

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. So I'm really glad that you joined us. For those of you new to the Prostate Cancer Foundation, please know that we are the world's leading philanthropy dedicated to the mission of reducing the death and suffering from prostate cancer. We fund research all over the world in 28 countries now. We support transformational prostate cancer research to accelerate progress towards this goal, and we fund teams of scientists and individual scientists from multiple disciplines and multiple institutions all over the world, and we're thrilled to be able to do that and to carry out our education and our communications function this evening with this webinar.

I would like to also point out that pcf.org has multiple resources that you may wish to tap into after the webinar on many topics, as you can see, related to those who are newly diagnosed with this disease, the caregivers, survivors, and those who come from populations such as veterans and others who have special challenges perhaps and special opportunities and resources available to them. So we look forward to seeing you over on pcf.org and you can please feel free to sign up for updates and download our guides, et cetera, et cetera, and we look forward to seeing you there.

My first guest tonight is Dr. Sherita King from Augusta University Health, and Dr. King is a urologic surgeon specializing in male and female sexual medicine and prosthetic urology. She's an assistant professor at the Medical College of Georgia at Augusta University, and her expertise, as we will soon see, includes erectile dysfunction, penile curvature, low testosterone, low libido, male incontinence, and arousal disorder. And Dr. King is also very involved in the initial workup and initial counseling of men who are newly diagnosed with prostate cancer. Dr. King, great to see you. Thank you for joining us.

Dr. Sherita King:

Thank you for having me.

Chuck Ryan:

So I would love to hear a little bit about your background and how you got interested in this topic and what brought you to today.

Dr. Sherita King:

So I'm from Augusta pretty much. I've been here since 1989, second grade, and I grew up in the community. I ended up going to medical school here. While in medical school I was all over the place, wanted to do a lot of different things, and then when I rotated on urology it kind of clicked and I loved everything. I loved robotic surgery, I loved prostate cancer, I loved ureteroscopies, anything under the sun with urology. But when I saw the penile implant, that's what sold me on the field and I decided that this is what I wanted to do with my career. The reason why I think I got into it is because I saw there was a great need for patients after cancer treatments because they didn't understand what they could do to get back their function and how they can get "back into the game" with their partners.

I just wanted to be able to help patients in that way and bring that quality of life back, because my ethos is sexual health is health. A lot of times it's the back burner, but at our institution it is at the forefront. When we diagnose patients with prostate cancer, a lot of times they come to me right off hand and we

start discussing what we can do to make sure that they stay on track before surgery and what we can do after surgery or any kind of treatment to get them back functioning.

Chuck Ryan:

Well, you've chosen a great path, and as a testament by the number of people signing up, but curious about this topic and perhaps experiencing these challenges themselves. We're so grateful for your presence in the field and for your presence with us tonight. So let's walk through the journey of a patient who's newly diagnosed with prostate cancer. They come to see you and you're going to meet with them and you're going to talk about how to manage their expectations before surgery. Walk us through sort of your approach.

Dr. Sherita King:

So with any type of treatment, honestly, because I think that's a misconception with a lot of patients, and even some of the practitioners who are treating these patients, is that any type of treatment for prostate cancer can cause problems with sexual health, whether it be erectile dysfunction or even stress incontinence later. It's just a matter of when does it happen in the gambit for these patients. So when I see them, we go through what their treatment plan is, what they're going to be having done and what to expect. So the thing with surgery is that you have these effects up front. So as soon as you have the surgery, pretty much everybody's going to leak once they get their catheter taken out, and then everybody has erectile dysfunction upfront. It's just a matter of how much function they'll gain back over time, and that kind of depends on a bunch of different factors.

One is the grade of their cancer, how aggressive it is, the type of treatment that they had. So if they had surgery, did they do a nerve sparing, were they able to do that, or did they had to do wide excision? And then also what about their pre-surgery erectile function? So did they have problems that would lead to erectile dysfunction like hypertension, diabetes, hyperlipidemia, all these things, or high cholesterol? So if they have all these issues, all these things contribute to erectile dysfunction over time. So it just compounds things. So we kind of get an idea of what they should be looking for going into it. I get what we call a SHIM score, which basically tells me what's their baseline function so that way we can keep track of what they're doing after surgery. Then a lot of times I like to go ahead and start talking to them about penile rehab.

