

**Transcript of Intimacy and Prostate Cancer Teleconference
Hosted by Us TOO International**

**Moderator: Elizabeth Cabalka
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Elizabeth Cabalka: Welcome to tonight's program, "Intimacy and Prostate Cancer." This program is brought to you by Us TOO International Prostate Cancer Education and Support Network and funded in part by a generous contribution from American Medical Systems. We have an excellent program for you tonight with a knowledgeable panel.

First, the purpose of this call is threefold – to provide you with information about the physical links between prostate cancer treatments and impotence, or erectile dysfunction, also called ED; secondly, to allow you to hear from a couple who has faced prostate cancer related erectile dysfunction and the challenge of recreating intimacy – reclaiming intimacy and finding satisfying solutions to bring intimacy back into their relationship. This couple is also featured in Us TOO's original book, "The Circles of Love Collection," available through Us TOO International. Finally, our third objective this evening is to provide you with an opportunity to ask questions and explore solutions that can bring intimacy back into your life.

My name is Elizabeth Cabalka. I am a member of the Us TOO Companion and Family Advisory Panel, as well as a consultant and author. We have an excellent panel participating in tonight's call.

Our first panelist is Dr. Lawrence Hakim, head of the Sexual Dysfunction Male Infertility and Prosthetics section at Cleveland Clinic Florida in Weston, Florida. Dr. Hakim, a Board-certified Urologist directs a state-of-the-art academic center at the Cleveland Clinic Florida, specializing in

diagnosis and all of available medical and surgical treatments of sexual dysfunction in men and women and male infertility.

Dr. Hakim is also the author of the acclaimed book, "The Couple's Disease, Finding a Cure for Your Lost Life." Stay tuned, folks. We have a special announcement about that book later in the call. He's also authored numerous academic abstracts, publications, and has written a number of textbook chapters in the areas of sexual dysfunction, penile microsurgical revascularization surgery, and male infertility.

Thank you so much for being on tonight's call, Dr. Hakim, and welcome to the program.

Lawrence Hakim: Thank you very much. I really want to thank you and the entire Us TOO organization, which does wonderful work, and especially thank American Medical Systems for helping to sponsor this. And I think it's wonderful to hear there are so many hundreds of people listening tonight that have been affected by these problems that are looking for the answer. And I think that's the key is really educating yourselves to understand many of the issues surrounding the treatments of prostate cancer and restoring intimacy after the treatment for prostate cancer. And I think that's where many of the myths come in that need to be addressed.

Elizabeth Cabalka: Yes.

Lawrence Hakim: You know, I think it's important for people to understand that even without prostate cancer, one out of two men will suffer from erectile dysfunction. It's estimated that 52 percent of men over 40 has some degree of erectile dysfunction. So, you know, it's a very important problem facing society as a whole.

And before we go too far, I want to reiterate my point, which is that sexual dysfunction is really a couples problem. It's a couples' disease. It affects both the man and his partner. And it's

important not to forget that. I think when we start looking at treatment options, we need to do what we do at the clinic – at the Cleveland Clinic is really involve the partner in every facet of the evaluation and even beyond that, to learn to understand that oftentimes the partner has issues (of) sexual dysfunction that need to be addressed, as well. So, we try to really improve sexual intimacy in the couple, and I think that's one of the issues that we talked about in the book and what we're going to hopefully have people focus on as they move forward.

Elizabeth Cabalka: Dr. Hakim, I'm just going to have you pause for a moment. I want to introduce the rest of our panel and tell people how they can submit questions to the call, and then we'll jump into the logistics and the meat of the program.

We're also thrilled to have Jerry and Jo Ann Hardy on the program tonight. Jo Ann serves as the only female member of the Us TOO International Board of Directors and she also serves as the Secretary of the Us TOO Executive Committee. In addition, she is a member of the Us TOO Companion Family Advisory Panel. Jerry is a prostate cancer survivor. He and Jo Ann are also active participants in an Us TOO Support Group Chapter near Detroit, Michigan. Welcome, Jerry and Jo Ann. It's wonderful to have you on the call.

Jerry Hardy: Thank you for having us, and we're excited that we have so many people here listening in today.

Elizabeth Cabalka: Absolutely.

Jo Ann Hardy: We sure are, Elizabeth. We're glad to be here.

Elizabeth Cabalka: Wonderful to have you.

Tonight's panel presentation will last approximately 30 to 40 minutes, followed by a 15 to 20 minute question-and-answer session. For our listeners, if you would like to submit a question of our panel, please press star one on your touch-tone keypad at any time during the call. When you press star one, you will be added to the question queue or lineup.

While in the queue, you will be able to continue listening to the main presentation until it's your turn to submit a question. After submitting your question, you'll be able to easily return to the program in process using your touch-tone keypad. Our call operator and Maureen Kiefert, also known as Mo, a member of our Us TOO Companion and Family Advisory Panel, will pass your questions on to the panel to be addressed later in the program. We'll make every effort to thoroughly address as many questions as possible this evening. Again, you may press star, one at any time to submit a question for our panel.

As I mentioned earlier, we have a fabulous panel this evening and you heard a bit from Dr. Hakim. I want to, again, welcome you to the call and thank you for sharing your knowledge on the topic of prostate cancer related erectile dysfunction and, perhaps most important to our listeners, the many solutions available today.

Dr. Hakim, let's start with the basics. What is the link between prostate cancer treatment and erectile dysfunction?

