

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

VOLUME 27

NUMBER 1

FEBRUARY 2018

◆ **TOO MANY OLDER PATIENTS GET CANCER SCREENING** ◆

The New York Times tells us about Elena Altemus who is 89 and has dementia. She often forgets her children’s names, and sometimes can’t recall whether she lives in Maryland or Italy. Mrs. Altemus, who entered a nursing home in November, was screened for breast cancer this summer. “If the screening is not too invasive, why not?” asked her daughter, Dorothy Altemus. “I want her to have the best quality of life possible.”

But a growing chorus of geriatricians, cancer specialists and health system analysts say that for the best quality of life, she’d be better off skipping the screening. Such testing in the nation’s oldest patients is highly unlikely to detect lethal disease. It is also hugely expensive and more likely to harm than help, since any follow-up testing and treatment is often invasive.

And yet such screening — and the resulting “over-diagnosis” of cancers in people who are unlikely to benefit — is epidemic in the United States, a result of medical culture, aggressive awareness campaigns and financial incentives to doctors.

“We find something that wasn’t going to hurt the patient, and then we hurt the patient,” said Dr. Sei Lee, an associate professor of geriatrics at the University of California, San Francisco. Nearly one in five women with severe cognitive impairment, including older patients like Elena Altemus, are still getting regular mammograms, according to the American Journal of Public Health, even though the procedure is not recommended for people with a limited life expectancy. And 55 percent of older men with a high risk of death over the next decade still get PSA tests for prostate cancer. Among people in their 70s and 80s, cancer screenings often detect slow-growing tumors that are unlikely to cause problems in patients’ lifetimes. These patients often die of something else — from dementia to heart disease to pneumonia — long before their cancers would ever have become a threat, said Dr. Deborah Korenstein, chief of general internal medicine at Memorial Sloan Kettering Cancer Center in New York. Prostate cancers, in particular, are often harmless. **(Continued on Page 12)**

◆ **INSIDE THIS ISSUE** ◆

Cancer Screening Page 1
PCa Specific Issues Page 3

Life after PCa Page 15

WRNMMC Us TOO
NEWSLETTER EDITOR

Write or Call
Vincent P. McDonald
8661 Chase Glen Circle

Fairfax Station, VA 22039
Telephone: (703) 643-2658
E-Mail: vpmjam@aol.com

MEDICAL ADVISORY STAFF

Colonel Inger Rosner, MC,
USA

Jane Hudak, RN, PhD

Debbie Jolissaint, RN, NP

Kimberly Peay, RN, NP

BOARD OF DIRECTORS

James Thompson
(President)

James Bohannon
(Treasurer)

Vincent McDonald
(Secretary)

James Padgett
(Speaker Coordinator)

David Bertrand

Robert Butterworth

John Halstead

William Mahr

Michael Pausic

◆ FROM THE EDITOR ◆

SO, HOW ARE WE DOING?

We have been publishing the newsletter four times a year since 1998, yet with seldom a word from the readership, except from my wife and daughter. And they aren't not even eligible for prostate cancer! We would like some feedback from the readership about the newsletter. We know you are out there! Let us hear what you like or suggest changes for improvement. Send any comments to me at vpmjam@aol.com.

◆ **SPEAKER'S REMARKS - NOVEMBER 2, 2017** ◆

Our speaker on Thursday, November 2, 2017, was Dr. Timothy Tausch, Director, Trauma and Reconstructive Urology, WRNMMC. His topic was **Life After Prostate Cancer Treatment: Treating Urinary Incontinence and Erectile Dysfunction.** A summary of his remarks is at page 15.

◆ **MEETING SCHEDULE FOR FEBRUARY 1, 2018** ◆

Our speaker for Thursday, February 1, 2018, is Jennifer Cullen, PhD, MPH, Center for Prostate Disease Research, WRNMMC. Her topic is "**The Critical Role of Patient-Reported Outcomes in Improving Decision-Making for the Treatment of Prostate Cancer.**"

Please join us at the America Building (Bldg 19), 2nd floor, Room 2525, WRNMMC (primary site) at 7:00 PM; or the Fort Belvoir Community Hospital, Oaks Pavilion, 1st floor, Library Lecture Room (S1.901) (via video teleconference). **See the back page for information about getting access.**

DISCLAIMER: The materials contained in this newsletter are solely the individual opinions of the authors. They do not represent the views of any Department of Defense agencies. This newsletter is for informational purposes only, and should not be construed as providing health care recommendations for the individual reader. Consult with your physician before adopting any information contained herein for your personal health plan.

◆ PROSTATE-SPECIFIC ISSUES ◆

Overtreatment of Low Risk Prostate Cancer. Such overtreatment has been recognized by every major medical society across the world as a top priority for the focus of physicians and scientists. As such, efforts to increase enrollment of men with low risk prostate cancer in active surveillance have included research by health policy experts and physician-scientists focusing in health services research and clinical trials. Despite data demonstrating safety for men who choose active surveillance, the majority of patients still choose radical treatments including surgery and radiation therapy.

Uniquely, researchers addressed how physicians speak with patients and aimed to improve communication of risk associated with monitoring cancer as opposed to undergoing immediate radical treatment. They were able to assemble a multidisciplinary team of experts and develop a novel counseling approach for physicians incorporating appropriate framing techniques derived from principles studied by negotiation scholars. The cohort for the training intervention comprised of 1,003 consecutive patients and the proportion of patients who selected active surveillance increased from 69% to 81% after physicians were taught the novel techniques.

