

# How We Reignited Our Passion for Intimacy after Prostate Cancer – Steve Frohman and Cindie Hubiak, 2012



## Steve

One in six men in America today is affected by prostate cancer. According to the American Cancer Society, more than two million men living in the United States have been diagnosed with prostate cancer at some point in their life. I am one of those.

Women are impacted by prostate cancer at an exponential rate. After all, most men relate to more than one woman. In addition to being a husband/lover, men connect to women as fathers, brothers, uncles, colleagues and friends. Almost every woman could tell you a story about a man in her life diagnosed with prostate cancer. I am one of those stories.

## Cindie

Steve and I learned early on that the survival rate from prostate cancer is extremely high, which we found comforting. We also learned that even with the latest

nerve-sparing surgery techniques or the most accurate delivery of radiation treatment, there was a high possibility that Steve's physical ability to engage in an intimate relationship would be negatively impacted, at least to some degree.

Our journey from just surviving cancer to living a sexually fulfilled life was full of challenges we didn't anticipate.

Many of the physical aspects we enjoyed in our relationship disappeared after Steve's prostate was removed. This negatively impacted our entire relationship, until we learned to look at sex in a whole new way.

At first, Steve and I focused on all the traditional medical solutions with little success. The breakthrough came when we were able to better define the problem as a lack of intimacy and sexual fulfillment. We expanded the "playing field" and created dozens of solutions for intimacy.

It didn't start that way though. We took many wrong turns and lived in survival mode longer than needed. Soon after Steve's diagnosis, he withdrew. Using a laser-like focus, he researched his options to remove the cancer from his body. I didn't know how to reach him, and his distance caused me to withdraw from the relationship as well.

As we reflect back, we see how we approached Steve's diagnosis and our less than satisfying sex life from our own unique perspectives. In the beginning Steve and I didn't fully

appreciate how men and women approach and solve problems in different ways.

We were also very good at avoidance, a common human trait. Too often it was easier to ignore our lack of intimacy rather than address it. We found ourselves growing apart because of the cancer

diagnosis and treatment, rather than allowing the experience to bring us closer together. Based on conversations with other men and women impacted by prostate cancer, this happens frequently.

Fortunately, Steve and I kept exploring ways to improve our intimacy until we found what worked. I didn't want to be like a woman I had met who had divorced after 16 years of marriage because of the isolation and lack of sexual fulfillment in her marriage. Our individual stories follow, along with five tips for reigniting passion for intimacy after prostate cancer.

### **Steve's Story**

It was May of 2007, early on a Friday evening at the Jefferson Hotel in Richmond, Virginia. The mood of the group was festive as we were celebrating the retirement of a business associate.

I felt apprehension, as it was still late afternoon in Phoenix. I nervously anticipated a phone call from my urologist with my latest biopsy results. This was my third biopsy over a 15-year period. I had a history of an enlarged prostate and high PSA score ever since my first PSA test in my mid 40's. When my cell phone vibrated, I quickly stepped into the ballroom foyer to take the call.

Dr. Bans let me know that the results of the biopsy were positive, indicating cancer had been found. Although no cancer is good, he explained that my cancer was a less aggressive form. This meant there was time to evaluate and select the best treatment method for my situation. I know he intended this information to be somewhat comforting, and it was, in a small way; though the fact still remained...I had cancer.

Over the next few weeks and months, I worked closely with Dr. Bans, Cindie and a close friend to put a plan in place. I wanted to further understand and evaluate my situation, select a treatment option and undergo treatment. I ultimately selected surgery, and my prostate was removed six months later.

I asked Cindie to keep my diagnosis private. She resisted, but I insisted. I'm a private person and didn't want anyone to know. I didn't realize, at the time, how painful she would find this seemingly simple request. I wasn't overly interested in sex after treatment. I'm embarrassed to say I just ignored our lack of intimacy. We lived a busy life and everything seemed okay. What I didn't realize is that we were drifting apart and living more like roommates. I also didn't realize how unhappy Cindie had become.

### **Cindie's Story**

I didn't engage a great deal in Steve's search for treatment options. He answered my questions, I went to San Francisco with him for a second opinion and I met his surgeon once before the surgery. Early attempts to engage more with

Steve didn't work. He seemed to prefer to handle the situation alone, so I gave up and went on with my life.

Initially we focused on Steve's recovery, ignoring my growing unhappiness. After all, I didn't have cancer and my body hadn't undergone an intense surgical procedure. Although, after several quarterly zero PSA tests, I still found myself struggling in a relationship that didn't work for me.

Steve's diagnosis and treatment impacted me physically, emotionally and spiritually. I didn't like myself after Steve's recovery. I didn't feel desired as a woman and my self confidence plummeted. Steve wasn't interested in sex; something we learned later that is quite common in men treated for prostate cancer.