Lawrence Hakim: Again, thank you so much for having me. I, you know, I think there is a significant link between any of the treatments for prostate cancer and erectile dysfunction. And I think one of the big myths is understanding that living with erectile dysfunction after prostate cancer does not have to be inevitable.

And I think there are excellent treatments out there that can fix the problem in men who have had radiation therapy, men who have had seeds or external radiation therapy, and men who have had

surgical treatment, whether it's laparoscopic, robotic, or open surgery. All of these treatments can affect both the nerve supply to the erection, they can affect the blood supply to the erection and significantly impair a man's ability to obtain or maintain an adequate erection (for) intercourse, which is really the definition of erectile dysfunction. And we see this, too, in men who have been treated with hormone therapy.

You know, I think another issue is keep in mind that there are many other risk factors for erectile dysfunction, including heart disease, diabetes, hypertension, cholesterol, smoking. The reason I bring these up is oftentimes men who are diagnosed with prostate cancer have other comorbid issues, and this is important when we look at treatments, when we look at the timing of treatments, for instance, let's say, a 40-year-old man with prostate cancer who is otherwise healthy with no erectile dysfunction may be treated a little different than a 75-year-old man who already had erectile dysfunction before treatment for prostate cancer. So certainly, there is an important link. And I think that's really what's going to make us look at treatment options and how we advance those therapies.

I think we have to understand that quality of life is important at any age and that certainly, erectile dysfunction as a result of prostate cancer treatment significantly does impact upon intimacy in a couple's relationship and quality of life. And again, as I mentioned before, it's important to understand that this problem can also – can always be fixed.

When we look at treatment options, I think it's nice to break the treatment options down into what we would consider to be first line therapies, second line, and then third line therapies. In most cases, most men will begin with first line treatment options after they've been treated for prostate cancer or once a diagnosis of erectile dysfunction is made. And it's important to understand that we look at timing of treatment, as well, whether it's after radiation therapy, whether it's after surgical therapy. And in our practice, we try and begin the – what we call rehabilitation or penile

rehabilitation process as early as possible. And in the case of surgery, we try and begin it certainly within a few weeks of the surgery, and in the case of radiation, sometimes even sooner.

The idea – excuse me – my cough – getting over this cold. The idea of penile rehabilitation especially as it pertains to men who had good erectile function prior to the treatment is to see if we can maintain that erectile function or help to bring it back to their normal baseline at an early time. This can – is typically done today with various oral therapies. And again, this gets backs to the first line therapies that we talked about before. The gold standard first line therapies today are what we call the PDE5 inhibitor treatments or drugs like sildenafil or Viagra, or vardenafil or Levitra, or tadalafil or Cialis. These are the agents that are most commonly used for men who have erectile dysfunction and now are being used, as well, in men whose treatments – again, surgery or radiation – to help rehabilitate their sexual function.

We also are very popular using the vacuum erection device – again, a device that helps to not only in men trying to have sexual intercourse to (allow) erection, but in during the rehabilitation stage, a treatment option that can often help to increase bloodflow and help to maintain and rehabilitate that normal sexual function in some men. The other key feature of rehabilitation therapy, or treating men early is helping them, again, to get back into their normal intimacy, understanding that this is a couple's problem and that once the man is over that acute phase of treatment, that the next step in their life is to get back to normal and part of that being normal is to be able to enjoy normal intimacy with their partners, and that's one of the reasons why this type of treatment is so popular and is instituted so early.

Second line therapies are typically used in men either in whom first line treatments are not effective or in the number of men where they can't be used. And, again, keep in mind the PDE5 drugs are not necessarily for everybody. Men who have significantly heart disease, for instance, who are on nitroglycerin or other nitrates should not be using the PDE5 drugs. And I think that's an important issue that men need to be aware of. Men who experience side effects of those

drugs may not use them. And men who have severe erectile dysfunction, such as men after prostate cancer treatment, may not respond to even high dose medication. In those situations, we do move onto second and third line therapies.

Are there any questions at this point that you wanted to ask or should I just keep ...

Elizabeth Cabalka: Please keep going. You're doing a beautiful job. Thank you.

Lawrence Hakim: As I said, with the second line therapies, first of all we talk about the non-medical therapies, such as the vacuum erection device. And as I mentioned before during the rehabilitation phase, this is a very popular treatment, as it is for men during the treatment phase itself. And it's a very simple non-invasive therapy which can be quite effective for some men. Other non-oral therapies include the urethral insert, known as Muse, and the gold standard of second line therapy, known as intracorporal injection therapy. Medications that are FDA-approved are typical, such as Caverject or (Edek), although in some cases (on) the medication, mixtures such as (Trinex) can be used, as well.

There are potential side effects with some of these medications, especially with injection therapy, and certainly the spontaneity factors, pain factors, nodules, and other problems, for some men, typically have led to the somewhat high incidence of men stopping to use these treatments over time and leaving them typically to third-line therapies. The other thing to keep in mind is that oftentimes people use combination of first and second line therapies where we may combine the use of a PDE5 drug with a vacuum device or other second line therapy. And this can help some men, as well, who don't respond to pure first line therapies alone.

Elizabeth Cabalka: So, continue on with the third line.