The researchers estimated that teaching physicians to better communicate risk with patients led to a relative reduction of overtreatment by 30%. Therefore, this study emphasizes that improving physician-patient counseling improves overall health delivery and may potentially decrease costs and suffering. The goal of this research is not to give physicians scripts or change what they say to patients. Instead, the aim is to guide physicians to understand patients' interests and instead of debating the patient's stated preference for a particular treatment, evoke all of a patient's interests for pursuing treatment.

We think the most exciting aspect of this research is that we can use these principles across medicine to improve appropriateness of treatments and improve value in healthcare. Specifically, we are currently applying these principles to improve prostate cancer screening decision-making. In addition, these communication principles can be applied to over-prescription of antibiotics in pediatrics or surveillance for patients diagnosed with breast or thyroid cancer.

As surgeons, we dedicate upwards of a decade in training to become expert in radical prostatectomy, the surgical removal of the prostate for the treatment of prostate cancer. This complex procedure follows a highly structured, carefully studied sequence of steps that require significant repetition and practice to achieve proficiency. However, the majority of contemporary patients diagnosed with prostate cancer actually harbor low-risk tumors that do not require immediate treatment and can be safely managed by careful monitoring, with subsequent curative treatment if evidence of cancer progression is found, an approach termed active surveillance. Surgeons receive little if any training in how to speak to patients about AS, a particular problem as men with prostate cancer report receiving little substantive information about treatment options. Many perceive AS as "doing nothing," and few men seem aware that immediate treatment may not improve their survival. In our study, we believe we have provided a framework to standardize physician counseling regarding prostate cancer and boost the appropriateness of active surveillance for men with low risk cancer. (Source: European Urology; Jan 24, 2017; Epub ahead of print; via URO Today, Jan 5, 2018; written by: Behfar Ehdaie)

Giving the "Bad News." Half of physicians (51%) and more than two in five nurses and advance practice nurses (44%) say they have delayed giving bad news to patients, according to a *Medscape Medical News* poll. The poll question was one of four pitched to readers September 6 after Medscape contributor and New York University medical ethicist Art Caplan, PhD, wrote a commentary in which he posed questions about whether physicians should get to decide the best timing for delivering bad health news and whether they should be punished if failure to disclose results in worsening of the condition.

Dr. Caplan used the example of a physician who had determined a patient had incurable lung cancer. The doctor also knew the patient was going on a 2-week cruise the next week. He chose to delay telling her and the patient went on the cruise, contracted pneumonia, and died. The family was angry with the doctor and considered his actions paternalistic rather than compassionate.

Respondents to the poll of healthcare professionals and other Medscape members totaled 470; 145 were nurses/advanced practice nurses, and 222 were physicians. Anxiety was the top emotion reported by physicians and nurses in describing their experience when delivering bad health news to a patient. Among physicians, 55% reported that anxiety was the primary emotion. The percentage was even higher among nurses, at 59%.

Next were feelings of failure and frustration. Among physicians, 36% experienced feelings of failure and 32% experienced frustration. For nurses, 32% reported feeling frustration and 27% reported feelings of failure. Some even felt anger (6% of nurses and 9% of physicians.)

Delivering bad news is a common requirement for both groups, although twice as many physicians (50%) as nurses (26%) said they frequently had to deliver bad news to patients. Only 4% of physicians and 10% of nurses/nurse practitioners said they had never had to do it.

Reactions of the patient and patient's family were drivers in how the professionals reacted, poll responses show. The patient's reaction is the biggest influence on the professionals' reaction; 66% of physicians and 70% of nurses answered that way. The next biggest influence for both groups was the family or caregiver's reaction. It was listed by 53% for physicians and 60% of nurses.

Other factors influencing how physicians and nurses deliver bad news included access to a private space, lack of time, communication challenges between healthcare professionals, and lack of training/experience in delivering bad news. Those who posted comments on the poll leaned toward full and immediate disclosure by providers.

A critical care/intensive care physician said physicians need more training in communicating difficult news in order to feel comfortable and pointed to a gap in medical training. "Many effective approaches exist but they have to be more broadly incorporated into the curriculum. That would be a useful topic to include in [maintenance of certification] instead of observing colleagues wash their hands!" the commenter wrote.

Dr. Caplan took the same view in the case of the patient who went on the cruise. There should have been full disclosure. He said he understood the doctor's actions, but the doctor also took away the patient's right to decide how to spend the time she had left. That might have included forgoing the cruise and spending time with family or taking the time to get her affairs in order.

Penile Rehabilitation after Robot-Assisted Laparoscopic Radical Prostatectomy.

Jung Ki, MD, et al, Department of Urology, National University Hospital, Seoul, Korea, said It has not been clearly proven in real practice whether early rehabilitation with phosphodiesterase type 5 inhibitors starting immediately after radical prostatectomy improves erectile function recovery more effectively compared with delayed treatment with the same regimen. We performed a prospective randomized trial to identify this outcome.

Patients with prostate cancer and pre-operative International Index of Erectile Function score of ≥ 17 were randomly assigned to regularly receive sildenafil (100mg twice a week for 3 months immediately after urethral catheter removal (the early group); or only at 3 months after nerve-sparing robot-assisted laparoscopic radical prostatectomy (the delayed group). The endpoint was full erectile function recovery rates (defined as IIEF-5 ≥ 17) over the 12 months.

In the 120 randomized patients, the proportion of patients achieving full recovery was significantly higher over the 12 months in the early group than in the delayed group. After 9 months following surgery, the proportion of patients achieving full recovery had steadily increased, resulting in 41.4% at 12 months in the early group, Patients in the delayed group had not shown further improvement, thus achieving full recovery only in 17.7% of patients at 12 months. Only early sildenafil treatment (hazard ratio 2.943, $p = 0.034$) independently improved full recovery at 12 months.