So if you think about it, when patients have heart surgery, they go to cardiac rehab. So for me, if you're having a prostate cancer treatment, you're going to penile rehab because we know that all these things are going to cause issues with the penis and its functioning. So what that entails is using a daily PDE5 inhibitor, which is medications like Viagra, Cialis, and then also using a vacuum erection device with that. With those two things combined, what we're trying to do is mimic the physiologic morning or nocturnal erections that men get because that helps increase the blood flow to the penis and keeps the tissues happy and healthy. So that's what I do pre-op. Now, afterwards, so if I don't get-

Chuck Ryan:

Sorry to interrupt, but you start patients on this before their surgery?

Dr. Sherita King:

Yes, [inaudible 00:06:54].

Chuck Ryan:

They start the Viagra, they start using a vacuum erection device well before their surgery, okay.

Dr. Sherita King:

If I can get my hands on them, yes, they're going to start it before surgery. Because in that way they know what to expect, because after surgery I know there's going to be a period of time where they're not going to want to do things. At least that way I know that they tried it and they've started it before. Now, after surgery we're going to still do that, but then once they get to the point where they're ready to try to engage in intercourse, then we try to figure out a way that we can figure out what treatment modality would be best for them, whether that be pills, injections, or we need to talk about the penile implant.

Pills and injections I usually will use in the first immediate post-op period up to a year typically to give them time to have their nerves recover, just so I know that we're not just preemptively putting or doing a surgery to someone that they don't need if they're going to recover their function. But once we get to a certain point, we know that they have reached their optimal function after their treatment. So that's when we start looking towards the penile implant if they're not able to achieve an erection with pills or injections.

Chuck Ryan:

But you're giving people a year after surgery to get to that optimal time, is that what I heard?

Dr. Sherita King:

That's typically what I do for most patients. Now, if somebody comes to me and they already have severe erectile dysfunction beforehand, then we will shorten that time, or there are some patients who are just like, "Listen, I just want to get back functioning." I try to have a good conversation with them so they understand that they may regain some of this function back, but we're realistic about it. So how bad is your function now? And we look at the timeframe. So if you're six months and you're not getting any erections with any treatment, the likelihood of you getting it back completely is going to be pretty slim.

Chuck Ryan:

Are there cases when you can tell immediately after the surgery because of the extent of the resection where you can say this person is probably unlikely? Can you give a prognostic index, a prognostic score based on the surgery result that you see, the surgical report?

Dr. Sherita King:

Yeah, typically if they have a complete non sparing, and I know they did wide excision, you pretty much know that they're not going to be able to get a lot of their function back, especially in the patients who've had erectile dysfunction beforehand.

Chuck Ryan:

Before we leave this topic, what about radiation? We talk about surgery as being the main risk to erectile function, but radiation doesn't get off scot-free here in terms of this being free of causing this problem, correct?

Dr. Sherita King:

Yes, absolutely not. So the thing with radiation is that what it does is it actually ... So when they're radiating, yes, we are doing a lot better these days than what we used to do. We're able to focus the beams a little bit better, but the penis is still an innocent bystander. If you look at the anatomy of the penis where the end or where the penis terminates inside the body, you have the urethra that goes right there, that urethra's what's connecting to the prostate and going up to the bladder. So you know that little area there is going to get hit by the radiation. So what happens with these patients is that it's more of a insidious process. So it starts off slow. So they'll notice I'm not able to maintain the way I used to. I'm not getting erections as quickly as I used to, and it's down the road. So it's usually like either months to years after the treatment that they start noticing these things to happen.

Chuck Ryan:

I remember seeing a graph where it was erectile dysfunction based on surgery versus radiation, and for surgery patients it was 100% got back up to 50 and for radiation it was 0% and it went up to 50. So the graphs converged over time. Is that still kind of true to think about?

