

WRNMMC Us TOO, Inc.
A PROSTATE CANCER SUPPORT GROUP
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◆ **AGENT ORANGE AND AGGRESSIVE PROSTATE CANCER** ◆

Men who were exposed to Agent Orange chemicals used during the Vietnam War are at higher risk for life-threatening prostate cancer than unexposed veterans, researchers have found. What's more, those who served where the herbicide was used were diagnosed with cancer about five years earlier than other men, on average, in the new study.

Agent Orange - named after the giant orange drums in which the chemicals were stored - was used by the U.S. military to destroy foliage, mainly in southern Vietnam. The herbicide was often contaminated with a type of dioxin, a potentially carcinogenic chemical.

Past research has suggested that U.S. veterans who served where Agent Orange was used are at an increased risk of lymphoma and certain other cancers, including prostate cancer. For this new study, researchers wanted to see whether exposure was more closely linked to slow-growing prostate cancers or aggressive tumors. Garzotto, et al., Portland Veterans Affairs Medical Center, Oregon, analyzed medical records belonging to 2,720 veterans who were referred to the Portland VA hospital for a prostate biopsy. About one in 13 of those men had been exposed to Agent Orange during the Vietnam War.

One third of all men in the study were diagnosed with prostate cancer, about half of which were high-grade cancers - the more aggressive and fast-growing type. When the men's age, race, weight and family history of cancer were taken into account, the researchers found those with Agent Orange exposure were 52 percent more likely than unexposed men to have any form of prostate cancer. Separating out different types of tumors showed the herbicide was not linked to an increased risk of slower-growing, low-grade cancer. But it was tied to a 75 percent higher risk of being diagnosed with aggressive prostate cancer. The researchers concluded that exposure to Agent Orange is a very strong predictor of lethal cancer. They cite the need for more research to establish why this is the case.

In the meantime, the study has important implications for individual screening decisions. Otherwise healthy persons who have been exposed to Agent Orange should discuss that issue with their doctors.

On the other hand, there were some reservations about the study. One expert not involved in the new study expressed concern about the study given the imprecise way it measured exposure, i.e., just asking veterans if they were exposed to Agent Orange or served in an area where it was sprayed.

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◆ ELECTION OF OFFICERS ◆

There was an election of officers at the meeting of the Board of Directors on May 30, 2013. The election was occasioned by the vacancies to occur upon the departure of Vin McDonald who is in the process of relocating. Jim Thompson was elected President and Jim Collins was elected Treasurer effective August 1, 2013. We are grateful to them for their willingness to serve in these important positions. We are also grateful to Vin for his twelve years of service within the WRNMMC Prostate Cancer Support Group. Vin intends to remain as the editor of our quarterly newsletter.

◆ MAY 30, 2013, SPEAKER'S REMARKS ◆

Our August program featured Catherine Gray, RN, urology incontinence nurse within the Urology Clinic, WRNMMC. Her topic was "Urinary Incontinence after Radical Prostatectomy." A summary of her presentation begins on page 8.

◆ MEETING SCHEDULE FOR AUGUST 1, 2013 ◆

Our speaker is Dr. Neal Barnard, president of the Physicians Committee for Responsible Medicine, a nationwide group of physicians that promotes preventive medicine and addresses controversies in modern medicine. He is widely published, especially in the role of nutrition and dietary influences on health. The title of his presentation is "Nutrition for Cancer Prevention and Survival."

Don't miss this opportunity to hear a distinguished speaker who always has something to say!

Join us at 7 PM, Thursday, August 1, 2013. Your family members and friends are always welcome.

**SEE THE BACK PAGE OF THIS NEWSLETTER FOR
IMPORTANT INFORMATION ABOUT THIS MEETING.**

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PROSTATE-SPECIFIC ISSUES

Prostate Cancer Patients Need Primary Care Physicians.

Although some men receiving androgen deprivation therapy for advanced prostate cancer receive bone mineral density testing, it is not routine. A new study found it is significantly more likely to occur when the men were being cared for by both a urologist and a primary care physician.

Androgen deprivation therapy, which is common and effective for advanced prostate cancer, can cause significant bone thinning in men on long-term treatment. Androgen deprivation therapy cuts off the production of testosterone by the male testes, which prolongs the life of men with prostate cancer, often by years. However, the therapy can cause osteoporosis, which increases the risk of fractures. Available treatments can help to reduce the extent of osteoporosis. Practice guidelines have recommended bone mineral density testing since 2002, but it does not seem to be carried out frequently enough.

