Chuck Ryan:

Hello everybody, and welcome to the third in our series of monthly webinars on topics important to men with prostate cancer and those who love them. I am Chuck Ryan from the Prostate Cancer Foundation, where I'm the CEO, and very happy to be joining you as the host for this session. As in previous webinars, we have really outstanding guests, and I'm really looking forward to my conversations with them, and I'm absolutely certain that you're going to learn from them tonight. Our next topic is going to be managing incontinence. Also an issue that becomes very important after treatment for prostate cancer, and I'm delighted to be joined by Dr. Lindsay Hampson, who is from the University of California San Francisco. She's an associate professor of urology there, and has multiple interests around genitourinary urinary reconstruction, adult male incontinence, and all of the treatments that can be done for it. And I believe what we're going to do here with Lindsay. Lindsay, great to see you. Dr. Hampson, I should say. We're going to have you do a short presentation, and then we'll ta take the discussion after that, and then the Q and A.

Lindsay Hampson:

Yeah, that sounds great. Thank you so much for having me.

Chuck Ryan:

Good to see you.

Lindsay Hampson:

I just love the questions already coming into the chat. There's so many people that are interested in talking about these issues. And before I get started, I want to say there was one question around, what do I do if I go to my urologist and they say, "Well, we've treated the prostate cancer and we don't care about anything else"? And that is not at all how we as urologists should be treating people. So, I love the focus of this session, on thinking about these really important quality of life issues that have such an impact on people's lives. And that's one of the reasons that I care so much about incontinence, is that I have the ability to really impact somebody's quality of life when we think about treating their incontinence. So, if you are ever seeing someone who says they don't know what treatment options there are, or they don't seem to hear you when you're talking about your impotence or your incontinence, go find somebody else who does, because treatment is out there and I think we need to be focused on getting more people to treatment when they need it.

So, I'm going to share these slides and this is really meant to just be a quick overview to try to get everybody on the same page. And I'm not going to go into too much depth, but I'm happy to talk more about it and answer questions as we go. So, I think a lot of times, when people are facing a decision about undergoing surgery for prostate cancer, they're focused on the prostate cancer and not as much on the long-term risks. But we do know, in big studies looking at Medicare databases, that about a quarter of men have some incontinence after prostatectomy. And we know that there are factors that impact this. So, older men, if you measure the sphincter length, people who have shorter sphincters or larger prostate size, those are all predictors of having higher risk of having incontinence after surgery. And we also know that continence is highly impacted by radiation. So, if you have surgery after radiation, which is less common, the rates of incontinence are quite high. If you have radiation after surgery, again, you might have a good result after surgery, and then you have radiation and you find that you're dealing with incontinence.

A question was asked in the chat about this. So, what's the timeline in terms of continence recovery after surgery? So, we really do see steady improvements for the first year. Now, everyone is different, and there may be some people who have a significant improvement right away and then have steady after that. There may be some who have just step-wise recovery during that first year. But what we do see is that beyond a year, there are very few people who will continue to get improvements in terms of leakage. So, typically we say where you are at a year is probably where you're going to be. There are some people who we wait until they get to a year to see how much their leakage improves. There are occasionally people who are leaking so much at six months that we may recommend treatment for them earlier.

Everybody talks about Kegel exercises. I'm sure you guys have talked about them on these webinars before. They're really helpful. We've seen in many studies how they can help improve time to continence, meaning, after surgery, if you're doing your Kegel exercises, you can decrease the time to your getting dry. However, studies show that using Kegels versus not using Kegels aren't going to actually impact your overall, long-term continence rates.

It is important to mention just that there's different types of leakage, urinary leakage. Stress incontinence is really what we're talking about mostly with this post-prostatectomy incontinence. It's because the sphincter itself, which is the muscle that controls urination in the urethra, is not working. There is also urge incontinence, which is caused by bladder overactivity, and this is often leakage that happens when you get the urge to urinate and you just can't get to the bathroom in time. And there are people who can have both. So, many of the patients that I see for stress incontinence, I'm also trying to assess if they have urge incontinence as well, because the treatments are different, and so we want to make sure we're treating both of those types of incontinence if present.