Our trial provides clinical data to suggest that the earlier rehabilitation with phosphodiesterase type 5 inhibitors can contribute more to the recovery of erectile function after radical prostatectomy in the clinical setting. (Source: Journal of Urology, January 4, 2018; Epub ahead of print)

Everyday Life After a Radical Prostatectomy - A Qualitative Study of Men Under 65

Years of Age. A Prostate Cancer Study from Skane University Hospital, Malmo, Sweden, was reported by *Cancer Weekly*. The purpose of the study was to illuminate how men under 65 years of age experience their "Everyday Life" one year or more after a radical prostatectomy for localized prostate cancer. Interviews with 19 men aged under 65 were performed 12-18 months after their radical prostatectomy.

The researchers analyzed the interviews using a thematic content analysis. The analysis of the interviews revealed three categories of experiences: 'Paying a price for survival', 'Feeling sidestepped' and 'Living with death lurking around the corner'.

The side effects of the prostatectomy, such as sexual dysfunction, resulted in a changed self-image with a loss of manliness and reduced self-esteem. The men felt sidestepped in that they did not receive enough support. Prostate cancer was experienced as an embarrassing disease and the men felt their fundamental needs could not be openly discussed. Having cancer was associated with death. Thoughts about death faded away during recovery after the operation, but grew stronger in certain situations and reminded the men about their cancer. Returning to work and to previous activities helped them cope with the thoughts about death. Our study suggests a need for improved rehabilitation after a radical prostatectomy, including more structured sexual rehabilitation, and involving the partner." The research also concluded that sharing the experiences of other men who have undergone prostate cancer surgery may also be beneficial. (Source: *European Journal of Oncology Nursing*, 2017;30():107-112: via US TOO "News You Can Use)

Active Surveillance: An Option for African American Men with Prostate Cancer?

Certain patients presenting with either low or very-low-risk prostate cancer (PCa) can represent a therapeutic dilemma for physicians. The oncologic outcomes of active surveillance (AS) for men with very-low-risk PCa are overall excellent. However, there are concerns about AS related to the potential for upgrading or upstaging. The African American (AA) population is under-represented in studies evaluating AS outcomes and this is particularly important because of the unique epidemiology of PCa in AA men.

A literature review through the Medline database published from 1990 until August 2015 was performed to identify studies reporting outcomes of the AA population with low-risk PCa that underwent either AS or treatment. An additional search for studies on genetic mechanisms involved in development of PCa in AA men was also performed.

Eleven studies on pathologic results of AA men who would qualify for AS were identified and in eight of these studies AA race was found to be associated with adverse pathological outcomes such as positive surgical margins, upgrading or upstaging. The other three studies reported no significance in these parameters with respect to race. Five more studies reported outcomes of AS in AA men with different study end points. AA men were mainly found to have a higher rate of disease reclassification subsequent to active treatment. The studies on genetic mechanisms also identified different genetic alterations in the AA population.

Conclusion: AA men with clinically defined low-risk PCa may have either a higher grade or volume of cancer that was not detected on routine evaluation. Therefore, AS among such patients should be approached with caution. We recommend discussing such risks with AA patients with an acknowledgement that existing favorable outcomes noted in largely Caucasian populations may not be applicable to AA patients. We propose a modified evaluation plan for AA patients that includes an early confirmatory biopsy preceded by an magnetic resonance imaging to optimally detect occult cancer foci. (Source: Prostate Cancer and Prostatic Diseases (2017) 20, 127–136; doi:10.1038/pcan.2016.56; published online 18 April 2017)

Androgen Deprivation Therapy for Prostate Cancer and Dementia Risk. Androgen deprivation therapy (ADT) to treat prostate cancer may be associated with an increased risk of dementia, but existing studies have shown conflicting results. Here we synthesize the literature on the association of ADT for the treatment of prostate cancer with dementia risk.

We conducted a systematic review of articles reporting the outcome of dementia among individuals with prostate cancer in those exposed to ADT versus a lesser-exposed comparison group (for example, ADT versus no-ADT and continuous versus intermittent ADT). The search was undertaken on December 4, 2016, by two authors. We meta-analyzed studies reporting an effect estimate and controlling for confounding. Random- or fixed-effects meta-analytic models were used in the presence or absence of heterogeneity.

Nine studies were included in the systematic review. Seven studies reported an adjusted effect estimate for dementia risk. A random-effects meta-analysis of studies reporting any dementia outcome, which included 50,541 individuals, showed an increased risk of dementia among ADT users. We separately meta-analyzed studies reporting all-cause dementia and Alzheimer's disease. There was no evidence of bias from small study effects.

Conclusion: The currently available combined evidence suggests that ADT in the treatment of prostate cancer may be associated with an increased dementia risk. The potential for neurocognitive deficits secondary to ADT should be discussed with patients and evaluated prospectively. (Source: Prostate Cancer and Prostatic Diseases (2017)00, i-6, via Uro Today, December 14, 2017)

Androgen Deprivation Therapy and Depression. In the last two weeks I've had one patient refuse ADT because of his history of depression, another who has been on ADT for 10 months asked me to refer him to a psychiatrist, and another, with CRPC who has been on ADT for 4 years, told me his depression is finally under control. This leaves a lot of issues to confront.

The broad spectrum with which patients react emotionally to losing their testosterone – or don't, has been of great interest to me for a number of years. The reality is this, after some men go on ADT they face profound changes in mood, energy and libido in particular. On the other hand, some men are fine with it and really have little complaint. And it's not all about sex.