Dr. Sherita King:

Yes, yes.

Chuck Ryan:

So a man should not choose his modality of treatment based on any expectation of better erectile function or should he?

Dr. Sherita King:

No, in my personal opinion, no. Now, everybody to each their own, I am not going to sit here and prescribe somebody that you have to do this. We have shared decision making in our practice, but they do send patients to me so that way they understand that, listen, just because you do radiation doesn't mean that you're not going to have these problems.

Chuck Ryan:

So you've talked about a couple of modalities. You've talked about Viagra and Cialis as the drugs that are available. You've talked about vacuum and erection devices, you've talked about injections and implants. Is there anything on that you didn't mention or is that pretty much the family of care of therapy options?

Dr. Sherita King:

Yeah, that's the main stays in my treatment wheelhouse. There are some other things out there. There are intra urethral pellets that you can put in, but a lot of times those are on back order and a lot of men just have burning sensation in the urethra when they use it, so they don't really like it. So I don't really pull that one out of the hat that much, but yes, typically that's my track that I go through patients with.

Chuck Ryan:

Okay, great. So I'm going to ask you at some point, ask you to talk about an emblematic case here in a few minutes. But before we do that, I want to just sort of have the listeners, the viewers sort of appreciate that you are highly focused on this problem, highly focused on sexual recovery, erectile recovery after surgery, and that makes you very special and somewhat unique, but there are specialists

like you out there, but there are a lot of urologists out there who don't have the expertise that you have. So one of the questions is, how do we help patients find a person like you in their region or in their health system, and how do we ensure that the people listening today are able to listen to you and say, okay, I'm going to get that for me, but I live in this place which isn't Augusta, Georgia.

Dr. Sherita King:

Yes. So there's a lot of different areas or places that they can go to on the web to find practitioners like me. One of those is the SMSNA website. So that's the Sexual Medicine Society of North America. They have a great patient domain on our website where they talk about a lot of different issues. So they go through patient satisfaction with implants, what to expect after an implant, what to expect with stress incontinence and its treatment. So there's a lot of information on that website, but they also have a link where you can find a provider. So that's one way.

Another way is through the implant companies. Both of them have provider portals where you can find providers in your area. Now, if you're thinking about getting a penile implant, I strongly suggest that you find someone that does them regularly because then that way you know that if anything comes up strange in your case and they'll be able to handle that, and you can definitely find that information on the two implant websites. So that's [coloplastmenshealth.com](http://coloplastmenshealth.com) and the other is [edsolutions.com](http://edsolutions.com). I have a slide later that has both of those.

Chuck Ryan:

Great, and we're going to get to your slides in a few minutes here. I think it's probably safe to say that if somebody's a preferred provider by the implant companies, they're probably doing the other things that you described and have perhaps a more comprehensive view of the process. I think that one of the other things I'm getting at is oftentimes the urologists who treat the disease, who do the prostatectomy are not the same people who are doing the sexual rehabilitation or the erectile implants or other things.

Dr. Sherita King:

Yeah. So there are a few unicorns out there that do it all and do them well, but a lot of times if you're finding a specialist in one thing, they're going to specialize in that thing. So here at Augusta University Medical College of Georgia, I do the sexual medicine portion, then we have Dr. Zachary Clawson that does the oncology portion. So then we are sharing patients back and forth all the time.

Chuck Ryan:

Okay, great. So tell us about, walk us through a couple of cases here. I know you're going to show us some slides, which we decided to go after we had this conversation, but tell us the story about some men you've been able to help and why your intervention was crucial.

Dr. Sherita King:

So a couple of patients come to mind. One of them is a patient who had prostate cancer. He ended up getting a prostatectomy and ended up needing radiation on top of that and then ended up on ADT afterwards just because the cancer kept coming back. So with him, it's a little bit different when you're treating someone who's had all the gamut of everything, especially with ADT because ADT itself, it can cause problems with erections in the physiologic sense just because if you're decreasing testosterone, that changes the architecture of the erectile tissue and it changes the health of it. But on top of that, it

also is going to decrease their libido because you're decreasing testosterone, which is a main driver of somebody's desire to have sex or sex drive.