Typical evaluation for somebody with stress incontinence is to do an exam. I always think about their prostate cancer status and where they are in their treatment. And then, if somebody is going to get surgery, our guidelines recommend a cytoscopy, which is using a small camera to look inside the urethra. And that helps us to assess the bladder, the urethra, and importantly, lets us see if there's scar tissue on the inside. If there's scar tissue, then sometimes we need to deal with that before we can actually treat their incontinence. There are some more testing that can be done in the case of some patients, and that's reserved for patients who have mixed symptoms, people who we're not sure if they have more stress or urge incontinence, people who might have neurologic conditions that might impact their bladder.

So, in terms of non-surgical treatments, there are some good options that work really well for people. Obviously, people are using pads and diapers. Some people use condom catheters. The Cunningham clamp is something that I've pictured here on the upper right. This is a clamp that has a soft foam on the inside, and it basically acts like a clamp that you put on the penis. So, you can use it to basically stop urine flow. But the thing to know about it is you shouldn't use it for more than about two hours at a time, because it can cause injury to the skin or the urethra over time. So, these are really good for people who say, "I really don't want surgery, but I do want to be able to go out to dinner with my friends and not worry about smelling like urine during that time." Or, "I have some specific activity that I want to do where I don't want to worry about my pads, and whether I'm going to leak through them."

The AFEX system is another, that's on the bottom right picture, where, they're these briefs that basically have, some people like it better than a condom catheter, because they don't have to do the whole putting the condom on. But it's basically a urine collection system. And then, we're going to just really briefly talk about surgery and I'm happy to answer and talk more as we go, but one of the first things that a lot of people ask about is urethral bulking agents. These are basically substances that you inject into the bladder neck, and the goal is to decrease the leaking. They're nice because they're endoscopic

treatments, meaning that we give them with a camera, so there's no cutting, no incisions. We basically put a scope through the urethra and inject the substance. However, they're really effective in women, but they really haven't been shown to be effective in treating male stress incontinence. So, our guidelines really don't recommend it. And I think if you go to see a surgeon who's been trained in reconstructive surgery, most of us won't do urethral bulking agents, because they're not effective. If they do work, usually they don't have sustained results, and we see that it's very rare that they do work in the first place.

Another option is in terms of surgical fix is called a male sling, and this is basically a piece of mesh, and there are different types of slings. There's quad slings, there's the Advance Male Sling. There's actually multiple under development. I think in the end, though, they all work similarly, which is that they put a piece of mesh under the urethra and lift it up. The goal of that is to increase the outflow resistance, so that if you're pushing or straining or bearing down, which causes urine to leak, you're trying to increase your resistance so that you prevent that leakage from occurring. The nice thing that a lot of people like about the sling is that you pee like you normally do. So, once the sling goes in, you get the normal sensation to pee and you pee just like you always would. Slings are really great for people with mild to moderate amounts of leakage. They're not as successful for people who have large amounts of leakage, or if people have had radiation.

And then there's the artificial urinary sphincter. This has been around for a long time, it's gone through a few iterations, and I'm happy to talk about the next step of where this technology is going. But basically, it's a cuff that goes around the urethra, and it is a fluid-filled device. There's no electronics with it, but it's all a hydraulic system. So basically, this cuff that goes around the urethra fills with fluid and closes the urethra off and prevents urine from leaking out. There's a pump that sits in the scrotum, and when you want to pee, you get the normal sensation to pee. You push this pump in the scrotum, it opens the cuff up, it allows you to urinate, and then after about 45 seconds, it automatically refills and closes back down to get you dry again. There's a little balloon that sits up here near the bladder, and that holds all of the fluid for the system.

So, I've done a lot of research in incontinence, in looking at, how do we help patients make these decisions? We know that the surgical results for slings and sphincters, when people are well selected, we have great success rates, meaning getting people dry, and also very high satisfaction rates. And I put this picture up of a study we just published looking at who has regret about the decisions that they're making, and we asked all of these people that we saw at UCSF who were seen by a specialist in incontinence and counseled about treatment options for stress incontinence. "Well, after you made your choice of what to do, did you have regret about that?" And there were very low rates of regret for people who had surgery, either sling or sphincter. And regret was actually higher for those who chose not to have treatment, and this correlates a lot with the fact that they're continuing to leak, continuing to have to use pads and diapers to manage their leakage.

