Hope • Recovery • Support
INSIGHTS TO HELP YOU LIVE LIFE RESTORED …after prostate cancer surgery

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Every year, more than a quarter of a million men are diagnosed with prostate cancer. It is the most commonly diagnosed cancer in American men today. If detected early, prostate cancer is usually curable.

Like many men, you have undergone surgical treatment for your prostate cancer. Advances in surgical techniques have allowed surgeons to successfully operate on a growing number of patients, and today surgery offers the greatest chance for cure for organ contained prostate cancer.

As you move into the recovery phase of your journey, we have put together this resource kit designed to provide you with important information about what to expect after your surgery, tracking your progress, support options, and other important things to know during the coming months.
POST-SURGERY RECOVERY
The issues surrounding prostate cancer aren’t limited to diagnosis and treatment. There are important physical and emotional considerations to deal with after surgery as well. It is likely you have many questions about the coming weeks and months. Your health care team will provide you with detailed instructions for post-operative care, but this section provides general information about how you may be feeling and what you might expect after your surgery.
“You are beating back cancer, so hold your head up with dignity.”
– LV-TX
Foley Catheter

When you are discharged, you will have a tube (Foley catheter) in your urethra coming out the tip of your penis to drain urine while the bladder recovers. The catheter will generally be in place for approximately one to three weeks, and must be properly cared for. You will be taught how to take care of the catheter and empty the bag periodically. If the catheter falls out or there is inadequate drainage, you should contact your health care team immediately and follow their instructions. You will be advised on removal of the catheter. Some physicians request that you make an appointment to have the catheter removed in the office, while others will provide instructions for you to safely remove it on your own.

Incision

Depending on the type of surgery you had, you may have multiple small incisions in your abdomen or one large incision and you may have a dressing. Some men will have this dressing removed on the day they are discharged or it may be removed at a later time. Your health care provider will review with you how to care for your incision site at home. Most men are able to shower as soon as the incision drains are removed, but are advised against extensive soaking in water, such as a bath, hot-tub or swimming pool. Call your physician if your incision becomes infected or re-opens. Signs of infection are fever, redness, swelling, and/or a puss-like discharge.
Medications

Most patients generally experience some discomfort after surgery, and ibuprofen or acetaminophen will usually help alleviate any pain. Your physician will discuss your pain management needs, and may provide a prescription for additional pain medication if needed. If you require additional pain medication it is likely this medication will be a controlled substance and require a written prescription. This type of medication cannot be telephoned into the pharmacy. It is generally advised to abstain from alcohol when on pain medications. An oral antibiotic may be prescribed, and a stool softener may be suggested to ensure that bowel movements don't cause additional strain on your surgical site.

Talk to your doctor about resuming any other prescription medications after your surgery. Most can be resumed upon discharge.

Diet

Most men are able to resume their previous diet following surgery, but your doctor will provide you with any specific requirements. Eating plenty of fresh fruit and vegetables and increasing your fluid intake can help keep your stools soft for comfortable bowel movements.
General Activities

Patients are generally advised to refrain from driving for a period of time, typically one week after surgery. After that, you can likely resume most of your normal routines, although strenuous and jarring exercises (such as heavy lifting, cycling, motorcycle riding and horseback riding) should be avoided for a full six weeks or as your doctor advises. In addition, abstain from sexual activity according to your doctor’s advice. This can vary from a few days to several weeks to a month or so following removal of the catheter. Depending on the type of work you do, you may be able to return to work within two to three weeks after surgery. Talk to your doctor about what’s right for you.

You are encouraged to walk and climb stairs as much as possible during your recovery and refrain from sitting in one position for longer than 45 minutes. Patients should not take baths or swim until the incision(s) is healed, generally around four weeks. Showering may be permitted 48 hours after the procedure.

After the catheter is removed, your doctor will advise you on beginning regular pelvic floor/Kegel exercises. These are designed to help strengthen the muscles of the pelvic floor below your bladder. This can lead to improved continence and sexual function.
“Prostate cancer is a journey, and I finally feel like I’m in the driver’s seat again.”
Recovering Bladder Control and Erections

In order to remove the cancer, the mechanisms in your body that help control your urine flow and ability to get an erection may be damaged. Most men are understandably concerned about their ability to regain bladder control and erections following their prostate surgery.

While men often experience incontinence (leaking of urine) immediately following surgery, the leakage usually tapers off within weeks or several months. When incontinence persists beyond several months, you should consult your doctor. The good news is that there are more treatment solutions than ever before.

The same is true for erectile dysfunction (ED). ED is known to be a potential complication following prostate cancer treatment. With the advent of nerve-sparing procedures, some men may regain their existing erectile function, although it may take anywhere from 6 to 12 months. The journey is different for every man, and some may not recover their ability to have a natural erection. However, it’s important to know that there are both short-term and long-term solutions that can be effective – nearly every man can be successfully treated and regain a satisfying sex life.
We have devoted an entire section to each of these topics, because they are important for most men during their recovery phase.