Eventually, I discovered that I had to address my issues if I wanted to find happiness. I would have to take the lead if I wanted to save our marriage. When I began to take responsibility for my situation and stopped blaming Steve, our relationship improved. When I got over feeling sorry for myself and settling for an unhappy marriage, I discovered ways to take the initiative to create a life where Steve and I looked at sex differently than we did before prostate cancer.

### **Steve – Reigniting Our Passion for Intimacy**

When Cindie and I began looking for ways to increase our intimacy, we started by defining sexual fulfillment.

My definition included emotional closeness, physical intimacy and mental intensity. I used words like trust, passion, vulnerability, oneness and excitement.

Cindie used a technique called circle drawing to uncover her definition of sexual fulfillment. She discovered sexual fulfillment meant aliveness, freedom, becoming one with God and an opportunity to get to know herself better.

Cindie and I didn't possess the skills necessary to reach sexual fulfillment, so we sought outside assistance. Cindie started an intensive study of men, improving her ability to communicate with me in order to get her needs met. We both uncovered destructive childhood patterns that required breaking.

We spent time with a tantrika, a woman who honors the beauty and fullness of sexuality and uses her knowledge to assist others. We learned how to move energy, the importance of slowing down and the necessity of scheduling time for intimacy.

Cindie and I also realized we each needed to go through a grieving process before we could completely heal and experience sexual fulfillment. We talked about our own mortality; the elephant in the room cloaked with our unspoken fears about death and being alone.

As we got to know ourselves better and took responsibility for ourselves—voila—we achieved sexual fulfillment and saved our marriage. Today we live a thriving life, filled with appreciation from our prostate cancer journey that

brought us closer together than we had ever imagined. We followed

five steps to reignite the passion in our life and in our relationship:

- Grieve. Anyone impacted by prostate cancer experiences immense change. Change means loss, which goes hand in hand with grief. You need to go through the process of the five commonly accepted stages of grief: anger, denial, bargaining, depression and acceptance. Then go through the process of these emotions again. Your experience will be unique. You may skip a stage or bounce backand- forth between several stages. Cindie and I live in the acceptance stage most of the time, assisting each other to grieve more when needed.

- Explore different solutions. Rely on a combination of resources, both traditional and non-traditional, to achieve a fulfilling sex life. Traditional resources include your urologist, other medical professionals and the use of pharmaceuticals. Non-traditional resources include a naturopathic physician, a psychologist, a hypnotherapist, a tantrika and a chiropractor. By balancing the benefits of high-technology Western medicine with the practices of a more holistic approach, Cindie and I ultimately achieved a more fulfilling relationship than we had ever imagined.

- Define and devote time to intimacy. Too often couples define intimacy as achieving a physical destination, i.e. an orgasm. Explore how you can broaden that definition. Learn how to look at your intimate relationship as a journey, one without a destination. You can do this best by scheduling intimate time together each week. Get to know each other's bodies without an expectation of

orgasm. Use all five senses during your intimate time and slow down. Christie and I amazed ourselves at the increased levels of pleasure we experienced simply by slowing down and expanding our awareness.

- Excellent communications. You achieve high levels of intimacy results when you, as partners, share feelings rather than thoughts. Learn what makes a safe environment for each other to make sure feelings are shared easily. Recognize the different communication styles of men and women. When I learned to just listen to Cindie without fixing the problem, she relaxed and felt closer to me. When Cindie learned to get my attention and make requests using a specific formula, I began to meet her needs every time.

- Believe in a thriving life. Know that you can do it. Commit to taking the journey. Be open to experiment. If you want a different result you must take a different action. You'll find things that don't work for you as a couple, stop doing them. You'll also find things that do work for you in your relationship, so make sure you do those things more often. By doing this you'll be creating the journey of a lifetime. Let Cindie and I know what works for you. Today, we celebrate Steve living cancer-free for more than four years. We also celebrate living a sexually fulfilled life.

Steve Frohman and Cindie Hubiak, co-founded Solutions For Intimacy™ to help men, women and couples get to the root of their intimacy struggles and enable them to live a sexually fulfilled life after prostate cancer. The program's cornerstone – The Personal Approach – addresses the physical, emotional and spiritual aspects of intimacy.

Cindie recently published a book titled "A Woman's Guide to Thriving after Prostate Cancer." It helps women and men gain new ideas, understanding and skills from her journey through what's typically considered a man's disease.

They can be reached at 480-607-6850 or [www.SolutionsForIntimacy.com](http://www.SolutionsForIntimacy.com).