So, I think in the end, this is a really individualized decision, and it should be one that you make with your urologist, to think about what your goals are. When I talk with patients, these are some of the things that I talk about. If you've had radiation, like I mentioned, the slings are less effective. If you leak more, slings are less likely to be successful. If you don't like the idea of a device, and there's some patients that I see who say, "I just don't want this kind of device where I have to use it and have it in my body," then they'll opt for a sling, even if they know it may have a lower chance of success. Certainly, the sphincter, because it's a device and it has parts, it has a higher chance of complications and needing re-operation. But the sphincter also has the upside of really being more definitive in terms of guaranteeing you dryness.

And I think the important thing to remember is even if you have surgery for stress incontinence, there is always the chance that you have recurrent incontinence over time. And as we all age, and our body, our muscles kind of atrophy, our urethra does the same thing. And so, you can see years, usually about eight to 10 years after treatment, that people may have leakage that comes back and needs to be reevaluated again.

So, I'll stop there to try to keep it short and focus more on our conversation and answering questions, but these are my resources for people to look at. People always ask me about Kegels, and there's this awesome YouTube channel by Michelle Kenway where she talks about how to do Kegel exercises, so check that out if you're interested. I think I don't often send people to the web when thinking about medical treatments, but I actually really do like the patient-facing website that Boston Scientific has, because I think it has a lot of information and stories that are easy for people to understand. And then, lastly, I would just say when you're looking for a urologist, if you want an anti-incontinence surgery, I would really look for somebody where this is part of their day-to-day practice. You want somebody who does a lot of implants, who does this surgery all the time, so that you're getting the experience of somebody like that. So, I'm going to stop sharing. And yeah, Dr. Ryan, happy to have a chat.

Chuck Ryan:

Well, great presentation. I think already probably answered a lot of questions and demystified this process. And I think this is a process and a clinical scenario and a challenge that men go through, which is I think mystified a little bit because people don't want to talk about it, or people just decide to live with incontinence, and that's why we are so excited to have you tonight with us. Why don't you start, if you could, just tell us a little bit about how you got to be where you are, which is your training, and how is it that somebody becomes an incontinent specialist with the capabilities that you have?

Lindsay Hampson:

Yeah, that's a good question. Most people, not everybody, but a lot of people who are doing specialized male incontinence got there because they got a fellowship after their urology training. So, meaning they went through and became a urologist, and then they did some additional training where they were spending time. And often that's in what we call the reconstruction sphere. So, as part of my job, reconstruction takes on many different aspects, but incontinence is a big one of them. And so, that's when I say, you want to look for somebody who's really been trained to do incontinence surgery. It doesn't mean that they have to have done a fellowship, but certainly you want somebody who's had that specialty training in implants and incontinence, and you want to look for somebody who does this as a routine part of their practice, not somebody who's doing one to five a year.

Chuck Ryan:

I think it's safe to say that in urology, as in so much of other medicine, there are no jack of all trades anymore. There are people who are specialized in various aspects, and we just had a wonderful conversation with Dr. King about sexual rehabilitation, and she talked about the training and how this is something where there are those who know what they're doing in this sphere, and those who just don't have the experience.

Lindsay Hampson:

I was just going to add, I do also think, I worry that a lot of men are out there not getting to treatment because they may not have a urologist who knows about all of the options. And so, part of it is also just making sure we actually tell people, it's not just that you have to use pads and diapers. There are

options. And I think once you know that and you're empowered to know what those options are and what they look like, then hopefully we encourage more men to get treatment and improve their quality of lives.

Chuck Ryan:

Right. Well, that was my question, is why is incontinence so undertreated? And I think you just answered it, which is that many urologists don't know what can be done or don't have the capabilities of doing that, and they think pads are enough.

Lindsay Hampson:

Right. And to your point before, it's a private issue for a lot of people too. I have done some interviews of people with stress incontinence, and it's amazing to me how many of them say, "I've never talked to anyone else about this." Maybe their partner knows, but nobody else. The lucky person has been a part of a prostate cancer support group or has a friend who went through it, and they've been able to talk about it. But many people think, "Well, this is just the new normal, this is just the aging process." And so, they don't mention it, they don't talk about it.

I think we as urologists need to take some responsibility too. It's not okay when you're seeing somebody back for your prostate cancer follow-up for somebody to say, you say, "How many pads are you using?" And they say, "Oh, I use three pads a day." And they say, "Oh, okay, great." Check, move on. If you're using three pads a day, the question is, how much does that bother you and do you want to be evaluated for treatment? And so I hope that this also empowers patients themselves to say, "I want something more, and who can you send me to that can talk to me about options?"