So for this patient, his wife was very supportive and she was like, "You know, don't have to do anything at all." But with him, we did go through the whole gamut. We tried the pills. When the pills didn't work, the next thing I do is the penile ultrasound. The reason why I do that is for two reasons. One is it tells me what's the function of the penis. So it tells me how well are they getting the blood into the penis and if they're able to trap it, because those are the two main things that have to happen for you to get and sustain an erection. Then also it tells me, will you respond to injectable therapies, because we do do an injection to try to induce this erection.

With him, he didn't have a great response and he had decreased inflow and then he wasn't able to trap the blood. So I tell patients it's like having a nail in the tire. So it doesn't matter how much blood you're getting into the penis, it's not sustaining and maintaining. And that's typically what we see after radiation because you're hitting the backside of the penis and that tissue starts to scar, so it doesn't expand to be able to trap that blood the way it's supposed to.

Chuck Ryan:

We should say that an erection, for those who don't know you, may explain this is basically your penis trapping blood. It pumps it in and it traps it in out. So that's how it inflates so to speak.

Dr. Sherita King:

Yes.

Chuck Ryan:

So that's getting to your point, yeah.

Dr. Sherita King:

Yeah. So I try to liken it to a tire. So your penis is like a bike tire. The erectile chambers are like the inner tube. So when you pump blood in or put the air in, that's the first part, but then you got to seal it off to keep the air in there. But if you run over a nail in the tire, or you run over a nail and you get a nail in the tire, then that's when you can't sustain that erection. So for him, he had a problem with sustaining. He wanted to try everything all the way to the max before he went to the penile implant, which I completely understand because once you get an implant you're always dependent on that. So we went through the whole gamut of injection therapies, where we went to the strongest one and he still didn't get a response.

After that, we decided that he wanted to move forward with the implant and now he's back functioning. He's pretty funny. He actually did an interview for PCF and he'll be on one of the videos discussing his implant later. So he's very excited about it. That's the thing with implants, they have great satisfaction rate, which I will talk about in my slides. So that's basically the gamut. So he went through everything with me and he went to all the way up to the penile implant, which is the end treatment for erectile dysfunction.

Chuck Ryan:

Got it. And we'll thank him for being recorded and sharing his story because that's really important, and that's part of what we're doing in building cancer patient voices, which I think he's going to be not on

PCF.org, he's going to be on Cancer Patient Voices, which we'll be launching soon. So that's a great story. Went through the whole process and eventually found something that worked for him.

So why don't we go, I know you have some slides which are going to probably prompt some questions. Let's do your slides, and I have some pictures I think that you want to show, which is great. And then we'll take questions for the last 15 minutes or so after you're done with that.

Dr. Sherita King:

So I discussed the treatment pathway that we have. So again, I start with pills as the first thing. When pills don't work, the next step is for us to get that penile ultrasound and it tells me whether you're going to be a responder to penile injections. If you don't really respond then we can go to the penile implant. I typically do go in a step-wise fashion just because I try to go from least invasive to most invasive thing that I can do. But according to the American Urologic Association, you can start anywhere on this map pathway here. You don't have to start at one, but I will say I find that if you try to jump or skip, then you start having issues with insurance. So that's another reason why I like to stay.

Chuck Ryan:

We didn't talk about insurance, but could you give us a sense also of the people who start out with just pills, the number who need to advance to the ultrasound or the injections? Are most people, is it a good proportion who are just fine with pills alone?

Dr. Sherita King:

I would say probably with my prostate cancer patients, I would say probably about 25% are good with just pills alone. Because again, if you look at the age of prostate cancer patients, they're going to have some form of erectile dysfunction. They probably went into the surgery having erectile dysfunction. So they probably already started on the pills before and I see that in a lot of my patients. So I would say most of our patients do progress on further down the pathway.

