

Dr. Zach Klaassen:

Good evening everybody. My name is Dr. Zach Klaassen. I am a urologic oncologist at the Georgia Cancer Center in Augusta, Georgia. And thank you so much for joining us for our Prostate Cancer Foundation June webinar. We are looking at men's health this month and the patient perspective. We have two excellent patients who we are going to chat with this evening, and I'd like to thank the Prostate Cancer Foundation for hosting this webinar as well as Lantheus for the support of the production as well.

But thank you all for taking time out of your afternoons or evenings, depending on which coast you're on. So the Prostate Cancer Foundation really comes down to funding research and the PCF mission is to reduce death and suffering from prostate cancer. At the Prostate Cancer Foundation, we support transformer prostate cancer research to accelerate progress towards our goal of curing prostate cancer. The Prostate Cancer Foundation funds many teams of scientists across disciplines and institutions with more than 2,200 projects around the world during the Prostate Cancer Foundation's 30 year history. We are growing the field of prostate cancer research by supporting the best and the brightest young investigators. Several of you, you can see picture to the right of the slide.

So the Prostate Cancer Foundation also prides itself on having resources for the community and for patients and family. So if you haven't already, we invite you to go to the pcf.org website. There's many updates you can sign up for downloading guides, viewing past webinars such as this one, and also importantly registering for our July 18th webinar. We'll be discussing a very important topic on hormone therapy. We also invite you to join our online support group at facebook.com/pcf.org/groups. One thing we do want to discuss briefly is a new website that we've been working on for the last 18 months or so. This is an excellent, excellent resource for anybody who is thinking about getting screened for prostate cancer, people that are going through active treatment discussions, people that have had treatment, and people that are going through treatment for advanced disease. And so this is prostatecancerpatientvoices.com.

And really what this is a one-stop shop for anything as simple as what is a PSA, what is a Gleason score? What are all these fancy names of medications that my doctors are suggesting? We break this all down, and more importantly, we have several excellent patient testimonials. And so the key to this website is centralization and to realize that you are not alone in your fight against prostate cancer. So Men's Health Month is basically looking to educate men and boys to take charge of their overall health by implementing healthy living decisions. Importantly, men are more likely than women to get certain diseases like heart disease and cancer. Certainly prostate cancer is very common in our community, and you can reduce your risk of many conditions through regular doctor visits and choosing healthy habits, not only prostate cancer, but other important health concerns such as heart disease. It's important to tell men that even with prostate cancer screening, it all starts with a blood test and having a discussion with your physician.

June is also pride month and we're celebrating the LGBTQ+ community and we recognize the struggles against discrimination and often these individuals are at risk for several health disparities, including lack of access to medical care. There's very little research on the experience of gay and bisexual men with prostate cancer and even less is known about transgender women that have prostate cancer as well. I'm joined today and you'll meet shortly Dr. Sherita King, who's also at Augusta University. We're at the same institution. We're actually co-residents together and we've been working together as partners in practice for the last five years. She's the director of prosthetics and men's health. She's now an associate professor of urology. She has excellent clinical expertise in erectile dysfunction, Peyronie's disease, low testosterone, low libido, male urinary incontinence and arousal disorders. Has research interests in many of these areas, specifically erectile dysfunction and male urinary incontinence disorder.

And I will say between the two of us, we share a lot of patients. As the oncologist, I deal with the prostate cancer and having Dr. King side by side with me to help men and their families with some of the side effects of treatment is an absolute indispensable resource for our patients. So I want to bring in our next speaker and co-host is my good friend, Dr. Sherita King. As I mentioned off the top, we have been colleagues for over a decade now. And I also want to bring in Dan, who's one of our prostate cancer patients from Seattle. And Dan was initially diagnosed in 2010 and throughout his journey, he's experienced a number of different treatments and participated in clinical studies. And Dan has also been in support groups and advocacy for gay men with prostate cancer. And so I want to welcome Dr. King and I want to welcome Dan to the second half of our webinar.

Dr. Sherita King:

Hi. So Dan, let's start off by you telling us a little bit about your story.

