

**WRAMC US TOO, Inc.**  
**A PROSTATE CANCER SUPPORT GROUP**  
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**NEWSLETTER**

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◆ **PROSTATE CANCER – ONE MAN’S ODYSSEY** ◆  
by Rod Shorter

**Introduction**

When I was diagnosed with prostate cancer, it is only a slight exaggeration to say I didn’t know a PSA test from a PAP smear test. It was 1995, unlike today when erectile dysfunction is a household word and TV commercials for Viagra, Cialis, and Levitra appear during prime time showing romantic older couples smiling knowingly at each other. Prostate cancer was still in the closet, so to speak.

I was watching local television when I saw repeated appeals for PSA screening at a nearby hospital. I ignored them, until finally, I said, “why not.” I showed up for the next available screening date. The doctor detected a lump on my prostate during the digital rectal examination (DRE), and said I should await the outcome of the PSA test. A week later, I received a postcard saying the combination of a detectable prostatic nodule and a PSA of 5.4 ng/ml indicated that I should contact a urologist. Instead, I went to my primary care physician where a DRE and a new PSA of 5.7 ng/ml confirmed the results of the initial screening. I was referred to a urologist at the small local hospital who performed an ultrasound and a six-core biopsy. The results showed that four of the six cores were positive for cancer. My Gleason score was 4. I was 62 and I had prostate cancer!

**Making the Treatment Decision**

Unlike most first-person stories where it is *de rigueur* for newly diagnosed cancer victims to report being “crushed” or “devastated,” I felt no such attitude—not that I was braver than others. It was simply that I had prostate cancer; I couldn’t change that fact—now the question was what to do about it?

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## Boy, Is My Face Red!

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### ◆ FROM THE EDITOR'S DESK ◆

**O**K! OK! I know! There were three egregious misspellings in the last issue—and all on the first page no less! It is so hard to get good help these days! I want to demonstrate conclusively that I know the difference between “prostate” and “prostrate” by telling you about my friend John Doe who went to see his urologist and said, “Doc, I have a severe prostrate problem.” The doctor smiled benignly and said, “No, Mr. Doe, you mean you have a prostate problem.” John insisted he had a prostrate problem. They bickered for several minutes until the exasperated doctor almost shouted, “Mr. Doe, the word is “pros-tate, pros-tate! If something is pros-trate, it means it just lies there.” “That’s it,” said John, “That’s my problem!”

**O**ur speaker for the February meeting was Dr. James R. Jezior, Assistant Chief of Urology, WRAMC. His topic was “Serving the Soldier - Military Medicine in Iraq,” a change of pace from our usual prostate cancer-related presentation. Drawing on his personal experience, Dr. Jezior demonstrated the remarkable achievements in treating combat-wounded soldiers in a difficult environment. A summary of Dr. Jezior’s remarks is presented beginning on page 15.

### ◆ PROGRAM FOR WEDNESDAY, MAY 4 , 2005 ◆

**O**ur speaker for May 4 is Dr. Myron I. Murdock, an educator, surgeon-practitioner, author, and medical director for Vibrance Associates, a world-wide medical website company. Dr. Murdock is a nationally recognized expert in the fields of impotence, prostate health, and incontinence. He is also a co-founder of the Society for the Study of Impotence and the Impotence Institute of America. Join us at 7 PM on Wednesday, May 4, 2005, in Joel Auditorium at WRAMC. Dr. Murdock’s topic is **Preventing and Treating Sexual Dysfunction in the Prostate Cancer Patient**. Plan now to attend and bring your spouse or a friend. They are always welcome.

**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

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### ◆ **“Give Me Viagra (or Levitra or Cialis) or Give Me Death!”**

No, Patrick Henry didn't quite say that, but he may have if the Continental Congress had entertained a motion to prohibit government payment for what some critics are calling “lifestyle drugs.” The current debate centers on whether a drug used to enhance sexual performance should be covered by Medicare. Those in favor cite the fact that erectile dysfunction often has underlying physical causes and their treatment can greatly improve the quality of a man's life. Opponents note the unsustainable growth of Medicare and object to funding “lifestyle” medications under the newly expanded Medicare drug benefit. Some congressmen are talking about introducing specific legislation to deny authorization for “lifestyle” drugs prescribed for impotence. There is some talk of a compromise. It would allow the coverage of these drugs when the patient's erectile dysfunction could be traced to some underlying, identifiable medical condition other than simply old age. (Source: AOL News, February 22, 2005)

### ◆ **Long-Term Androgen Deprivation Can Be Quickly Reversed.**

Fridmans, et al., at the Shaare Zedek Medical Center, Jerusalem, studied 22 prostate cancer patients to examine the reversibility of androgen deprivation. Seven had received a hydrogel implant for up to three years; eight had been treated with long-term depot super agonists; and seven who had no prior hormonal therapy received bicalutamide. In the hydrogel implant group, testosterone levels had reached the castration stage, but when the implant was removed, luteinizing hormone levels and testosterone increased within six weeks. Pa-

tients in the depot group experienced continued suppression of testosterone, luteinizing hormone, and PSA for at least nine months after their last injection. Most of the patients treated with bicalutamide had a significant increase in testosterone and luteinizing hormone levels within seven days of starting bicalutamide and a decrease in PSA at eight weeks. The researchers concluded that (1) hydrogel implants allow for the quick and simple implementation of intermittent hormonal therapy; (2) because of the long-term effects of depot injection, testosterone levels must return to normal before depot injection interruption can be considered as “bona fide intermittent therapy.” (Source: *J of Urol* 2005;173:784-789 via Reuters Health Information, March 23, 2005)