Chuck Ryan:

You've talked a lot about the options, and I want to just go back and walk through the thought process you go through on who gets this and how you do that. And you've used terms like a lot of incontinence, you've made quantitative adjustments. But for folks who are out there, what is a lot of incontinence, and what is something where a little light should be going off saying, "I should be evaluated for this"?

Lindsay Hampson:

Yeah, great question. Well, first of all, I would say you should be evaluated if it's enough to bother you. So, really, there are some people who I treat who have very mild amounts of incontinence, very small amounts of leakage, and they just want to improve even that, because even that impacts their quality of life. So, if it bothers you, you should get evaluated. Now, in terms of volume, it's a great question. There are actually quantitative ways of measuring how much leakage you have. So, if you guys Google 24-hour pad weight test, for example, it will show you how to actually, in a 24-hour period, save up all of your pads and diapers and weigh them, and it'll give you a sense of how much leakage you have. And some people in studies have used that as a cutoff to say who's an optimal candidate for a sling versus who should be pushed towards a sphincter. So that can be helpful.

I think in general, if you want generalities, one to three, maybe four pads a day that are not fully soaked when you're changing them, I would consider that mild to moderate incontinence. If you're having to use briefs, if you're going through five or more pads a day, that's probably more on the more severe end of incontinence. But again, it depends. There's people who throw their pads out when they have a drop in them because it bothers them, and there's people who don't throw their pads out and change to a new one until they're completely soaked and overflowing. So, again, it matters. And a lot of my job as

the urologist is talking to them and understanding, how much are you actually leaking? Are you just leaking when you have sex, which Dr. King I think alluded to? Or you leaking as soon as you stand up, and you actually can't hold anything in your bladder? So there's a huge range, and all of it's valid. All of it can impact your life. So, you can get evaluated no matter how much it is, as long as it's impacting you.

Chuck Ryan:

Yeah, I mean, my experience from patients who have had, as an oncologist, I'm treating them for recurrent prostate cancer typically, but for many men, quality of life, their quality of life comes from their urinary control. And they go and they get these procedures, and they come back and their quality of life is so much better. So, I've seen it. So, that leads me to my next question, which is, what if it fails, and how does it fail, and what are the risk factors for these types of interventions to fail, and what do you do in those scenarios?

Lindsay Hampson:

Yeah, it's a great question and it's one that I talk to everybody about upfront, because I think it's good to go in with eyes wide open. So, there's a lot of different aspects we can talk about. I'll give some of the broad strokes. I think when we think about the slings, as I mentioned, the nice thing about slings is that they don't have that device component. So, we don't worry about them breaking over time and stopping working. But you can, even when you get a sling put in, there can be reasons that you want that sling taken out. Very rarely the sling works so well that you can't pee afterwards. That happens incredibly rarely, but it does happen from time to time, and people need the slings cut out after they've put in.

There are people who just won't get improvement from a sling. So, even though you put it in, it just isn't helping with their leakage. And so, then you have to reassess and say, "Well, do we want to move to a sphincter or do something else?" It's very rare with slings to get infection or erosion, these things that can happen that would make you urgently need to remove it. But you can see, as I mentioned, over time, 10 years goes by and everything, all your tissues atrophy, and you may get some recurrent leakage even though you've got great benefit from a sling upfront. And then you have to do a reassessment and say, "Okay, where do we think that leakage is coming from now? And then, what can we do about it?"

I think in terms of the sphincter, there's a lot more to think about, and I mentioned a little bit that I think the risks are higher in the long term for sphincter. First of all, it's a device. That device lasts on average for about eight years before some part of it breaks. Now, that means that it could last, I've replaced them as long as 20 years that somebody had one in that worked before it needed replacement. I've also had one stop working at three months. So, it really depends, but on average it's about eight years. And then, I think the big risk that I always warn people about with sphincters is that you can get infection of the device, and if the device gets infected, you have to remove the whole thing. Remember, it's a foreign body, so if it gets infected, the whole thing has to come out. And that's disappointing for men when that happens, because they go from being continent to all of a sudden being totally incontinent again.

Now, devices can be put back in after infection. You have to treat the infection, let things settle down, and then you can go back and put one in if people want it. Erosion happens when that cuff that sits around the urethra erodes through the urethra. And usually, men notice that because they notice some blood in their urine or they start to have infections. And in that case, the device, again, needs to be removed. The urethra has to heal and be repaired until you can potentially put another one back in again. Usually when I'm seeing people for erosion or infection, when I'm seeing them to take it out, their question is, "When can I get it put back in?" Because they've had such an impact from it, and they don't

want to go backwards again. But it is possible in a lot of cases to put a fresh one in after the acute process has resolved.