“I want my husband to be himself again. And I want us to be ourselves again, together.”
“It can take some time to get past prostate surgery. Now, after 24 months, my life is so much the same as before – and so very different.”
REGAINING CONTINENCE
“Knowing what and why it’s happening is your first goal, then once you know what’s happening you can do something about it. Having to live with it isn’t a requirement, you’re in charge of your life, incontinence isn’t in charge.”
While getting rid of the cancer is most patient’s top concern, the fear of becoming incontinent is often on a man’s mind. Prostate cancer surgery may cause weakness in the pelvic floor muscles and the urinary sphincter that normally control urine flow. Once the catheter is removed after your surgery, you may experience symptoms ranging from light urine leakage (a few drops when you exercise, cough or sneeze) all the way to a complete inability to control your urination.

The Journey to Continence

Continence tends to improve over time. While every man’s situation is different, many find they regain continence within six months to a year after surgery. Recovery can be impacted by factors such as your age, your general physical health, and the degree to which you had full bladder control before the surgery. If after 6 to 12 months the symptoms persist, contact your doctor.

Until urinary control returns, using absorbent pads or special absorbent underwear can help. Your doctor will also likely encourage you to perform regular pelvic floor/Kegel exercises. These isolate and strengthen the pelvic floor muscles and can help many men regain bladder control following prostate surgery. It is important to do the exercises correctly and regularly. It may help to work with a nurse or physical therapist on the exercises to ensure you are doing them properly and often enough. You may ask your physician for a physical therapy referral if you feel you need one. Some men use collection devices such as external or condom catheters or urine collection pouches to avoid accidental leakage. In the weeks and months following your surgery, talk to your doctor about your treatment options and your progress in regaining continence.
How Common Is Incontinence Following Prostate Cancer Surgery?

Although urine leakage is temporary for many men after prostate cancer surgery, persistent leakage is not uncommon. According to the US TOO International Prostate Cancer Education and Support Network, patient surveys have shown a 39-63% prevalence of some level of incontinence one year after surgery, with 24-56% of patients wearing absorbent pads. Long-term incontinence can have significant consequences on physical and emotional well being as well as quality of life. If you are experiencing ongoing urinary leakage a year after surgery, we urge you to have continued discussions with your doctor about the available solutions.
“I couldn’t walk on the golf course or go to the driving range. At work it seemed as if I was always in the bathroom, I needed to find out what I could do about it before it took over my life.”

“Seeing my doctor was one of the best things I’ve done. I don’t think we could have dealt with it much longer. Now it’s as if it never happened and we are enjoying our lives as we did before I became incontinent.”
Taking Control: LONG-TERM SOLUTIONS

For those men who do experience long-term incontinence, it’s important to remember that there are effective medical and surgical solutions available that can restore your dignity, control and quality of life.

“You just have to make peace with yourself and answer the question: ‘Am I willing to leak the rest of my life?’ If the answer is ‘NO’, you’ve taken the first step. I had my Artificial Urinary Sphincter implanted 8 months ago and the results have been wonderful.”

– Gene
• **Injections** – Injecting bulk-producing agents, such as collagen into the bladder neck can help keep the urethra and bladder opening closed and may help prevent small leaks. If successful, you may require repeated injections over time to maintain continence.

• **Male Sling** – The AdVance® Male Sling System from American Medical Systems (AMS) is a minimally invasive, surgical procedure for correcting mild to moderate stress urinary incontinence. A small “sling” made of synthetic mesh is placed inside the body through three small incisions. The sling supports the urethra, restoring normal bladder control. Most patients are continent immediately following the procedure and can resume normal, non-strenuous activities within a few days.

• **Artificial Urinary Sphincter** – The AMS 800® Urinary Control System is the “Gold Standard Treatment” for moderate to severe incontinence. This implantable device mimics the function of a healthy urinary sphincter, closing off the urethra in order to stop the flow of urine. The procedure involves implanting an inflatable cuff around the urethra, which is inflated by a fluid-filled balloon that is placed behind the pelvic bone. A pump inside the scrotum allows the man to deflate the cuff when he needs to urinate. It will automatically re-inflate firmly closing off the urethra and preventing leakage.
Pelvic Floor/Kegel Exercises – A Kegel is the name of a pelvic floor exercise, named after Dr. Kegel who discovered the exercise. These muscles are attached to the pelvic bone and act like a hammock, holding in your pelvic organs. To isolate these muscles try stopping and starting the flow of urine. Kegel, or pelvic floor muscle exercises are done to strengthen the muscles which support the urethra, bladder, uterus and rectum. At first you may need to perform these exercises while sitting. As the muscles strengthen you can progress to exercise standing up. Like any activity, start with what you can achieve and progress from there. Remember to use your muscles whenever you exert yourself during your daily activities such as coughing, sneezing, lifting, bending, or getting out of a chair. Anticipate that improvement in pelvic floor muscle strength will take 3 to 6 months of regular training of the muscles.
RESTORING YOUR SEXUAL HEALTH
Erectile dysfunction (ED) following major pelvic surgery is not uncommon. The nerves which control an erection lie very close to the prostate, and may be injured by being cut or separated from the prostate during surgery. This may cause temporary or permanent difficulty in achieving an erection, although sexual desire is not usually affected. After prostate cancer surgery you can still have an orgasm (climax), but you will ejaculate little to no semen.
Many men find that it takes 6 to 12 months to regain their ability to have an erection if it is going to return. Nerve-sparing surgical techniques can help to minimize the potential for erectile dysfunction. Talk to your doctor about your expectations and experiences after surgery. Should the ED persist, there are both short-term and long-term solutions that can be considered, and you will want to discuss which solution may be right for you. Sexual performance will be dependent on your abilities prior to the surgery. If you were able to perform well before the surgery chances are better you will perform well after the surgery.