### ◆ **Is Cryosurgery Making a Comeback?**

Yes, according to a report of the experience at Roper Hospital, Charleston, SC. Cryosurgery has been around for decades, but it never caught on as a primary therapy for prostate cancer because of the high complication rates associated with it. If the Roper Hospital experience is any indicator, new technology may allow cryosurgery to compete in effectiveness with surgery and radiation. The Roper study followed 88 men and 85 % of them remained free of prostate cancer for 10 years after having the freezing treatment. The long-term side effects also compared favorably with the more established therapies. The study was funded by the manufacturer of new technology (guided probe machine) that makes cryotherapy more effective. A commentator notes that cryotherapy is emerging as a promising technique, but says the new technology is still too new to provide good long-term data on its effectiveness. (Source: *69th Annual Meeting of*

*the South East Section of the Amer Urol Assn., March 3, 2005 via CBSNEWS.com, March 10, 2005)*

◆ **Androgen Deprivation for Prostate Cancer May Cause Metabolic Disturbances.**

Japanese researchers at Nigata University, Japan, studied 49 men with non-metastatic prostate cancer to identify the metabolic outcomes of androgen deprivation therapy (ADT). Although ADT suppresses tumor growth in prostate cancer patients, it can also lead to undesirable effects. The researchers want to increase awareness of the consequences of ADT so that strategies for coping with adverse effects can be incorporated into routine practice. The patients were followed during a 6-month course of ADT prior to receiving a primary therapy. They experienced significant increases in body weight, blood sugar, total cholesterol, and blood urea nitrogen. There was also a significant reduction in red blood cell counts, hemoglobin level, hematocrit and radial bone density. The researchers say these possible effects of ADT warrant systematic study in clinical trials. (Source: *J of Clin Endocrinol Metab* 2005; 90:657-660 via Reuters Health Information, March 24, 2005)

◆ **“OK, Doc, So You’ve Done Over 300 RPs. Now, How Old Are You?”**

A study by Harvard Medical School indicates that, as a group, older doctors know less, provide lower-quality care, and may expose patients to greater risks than doctors more recently out of medical school. Older doctors were less likely to know or to follow up-to-date treatment standards on procedures ranging from surgery to treating a child’s fever. Older doctors agreed that the explosion in new medical knowledge and technology can be hard to keep up with. A Harvard spokesman said that the basic philosophy of medicine has

shifted over the past 30 years. Formerly, doctors relied on their own experience in making medical decisions, but now the emphasis is for reliance on research published in medical journals. Doctors who haven’t been trained in the new “evidence-based medicine” may be slow to adopt new approaches or to abandon outdated ones. The problem is exacerbated by the fact that, in some cases, specialty board certification either does not need to be renewed, or has limited requirements for renewal, or has generous waiver provisions. The Harvard study says there is evidence that certification renewal processes are being toughened. One commentator says it would be absurd for patients to avoid experienced doctors, but agrees that the evidence from the Harvard study cannot be ignored. **(Editor: Next time you visit a doctor, ask to see some ID!)** (Source: *The Boston Globe*, boston.

com, February 15, 2005)

◆ **The RP Was Easy, But the Biopsy Was Murder!**

Many men say the biopsy experience was more distressing than the actual radical prostatectomy they eventually underwent. This is especially true for those men whose situation required multiple biopsies, e.g., those men on “watchful waiting.” Recently, there was a clinical trial to evaluate a topical pain reliever, 0.2% glyceryl trinitrate (GTN), a paste used to relieve the biopsy-related pain. In this trial, 134 patients were undergoing their first biopsy. Patients either received GTN thirty minutes before biopsy or a placebo. After biopsy they completed a pain questionnaire

using a 10-point pain scale. Patients using GTN had a significant reduction in pain, 3.7 on a scale of 10, compared to the placebo group which reported 5 on a scale of 10. Some GTN patients reported headaches. The researchers concluded that GTN appeared to reduce pain associated with prostate biopsies. Patients about to undergo a prostate biopsy may wish to discuss with their doctor the individual risks and benefits of GTN compared to other available pain relievers prior to the biopsy. **(Editor: See “The Doctor Is In” column later in this newsletter for a discussion of discomfort and the prostate biopsy.)** (Source: CancerConsultants.com, February 22, 2005)

◆ **Prostate Cancer-Related Suicides.**

Researchers sought to determine the incidence of suicide among men with prostate cancer based on a study of men age 65 or over living in South Florida between 1983 and 1993. The average annual prostate cancer-related suicides were compared to other age and gender-related rates during the same period. The average annual incidence of suicide for all men was 55.32 per 100,000 persons, but for men with prostate cancer, the rate was 274.7 per 100,000, more than four times higher. The incidence of suicide among older men with prostate cancer is higher than previously recognized. Depression, diagnosis within six months of suicide, pain, and being foreign-born were important correlates. The study concluded that screening for depression and suicide in older men with prostate cancer should be done after initial diagnosis and regularly thereafter. (Source: *Amer J of Geriatric Psychiatry* 2005: 195-201, March 2005, via psychiatryonline.org)