Chuck Ryan:

Got it.

Dr. Sherita King:

Yep, definitely. So these are all the different types of penile implants that we have out there. The main thing is you have the cylinders, and that's what goes inside the inner tube of the penis. Okay, so that's going to basically replace that erectile tissue and it's going to give you the functional erection. So you can go anywhere from a semi rigid device, which is the most simple device, which is just the cylinders. I tell patients it's sort of like a pipe cleaner. So when you want to have intercourse, you stick it up, when you're done, you just bend it down for concealment. Then you have two pieces which just have a pump and then you have the cylinder. So that way it gives you a little bit more concealment because you can move fluid back and forth, and then what most people call the Cadillac of implants, which is a three piece.

So this is one company, Boston Scientific, you have Rigion up here and then you also have Coloplast here. All of them have their merits and which patient population will work best for, but they all pretty much have the same mainstay where you have the pump that controls the fluid moving back and forth from the cylinder to the reservoir. So this allows the complete concealment because you're moving fluid from the cylinders up into the reservoir, so the penis is completely flacid.

The good thing about the implant is you'll put it up and it'll stay up as long as you want to. So that's a huge selling point for a lot of my patients, is that they can climax and keep going until you deflate the device or if it's the semi rigid, just push it down for concealment.

Chuck Ryan:

So what else do you hear about the quality of the intercourse that people are able to have? Does it feel like it did before they have prostate cancer or does it feel different but good, or what's sort of the general feedback you get?

Dr. Sherita King:

So for most patients, honestly they're just happy to be able to be functioning. So they're just glad that they're able to get a functional erection that they'll be able to have penetrative intercourse with their partner. A lot of patients will describe it as almost feeling like they have a condom on. So it's a little bit decreased sensation, but if you had any surgery, even a prostatectomy, you know on this surgical site, on the incision, you're going to have a little bit of decreased sensation just because it's the nature. We're cutting through the skin sub-q tissue and getting down to where we need to work. So those nerves have to regenerate and sometimes they regenerate in weird ways. So the sensation may be a little bit altered, but most people don't have an issue at all.

Chuck Ryan:

Got it.

Dr. Sherita King:

Yes. So then leading into what you were just discussing, patient satisfaction. So I pulled this from a survey article that was done in the Journal of Sexual Medicine this year, and they sent the survey out to a bunch of patients at a large institution and this is what they found after the survey came back. So that 93.1% had overall satisfaction with the penile implant, had 93.1% satisfaction with the function and its effect on their relationship, 94.7% satisfaction found with increased social confidence, being able to feel like feeling more like themselves. Then also related to that 94.4% satisfaction in their relation to their self-esteem, their self-worth. Because what I find with men, erectile dysfunction is like fertility is to women. Some men don't feel like they're a man unless they are able to get an erection.

So this article went a little bit further and they started talking about the changes in sizes. Now, I will caution you, everybody does not have increase in length and girth with the penile implant. They show that because they also show that there are some patients who actually had a decrease in length and girth with this. But the main takeaway is that 60% had a perceived change in penile length. So this is important because with most of the treatment options that they have for prostate cancer, you're going to have some penile shrinkage. And even if you have just erectile dysfunction without having prostate cancer, if you have it for a prolonged period of time, your penis will shorten because it's a muscle, use it or lose it kind of deal. So it's important, this is why it's important to do penile rehab and that's why I'm very passionate about it because it helps keep that tissue happy and healthy.

But the most important thing that I think they found with this paper was that patients were most satisfied when they go into it with realistic expectations and if they have solid communication with their surgeon upfront. And that's what you'll get with the sexual medicine expert, is that they'll be able to talk to you about what to truly expect. So what I tell patients is that I wished I could make your penis longer, but I can't. All I can do is give you your current stretched flacid length. So when your penis is completely



soft, if you pull it out as far as you can, that's what you can expect to have with the penile implant. That way we manage those expectations up front. I do measurements in my office so that way we're all on the same page and everybody understands what I can give them.