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# Robotic Prostatectomy in 2014: Current Status, and Future Trends Ash Tewari, MD and others, 2014

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## INTRODUCTION:

Prostate cancer (CaP) is the most commonly diagnosed solid organ tumor in men in the United States. It is estimated that 250,000 men will be diagnosed and approximately 30,000 will die from the disease this year[1]. Prostate Specific Antigen (PSA) screening has led to stage migration of the disease; that is an increasing number of men are presenting with cancers that are confined to the prostate versus their historical counterparts. Currently, robotic prostatectomy is the most common surgical treatment modality for localized prostate cancer in the United States. Radical prostatectomy offers an excellent potential for cure, with cancer specific survival of 93% to 95%[2]. In this article we detail our current prostate staging protocol along with a review of the

literature as it relates to robotic prostatectomy outcomes.

#### PREOPERATIVE WORKFLOW: OUR CURRENT APPROACH

Transrectal ultrasound (TRUS) guided biopsy uses ultrasonic vision to guide at least 10 or more biopsy cores in patients with suspected prostate cancer. The limitations of transrectal biopsy are well described in the literature. Annually, nearly a million biopsies are performed in the US. A majority of cancers detected on TRUS biopsy in a screening population, will most likely not be clinically relevant disease [3].

Our clinic utilizes MRI-TRUS fusion, where an MRI image of the prostate is obtained prior to biopsy. Firstly, a multiparametric MRI of the prostate is performed. The radiologist will perform a standard reading of the MRI and identify regions of interest. This image is loaded onto a workstation where specific targets of the prostate can be identified. The biopsy needle location is co-registered with the MRI and specific targets of the prostate are taken. This approach offers several advantages in the active surveillance setting as well as the pre-prostatectomy setting (Figure 1).

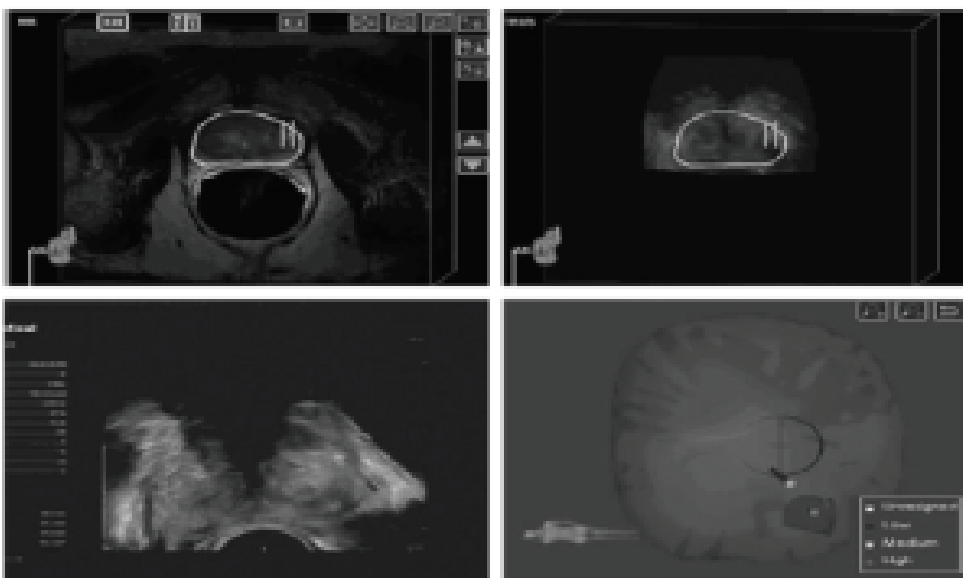


Figure 1: MRI-Fusion biopsy with planned biopsy targets.

Figure 1: MRI-Fusion with planned biopsy targets

#### The Steps to undergo a MRI-Fusion Biopsy

1. The prostate is scanned – Using a standard ultrasound connected to the fusion device; a 360-degree scan of the prostate is performed. This image is converted into a real-time 3D along with views in different planes (coronal, transverse, and sagittal). Image segmentation calculates the prostate gland boundaries and the prostate volume.
2. Biopsy Planning – Using MRI images, targets of interest where prostate cancer lesions are believed to exist are identified. If the patient has had a previous biopsy, we are able to input previous biopsy plans to locate where previous biopsy cores were taken. This plan can be used to revisit a positive core from a previous procedure to monitor disease progression in cases of active surveillance.
3. Biopsy – Using real-time biopsy needle tracking capabilities, we are able to accurately place the needle. The biopsy needle is placed into the prostate and a core is taken.
4. Reporting – We generate a report with images from the biopsy. This includes measurements made during the biopsies, such as linear measurements, prostate volume, etc. The report also includes type of plan and other navigational data.