◆ **Cancer Vaccine Shows Promise.** An experimental treatment that mobilizes the immune system to attack tumors may extend the lives of men fighting advanced prostate cancer. Researchers hope this new study will reinvigorate interest in cancer vaccine therapy that has failed to fulfill earlier expectations. Cancer vaccines are designed to treat, rather prevent, disease by stimulating the patient’s immune system to attack cancer cells just as it does for invading bacteria or viruses. Doctors remove certain immune cells from patients with advanced prostate cancer, process them with a protein (prostatic acid phosphatase), then inject the modified cells back into the patient in three infusions over the course of a month. The idea is for these modified cells to stimulate other immune system entities known as T cells to seek out and destroy prostate cancer cells throughout the body. In this new study, Small, et al., at the University of California, San Francisco, gave the vaccine to 82 men with advanced prostate cancer after failed surgery or radiation. A placebo was administered to 45 similar men. Those receiving the vaccine survived a median of 25.9 months and those receiving the placebo survived 21.4 months. This 4.5 month difference exceeds the benefit produced by chemotherapy. After 36 months, 34% of the men receiving vaccine therapy were alive, compared to 11% of men receiving the placebo. The researchers say that the 4.5 month difference has important clinical significance. They also report that side effects, such as fever, chills, and other flu-like symptoms were relatively benign compared to chemotherapy. Observers applaud the study, but cite the need for confirming studies. (Source: *The Washington Post*: Thursday, February 17, 2005, page A2)

◆ **“Getting to the Bones of Prostate Cancer.”** Treatment for prostate cancer bone metastases has been aimed primarily at reducing the pain and delaying bone fractures by the use of hormone therapy, chemotherapy, radiation therapy, or bisphosphonates. Eshar, et al., Weizmann Institute of Science, Israel, have shown these common treatments for prostate cancer may help redirect immune cells to prostate cancer in the bones. Patients’ immune cells are engineered to detect specific cancer cells and have the capacity to kill the invading cancer cells. In experimental mice models, a significant drop in PSA, tumor load, and increased survival time were observed when prostate cancer-bearing mice were “preconditioned” using common forms of cancer therapy such as low-dose radiation or chemotherapy before immune cell injection. This method holds promise for bone metastases in prostate cancer resistant to conventional therapy. The research was supported by the DOD’s Congressionally Directed Medical Research Program for prostate cancer. (Source: *DOD Prostate Cancer Research News Item*: CDMRP, February 15, 2005)

◆ **Thanks, But No Thanks to Viagra!** Why would a high percentage of men who sought treatment for erectile dysfunction (ED) and had success with sildenafil (Viagra) subsequently abandon the treatment? To answer that question, a study in Germany followed men who reported ED attributable to various causes. The average age was 60.5 years. In all, 40% of the patients had hypertension, 51% were active or former smokers, and 16% had diabetes. Each patient received an initial prescription of sildenafil (Viagra) consisting of four tablets (50 or 100 mg). A questionnaire was used to identify those who were successful more than once in achieving vaginal penetration. A total of 234 patients reported success. Despite this success in dealing with their ED, only 69% of the participants sought a refill prescription within six months of the first prescription. The remaining

31% were considered to have abandoned the treatment. The 73 men who abandoned therapy were queried to determine the reason for their failure to continue the use of sildenafil (Viagra). Lack of opportunity or lack of sexual desire was cited by 45%; another 23% reported that their partners showed no sexual interest; the high cost of the drug was the reason offered by 12%; and adverse reactions caused 5% to end treatment. The remainder offered miscellaneous reasons. The researchers concluded that a large portion of patients with ED are satisfied with the knowledge that they have access to an efficacious treatment (sildenafil) even if they do not engage in sexual intercourse. (Source: *Inter J of Impot Research*: 2005; 17 (1): 2-4, via Medscape)

◆ **Prostate Cancer Management Tool.** HealthMark Multimedia has developed a CD-ROM entitled “Prostate Cancer: Your Decision Notebook.” It provides information about treatment options, the various medical tests and procedures, interactive decision-making tools, and personal stories from men about their experiences in coping with prostate cancer. It also offers a useful means for recording personal health data to help the user chart his own experience. The program is intended to help the user work in an informed manner with his own physician throughout the treatment process. The CD-ROM is user-friendly and the graphics are attractive and well-done. For more information, contact HealthMark at (202) 265-0033 or 1-877-722-2255. ( **Editor** )

◆ **The Emotional Side of Cancer.** The anxiety, fear and depression that often accompany a diagnosis of cancer are frequently overlooked in treating the disease even though they may interfere with treatment. A study at Johns Hopkins University estimated that more than one-third of cancer patients experience significant levels of stress that require help, but only about 5% ever get it. Now the American Cancer Society and 19 cancer centers

have joined forces to develop evaluation guidelines to help identify and monitor patients who may need counseling assistance by mental health professionals. Distressed patients miss appointments, fail to take prescribed medications, or otherwise fail to follow doctors' orders. "Screening for distress" should be a standard part of any visit to an oncologist's office, akin to questions routinely asked about physical symptoms, says a spokesman. The guidelines use a 0-10 point scale where patients rate on a "distress thermometer" how much cancer-related stress they are experiencing. Given a list of possible causes of their stress, they check off the areas that are bothering them. A score of 5 or more on the distress scale is considered significant enough to warrant referral to a mental health professional. Most studies to date have not found a correlation between a patient's distress level and survival outcomes. Nevertheless, proponents of emotional stress measurement will continue to study the relationship. (Source: *The Wall Street Journal Online*: Health Section, page D1, January 11, 2005)

◆ **Hormonal Therapy and Broken Bones.**

The medical records of 50,613 men, aged 66 and older, diagnosed with prostate cancer were reviewed to compare those who received hormone therapy within one year and those who did not. Five years later, 19% of men in the hormone-therapy group had broken a bone, compared to 13% of those who did not take the drugs. The risk of fracture increased as the number of doses increased. Men who had surgery to remove one or both testicles, which produce testosterone, were 54 % more likely to break a bone. The study noted that about 220,000 men in the United States are diagnosed with prostate cancer annually, and about 40% of them are treated with hormone-suppressing drugs. It was concluded that men with prostate cancer may want to talk to an oncologist about the risks associated with hormone therapy before selecting a therapy. (Source: *The Washington Post*: Health Section (F6), January 5, 2005)



## **VOLUNTEER COUNSELORS**

Each edition of the WRAMC US TOO newsletter lists our volunteer counselors on page 19. These men and women are available

by telephone to consult with our readers regarding various aspects of prostate disease from the perspective of someone who "has been there, done that." They are an ideal information source for the newly diagnosed; those whose disease may have progressed thereby requiring new decisions; or simply someone seeking reassurance about a course of therapy. The listing is organized by the prostate cancer therapy or condition that the counselors are comfortable in discussing. Remember that the volunteers are not a substitute for the advice of your physician, but they can be a useful sounding board to men and their families in confronting prostate cancer.