To determine current levels of testing, a research team examined the medical records of over 80,000 men with prostate cancer in a Medicare claims database between 1996 and 2008. Though they found that the levels of bone mineral density testing had increased over those years, just over 11% of the men had received a test for osteoporosis in the last year studied. The absolute rates of bone mineral density testing remain low, but were higher in men who have a primary care physician involved in their care. Levels of testing were lowest in men being cared for by just a urologist alone.

Vahakn Shahinian, MD, and Yong-Fang Kuo, PhD, from the Universities of Michigan and Texas, respectively, emphasized that

bone care is not within the usual purview of most urologists and thus its diagnosis and management may be outside their comfort zone. This is not just urologists, as breast and colorectal cancer patients also tend to fare better when a primary care physician is involved in addition to their oncologist.

This study indicates that primary care physicians should remain involved in the care of men with prostate cancer. Additionally, urologists need to be more aware of the risk to bones. Men starting androgen deprivation therapy should be aware of the need to ask about the test. (Source: *Journal of General Internal Medicine* (2013; doi: 10.1007/s11606-013-2477-2 via Oncology Nurse Advisor, June 4, 2013)

Use of Testosterone Therapy. Those late-night ads telling aging men that "low T" may be the reason they've lost the spring in their step appear to be reaching their audience. Use of testosterone therapy has increased dramatically over the past decade, according to a new study. But experts worry that too many men may be taking the supplements without understanding the potential risks.

Researchers at the University of Texas Medical Branch, Galveston, say that the development of new drugs, particularly topical gels, also likely played a role in this trend. The study involved more than 10 million men aged 40 years and older. The researchers found use of testosterone therapy was three times higher in 2011 than it was in 2001. The investigators noted that 2.29 percent of men in their 40s and 3.75 percent of men in their 60s were taking some form of testosterone therapy by 2011.

While sales may be booming, the risks involved with supplements of the powerful

male hormone remain uncertain. One study presented last month at the annual meeting of the American Urological Association suggests that use of testosterone might be an underappreciated cause of male infertility. That study, from the University of Alabama, found that sperm production bounced back to healthier levels when some men being treated at fertility clinics stopped using testosterone supplements!

Another study published at the same meeting found that many online vendors of testosterone supplements accentuate supposed benefits from the drug, but minimize the risk.

That study, which looked at 70 websites from companies across the United States, found that just 27 percent of the online vendors described potential side effects, which experts say can include liver problems, male breast growth, increased male pattern baldness, possible harm to prostate health, raised risks for blood clots, congestive heart failure and a worsening of urinary symptoms.

One expert added that, due to these risks, men should be cautious before succumbing to "low T" advertisements. According to Dr. John Amory, professor of medicine at the University of Washington, Seattle, the supplements -- which can cost between \$75 to \$300 per month -- are currently "being oversold to patients."

In the new study, hypogonadism -- a condition that affects a man's ability to produce normal levels of testosterone -- was diagnosed in about half of the men treated with testosterone therapy. However, about one-quarter of the men given the hormonal treatment did not have their testosterone levels checked first. Of the remaining 75 percent of men who did have their hormone levels tested, it remains unclear what percentage had low testosterone levels.

The researchers concluded that this trend toward increased use of testosterone therapy has been driven, in large part, by direct-to-consumer marketing campaigns that have targeted middle-aged men and the expansion of clinics specializing in the treatment of low testosterone or 'low-T centers. (Source: University of Texas Medical Branch at Galveston, news release, June 3, 2013, via HealthDay News, June 3, 2013)

Oncological Outcomes Similar Despite Prostatectomy Timing.

Outcomes are similar between men with histologically comparable prostate cancer (PCa) who receive a radical prostatectomy (RP) after a period of active surveillance (AS) and those with low-risk disease who undergo immediate prostatectomy,

Satkunasivam, MD, University of Toronto, et al., identified patients on AS treated with RP. They compared 289 AS patients who were ultimately treated with RP to age- and PSA-matched men undergoing immediate RP after a diagnosis of low-risk disease who were candidates for AS (group 1). Patients on AS with progression to Gleason 7 disease were also compared with men treated who had similar de novo disease (group 2).

The RP-after-AS group had worse pathological outcomes compared to group 1, whereas group 2 and those patients undergoing RP after AS with progression to Gleason 7 disease had similar pathologic outcomes. Biochemical recurrence was low and comparable between the RP-after-AS group and group 1 (2.6% vs. 5.4% at a median of 3.5 years after RP. Both groups had comparable erectile function and continence.

"Radical prostatectomy after a period of active surveillance does not appear to result in adverse pathological outcomes compared to patients with a similar preoperative pathology," the authors

concluded. (Source: *The Journal of Urology* (2013;190:91-96).

Wait-and-see for Early Prostate Cancer.

