higher share of metastatic disease (17 vs. 12%). Patients using on-line support groups reported greater distress. There were no significant differences in anxiety, depression, and global quality of life. In the face-to-face support groups, patient ratings were better for exchanging information, gaining recognition, and caring for others. Patients using on-line support groups demanded a more active role in the treatment decision-making process (58 vs. 33%) and changed their initial treatment decision more frequently (29 vs. 25%).

Both modalities of peer support received very positive ratings by their users and had significant impact on treatment decision-making.

Older patients might benefit more from the continuous social support in face-to-face support groups. On-line support groups offer low-threshold advice for acute problems to younger and better educated patients with high distress. (Source: *Journal of Cancer Survivorship : Research and Practice*, August 31, 2017 (Epub ahead of Publication))

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**◆ FROM THE EDITOR ◆**

Presenting our quarterly speaking program from the Fort Belvoir Community Hospital with a video link to our location at WRNMMC has worked well. It enhances attendance from both our regular members and our Board of Directors.

**◆ SPEAKER'S REMARKS - AUGUST 3, 2017 ◆**

Our speaker on Thursday, August 3, 2017, was Dr. Sean Kern, Department of Urology, Fort Belvoir Community Hospital. His topic was **"Overview of the Surgical Treatment Of Prostate Cancer."** A summary of his remarks is at page 11.

**◆ MEETING SCHEDULE FOR NOVEMBER 2, 2017 ◆**

Our speaker for Thursday, November 2, 2017, is **Dr. Timothy Tausch**, Director, Trauma and Reconstructive Urology, WRNMMC. His topic is **"Life After Prostate Cancer Treatment: Treating Urinary Incontinence and Erectile Dysfunction."** Please join us at 7:00 PM at Fort Belvoir Community Hospital (Oaks Pavilion, 1st floor, Room 332 (primary site) and at WRNMMC, the America Building (Bldg 19), 2nd floor, Room 2525 (via video teleconference).

Remember, your family and friends are also welcome.

**See the back page for information about getting access.**

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## ◆ PROSTATE-SPECIFIC ISSUES ◆

**Prostate Cancer and How You Might Avoid Buyer's Remorse.** According to the National Cancer Institute, nearly half of all men diagnosed with prostate cancer in the U.S. choose surgery. A study published in the journal *Research and Reports in Urology* found that the rate of prostatectomy-related regret increases over time, with up to 47 percent of men reporting regret five years after surgery.

My favorite article about regretting prostate surgery is titled, "I Want My Prostate Back." I suspect most men who've had prostate surgery can relate to the following paragraph from that article:

"Now, almost 2 years later, I'm not going to say, 'thank god they caught it in time ... I'm so blessed, each new morning is a miracle...Blah blah blah blah.' No, what I'm thinking is more along the lines of: I want my prostate back."

I've spent some time wishing I had my prostate back. Did you?

Multiple reasons explain why a significant number of men who choose robotic surgery experience buyer's remorse. The first source of buyer's remorse comes from believing exaggerated and unsubstantiated claims.

A 2011 study by Johns Hopkins School of Medicine found that 164 hospital robot-surgery websites surveyed "overestimate benefits, largely ignore risks and are strongly influenced by the manufacturer."

A second source of buyer's remorse comes from miscommunication between the surgeon and the patient about regaining urinary control. When a surgeon states that more than 90 percent of his patients regain urinary control, what are they saying and what's left out?

Some surgeons define urinary control as using one pad a day. Others say living without a pad is regaining urinary control. What the patient hears is that his pre-surgery level of urinary control will return.

What's left out of the discussion is the issue of leaking. Statistically, I'm counted among those who regained urinary control because I don't use a pad. In order to live pad-free, I'm constantly vigilant about the state of my bladder.

If my bladder is full, a sneeze, a cough, or lifting something heavy will cause me to leak urine. The volume of urine I leak depends on the fullness of my bladder. It's something I constantly monitor during my waking hours. This doesn't feel like a return of urinary control — it's more like leak management.

There's another place I leak urine and I hate it. Every man who agrees to prostate surgery should receive written information about this possibility. If you leak urine before or during orgasm you're coping with climacturia.

According to the International Society for Sexual Medicine, "An estimated 22% to 43% of men experience climacturia after prostatectomy. It can be a distressing situation for both men and their partners."