**Penile Rehabilitation**

A penile rehabilitation program refers to a course of action designed to help the nerves responsible for erections recover after surgery, while maintaining the health of the penile tissue.

There are several factors that play a role in erection problems after prostate surgery. First of all, nerve damage can lead to erectile dysfunction. Even though your surgeon may have performed a “nerve sparing” operation, the techniques that are used to protect the erectile nerves may temporarily cause the nerves to be damaged and it may be more than a year before they recover. There is also some evidence that these operations may cause decrease in blood flow to the penis. It is also known that going for a long period of time without an erection is unhealthy for the muscle tissue inside the penis, and may damage the tissue.

Some studies show that encouraging a man to get erections using medications and/or the vacuum device may keep the tissue healthy and may increase the chances of a man regaining the ability to have an erection on his own. Your doctor will discuss the specifics of penile rehabilitation with you.
Taking Control: TREATMENT OPTIONS

• Oral Medications –
There are a number of prescription medications (VIAGRA,® Cialis® and Levitra®) available that may improve blood flow to the penis by allowing more of the chemical that helps the blood vessels to be present in the penis. Combined with sexual stimulation, this can produce an erection. Drug therapy is usually a first line treatment option for most men experiencing ED, and may be used in conjunction with other methods as well.

• Vacuum Pumps –
Mechanically enhance the flow of blood into the penis. A plastic cylinder is placed over the penis, and a pump (either manual or battery operated) creates vacuum suction within the cylinder, drawing blood into the penis to create an erection. A stretchable tension band placed at the base of the penis can help maintain the erection.
• **Injections & Urethral Suppositories** –
  With injection therapy, a small needle is used to inject medication directly into the base of the penis. The medication allows blood to flow into the penis, creating an erection. Many men find this method effective, but the idea of regular injections can be difficult to accept. Another option MUSE® is the same drug available in the form of a small pellet (suppository) that is inserted into the opening of the penis. The pellet is easier to use, but it doesn’t work quite as well as the injections to create an erection sufficient for sexual relations.
Taking Control: TREATMENT OPTIONS

• Penile Implants –
  When drug treatments, injections and other non-surgical therapies are not successful or unsatisfactory in resolving ED, a penile implant is a permanent, satisfying solution. Today’s state-of-the-art inflatable device from American Medical System (AMS) uses a pump surgically placed in the scrotum to inflate and deflate the penile implant. All components are completely concealed, and the implant allows for the ability to have a spontaneous, reliable erection at any time. Another type of penile implant from AMS is the positionable or malleable prosthesis, a non-inflatable implant for men. It provides ease of positioning, cosmetic concealment and rigidity for sexual intercourse.

An erection achieved with a penile implant can be safely maintained for as long as desired, which many men and their partners find adds to the quality of their sex life.
“When other couples hear how we went from hopeless to wholeness, they begin to believe that there is help for them and their relationships, too.”
The Journey to Restored Sexuality

For some men – and their partners – conservative treatments (vacuum pumps, injections, etc.) for ED may seem a little artificial and disruptive, and may affect the quality of their sex life. However, permanent surgical solutions may provide for more spontaneity. Whatever you are experiencing, it’s important to maintain open lines of communication. Involve your partner in the decision making, talk about what you are feeling, and experiment with new ways of being intimate together. The journey might be a challenging one, but working through it can actually strengthen your love life in unique ways.
“Now I have complete confidence in my ability to be spontaneously intimate. Think of it... I am in complete control over my body again.”
– Patient after penile prosthesis surgery
PSA Scores

Your doctor will schedule follow-up examinations that include testing your serum PSA levels at regular intervals. To help you keep a personal record of your PSA scores, track them on this handy journal page.