Lawrence Hakim: The third line therapy typically becoming increasingly popular for men and increasingly the best choice for many men with what we consider more moderate to severe form of erectile dysfunction is the penile prosthesis. This is especially useful in men after prostate cancer therapy, whether it's surgical therapy, whether it's radiation therapy, and as I mentioned before, men with other types of significant vascular disease. One of the main advantages is that it allows men to get an erection any time they want, anywhere they want, for as long as they want. No other treatment gives them that degree of effectiveness and spontaneity. The pleasure sensation is completely preserved, men can ejaculate when using the implant; however, it doesn't go down after an orgasm. So, it's another advantage.

Studies have shown greater than 95 percent patient satisfaction after five years, so, again, this is a very popular treatment with probably a higher satisfaction rate across the board than any of the other treatments. There are different types of penile prosthetic devices. The gold standard is what we refer to as the three-piece penile prosthesis, which best approximates the normal feel of a natural and normal erection. These basically devices are implanted in a about a 20 to 30-minute procedure through typically a small opening in either the scrotum or the lower abdomen. They are completely concealed and they allow men during sexual activity to get a very natural and normal feeling erection.

There is a small pump that is placed into the scrotum that helps to transfer the fluid which is typically just normal semen or IV fluid from the pump and reservoir into the cylinder, so giving a man a very natural feeling erection. There is a small deflate pump mechanism that allows men to deflate the device when intercourse is over, allowing them to go back to a very natural flaccid state. As I mentioned, the device is completely concealed, it does not affect urination or sensation. It allows them to be sexually active with a very natural feeling erection anytime they want.

And that's one of the big advantages over treatments such as the oral medications or injectable medications that do lack that degree of spontaneity. There are different companies that make the device. American Medical Systems is the leader in this – in this area, as well, and their newest device allows for a quick deflate, so it's much more simply for men to utilize this device with excellent cosmetic and physical results.

Any questions at this point?

Elizabeth Cabalka: Well, I think what I'm hearing you say, Dr. Hakim, whether listeners remember all of the different options that you listed or not, most importantly they're hearing that there are options.

Lawrence Hakim: Correct.

Elizabeth Cabalka: There is hope. There are possibilities.

Lawrence Hakim: Right. I think that's the most important thing to remember, whether we're talking about first or second or third line treatment options, the treatment options that are available – the problem can always be fixed. There are different types of pills, there are different other treatments, and there are different types of implant devices. And some men, as I mentioned, there's the three-piece device, there are two-piece combined devices, there are malleable devices. Again, these are decisions made with the patient and the couple. Again, this is a couple's decision, and that will allow them to make that decision for the device that best suits them. And again, these are very individual decisions, and these are made, you know, between the physician and the patient.

Elizabeth Cabalka: Such terrific news. Oftentimes I hear prostate cancer patients and their loved ones or their partners talking about their urologist wasn't able to engage in discussions of sexual function

or dysfunction. How do patients go about finding a urologist who is so knowledgeable and interested and willing in speaking with him and working with him to find solutions?

Lawrence Hakim: You know, I think that's a great question. And I face this all the time when I'm talking to patients, whether they're prostate cancer survivors or not, is that nobody talked to them about this problem, whether men with sexual dysfunction, women with sexual dysfunction. It's something that we just don't talk about, and many physicians feel very uncomfortable talking about it. So, I really put the onus on the patient and on the couple to, number one, bring it up to their physician and, you know, talk to them and to understand what their alternative – their options are and to educate themselves as to the treatment of, you know, options available so that they can specifically request certain treatments.

The other thing is to keep in mind that many of the doctors that are treating the prostate cancer, that's really the focus for a typical oncologist that's treating prostate cancer – urologic oncologist, the focus tends to be really on the cancer. And once the cancer is cured, for many people as I've heard, that's kind of where it ends. And as long as the patient's cured, it's felt that – that it's been a great success. And I think in some situations, that almost is doing people a disservice because we're not looking beyond the disease. We need to look beyond the disease and look, as I mentioned before, at quality of life issues.

Now that we have a survivor, we need to help restore their quality of life, we need to restore that intimacy in a couple, and I think it's really up to you and your partner to seek out a physician who specializes in the area of sexual medicine, sexual dysfunction that can offer you the different treatments, to talk to your physician about the treatment options to find the option that's best for you.

Again, there's no magic treatment, there's no single therapy that's going to be right for everybody. And I think understanding that and understanding that you need to speak to someone who really

understands this field and is really interested in talking to you about it and helping you will give you the ability to restore your sexual function. And I – and I tell men there's no reason we can't restore your sexual function to when you were in, you know, your twenties and thirties with the various treatment options out there. And I think it's very important to keep that in mind, that you don't have to give up that degree of intimacy and that level of sexual function despite having had some treatment for prostate cancer.

And again, I go back to the point before. It really doesn't matter if you've had surgical treatments, if you've had the minimally invasive treatments, if you've had radiation therapy. Really very few – there's no treatment for prostate cancer that's been shown not to have any impact on sexual dysfunction, and many, many men after prostate cancer treatment, especially those men who had some problem who are over 60 years old are going to notice significant sexual dysfunction. And the sooner they get treated, they sooner they look at their treatment options, the sooner they consider the therapies that are available to them, they sooner they're going to help restore that quality of life and intimacy that they would otherwise be lacking and I think would be a shame to give up.

Elizabeth Cabalka: Dr. Hakim, is it safe to say that the majority of the physicians that are specializing in treating sexual dysfunction would be urologists?