Watching and routinely examining men with early, slow-growing prostate cancer is more effective and cheaper than sending them to surgery or radiation right away, according to a new study. The findings are based on a model of 65- to 75-year-old men that takes into account costs of tests, treatment and missed work, treatment side effects, men's quality of life and their chance of dying from prostate cancer.

Hayes, et al., Dana-Farber Cancer Institute, Boston, say that most of the men who are diagnosed in this country these days have low-risk prostate cancer. That type of disease may never grow large or fast enough to threaten a man's life. But treating it can cause side effects such as incontinence and impotence. The American Cancer Society estimates about one in six U.S. men will be diagnosed with prostate cancer during his lifetime, and one in 36 will die of the disease. The researchers compared the effects of immediate treatment after a diagnosis of low-risk cancer to one of two wait-and-see approaches.

With active surveillance, men had a prostate specific antigen (PSA) test every three months, as well as regular prostate biopsies and digital rectal exams. Watchful waiting involved a less intensive follow up, with PSA tests every six months and a bone scan every five years.

Among hypothetical 65-year-old men, 78 percent under active surveillance would ultimately undergo prostate cancer treatment, compared to 34 percent of those who went the watchful waiting route, Hayes and her colleagues found.

Because of that - and the fewer tests and biopsies along the way - watchful waiting turned out to be the cheapest approach. It

also didn't leave men any worse off than other treatment strategies, according to the researchers.

Their model showed that men's risk of ultimately dying from prostate cancer itself was 4.8 percent for those treated with active surveillance, 6.0 percent for watchful waiters and 8.9 percent among men who went straight to treatment. Men in all three scenarios had a life expectancy between 81 and 82 years.

Watchful waiting and active surveillance were both tied to improved quality of life, with a slight edge going to the less intensive monitoring, depending on what data was put into the model.

An observer said that this is an important study that adds to mounting evidence about the value of observation (watchful waiting) as a treatment option for many men, in particular for men with localized, low-risk prostate cancer. It offers better quality of life and lower cost. The vast majority of the data suggests that observation is superior to early intervention with surgery or radiation and that it's even superior to active surveillance, allowing men to live longer, live better and less expensively. (Source: *Annals of Internal Medicine*, online June 17, 2013 via Reuters Health)

African-Americans and Prostate Cancer.

A Johns Hopkins study of more than 1,800 men ages 52 to 62 suggests that African-Americans diagnosed with very-low-risk prostate cancers are much more likely than white men to actually have aggressive disease that goes unrecognized with current diagnostic approaches. Although prior studies have found it safe to delay treatment and monitor some presumably slow-

growing or low-risk prostate cancers, such active surveillance (AS) does not appear to be a good idea for black men, the study concludes.

The researchers say this study offers the most conclusive evidence to date that broad application of active surveillance recommendations may not be suitable for African-Americans, according to Schaeffer, et al., Johns Hopkins University Hospital. This is critical information because if African-American men do have more aggressive cancers, as statistics would suggest, then simply monitoring even small cancers that are very low risk would not be a good idea because aggressive cancers are less likely to be cured. A report of the study, posted online and ahead of the print version in the *Journal of Clinical Oncology*, describes it as the largest analysis of potential race-based health disparities among men diagnosed with a slow-growing, very nonaggressive form of prostate cancer.

The Johns Hopkins study also showed that the rate of increased pathologic risk, as measured by the Cancer of the Prostate Risk Assessment (CAPRA), was also significantly higher in African-Americans (14.8 percent vs. 6.9 percent). The 12-point CAPRA score is an accepted predictor of biochemical disease recurrence based on blood levels of prostate specific antigen, Gleason score, lymph node involvement, extracapsular extension, seminal vesicle invasion, and positive surgical margins.

All study participants, of whom 1,473 were white and 256 black, met current criteria for very-low-risk prostate cancer, and were thus good candidates for AS. The study showed that preoperative characteristics were similar for very-low-risk whites and blacks, although black men had slightly worse Charlson comorbidity index scores, a commonly used scale for assessing life expectancy. Detailed analysis showed that black men had a lower rate of organ-confined cancers (87.9 percent vs. 91.0 percent), a higher rate of Gleason score upgrading (27.3 percent vs. 14.4 percent) and a significantly higher hazard of prostate-specific antigen (PSA) defined biochemical recurrence (BCR) of prostate can-

cer. The latter measure is widely used for reporting the outcome of surgical prostate removal.

The researchers emphasize that the criteria physicians use to define very-low-risk prostate cancer works well in whites -- this makes sense, since the studies used to validate the commonly used risk classification systems are largely based on white men. But, they added that among the vast majority of African-American males with very-low-risk cancer who underwent surgical removal of the prostate, the researchers discovered that they face an entirely different set of risks.