Chuck Ryan:

So I think a lot of people who are listening might say, well, are the penile implants one size or are there multiple sizes? And how do I get the Cadillac?

Dr. Sherita King:

So sizing, right. Okay. So the important thing about sizing is that it's a whole gamut. So if you're looking at the different implants, they can go anywhere from 12 centimeters all the way up to 28 centimeters and then there's rear tip extenders. So there's little pieces that we can attach like legos to the end of it to give me a customizable size for you. When I'm telling you the centimeters, I'm not just talking about what you're seeing on the outside, because when we put this in is what's also on the inside. So the penis actually ends on the seat bone. So if you think about the bone that you're sitting on right now, that's where the penis actually ends and then it comes all the way out.

Another thing to remember, and I tell patients this all the time, and it's an encouragement to lose weight, is that as you gain weight, your belly is going to encroach over your penis. So you got to think about that when you're thinking about your size. So a lot of patients they start putting on weight, especially some of our ADT patients, it's important for them to think about those things. So there's ways that we can try to help modify this, but I can't give you the erection you had before you ended up in this erectile dysfunction journey.

Chuck Ryan:

Yeah.

Dr. Sherita King:

You had another question?

Chuck Ryan:

So no, keep going. I think you skipped over a slide, actually. I wanted to make-

Dr. Sherita King:

I did. So one of the questions that was in the email was about post-op experience with the surgery. So one thing you saw the components that can go with the penile implant. The amazing thing is I can put all that in through an incision that's about this big. Okay, and patient's like, "Oh my gosh, how do you do that?" I tell them it's magic. So the reason why I like to do a small incision is because it helps with the post-op experience. So we call it a minimally invasive penile implant. So the smaller the incision, the less pain that you have afterwards.

Another thing that I do is a pudendal nerve block. So that's just basically like putting a lot of anesthetic in to the main nerves that supply the penis before we start surgery. I actually did a study on this and it showed that they got less narcotics in surgery and then they also had less narcotic use after surgery. So this has really been helping our patients, especially with the narcotic or the opioid crisis that we're having in our country currently. So they have minimal pain medicine requirement. They usually, most of

our patients, after about a couple of days of using a few pills if they needed it, are switching over to ibuprofen and Tylenol without any issues.

Another important thing that I think helps a lot of my patients, if they listen, if they ice and use scrotal support that will help with their pain post-op. And then at two weeks, that's when we learn how to cycle the device. So if you have a three piece, that's when you learn how to pump it up and let it down. So if you're able to cycle this device, you can imagine their pain levels are pretty much subsided. So most people by about two weeks in my practice are feeling like I can get back to my daily activities that I normally would do without much pain. But I caution them if they have pain, they're probably doing something, they have no business. Then it's a total of six weeks recovery that I tell patients. So at six weeks, that's when I clear them to resume all activity. I tell them to resume things slowly, but this is when they can start having intercourse after the implant.

Chuck Ryan:

Six weeks after the implant. Okay.

Dr. Sherita King:

Six weeks, yeah. So then one of the other questions was about the psychological aspect of erections. So I think in order to understand how the mind kind of plays into this, it's important to understand the erectile physiology. So in order to get an erection, you have to have smooth muscle relaxation, which I know it sounds kind of counterintuitive. You're in the moment, you're hot and heavy, you're breathing, you're panting heavy. It's not the fight or flight response that you have from the other part of your nervous system. This is the relaxation portion, because if you think about the evolution of men, if you had a caveman and he was having intercourse and a saber tooth tiger jumped out of the woods, that erection needs to go away so you can get up and run away from that tiger.

So the same thing happened. So if you think about it, things that tap into that other side, that fight or flight part of your nervous system, that's your depression, that's your anxiety, that's when you're worried about treatment modality not working. All these things are very important because it will kill an erection before it even starts. The mind is very powerful.

Chuck Ryan:

One of those things can be identified even before the surgery. People who have a proclivity for depression and other things that could complicate their recovery after the surgery.