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![Graph showing PSA scores over time]

3 mos. 6 mos. 9 mos. 12 mos. 18 mos. 2 yrs. 3 yrs. 4 yrs. 5 yrs.
Stress Urinary Incontinence (SUI) Quiz

This standard quiz helps evaluate your level of incontinence and can be a useful tool in discussing your progress with your doctor.

1. Do you ever experience unplanned, sudden urine loss either while sleeping or during the day?
   - Yes    - No

2. Do you experience leakage while laughing, sneezing, jumping or performing other movements that put pressure on the bladder?
   - Yes    - No

3. Do you have trouble holding urine as you hurry to the bathroom?
   - Yes    - No

4. Do you frequently experience a sudden and immediate urge to urinate?
   - Yes    - No

5. Have you noticed a change in your frequency of urination?
   - Yes    - No

6. Do you visit the bathroom to urinate more than 8 times per day?
   - Yes    - No

7. Do you currently wear pads or liners to protect against unplanned leaks?
   - Yes    - No

8. When planning a trip, outing or event, does the availability or location of the restroom facilities affect your decision?
   - Yes    - No

If you answered “Yes” to 2 or more of these questions, you should know that there are solutions available for you. Bring the completed quiz with you when you meet with your urologist to discuss your situation.

source: http://malecontinence.com/overview/facts.htm#
Pad Usage – Weekly Journal

Use this journal page to keep track of your pad usage. It will help you and your doctor evaluate your return to continence, and help to determine the best solutions for you.

For more information about Male Incontinence
Go to: www.malecontinence.com
Frequency of Intimacy

Keeping track of your sexual experience post-surgery can be helpful for you and your health care provider as you evaluate your erectile function. Use this journal page to make note of erection quality, frequency of intercourse, attempts at sexual activity, masturbation, etc. Don’t forget to include the results of your experience with the oral agents (Viagra®, Levitra®, Cialis®), vacuum device, penile injections or MUSE®.

_________________________________________________________________________

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Sexual Health Inventory for Men (SHIM)

This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that best describes your own situation. Please be sure that you select one and only one response for each question.

Over the Past 6 Months:

1. How do you rate your confidence that you could get and keep an erection?
   - Very Low 1
   - Low 2
   - Moderate 3
   - High 4
   - Very High 5

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?
   - No sexual activity 0
   - Almost never or never 1
   - A few times (much less than half the time) 2
   - Sometimes (about half the time) 3
   - Most times (much more than half the time) 4
   - Almost always or always 5

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?
   - Did not attempt intercourse 0
   - Almost never or never 1
   - A few times (much less than half the time) 2
   - Sometimes (about half the time) 3
   - Most times (much more than half the time) 4
   - Almost always or always 5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

- Did not attempt intercourse: 0
- Extremely difficult: 1
- Very difficult: 2
- Difficult: 3
- Slightly difficult: 4
- Not difficult: 5

5. When you attempted sexual intercourse, how often was it satisfactory for you?

- Did not attempt intercourse: 0
- Almost never or never: 1
- A few times: 2
- Sometimes (about half the time): 3
- Most times (much more than half the time): 4
- Almost always or always: 5

Add the numbers corresponding to questions 1-5.

TOTAL: ___

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

- 1 - 7: Severe ED
- 8 - 11: Moderate ED
- 12 - 16: Mild to Moderate ED
- 17 - 21: Mild ED
Hardness Score

This standard scoring model helps evaluate your level of erectile ability, and can be a useful for discussing your progress with your doctor. Do not be discouraged if you have no erectile response in the beginning. You should see improvement over time.

Level 0: No increase in size or firmness

Level 1: Larger, but not hard

Level 2: Hard, but not hard enough for penetration

Level 3: Hard enough for penetration, but not completely hard

Level 4: Completely hard and fully rigid
Mood Scale

Cancer and surgery are challenging issues, and it’s common for your mood to be affected. Using this mood scale can help you discuss your emotional state with your doctor.

[Diagram showing a mood scale with weeks after surgery on the x-axis and mood levels on the y-axis.]
Exercise/Level of Activity
In the first few weeks following surgery, your activity level will continue to increase. Make any notes on this journal page to help you track your progress and discuss how you’re feeling with your doctor. Include activities such as walking, working out, golfing, swimming, etc.