Chuck Ryan:

I've noticed that you haven't mentioned anything about medications, and there's some questions in the chat here about overactive bladder and things like that, and should those be treated with medications? Speak to that if you could, about the effectiveness or ineffectiveness of medical therapies.

Lindsay Hampson:

Absolutely. So, there's no FDA-approved medication to treat male stress incontinence. There's medications that have been tried. They really haven't been found to be effective, although sometimes people will try it, but they tend to have side effects, so it's not a no-risk situation. However, if somebody has concomitant urge incontinence or bladder overactivity, I absolutely use medications to treat that. And I find that if I see somebody with a mixed picture of incontinence, meaning they have this activity-related stress incontinence, but they also have the urge related overactivity incontinence, I want to treat their overactivity first, to see where the stress incontinence levels out. Because there are many patients where, once I treat their overactivity, their stress incontinence either becomes not bothersome at all, or the leakage becomes less, where we thought maybe when they came in, "Oh, you're really a sphincter candidate," we may actually decide that, now that we've treated the overactivity, a sling becomes a more viable option in terms of success rate.

Then, there's lots of ways to treat overactivity. There's medications. There's nerve stimulation, so you can actually do this type of acupuncture in a little nerve that runs behind the ankle bone, and that actually works as effective as medications to decrease overactivity. There's medications like Botox that you can inject into the bladder that help relax the bladder and stop that overactivity from happening. So, it's really important when I'm assessing somebody to listen to their history and to understand if they have some of that urge incontinence.

And I would say for patients, one easy thing to think about is when you have pure stress incontinence, when it's that activity-related incontinence, you're coughing, you're sneezing, you're leaking when standing up from a sitting position, at night, you should be dry, because you're lying down. You're not upright. So, if you're completely dry at night and you sleep through the night without having to pee, and even wear a pad, or you wear a pad at night but you wake up and every day it's dry. That often is a sign to me that you have more of that stress incontinence picture. If you're noticing that when you're waking up in the morning that you're wet, or you're leaking overnight or having to get up overnight, often that's a sign to me that you may have some urge-related incontinence, regardless of what's going on during the day. So, it can just be a nice window to differentiate that in people's minds.

Chuck Ryan:

So, there are a lot of questions here about treatment choice. If you've been diagnosed with prostate cancer, and let's just say, we kind of had this question for the last, Dr. King. If cancer control are equal on both sides and your major worry is incontinence, how should you treat your prostate cancer? You touched on this a little bit, but I think it bears a little bit more conversation.

Lindsay Hampson:

Yeah. Well, I'll say this, I think these choices are really individualized. And obviously there's people who have reasons why they want to pursue surgery versus radiation. So, all of your own personal values and

fears should play into that. So, if you're somebody who says, "I am deathly afraid of this activity-related leakage, I don't want it," well then, maybe that means that it should steer you away from surgery. However, we know on the other side, with radiation, that you are more likely to develop overactivity of the bladder, which can cause urge-related leakage. So, when we look at these big studies, like capture studies that look at all kinds of patients who are undergoing lots of treatments, there's impact on either side, whether you're doing surgery or radiation, to urinary function and bother. But I would say the bigger impact is definitely on the surgery side, because you have that immediate impact where you're leaking right away. Most people are leaking right away after surgery. It's pretty rare that people wake up, they get their catheter out and they're completely dry.

But if you look at a year, that's a better marker of where you've gotten after that one-year period of improving your continence over time. And that's where we see that about a quarter of men still have to wear something. Now, that may be that they just wear a safety pad, they put a pad in the morning, they wear that during the day and toss it out at night, and that may be just fine for them. And then obviously, there are people who have a lot more leakage than that. So, I do think it's important when going into these discussions with your urologic oncologist, talking about the treatment options, that you think about what's important to you. From my perspective, as I said, I'm a reconstructive urologist. I deal with all kinds of reconstruction. I do a lot of work on scar tissue in the urethra that gets formed after radiation. And so, I know that there are impacts that radiation have, apart from just causing leakage too, and all of that factors into the decision-making process.

Chuck Ryan:

Also, a lot of questions about our previous discussion on penile implants, et cetera. What about patients who have both problems that we're discussing? [inaudible 00:28:38] Erectile dysfunction and they need both procedures. Can you do both?