Dan:

Okay. I was fortunate enough to have a health insurance that encouraged getting tested. So I learned that I needed to take this seriously about PSA, and that was in 2010 that the journey started. I kind of fooled around being worried about the wrong kinds of things you might say, and not wrong things, but I had never heard of anyone dying of prostate cancer. I just heard it was the tortoise of cancers and there was a no hurry. But then I started to learn about how grave it can be and some people put the fear of God in me, but most of the time, for about a year just looking for odd options, cryotherapy other things that would, I hoped preserve my sexual abilities as a gay man. And that was a big worry. And I wasn't as worried about the actual cancer for a while. But I had, like Ricky a prostatectomy after about a year and after realized the gravity of the situation enough, I had to have follow-up radiation.

It continued to be an issue with rising PSA even after that. I could talk about it in various different ways because the sexual journey changed, the different kind of treatment, went through whole bunches of different phases. Now I'm the second time on hormonal treatment, which is a whole different chapter in my life than what was after just the mere surgery and radiation. I still had quite a bit of sexual function, but it was just different. It was a learning process for three and a half years before I went on my first hormonal phase, which changes as many people know your libido entirely. Yeah.

Dr. Sherita King:

Yeah. No, absolutely. And I think you touched on the very important point where a lot of men are afraid of treatment because of the side effects that can along with those treatments. And we'll go into that a little bit more, a little bit later. Because that's my specialty. So Dr. Klaassen will cure the cancer and then they come to me and then we can talk about all the fallouts, the erectile dysfunction and the leakage of urine. So as a homosexual man, how were you able to find a group and a physician that you felt comfortable with?

Dan:

A lot of gay men are pretty estranged from their families of origin depending on where they were raised and what their families were like. And although I'm not entirely estranged, I do have a brother who didn't want to talk about it, but also found out he had prostate cancer. And so it was a shame that we didn't have a closer relationship. But where my surgeon was at the hospital in Seattle, there was a handmade poster from a gay man who started his own support group. He had had a prostatectomy and nerve sparing surgery, and he was someone who shared a lot about the injectables that helped him to

have erections and so on. He even said, and this is unusual to hear that sex for him was in some ways better after his surgery. And so that's not what everyone's experience is, but it gave me hope.

And I've always been a big believer in support groups. I've helped us get a group started for gay men related to Us Too. And I've been a part of support groups, both regular groups in general and gay men in particular. So finding, I agree with what Ricky said, you got to find your support. I also have, I'm married, my husband is incredible support for me, but I also really believe in getting together people that are experiencing the same thing I am. And I do regularly and I'm at a stage where I can help them, but I'm also learning all the time.

Dr. Sherita King:

Yeah, no, absolutely. I think that's an excellent point. Us Too is a great resource. We have a chapter here that meets regularly, so I think it's a good opportunity for patients that are on the line to try to look out there and find resources near you that you can get hooked into. So what advice, so you did talk about how you wish you and your brother talked more about your prostate cancer diagnosis or his prostate cancer diagnosis. So was he diagnosed prior to you?

Dan:

No, my straight brother was just a very different personality. I'm kind of an open book. He's kind of holds everything close to his chest and he's even had a history in the healthcare field, but he wanted not everyone to know what he was experiencing. And I found out by accident through a third party and that sort of thing. So yeah, it's better now. We can talk some, but he probably wouldn't like it that I'm telling the world that about him.

Dr. Sherita King:

We won't tell them. Like Ricky said, and you have mentioned also, it is very important that if you have been diagnosed with prostate cancer, you need to spread that word with your family because we want to make sure that they get their diagnosis early, because they need to be screened earlier, and their screening criteria is going to be different than the general population. So you mentioned the different treatments that you've had, and it depends on you. It's whatever you feel comfortable with. What treatments have you had for the side effects from the cancer and from the radiation. And you had the hormonal treatment. So what have you experienced and what have you done to help as a treatment option for those?

Dan:

Yeah, the key time for a formal working on that for was for sexual and urinary rehab through a actual clinical trial called the Restore study in 2019 and '20 out of University of Minnesota. And that was for gay men and they gave us pumps to try to keep the blood flow and the equivalent of Viagra and all kinds of stuff to try to encourage... And conversation, interaction, try to get people working on what they called restoration. I wouldn't say it was a completely successful clinical trial in that I'm not restored to the past, but I'm certainly enjoyed experimenting with the possibilities and it's a wide range of what other people experience with injectables with just... So I guess I've experimented a lot. It's not been bad getting used to different realities, leakage. Ricky also mentioned doing Kegels, and I agree that that can go a long ways, especially if you've had prostatectomy, but probably radiation too.