Week 1: ________________________________________________________________

Week 2: ________________________________________________________________

Week 3: ________________________________________________________________

Week 4: ________________________________________________________________

Week 5: ________________________________________________________________

Week 6: ________________________________________________________________

Week 7: ________________________________________________________________

Week 8: ________________________________________________________________

Week 9: ________________________________________________________________

Week 10: ______________________________________________________________

Week 11: ______________________________________________________________

Week 12: ______________________________________________________________
FREQUENTLY ASKED QUESTIONS

How common is prostate cancer?
Prostate cancer affects 1 in 6 men. In 2009, more than 192,000 men will be diagnosed with prostate cancer, and more than 27,000 men will die from the disease. It is estimated that there are more than 2 million American men currently living with prostate cancer.³

Are some men more likely to be diagnosed with prostate cancer?
Older age, African American race, and a family history of the disease can all increase the likelihood of a man being diagnosed with the disease. As men increase in age, their risk of developing prostate cancer increases exponentially.³

How much does family history of prostate cancer increase the risk for it?
For men with a primary relative with prostate cancer (a brother or father), the risk is two-fold higher. Men with familial prostate cancer may develop the disease at an earlier age, so screening should be considered as early as age 35-40.²

How curable is prostate cancer?
In general, the earlier the cancer is caught, the more likely it is for the patient to remain disease-free. Because approximately 90% of all prostate cancers are detected in the local and regional stages, the cure rate for prostate cancer is very high – nearly 100% of men diagnosed at this stage will be disease-free after five years.³

What are the symptoms of prostate cancer?
If the cancer is caught at its earliest stages, most men will not experience any symptoms. Some men, however, will experience symptoms such as frequent, hesitant, or burning urination, difficulty in having an erection, or pain or stiffness in the lower back, hips or upper thighs.³
Is it normal for a patient to feel anxious or depressed after prostate cancer surgery?
It’s natural for a man to feel anxious and/or depressed. However, these feelings pass with time, as men resume their regular activities and lives.¹

What are some of the side effects from removing a prostate?
The two most feared side effects of radical prostatectomy are loss of erections and urinary incontinence. These side effects can occur but there are successful treatment options available. Also, after total removal of the prostate, there is little, if any, ejaculate, although there is the sensation of climax and orgasm.¹

Will I still be able to exercise after discharge from the hospital?
During the first month or two of recovery, the body is repairing the physical trauma caused by the surgery and the incision(s) is also healing. You should refrain from physical activities that place a stress or strain on the abdominal and pelvic regions of the body. Your physician will instruct you as to when it’s safe to return to your normal exercise routine.⁴

Are there any exercises that can be done before and after prostate surgery?
In addition to Kegel exercises; walking, biking, and swimming are beneficial to cardiovascular and general health. Good physical conditioning is helpful in recovery from prostate cancer surgery.¹

Once a prostate gland has been removed because of cancer, can diet help prevent the cancer from recurring?
Nobody knows for certain but good nutrition is important to overall health and well being.
FREQUENTLY ASKED QUESTIONS

It’s been 6 months since my prostatectomy and I still have no control of my bladder. What can I do?

Although some patients continue to have improvement in continence for up to 12 months after surgery, the general consensus is that if there is no return of urine control after one year further intervention is needed. While it has not been 12 months since your surgery an artificial urinary sphincter (AUS) or AdVance® Male Sling could dramatically improve the quality of your life. You may want to see a surgeon who specializes in these types of restorative surgeries.1

When will erections return after a nerve-sparing prostatectomy?

Erections usually begin to return as partial erections 3 to 6 months after surgery and then continue to improve for about 12 months after surgery, as the nerves recover from the trauma of surgery. Despite expert application of the nerve-sparing prostatectomy technique, early recovery of natural erectile function is uncommon. Even when the nerve-sparing surgery is performed with meticulous technique, patients generally do not recover erectile function as quickly as they do urinary continence.1

Why does it take so long to recover potency?

A number of explanations have been proposed for this phenomenon of delayed recovery, including mechanically induced nerve stretching that may occur (during the operation), thermal damage to nerve tissue caused by cauterization during surgical dissection, injury to nerve tissue amid attempts to control surgical bleeding, and local inflammatory affects associated with surgical trauma.1
Why don’t all men recover erectile function after nerve-sparing surgery?
The most obvious determinant of post-operative erectile function is how potent the man was prior to the operation. Post-operative erectile dysfunction is compounded in some patients by pre-existing risk factors that include: older age, cardiovascular disease, diabetes, cigarette smoking, alcohol abuse, physical inactivity and certain medications such as anti-hypertensive drugs.¹

What is Penile Reconditioning or Penile Rehabilitation?
The relatively new strategy of rehabilitation in clinical management after prostate cancer treatment comes from the idea that early-induced sexual stimulation and blood flow in the penis may facilitate the return of natural erectile function and resumption of normal spontaneous sexual activity. Some experts in erectile dysfunction now believe that taking agents such as Viagra®, Levitra®, or Cialis® will hasten the return of erections. Alternatively, vacuum erection devices, MUSE suppositories, or penile injections can produce good erections in some patients.¹

How should I approach my partner about seeking treatment for ED?
This is often a difficult and uncomfortable subject for both men and women. Many men complain that their partner is not interested in sexual activity, but this may be related to the man’s difficulty in achieving or maintaining an erection which is satisfactory for sexual activity. The man may fear failure and may avoid the lovemaking process entirely. The partner may feel abandoned.⁵
When is it safe for a man to resume sexual activity after a prostate cancer surgery?