The shame, embarrassment, or disgust about leaking urine during sex are deal breakers for many couples. Couples give up their sexual relationship. Some single men give up on dating and marriage.

Climacturia is one of the factors that explain why Dr. Claus Roehrborn, a professor and chairman of the urology department at University of Texas Southwestern Medical Center in Dallas, told the Australian Financial Review: "A year after a radical prostatectomy, 15 per cent of men will still be leaking urine in some way, and of those who enjoyed full potency before the operation, only one in six will have resumed sexual activity."

Pause for a moment and wonder why so many men post-surgery who are capable of achieving an erection give up on sex.

The third source of buyer's remorse occurs during the discussion about the return of erectile functioning. Men enter this discussion thinking that a return of sexual functioning means a return to their pre-surgery abilities and sex life. Unfortunately, that's not what it means.

Here's a list of potential post-surgery changes:

- All prostatectomies cause the loss of ejaculation. No one told me this would happen. Initially, this loss took all of the pleasure out of experiencing an orgasm. I experienced this as a devastating loss.
- The majority of men will experience a temporary bout with impotence. Few of these men and couples receive information, help, or support with an issue that causes an earthquake in their relationship.
- Some men require a vacuum pump, ED medication, or penile injections in order to achieve an erection.
- Changes in the intensity of your orgasm. For some it's more intense, for others like myself, it's severely diminished.
- Penile shrinkage. Some men experience a noticeable reduction in the length of their penises.
- Climacturia is defined by leaking during orgasm.
- Changes in the desire for sex. Some men experience a diminished desire for sex, and some lose their desire for sex.
- A change in the level of hardness. Many men achieve a hardness that allows for penetration, but their level of hardness is nowhere near pre-surgery levels.

These changes can diminish a man's self-esteem, manhood, and sexuality. Relational difficulties also arise.

Whether you choose surgery or a different treatment modality, it's important for you to understand the quality of life issues and changes you'll experience with each of your treatment options. (Source: Prostatenewstoday.com; October 6, 2017)

(Note: Prostate Cancer News Today is strictly a news and information website about the disease. It does not provide medical advice, diagnosis, or treatment. This content is not intended

to be a substitute for professional medical advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health provider with any questions you may have regarding a medical condition. Never disregard professional medical advice or delay in seeking it because of something you have read on this website. The opinions expressed in this column are not those of Prostate Cancer News Today, or its parent company, BioNews Services, and are intended to spark discussion about issues pertaining to prostate cancer)

**Long-term Outcomes in Patients Treated with Proton Therapy for Localized Prostate Cancer.** The aim of this retrospective study was to report long-term clinical outcomes in patients treated with proton therapy for localized prostate cancer. Between 2001 and 2014, 1,375 consecutive patients were treated with proton therapy.

This study represents the largest cohort of patients treated with proton therapy for localized prostate cancer, with the longest follow-up to date.

The results demonstrate that the biochemical control of proton therapy is favorable particularly for high- and very high-risk patients with lower late genitourinary toxicity and indicates the necessity of considering patient age in the treatment protocols. (Source: [www.ncbi.nlm.nih.gov/pubmed/28879658](http://www.ncbi.nlm.nih.gov/pubmed/28879658))

(Editor's note: This article was edited to remove the complex statistical analyses)

**Outcome 'Trade-off' With Open, Robotic Prostatectomy.** There may be a trade-off between early recovery of erectile function and lower rates of positive surgical margins (PSMs) with robot-assisted laparoscopic radical prostatectomy and open retropubic surgery, respectively, a nonrandomized study suggests.

“Earlier recovery of erectile function in the robot-assisted surgery group in lower-risk patients is counterbalanced by lower PSM rates for open surgeons in organ-confined disease; thus, both open and robotic surgeons need to consider this trade-off when determining the plane of surgical dissection,” researchers write in *European Urology*, online September 4, 2017

Most radical prostatectomies in the U.S. use robotic assistance, but many have pointed out that it costs far more than other approaches and has not been shown to improve cancer control or functional recovery, note Dr. Prasanna Sooriakumaran from Karolinska Institute in Stockholm, Sweden, and University College London in Oxford, UK, and colleagues.