But yeah, it's like a muscle to work your penis and it's like any other muscle you have to keep work. And especially after hormonal treatments, my bone density has weakened greatly. Even though I go to the

gym, I walk over an hour every day with my husband and my dog, but I found out I had osteopenia. So there's always something else lurking that can be affected by the meds you have to take, and it's kind of a constant dance. But I'm a happy camper because I'm supported and I'm loved and I'm grateful that I have that community of choice or that family of choice around me, my friends, my gay pals, et cetera.

Dr. Sherita King:

Yeah. And it is, it's good that you have that community because as Mr. Ricky also talked about a staying positive. So the mind is very powerful, and I preach this to my patients all the time because so, say you do have erectile dysfunction and you're down on yourself and you're really sad about it, and it's just a vicious cycle. Because if you are getting anxious because you're trying to get an erection, you're going to prevent yourself from getting one because you're countering the effect that your body's trying to do. So it is very important. In your healthcare system, did they ever bring into it a mental health provider like Dr. Klaassen had spoke about?

Dan:

Well, I definitely needed that, and fortunately Medicare allowed for me to have it at a time when my medical team sort of emotionally I felt failed me. It talked about the importance of cardiovascular issues. I did have a heart attack at one point when I was on hormonal treatments. I did have a TIA that scared the hell out of me, and I felt like there wasn't a great deal of emotional support at that point. In fact, institutionally they freaked out a little bit, I think, and were asking me to sign this new document that was detailed, and I had to see a therapist at that point. More recently, I found it is a really excellent Seattle based team. Fred Hutch is what it's called. Man. They have a lot of resources like physical therapist. And I recently found out about their pastoral care team and started meeting with someone there who is an extremely competent young woman who knows her stuff. And I've been enjoying meeting with her even though this hasn't been the crisis point that it once was for me.

Dr. Sherita King:

Yeah, I think that's awesome because when I went through fellowship, we called it the bio-psychosocial. So we're not just looking at the biology of it, but we have to look at the psychosocial part of it. And that's part of cancer survivorship. Yes, we diagnosed you with cancer, we have treated the cancer and we're still treating the cancer, but how are you doing outside of the [inaudible 00:16:30]-

Dan:

Yeah, you're right. It's absolutely necessary. And I'm a lucky guy to have the resources I do that I know lots of my compatriots don't have around the country, especially in more rural areas, I suspect.

Dr. Sherita King:

Yeah, no, absolutely. And to touch on that, if you are looking for a mental health provider closer to home, you can either ask your cancer treatment team or you can go to Psychology Today. They have a good resource where you can look up therapists in your area and try to find someone that can potentially help you.

Dan:

Yeah. And I would add that there's financial toxicity issues for a lot of people too. And I've been fortunate enough, we don't make a high income in a very expensive part of the country. And so I was

able actually with the help of my medical team to get at least temporary meds, very expensive meds, the hormonal treatment that I'm on, from the manufacturer directly. So sometimes there's things like that that can help you, and there's also aid of various kinds that sometimes people can be helped with, so that can really scare people away. And it was scary for us as well.

Dr. Sherita King:

Yeah, no, absolutely. I think another important thing when we're talking about the men who have sex with men, when you're talking about having prostate cancer treatment, especially a prostatectomy, if they are a receptive partner, then that changes the way intercourse is. So it's important that you tell your team or find a team that you're comfortable telling this to because it's going to change your life and they need to be able to explain to you how it's going to change your life. And if they don't know, they don't know. So yeah, that's a very important-

Dan:

Yeah, here I had been out so much and for so long I didn't have any hesitancy to initiate the conversation, but I understand that it's probably more gay people that would love their medical team to go ahead and ask if they're comfortable, but if they're awkward about it themselves, then they don't feel safe. Yeah, yeah.

Dr. Sherita King:

No, absolutely. Absolutely. Do you have any other thoughts that you would like to share with the group?

Dan:

Oh gosh, I guess I'm 71 years old now. I feel like my life is good. I've got a loving partner. Not everyone has that. If you're single, you're dealing with sex. I want to say that as a gay man, I've had a pretty good run. And sex changes when you have prostate cancer, a lot of other things do too. It doesn't necessarily disappear. It hasn't disappeared entirely, but it's certainly changed. It's much less central to my life at this point, whether you could say that about a lot of people in their 70s, a lot of men note regardless of whether they have prostate cancer or not.