Sexual activity can generally be resumed within 4 to 6 weeks after prostate cancer surgery, but check with your doctor. Most patients tend to resume sexual activity as soon as they feel an interest and when their urinary control is adequate for sexual activity. For those men who have return of erections, it is a gradual process. Many men, however, do experience improvement over the first year after the operation. The stimuli for erection during the first year will also be different. Visual stimuli will be less effective, and physical stimulation will be more effective. For this reason, do not be afraid to experiment with sexual activity. Re-familiarize yourself with your body. You can do no harm. Do not wait until you have the “perfect erection” before attempting intercourse. In addition, you should be able to have an orgasm even if you do not have an erection. With orgasm, there will not be ejaculation (emission of semen) because the prostate and seminal vesicles have been removed. There are many successful erectile dysfunction treatment options available. Become familiar with them and let your health care provider know you would like to begin treatment as soon as possible.¹

Is it normal to have pain with return of sexual activity?

It is not uncommon to have pain with orgasm after a radical prostatectomy. This pain occurs because the deep pelvic muscles have not completely recovered from the trauma of surgery.

Will I still be fertile after a radical prostatectomy?

There is no seminal fluid after the prostatectomy, so you will no longer be fertile or able to father children.¹
What kind of follow-up is recommended after a radical prostatectomy?
With any cancer, not only prostate cancer, there’s always a possibility that the cancer can come back. Your doctor will let you know how often you should be seen following your prostatectomy.1

I’ve tried the “pills”, vacuum device, suppositories, and injections and nothing worked. Is there anything else available for me?

Penile implants are an excellent, safe, surgical treatment option, have a high degree of patient satisfaction and provide a very natural erection. Ask your doctor to provide you with more information about this option.
ONLINE LINKS & SUPPORT GROUPS

American Cancer Society
The American Cancer Society is the nationwide community-based voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy, and service.
www.americancancersociety.org

American Urological Association (AUA) Foundation
The American Urological Association (AUA), founded in 1902, is the premier professional association for the advancement of urologic patient care. UrologyHealth.org offers a wealth of patient education and information written and reviewed by urology experts in partnership with the American Urological Association Foundation. Patients can call their National Urology Health Hotline toll free at 1-800-828-7866.
www.auafoundation.org

Erectile Dysfunction Institute
A comprehensive resource for information about ED. You’ll find plenty of information here to inspire and educate you on today’s satisfying solutions – including the most advanced penile implants.
www.edcure.org

Healing Well
A social network and support community. You’ll find information, resources, and support, plus access to helpful forums and chat rooms where you can ask questions to members of the prostate cancer community.
www.healingwell.com
Institute for Urologic Excellence (IUE)
The IUE is a network of medical facilities and associated physicians specializing in urologic disorders – specifically erectile dysfunction (ED), penile curvature and incontinence.
www.visitiue.com

Male Continence.com
Provides you, your partner and medical professionals a place to not only learn about the condition of male urinary incontinence, but also to interact with others who are seeking similar information. It can be a useful tool in your search for information and solutions to take control of your bladder.
www.malecontinence.com

Prostate Cancer Research Institute
The Prostate Cancer Research Institute’s mission is to improve the quality of men’s lives by supporting research and disseminating information that educates and empowers patients, families and the medical community.
www.prostate-cancer.org

US TOO International Prostate Cancer Education & Support Network
US TOO is a grassroots organization started in 1990 by prostate cancer survivors to serve prostate cancer survivors, their spouses/partners and families. This not-for-profit charitable organization is dedicated to communicating timely and reliable information enabling informed choices regarding detection and treatment of prostate cancer. Ultimately, Us TOO strives to enhance the quality of life for all those affected by prostate cancer.
www.ustoo.org
BOOKS & REFERENCE MATERIAL

A Primer on Prostate Cancer:  
The Empowered Patient’s Guide  
by Stephen Strum, MD, FACP and Donna L. Pogliano  
The Life Extension Foundation

A basic resource to be used by patients and physicians when there has been a diagnosis of prostate cancer. It outlines a strategy of disease management that is designed to maximize outcomes for the patient and his loved ones. Discussion of treatment options includes information on side effects and includes questions the patient may not think to ask his doctor. This is a current, comprehensive guide to prostate cancer presented in understandable terms with a user-friendly color format that will help the reader educate himself about prostate cancer. The book strives to help patients and their loved ones to combat ignorance and fear, replacing that with the empowerment of education.