In the new study, called LAPPRO, the researchers compared erectile functional recovery, PSM, and prostate-specific antigen (PSA)-relapse rates between men who underwent open versus robot-assisted laparoscopic radical prostatectomy for prostate cancer. The groups were determined by place of residence, as different hospitals performed either open or robot-assisted surgery, but not both.

Among the 2,545 men for which information was available, 1,792 had undergone robot-assisted surgery and 753 the open procedure.

Erectile-function recovery rates were significantly higher in the robot-assisted group, though the differences diminished somewhat at 12 and 24 months of follow-up. At 24 months, 40% of

men in the robot-assisted group reported functional erections on more than half of occasions, compared to 28% in the open-surgery group.

Among men with high-risk tumors, erectile function recovery rates were nominally higher at 24 months in the open-surgery group.

“Open surgeons doing prostate cancer surgery are unable to differentiate between different planes during their nerve-sparing dissections,” Dr. Sooriakumaran told Reuters Health. “There was virtually no correlation between what dissection they said they'd done and erectile function outcomes.”

For men with pT2 tumors, the PSM rate was significantly higher in the robot-assisted group (17.0%) than in the open-surgery group (10.2%), whereas it was higher with open surgery (48.1%) than robot-assisted surgery (33.3%) for men with pT3 tumors.

PSA-relapse rates within two years did not differ between the groups for pT2 tumors, but they were significantly higher in the open-surgery group for pT3 tumors (21.5% vs. 13.5%). The study made multiple statistical comparisons but did not correct for this. (Source: *European Urology* (On line) September 4, 2017)

**Targeted Prostate Biopsy in the Era of Active Surveillance.** Targeted prostate biopsy using magnetic resonance imaging (MRI) guidance is improving accuracy of prostate cancer (CaP) diagnosis. This new biopsy technology is especially important for men undergoing active surveillance, improving patient selection for enrollment and enabling precise longitudinal monitoring. MRI/US fusion biopsy allows for three functions not previously possible with US-guided biopsy: targeting of suspicious regions, template-mapping for systematic sampling, and tracking of cancer foci over time. This article reviewed the evolving role of the new biopsy methods in active surveillance, including the UCLA Active Surveillance pathway, which has incorporated MRI/US fusion biopsy from program inception, as a possible model. (Source: *Urology*. September 26, 2017) [Epub ahead of print]

**The Accuracy of Patients' Perceptions of the Risks Associated with Localized Prostate Cancer Treatments.** A recent study assessed localized prostate cancer (PC) patients' understanding of the differences in outcomes and risks of radical prostatectomy (RP), radiotherapy (RT), and active surveillance (AS), and to identify correlates of misperceptions.

The researchers, centered in The Netherlands, used baseline data (questionnaires completed after treatment information was provided but prior to treatment) of 426 newly diagnosed localized PC patients who participated (87% response rate) in a prospective, longitudinal, multicenter study. Patients' pretreatment perceptions of differences in adverse outcomes of treatments were compared to those based on the literature. They used univariate and multivariate linear regression to identify correlates of misperceptions.

Approximately two-third (68%, n=211) of the patients did not understand that the risk of disease recurrence is comparable between RP and RT. More than half of the patients did not comprehend that RP patients are at greater risk for incontinence (65%, n=202) and erectile dysfunction (61%, n=190), and less at risk for bowel problems (53%, n=211) compared to RT

patients. Many patients overestimated the risk of requiring definitive treatment following AS (45%, n=157), and did not understand that mortality rates following AS, RP, and RT are comparable (80%, n=333). Consulting a radiotherapist or a clinical nurse specialist was positively associated with, and emotional distress was negatively associated with better understanding of the risks ( $p<0.05$ ), although effect sizes were small.

Prior to choosing treatment, the majority of PC patients poorly understood the differences in treatment risks. The researchers concluded that greater efforts should be made to better understand why these misperceptions occur and, most importantly, how they can be corrected. (Source: *BJU international*. 2017 Sep 28 [Epub ahead of print] and PubMed at <http://www.ncbi.nlm.nih.gov/pubmed/28960827>)

**Brachytherapy + EBRT for High-Risk PCa Offers 'Excellent' Outcomes.** Permanent brachytherapy and supplemental external beam radiation therapy (EBRT) for high-risk prostate cancer (PCa) offers “excellent” long-term biochemical control and cancer-specific survival, according to researchers.