So I guess I just want to also, like Rick, he just encourage people to realize that there is life after a diagnosis or after prostatectomy or radiation there. And sometimes even when there's recurrence, there's been a long journey for me, but it's not been a bad journey. It's just I have to keep on my toes in different ways than I used to, and I feel supported, and I'm so grateful for that. And I hope people can find that wherever they are, because you need that. And also just to go ahead and initiate looking for that because no one's going to come to you if you're invisible to them.

Dr. Zach Klaassen:

Just monitoring the chat here and try to answer some of the comments coming in. Dan, do you know if there's any support groups in the Delaware area? Question in the chat.

Dan:

For gay men in particular, do you think?

Dr. Zach Klaassen:

Yes.

Dan:

Well, there are national groups that... Male Care out of New York City has more than one group for example. Us Too has a group or maybe two or more. So if you don't mind going online, like we're doing this process on Zoom. There are several groups through either malecare.com or doing ustoo, I think.org or.com. Groups like that that deal with prostate cancer have started to do groups for specifically for gay men. And I participate in more than one of those, at least from time to time.

Dr. Zach Klaassen:

That's great. Dr. King, we had a couple of questions in advance that I think are important to discuss. Do you want to discuss your question then I'll take mine. Looks like we've got about 18 minutes.

Dr. Sherita King:

Yeah, and I saw a couple of questions that came through about the side effects and how we can treat that. So if we're talking about erectile dysfunction, so the two main side effects that I deal with afterwards is erectile dysfunction and stress urinary incontinence. So that's leaking with cough, sneeze, movement, or even sometimes with intercourse. So we'll tackle erectile dysfunction first. So with erectile dysfunction, there are a lot of different treatments that we have, and I'm sure a lot of y'all have been through these. We start... Well, the way my algorithm goes is I start with pills first. See how you're doing with that. Hopefully if you had your surgery elsewhere for your prostate cancer, your treatment elsewhere, they have put you on a penile rehab program. If you've gone to Dr. Klassen because we're a team here, then he has already probably sent you to me, and I've started you on a penile rehab program.

So that means you're taking a daily oral medication. So those are the PDE 5 inhibitors, that's your Viagra and Cialis equivalents. So you just take a low dose of that every day, and you use a vacuum erection device along with that. And what that does, just like Dan mentioned, and I think Ricky talked about it too a little bit, is the penis is a muscle. The use it or lose it is definitely the truth. So you want to try to keep the blood flow going to the penis, keep that tissue happy and healthy while your body's recuperating and the nerves are regenerating from whatever treatment you had. So if you are able to regain that aspect, then the tissues are happy and healthy.

So if you're doing that, you're coming to see me, we're going to try you on a full dose of those medications, those orals. If that doesn't work, then we're going to talk about injection therapy. So that I tell patients it's sort of like a liquid Viagra, so it's a medicine you're injecting directly into your penis whenever you want to have intercourse. The good thing about this is you don't have to wait the hour for you to get the effect. If it's going to work for you, it's going to work with you, work for you within five to 10 minutes, typically for most men.

And so we try that. If that doesn't work, then the next step is penile implant. So my main thing that I tell patients is that don't let the fear of these side effects stop you from getting treatment. I can get you back to your erection as long as you're healthy enough to get there and you want to go that far to a surgery if needed. It's just a matter of what you want your sex life to be like. And I think that was a very important point that Dan brought up. I can't run like I did when I was 18, I used to run track at the University of Georgia, so I can't expect the rest of my body to do the same, and you can't expect the rest of your body to do the same. So things will be different. You may have to get there in a different way, but we can still get you there.

So if we switch gears over to stress incontinence, so that's a different thing. With that I typically like to send patients to pelvic floor physical therapy, have them do the Kegel exercises so that way you can

strengthen your pelvic floor. So when you have your prostate removed, you have the urinary sphincter, so that's the muscle that controls your continence that you hold your urine in with, and that's what you're trying to kind of strengthen with those Kegel exercises. Once the prostate comes out, that area becomes stunned. The nerves that control it are right intimate with the prostate, so even radiation can affect this also. So once that starts to happen, those muscles start to weaken. So going to a physical therapist is like taking your pelvic floor to the gym, so you're trying to strengthen everything, so hopefully you won't leak on yourself. Now, for some men, they will regain their continence over time, and this is just gravy for them.