Better Than Ever: Love and Sex at Midlife
by Bernie Zilbergeld, Ph.D.
Crown House Publishing

Is it better than ever? Now that the children have grown and there’s more time on your hands as a couple, are you finding that the love and intimacy has gone from your life? It is a fact that as we mature, our sexual drives mature as well, but it is also a fact that while you may slow down and your lovemaking may be different than it was in your youth, that doesn’t mean that the quality has to be lower or your pleasure less. In this honest, yet light-hearted volume, Bernie Zilbergeld, well-known sex therapist and author of the widely quoted, “The New Male Sexuality,” draws on his many years of clinical and life experience. He explains why we should be enjoying our lovemaking and our intimacy even more than ever and certainly better than ever.
Coping With Erectile Dysfunction: How to Regain Confidence and Enjoy Great Sex
by Michael E. Metz, Ph.D. and Barry W. McCarthy, Ph.D.
New Harbinger Publications

The book begins with an uncomplicated explanation of ED and a discussion of the mythologies that surround much of male sexuality. After describing the integrated treatment approach, the book helps men develop a set of realistic sexual expectations for each phase of their lives and explores the role of their partners in resolving ED problems. Exercises help men assess the nature of their problems. The results of the assessments lead readers to explore medical, psychological, and couples-related interventions. Ultimately, the Metz-McCarthy approach encourages couples to explore their own sexual intimacy as a means of overcoming the problem.

Dr. Ruth’s Sex After 50: Revving up the Romance, Passion & Excitement
by Dr. Ruth Westheimer
Quill Driver Books

Many people enjoy the best sex of their lives after 50! More passionate, more thrilling and more satisfying sex. The kind they only dreamed of before. Sure, aging brings physical and psychological changes, but the misconceptions and inappropriate attitudes developed over the years about the natural aging process may cause more damage to a couple’s sex life than anything physical. So, while one needs to take certain steps to compensate for changes the body is undergoing, more important are the attitude adjustments that must be undergone to compensate for these physical changes.
His Prostate and Me: A Couple Deals with Prostate Cancer
by Desiree Lyon Howe
Winedale Books

His Prostate and Me addresses from a woman’s point of view the prime issue that obstructs men from seeking treatment for prostate cancer: Will I or won’t I be able to function sexually for the rest of my life? Desiree Howe, who met and married husband Dick Howe after his prostate cancer surgery, answers that question with a resounding yes as she offers a frank and information-rich examination of her husband’s and her experience with this “dangerous disease.” The keystone of the book is Dick Howe’s story, from diagnosis all the way through successful treatment for post-surgical side effects, including incontinence and erectile dysfunction.

Intimacy with Impotence: The Couple’s Guide to Better Sex After Prostate Disease
by Ralph and Barbara Alterowitz
DeCapo Press

Erectile dysfunction is a frequent consequence of prostate cancer and other prostate disease treatments. Though unwelcome and embarrassing, it doesn’t have to end a couple’s sex life. Both informative and practical, Intimacy with Impotence gives couples cause for hope. It discusses impotence in lay terms, provides information on the commercial therapies and medications both available and being researched now, and gives practical advice about lovemaking – from getting in the mood to common sense suggestions to erection-less satisfaction. Written with complete honesty and compassion by a prostate cancer survivor and his wife, this is the essential resource for couples trying to reestablish intimacy and sex in the face of impotence.
Making Love Again: 
Hope for Couples Facing Loss of Sexual Intimacy 
by Virginia and Keith Laken 
Ant Hill Press 
Married for 30-some years, the Lakens confronted and survived male erectile dysfunction as a side effect of prostate surgery. Their first-person account is readable, informative, and persuasive. While Keith had the dysfunction, both he and Virginia underwent mutual and individual healing to reinstate sexual intimacy disrupted by the surgery. The passages that explore their emotional conflicts allow readers to empathize and to validate their own hesitations about seeking treatment without minimizing the difficulties.

Promoting Wellness for Prostate Cancer Patients 
By Mark Moyad, MD, MPH 
Ann Arbor Media Group 
A basic nutrition reference guide for men with prostate cancer who are interested in healthy eating and promoting wellness.

Saving Your Sex Life: 
A Guide for Men with Prostate Cancer 
by John P Mulhall, MD 
Hilton Publishing 
In a straightforward style, Dr. John Mulhall guides the reader through the basics of male sexuality, explains the role of testosterone, the functions of the prostate, and the common difficulties men encounter when disease strikes. In plain language, this book spells out the causes and symptoms of prostate disease and diseases of the lower urinary tract and the approach to deal with the aftermath of treatment.
BOOKS & REFERENCE MATERIAL

The Magic of Sex: The Book That Really Tells Men about Women & Women About Men
by Miriam Stoppard, MD
Dorling Kindersley, Inc.

In this illustrated work, Dr. Stoppard explores the world of sex, from attraction and arousal to foreplay and the experience of making love. There are “his and her” viewpoints on every aspect of sex and love-making and questionnaires are provided to help couples understand their sexual profiles.