## GOOD NEWS!



**Dr. Judd W. Moul, co-founder of WRAMC US TOO and our mentor for over ten years, returns as guest contributor to "The Doctor Is In" feature for this issue of the newsletter. Thank you, Dr. Moul!**

### **(Prostate Cancer - One Man's Odyssey - Continued from page 1)**

Let me return for a moment to my own general practitioner available through my employer. My employer's health plan provided an annual physical examination that, unbeknown to me, included a PSA test, whatever that was! Each year, a few days after the examination when the laboratory tests (urinalysis and blood work) were available, the doctor would call to say the lab work results were "within normal limits—see you next year." Only after my diagnosis for prostate cancer did I learn that in the eleven months prior to my diagnosis, my PSA rose from 2.7 ng/ml to 3.5 ng/ml. It had never reached the "magic number" of 4.0 ng/ml that would have triggered concern. The term "PSA velocity" probably was not familiar to the doctor in those days.

The urologist, a surgeon, recommended a radical prostatectomy—what else? But he also acknowledged that my condition (a T2a—a palpable nodule detected by digital rectal examination; a PSA of 5.7 ng/ml and a Gleason score of 4) made me a likely candidate for either surgery or radiation. Accordingly, he referred me to another surgeon and a radiation specialist for second opinions. He also provided me with a

raft of reading material to educate myself about the disease.

My visit to the radiologist was very helpful. He took pains to explain the available therapies, and even offered brachytherapy—I couldn't even pronounce it, much less spell it! I soon discounted brachytherapy because it had just become available at the hospital, and everything I had read warned about the need to be treated by an experienced practitioner, whether surgeon or radiologist.

Upon consulting with my primary care physician, he recommended surgery because he said it was the more definitive primary therapy. His recommendation coincided with my own developing preference—"get it out!"

Now I had to choose between the two urologists I had consulted. The first one was congenial and attentive, but relatively new in the business, and, again, my reading convinced me that the more experienced surgeon would be the better choice. The second surgeon had considerable experience in a larger hospital, so I chose him. He was very matter-of-fact.

He dismissed almost out of hand the possibility of the nerve-sparing technique. No doubt he did so based on the DRE he performed, a review of the ultrasound, and the biopsy, but he never explained why. Instead, he emphasized that his primary objective was to get all the cancer, then to preserve continence because his experience showed that incontinence was a greater quality-of-life factor than impotence (easy for him to say!). Impotence was obviously a tertiary goal. He also disdained my queries about an MRI or CT prior to surgery to determine if the cancer was contained within the capsule, saying that the clinical evidence in my case made it very unlikely that the disease had spread beyond the capsule, and in such circumstances, the MRI and the CT scan were of little help. The Partin Tables showed a high probability that the cancer was contained.

### **The Operation and Aftermath**

I had never before undergone any surgery, so naturally, I was apprehensive about the operation and recovery. My concern was heightened by reading a personal account of a well-known personality who reported a very difficult post-operative experience. I need not have worried. I tolerated the surgery well and my post-operative experience was surprisingly easy. In fact, my biggest discomfort was from having the Foley catheter in place for 21 days to ensure the anastomosis of the bladder and the urethra. I count the day the catheter was removed as one of the happiest days of my life! I was home in four days after surgery buoyed by good news—the post-operative pathology report confirmed that the cancer was confined within the capsule. Aside from the usual precautions for recovery from major surgery, I was soon up and about, out and around.

**Incontinence.** Incontinence was another matter. I understood that there would be a degree of incontinence after surgery, perhaps for six months or more. Nevertheless, I had trouble coping with my persistent incontinence. The need for rubber sheets on the bed, the wearing of diapers when pads offered insufficient protection, the frequent need to urinate in order to reduce leakage—all these conditions started to affect me emotionally. Once in a restaurant with friends, I started to cry as I felt the urine flowing without control as I sat there. My friends were kind enough to pretend not to notice. The lowest point came when I was caught in traffic on a day I had decided to go without a pad. Big mistake! I could see a Burger King only fifty yards away, but I soon knew I would not reach it in time. So there I sat, a business executive in a good suit and a nice automobile, wetting my pants and the car seat. (Humility, thy name is Incontinence!)

My urologist kept reminding me that it was only four months since my surgery. He also mentioned that the reconnection of my bladder and urethra had been “tricky.” I had to admit I was detecting some improvement, so I persevered. Then one day, exactly five months after surgery, I simply stopped leaking—just like that! My five-month experience convinced me that my urologist was right when he said incontinence came next in importance to excising the cancer.

**Impotence.** My surgeon had not attempted nerve-sparing in my case. The post-operative pathology report confirmed his judgment. It showed five tumors located so as to make nerve-sparing very risky, if not reckless, on his part. He was right again.