An initial study utilizing fusion biopsy in 171 patients who underwent the procedure, investigated 106 patients under active surveillance for confirmed CaP, and 65 patients with increasing PSA, prior negative conventional biopsy CaP was detected in 53% of all men. MR-TRUS fusion biopsy based targeted cores had higher yield of 21% as compared to 7% for systemic biopsy cores. Moreover, a higher number of Gleason 7 cores (36% vs. 24%) were detected [4].

### **RISK STRATIFIED GRADES OF NERVE SPARING**

Nerve sparing (NS) has been found to be independently associated with post-operative recovery of erectile functioning in prostatectomy patients. Various approaches to NS technique have been described in the literature. This includes cautery-free [5], where no thermal energy is used during the dissection of the neurovascular bundle. Different planes of dissection have also been described, such as the

“Veil of Aphrodite”, where dissection of the prostatic fascia is carried to the prostatic surface, and the periprostatic tissue is released in an avascular plane [6]. Finally, a clip-less technique was also described [7].

Our risk stratified approach to athermal, traction free NS during robotic radical prostatectomy is based on the patient’s preoperative findings, which predict extra-prostatic extension (EPE). This preoperative decision making model incorporates serum PSA level, clinical stage, digital rectal exam findings, biopsy Gleason score and MRI findings. This workflow strives to optimize the competing goals of cancer control and preservation of continence and potency by varying degrees of preservation of the nerve fibers in different fascial planes (Figure 2) [8] [9]. These degrees of preservation are described as follows:

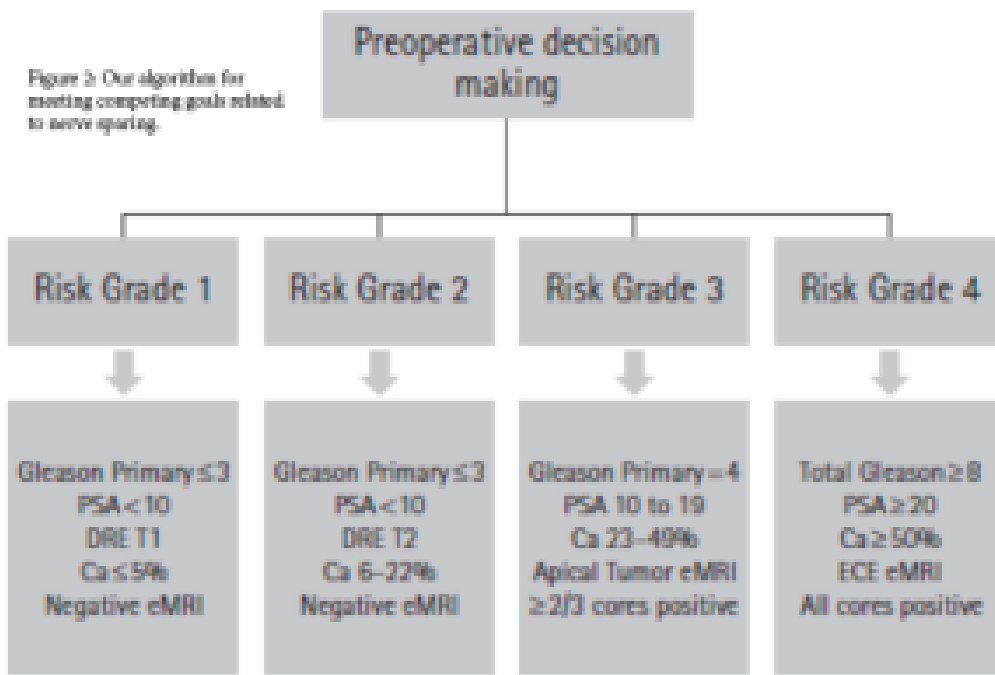


Figure 2.

**Grade 1 NS [nerve sparing]:** The Denonvilliers’ fascia and the lateral prostatic fascia (LPF) are incised just outside the prostatic capsule to preserve the neural hammock. We also describe this as medial venous plane for complete hammock preservation. This is the greatest degree of NS possible, and

we perform this procedure for patients with no-to-minimal risk of extra prostatic extension (EPE).

**Grade 2 NS:** The Denonvilliers' fascia (leaving deeper layers on the rectum) and LPF are incised just outside the layer of veins of the prostate capsule. This allows the preservation of most large neural trunks and ganglia and is used for patients at low risk of EPE.

**Grade 3 NS (partial/incremental):** An incision is made through the outer compartment of the LPF (leaving some yellow adipose and neural tissue on the specimen), excising all layers of Denonvilliers' fascia. This is performed for patients with moderate risk of EPE because some of the medial trunks are sacrificed, whereas the lateral trunks are preserved.