Merrick, MD, et al, Schiffler Cancer Center, Wheeling Hospital, Wheeling, West Virginia, analyzed outcomes of 448 patients with high-risk PCa as defined by National Comprehensive Cancer Network criteria. They stratified patients by pre-treatment PSA level (10 or less, 10.1–20, and greater than 20 ng/mL).

The 10-year overall mortality, biochemical failure, and PCa-specific mortality (PCSM) rates for the entire cohort were 28.5%, 13.3%, and 4.9%, respectively, the investigators reported in the *Journal of Contemporary Brachytherapy* (2017;9:297-303). The PCSM rates were 2.5%, 10.7%, and 4.5% for patients with pre-treatment PSA levels of 10 or less, 10.1–20, and more than 20 ng/mL, respectively. Dr Merrick's group found no significant difference in biochemical failure or overall survival according to PSA category. Distant failure most commonly occurred in the 10.1–20 ng/mL group.

In multivariate analysis, percent positive biopsies and tobacco use were the strongest predictors of PCSM.

“High-risk prostate cancer treated with permanent prostate brachytherapy and supplement EBRT results in excellent long-term biochemical control and PCSM,” the authors concluded. (Source: *J Contemp Brachytherapy*. 2017;9:297-303)

**Communicating Risk in Active Surveillance of Localized Prostate Cancer.** One in five men is likely to receive a diagnosis of prostate cancer (PCa) by the age of 85 years. Men diagnosed with low-risk PCa may be eligible for active surveillance (AS) to monitor their cancer to ensure that any changes are discovered and responded to in a timely way. Communication of risk in this context is more complicated than determining a numerical probability of risk, as patients wish to understand the implications of risk on their lives in concrete terms. This study examined how risk for PCa is perceived, experienced and communicated by patients using AS with their health professionals, and the implications for treatment and care.

This is a proof of concept study, testing out a multimethod, qualitative approach to data collection in the context of PCa for the first time in Australia. It is being conducted from November

2016 to December 2017 in an Australian university hospital urology clinic. Participants are 10 men with a diagnosis of localized PCa, who are using an AS protocol, and 5 health professionals who work with this patient group (eg, urologists and Pca nurses). Data will be collected using observations of patient consultations with health professionals, patient questionnaires and interviews, and interviews with healthcare professionals. Analysis will be conducted in two stages. First, observational data from consultations will be analyzed thematically to encapsulate various dimensions of risk classification and consultation dialogue. Second, interview data will be coded to derive meaning in text and analyzed thematically. Overarching themes will represent patient and health professional perspectives of risk communication. Source: BMJ. October 5, 2017 Oct 5, epub; PubMed <http://www.ncbi.nlm.nih.gov/pubmed/28982830>)

### **Radical Prostatectomy Innovation and Outcomes at Military and Civilian Institutions.**

Limited data are available regarding the impact of the type of healthcare delivery system on technology diffusion and associated clinical outcomes. This study assessed the adoption of minimally invasive radical prostatectomy (MIRP), a recent clinical innovation, and whether this adoption altered surgical morbidity for prostate cancer surgery.

**Study Design:** Retrospective review of administrative data from TRICARE, the healthcare program of the United States Military Health System. Surgery occurred at military hospitals, supported by federal appropriations, or civilian hospitals, supported by hospital revenue.

**Methods:** The study evaluated TRICARE beneficiaries with prostate cancer who received a radical prostatectomy between 2005 and 2009. MIRP was identified based on minimally invasive surgery codes. We assessed yearly MIRP utilization, 30-day postoperative complications, length of stay, blood transfusion, and long-term urinary incontinence and erectile dysfunction.

**Results:** A total of 3366 men underwent radical prostatectomy at military hospitals compared with 1716 at civilian hospitals, with minimal clinic-demographic differences. MIRP adoption was 30% greater at civilian hospitals. There were fewer blood transfusions (odds ratio, 0.44;  $P < .0001$ ) and shorter lengths of stay (incidence risk ratio, 0.85;  $P < .0001$ ) among civilian hospitals, while 30-day postoperative complications, as well as long-term urinary incontinence and erectile dysfunction rates, were comparable.