I soon learned that the newly available Viagra was not an alternative for men who had both neurovascular bundles removed during radical prostatectomy. I turned to the other alternatives available to impotent men. Two support group acquaintances told me they overcame erectile dysfunction by using the vacuum pump to gain an erection. My experience was different. I found the device to be awkward and unappealing. My understanding and cooperative wife and I would burst into laughter as I tried to manipulate it! If we weren't laughing so hard, we probably would have been crying! So much for the pump.

Next, we turned to MUSE, an interurethral device that inserts an aprostadil pellet into the penis. We found it moderately successful, and even more so when my urologist eventually prescribed the maximum available dose. We relied on it for several years. We were also aware of CAVERJECT which injects alprostadil directly into the penis. We avoided it for two reasons. First, it relied on a cumbersome mixing of the product prior to injection; more importantly, the idea of self-injection was a turn-off. I have trouble getting eye drops into my eyes, now I would be required to stick a half-inch needle into my penis? Forget about it! Eventually, one of my reservations about CAVERJECT was overcome when it became available in pre-mixed form. So we decided to try it and were pleasantly surprised. We now rely on it exclusively.

**The “Not-So-Big” Surprise!** Having selected surgery as my primary therapy, I was well aware of the possible side effects—*incontinence and impotence*. But nowhere did I read, nor did anyone tell me, about diminished penile length often associated with RP. I noticed this condition while the catheter was still in place, but I

attributed it to the temporary effect of the catheter. Not so! During a follow-up visit with my urologist, I called the problem to his attention. I sensed from his reaction that he was perplexed, even a bit defensive. He offered no explanation, although I would read later that diminished penile length is not an unusual outcome of the RP. His only advice was “to keep pulling on it,” the idea being that since the surgery was done only five weeks prior, there was still a chance to influence the condition. Wrong this time, Doc!

### **Getting Involved with Support Groups**

At the outset, I had no involvement with prostate cancer support groups. There were two reasons. First, I had the vague impression that they were “touchy-feely” groups, attracting persons comfortable with the Oprah Winfreys and Dr. Phils. Not for me! But there was a more basic reason. Despite the fact that the hospital had a prostate cancer support group, no one told me about its existence during the six weeks leading up to my operation. I learned of its existence during my hospital stay as I shuffled up and down the ward corridors, reading out-of-date bulletin boards.

My wife subtly, and not so subtly, encouraged me to attend a session. So I went, of course! I almost did not return after I heard one attendee say that prostate cancer was the best thing that ever happened to him. (Right! Sure!) My early suspicions were being confirmed. But I did go back and I was glad I did. I was impressed by the willingness of the group to talk openly and frankly about the very personal and intimate aspects of coping with the disease, especially the side effects of *incontinence and impotence*. Those were just the problems I was facing during

my immediate post-operative recovery. I learned no earth-shaking facts. After all, I had read enough to be very familiar with these topics. Nevertheless, I was sustained in no small degree by the shared experiences of the support group members. I have a whole new and favorable outlook on the value of prostate cancer support

groups. Just don't ask me to join in candlelight vigils!

### **How Am I Doing Now?**

It has been about ten years since my RP, so how am I doing overall? Well, my PSA continues to be undetectable; by any clinical standard, I am "cured." I am completely continent after that five-month bout with incontinence. And I am completely impotent, relying on a drug in order to perform sexually. My situation reminds me of the rock star in the 1980's who sang:

**"Now don't feel sad,  
Cuz two outta three ain't bad."**

**Editor's note:** The author of this first-person account prefers to remain anonymous. The name Rod Shorter is a pseudonym. The newsletter welcomes your personal experience in dealing with prostate cancer. If you have a story to tell, contact the editor.

**The WRAMC Us TOO newsletter, including back issues, is available on-line at the website of the Center for Prostate Disease Research (CPDR) at [www.cpdr.org](http://www.cpdr.org). The website also offers other useful prostate cancer-related information. Be sure to visit it regularly.**



## “THE DOCTOR IS IN”

**Dr. Judd W. Moul, FACS**  
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**Division of Urologic Surgery, Duke University Medical Center**

**(Editor's Note: Readers should not act on the responses without prior consultation with their own physicians.)**

**QUESTION:** I had a bilateral nerve-sparing radical prostatectomy two years ago. Although my pre-operative potency never returned, I have compensated with reliance on Viagra. Instructions accompanying the prescription caution the user to seek immediate medical assistance in the event an erection persists for more than four hours. I have seen that same caution in other places, but I have never read what the remedy is. What should I expect to happen if I sought medical attention for prolonged erection?

**ANSWER:** The use of oral medications to treat erectile dysfunction (ED) after prostate cancer treatment is now very common. Sildenafil Citrate (Viagra), Vardenafil Citrate (Levitra) and Tadalafil Citrate (Cialis) are all FDA-approved medications that help to improve blood flow into the penis to improve erection firmness or rigidity and duration. With Viagra now on the market for over 5 years, experience has shown it to be very safe and effective. In the setting of radical prostatectomy (RP), the success of these oral agents depends on whether the nerve-sparing RP was done. Specifically, when men have a non-nerve-sparing RP (i.e., the nerves on both sides of the prostate were cut during the operation), the chance of spontaneous erection firm enough for intercourse with or without oral medications is less than 10%. In men who have a unilateral nerve-sparing RP (i.e., the nerve on one side was not cut), the chance of having erection return without oral medications is 20-50% depending on a man's age, and in-

creases to 40-80% with the use of oral agents. For men who have a bilateral nerve-sparing RP (i.e., both nerves are spared), the chance of spontaneous erection is 60-95%, again depending on a man's age and overall health. With oral agents, this can approach 100% if the man is healthy and had good sexual function prior to the operation. It must be remembered that even with nerve-sparing, the nerves can become bruised and stretched during the operation and it can take up to three years until the final post-operative function is reached with or without pills.