Lawrence Hakim: For men, typically that tends to be true. And I think most of the centers around the country, where there are centers of sexual medicine, sexual dysfunction, you're going to find these are typically run by urologists, and I think for very good reason because there are many different treatment options, as we mentioned before. And to just be given one alternative doesn't really give you all the options that would possibly be appropriate for you. And a urologist is really the only kind of physician that can offer you first, second therapies – second line treatment options, third line treatment options.

All too many times I've heard from patients that their primary doctor – the primary care physician gave them a pill and it didn't work and told them there's no more hope. And that's the worst thing you can tell a patient because for the urologist that specializes in ED, you know, you can always fix the problem. I tell a man that comes into the office, as long as you have a penis, we can get it hard. There's one way or another, whether it's a simple oral therapy or a surgical treatment option.

As I mentioned before, the new implants which are the surgical gold standard can be placed in a 20 – 30-minute procedure typically done as an outpatient that restore a man's normal a man's normal sexual function. So, again, it's something that the urologist is able to treat and finding a urologist who specializes in sexual dysfunction therapy will really give you that chance to, you know, achieve the greatest success.

Elizabeth Cabalka: That's such terrific information, Dr. Hakim. Can you stick around for our question-and-answer portion of the call later?

Lawrence Hakim: Oh, sure.

Elizabeth Cabalka: OK, terrific. As I mentioned, folks, we have a very special announcement regarding Dr. Hakim's best-selling book, "The Couples' Disease, Finding a Cure for Your Lost Love Life." Dr. Hakim has generously donated 200 copies of this best-selling book to us to international. For our listeners, the first 200 people to e-mail a request to receive this book. Get your pens and pencils, folks. I have the instructions. In the subject line of your e-mail, the words "Free Book," your address to send that request to Gus – G – U – S – as in Sam, @ ustoo – that's U – S – T – O – O. org. Once again, it's Gus – G – U – S – @ustoo. org. In the body of the e-mail, include your mailing address and of course your name, and the first 200 to do that will receive a free book. We'll talk more about that later in the program, but I do want to thank you, Doctor Hakim, for your generosity.

Lawrence Hakim: Oh, thank you very much.

Elizabeth Cabalka: Again, if you'd like to submit a question for our panel to be answered during the question-and-answer portion of the call, please press star, one on your touch-tone keypad at any time. When you press star one you'll be added to the question queue, or line-up. While in the queue, you'll be able to continue listening to the remaining presentation until it's time to submit your question. After asking your question, you'll be able to easily return to the program in process using your touch-tone keypad. Our call operator and Maureen from Us TOO's Companion and Family Advisory Panel will pass your question on to our panel to be addressed later in the program. Again, you can push star, one at any time to submit a question for our panel.

Next we'll hear from dear friends Jerry and Jo Ann Hardy. I'm so pleased they're on the call. We'll hear from them about their journey to reclaim intimacy. Again, thank you so much for being on tonight's program and for sharing your inspiring story.

Jo Ann Hardy: You're so welcome, Elizabeth. We're really glad to be here. We're sitting here trying to figure out how we can get in the queue to get one of Doctor Hakim's books, but maybe we'll talk about that later after the call.

Elizabeth Cabalka: Sounds good. Jerry and Jo Ann, will you talk a little bit about how your journey with prostate cancer began?

Jerry Hardy: Yes. About August – the end of August of 2000, I was in my doctor's office for something totally unrelated. And at the end of my visit I just mentioned that I had a slight urinary problem. I didn't think much of it. But my doctor was really on top of it. He had taken a baseline PSA some time ago and decided to take another blood test – PSA – this time. So, when I returned to my

doctor to get the results, I found out that it was elevated – the PSA was elevated. It was at 4.5. It had been 2.0 earlier. Then we went on to the biopsy, and that's when we found out that we had prostate cancer.

Jo Ann Hardy: Yes, Jerry was only 46 years old at the time, so it was really shocking to us. And we really set about doctor shopping and trying to figure out the best treatment for Jerry, really the treatment that we felt would give him the longest – the longest life afterwards – the longest, healthiest life. So, we did actually go to three different oncology clinics to find out the treatment that we thought would be best for Jerry. And we did decide to have a radical prostatectomy in November of 2000.

Jerry Hardy: Right. In November of 200, right after Thanksgiving – as a matter of fact the Monday after Thanksgiving I did have the radical prostatectomy. It was successful. After maybe two months of recovery, we began to think about the side effects of the surgery.

Jo Ann Hardy: Yes, all of the treatment options, as doctor mentioned, pretty much listed erectile dysfunction as a possible side effect, but really we didn't base our decision on that. We'd done a lot of reading, and we figured, well, when we came to that point in our lives where Jerry was well and we wanted to reclaim our sexual intimacy, we just figured we would deal with it at that point. But the most important decision for us was to make sure that he was cancer free. And that's what we did.

Once Jerry did go back to work and I really liked what the doctor said about how important it is for couples to go back to their sexual lives. Now, for Jerry, there was no erection. There was a partial erection but not enough for intercourse, but it still was really important for us to go back to try have – reclaim our sexual intimacy. But after a while, we did realize that we needed to make some changes, and so we started our journey to deal with erectile dysfunction. Jerry can kind of say where we started our journey.

Jerry Hardy: We started our journey after about – a couple months after the surgery. There was also some incontinence involved, which lasted about three weeks, and that went away. I also nerve (sparing) surgery like Jo Ann said, I had a partial erection, but not enough to have intercourse. So, we tried Viagra, we tried Cialis, we tried the Caverject shots, and none of those worked.