**Grade 4 NS (non-NS):** These patients have a high risk of EPE and are not candidates for NS. In such cases, we perform a wide excision of the LPF and Denonvilliers' fascia containing most of the peri-prostatic neurovascular tissue. In selected patients, we attempt nerve advancement of the identifiable ends of the neurovascular bundle.

These planes are developed athermally (no use of thermal energy) by sharp and blunt dissection, proceeding distally toward the apex and laterally on both sides. At the lateral attachments, the perforating arteries enter into the prostatic capsule. They are sharply cut after being secured by clips and the plane is created between the capsule and the medial aspect of the pedicular vessels.

Our cancer control rates are reported in Table 1.

## COMPLICATIONS

The perioperative complications rate in published reports ranges from 2.5 to 26%. The most common complications include hemorrhage, rectal injury, ureter injury, and stricture due to the anastomosis. The reported blood loss rate amongst robotic and laparoscopic prostatectomy case series is between 50-200 mL. Blood transfusion rates are 2% or less [10].

Intraoperative rectal injury occurs in 0.7% to 2.4% of cases. Ureteral injuries occur in less than 0.5% of all cases [11].

Anastomotic strictures following robotic prostatectomy in reported case series occur between 2.0% to 14.0% of cases. This usually is correlated with surgical approach and surgeon experience [12].

## OUTCOMES FOLLOWING ROBOTIC PROSTATECTOMY

### Surgical margins

Surgical margins are a measure of cancer control during radical prostatectomy. Negative surgical margins indicate that the cancer has been removed during surgery. In a meta-analysis with data abstracted from 400 original research articles representing 167,184 Open Radical Prostatectomy (ORP) Patients, 57,303 Laparoscopic RP (LRP), and 62,389 Robotic Radical Prostatectomy (RALP) patients (total: 286,876), RALP was found at least equivalent to ORP or LRP with respect to surgical margin rates. The overall positive surgical margin (PSM) rates were 24.2% for ORP patients and 16.2% for RALP patients; pT2 PSM rates were 16.6% for ORP patients and 10.7% for RALP patients; pT3 PSM rates were 42.6% for ORP, 39.7% for LRP, and 37.2% for RALP [13].

We present results from case series for cohorts of greater than 700 patients (Table 1).

## BIOCHEMICAL RECURRENCE

The American Urological Association defines biochemical recurrence as an initial serum PSA value equal to or higher than 0.2 ng/mL followed by a subsequent confirmatory level of PSA [14]. The European Association of Urology defines it as PSA values >0.2 ng/mL, confirmed by two consecutive measurements [15]. BCR is positively associated with the PSM, tumor stage and Gleason score. PSA elevations developed within the first 2 years following surgery are more often associated with distant metastatic disease. In a retrospective review of 357 open RP patients and 669 RALP patients who underwent surgery between 1999 and 2010 were compared for biochemical recurrence-free survival rates according to surgical approach, no differences were seen at 24 or 60 months postoperatively

between open RP patients (87% and 71%, respectively) and RALP patients (87% and 73%, respectively) [16]. In a similar study, evaluated 522 patients undergoing RALP with open RP patients; short-term follow-up yielded BCR rates of 93% for open and 94% for RALP [17].

### *Urinary Continence*

Urinary incontinence after radical prostatectomy is often caused by damage to the urinary sphincter and alterations in the pelvic floor musculature. Less often, unstable detrusor muscle can lead to urgency incontinence; while post-operative anastomotic stricture and/or low-compliance bladder can induce overflow incontinence. Various surgical techniques such as 1) optimizing preservation of urethral rhabdosphincter length, without affecting the positive surgical margin rate [18]; 2) total reconstruction of the vesico-urethral junction [19]; 3) preservation of puboprostatic ligaments and arcus tendineus. Incising the puboprostatic ligaments just proximal to the prostate apex, and careful dissection in that plane is used so as to avoid detaching the urethral rhabdosphincter from its anterolateral ligamentous attachments [20]; 4) periurethral retropubic suspension stitch [21]; and 5) nerve sparing [22] are known to improve urinary continence outcomes.

### *Sexual Functioning*

Postoperative potency rates ranging from 3.4% to 96.6% have been reported. These rates are largely dependent on the type of nerve sparing done and the surgical technique. For patients with postoperative erectile dysfunction, the choices of treatment include phosphodiesterase type 5 inhibitors (e.g. sildenafil, tadalafil, etc.), intraurethral or intracavernosal vasodilators, vacuum erection devices, and penile prosthesis.

### **CONCLUSIONS**

Robotic radical prostatectomy has been shown to be a viable option for patients with clinically localized prostate cancer. Future studies with longer follow-up will address oncological

outcomes such as disease-specific and overall mortality after robotic prostatectomy. In addition, questions regarding the economics of RALP remain.