Now to the question at hand about erections lasting more than 4 hours. This is called “priapism.” In my experience, this complication is very rare when using only oral therapy. In fact, I have never seen anyone in the ER for this complication when they were only using Viagra or one of the other pills. On the other hand, when men use penile injection therapy particularly with the prostaglandin drugs,

priapism is not uncommon. If it does happen, the man must get to the ER and ask the staff to call the urologist on call. The treatment may require an injection of medication into the penile tissues to cause the penis to relax and

release its blood. But to conclude, the chance of this happening with oral medications alone is very rare. The benefits of these oral medications far outweigh the risks involved in my opinion.



**QUESTION:** In my support group, men frequently remark that the biopsy was more distressing than the actual primary therapy they chose to deal with their prostate cancer. This was my experience too. Can anything be done to improve this situation?

**ANSWER:** Prostate biopsy is one of the most common procedures performed by contemporary urologists. As a bit of background, a prostate biopsy is indicated when a man has a persistently elevated PSA level in the blood that may indicate the possibility of prostate cancer. It is also indicated for men who have an abnormal digital rectal examination (DRE). In some men, multiple prostate biopsies may be indicated over many years due to a persistently elevated PSA or abnormal DRE that cannot be explained as due to other non-cancerous causes.

In the last 20 years, prostate biopsy has evolved quite a bit. Initially, the procedure was improved by the use of transrectal ultrasound to help guide the prostate biopsy needles. In 2005, using transrectal ultrasound is the standard of care for virtually all prostate biopsies. Also, the way the biopsies are done has changed over the last decade. Now, most urologists will use a 10-12 core biopsy procedure that has been shown to improve accuracy over the old “sextant” or 6 core technique.

In addition to using ultrasound and taking

10-12 biopsy needle cores, the use of local anesthetic to “block” the prostate has gained popularity over the last 3-5 years. Most urologists now use this block technique. However, since Medicare does not reimburse doctors for the needles or local anesthesia to do the block, some doctors feel they cannot afford to do this technique due to the financial pressures they face, such as skyrocketing malpractice insurance costs. Some doctors also use numbing jelly in the rectum to make the procedure more comfortable. In my own practice while I was at Walter Reed, I found the prostate local anesthesia block to help a lot with patient comfort. In my opinion, it did make a big difference. In my new practice at Duke, we also use the prostate block procedure.

Men undergoing a prostate biopsy should specifically ask their urologists if they will be using a prostate block technique with local anesthesia. Depending on the answer they get, they will feel comfortable working with their doctor or will ask for another opinion with a doctor who uses the block technique. Most urology clinics will have patient education handouts about prostate biopsy that you should ask for.



## **National Conference on Prostate Cancer - 2005**

### **“Exploring New Pathways; Sharing the Journey”**



**WHEN:** June 16-19, 2005

**WHERE:** Omni Shoreham Hotel, Washington, D C

**SPONSORED BY:**

- Foundation for Cancer Research & Education
- Prostate Cancer Research Institute
- Us TOO Prostate Cancer Education & Support

**MODERATOR:** Charles “Snuffy” Smith, MD



**REGISTRATION FEE:** \$50 (through April 15)

**CONTENT:** Dr. Charles “Snuffy” Smith, well-known practitioner and patient advocate, leads a distinguished array of prostate cancer specialists and spokespersons who present a broad spectrum of the latest developments in the fight against prostate cancer.

**OTHER CONFERENCE FEATURES:** Support Group Sessions, Caregiver & Partner Sessions, “Meet the Speakers,” Exhibits, Trip to Capitol Hill

**MORE INFORMATION AND REGISTRATION:** To see the detailed agenda, the participating faculty, and registration information, visit the website of the Prostate Cancer Research Institute at [www.pcri.org](http://www.pcri.org)

**Serving the Soldier-**

**Military Medicine in Iraq**

**Lieutenant Colonel James R. Jezior, MC  
Department of Urology, WRAMC**

(A summary of a presentation to the WRAMC US  
TOO on February 2, 2005)

Good evening. It's my honor to be here with you tonight to share with you my experience while serving in Iraq with the 28th Combat Support Hospital.

Let me begin by briefly mentioning the levels of medical care available to our soldiers in the field. First, and very important, is the immediate, on-the-spot care a wounded soldier receives from his buddy or the unit medic. Next, the soldier is moved to an aid station where, for the first time, the soldier will be seen by a physician before being sent to the supporting medical company. It is only at the third level (corps level), that facilities for surgery are available. That is the function of a combat support hospital such as the 28th Combat Support Hospital.

A combat support hospital resembles a mammoth tent city when it is deployed. The typical combat support hospital has 250 beds. My hospital actually had 296 beds. As you may know, our forces move fast these days, and these large hospitals just could not keep up with them. So based on the early experience in Iraq, the combat support hospital was re-engineered into two separate hospitals to make it more mobile. When we are on the battlefield, mobility is always a problem. We compensated by reconfiguring the way we do business by forming what we call "forward surgical teams"—I'll explain more about that shortly.



**(Editor's note:** Dr. Jezior now showed a series of slides depicting the layout and facilities of his hospital, as well as the environment in which it operated.)