Jo Ann Hardy: Yes, I want to back up and say that we – they have the commercial out now with the guy singing about Levitra, I think – no, viva Viagra is it, and everybody's singing and having a good time. Well, we did sing the viva Viagra song, we did lot of things to try and get Jerry to have an erection, but it was not to be. But I would like to put in a commercial for the male anatomy. There are a lot of fun and games that you can do without an erection, but for us, we found that the inability to have intercourse was really harmful to us and was really something that we missed and it was important.

But I think this having other types of sexual intimacy really help a couple bridge that gap while they're working on the problem. And for us, actually we waited about three years until we heard another couple give their story about how they solved the problem, and then we decided that we would go ahead and have an implant done. After trying the first and second line therapies, we went ahead and made the big decision for us to have the implant done.

Jerry Hardy: So, in about March of 2004 we decided to have the implant done. So, we did it. That was also successful. Of course, it's surgery, so it's going to involve some swelling. Three warm baths a day went a long way toward my comfort. So, after about four weeks, I went back to my urologist. We went over how to use it. Then I went home and we tried to take it for a spin.

Jo Ann Hardy: Absolutely. Now, I need to back up a little bit, Jerry, and just let our listeners know that we decided we would have an implant after three years, ...

Jerry Hardy: Yes.

Jo Ann Hardy: ... but our insurance company didn't decide that we would have an implant. We want to say right here how important it is for couples and for patients to really lobby for their own healthcare and for what they need. And it really took a lot of work and letter-writing and, you know, just really hanging in there with our insurance company. And ultimately after we fought so hard to get Jerry's implant covered, now it's in the handbook and it is a benefit that's offered by insurance companies. We just want to say don't let that be a barrier. You have a lot of fight in you. You made it through prostate cancer as a couple, and so you can continue to fight to get the other part that you need to restore your sexual intimacy, as well.

Jerry Hardy: Yes, so, that was in 2004. Like Jo Ann said, there have been some changes with the insurance company. So, if any of you decide to have that done, hopefully they'll OK it right away. So, once we – once the swelling went down and we learned how to use it, like I said, we came home and took it for a spin. It was nerve-wracking at first. It was something new – it was something new to my body. After awhile, the weight of – the weight of it just went away. You know, you can't feel it. It's really easy to operate.

Jo Ann Hardy: Yes, we've been truly enjoying it ever since. In fact, we certainly consider ourselves to be part of the 92 percent that's highly satisfied as the user and as the partner. And the best testimony I can give is to say if we wear this one out or when, we'll certainly be intending it on replacing it.

Jerry Hardy: Absolutely. One thing that's important throughout this whole journey is communicating with your spouse or your partner. Please communicate early and often. Please talk to your partner.

Jo Ann Hardy: Yes, Doctor Hakim said it is a couple's disease, it is a partner's disease, and I think that the reason why we are so satisfied is that we did work through the problem together. It's like I

usually when we do a presentation, a penile implant is not – maybe not so good a surprise for your spouse or partner. You don't have them come home after a time away and that's what you've done. I think it's something you need to talk about. And when you talk about it and you do it together, you can learn to use it together and learn to enjoy it together and get all of its benefits. And that's the way we approached it, and we just want to give our listeners tonight hope. There is treatment for you with erectile dysfunction. There is a way to have a satisfying sexual life again. And that's just why we're here. We're just here to give everyone hope tonight.

Jerry Hardy: Men, you know how we are. We don't communicate. This is not the time. Please communicate. Talk to your partner.

Jo Ann Hardy: Sure. We can be very understanding and we're here to help and support our loved ones.

Elizabeth Cabalka: I love the way you both use the term we have prostate cancer. We decided to have an implant. Clearly you are partners in this journey in every sense of the word.

Jo Ann Hardy: Absolutely, Elizabeth. We sure are.

Jerry Hardy: Yes.

Elizabeth Cabalka: My understanding, since we're talking about multiple possible options – you went through, started at the first line that Doctor Hakim mentioned, went through the second line, and then made the decision – a big one for your, as you mentioned, to have the third line treatment – the implant. My sense is that those people like you who will be successful are willing to try multiple options and not just give up after that first option. Would you agree?

Jerry Hardy: Oh, certainly I would agree. You can start off with the first option. If that doesn't work, go up to the second option. If that doesn't work ...

Jo Ann Hardy: ... conversations of more than one and your urologist, you keep shopping for a urologist that will listen and talk to you and help you work your way through the continuum until you find a solution that's satisfying for you, absolutely.

Elizabeth Cabalka: What I also hear you saying is the ultimate goal was reclaiming your intimacy and not being overly stuck on what form that took. You were committed to reclaiming in your life in the way that you wanted to have intimacy in your life, and you were willing to try multiple things to reach that goal.

Jo Ann Hardy: Absolutely.

Jerry Hardy: Absolutely. We're committed to each other, so we're committed to finding what we need to do to satisfy each other.

Jo Ann Hardy: Absolutely.

Elizabeth Cabalka: Thank you so much, Jerry and Jo Ann. I appreciate your frank discussion. And no doubt your story will provide hope for other couples facing similar challenges.

I want to remind people that the first 200 people to e-mail their request for Doctor Hakim's best-selling book, "The Couples' Disease, Finding a Cure for Your Lost Love Life." Please e-mail your request. In the subject line, write "Free Book." The address to send your request is Gus – G – U – S – @ustoo.org – U – S – T – O – O – .org. In the body of your e-mail, please include your name and mailing address and we will make sure that you get a free copy of Dr. Hakim's best-selling book, "The Couples' Disease." We really appreciate your generosity with that, Doctor Hakim.