In experienced hands, robotic assistance offers effective cancer control for prostate cancer patients. Furthermore, preliminary studies show that outcomes following RALP are promising. Finally, application of image-based diagnostic modalities such as MRI guided fusion biopsy, may better select patients suitable for robotic surgical treatment versus those best managed by other treatment modalities.

Table 1: Outcomes following robotic radical prostatectomy in select reported studies.

Author	Total cases	PSM	FU	Patients evaluated	Follow up method	Definition of continence	Continence rate, %	Definition of potency	Potency rate
Menon[US], 2003 [8]	3832	-	36 months	1142	Self administered, validated	No pad or 1 pad/week	95.20%	ESI	93%
Shikanov[US], 2009 [23]	1362	19.50%	24 months	380	Self administered, validated	No pad	80%	ESI	69%
Fatel [US], 2010 [21]	1100	10.64%	18 months	404	Self administered, validated	No pad	97.90%	ESI	96.60%
Tewari [US], 2011 [24]	2536	8.50%	>12 months	1335	Self administered, validated	No pad	98%	ESI	92.40%
Sonn[US], 2011 [25]	1436	13%	12 months	1105	Self administered, validated	No pad or security pad	93%	SHIM-16	84%

PSM- Positive surgical margin, FU- Follow up period

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# **Life After Prostate Cancer Treatment; Sexual Healing – Jeffrey Albaugh, PhD, 2015**

Jeffrey Albaugh, PhD, APRN, CUCNS

When a man is diagnosed with prostate cancer, he is not alone. Prostate cancer occurs in about 1 in 7 men in their lifetime (American Cancer Society, 2015). The most common treatments for organ-contained prostate cancer are radical prostatectomy [surgery] and radiation therapy. Both treatments are associated with excellent outcomes in terms of cancer control *for the right patients* (American Cancer Society, 2015). The good news is that the large majority of men with organ contained prostate cancer will survive prostate cancer. The challenging news is that many of those men will have sexual side effects that may impact their quality of life.

Sexual side effects may include dry ejaculation, penile shrinkage, and erectile dysfunction (Albaugh, 2012). Erectile dysfunction after prostate cancer treatment is common, with many varied statistics for prevalence. For example, a population-based study reported that 78% of men (average age= 69) continued to struggle with erectile dysfunction 2 years after radical prostatectomy (surgery) and 72% of men were still struggling 5 years after surgery (Penson et al., 2008). The

National Institute of Health (NIH) identified the definition of erectile dysfunction as the “inability to attain and/or maintain a penile erection sufficient for satisfactory sexual

performance" (NIH Consensus Development Panel on Impotence, 1993) and this definition was subsequently accepted by the World Health Organization and the International Consultation on Urologic Disease (Jardin et al., 2000). Ultimately, when any man is struggling with sex after prostate cancer treatment, it doesn't matter to him what the statistics say about how many men have these problems.

**Every man and his partner are different and may be in different places in their lives in terms of sex and intimacy.** Although some people remain sexually active throughout life, some do not. If intimacy and sex were a priority and important before prostate cancer treatment, they can remain important and sex can remain enjoyable after prostate cancer treatment. It is up to each individual man and/or his partner as to how he wants to move forward with sex and intimacy. This article is specifically written for men and their partners who wish to continue to have an intimate sexual relationship after prostate cancer treatment.

Intimacy can be defined as the process by which two people attempt to move towards communication on a deeper level and it may include verbal and nonverbal communication (Hatfield, 1982). Sex is described in this article as any type of genital stimulation for the purpose of pleasure. ***Sex and intimacy are intertwined, but they are two separate concepts.*** After prostate cancer treatment, intimacy and sex can be different, but still enjoyable. Most men who have undergone prostate surgery or radiation without androgen deprivation therapy will continue to have a normal sex drive. So the desire for sex is still there, but the mechanics of getting an adequate blood-filled engorged penis are no longer cooperating in some men.

During surgery the nerves which transmit signals for erections are dissected off the prostate (with typical nerve

sparing surgery) and left in the prostatic bed. The nerves were never meant to be touched and this surgical manipulation leads to inflammation and neuropraxia (the nerves are there, but they don't function). After radiation therapy is completed, the nerves for erections can eventually be impacted by the radiation, and erectile function may diminish. This is because the nerves for erections are not working properly to transmit information. After surgery or radiation for prostate cancer, the signal between the brain and penis may no longer be clear so the penis does not engorge with blood and become erect.