**Conclusions:** Compared with military hospitals, civilian hospitals had a greater MIRP adoption during this timeframe, but had comparable surgical morbidity.

(Source: <https://www.ncbi.nlm.nih.gov/pubmed/28817298>)

**Outcomes of Men on Active Surveillance for Low-Risk Prostate Cancer at a Safety-Net hospital.** Active surveillance for low-risk prostate cancer is a management strategy to mitigate risks of immediate surgery or radiation and is recently supported by AUA/ASTRO/SUO 2017 guidelines as standard of care for low-risk prostate cancer. Active surveillance requires appropriate follow up, with PSA testing and surveillance prostate biopsies at regular intervals. Disparities in health care access, particularly for uninsured and vulnerable individuals, remain major barriers.

In this study by Osterberg, et al, the authors conducted a retrospective cohort study to examine outcomes of active surveillance at a safe- net hospital in San Francisco. This population



was comprised of uninsured or low-income patients in a large metropolitan area. Between 2004 and 2013, 104 men chose active surveillance. Approximately two-thirds of these patients were non-English speaking, and one quarter had a history of mental illness or homelessness. A large portion of the cohort had multiple co-morbid diseases. Median follow up time was 29 months. During this time, 18 men (17.4%) were lost to follow up, defined as inability to find patient after three attempts at communication and no evidence of being treated in other available records. Pathologic upgrade occurred in 20.6% of men, triggering treatment. Radiation was more common than radical prostatectomy (12.5 vs 7.7%). There was one cancer-related death in a patient lost to follow up for 30 months, and three deaths from other causes.

Lost to follow up rates on active surveillance are rarely reported in the literature, but range on average from 5 to 22%. Future directions of AS programs in safety-net hospitals should target disease registries whereby long-term follow-up tracking of patients is centrally maintained across regional health networks.

Furthermore, addressing barriers to care among this population is critical as the field evolves to incorporate advanced imaging techniques. Multiparametric prostate MRI, molecular imaging techniques such as PSMA-PET and Axumin, MRI-fusion biopsy, and cancer genomics have enhanced the management of low risk prostate cancer and are increasingly incorporated into clinical practice. While these strategies may improve diagnostic accuracy and risk stratification, cost and availability remain primary barriers to underserved populations. Addressing social and cultural barriers, improving adherence at the patient level, and providing avenues for access is critical to ensure good outcomes within this population. (Source: *Urologic Oncology*, August 17, 2017-epub)

**Patients' Expectations After Radical Prostatectomy May Be Unrealistic.** Patients with prostate cancer who have undergone radical prostatectomy have largely unrealistic expectations with respect to their postoperative sexual function, according to a study published online ahead of print in the journal *BJU International*.

Because clinical experience has suggested that some patients who have undergone radical prostatectomy have unrealistic expectations about their long-term sexual function, researchers at Memorial Sloan Kettering Cancer Center in New York and Acibadem University Medical School in Istanbul, Turkey, sought to evaluate patients' understanding of their postoperative sexual function following surgery.

For the study, researchers surveyed 336 patients who had undergone either open or robotic radical prostatectomy within the last 3 months. Participants were questioned regarding the information on sexual function they received preoperatively, as well as about sexual function, postoperative ejaculatory status, orgasm changes, and postoperative morphology changes.

Results showed that patients who had undergone robotic radical prostatectomy expected a shorter erectile function recovery time (6 months vs 12 months), a higher chance of recovery back to baseline erectile function (75% vs 50%), and a lower likelihood of requiring therapy to achieve an erection (4% vs 20%).

Researchers found that nearly half of all patients were not aware that their surgery rendered them anejaculatory. The study also demonstrated only 10% of patients who underwent open radical prostatectomy and none of the patients who underwent robotic surgery recalled being

informed of the possibility that they may lose penile length. (Source: *BJU Int.* [published online December 21, 2015 via Oncology Nurse Advisor, January 5, 2016].)