Lawrence Hakim: Oh, you're welcome.

Elizabeth Cabalka: Now it's time to hear your questions. Before we do that, I want to acknowledge Maureen, also known as Mo, a member of Us TOO International's Companion and Family Advisory Panel. Thank you so much for helping us with this evening's question-and-answer session, Mo.

Maureen Kiefert: Oh, thank you. It's been – it's been my pleasure.

Elizabeth Cabalka: Tell us, Mo, what's our first question night?

Maureen Kiefert: Our first question is from Jeannie in Oklahoma City for the doctor. This patient is eleven months out of surgery and does suffer from ED. And his question is when can he begin to expect some improvement? And if the improvements take much longer, at what point should he be seeking further treatment for his ED?

Lawrence Hakim: How many months is he out?

Elizabeth Cabalka: Eleven months.

Lawrence Hakim: Eleven you say. And I think that's a great question. And I think one of the big problems with many physicians who treat prostate cancer is they tend to – as I mentioned before, have a very casual attitude towards erections, function, and have the feeling that, well, let's wait six months or a year for the erections to return.

One of the things that we've been undoing is trying to begin rehabilitation – penile rehab certainly after a few weeks, whether it's four weeks, six weeks, as I mentioned before, some of the first line and second line therapies. If certainly by six to twelve months out using these treatments, there's

no resolution, typically the function may require other types of therapies. And that's something that they need to discuss with their physician.

Elizabeth Cabalka: That is really an important question. If they're not finding the answers from their particular physician, perhaps can they ask for a referral to a urologist who specializes in sexual dysfunction?

Lawrence Hakim: Oh, I think that's vital as Jerry and Jo Ann talked about , you need to find someone who can help you in your area or, you know, seek out a physician who specializes in the treatment of sexual dysfunction.

Elizabeth Cabalka: Excellent. Thank you so much. Mo, what is our next question?

Maureen Kiefert: Our next question is from (Steve) down in (Houston). (Steve) had a radical prostatectomy four years ago and suffers from both incontinence and impotence. He had an artificial urinary sphincter put in three years ago, but still experiences some stress incontinence. He's been discussing having a penile implant, but he is concerned with leakage before, after, and possibly during intercourse. Can you address that please?

Lawrence Hakim: Yes, a very good question. And many of our patients after prostate treatment have both problems of incontinence and erectile dysfunction. It's very common, as I think, was mentioned by Jerry to have some minimal incontinence early on and in most cases ...

Elizabeth Cabalka: Yes. I think we have a phone ringing somewhere.

Lawrence Hakim: Yes, it's not on my line.

Elizabeth Cabalka: OK.

Lawrence Hakim: As I mentioned, in most cases it does tend to resolve.

Elizabeth Cabalka: There we go. All better.

Lawrence Hakim: Oh, good. OK. As I said, in most cases it does tend to resolve. But for men in whom those problems persist, the treatments include such devices such as a male sling or an (artificial) urinary sphincter. The thing to keep in mind even in the best situation is that these devices are not going to make men completely dry 100 percent of the time.

There are certainly disadvantages of making, for instance, a sphincter too tight or a sling too tight. And so men will not infrequently notice some mild stress incontinence even after placement of a successful sphincter device. In those cases – and it certainly should not be, you know, a reason not to proceed with a penile prosthesis, and typically we tell men before sexual activity to empty their bladder. Sometimes they have to activate the sphincter multiple times to make sure the bladder is completely empty.

As far as placing a penile prosthesis into someone who already has a sphincter or a sling, it certainly is not a problem in someone who is experienced doing this. And as I said before, we very typically do them both at the same time through a single small opening in approximately one hour procedure, we can place both an artificial urinary sphincter or a male sling and a penile prosthesis. So, again, these are very common problems that can easily be treated in men who have, again, in this case, through the erectile dysfunction as well as significant urinary ...

Elizabeth Cabalka: Excellent, thank you. Maureen, do we have another question?

Maureen Kiefert: Oh, yes, we have all kinds of questions.

Elizabeth Cabalka: Perfect.

Maureen Kiefert: Two are very similar. They are that – two of the people who called indicated that they are not having any ED problems, but where their problems are stemming from is lack of libido. And they wondered if you could address that.

Lawrence Hakim: Lack of libido can be due to many different things. And gentlemen, especially over 50 – 60 years old, we certainly can see a decrease in hormone levels such as testosterone which can certainly impact desire or libido. And in some men, just the fact that they're not able to perform to the degree sexually they were before, libido can be affected. Certainly in the latter case, by improving erectile dysfunction and whether it's with first or second line treatments or with a penile prosthesis, libido in those situations typically does improve.

It is a bit of a problem in men who have, I've mentioned, completely normal erections to have poor libido let's say due to a low testosterone level in prostate cancer because still the standard of care in most centers is not to replace testosterone in men who have a history of prostate cancer, especially within the first few years of treatment. After five years, some doctors and some centers are looking at the efficacy of treating those situations, but, again, the standard of care is not to proceed with that type of therapy and looking for another cause of the poor libido.

Elizabeth Cabalka: Is it possible to encourage couples to also find other ways to stimulate intimacy and maybe open that door a little bit?