But let's focus directly for a moment on the link between ADT and clinically significant Depression – what we might call Major Depression. While there has been a flurry of papers recently, and reasonably well-designed studies, that have explored the connection between ADT and cognitive function, few have indicated the proportion of patients who meet criteria for major depression following ADT.

In point of fact, it may actually go the other way around, as several studies have shown that major depression or depressive symptom burden can alter cognitive function in men. So how much of the cognitive decline that we are seeing with patients on ADT may be attributable to a broader depressive symptomatology is not known.

It is not uncommon for me to see patients with a history of depression who were diagnosed with prostate cancer after going on supplemental testosterone – which was given to manage their depression. On the other hand, it is not uncommon for me to see a patient who is perfectly well from a mental health perspective prior to ADT, only to need intervention later for a new diagnosis of depression.

Of course, there are all kinds of potential biases here. In the first case, men with depression who are on testosterone are probably more likely to be screened for prostate cancer than those who are not, which may lead to a prostate cancer detection bias. In the second case, when men go on ADT they get seen more, and I ask about their mood and function, so I might be more likely to diagnose them with an underlying (i.e., not caused by the ADT but occurring alongside it) depression.

There are two hypotheses to consider on this link: One, some men are simply in a 'pre-depression' state and the androgen deprivation simply tips them over the edge into a full on depression syndrome; Two, Some men's mood and mental state is governed to a larger degree by testosterone than others, and depleting that pulls the rug out from under their feet.

Putting prostate cancer aside for a minute, it is also possible that depression also leads to a lowering of androgen levels, not necessarily the other way around.

I believe I have observed both sides of the story. So what are the data?

First, consider that the brain is filled with androgen receptors and that they must be there for a reason. So it follows to reason that the deprivation of activity of these androgen receptors may have some medical consequences.

Second, consider that data from the large studies of cognitive function in men on ADT, of which a few have been published in the last couple of years, do not demonstrate a consistent, reproducible link between ADT and Depression. Yet the instruments used were not specific for the detection of depression

Studies in which men with a pre-existing diagnosis of depression were given therapeutic testosterone *to treat the depression* have been met with positive, but inconsistent and not-striking results.

Data from those diagnosed with post finasteride syndrome (which I will cover in a later post) have sought to link depressive symptoms with lowered levels of CNS androgens and steroids in general, but fail to demonstrate a causal link, even if there appears to be guilt by association.

And let's not forget the fact that these men have cancer too. In fact, as the cancer progresses it can compound the likelihood of psychic distress in patients, which we may misperceive as depression, or even a cognitive decline.

Last week, one of my patients (who's prognosis is not bad) told me simply that he was "ready to go" and expressed no enthusiasm for the 'I can make you live forever' vibe that sometimes I'm afraid we (I) give off in the clinic. Was he depressed or was he, at age 80, just being realistic? His point was that he had had a good life and maybe pursuing quantity of life wasn't quite as important to him as maintaining quality. Or, maybe he just didn't think there was too much left to look forward to. At age 35 that would be depression. At 80, is it wrong?

His comment prompted me to probe a little bit. I asked about his family connections, and his social life. Turns out he is living alone and his main interaction on a day is with his beagle.....and his disease isn't really at a stage where it is 'ready to take him'. But, beyond what sounds like some isolation and a bit of loneliness, I couldn't convince him or myself that this was depression. So we'll continue this conversation in a subsequent visit....(Source: Written by Charles Ryan, MD; Uro Today, December 15, 2017)

Fear of Testosterone in Advanced Prostate Cancer. A small pilot study delivered a big message about the use of testosterone in men with advanced or metastatic prostate cancer, according to a "Best Abstract" presented at the Sexual Medicine Society of North America (SMSNA) Fall 2017 Scientific Meeting.

Testosterone therapy greatly improved quality of life in all the patients, without triggering the kind of complications that have made this treatment taboo for decades, reported Abraham Morgentaler, MD, director of Men's Health Boston at Beth Israel Deaconess Medical Center in Massachusetts. The study's first author was Yonah Krakowsky, MD, from the University of Toronto, Ontario, Canada.

"We have all been told you can never do this. That terrible things will happen quickly. That patients will be paralyzed or die," Dr Morgentaler told *Medscape Medical News*. "I'm not advocating that we give testosterone therapy to all men with advanced prostate cancer. But I think there is room for us to deviate a little bit from our historical idea that testosterone is bad in all cases."

While recognizing the potential risks of this practice and signing informed consent, seven men with advanced prostate cancer who had previously received androgen deprivation therapy (ADT) were given testosterone for up to 7 years. All experienced improvements in vitality, strength, sexual desire, and function, and none had a "precipitous progression or unexpected complication" during treatment, he reported at the meeting.

"What we did not see is maybe what's most important, and that was no vertebral collapse, spinal compression, or acute death. On the contrary, these men expressed gratitude for the opportunity to live a more satisfying and full life. They thanked us for our willingness to offer them a treatment that every other doctor said was going to kill them," he said.

These 7 men were drawn from a larger study of 202 "all-comers" with prostate cancer who received testosterone therapy in his practice. After 47 months' median follow-up, no evidence of increased recurrence or progression risk was observed. Recurrence/progression rates were consistent with published rates for the various forms of prostate cancer treatments: 6.5% after radical prostatectomy, 2.0% after radiotherapy, 67% after high-intensity focused ultrasonography (2 of 3 patients), and 3.5% after active surveillance, the researchers reported at the meeting.

Experience Contradicts Conventional Wisdom

John Mulhall, MD, from Memorial Sloan Kettering Cancer Center, New York City, called the findings in the patients with advanced prostate cancer "fantastic" but pointed out that they fly in the face of many published reports. "We have all this literature on the topic. Should we just ignore it?" he questioned.