**Metastatic Prostate Cancer: Recommendations for Primary Therapy.** The standard treatment for patients with metastatic, hormone-sensitive prostate cancer (mCSPC) has so far consisted of medical or surgical castration. However, two published clinical trials using docetaxel in combination with castration (CHAARTED and STAMPEDE) recently provided evidence for a substantial improvement in overall survival. The survival benefit was 14 and 22 months, respectively, in the two trials. In addition, the CHAARTED trial showed that patients with high-volume disease may benefit most from chemohormonal treatment. According to the current available evidence, the new standard of treatment for patients therefore consists of castration in combination with docetaxel-based chemotherapy, which should be offered to all patients who are fit to receive chemotherapy. With the results of the LATITUDE and a further study-arm of the STAMPEDE trial, the combination of androgen-deprivation therapy (ADT) plus abiraterone/prednisone has recently become an alternative treatment to chemohormonal treatment. This combination leads to an identical survival benefit compared to chemohormonal treatment and is recommended by expert panels. Based on the current evidence, it is not possible to decide which patient may benefit from chemohormonal treatment and who will benefit from the combination of ADT plus abiraterone/prednisone. (Source: *Der Urologe. Ausg. A*, October 5, 2017, Epub, via PubMed <http://www.ncbi.nlm.nih.gov/pubmed/28983763>)

**Should Radical Prostatectomy be Encouraged at Any Age? A Critical Non-Systematic Review.** Elderly men are likely to be diagnosed with clinically localized prostate cancer, however only few studies have assessed the appropriate treatment in such patients. Radical prostatectomy is one valid alternative. Perioperative outcomes, functional outcomes and oncological outcomes have to be carefully discussed in patient counseling. Fewer perioperative complications, lower perioperative mortality, and shorter hospitalization times have been reported for patients undergoing radical prostatectomy by high-volume surgeons at high-volume centers. Although elderly patients are more likely to be preoperatively incontinent, and increasing age impacts negatively on continence recovery, long-term urinary continence rates have been reported to be satisfactorily high also in older patients. Potency should not be considered as a relevant outcome, since many elderly patients already suffer from longstanding erectile dysfunction and advanced age itself is associated with low chances of recovery. Although some inter-study variability exists in different oncological outcomes measured, most studies are consistent in showing no different cancer-specific survival rates between younger and older patients, thus implying that even elderly patients may benefit from radical treatment. Biological rather than chronological age should be used to base the decision as to whether a patient will profit from definitive treatment. Therefore, elderly men should undergo a health assessment using validated tools before any treatment decision. Only fit and motivated individuals with a reasonable life expectancy and, above all, high-risk disease should be offered radical prostatectomy. In these patients, high-volume surgeons and minimally invasive approaches should be preferable to minimize perioperative complications. (Source: *The Italian Journal of Urology and Nephrology*. September 27, 2017; via PubMed <http://www.ncbi.nlm.nih.gov/pubmed/28952706>)

# ◆ OVERVIEW OF THE SURGICAL TREATMENT OF PROSTATE CANCER ◆

by  
**MAJOR SEAN Q. KERN, MD**  
**Chief, Urology Service, Fort Belvoir Community Hospital**

( A summary of a presentation to the WRNMMC Prostate Cancer Support Group, August 3, 2017)

## Introduction

Good evening! I welcome the opportunity to present an overview of the surgical treatment of prostate cancer. Certainly there are other treatment modalities that may be available to a particular patient and the selected therapeutic option depends upon a careful evaluation. But tonight, it's about the surgical option.

## The Diagnosis

The diagnosis relies upon the outcome of the Prostate Specific Antigen test (PSA), a digital rectal examination (DRE), a prostate needle biopsy, and the possible use of an MRI. The ultrasound prostate needle biopsy provides information relative to the size of the prostate, and most importantly, about the volume of cancer within the cores for use in the grading process.

The Gleason grading system describes the degree of aggressiveness of the prostate cancer based on the appearance of the cancer cells. The examined cells may be normal, atypical ("pre-cancerous"), or cancerous. The successive scores of the two predominant patterns are added to produce the Gleason score.

(Dr. Kern showed a series of slides depicting the ultrasound prostate needle process and the Gleason grading system.)

## Treatment Options

The range of options includes Watchful Waiting, Active Surveillance, Radiation and Surgery. Each option has its place in dealing with prostate cancer. Each option has its advantages and disadvantages, its risks and potential for side effects. The appropriate option must be chosen based on the risk categories and shared patient-physician decision making. For example, the surgical option is indicated for organ-confined disease.