It's going to be icing on a cake. It's going to help them out, get them there faster, but not everybody's going to recover full continence. So there's other things that we can do if our conservative management doesn't work, and those are different types of surgeries. So we have the artificial urinary sphincter, which is a cuff that goes around the urethra, and what it does is it stays closed all the time until you have to use the bathroom, and then you have a little pump and you squeeze that and it opens it up and allows you to urinate, and then it closes itself on its own. If you don't want to go through that invasive of a procedure or your incontinence is not that bad, then there's slings that are available. So those are pieces of mesh that we put around the urethra that kind of compress, and some can also elevate the urethra.

And what that does is, again, it puts a little bit more tension on the urethra, so it prevents you from leaking with that increased abdominal pressure with the cough, sneeze, heavy lifting, having intercourse type deals. So I think that covered most of those questions. There was a question about having low self-esteem and the negative thoughts during intercourse. Again, like I said, the mind is very powerful. If you're trying to get an erection and you're just having these negative thoughts, you're never going to get there. So that's why it's important to have that support and to have possibly a mental health provider help you through some of that. And then sometimes with the treatments, and you start to see a difference in a change, then that can kind of help those negative feelings that you're having. As far as low libido that can go along with this, that can happen, especially with men who are on hormonal therapies because we're decreasing your testosterone. Testosterone's very important for your libido.

Unfortunately, if you're on something because we're trying to deprive you of testosterone, so your prostate cancer won't thrive, then it's hard for us to treat that. And again, that's when mental health is very important. But if you're a patient who has prostate cancer and you have been adequately treated and your PSA has been undetectable or very low, then we could potentially talk about giving you testosterone monitored very closely, but be able to get your levels back up where you're starting to feel better and have a change in your libido. And yeah, I think that was everything in my question, Dr. Klaassen.

Dr. Zach Klaassen:

Okay. Go ahead, Dan. You were going to say something?

Dan:

All of that, yeah, I could relate to that in my own personal way and my own personal experience that definitely continue to be a sex affirming, gender evolving man because of hormonal changes and not having testosterone, but you don't miss what you don't desire anymore. And that sounds scary as hell to people like me where sex was so central to my very identity. And it's evolved some, so there are all these methods to make it last and so on. But ultimately, for me, I'm evolving into a new phase of my life, and I take the generic Viagra every day just to keep the blood flowing, the muscle working, try to work the muscle, but it's more like an exercise or a responsibility rather than a spontaneous thing for me at

this stage in my prostate cancer journey. But that's okay. I've had a good run. And so you're talking probably to a lot of single guys. That's the... You're talking about some of the most important, not just, but.

Dr. Sherita King:

Yeah. So it just depends and everybody's different. And that's why it's very important to talk to your providers and be honest about what you want because I'm not one that's going to hog tie anybody and make them have any of these things. I love doing penile implants. That's like my favorite thing to do. But if that's not what the patient wants or what the patient sees that they need at this time in their life, yeah, I'm okay with that. Get you whatever treatments you need in order to make you happy so that way you can have a more fulfilled life. And then I think I did my job at that point to help you survive your cancer beyond just a diagnosis of cancer.

Dan:

Yep.

Dr. Zach Klaassen:

I do want to just, the other question that was a present question, and I think looks like there's a response to your testosterone replacement, Dr. King. So I'll let you think about that for a minute while I talk about one of the emailed in questions. So the very excellent, actually, several questions around this topic. So a gentleman emailed and said, recently diagnosed with stage one low risk prostate cancer, confirmed at age 53, I'm otherwise perfectly healthy. First question is, my choice is active surveillance. This is wise. And my answer is, I mean, my bias is that I really believe in active surveillance. I trained in Toronto, which is one of the places where active surveillance really started about 20, 25 years ago. And I think active surveillance really needs two key components. It needs a compliant physician who's going to follow people closely and appropriately. It also needs a compliant patient.