Lindsay Hampson:

Yes.

Chuck Ryan:

How do you sequence them, and how does that fare?

Lindsay Hampson:

Great question. Yes, you can have both. There's been studies done looking at doing them both at the same time, and the infection and complication rates are slightly higher if you do them together. So, I think the trend has been recently that most people will stage them just for the risk of, if you get a complication with one device, you worry about it affecting the other if you do it at the same time. So typically, I would say, when people see me or talk to me about it, I tell them, "Address the thing first that's bothering you the most, and we can always come back and do the other one later." And so, if somebody has a penile implant, I can absolutely do a stress incontinence surgery. Same thing, if you do a stress incontinence surgery, you can still go and do a penile implant if you want. So, both are absolutely treatable. There are probably some people who do them at the same time, but again, I think most are doing them sequentially just to avoid the risk of complications.

Chuck Ryan:

And are there predictors before the surgery? We talked about this in the last time, erectile function before surgery is the major predictor of erectile function after surgery or radiation. How do you speak to that issue around incontinence, and is there a way to assess before you even intervene at all against the prostate cancer and what the outcome's going to be, irrespective of the modality?

Lindsay Hampson:

Yeah, it's a good question. I think, unlike erectile function, where your pre-op function is so important, most people come into this discussion being continent. So, it's not like we have all these people that are already incontinent. I think the bigger predictor with incontinence really has to do with age. As you get older, you have a higher chance of developing incontinence after surgery. So, we've seen that in big studies, that the older patients tend to have a bigger drop in terms of their function and bother related to urination and urinary leakage after surgery, and they don't get as good of a rebound at that one-year point. Younger patients tend to do better. They see less of a drop and they get back faster to a higher level. That said, many younger patients are actually more bothered by it, because it may be that the older patients say, "Oh, I knew this was coming," and they live with their leakage, and the younger patients are really bothered by even a small amount of leakage. But we do see that, in general, older patients are more likely to have leakage afterwards.

Chuck Ryan:

And if you're seeing a patient and they're going to have their prostatectomy in six weeks, and they say, "What should I do to help prepare myself to ensure continence after surgery, or optimize," I should say, "What happens?" What do you tell them to do?

Lindsay Hampson:

I tell them, "Work on Kegel exercises," because I think it's helpful to have practiced ahead of time. And if you want to decrease that time to continence, meaning, after surgery, how long does it take you until you get to your dry state, then Kegel exercises are going to help with that. And I think that's something easy that you can be doing leading up to surgery to practice that. I think the other things that are helpful are just the things in general that are helpful for surgery. Eating a good diet, losing weight, stop smoking. Do the other things that can improve your recovery, because we know that that'll help overall as well.

Chuck Ryan:

Okay. A few questions coming in now, you've used the terms older and younger, and people want a little more clarity on what you mean by that.

Lindsay Hampson:

Yeah. Well, that's a really good question. And remember, and we always talk about this in this aging research sphere, that there's young 80-year-olds and old 60-year-olds, so you have to take it with a grain of salt. But referencing the studies that have been done, the studies have looked at different cut points of both 65 and older, and 75 and older. And if you divide people by that 65 cutoff or that 75-year cutoff, you see that as you're older than 65, you overall have worse outcomes in terms of your incontinence. And as you get older than 75, you, again, see a drop-off afterwards in terms of your continence afterwards. So, again, everyone's different. If you are a healthy, very active 75-year-old, you may actually fall more into that less than 65 category. It depends on who you are, rather than your, necessarily, stated age.

Chuck Ryan:

Right. And then, other questions coming in about insurance coverage, and is it complicated to get insurance coverage? Is this all covered? Can you speak to your experience and what you know more generally?

Lindsay Hampson:

Definitely. Medicare covers these procedures and, in general, we really don't have much trouble getting approval for insurance coverage for these, even in other insurance situations. So, in general, I would say that doesn't tend to be a barrier. Obviously there are some people who will have to investigate how much their copay is or what their out-of-pocket cost will be, but, unlike some surgeries, we really don't tend to run into problems with getting insurance approval.

Chuck Ryan:

Okay, good to know. I'm just surprised there are so many questions about the dual use of artificial urinary sphincters and penile implants. It's probably a third of the questions that I'm getting, so it reflects the popularity of this topic and the importance of this topic, I should say.