The researchers note that they are developing new strategies to more accurately risk-classify African-Americans with newly diagnosed prostate cancer, in order to determine whether a patient should undergo active surveillance or have immediate treatment. The researchers also note that the main limitation to their study is that it is a retrospective analysis of the experience of a single academic medical center. As such, the study does not support the universal rejection of AS in black men, but, rather, should promote future studies to address whether alternate race-specific surveillance entry criteria should be used for African-American men to ensure oncologic parity with their white counterparts. (Source: *Journal of Clinical Oncology*.2013.DOI:10.1200/JCO.2012.47.0302)

Denosumab Delays Bone Mets in Non-Metastatic CRPC. Denosumab significantly delays the time to bone metastases in men who have non-metastatic castrate-resistant prostate cancer (CRPC) and a PSA doubling time of six months or less.

Egerdie, et al., Urology Associates/Urology Medical Research, Kitchener, Ontario, showed that the median time to the development of bone metastases was 25.9 months for patients treated with denosumab compared with 18.7 months for placebo

recipients, for a significant 23% risk reduction. In addition, the median time to multiple or symptomatic bone metastases was 44.6 months for denosumab-treated patients compared with 30.6 months for placebo recipients, for a significant 30% risk reduction.

The researchers said that they were not preventing bone metastases with this group of patients, who are the riskiest of the risky in terms of bone metastases. Rather, they improving quality of life.

Denosumab is a human monoclonal antibody that inhibits osteoclast-mediated bone destruction. The new study confirms a previous study showing that the medication delays time to bone metastases in patients with non-metastatic CRPC.

Of the 716 patients who were randomized to each arm, 427 in the denosumab arm and 419 in the placebo arm had a PSA doubling time of six months or less. The researchers focused their analysis on these patients. The men in the two groups had the same median age (73 years) and were generally similar with respect to other baseline characteristics.

The denosumab and placebo arms had similar proportions of patients who experienced adverse events (AEs). Serious AEs occurred in 44.9% of denosumab-treated patients and 42.0% of placebo recipients. The most common side effects were back pain, constipation, arthralgia, and peripheral edema. (Source: Renal and Urology News. June 26, 2013.)

Rise in High-end Treatment for Low-risk Prostate Cancer. The proportion of U.S. men with early, slow-growing prostate cancer who received robotic surgery and other expensive treatments increased between 2004 and 2009, according to a new study. Researchers found that use of those therapies also rose among men who were unlikely to die from prostate cancer

because they were sick with other chronic diseases when their cancer was diagnosed.

Evidence has been building that a wait-and-see approach might be most effective for men with low-risk prostate cancer that may or may not progress, rather than scheduling surgery or radiation right away. But both doctors and patients have been hesitant to adopt that strategy, also known as watchful waiting or active surveillance, researchers said.

One observer noted that there is no incentive for doctors to do it, because there is no real payment, and it is not easy to do active surveillance. Furthermore, some patients may prefer the most advanced technology and get rid of the cancer, making them feel more secure.

Hollenbeck, et al., University of Michigan, analyzed data on about 56,000 older men diagnosed with prostate cancer and covered by Medicare, the government's health insurance program for the elderly and disabled.

They found that among men with low-risk cancers, use of high-end treatment - including robotic surgery and high-precision radiation, known as intensity-modulated radiation therapy - increased from 32 percent in 2004 to 44 percent in 2009.

Likewise, the technologies' use among men with other serious health problems increased from 36 percent to 57 percent. Those high-end treatments largely replaced the use of older therapies, which became less common. Close to half of men diagnosed with low-risk cancer across the study period took a wait-and-see approach.

According to Healthcare Blue Book, prostate removal costs about \$13,000 - and robotic surgery usually adds to the price tag. In addition, treatment also comes with a risk of side effects including impotence and incontinence. However, one of the

challenges of taking a more conservative approach such as active surveillance is that

there are no standards for how often to check men to make sure their cancer hasn't grown, or on when to intervene. And it's not always clear which patients are the best candidates for watchful waiting or active surveillance. It can also be hard to tell which men have a limited life expectancy because of other diseases, and which ones can expect to live long enough to possibly benefit from treatment.

The researchers concluded that patients that are older and have low-risk disease or have a lot of other health problems should certainly have a frank discussion with their physicians about the perceived benefits of actively treating their cancer as compared to active surveillance. (Source: Journal of the American Medical Association, online June 25, 2013, via Reuters Health, June 25, 2013)

Soy Use Challenged. A new small study finds soy supplements don't prevent a recurrence of prostate cancer after surgical removal of the prostate. Bosland, et al., University of Illinois, said that many men think that soy is beneficial, but the risk of recurrence is not reduced. On the other hand, soy posed no adverse side effects.