And I think the reason that is because there's a series and you'll see a lot of different follow-up algorithms for active surveillance. But typically mine is a PSA every six months. I typically repeat MRIs every two years based on the European guidelines and repeating biopsy, at least a confirmatory biopsy within 12 months, and then usually biopsy for cause, either with an elevated PSA going up or an MRI that looks suspicious. So to answer your question, I don't necessarily put an age restriction on active surveillance. I will say the conversation with somebody at 53 may be different than with somebody who's 83 in the sense that at 53, there may be a chance that we do have to do something 5, 6, 7, 8 years down the road. But that's 5, 6, 7, 8 years of no urinary incontinence, good sexual function. Whereas the gentleman who was 83, I'm hoping I never have to do anything to him because he will die with prostate cancer, not of prostate cancer. So age, in my opinion, does not necessitate or does not lead to not doing active surveillance.

Dan:

And Gleason scale is important, how-

Dr. Zach Klaassen:

Yeah, low volume Gleason 6. Absolutely. And I'll also say that that goes the same, and there's been some studies showing that even in African American men who are at higher risk of disease progression in a low volume Gleason 6 with a good patient and a attentive physician who's going to monitor it's safe. In

terms of diet and exercise regimen, will this help slow the prostate cancer? We don't really know. It may or may not, but as I mentioned before with Mr. Lee, it certainly will help your heart, your cardiovascular risk factors, and I think that's as important for sure.

Dan:

The phrase I always hear is heart health is prostate health.

Dr. Zach Klaassen:

Absolutely, could not say better health.

Dr. Sherita King:

And it's penis health.

Dan:

Yeah, it really is.

Dr. Zach Klaassen:

The last question, or going along this, would some sort of immediate focal treatment be better option than active surveillance? And would focal treatment result in losing my candidacy for prostatectomy? Focal therapy is very interesting. I think in the right hands, I think focal therapy can be a very useful treatment option. And right hands meaning somebody that's not out for financial gain. And that's a very realistic assessment because in my opinion, in the right patient, usually with intermediate risk prostate cancer where the prostate cancer correlates to an visible image on MRI, focal therapy can be used to treat just that area, spare the side effects that we're used to seeing with radiation and prostatectomy. Where we run into issues is where physicians are treating multiple areas or higher grades, say Gleason 4+3 or 4+4, we get into the multifocal areas in the prostate, so not just one area.

So I think you have to be in conversation with somebody who's not just looking to add more or help their car payments to be honest. And in terms of help or candidacy for radical prostatectomy, I have done several surgeries after Focal HIFU, which is ultrasound therapy. It's not drastically different so that simply, I don't think it affects the planes that much. You still would be a candidate for surgery and certainly would be a candidate for radiation therapy after a focal option. So hopefully that answers the questions. They were very good questions, and we could probably spend a whole webinar talking about those great questions.

Dan:

And if I could add that just my biopsy showed a kind of safer end intermediate, a 3+4, and then when I had the prostatectomy, it was a 9 on the Gleason scale. So I didn't really know how bad it was until after the prostatectomy and then there was recurrence.

Dr. Zach Klaassen:

Yep, absolutely.

Dr. Sherita King:

Yep. All right. So I'll tackle this testosterone question. So remember when I said giving testosterone, this is for very specific patients. These are patients who have been treated and they have undetectable PSA, and they have demonstrated that they have had an undetectable PSA for many years. My cutoff personally is about three to five years that you've demonstrated that your cancer has been treated and well controlled. There are studies actually going on now where people are giving patients testosterone who are on active surveillance or who still have a low PSA number. So it just depends on your comfort level and the comfort level of your practitioner. But it can be done in a safe way. And the way that I do testosterone, all of my patients get labs routinely. And for my prostate cancer patients, they're going to get their P SS a every three to six months. So I am following it very closely just to make sure that we're not going to have a problem. And it has been demonstrated that this is safe to do.

I'm trying to see somebody asked about estrogen therapy. So it depends on what you're talking about. If you're talking about just giving estrogen-

Dr. Zach Klaassen:
Patches.

Dr. Sherita King:

... treatment for... Yeah, you can, but if you get testosterone... So the thing is with estrogen, you have to be careful in men. Yes, men do need estrogen, just like women need testosterone. But if your levels are going too high, then you're going to start having the side effects from that. So that'd be like breast tenderness, breast growth, which is gynecomastia. So you just have to be careful with that. I typically don't do estrogen therapy because if I'm going to give you testosterone therapy, typically your estrogen's going to go up because that's how you make estrogen. You could convert testosterone over to estradiol. And then let me see. There was a question, one of the people said that eight months after a prostatectomy, he's doing daily Cialis, he's doing his pump three days a week.