Here is a forward surgical team in action. This is a two-bed facility that places surgical capability at the brigade level. As you can see, it is much more mobile than the combat support hospital. This picture was taken at Baghdad National Airport in the early phases. Notice the chemically-protected units that we were able to deploy. This is the inside of the treatment facility where the patient is evaluated initially before referral to surgery. Fortunately, chemically-protected facilities were not needed in this conflict, but it was beneficial to have them because they provided a protected environment from the dust and dirt that was everywhere. This mobile medical unit probably relocated more than any unit out there, moving north and south—literally hundreds of miles in its year of deployment.

Now let's look at a much larger combat support hospital. There is a helicopter landing pad to receive patients who then are taken to the emergency tent for evaluation before going to the surgical center. Each of these pods accommodate two operating tables. Here are the tents which we sometimes erect. The tent has

internal environmental controls. This plenum runs down the middle to supply either hot or cold air to maintain the right temperature. There is electrical lighting, but unfortunately it often burns out when temperature reaches about 115 degrees (as it often did!). We frequently worked without light.

This is the operating room. It can be moved as a separate container. It is linked to the rest of the hospital by narrow passage ways. This is one of the beds in the operating suite. Moving this hospital requires a substantial effort. Here you see us in the process of moving a forty-four bed segment. We are loaded on trucks and ready to roll, but what you see is only one of the four convoys required. The hospital itself can provide only about one-third of its transportation needs, so we must depend on supporting transportation units to redeploy.

This is Camp Doha in Kuwait. We left our own equipment at Fort Bragg because we were relying on equipment already pre-positioned aboard ships and sent to Kuwait as part of the Army's fast deployment strategy. We found ourselves unpacking, checking, and repacking this ten-year-old equipment! We had to choose what we wanted and discard what we didn't want. In addition, we moved several weeks before the actual invasion without much transportation support, so we resembled a nomad caravan crossing the desert.

We moved into Iraq on March 29, about ten days after we first landed in Kuwait. Here we are crossing the border into Iraq. The M-1s and Bradleys had crossed here about two weeks before. As we moved through, we saw many sights which you likely viewed on TV—burning oil fields, burned out vehicles, and abandoned equipment. After our nearly 400-mile

journey across the desert, we set up about 15 kilometers outside of Baghdad.

Now we had to establish the hospital. Everyone pitched in. As you can see, at the end of the first day we were covered in dirt, but we would not get to shower for about two weeks as we raced to put the hospital together.

Of course, we were not the only medical facility in the Baghdad area. This chart shows the location of all our medical facilities around Baghdad. As the theater developed and conditions stabilized, the medical structure became more consistent with Army medical doctrine. In patient evacuation, we would frequently overfly non-trauma hospitals to get patients directly to trauma centers.

Here you see patients coming off the aircraft and moving directly to our emergency treatment tent for evaluation and treatment. This is the operating room with two operating tables that I mentioned earlier. We frequently had between four and six tables running at a time, depending on the combat situation. Combat-wounded soldiers often require multiple operations affecting the extremities, head, chest, and abdomen. As you can see, it gets crowded in there.

Let's talk about why we need all these medical assets in a combat zone. Obviously in war—even in civilian trauma facilities—time makes a difference in who lives and who dies. This chart represents one thousand combat injuries in a generic distribution. While a certain percentage are head and neck injuries, the vast majority are limb injuries. If you look at untreated survival rate in the first twenty-four hours, about 36% of those patients will die. About half of those—17-20%—

will die no matter what we do for them. The remainder are survivable and they are the ones we can make a difference for. Thanks to commitment of medical resources manned by dedicated military medical professionals, the survival rates in Iraq are among the highest ever achieved in combat.

We did other things as well. There were very few Iraqi hospitals functioning in the early phases of the war, so we frequently treated the civilian population as a humanitarian gesture. This is one of the civilian hospitals in Baghdad. Their physicians are very good. The lack of electricity, water and adequate equipment hindered their efforts. As time progressed, however, their facilities seemed to improve dramatically.

Initially, we moved about the area rather freely. We were not quite as nervous about the population. There seemed to be a lull before the insurgency started to develop. The security situation was much different six months later. The Iraqi people early on were very pleasant, and appeared to be very supportive of us. I never saw that wane during my year there. After I returned home, I thought that many things on the news conflicted with my own experience in dealing with the Iraqi people. Of course, my experience may have been colored by the fact that the Iraqis I encountered were actually seeking us out for help. Overall, my impression was that the population seemed to appreciate our efforts.

This was an ammo dump right next door to us. A fire there caused us to evacuate the We had neurosurgery, ophthalmology, and other resources at the hospital in Baghdad, so we got the brunt of the combat injuries. About half of the trauma admissions were

entire hospital. We moved sixty patients to a medical company about three miles away. We returned to find ammo and debris scattered throughout the entire area. Fortunately, we stayed in the desert for only about six months, and then, like the Beverly Hillbillies, we moved into town into the secure Green Zone in Baghdad. Soon after I left, a small cafe and a nearby market were both bombed. Here is our Green Zone hospital with the helipad behind it. It used to be Saddam's hospital, and it had been badly looted. It took quite an effort to get it reasonably restored, but it beat the heck out of the boondocks!

I am very proud of what the 28th Combat Support Hospital accomplished in Iraq. We admitted almost 3,300 patients during the eleven months that we were functional there. Almost half of these soldiers returned to duty; the other half were evacuated from the theater. This chart shows you the distribution and intensity of the operation. About a third of the patients' injuries were critical enough for them to be admitted into intensive care units. About two-thirds of the patients that we saw were US personnel; the rest were a mixture of Iraqi civilians and Iraqi prisoners. The average stay of the Iraqis was often about three or four times longer than US soldiers. Our wounded or injured personnel requiring more intensive care would usually be flown to Landstuhl Army Hospital within twenty-four to forty-eight hours. The medical evacuation system was remarkable. My hat is off to the Air Force and its medevac teams. They likely saved a great many lives by getting patients quickly and safely to other facilities.

for gunshot, shrapnel and burns. We initiated the only burn facility in-theater and had about 111 patients in all with about 100 of those surviving their time with us. Many

others had gunshot wounds to the leg, unfortunately sometimes self-inflicted. For example, this patient exiting his Humvee caught his trigger on the door and put about five rounds through his leg. Multiple shrapnel wounds in the extremities was a frequent condition.

