

Yale CANCER CENTER *answers*

WNPR Connecticut Public Radio



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Dispelling the Myths of Prostate Cancer

Guest Expert: Charles Walker, MD

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Welcome to Yale Cancer Center Answers with your hosts doctors Anees Chagpar, Susan Higgins and Steven Gore. Dr. Chagpar is Associate Professor of Surgical Oncology and Director of the Breast Center at Smilow Cancer Hospital. Dr. Higgins is Professor of Therapeutic Radiology and of Obstetrics, Gynecology and Reproductive Sciences and Dr. Gore is Director of Hematological Malignancies at Smilow and an expert in Myelodysplastic Syndromes. Yale Cancer Center Answers features weekly conversations about the research diagnosis and treatment of cancer and if you would like to join the conversation, you can e-mail your questions and comments to canceranswers@yale.edu or you can leave a voicemail message at 888-234-4YCC. This week it is a conversation about men's health and prostate cancer with Dr. Charles Walker. Dr. Walker is Assistant Professor of Urology at Yale School of Medicine. Here is Dr. Steven Gore.

Gore Dr. Walker, you are an urologist, is that really a surgical profession?

Walker Absolutely.

Gore And do you do all aspects of urology?

Walker At a certain point in time I have. I consider myself to be somebody who in the first part of my practice was more of a general urologist. I did a lot of prostate cancer. More recently, I have really started to focus on the area of men's health, and it is sort of funny, because people say isn't all of urology men's health and in truth, it is. I think we as urologists deal with men's health across the board but the subspecialty area of men's health is now sort of a recognized subspecialty within urology that deals with areas of sexual dysfunction, reproduction, things such as low testosterone and erectile dysfunction and also prostate issues in general, so benign prostate diseases like BPH and others like that.

Gore BPH, what is that?

Walker BPH is benign prostatic hyperplasia and what that refers to is just a benign process whereby the prostate becomes enlarged and can cause urinary symptoms.

Gore And this happens in men as they age, is that right?

Walker This happens in men as they age. Statistically with each decade of life beyond 50, your risk of having BPH increases substantially.

Gore We will be interested in talking about that since today happens to be my 58th birthday.

Walker There we go.

Gore So your practice is not limited to cancer at all?

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- Walker No, in fact, at this point I probably do more of the men's health per se, erectile dysfunction and BPH. I am very interested in prostate cancer outreach as well, so I do less clinically and more outreach and education in the community and also research. I am involved with 2 clinical trials that I run at the VA Hospital in the prostate cancer space.
- Gore We will want to talk about that in a few minutes. I would like to say that it seems to me in the past 10 years the media has done, in particular Madison Avenue, has done a lot of promotion in this field of men's health starting with the FDA approval of Viagra but all of a sudden erectile dysfunction, low T, it is all over sports shows, it is a hot topic.
- Walker It is a very hot topic and I am glad that you bring up these different almost at times areas that seem to have conflicting interests, but there is the industry end of it in terms of companies that want to promote testosterone sales and things of that nature. For me, anything that brings attention to men's health is important and so while it is a hot topic and sort of a trending area, there is some real substance to it because we really are trying to make people aware that there are conditions that are unique to men for which we need to have very directed and personalized approaches to dealing with those issues and the reason it is so important is that men do not go to the doctor.
- Gore That is what my wife says.
- Walker We all know that personally.
- Gore They do not ask for directions either by the way.
- Walker We do not ask for directions and we do the same thing with our health and so we wait until we are lost before we start to look for help and we are trying to increase awareness, educate men about what sort of things might be going on with them and how to address them and how to prevent them, really. We want to be able to prevent issues and not have to always do reactive medicine when people come in and they already have disease.
- Gore At what age should men start thinking about this? We are all trained to at least encourage testicular self-exam in younger men, observe for masses, but after that, it is kind of like you are on your own buddy, and let us know if you have got a problem.
- Walker Unfortunately that is what has happened, but I think what we are trying to get men to understand is that across the continuum of a man's life, there are issues that they need to be aware of. There are ways that they can promote their own health. There are things that they can do to prevent illness and if you think

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it, the reason that probably most men do not worry about things until they are too late is that most of us do not have illnesses in our 20s and 30s and because of that we do not necessarily have to worry about whether or not we have a healthy lifestyle. We can eat what we want, do what we want and we do not get into trouble until later. Diseases really become manifest in all adults, men and women, as they start to age and get into their 40s and 50s and 60s, so we need to be ahead of the game and we need to find ways to educate men in their 20s and 30s, and say, listen this is what you need to start doing now and this is what you need to start thinking about now to prevent disease in your 40s and 50s.