All of the men studied had an increased risk of having cancer recur because their radical prostatectomy hadn't removed all the cancerous cells. More than 177 men were assigned to drink either a powdered soy protein drink or an inactive placebo beverage daily for two years. Levels of prostate specific antigen, a marker of prostate cancer, were measured periodically. At the end point, no significant difference was seen between the two groups in terms of cancer recurrence.

One expert, not involved in the study, thinks the study was too small to be definitive. He also cited Asian prostate cancer rates being

much lower than they are in the United States. Soy consumption in Asia starts almost at birth. The trial was stopped early because there was no benefit to the men taking the soy drink.

Overall, 28.3 percent of the men taking the supplement had a recurrence of their prostate cancer within two years -- 27.2 percent of the soy group and 29.5 percent of the placebo group. Men taking the soy supplement developed their cancer sooner than the men taking placebo (31.5 weeks versus 44 weeks), but this small difference was not statistically significant, the researchers added. (Source: WebMDNews from HealthDay News, July 9, 2013)



(AGENT ORANGE - CONTINUED FROM PAGE 1) Of those most heavily exposed in the military as best we know, only a relatively small percentage of them had elevated dioxin from Agent Orange in their blood when tested by the U.S. Centers for Disease Control and Prevention. Vietnamese who have high levels of that type of dioxin in their blood live in places where the chemical has become integrated into the food supply - or were sprayed directly with Agent Orange.

Another researcher who has studied the effects of Agent Orange agreed that not having blood dioxin levels is a drawback, but said the findings are consistent with past research and general thinking about the chemical.

Almost all studies have implicated that men with Agent Orange (exposure) either have higher-grade prostate cancer or a more aggressive clinical course, according to another independent observer who also wasn't involved in this new research. But, he added, as long as men are getting into the VA system and getting regular evaluations and treatment for cancer, Agent Orange exposure "is not a death sentence

by any means." (Source: <http://bit.ly/gzHzeL> Health)
Cancer, online May 13, 2013 via Reuters

"Urinary Incontinence after Surgery"
by
Catherine Gray, RN
Urology Department
Walter Reed National Military Medical Center

(Summary of a presentation to the WRNMMC Prostate Cancer Support Group, May 30, 2013)

INTRODUCTION

Thank you all for serving in our country's military keeping us all safe and free. I am honored to present this lecture to you this evening on urinary health after surgery. I would also like to acknowledge and thank Dr. Jezior, our Chief of Urology, for educating me in Urology and about urinary incontinence. I work with Dr. Jezior seeing patients in the Urology Continence Clinic. I am grateful to Dr. Jane Hudak for giving me this wonderful opportunity to be with you tonight. She does a magnificent job in educating men about their urological health.

I have a personal interest in understanding urinary incontinence and its effective treatment options for patients. At the end of this lecture the participants will understand what is urinary incontinence, recognize the human pelvis, become familiar with pelvic muscles, and be informed about treatment options for urinary incontinence.

THE MALE SKELETON

The male bony pelvis is located in the abdomen underneath the hips. There is a large hole in the skeletal pelvis in the area between the legs. This hole is filled in with muscle. These muscles are called the pelvic floor muscles. (Nurse Gray showed a series of slides depicting the male skeleton, pelvis, the pelvic floor muscles and the relationships among them.)

THE PELVIC FLOOR MUSCLES

There are several muscles within the pelvis. The organs located within the pelvis are the bladder, prostate, urethra and rectum. The muscles of the pelvic floor are located in the base of the pelvis between the pubic bone and tail bone. These muscles have three main functions: (1) to help support abdominal and pelvic organs; (2) to assist in sphincter closure for urine and stool, and; (3) to support external genitalia, such as the penis and scrotum.

The external urethral sphincter is the muscle which closes the urethra to stop the flow of urine. This sphincter is the primary mechanism to maintain continence after prostatectomy.

PELVIC MUSCLE FIBERS

You should be aware that the pelvic floor muscles have two different types of muscle fibers termed fast and slow twitch muscle fibers. The fast twitch muscle fibers react quickly to the increases in abdominal pressure caused by coughing or sneezing. They engage in strong, quick contractions such as the end of urination when the sphincter closes.

Slow twitch muscle fibers react slower, maintaining a constant tone supporting the bladder and urethra, and affecting the closure of the urethra and the anus. The slow twitch muscle fibers make up about

two-thirds of the pelvic muscle fibers and the fast twitch muscles fibers make up the remaining one-third.