Lawrence Hakim: Certainly, and I think that's an excellent point. And to take it even a step further, we work very closely with sexual therapist that use sex therapy and understanding there are many different types of sexual activity – non-coital sexual activity that can have an impact on libido and can improve it. And these are things that we look at.

The other issue we look at, again, is the partner being affected with sexual problems. One of the typical reasons that we see poor libido is, let's say, in a couple that, for instance, a married couple where the woman is having problems with sexual function, so she's lost interest or has pain or other problems with sexual activity and as a result is no longer initiating or responsive to sexual activity. And that can have an impact on sexual function and libido, and I think that's one of the important reasons why, again, in the book and in general we focus on sexual dysfunction as a couple's problem and really go let's say beyond testosterone, beyond those other issues to see what other factors are going on that can be impacting upon the poor libido and trying to address those, as well.

Elizabeth Cabalka: Jerry and Jo Ann mentioned that as well, that if you communicate and communicate often and communicate well that that or even to the best of your ability that that will certainly go a long way in finding solutions because it sounds like we have a logistical physical function challenge and we also have the mental, emotional, and relationship dynamic that's a part of erectile dysfunction or sexual dysfunction as a whole.

Lawrence Hakim: I think that's a very important point. And, again, one of the things I point out in the book – in "A Couple's Disease," is really the focus and the goal is intimacy. And if you really look at the letters, we talk about intimacy, the I is identifying the problem, N – notifying your partner and your physician, the T is really need a thorough evaluation, looking at other factors, I – there are lifestyle incorporating lifestyle changes, M – understanding the medical and surgical treatment options, A – in some cases alternative therapies, but C, again, is communication. I think communication is critical with your partner, with your physician, and talking about this early on will lead to Y, which is youthful rejuvenation and allowing you to, you know, basically retain that sexual function that you had before you had prostate cancer, before you had any problems with your erectile function. So, again, I think achieving intimacy is critical and communication is a very big part of that.

Elizabeth Cabalka: Thank you. Mo, what's our next question?

Maureen Kiefert: Our next question is twofold from Joe from Buffalo. His first question is, "Does Viagra – if used two or three times a week, does it have any negative effect on vision?"

Lawrence Hakim: You know, I think whether it's used two or three times a week or once a week, it doesn't necessarily have the impact, and I think the first part of that is there are men who use it regularly, both for the idea of penile rehabilitation, and second, for the idea of just treatment, and assuming that someone isn't – again, there are no other contraindications such as someone, for instance, using nitrates and there's – assuming that the drug is effective, it's certainly a very excellent option for some men. There's no predisposition to having visual problems and if a certain individual is having visual problems, noting blurred vision or colored vision changes, blue vision, that's something they need to talk with, you know, after they stop using the drug, they need to talk to their physician about it.

Maureen Kiefert: The second part of Joan's question is that he says that he is experiencing pain after ejaculation on a scale of two to five is where he – on a scale of one to ten, his is from two to five usually on the lower end, but it is persistent. And is that normal and what can he do about it?

Lawrence Hakim: It's not that uncommon and it's more commonly seen in men sooner after prostate cancer surgery. I don't know if he had a radical prostatectomy, but it's very common after men who've had a radical, even though they have a dry orgasm, they can sometimes have some discomfort there, whether it's the healing (phase), whether it's directly related to surgical – the surgery itself, in most men in our experience, that typically resolves over time and most men, after a period of time don't have that type of problem. In fact some men state that their orgasm after prostate surgery is even stronger and more intense without pain.

Elizabeth Cabalka: Now, he had seeds in '03. Does that change what you're saying?

Lawrence Hakim: Well, you know, again, radiation can have some other impact of – and, again, this is something he should discuss with his physician, but it can have impact on the nerves, on the – on the tissues in the (area of) the sphincter and these are things that may be, again, depending on the time out from the time of the seeds, something that he should discuss with his physician may have some impact on that.

Elizabeth Cabalka: Does that possibly improve with an implant?

Lawrence Hakim: What would – what an implant does – and, again, what an implant does better than any other treatment is restore normal sexual function. It restores a man's ability to get a very natural feeling, normal erection any time they want for as long as they want – very spontaneously. It has no impact on orgasm; it has no impact in this case on ejaculatory discomfort. And again, it has no impact on sensation. They'll still maintain their normal sensation and the pleasure sensation, again, is very well maintained. And I think that's the – what men can expect from an implant. I would not suggest that an implant is going to affect ejaculatory discomfort or anything along those lines.

Elizabeth Cabalka: Thank you for that clarification. Mo, back to you.

Maureen Kiefert: Yes, a question from (Karen) in Orlando. The question is, "Does blood pressure and cholesterol medication have any interaction with Viagra?"

Lawrence Hakim: Viagra is a drug that can cause smooth muscle relaxation and certainly cholesterol medication probably will not, but if men are on multiple antihypertensive agents, it's something they should discuss with their physician. Although men who have blood pressure problems who are on antihypertensive agents are typically some of the most common men using Viagra. So, again, it's a very safe drug, again, if used properly and recommended by your physician.

Elizabeth Cabalka: Maureen?

Maureen Kiefert: Yes. Gary from Minnesota has been on Lupron for 18 months and he feels that his penis has become so short that he's having great difficulty preparing to urinate. He does not have trouble with urination itself, but just preparing for it he's having some difficulty.