Many of the events you saw on TV—e.g., car bombs—translated into multiple casualties for our hospital. There were about seven major mass casualty events while I was there. Many of the casualties came to our hospital. One was an especially memorable incident. The nearby Iraqi Red Cross headquarters was car-bombed and a Chinook helicopter picked up all seventeen casualties. I later saw the father of the Chinook pilot on TV talking about his son. Sure enough, I believe his son's actions on the ground made it possible for us to save at least some of patients from that event.

All in all, it was an eventful, satisfying year in the sense that we were able to care for our combat-wounded, help Iraqis, and influence the evolution of military medicine. It was great to return home after one year, but the memories of the dedicated military medical professionals and what they achieved, and continue to achieve, will linger.

Thank you for listening. I enjoyed being with you. Are there any questions?

Q: Did you see or treat any particular types of wounds in the prostatic area?

A: I did see some prostate cancer out there, but I did not include it in my remarks. Also, a gunshot wound that penetrates the perineum is a very devastating wound. Eventually I started repairing as many as were feasible. Overall, I was involved in about 63 trauma-related urologic procedures.

Q: How much good did the body armor do in the cases where they had it?

A: It was very effective. Overall, I estimate that body armor reduced torso and abdominal injuries by about half. It really made a big difference. Of course, improvements still need to be made. For example, I recently read that adjustments should be made to the helmet and to protect the space underneath the arms. It's a tradeoff between mobility and protection. I leave the matter to the experts.



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◆ **WRAMC US TOO COUNSELORS** ◆ (AS OF MAY 1, 2005)

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

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Jack Barnes	Oakton, VA	(703) 620-2818	
Jack Beaver	Falls Church, VA	(703) 533-0274	
Jerry Bussing	Laurel, MD	(301) 490-8512	
Edward Courey	Silver Spring, MD	(301) 598-4092	
Gil Cohen	Baltimore, MD	(410) 367-9141	
Richard Dorwaldt	Burke, VA	(703) 455-8657	(Laparoscopic Surgery)
John Fellows	Annandale, VA	(703) 503-4944	
Tony French	Annandale, VA	(703) 750-9447	
Robert Gerard	Carlisle, PA	(717) 243-3331	
Ray Glass	Rockville, MD	(301) 460-4208	
Monroe Hatch	Clifton, VA	(703) 323-1038	
Bill Johnston	Berryville, VA	(540) 955-4169	
Dennis Kern	Reston, VA	(703) 391-9418	
Steve Laabs	Fayetteville, PA	(717) 352-8028	(Laparoscopic Surgery)
Don McFayden	Pinehurst, NC	(910) 235-4633	
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**RADIATION**

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Leroy Beimel	Glen Burnie, MD	(410) 761-4476	(External Beam Radiation)
Philip Brach	Washington, DC	(202) 966-8924	(External Beam Radiation)
Ron Gabriel	Bethesda, MD	(301) 654-7155	(Brachytherapy)
Irv Hylton	Woodstock, VA	(540) 459-5561	(Brachytherapy)
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Bill Melton	Rockville, MD	(301) 460-4677	(External Beam Radiation)
Oliver E. Vroom	Crofton, MD	(410) 721-2728	(Proton Radiation)
John Waller	Yorktown, VA	(757) 865-8732	(Brachytherapy)
Barry Walrath	McLean, VA	(703) 442-9577	(Brachytherapy)

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Ray Walsh	Annandale, VA	(703) 425-1474

**HORMONAL**

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Tony Bicknell	Springfield, VA	(703) 451-7517

**WATCHFUL WAITING**

Tom Baxter	Burke, VA	(703) 250-9676
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**SPOUSE SUPPORT**

Faye Lohmann	Kensington, MD	(301) 933-3678
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**OTHER THERAPIES/MULTIPLE THERAPIES**

Howard Bubel	Fairfax, VA	(703) 280-5765	(Cryosurgery, Hormonal, Sexual Function)
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S.L. Guille	Sumerduck, VA	(540) 439-8066	(Surgery, Radiation, Hormonal)
Glenn A. Leister	Lynchburg, VA	(434) 384-1661	(Surgery, Hormonal, Chemotherapy)
Hank Lohmann	Kensington, MD	(301) 933-3678	(Surgery and Radiation)
Charles Preble	Annandale, VA	(703) 560-8852	(Cryosurgery, Hormonal, Intermittent Hormonal)
Emerson Price	Absecon, NJ	(609) 652-7315	(Hormonal, Radiation, Cryosurgery)
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Ken Simmons	Alexandria, VA	(703) 823-9378	(Radiation and Hormonal)
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**◆ MEETING ANNOUNCEMENT ◆**

**WEDNESDAY, MAY 4, 2005  
7 PM**

**JOEL AUDITORIUM (SECOND FLOOR)**

**WALTER REED ARMY MEDICAL CENTER**

**◆ SPEAKER ◆**

**Myron I. Murdock, MD  
Medical Director of Vibrance Associates**

**◆ TOPIC ◆**

**“PREVENTING AND TREATING SEXUAL DYSFUNCTION IN THE  
PROSTATE CANCER PATIENT”**