You should exercise the pelvic floor muscles in a manner that targets both fast and slow twitching fibers. Exercising the short twitch fibers involves the quick, repeated contractions of the muscles of the pelvic floor for about three seconds each. Exercising the long twitch muscle fibers involves the contraction of the pelvic floor for a sustained period of time, say, about ten seconds. This improves muscle tone over a long period of time providing support to the bladder and the urethra. More about this later.

STRESS INCONTINENCE

Urinary incontinence is the involuntary leakage of urine. There are several kinds of incontinence. Following prostatectomy, stress incontinence is the most common type of incontinence. Stress incontinence is the involuntary loss of urine during activities like coughing, sneezing, lifting, and exercising. These activities cause abdominal pressure to rise, and this pressure pushes down on the bladder. If the muscles surrounding the bladder outlet (the urethra) are weak or injured, the muscles will be unable to completely close the outlet. When this occurs, urine leaks out. In stress incontinence, the volume of the leakage is typically low, but if you are using 6-8 pads daily, you may have urge incontinence or mixed incontinence.

Treating Stress Incontinence. The external urinary sphincter can be strengthened by exercising the muscles of the pelvic floor. The conditioning of the pelvic floor muscles to regain strength and function can be helpful in regaining continence.

Pelvic Floor Exercise. When contracting your pelvic floor muscles, it is the same squeezing sensation used when trying to hold back passing gas. You can use a mirror to observe the muscles of your anus contracting inward when you squeeze; or you can insert your finger in your rectum and squeeze. Then you have identified the correct pelvic floor muscles to contract.

When performing pelvic floor exercises, breathe normally and try to avoid holding your breath, or contracting your stomach, hips, or buttocks. If you are performing the exercises correctly, no movement of your body should be visible.

"How can I be sure that I am doing these exercises correctly?" This is the most common question I get. As I have previously mentioned, it is the same sensation you feel when you try to repress the urge to pass gas! Just imagine that you are in the presence of family and friends and you sense that frightful gassy feeling coming over you. What to do? You know what! You contract your anus and the muscles of the pelvic floor to make the gas go retreat into your intestine.

Strengthening your pelvic floor muscles involves conscious effort and consistent exercising. Two types of exercises need to be practiced:

(1) Short duration pelvic floor contractions. The first exercise is quick pelvic floor contractions: squeeze, relax, squeeze, relax, squeeze, relax. Then you should rest for ten seconds.

(2) Long duration pelvic floor contractions. The second exercise is a sustained pelvic floor contraction: squeeze for ten seconds. You should then rest for ten seconds.

You may find initially as you begin your exercise program that you cannot contract for more than a few seconds. Over a few weeks time you will gradually progress to ten seconds. To improve pelvic muscle function you must exercise daily. Begin with both short and long duration pelvic floor exercises three times a day. Progress at your own pace, doing more exercises over time. The amount of time required to see improvement varies from person to person.

Another frequently asked question is whether the ten-second hold is the maximum. Various sources give various answers. My recommendations are based on studies that provide convincing evidence. There are always different kinds of variables and levels of effort. So a young man in good condition could probably contract his pelvic floor muscles for more than ten seconds. Still, I recommend holding the contraction for ten seconds. The patient often thinks he has held for a longer period than he actually has. At the outset, the patient will experience muscle fatigue and it takes time to overcome it

URGE INCONTINENCE

On TV we often see commercials about "you gotta go, you gotta go." Urinary urgency is the pressing need to get to a bathroom due to a bladder spasm. It does not mean that your bladder is full and you desperately need to empty it. When a urologist refers to urgency, he is referring to a bladder spasm, that is, your bladder is contracting on you all by itself. This is not the same condition as actually having a full bladder that you truly need to empty. With urge incontinence, you likely are going to have a higher leak volume.

Looking at it another way, urge incontinence is the involuntary loss of urine when a strong need to urinate is present and there is no opportunity to get to the toilet in time. This occurs when the nerves controlling the bladder overact causing the bladder to go into spasms or contractions. These spasms occur before the bladder is full. What to do about it? As Americans, what we want is a quick fix - just take a pill and make it go away! We don't want to expend much effort; and we are reluctant to change our behaviors. Medication is the easy thing to do. The medications unfortunately can have unpleasant side effects such as dry mouth and constipation.

Treating urge incontinence. Well then, what can be done? Treatment for urge incontinence includes medication; abstinence from such bladder irritants as coffee, tea, alcohol, carbonated beverages, and citrus products; certain urge suppression techniques; percutaneous tibial nerve stimulation; and sacral nerve stimulation.

The caffeine within the coffee or tea stimulates your central nervous system which, in turn, stimulates your bladder to feel the need to urinate even when your bladder is not full. This is a classic example of urge incontinence.