Dr. Sherita King:

Yes, absolutely. Absolutely, and then if they're on treatment for those things, some of those treatments also can cause issues. So some antidepressants can do it, some anti-anxiety medicines. Now, I'm not telling patients not to take their medications, but we can have conversations with their primary care doctor or their mental health provider, whoever's treating this, and discuss which treatments or which medications may have less sexual side effects that they can use. So this is a very important part. So yes, the mind is very powerful. It can kill an erection before it even starts.

Then another question brought up climacturia. So climacturia is basically just a very mild form of stress incontinence. So it's when you leak urine with orgasm or climax. This happens because the prostate is gone. Just like you have stress incontinence with cough, sneeze, and we'll talk about that later, this happens just when you orgasm. So this is the most mild form, if this is the only thing you have, consider yourself lucky. But there are still some treatment options out there and this is just one of them that's

non-surgical. So it's a constriction band basically and you just put it around the outside of the penis and it will collapse the urethra that will prevent that leakage of urine once you have climax.

Now, if this doesn't work there's a lot of other gamuts, there's different surgeries that you can do. The main one that people do if they only have climacturia is a mini sling that they can put across the urethra that they typically will do at the same time as a penile implant. So that is an option out there if needed. Then there was another question about shockwave therapy. So this is the position statement from the society that I talked about earlier, the Sexual Medicine Society of North America, where they talked about what is their stance on restorative therapies. So that would include anything from the stem cells. I know we heard about the P shots, so that's PRP, or shockwave.

So what they have found is that in early clinical trials that it has shown some improvement, but this is mainly in mild erectile dysfunction, but there's not enough evidence to show that is efficacious enough in treating all men with the erectile dysfunction. So it is the stance of this society that it should be used as strictly experimental. And then if you look down below at one of our meetings, this was the comment that was made was that until then, until we can figure out that this is definitely going to work, we should not be charging our patients for this restorative therapies. This is very important because there's a lot of clinics out there that are very predatory towards men and they will have their advertisements on the internet, have late night commercials, and that's just because they know men are so desperate to get back to functioning that they're willing to do just about anything. We have one in our area, they usually charge like thousands of dollars for men and promising them the world and they get nothing from it. So I would just caution patients about finding places that claim they do shockwave therapy.

Chuck Ryan:

So we haven't talked about this much, but is insurance coverage a challenge for the implants and all of the therapies that you've been talking about tonight?

Dr. Sherita King:

So for pills, yes. Pills used to be a huge problem back in the day, but now with all the different services like GoodRx, and Cost Plus Drugs, and a couple of other ones out there, pills are a lot less expensive, especially for the generic versions of it. So that's not a problem anymore. In my area I can get generic Cialis, 30 tabs for about less than \$30, which is completely, drastically different when they used to be \$50 just for one before. Now, as far as injection therapy, if they're using a compounded medication, which I use in most of my patients at my practice at Augusta University, insurances don't cover that. It's not because it's not a tried and true treatment option, it's just that no pharmaceutical company has done all the studies to make it FDA approved so that they can take it to insurances. So you do pay out of pocket for that. But with most compounding pharmacies, if you look at the cost for the vial of the medication and how many doses you actually get out of it, the cost per injection is pretty low and it was actually lower than that of the pills prior to them going generic. So that's why a lot of men would go to injection therapy.

Now, there are a few FDA approved formulations, but those are just single agents rather than being compounded with multiple different agents that can help with erections. Those tend to be a little bit more expensive and they limit the number that you can get because that's what insurance companies do. You get about, I think you get six for most insurance companies per month. So that's only six times you can have intercourse in the month. Can get those from commercial pharmacies, but not all insurance companies will cover those.