## The Surgical Options

- HIFU employs ultrasound waves to heat the prostate in order to kill cancer cells. It is performed under general anesthesia and requires a 23 hour hospitalization. A catheter is required postoperatively to facilitate healing. HIFU is approved as a prostate cancer therapy in several nations, but here in the US it is not yet so approved, although clinical trials are underway.
- Cryosurgery freezes the prostate to kill prostate cancer cells. It is considered be an

alternative if prostatectomy or radiation are not suitable options. Comparative data with the other more traditional surgical options is lacking. Erectile dysfunction and adverse urinary conditions are likely side effects.

- The Prostatectomy Approach has three sub-options: the traditional Open Approach, the Laparoscopic Approach, and the Robotic Approach. The Robotic Approach has eclipsed the traditional Open Approach as the most often selected surgical option. Nerve sparing is always a major concern of the Prostatectomy Approach. It involves the preservation of the neurovascular bundles that surround the prostate. There are several variables that affect the ability of the surgeon to preserve the erectile function, not the least of which is the skill and experience of the surgeon. Removal of the lymph nodes is another critical issue. Doing so enhances the pathologic analysis of the tissue and assesses the possibility that the cancer has spread beyond the capsule. But it may result in slightly increased risk.

The risks and outcomes are very similar for Open and Robotic Approaches in terms of cancer control, continence recovery, and sexual recovery.

## **Other Surgical Issues**

**Recovery and Surgical Follow-up.** Of course, each patient's recovery experience will vary. The post-operative hospital stay will be 2-3 days including the day of surgery after open prostatectomy, and likely less for laparoscopic and robotic surgeries. At home, common sense applies. Regular exercise, especially frequent daily short walks, is essential. Resume regular activities gradually as strength returns. Again, return to work depends on the return of reasonably full strength returns. In short, seek your provider's guidance in these matters and follow it.

Surgical follow-up includes catheter removal, review and assessment of the pathology report and its implications for additional therapy, PSA monitoring, and Kegel exercises to combat any incontinence issues

## **Side Effects**

The side effects of greatest concern are erectile dysfunction (ED) and urinary control. The degree of ED depends in large measure on the success of the nerve sparing procedure. Urinary control is affected by the reconnection of the urethra to the bladder after the removal of the prostate.

In the case of both ED and incontinence, the side effects must be evaluated by comparison with the preoperative assessment of both functions. This provides a baseline for post-operative assessment. There are many treatments available to minimize side effects: for example, the oral therapies Viagra, Levitra, and Cialis; intracavernosal injection; as well as implanted prostheses to overcome ED and incontinence.

## **Patient Education**

Be sure to get informed about prostate cancer - Join a local support group such as the CPDR Support Group within the Walter Reed National Military Medical Center. Become fully

engaged with your providers to be informed about the disease, your treatment options, and their potential side effects. Become aware and exploit the many reputable on line information sources such as the American Urological Association (at AUA.net.org). But by all means beware the infamous "Dr. Google" and his spurious advice!

**(Editor's Note:** We were unable to record Dr. Kern's presentation. Instead, we relied on the slides he used to illustrate his remarks.)

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◆ MEETING ANNOUNCEMENT ◆

THURSDAY, NOVEMBER 2, 2017

7:00 - 8:30 PM

FORT BELVOIR COMMUNITY HOSPITAL (OAKS PAVILION, 1ST FLOOR, ROOM 332 AND  
VIA VIDEO TELECONFERENCE AT WRNMMC, AMERICA BUILDING (BLDG 19, 2D  
FLOOR) ROOM 2525

◆ SPEAKER ◆

TIMOTHY TAUSCH, MD

DIRECTOR, TRAUMA AND RECONSTRUCTIVE UROLOGY

WALTER REED NATIONAL MILITARY MEDICAL CENTER

◆ TOPIC ◆

"LIFE AFTER PROSTATE CANCER TREATMENT: TREATING URINARY INCONTINENCE  
AND ERECTILE DYSFUNCTION"

**Security:** A military ID card is required to get on base at Walter Reed. Persons without a military-related ID card who are attending the meeting are required to register in advance in order to gain entry. To register, contact the CPDR front desk at 301-319-2900 at least four business days prior to Thursday, November 2, 2016, to arrange entry. Have a photo ID card ready when arriving at the gate.