Lindsay Hampson:

Yeah, and I think it also shows, I mean, we see impacts in both. And whether you get radiation or surgery, we see these impacts. And I would say a lot of the times now that we're doing robotic prostatectomies, we're often doing nerve sparing. It may not be that you're seeing these impacts right away, but you may see them down the road. So, when we're treating recurrent prostate cancer with radiation, I see a lot of patients for stress incontinence after that happens. And they come and say, "I had great continence after my prostatectomy, then I got my radiation and my hormone therapy, and now I'm dealing with incontinence." And same thing, I think, can be said for erectile dysfunction, that it can be that there's a drop-off that happens immediately after treatment, but over time you can also see further decrements. And so, especially for radiation, which really works over time, we see that the falloff really does have a long lifespan. And so, there are, I think, a lot of people who are dealing with both issues, and certainly both issues can be treated.

Chuck Ryan:

A few questions about neurostimulation, more physical therapy beyond Kegels. Is there a time when one would see a pelvic floor physical therapist, and what do they actually do?

Lindsay Hampson:

Yeah, that's a great question. So, there's a lot of work that's been done on pelvic floor physical therapy. So, believe it or not, there are specialized physical therapists who literally are focused on the pelvic floor. And there's different types of pelvic floor therapy, depending on what the pelvic floor dysfunction is. On the side of people who need to work on Kegels and understand that they're doing Kegels correctly, sometimes meeting with a pelvic floor physical therapist can be helpful because they can get biofeedback to know, "Is this movement that I'm doing the right thing? Am I actually moving the muscles in the right way?" And so, they can get training on how to do Kegels the right way.

There are other people who need pelvic floor physical therapy to actually relax their pelvic floor. And so, some of that's nuanced and can be determined by both the urologists who's seeing the patient, and also these pelvic floor physical therapists are very experienced, and are great at doing assessments and

figuring out a treatment plan. When you look at the guidelines, so if you look at our associations and what they've said about pelvic floor physical therapy, and this is based on a review of all of the evidence out there, they've said that working with a pelvic floor physical therapist doesn't seem to impact your overall continence outcomes. Meaning, again, kind of like Kegels, it may help you in your time to continence, but it's unlikely, if you look a year, two years down the road, to actually impact whether you're continent or not.

Chuck Ryan:

And how can somebody find a pelvic floor physical therapist?

Lindsay Hampson:

Oh, really good question. I keep, and I think most of us do, I keep a list of pelvic floor physical therapists in my area, because once I find one that's good, it's like gold. And so, I keep a running list that I distribute to people. Often it's word of mouth, asking your urologist if they have somebody who they work with. And most of us will be able to refer people to the good pelvic physical floor therapist in our area. I will say, working with the pelvic floor physical therapist does present challenges insurance-wise. Sometimes, insurance coverage is difficult. Often you have to go through a process of, you get the referral to them and then you have to work with your insurance company to make sure that the person you've selected, that they'll pay for it. So, there can be a little bit of back and forth in that.

Chuck Ryan:

But is that person a standard member of an academic urology department? If we said [inaudible 00:38:10]

Lindsay Hampson:

Yes and no.

Chuck Ryan:

... Urology practices as well?

Lindsay Hampson:

Yeah. Some, yes. A lot of them are in the community. So, for example, at UCSF, we do have a specialized pelvic floor physical therapist that works with male patients. But I would say a lot of the patients that I see don't live in the city of San Francisco, and so, I send them to a lot of community physical therapy places. So, I would say the majority of pelvic PT people that I work with are actually not academically-based, and they're in the community. When you're asking around, you want to ask for somebody who specifically works with male patients doing pelvic floor physical therapy, and I would say if it's because you want to work on Kegel exercises, you specifically want to ask, "Does somebody work on Kegel exercises and do biofeedback?"

Chuck Ryan:

Yeah. Great, great. So, a lot of wonderful information, and we got just a few minutes left, and I want to talk about a few things that have also come up in the questions, and I think some of the other issues around just overall management of prostate cancer. We haven't really talked about ADT in this context, and its role in incontinence, in particular for patients who may have never had a prostatectomy. Maybe

they, god forbid, have metastatic disease, so they have to be on ADT, or they've not had radiation. So, that's number question number one. And then, question number two is, what about late relapses, if you will, of incontinence? In other words, we talk about this as a thing that happens right after surgery. And you showed that nice graph that I think went out to a few years. But the suggestion was that it's a problem right after surgery, but are there cases where people get it after many, many years after their initial treatment?