Then when you move into vacuum erection devices. Since I've done my training, Medicare stopped covering vacuum erection devices, which prompted all the other insurance companies to stop covering it. So those are no longer covered. So that has made it a barrier, the patients being able to get that and afford it. Then as far as the penile implant, if you have Medicare, then those are my favorite patients because I don't even have to worry about it. I know it's going to get covered. Now, some commercial insurances, especially depending on what your employer puts in there, they will have erectile dysfunction as an exclusion. So then that makes it a little bit more difficult, and then you have to get into discussing with the insurance companies and discussing with the employer and sending in letters to try to show that this is linked to something else, especially with prostate cancer. It doesn't always work, so I've had some patients who've been right on the cusp of getting on Medicare and they're like, "You know what? That's okay, I'll retire." And they'll go get their Medicare and then come get their implant. But I definitely do go to bat for my patients with insurance companies.

Chuck Ryan:

It sounds like it. So really, really comprehensive. We have a few questions to go through in the last couple minutes. So I'll just go through a couple of questions, kind of rapid fire here. Orgasm, how do the implants affect orgasm? There's some questions coming in about that.

Dr. Sherita King:

No, so it does not affect orgasm. So my mentor that I did my fellowship with, he was like, "If you could ride a bike before the implant, you could ride a bike afterwards." So if you can have an orgasm before, you're going to have an orgasm afterwards. Now, can you have orgasmic dysfunction, like I said, from some of the treatments? Yes, and then that's a different conversation and we can definitely treat that, but the implant doesn't change anything with that.

Chuck Ryan:

Okay, and very good. Let's see, you talked about mental health. What about testosterone supplementation? You've really not talked about this, but always kind of a little controversial for people who've had prostate cancer therapy, but when do you bring that into the mix?

Dr. Sherita King:

If they remain ... And there's actually been a lot of studies on this recently and we're waiting for, anxiously awaiting that information to come out. But the way I approach it in my practice is if you've been undetectable for about two to four years and you haven't shown any signs that the cancer is coming back, then we can start broaching that subject and we can start getting you on testosterone replacement. Now, I do have some patients that are like, "I'm on ADT, I need testosterone." And I was like, "I understand, but that's the whole point of the ADT." So we can't do testosterone replacement in those patients, but I do do it in some of my prostate cancer survivors.

Chuck Ryan:

Right. With the penile implants, do you ever have to replace them? Do they ever fail and you have to redo a surgery or something?

Dr. Sherita King:

So the companies usually quote as a lifespan is about 10 years, okay. If you really get to the granular part of it, it's the number of cycles that you do. So it's just like a car. The more wear and tear you put on it, the quicker it's going to wear out. Even though they quote 10 years, we have seen and there's actually been studies in the Journal of Sexual Medicine that show that these can last 15 to 20 years. So it's better for the companies to underpromise, overdeliver. So typically I would say I see the lifespan for my patients is 10 to about 20 years. I think the oldest functioning one I've ever seen was 30 years old. So they can last a long time.

Chuck Ryan:

That's great. So let's tackle one other question that comes in. I'm sure a lot of people have it, is any data on whether all of this manipulation, implants, injections has any bearing on the cancer recurring?

Dr. Sherita King:

No. No, because they're totally different systems that we're talking about and what we're doing. The prostate is in a separate place. They're neighbors but they're not related really.

Chuck Ryan:

Right. So I want to dispel that concern because I think that I've seen in the question a few people who have some concerns about that. Well, we've got a minute left and I really can't thank you enough. It's been educational for me. I've been practicing oncology for prostate cancer patients for many years and I've learned a lot from you tonight, and so I suspect that our listeners have as well, and I want to thank you for that. Any last words about resources or where people should turn or advice you can give?

Dr. Sherita King:

Yeah. So the main thing that I would say is do not let prostate cancer or let the possible side effect of erectile dysfunction change the best management for your prostate cancer. Because even if they do all of the above, like I told you with my patient, he had a prostatectomy, he had radiation and ADT, I still had him functioning. So there's ways to get back to the game, get back in the game, get back functioning. Do what you need to do to become a survivor and then come see a sexual medicine specialist to get you back going.

Chuck Ryan:

I think that's great advice and we'll leave it there. Thank you so much Dr. King. Great to see you. Thank you for your work and we'll hope we can chat with you down the road for an update.

Dr. Sherita King:

Absolutely. Thank you for having me.