Percutaneous tibial nerve stimulation. This technique is used to relieve urge incontinence for selected patients. It involves placement of an acupuncture needle into the tibial nerve of the leg and the use a small, hand-held computer to stimulate the tibial nerve which is part of the nerve system to the bladder. If the bladder is having a spasm, stimulating the tibial nerve makes the overactivity stop.

Sacral nerve stimulation. When several treatment modalities have failed, sacral nerve stimulation may be employed. It is a surgical procedure that emplaces a permanent nerve stimulator to relieve the bladder spasms.

MIXED INCONTINENCE

Mixed incontinence is the complaint of involuntary urine leakage associated with both urgency and exertion, coughing or sneezing. This type of incontinence involves both stress and urge incontinence together, so you can actually have different types of incontinence affecting you.

INCONTINENCE AND RADICAL PROSTATECTOMY

No doubt you are all aware of the potential side effects of the major therapies for prostate cancer. So what is the incidence of incontinence following radical prostatectomy? Studies indicate as many as 90 percent of men report incontinence in the first few weeks following prostatectomy and the removal of

the catheter. In the first year following surgery, continence returns for the majority of men, but about 5-20 percent will continue to have incontinence to some degree.

Post-prostatectomy incontinence is attributable to injury to the sphincter during the surgical procedure. A weakened sphincter is the most common cause of having post-prostatectomy incontinence. Those of you who have sought help for incontinence are familiar with the term intrinsic sphincter deficiency. The sphincter squeezes, but not well enough to keep you dry. Another reason for the incontinence would be damage to the pudendal nerve.

BIOFEEDBACK THERAPY

If you really want to be assured that you are doing the pelvic floor exercises correctly, we can employ biofeedback therapy. Biofeedback therapy utilizes a computer to help patients identify their pelvic floor muscles. I place surface electrodes on your buttocks near your pelvic floor and on your abdomen. Then I have you steadily squeeze and relax your pelvic floor muscles while I make an assessment of your performance of the exercises and your breathing.

PELVIC FLOOR BALL AND BAND

Just doing the Kegel exercise is not good enough. You have to have resistance exercise training. (Nurse Gray distributed pelvic floor balls and bands among the attendees and demonstrated their use in providing resistance training to strengthen the pelvic floor muscles. The inflated ball is placed between the knees and pressed between them. The expansible band is placed at the knee and pressure exerted against it. It takes about two months of daily, conscientious effort before improvement will be seen.)

ASSISTANCE WITH PELVIC FLOOR EXERCISES

There are several devices and techniques available to help locate, exercise and rehabilitate pelvic floor muscles. They include biofeedback therapy, electrical stimulation, the pelvic floor ball and elastic band, and adduction/abduction exercises.

Biofeedback therapy is performed by Nurse Gray under the direction of urologists within the Urology Department at the Walter Reed National Military Medical Center (WRNMMC). In addition to biofeedback, Nurse Gray provides instruction in the other devices mentioned above, as well as education in urinary continence, bladder retraining, and fluid/behavioral management. If you are eligible for military health care, your primary provider can consult with a WRNMMC urologist to get a referral to Nurse Gray.



INTERESTING WEBSITE. Stanley Klein is a long-time leader within Boston's prostate cancer awareness and education community. He is president of the Boston Prostate Cancer Support Group. In that capacity, he has developed and maintains its website based on many articles written by prostate cancer specialists. He combines this material with his own personal observations and the inputs from over 3,000 attendees who have attended his support group functions over the past twenty years. The website has six segments: Active Surveillance/Watchful Waiting, Causes and Prevention, Diet and Nutrition, Recurrence, Treatment Options, and Treatment Side Effects. You can access the website at www.bostonpcsupportgroup.com.

◆ **WRAMC US TOO COUNSELORS** ◆ (As of August 1, 2013)