Lindsay Hampson:

Yeah, so, great question. So, first, regarding the ADT, this is an active area of study. So, there's been a lot of talk recently about hormone levels in the body, and particularly in the tissues and the urethra and the perineum, and looking at whether testosterone actually influences the health of the tissue. And there's some suggestion based on basic science studies that there is. And so, I think it's probably in the next few years, my guess is that we're going to be seeing more thinking about this, about how much ADT actually impacts the urethra, tissue atrophy in the urethra, and could that actually lead to problems? Even just when you're doing surgery, does it present risk if somebody's on ADT, because they're less likely to have robust tissue? So, TBD. We'll see. But I think there is some evidence that shows that probably there's some linkage there.

I think in terms of the late incontinence, really where I see it most is men who have their prostatectomy, may go through several years, five, eight years of being cured, and then they have a biochemical recurrence where their PSA becomes detectable again. And at that point, some of them are getting radiation for local recurrences. And I would say that's the biggest second wave that I see, is those people who are getting radiation for recurrences. They may have good continence after surgery, they've improved and they're in a steady state, and then that steady state gets impacted by the radiation and the ADT that they're on for their recurrence.

There are also people who we treat for stress incontinence. We do a surgery for them and it works well. And then, like I said, after years go by and they've had some tissue atrophy, they may have recurrence. So, for example, when we put a sphincter in, I can see people five, 10 years out who have, they say, "I was great for a long time, and then I kind of noticed that I started leaking again." And we evaluate them, and we find that their sphincter cuff, which was once a really nice fit and what kept them very dry, now is oversized because of that atrophy, and we can actually go in and decrease the size of their cuff in that case. So, there are chances to fix those recurrences of incontinence when they come back after you've had good treatment.

Chuck Ryan:

Well, this has been a very comprehensive review. There are a few more questions, but we've gotten to all of the most common ones, I think. I really want to thank you for your time. And just, if you could speak to those men out there who, they're tuning in and they have concerns, and maybe they haven't asked a question, but just give a little sendoff to our folks about what they should be doing and thinking if they're experiencing incontinence.

Lindsay Hampson:

Yeah, absolutely. I would say, I hope you can tell I'm passionate about getting people treated for incontinence, because I think it's this kind of unspoken thing. A lot of people are embarrassed or don't want to talk about it. But it truly impacts people's quality of life. So, if you are somebody who has incontinence and you haven't talked to somebody about it, but it bothers you and you want it treated, find somebody that you can talk to about it. So, if you feel like your urologist who you're seeing isn't

listening to you, get a second opinion of somebody who specializes in, whether it's sexual dysfunction or incontinence treatment, I really think it's important that, as urologists, we care, we should care a lot about people's quality of lives. And so, we're not just treating your prostate cancer, we're also treating the things, the sequelae of the prostate cancer treatment. This is something that so many men deal with, but they don't talk about it.

So, you're not alone. There's so many people like you, if you're dealing with leakage and impotence, and there are treatment options. And so, we should get people to specialists who can actually provide them with good treatment. And I'll say lastly, I see a lot of people for evaluation, for stress incontinence in my clinic. Many of them decide to have surgery, but a lot of them decide not to. And that's totally fine. Even if you just want to have a discussion with somebody about what your options are, what success might look like for you, you can still always decide that you don't want surgery. And there are many people that I see where I give them all the options and we talk about it and we do an evaluation and they say, "I'm not ready now, but I'll let you know if I am in the future." And sometimes those men come back and want treatment and sometimes they don't, but I'm just happy that they're learning about the options, getting informed, getting information, and being able to make the right choice for them.

Chuck Ryan:

Well, thank you so much, and we're at our time here, and I've learned so much just talking to you and listening to you. it's really been a delight. So, for those of you listening, I encourage you to go to pcf.org/guides to download free guides on prostate cancer and wellness. And join us on January 17th to discuss what to do when your PSA is rising after treatment, and we'll have Dr. Ashley Ross, a urologist, and Dr. Paul Nguyen, who is a radiation oncologist, joining me for that conversation. A really important one, and that's an area where I pick up a lot of patients and treat them as well. So, you can go to the pcf.org/pcfwebinarseries to register. And we always welcome your feedback, and thank you so much for joining us, and happy holidays and happy new year.