"No, but I would say we have misunderstand those older data," Dr Morgentaler responded. He noted that there are differences between his patient population and those discussed in the bulk of the literature and that this can make a significant difference.

Rationale for Pilot Study

Testosterone therapy has been contraindicated for decades in men with a history of prostate cancer because of fears that it will "add fuel to the fire," he said. But recent favorable experiences in men after treatment with radical prostatectomy, radiation therapies, and even active surveillance have sparked a major re-evaluation of this contraindication.

Dr Morgentaler said he has been particularly "emboldened" by positive reports with "bipolar" androgen therapy, in which the body is alternately flooded with and starved of testosterone. Castration-resistant patients receive a high dose of testosterone every 28 days while also receiving luteinizing hormone-releasing hormone (LHRH) therapy. In addition to symptomatic improvement, tumor shrinkage has been observed along with declines in prostate-specific antigen (PSA), researchers from Johns Hopkins University in Baltimore, Maryland, have reported.

Although such studies suggest testosterone might actually have some therapeutic benefit, Dr.

Morgentaler's goal has been different: to help select patients who report being "miserable" on or after ADT live "better," not necessarily "longer."

Study Details

The seven men with advanced/metastatic prostate cancer, identified through a retrospective chart review, were treated with testosterone therapy between 2005 and 2016. Electronic records were reviewed for baseline characteristics, additional treatments, outcomes, and qualitative responses that were documented from patient communication. All men signed informed consent, which indicated that the treatment may hasten disease progression and death.

All had symptoms characteristic of testosterone deficiency, including decreased sexual desire and function, decreased energy, fatigue, and impaired cognition. Average age was 69 years (range, 54 to 94 years). Pathology was a Gleason score of 7 to 9. Median PSA at initiation of testosterone was 2.1 ng/mL (range, 0 to 546 ng/mL). Five men presented with biochemical recurrence after definitive local treatment with radical prostatectomy or radiation. Four men presented with asymptomatic bone metastases.

Six of seven (86%) had previously undergone at least one injection of LHRH agonist or antagonist and discontinued it. One declined ADT despite the presence of bone metastases. Treatment consisted of injections, pellets, and/or topical forms of testosterone. Median treatment duration was 30 months; one patient received testosterone for 84 months.

All patients reported symptomatic benefits, including improved energy, cognition, libido, sexual function, and sense of well-being. There were no cases of disease flare, acute pain, or vertebral collapse.

One patient with an obstructed ureter and nephrostomy tube was able to have sex for the first time in 3 years. Another man was able to demolish his outdoor deck when his contractor failed to show up. "He was thrilled because he had been weak for years. This is who he used to be," Dr Morgentaler commented.

Three patients are continuing on testosterone; two discontinued once PSA rose above 20 ng/mL; and two died of causes not related to prostate cancer. The rise in PSA may well be a manifestation of the disease course, but "it made us nervous," he acknowledged.

Dr Morgentaler said that on the basis of these encouraging findings, "we will start looking at this in a more careful way going forward." He hopes that the results of the pilot study, and the larger study in mostly earlier-stage disease, will shift the thinking about testosterone in patients with prostate cancer. "Until recently, men with testosterone deficiency were unable to experience the benefits of testosterone therapy if they had any prior history of prostate cancer, even if cured. These results suggest there may no longer be a need to continue this prohibition, particularly in men with low-risk disease."

Uncertainty Still Exists

Faysal A. Yafi, MD, director of men's health at the University of California Irvine, commented that "this is obviously a very contentious topic" that is being turned on its head by a "trailblazer in the field of testosterone therapy, particularly in prostate cancer."

Dr Yafi explained that the use of testosterone replacement in earlier-stage prostate cancer is not as controversial because there are "little to no data" suggesting testosterone is likely to in-

crease the risk for prostate cancer. "Many urologists today will give testosterone replacement to men with low- and intermediate-risk, treated or untreated, prostate cancer in certain settings," he said.

However, the concerns about testosterone in men with metastatic prostate cancer are not likely to dissipate overnight. The effect of the hormone in this setting are unclear; clinicians will continue to fear the potential for the "flare of cancer" and "serious complications," and patients who choose to get testosterone may forego other new "life-prolonging" options now available for prostate cancer, he said. On the other hand, Dr Yafi acknowledged that testosterone could have benefits in patients with advanced prostate cancer. "These men are usually quite weak and frail, and testosterone may improve their quality of life." (Source: Sexual Medicine Society of North America (SMSNA) Fall 2017 Scientific Meeting. Abstracts 132 and 340. Presented October 26, 2017)

Continued from page1 - "Too Many Older Patients get Cancer Screening")

"It generally takes about 10 years to see benefit from cancer screening, at least in terms of a mortality benefit," Dr. Korenstein said. Yet enthusiasm for cancer screenings runs high among patients and doctors, both of whom tend to overestimate the benefits but underappreciate the risks.

Although screenings can extend and improve lives for healthy, younger adults, they tend to inflict more harm than good in people who are old and frail, Dr. Korenstein said. Testing can lead to anxiety, invasive follow-up procedures and harsh treatments. "In patients well into their 80s, with other chronic conditions, it's highly unlikely that they will receive any benefit from screening, and more likely that the harms will outweigh the benefits," said Dr. Cary Gross, a professor at the Yale School of Medicine.

By screening patients near the end of life, doctors often detect tumors that don't need to be found and treated. Researchers estimate that up to two-thirds of prostate cancers are over-diagnosed, along with one-third of breast tumors. "Over-diagnosis is serious," Dr. Gross said. "It's a tremendous harm that screening has imposed. It's something we're only beginning to reckon with."