Gore That is really important advice and so the question is, at what level are these kinds of issues addressed by primary care physicians? Who as I understand, younger men are also not seeing and at what point do people like you in urology get involved? Is that specifically over sexual and urinary problems or can you be involved in sort of general health counseling?

Walker I think that that is really the unmet need that we need to try to bridge. What happens is that we often do not see men until they have ED or they have urinary problems.

Gore ED means sexual dysfunction right?

Walker Erectile dysfunction.

Gore Difficulty with erection?

Walker Inability to have an erection that is adequate for intercourse, essentially either to initiate or to maintain that erection, that is the actual textbook definition but it does not have to be ED. There is a whole spectrum of sexual dysfunction and issues that come with that that become manifested as men get older and with relevance to prostate cancer, you know this is one of the major side effects or treatment for prostate cancer, so often times, we may not see men until they have had treatment for prostate cancer. We may not see men until they are in their 50s and have other risk factors for ED such as diabetes and obesity and heart disease and at that point, I am not going to say, it is too late because it is better late than never but we want to educate men and begin to explain to them what predisposes them from these issues when they are in their 30s and 40s.

Gore There has been a lot of controversy in the past, or at least conflicting data that is being presented to both general practitioners as well as the public, about prostate cancer screening and you mentioned about people having trouble with side effects of prostate surgery and the question has been raised whether men are having unnecessary prostate surgery because of screening, so who should be screened?

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Walker You bring up a great point and I am always happy to talk about this and try to set the record straight. There was an epidemic of over treatment for prostate cancer, and over diagnosis that took place, really after the PSA test was well established and we were able to diagnose cancers earlier. We then treated men more than we should and as a result of that, we have become very aware of what the side effects and harms of treatment are and those harms are significant. We can talk about those in a few minutes, but the problem I think is that the backlash of that is that everybody turned around and said, okay we need to stop screening and that was a big mistake and so those of us in the urologic community, and a number of other well established organizations in this country like the American Cancer Society, the American College of Physicians, the National Cancer Comprehensive Network, I can go on and on, recognize the importance of screening and we could do a whole show on this so I will not go on too far, but the United State Preventative Services Task Force came out with this level of recommendation which is essentially a recommendation against the routine use of screening for men with prostate cancer. It was based on 3 studies that as we came to look more closely at them, 2 of them actually showed benefit to screening and one did not and the one that did not had a lot of methodological flaws, so the way that it was set up was there were a lot of flaws there, so what we have taken from this is that screening is essential. It saves lives. It allows us to diagnose cancer at an earlier stage so that we can actually offer curative therapies and in some cases, we may not have to treat, but if we do not screen, then we do not know who has cancer and so we are very passionate in our advocacy that screening be done. The questions I think are, when do you screen? Who do you screen? And that is an ongoing debate. Right now, we follow the American Urologic Associations recommendation which says that routine screening for men should begin at age 55 and for sure should continue through age 70 and for men at risk, African-American men and men with a family history, we want to start much earlier, so we advocate starting at age 40 at Yale in our screening program, the American Cancer Society recommends age 45 to start for those groups, so we are not on the same page about when to start and how often to do it, but we all agree that it needs to be done. The most important issue though is that men have to be informed of the risks, both of screening and of treatment and they have to make a shared decision with their doctors, so no man should be coming in and we are simply ordering a PSA test for them. We have to sit down with them, really speak seriously about what the benefits and risks of screening are and then make that decision with them in a shared fashion and I think that is a responsible way to do it and that is really important.