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

SURGERY

| | | | |
|-------------------|-------------------|----------------|------------------------------|
| Tom Assenmacher | Kinsvale, VA | (804) 472-3853 | |
| Jack Beaver | Falls Church, VA | (703) 533-0274 | 1998 (Open RP) |
| Gil Cohen | Baltimore, MD | (410) 367-9141 | |
| Richard Dorwaldt | San Antonio, TX | (210) 310-3250 | (Robotic Surgery) |
| Michael Gelb | Hyattsville, MD | (240) 475-2825 | (Robotic Surgery) |
| Robert Gerard | Carlisle, PA | (717) 243-3331 | |
| Tony Giancola | Washington, DC | (202) 723-1859 | 2013 (Radical Prostatectomy) |
| Ray Glass | Rockville, MD | (301) 460-4208 | |
| Monroe Hatch | Clifton, VA | (703) 323-1038 | |
| Tom Hansen | Bellevue, WA | (425) 883-4808 | 1998 (Robotic Surgery) |
| Bill Johnston | Berryville, VA | (540) 955-4169 | |
| Dennis Kern | San Francisco, CA | (415) 876-0524 | |
| Sergio Nino | Dale City, VA | (703) 590-7452 | |
| Ed Postell | Collegeville, PA | (610) 420-6765 | (Robotic Surgery) |
| George Savitske | Hellertown, PA | (703) 304-3081 | 2000 (Open RP) |
| Artie Shelton, MD | Olney, MD | (301) 523-4312 | |
| Jay Tisserand | Carlisle, PA | (717) 243-3950 | |
| Don Williford | Laurel, MD | (301) 317-6212 | 2000 (Open RP) |

PROSTATE CANCER AND SEXUAL FUNCTION

| | | | |
|-----------------|-------------------|----------------|--|
| James Padgett | Silver Spring, MD | (301) 622-0869 | |
| George Savitske | Hellertown, PA | (703) 304-3081 | |

RADIATION

| | | | |
|------------------|--------------------|----------------|---------------------------------|
| Leroy Beimel | Glen Burnie, MD | (410) 761-4476 | 1987 (External Beam Radiation) |
| Bob Bubel | Grand Junction, CO | (970) 263-4974 | 2010 (Proton Beam Radiation) |
| Harvey Kramer | Silver Spring, MD | (301) 585-8080 | 1998 ((Brachytherapy) |
| Bill Melton | Rockville, MD | (301) 460-4677 | 2001 ((External Beam Radiation) |
| Joseph Rosenberg | Kensington, MD | (301) 495-9821 | 2009 (Brachytherapy) |
| Barry Walrath | McLean, VA | (571) 969-8269 | 2001 (Brachytherapy) |

INCONTINENCE

| | | | |
|-----------|---------------|----------------|--|
| Ray Walsh | Annandale, VA | (703) 425-1474 | |
|-----------|---------------|----------------|--|

WATCHFUL WAITING

| | | | |
|------------|---------------|----------------|---------------------|
| Tom Baxter | Haymarket, VA | (703) 753-8583 | Active Surveillance |
|------------|---------------|----------------|---------------------|

SPOUSE SUPPORT

| | | | |
|-----------------|-------------------|----------------|--|
| Renate Bubel | Fairfax, VA | (703) 280-5765 | |
| Karen Collins | Mechanicsburg, PA | (717)-766-6464 | |
| Betty Kramer | Silver Spring, MD | (301) 585-8080 | |
| Ellen Rosenberg | Kensington, MD | (301) 495-9821 | |
| Nancy Wallrath | McLean, VA | (703) 915-8108 | |

OTHER THERAPIES/MULTIPLE THERAPIES

| | | | |
|------------------|----------------|----------------|--|
| Howard Bubel | Fairfax, VA | (703) 280-5765 | 1995,1996 (Hormonal, Cryosurgery, Sexual Function) |
| Arthur E. Clough | Kerryville, TX | (830) 896-8826 | 1993 (Surgery and Radiation) |

Pete Collins
Charles Preble
Ray Walsh

Mechanicsburg, PA
Annandale, VA
Annandale, VA

(717) 766-6464
(703) 560-8852
(703) 425-1474

2007, 2009 (Surgery, Radiation, Hormonal)
(Cryosurgery, Hormonal)
1999, 2001 ((Surgery and Hormonal)

◆ **MEETING ANNOUNCEMENT** ◆

**THURSDAY, AUGUST 1, 2013
7 PM**

**ROOM 2525
AMERICA BUILDING (2D FLOOR)
WALTER REED NATIONAL MILITARY MEDICAL CENTER**

◆ **SPEAKER** ◆

NEAL BARNARD, MD

PHYSICIANS COMMITTEE FOR RESPONSIBLE MEDICINE

◆ **TOPIC** ◆

"NUTRITION FOR CANCER PREVENTION AND SURVIVAL"

We meet this month in Room 2525 (2d floor), America Building, at the Walter Reed National Military Medical Center located at 8901 Wisconsin Avenue, Bethesda, MD 20889. **This is a different location than previous meetings.**

Gate/Parking: If you enter the base through South Gate (Gate 2) off Rockville Pike/Wisconsin Ave, take the first right (Palmer Road South). On your left you will see the Emergency Room. Continue to follow signs to the America Building and the America parking garage.

Security: A military ID is required to get on base. 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 **no later than noon on Wednesday, July 31, 2013, to arrange for entry.** Have a photo ID card ready when arriving at the gate