A variety of medical specialties — from the American College of Surgeons to the Society of General Internal Medicine — have advised doctors against screening patients with limited time left. For example, the American Cancer Society recommends prostate and breast cancer screenings only in patients expected to live 10 years or more.

Yet patients with terminal cancers often continue to be screened for other malignancies. In a 2010 study, 9 percent of women with advanced cancers, including tumors of the lung, colon or pancreas, received a mammogram, and 6 percent received a cervical cancer screen. Among men on Medicare with incurable cancer, 15 percent were screened for prostate cancer.

In November, a coalition of patient advocates, employers and others included prostate screenings in men over age 75 in its list of the top five "low-value" medical procedures. Dr. A. Mark

Fendrick, co-director of the coalition, referred to the five procedures as “no-brainers,” arguing that health plans should consider refusing to pay for them.

Prostate cancer screening in men over 75 cost Medicare at least \$145 million a year, and mammograms in women over 75 cost \$410 million a year. And while many cancer screenings are relatively inexpensive — a mammogram averages about \$100 — they can set off a cascade of follow-up tests and treatments that cause the total cost of care to soar.

Most spending on unnecessary medical care stems not from rare, big-ticket items, such as heart surgeries, but cheaper services that are performed much too often, according to an October study in *Health Affairs*.

A Hard Habit to Break

Many older patients expect to continue getting screened, said Dr. Mara Schonberg, an assistant professor at Harvard Medical School and Beth Israel Deaconess Medical Center in Boston. “It’s jarring for someone who’s been told every year to get screened and then at age 75 you tell them to stop,” she said.

John Randall, 78, says he plans to live into his 90s. He sees no reason to skip cancer screening. “I, for one, do not like to hear what my life expectancy is,” said Mr. Randall, who lives near Madison, Wis. In January he plans to have his next colonoscopy, a procedure the United States Preventive Services Task Force recommends only in patients 50 to 75. He feels healthy and walks two miles at a stretch several days a week. “No one knows when I am going to die.”

Decades of public awareness campaigns have convinced patients that cancer screenings are essential, said Dr. Lisa Schwartz, a professor at the Dartmouth Institute for Health Policy and Clinical Practice. Her research found that many people see cancer screening as a moral obligation and can’t imagine a day when they would stop getting screened.

Public health campaigns have convinced many women that “mammograms save lives.” But those campaigns don’t mention that doctors need to screen 1,000 women for a decade in order to prevent one death from breast cancer, Dr. Schonberg said.

Yet screenings can have dire consequences. Medical complications during colonoscopies — such as intestinal tears — are almost twice as common in patients ages 75 to 79 compared with those 70 to 74. Colonoscopies also require extensive bowel cleansing before the procedure and can leave older people dehydrated and prone to fainting.

PSA tests can lead to prostate biopsies, in which doctors use needles to sample tissue, causing infections in about 6 percent of patients. These infections send about one in 100 men who undergo the procedure to a hospital.

Even removing nonfatal skin cancers can cause problems for older patients, said Dr. Eleni Linos, an associate professor of dermatology at the University of California, San Francisco, School of Medicine. Frail patients can struggle to care for surgical wounds and change dressings; their wounds are also less likely to heal well, Dr. Linos said. More than one in four patients with nonfatal skin cancers report a complication of treatment, her research shows.

Yet most of the 2.5 million slowest-growing skin cancers found each year are diagnosed in people over 65. More than 100,000 of these generally nonfatal skin cancers are treated in patients who die within one year.

Screenings, follow-up tests and treatments can cause emotional trauma as well, especially among patients with dementia. “For a woman of that generation who doesn’t have the cognitive ability to understand what’s going on, having private parts of their body exposed and pressed against a machine can be very agitating and upsetting,” Dr. Lee said.

Among older women, about 70 percent report significant stress at the time of a biopsy, Dr. Schonberg said. Simply lying on a table for a 45-minute biopsy can cause pain for women with significant arthritis, she said.

Virtually all older women with breast cancer wind up getting surgery, which poses additional hardships, Dr. Schonberg said. Many are prescribed hormonal therapies that can cause bone pain, fatigue and increase the risk of stroke.

With prostate cancer, doctors today try to reduce the harm by offering men with early-stage disease “active surveillance” instead of immediate treatment. A study published last year in the New England Journal of Medicine found that men are just as likely to survive 10 years whether they choose to be treated or monitored.

Jay Schleifer, 74, of Wellington, Fla., was found to have a low-risk prostate cancer last year. Since then, his doctor has monitored him with additional tests. He’ll be treated only if tests suggest his cancer has become more aggressive, an approach that aims to spare him from long-term side effects. Among men who have had prostate cancer surgery, 14 percent lose control of their bladders and 14 percent develop erectile dysfunction.

Dr. Richard Hoffman, director of general internal medicine at the University of Iowa Carver College of Medicine/Iowa City VA Medical Center, found that 15 percent of prostate cancer survivors regretted their treatment decision. Those treated with surgery and radiation were about twice as likely to regret their choice compared with those who opted to monitor their disease. Men are more likely to regret their prostate cancer treatment decisions if they don’t understand the risks beforehand, Dr. Hoffman said.

Harold Honeyfield, 87, said he didn’t fully understand the risks when he had prostate cancer surgery 12 years ago. Although he is glad he was treated, the surgery caused irreversible erectile dysfunction, which has caused stress and sadness for him and his wife of 47 years. “When a man has no erections, that is paralysis,” said Mr. Honeyfield, of Davis, Calif., who started a support group for other men dealing with prostate cancer. “You’ve lost the ability to be a man.”