Some men also notice penile shrinkage after surgery, which is thought to be related to increased muscle tone immediately following surgery and then muscle atrophy from lack of erections (Gontero et al., 2007; Kohler et al., 2007). The shrinkage can be transient, but if erections do not return, it can be permanent. The nerves for the climax sensation lie out further than the nerves for erections and so most men will continue to enjoy the climax feeling, even without any erection. Although most men are able to and continue to enjoy orgasm/climax post prostate cancer treatment, some men describe the climax sensation as similar or diminished, albeit still enjoyable. A small amount of men report improved orgasm after prostatectomy. After radiation therapy, the sexual changes occur slowly over time (often not for 6 months after radiation treatment) as compared to the immediate erectile dysfunction that may occur after radical prostatectomy. Erectile dysfunction, changes in orgasm/ climax, and penile shrinkage may also occur after radiation therapy.

In the face of sexual side effects after prostate cancer treatment, the focus becomes how to reclaim intimacy and sex. Although it may be challenging, many men go on to have fulfilling, intimate sex lives. Probably one of the most difficult things to do is to re-align thinking about intimacy, sex, and erections. Although intimacy, sex, and erections are

intertwined, intimacy and sex can be enjoyed, and occur, without erections. Masters and Johnson did landmark research to determine that women do not need a hard penis to reach orgasm and climax (Masters & Johnson, 1970, 1986).

Most men with erectile dysfunction after prostate cancer treatment continue to enjoy orgasm and climax. If sex in the later stages of life is only about pleasure (no longer about reproduction) and there are many ways to experience pleasure that do not require an erection, then men and their partners can have pleasure and orgasms without hard erections. Anxiety produces adrenaline and adrenaline is part of the fight or flight response, so typically it will diminish erectile function. The more a man worries about erectile hardness, the more he struggles with hardness. It may be helpful to seek professional help from a therapist to help a man come to terms with the challenges of sex and intimacy after prostate cancer treatment.

In addition to therapy to deal with sexual issues, depression, or anxiety, there are several treatments for erectile dysfunction. Some of the treatments include various oral agents called PDE5 Inhibitors (Sildenafil, Vardenafil, Tadalafil, and Avanafil), the vacuum constriction device, the intraurethral suppository, and penile injections. The penis is mostly made up of muscle. Penile rehabilitation is used to get the penis back into shape after surgery or radiation (similar to how cardiac rehabilitation is used to get the heart in shape after a heart attack). The goal of penile rehabilitation is to improve blood flow to the penis, and therefore enhance muscle activity of the muscles surrounding the blood vessels in the penis through regular stimulation and/or the use of erectile function treatments (such as pills, the vacuum device, intraurethral suppositories, or penile injections). The muscles surrounding the blood vessels of the penis contract and relax as blood engorges and leaves the penis. When the penis becomes fuller,

thicker, and/or harder with stimulation, the muscles move around the blood vessels. This may help preserve muscle function while the nerves are recovering after surgery or not conducting as well after radiation therapy.

**All treatments have pros and cons and no treatment is right for everyone.** Men must understand the positive and negative aspects of each treatment and decide on the best option for them. Some men may decide to enjoy the many ways of having sex, intimacy, and climax without erections and the erectile dysfunction treatments, which are not needed for nonpenetrative types of sex.

Table 1 identifies some of the pros and cons to each treatment.

TABLE I. Advantages and Disadvantages of Each Treatment

TREATMENT	PROS	CONS
Oral PDE5 Inhibitors Viagra® (sildenafil), Levitra® (vardenafil), Cialis® (tadalafil), Stendra® (avanafil)	<ul style="list-style-type: none"> <li>Quick and easy to administer</li> <li>Discreet</li> <li>Suitable for travel</li> </ul>	<ul style="list-style-type: none"> <li>Poor efficacy rate in men after prostatectomy</li> <li>Expensive</li> <li>Side effects possible (headache, nasal congestion, flushing, stomach upset)</li> <li>Not everyone can take them (i.e. men who take nitrates)</li> </ul>
VACUUM CONSTRUCTION DEVICE Penis Pro-2 Sonotherapy (SP) Osion One (AO)	<ul style="list-style-type: none"> <li>Non-invasive</li> <li>High efficacy rates</li> <li>Fairly quick and easy after "mastered"</li> <li>Suitable for travel</li> <li>May be incorporated into foreplay</li> </ul>	<ul style="list-style-type: none"> <li>Cumbersome &amp; awkward</li> <li>Noisy</li> <li>Time-consuming to "master"</li> <li>Cool feeling to penis</li> <li>Penis is swollen at the base</li> <li>Challenges and comfort of wearing tension rings during sex</li> <li>May have side effects of bruising, pain, or discomfort</li> </ul>
INTRARETHRAL SUPPOSITORY (MUSE)	<ul style="list-style-type: none"> <li>Simple to use</li> <li>Less invasive than injections</li> </ul>	<ul style="list-style-type: none"> <li>Medication does not work well enough in most men</li> <li>Expensive</li> <li>Side effects may occur (pain, burning, hypotension, increased heart rate, dizziness, and lightheadedness)</li> <li>Some patients uncomfortable with putting medication in urethra</li> </ul>
PENILE INJECTIONS prostaglandin E1 (phosphodiesterase) papaverine Edex and Coverject	<ul style="list-style-type: none"> <li>High efficacy rates</li> <li>Reliable treatment</li> <li>No tension rings needed to hold erections</li> </ul>	<ul style="list-style-type: none"> <li>Invasiveness: need to inject the penis each time for erections</li> <li>Side effects possible (pain, bruising, bleeding, priapism, and Peyronie's)</li> <li>Need to refrigerate some medications</li> <li>Comfort level with self-injecting and the hassle of doing this procedure</li> <li>Travel is challenging since some medications must be refrigerated</li> </ul>
PENILE IMPLANT Titan (TR), AMS 700™, AMS Spectra™	<ul style="list-style-type: none"> <li>High efficacy rate</li> <li>High satisfaction rates</li> <li>No travel issues</li> </ul>	<ul style="list-style-type: none"> <li>Permanent changes to the structure of the penis</li> <li>Side effects (Pain, infection, mechanical failure, decreased erect size of penis, and erosion of the device through the skin)</li> <li>Surgery: some risks as any surgery</li> </ul>