Gore But PSA is not the only element of screening, is that right?

Walker The PSA test I think is the one that has really gotten all the attention, but really it is a two part thing right now. There is a rectal examination to examine the prostate, so that we can see if there are any what we call nodules or lumps in the prostate to suggest the presence of cancer and also the PSA test, so there is the PSA test and what we call the DRE.

Gore Digital rectal exam?

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- Walker I know I do not have to tell you that, and I think most men know exactly what that is, so those are two components and it is really important that we do both and that is what we want to make men aware of.
- Gore It is actually interesting, I moved up here a couple of years ago from Baltimore and at that time, I sort of decided for myself, that I would sort of walk the walk and not get screened anymore, and I set up a relationship with a new intern who gave me the option and I said no, I have decided to follow guidelines and not get screened and I was sitting in one of our Grand Rounds of one of your colleagues and I mentioned that to him and he totally disavowed me of that saying, wrong.
- Walker I am glad and I think I probably know who it was, but I think the real damage that has been is that not only are primary care doctors less likely to offer screening, but there is no discussion being had and I think that is really what bothers me the most, if you decide not to screen I think that is fine, it is a personal decision. If your primary care doctor thinks that you should not be screened, that is his or her choice, but I think that you have to inform people, give them the facts and let them make their own choice.
- Gore How confusing, and I am as a board certified oncologist working at Yale Cancer Center having come from Johns Hopkins Cancer Center and getting sort of mixed messages at the highest level, how is Joe Schmo from any of the neighborhoods supposed to process that information?
- Walker Absolutely, and I think that for you to say that really highlights just how confusing it can be and why it is so important and it is great that I can have this conversation with you so that you can now go out and be pro-voice, somebody that can clarify this for people, so that is really important.
- Gore We are going to need to take a short break for a medical minute. Please stay tuned to learn more information about prostate cancer and screening with Dr. Charles Walker.

Medical Minute Smoking can be a very strong habit that involves the potent drug nicotine and there are many obstacles to face when quitting smoking, but smoking cessation is a very important lifestyle change, especially for patients undergoing cancer treatment. Quitting smoking has been shown to positively impact response to treatments and to decrease the likelihood the patients will develop second malignancies. Smoking cessation programs are currently being offered at federally designated comprehensive cancer centers such as Yale Cancer Center and at Smilow Cancer Hospital at Yale-New Haven. The smoking cessation service at Smilow operates on the principles of the US Public Health Service clinical practice guidelines. All treatment components are evidenced based and therefore all patients are treated with FDA approved first line medications and smoking cessation counseling. This has been a medical minute brought to you

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Gore Welcome back to Yale Cancer Center Answers. This is Dr. Steven Gore and I am talking with our guest, Dr. Charles Walker about men's health in general and prostate cancer specifically. Carli, before the break, we were talking about sort of the mixed messages men have gotten about the dangers of prostate cancer screening and coming around to informed screening being potentially quite beneficial and I think again, speaking as a man of middle age and of course hoping one does not have cancer, as one approaches one's annual exam thinking about the screening and if it is positive and if it is positive in such a way that let us say everyone agrees that definitive therapy is going to be recommended or important, we all do really worry about side effects, so how do you counsel men about that? I mean we worry about both urinary problems and of course sexual problems?

Walker First and foremost you have to really be transparent about what those harms are and you have to tell them and listen. The data shows that there is anywhere from 50-75% chance that you can have erectile dysfunction after treatments for prostate cancer, whether that would be surgery to remove the prostate or radiation therapy which are probably the two most commonly practiced treatments for prostate cancer, so you have to make them aware that ED is a real potential outcome.

Gore Is it always very significant, as in you can never get an erection or is it variable?

Walker There is a spectrum and it depends on a lot of things, but obviously the better your health is, the better the quality of your erections are before you have treatment and there are certain techniques where you can try to spare function and so when you do the operation, the nerves that are necessary for erections travel very closely to the prostate and you can try to actually spare those nerves when you do the surgery and studies show that if you spare nerves in men who have good function before surgery, you can preserve erections in a good percentage of them. If you begin to institute treatments in the early period after surgery to begin to rehabilitate those nerves and also the penis itself, we call that penile rehabilitation, this is where we begin to offer treatments that have been shown to help preserve the health of those tissues and to allow them to recover.