Lawrence Hakim: Any of the treatments for prostate cancer can affect length. Often we can see what we call corporal fibrosis and scarring and in addition to having sexual dysfunction, we can see physical changes in penile length on many men, whether it's Lupron or especially (combination) of radiation and surgery will tell you that they've noticed a significant decrease in the length of the phallus compared to the length it was prior to any treatment. Again, this is something that can be attributed to the type of therapy and, you know, as a result, can have that physical impact.

Elizabeth Cabalka: So, what about solutions in that situation?

Lawrence Hakim: Well, for men, for instance, after prostate cancer therapy such as a radical prostatectomy, one of the things that people have tried using is regular use of a vacuum device, typically done without the ring, used almost as a penile rehabilitation exercise where they use the device two to three times a day for 10 or 15 minutes. And there are – there are some data out there to suggest that that may improve penile length and is something that, again, as part of the penile rehabilitation protocols that are commonly used in men especially after prostate cancer surgery that can help to restore length back to the level they were before or at least beyond where they are post-surgery.

Elizabeth Cabalka: Terrific. Thank you.

Maureen Kiefert: Keith in Wisconsin had surgery one year ago, and he believes his sexual function is beginning to return. Even though he has no partner at this time and he wonders what effect that has on his improvements or lack thereof.

Lawrence Hakim: Well, certainly, if he's not – someone is not sexually active at all, one of the things men notice after prostate cancer surgery, for instance, is a loss of nighttime erection. So if they're not getting the blood-flow during the nighttime during the REM cycles of sleep, which most men who have normal sexual responses will do, and they're not sexually active during the rest of the week and this goes on for months and months and months after a prostate cancer surgery, that problem we talked about, whether it's corporal fibrosis or scarring can progress to the point where they may not be able to regain their normal sexual function. And I think that's one of the reasons why people are so interested in looking at the idea of penile rehabilitation.

And while I think the jury is still out, it certainly inherently would make sense that if you can improve erectile function and improve erection and improve blood flow to the penis and improve the oxygen level to the tissues that are not getting there because of a lack of nighttime erections or lack of sexual function, by using things as I've mentioned before regularly such as the vacuum device two or three times a day or the PDE5 drugs on a regular basis or even injection therapy two or three times a week, that by doing these things, the changes of retaining and regaining some degree of normal function I think is going to be improved. And again, especially in a situation where you're not sexually active with a partner, I think these types of exercises become much more important.

Elizabeth Cabalka: Well, folks, we're reaching the top of the hour here. I imagine we have many questions that have gone unanswered, and we will do our best to try to answer those on our Web site after the call. I want to thank all of you who submitted questions and very special thanks to Mo for supporting this part of the program.

For additional information about prostate cancer related erectile dysfunction or for further information about some of the solutions discussed on today's call, please call Us TOO International toll free at 1-800-808-7866 Monday through Friday from 9:00 a.m. to 5:00 p.m. Central. Again, that's toll free 1-800-808-7866. You may also go to our Web site which is loaded with terrific information, and that's www.ustoo.org – www.ustoo.org for a wealth of information about this topic and many, many other prostate cancer related topics.

A reminder, we have 200 copies of Dr. Hakim's best-selling book, "The Couple's Disease, Finding a Cure for Your Lost Love Life." To get your copy, send an e-mail to [gus – G – U – S – @ustoo.org](mailto:gus-gus@ustoo.org). I'll repeat that. [G – U – S – @ustoo – U – S – T – O – O – .org](mailto:gus-gus@ustoo-ustoo-t-o-o.org). In the subject line, place the words "Free Book," and in the body of the e-mail include your name and mailing address. Again, special thanks to Doctor Hakim for his generous donation of these books.

Lawrence Hakim: Oh, you're very welcome.

Elizabeth Cabalka: We so appreciate Jerry and Jo Ann sharing their time and their invaluable insights and the time that Doctor Hakim has shared with us tonight. I know you have a cold and I know that it's challenging to talk ...

Lawrence Hakim: ... And again, I want to thank you so much. It's really a great format and a great process to allow people to learn more about this important problem. And hopefully from reading the book, "The Couple's Disease" and even on our Web site, SexandWellness.com, they'll get a lot of information about the treatment options for sexual dysfunction and understand that they just need to see a physician in their area that specializes in sexual medicine, and they can restore their normal sexual function.

Elizabeth Cabalka: Jerry and Jo Ann, was there anything that you wanted to add before we sign off for the evening?

Jerry Hardy: Nothing to add. We are just happy that so many signed up to learn about erectile dysfunction and hopefully we said something to inspire or help someone tonight.

Elizabeth Cabalka: Oh, you certainly did. Thank you. And most of all, what I sense from tonight's call is that there is hope, there are many options. Those who communicate well, those who are advocates for their own healthcare, there are options, there are solutions. Thank you for listening to tonight's program. Be sure to watch our Web site – again, that's www.ustoo.org in the coming weeks. We'll have a complete downloadable transcript as well as a downloadable audio recording of tonight's call. In addition, we encourage you to explore the Web site, ustoo.org, for excellent information, free materials, and valuable links about many prostate cancer related topics.

For those of you in the Chicago area, we ask that you also pay attention to Us TOO's International's Windy City Update Prostate Cancer Symposium taking place this Friday evening, November 2, featuring world-class speakers on a variety of timely topics, food, music, and exhibitors. You can register and learn more about the Windy City Update by going online to www.ustoo.org.

This program was brought to you by Us Too International Prostate Cancer Education and Support Network and is funded by a generous contribution from American Medical Systems. For all of us at Us TOO International, we wish you and your families the best of health. Good night.

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