The most popular treatments are pills because they are simple and discreet. However, they do not always work after prostate cancer treatment because the peripheral nerves are negatively impacted by surgery, radiation, or both. The lack of proper nerve impulse conduction causes communication issues between brain and penis leading to lack of the blood engorgement required for erections. Pills only work with sexual stimulation and if the communication is

not working between brain and penis, the penis will not respond. As nerves recover after surgery (which may take 1-2 years), the communication between brain and penis may improve, possibly leading to better engorgement and erectile responses with or without pills. As radiation eventually impacts the nerves for erections (which may take 3-12 months), communication between the brain and penis may diminish leading to decreased erectile function with or without pills. The pills have to be taken properly for maximum effect (typically on an empty stomach and waiting 1-2 hours for maximum effect).

The second most prescribed treatment for erectile dysfunction after prostate cancer treatment is the vacuum constriction device, which requires excellent one-on-one training for success. Just like other mechanical devices, a man must learn to master the vacuum constriction device through instruction and daily practice. With proper training and practice, the device has fairly high success rates, but it can be cumbersome and awkward.

Third, penile injections are commonly used in men after prostate cancer treatment. Since they work directly on the penis, they tend to work in the majority of men (Albaugh & Ferrans, 2010). Penile injections, like all other treatments, have pros and cons and are not for everyone since they require self-injection prior to each sexual encounter. In addition, they can have side effects in some men. The intraurethral suppository is fairly simple to instill immediately following urination, but it is not effective in some men and some men have side effects—pain or burning is the most common side effect.

Fourth, the penile implant surgery has been around for decades and still remains a viable surgical treatment option for erectile dysfunction. The implant permanently changes the structures inside the penis, so it is a final treatment option only to be used when other options are either ineffective or



undesirable. When considering each treatment option, it is important to understand how you might integrate the treatment into love-play with a partner. Each man should consult with a qualified provider to carefully examine the advantages and disadvantages of each treatment and determine the right treatment for them.

Sex and intimacy are about pleasure. Many men will continue to enjoy affection, cuddling, genital play, and orgasms after prostate cancer treatment. The penis has functioned and become erect for most men their entire life. Thus, lack of erections, penile shrinkage, and changes in climax can be very frustrating. Men struggling with sexual dysfunction can access expert help to deal with physical or psychological issues. Professional psychological help is available in terms of education, counseling, and therapy through [www.aasect.org](http://www.aasect.org). You can access a library of free videos on male and female sexual dysfunction at – <http://www.northshore.org/urological-health/patient-education/sexual-health-videos/>.

More in-depth information on this topic is also available in the book I wrote for prostate cancer patients and their partners “Reclaiming Sex & Intimacy after Prostate cancer Treatment” available through Amazon.com or at [www.drjeffalbaugh.com](http://www.drjeffalbaugh.com).

In addition, it is important to seek out a urology healthcare professional who can take the time to help men and their partners understand each treatment option (without any biases) and receive appropriate instruction on how to safely and effectively incorporate treatments into a man’s sex life.

After prostate cancer treatment, men and their partners can continue to have a fulfilling intimate sex life. Each man will experience changes in sex and intimacy to varying degrees and with varying importance. Most importantly, there is help and hope for sexual healing after prostate cancer treatment.

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