Gore Can we discuss that on air?

Walker I think it is totally fair for the air. And so if we begin that early in the process after treatment then we see that men do better and they recover more function, so it is not necessarily an end-all and more importantly, there are a whole lot of treatments out there that go beyond the pill that are tremendously effective for men. We have injection therapy, we have what we call vacuum devices and also there is

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something called a penile prosthesis or penile implant as most people have heard of and these devices and these treatments are extremely effective at restoring erectile function, so even if you had treatment and could not have an erection at all after surgery, there are things we can do for you that are tremendously effective and that are well received by men and can restore quality of life. It is important that you tell men about these options and you make them aware that it is not necessarily the end of sexuality and provide them with options that can restore their function and their quality of life and I think that takes some of the anxiety and the stress away from the decision making process but you have to be upfront; I mean if you are not telling them that this is potentially an issue then you have sold him short and the same is true for incontinence, a significant percentage of men can have incontinence, it is unlikely that in good surgical hands or in people who are experienced to do the operation, you are going to see a high percentage of total incontinence which is where men are leaking constantly, but if you really ask men in a directed fashion, you will find out that a good percentage of them are experiencing some degree of leakage particularly in the first few months after surgery, so you have to make them aware and say, incontinence is a real potential side effect of treatment but again we have treatments that we can offer men that can restore their control and their continence and can make a real difference in their quality of life, so it is really important that we make them aware that these things that are out there.

Gore Back to the erection issue, for these men who are having problems that are requiring say a prosthesis or the injection therapy, are they able to orgasm or is that a separate problem or not a problem?

Walker Great question and one that I get asked a lot.

Gore We do not hear about that at all, we hear about the erection.

Walker But we have to talk about these things and this is a great place to do it because what happens is men come in to see me and they do not understand that and so what is really cool about these treatments is that they actually have nothing to do with orgasm, ejaculation and sensation, whether it be an injection simply to increase the blood flow to the penis, so it takes the place of an erection, everything else is going to be the same. The implants are similar in that they are entirely internal and what they really are is a mechanism to replace the blood flow, so men use these implants, they have a pump mechanism that they can actually access which we place right underneath the skin and they can actually cycle these devices to give themselves an erection which is much like a real erection prior to treatment, and so everything else is going to be the same. Now, the treatments themselves, the prostate cancer treatments themselves, can effect the ability to ejaculate, so there may be some issues there that we have to take into account but these are not affected by the treatment, so whatever you have coming out of your treatment in terms of your ability to have an ejaculation, is not going to be effected by the implants. The implants simply restore the blood flow so sensation, orgasm, everything else is going to be the same.

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- Gore And is it possible, again forgive my ignorance here, is it possible to experience orgasm in people who cannot ejaculate?
- Walker Yes, it is and so the reason that these men do not ejaculate and they will go through the process ejaculation and ejaculation is really a series of rhythmic contractions that happen that propel semen out of the urethra right, so what happens after prostate cancer treatments is that you no longer have the semen because the prostate has either been removed or it has been irradiated and you just are not producing the fluid any more, but the contractions still happen and the sensation of orgasm and the pleasure and everything else still happens, so you may have a dry ejaculate but you are going to go through the motions and you are going to have the sensation or orgasm and everything else is going to be the same but that is something that you have to make men aware of.
- Gore Because I think a lot of men do not realize these two experiences are separable.
- Walker Exactly and the other thing too is that for some men the process of actually having an ejaculation is very important psychologically, it is an important part of the process, so I think you have to make them aware that that is going to be different because if you do not, they could come in pretty disconcerted after their treatment for prostate cancer and I see men that come in and say, nobody told me that this was going to be an issue but once you let them know that there are ways for them to have an erection, ways for them to experience pleasure sexually and also to satisfy their partner's needs, that is really important and to have intimacy and that is an important part of their recovery process and I think it is one that we have to talk about and make more of.
- Gore Do the partners often come in for the pre-op discussions or is this mostly the guy comes in and is kind of curious how that works?
- Walker It depends. I think a lot of times what we see is that a guy comes in, has a prostate biopsy, comes back by himself, you give him the news and then within an hour you get a call from the spouse saying, what is going on, he did not tell me anything, and so almost always you are going to have that discussion or you should be having a discussion with your patient and their significant other, their spouse or partner and they ought to be part of that process but unfortunately, sometimes it does not happen as early as it should, before treatment and also after treatment, it is really important that you engage both partners in that discussion because both are involved and so one of the things that I deal with is that men will come back after treatment for prostate cancer to talk about ED and will be by themselves and will go through a process of talking it and they will decide they want to have an implant, they go home and tell the wife and then I get an angry phone call, what is going on or they will call me and say, well my wife is really not supporting this, what do we do? So I want to have everybody involved and we are actually working within urology on developing a clinical pathway for survivorship that would allow us to create established