A Tough Sell

Doctors have a number of incentives to continue ordering screening tests as people age. “It’s a lot easier to say, ‘Fine, get your regular mammogram this year,’ than to have the much more difficult conversation that it’s not helpful when life expectancy is limited,” Dr. Gross said. -Dr. Schonberg said she tries to be diplomatic when talking to patients about halting screening. “It’s hard to tell people, ‘You’re not going to live long enough to benefit.’ That doesn’t go over well.”

Many physicians continue screening older people because they're afraid they'll be sued if they miss a cancer, Dr. Schonberg said. And she notes that some health systems award bonuses to clinicians whose patients have high screening rates. In addition, "doing less can be perceived as a lack of caring or as ageism," she said. "It can be uncomfortable for a physician to explain why doing less is more."

Doctors should prioritize what they can do to help patients be healthier, said Dr. Louise Walter, chief of geriatrics at the University of California, San Francisco and a geriatrician at the San Francisco VA Medical Center. For many older patients, screening for cancer is not their most pressing need.

"Instead of spending time and effort on things that are hurtful and never going to help them, why not direct time and energy on things that will help them live longer and better?" Dr. Walter asked. For example, Dr. Walter might tell a patient, "Right now, you have really bad heart failure and we need to get that under control."

Other key issues for many older people include preventing falls, treating depression and alleviating stress in their caregivers, Dr. Walter said. Dr. Gross said he urges patients to take steps shown to improve their health, such as getting a flu shot or exercising at least 15 minutes a day. "These are things that can help them feel better very quickly," Dr. Walter said. "Screenings can take years to have a benefit, if at all." (Source: Kaiser Health News, December 19, 2017, via The New York Times, December 19, 2017)

THIS SPACE INTENTIONALLY BLANK

◆ LIFE AFTER PROSTATE CANCER TREATMENT ◆

by
TIMOTHY J. TAUSCH, MD
Director, Trauma and Reconstructive Urology
Fort Belvoir Community Hospital

(A summary of a presentation to the WRNMMC Prostate Cancer Support Group, November 2, 2017)

Introduction

Good evening! Thank you for the invitation to be with you tonight. Yes, there is life after you undergo therapy for prostate cancer! I want to discuss with you the treatment of urinary incontinence and erectile dysfunction. First, incontinence.

The Male Anatomy

Simply put, the bladder stores urine that exits the body via the urethra. Part of the urethra is surrounded by muscles called sphincter muscles. The sphincter muscles remain contracted to retain the urine within the bladder. When the sphincter muscles relax, urine is able to exit the body via the urethra.

Types of Incontinence

Incontinence is the involuntary loss of urine. Overactive bladder involves symptoms of urgent urination with or without involuntary loss of urine, usually with frequent urination both during the day and at night.

Stress Urinary Incontinence is the complaint of involuntary leakage on effort or exertion, sneezing or coughing.

Urge Incontinence is leakage accompanied by or preceded by urgency (an overwhelming need to urinate...*Gotta go, gotta go!*).

Mixed Incontinence is leakage associated with urgency **and** effort, exertion, sneezing and coughing.

Incontinence has several causes: prostate cancer surgery; pelvic trauma or surgery; and such causes as diabetes, multiple sclerosis, Parkinson's disease, and stroke.

Worldwide, over 43 million men suffer from urinary incontinence (stress, mixed and urge). Approximately 3.4 million men in the U.S. ages 60+ suffer from incontinence. The rate of incontinence ranges from 2.5% up to 69% among men who underwent prostate cancer surgery.

WHY TREAT INCONTINENCE?

Incontinence can cause men mental distress by causing loss of confidence, fear of giving of-

fense, hygiene issues, limitation of their social activities, skin irritation and sleep disturbances.

MANAGEMENT AND TREATMENT OPTIONS

Management and treatment options include behavioral modification, such as limitation of fluid intake, avoidance of bladder irritants, such as caffeine and alcohol, and the performance of pelvic floor exercises (kegels). Drugs to treat overactive bladder are sometimes prescribed "off-label" to treat male stress urinary incontinence.

In addition to pelvic floor stimulation and pelvic muscle exercises, there are other familiar treatment options:

Absorbent products such pads, diapers, bed and chair pads and the like. While adequate for many men, they are not without disadvantages such as skin irritation, leakage, and odor.

Penile clamps placed on the penis to apply pressure to the urethra to prevent involuntary loss of urine. This non-medical, non-surgical technique is discreet and inexpensive, however, it may cause pain, scarring, and other skin and tissue problems.

Penile catheters, both external and internal. The former relies on a condom-like device with tubing that collects urine to a bag. The other is a catheter inserted in the urethra allowing the bladder to drain continuously. There is risk of urinary tract infection and urethral blockage.

Bulking agents such as collagen are injected into the urethral tissue to increase tissue bulk around the urethra. It is considered to be the most minimally invasive surgical treatment for stress urinary incontinence. Success rates in nine studies ranged from 17% to 69% depending on the type of bulking agent. Multiple injections are required to sustain effectiveness, and treatment results deteriorate over time.

Surgical Options

The Advance® Male Sling System is a small, synthetic sling designed to treat male stress urinary incontinence. Anchored in the pelvic bone structure, it functions as a "hammock" during physical activity. The sling supports the urethra and is designed to restore normal bladder control. Success rates ranging from 54.6% to 90.6% have been reported in six clinical trials. In a study of 42 patients, 94.4% would recommend the procedure to a friend. Side effects include pain and inflammation, bleeding and irritation at wound site, and urethral or tissue erosion.

AdVance® is not recommended for men with urinary tract infections, blood coagulation disorders, condition that would compromise healing, renal insufficiency, or urinary tract obstruction.