I typically tell people to do it every day. It's like the gym, the more you go, the more you get out of it. And he is using Trimix, and he had no reaction and his doctor said he is, he's expecting too much too soon. It is up to you, right? At the end of the day, you're driving this bus, depending on how your prostatectomy was done, if it was nerve sparing, doing robotic prostatectomy really have changed the game for how long we wait to talk about penile implants. But it depends on what was your function before surgery? Did you have problems with erections before? If you did, you're probably never going to get back to that spot. So any treatment you have for your prostate cancer is going to change your erectile function. And most men never get back to where they were before their treatment.

So to me, it's not too early to start talking about it. But again, it depends on the comfort level of your practitioner. And have I done patients like nine months post-op? Absolutely. Especially if they've had erectile dysfunction prior to it. And they understand that once you get an implant, you're always dependent on an implant. So this is not something you're just going to try and be like, "Oh, I don't like it, and I'll just go back to doing the other things." That won't happen. So you just have to know what you're getting into for that. And you see any other questions that you think we need to tackle?

Dr. Zach Klaassen:

I'm trying to answer as many as I can typing, but you're doing a great job of talking about them too. So I feel like we're hopefully hitting the majority of them between the two of us. But we have a couple of minutes left, so we want to be respectful of our attendees time and certainly have Dan and Dr. King's time. And so anything else you can see in the chat, Dr. King, before we sign off.

Dr. Sherita King:

So somebody was talking about regular time for recovery of erections. So again, it kind of depends on the nature of the surgery that you had. If you've had, so it looks like this gentleman had surgery, radiation and ADT and has been 18 months, you're probably where you're going to be at this point. So if you, you need to start progressing in that algorithm of trying to get your erections back. And it just depends on how far you want to go with that. Is urinary incontinence a product? Okay, so yeah, I'm very passionate about this and Dr. Klaassen's heard me say this many times, it doesn't matter what kind... People will tell you, oh, if you get radiation, then you won't have these side effects, or I did a complete nerve spare, so you shouldn't have problems with erections. It's not all about that. If you look at diagrams that show the prostate, these nerves are very intimate to the prostate. If you look at the prostate wrong, there's a risk of you having erectile dysfunction and stress incontinence. Even for some of the treatments that we do for enlarged prostates can cause these problems.

So yes, surgeon skill does pay play a role into it. If you get hacked up, yeah, you're probably going to have a worse outcome, but it's the prostate cancer, it's not the treatment. You know what I'm saying? You have to kind of separate that. And again, that comes back to, I find making sure that you're being positive and having a good attitude. And I know a lot of men come into my office and be like, "Oh, woe is me. If I would've known this and I wouldn't have had my surgery done, or I wouldn't have had my radiation done." The thing is, you're cancer free now for most of these men, so I can get you back on track for the other things. You need to flip that switch in your brain that I've been treated for my cancer, now I need to get treatments for these other things. And unfortunately not everybody's going to recover it. But again, I have many tricks up my sleeve to be able to fix.

Dan:

And if you do go for a prostatectomy, try to look for someone who's had a lot of experience that's going to help you if you're going to try to do nerve sparing or anything else.

Dr. Sherita King:

But again, that depends on the grade of your cancer. So it's very important to remember that.

Dan:

Mm-hmm.

Dr. Sherita King:

Do you have to do Kegels forever? So if you stop going to the gym, what happens to your muscles? They go away, right? So yes, you should do Kegels forever because you should be doing aerobic exercise like multiple times a week just to keep your health up. So if you stop doing them, you're not going to have the response from them. And I think...

Dan:

Yeah, that's the main thing for me is exercise it even when you don't feel like it every day. Some kind of a workout for weight bearing, because especially if you're on hormonal, your bone density can weaken and you want to keep us everything working, every single part of the body working.

Dr. Zach Klaassen:

Yep, exactly.

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Dr. Sherita King:

Absolutely. Well, you see any other questions, Dr. Klaassen?

Dr. Zach Klaassen:

I wish we had three hours. I know. I think to stay within our allotted time, I want to thank Dan for his excellent discussion, Mr. Ricky Lee, Dr. Sherita King's expertise, the Prostate Cancer Foundation for giving us this platform to discuss these topics today. And I encourage you to register for the July 18th Hormonal Therapy webinar and once again, thanking Lantheus for their support for allowing us to put on this webinar tonight. Thank you very much and appreciate everybody's attendance. Thanks.