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visits before surgery, after surgery, so that we can talk to men about the side effects of treatment, sexual function, sexual dysfunction and also urinary incontinence and begin to create the appropriate referral process for them to have different things done. There are men who need physical therapy, pelvic floor physical therapy after treatment which has been shown to improve continence and also sexual function, so we are working with our colleagues within our department and also with physical therapists to find ways to create those pathways and also some men require psychological counseling because they deal with depression and psychological stress and distress as a result of their treatments, so we want to be able to create a multi-disciplinary pathway for these men so that we can address all their quality of life issues.

Gore I imagine that it can be especially complicated since some of the medications used to treat depression can sometimes have adverse effects on sexual function.

Walker I think that you might be a men's health specialist in hiding because you really are hitting all the right questions and that is exactly right. The meds for depression, and we have not even talked about therapies that manipulate your hormonal environment, what we call androgen suppression therapy or treatments to suppress testosterone which can be an adjunct to surgery and radiation for the treatment of prostate cancer, and those bring on a whole list of sexual side effects, metabolic side effects, psychological side effects and so that is also a whole discussion on to itself but that is something else that we try to address in this form.

Gore Do you get involved at all in sexual rehab that is directed at taking away focus from the only valid sexual expression being penile, vaginal intercourse? I think in our society, media sort of promotes that this is the be-all and end-all but I know certainly in other aspects of sexual dysfunction, we hear a lot about the Masters and Johnson thing about learning to express each other sexually, pleasure to each other sexually in other ways, is that part of this?

Walker It goes well beyond vaginal intercourse or penetration. There are many different levels to intimacy and one of the important things is that when we begin to rehab these individuals we have to incorporate our colleagues in psychology who have a background in sexual health, so I work with one of my colleagues here, Dwain Fehon, and he has done a lot of work with me and it has been incorporated in our program. This has already been approved and is moving forward, but we have an affiliation now with our colleagues in gynecology who have been running this sexuality intimacy and menopause program here and we now are going to be a unified multidisciplinary sexuality and intimacy program for cancer patients within Smilow and Dr. Fehon and I are trying to work on ways to be together in real time in the clinic together. Right now, it is going to be a virtual relationship but we are going to be working together to address the male intimacy issues and that would allow us really to cover the whole gamut. I am not somebody who necessarily has the expertise to counsel people in all areas of intimacy. I do ED and I think I do it pretty well, thank you, but my colleague can then step in and begin to say, well listen there are

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marital issues, there are psychosocial issues that go well beyond your cancer and well beyond your ED that we need to address and heal so that we can move forward, so we want to have all the same people on the same page and that is a great point you bring out.

Dr. Charles Walker is Assistant Professor of Urology at Yale School of Medicine. We invite you to share your questions and comments, you can send them to canceranswers@yale.edu or you can leave a voicemail message at 888-234-4YCC and as an additional resource, archived programs are available in both audio and written form at YaleCancerCenter.org. I am Bruce Barber hoping you will join us again next Sunday evening at 6:00 for another edition of Yale Cancer Center Answers here on WNPR, Connecticut's Public Media Source for news and ideas.