AMS 800 ® Urinary Control System is the "gold standard" for treatment of incontinence. It is an artificial urinary sphincter designed to restore the natural process of urinary control. It has three components, a urethral cuff, a pressure regulating balloon, and a control pump. It works like this: the cuff is wrapped around the urethra and inflates to close the urethra, retaining urine within the bladder. Squeezing the control pump deflates the cuff, opening the urethra and allowing urine to exit the body. The device is placed entirely within the body.

One study of fifty patients, 90% reported satisfaction; 96% would recommend the device to a

friend; and 92% would have the AMS 800® placed again. In another study of 34 patients, 59% to 90% of patients reported the use of 0-1 pads per day after the procedure. Possible side effects include pain, infection, and tissue erosion.

Proper patient evaluation, selection, and counseling regarding realistic expectations are essential. The AMS 800® is not recommended for men with low manual dexterity, an irreversibly-blocked lower urinary tract, permanent bladder dysfunction or bladder instability, or a known allergy or sensitivity to rifampin, monocline, or tetracycline.

SUMMARY

You are not alone! Incontinence is a common problem, **BUT THERE ARE TREATMENTS AVAILABLE.** Surgical treatment options offer proven, long-term treatment options. Discuss your condition with your urologist and your partner. You could live every day **DRY!**

ERECTILE DYSFUNCTION

Now let's turn to the topic of erectile dysfunction,

Erectile dysfunction (ED) is the persistent inability to achieve or maintain an erection firm enough to have sexual intercourse. You are not the "Lone Ranger!" About 1 in 5 American men twenty years of age or older experience ED to one degree or another. That amounts to approximately 30 million American men!

CAUSES OF ED

In order of their prevalence, the main physical causes of ED are Vascular (40%); Diabetes (30%); Medication (15%); Pelvic Surgery, Radiation, or Trauma (6%); Neurological Causes (5%); Endocrine Problems (3%); and Other (1%).

ED RESTORATION TREATMENT OPTIONS

Oral Prescription Medications

No doubt you are aware of the familiar oral prescription medications - Viagra®, Cialis®, and Levitra®. They are effective in 70-80% of cases. They work in response to sexual stimulation and are usually taken within one hour before anticipated sexual activity. The effect typically works for up to four hours (36 hours for Cialis®). These medication should not be taken more than once a day. Some oral medication efficacy can be affected by certain food consumption.

Common side effects from oral medications are headache, facial flushing, stuffy nose, upset stomach, and dizziness. There are other precautions, too. These oral medications cannot be take with nitrates. For example, you should be stable on your alpha-blocker therapy before using an oral medication. Furthermore, these medications should not be used if sex is inadvisable due to your cardiovascular status.

Be sure to alert your physician if you had ever had heart problems, stroke or low or high

blood pressure, liver or kidney problems.

Other familiar devices and medications include:

(1) The vacuum erection device is non-invasive, drug-free, cost effective option. Its side effects include bruised blood vessels, some penile discomfort and numbness, and delayed ejaculation.

(2) The Alprostadil urethral suppository (Muse®) that is inserted into the penis and provides an erection within 10-15 minutes. Its possible side effects include penile pain, urethral burning sensation, urethral bleeding/spotting, low blood pressure and dizziness.

(3) The intracavernosal injection Alprostadil (Caverject®) that is the most widely used agent. It is injected directly into the corpora cavernosa. Side effects may be penile pain, prolonged erection, and scar tissue.

Penile Implants

Penile implants provide an option for men who have tried other therapies without success. It is a surgical procedure that has been available for over thirty years. It is estimated that more than 300,000 of the devices have been implanted during that time. High patient and partner satisfaction rates have been reported in clinical studies. In one study, 93% of patients would recommend implants to others and 90% of partners would do likewise. The implant may offer a long-term solution to ED.

The three-piece inflatable penile implant is emplaced entirely in the body. The device is inflated to provide rigidity and deflated for concealment. The implant provides for spontaneity. Once activated, the erection can be maintained for as long as desired. It typically does not interfere with ejaculation or orgasm. When deflated, the cylinders are designed to be soft and flaccid.

Of course, there are risks and not all patients are candidates for the procedure. Patients should understand the risks and benefits involved in the implant therapy. Possible risks include: In the event of infection, the implant may have to be removed; the penis may become shorter, curved, or scarred; there may be mechanical failures; other interventional treatment options may be impossible; and pain typically associated with the healing process).

As you can see, there are therapies to combat erectile dysfunction. Consult with a prosthetic urologist who can offer the complete spectrum of treatment options. Finding a satisfying solution to ED can be a life-changing event for many men and their partners.

(Editor's note: a verbatim transcription was not possible. This article relied on the slides presented by the speaker)

◆ MEETING ANNOUNCEMENT ◆

THURSDAY, FEBRUARY 1, 2018

7:00 - 8:30 PM

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

◆ SPEAKER ◆

JENNIFER CULLEN, PhD, MPH

DIRECTOR OF EPIDEMIOLOGIC RESEARCH

CENTER FOR PROSTATE DISEASE RESEARCH

WALTER REED NATIONAL MILITARY MEDICAL CENTER

◆ TOPIC ◆

"THE CRITICAL ROLE OF PATIENT-REPORTED OUTCOMES IN IMPROVING OUTCOME
IMPROVING DECISION-MAKING FOR THE TREATMENT OF PROSTATE CANCER"

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, February 1, 2018, to arrange entry. Have a photo ID card ready when arriving at the gate.

Fort Belvoir: Persons without a military ID card should arrive at the entrance one hour before the presentation to complete the entrance procedure. Have a picture ID with you.