The New Love and Sex after 60
by Robert N. Butler, MD and Myrna I. Lewis
Random House Publishing Group

This update merely strengthens its credentials as the best all-around sex manual for older adults. There is thorough coverage of the standard topics: the effects of normal aging, medical problems, and drugs on sexuality and how to overcome roadblocks; physical and emotional sexual fitness; singlehood and relationships; sexual enhancement tips; dating, remarriage, and one’s children; and finding help. This new edition incorporates same-sex relationships more equitably.
GLOSSARY

A

Adenocarcinoma: A malignant tumor that originates in the cells of a gland, such as the prostate gland.

Adjuvant: A supplemental treatment that follows cancer surgery, typically enhancing the effectiveness of the primary treatment. Radiation and hormonal therapy are examples of an adjuvant. Adjuvants are agents that modify the effect of other agents while having few if any direct effects when given by themselves.

Adjuvant Therapy: Treatment occurring immediately after the primary treatment with the purpose of increasing the probability of success.

Androgen: A type of hormone that controls the development and maintenance of masculine characteristics.

Anti-Androgen: A substance that tends to inhibit the production, activity, or effects of a male sex hormone, typically preventing the growth of prostate cancer cells.

Anti-Androgen Withdrawal Response: A reduction of prostate-specific antigens caused by the withdrawal of an anti-androgen.

B

Benign: Non-cancerous tumors that do not travel to the lymph nodes or distant tissues.

Biopsy: The removal and examination of a sample of tissue for diagnostic purposes.

Brachytherapy: A treatment where radioactive material “seeds” is introduced directly into the treatment site (prostate).
Catheter (Urinary): A hollow tube used to drain fluids from the bladder.

Climax: Sexual climax is another term for orgasm.

Clinical Trial: A research program conducted with patients to evaluate a new medical treatment, drug, or device. The purpose of clinical trials is to find new and improved methods of treating different diseases and special condition.

Differentiation: Refers to the level of development of cancer cells in a tumor. The level of cellular differentiation is used as a measure of cancer progression.

Digital Rectal Examination (DRE): A digital rectal exam is an examination of the lower rectum. The doctor uses a gloved, lubricated finger to check for abnormalities.

Dihydrotestosterone (DHT): An androgenic hormone that is thought to be responsible for the development of male sexual functions.

Ejaculation: The discharge of semen from the penis usually accompanied by orgasm.

Endorectal: The process of going through the rectum.

Endorectal Ultrasound (ERUS): A procedure used to formulate an image of internal body tissues. It involves the insertion of a sound wave-emitting probe into the rectum. (Also called transrectal ultrasound.)

Epithelium: A thin layer of tissue that covers organs, glands, and other structures within the body.
GLOSSARY

E

Erectile Dysfunction (ED): The inability to achieve or maintain an erection satisfactory for sexual relations to engage in sexual intercourse. May be referred to as impotence.

Erection: The state of swelling, hardness, and stiffness due to increased filling of the penis during sexual excitement.

External Beam Radiation (EBR): A form of radiation therapy where radiation is delivered by a machine pointed at the specific area to be radiated. May be referred to as external beam radiation (EBR, XBR) or external beam radiation therapy (EBRT, XBRT).

F

Fistula: A permanent abnormal passageway between two organs in the body or between an organ and the exterior of the body. It is an uncommon complication of some prostate cancer treatments.

Fraction: One session of a course of radiotherapy treatment.

Free PSA (fPSA): A prostate specific antigen (PSA) is either bound to protein or unbound (“free”). Risk of prostate cancer can be further evaluated by measuring both forms.

Frequency: The need to urinate many times a day. This can be caused by a prostate problem.
**G**

**General Practitioner (GP):** A medical doctor who provides primary care and specializes in family medicine.

**Gleason Score (GS):** A grading system used to help evaluate the aggressiveness of cancer and prognosis of men with prostate cancer. It is based on a 2 to 10 scale, the higher the score the more likely cancer cells will or have spread.

**Genes:** The basic unit of heredity that controls how your body works.

**Grade/Grading:** A means for providing information about the probable growth rate of a tumor and its likelihood of spreading. See Gleason Score.

**H**

**High-Dose-Rate (HDR):** A type of internal radiation treatment where the source of radiation is removed between treatments.

**Histology:** The microscopic study of tissues and cells.

**Hormone:** A chemical produced by glands in the body that control the actions of certain cells and organs.

**Hormone Antagonists:** Chemicals that inhibit a hormone’s function.

**Hormone Refractory Prostate Cancer (HRPC):** Prostate cancer that is resistant to hormone therapy.

**Hormone Therapy (HT):** Treatment that adds, blocks, or removes hormones using surgery, injections or tablets.

**Hormone Refractory Prostate Cancer (HRPC):** Prostate cancer that resists hormone therapy.
GLOSSARY

I

Incontinence: Loss of control of urine or feces.

Impotency: The inability to achieve or maintain an erection of the penis adequate for sexual intercourse. Also referred to as erectile dysfunction.

Intensity Modulated Radiation Therapy (IMRT): A type of radiation therapy that uses 3-dimensional images to show the size and shape of the tumor to better focus therapy towards the cancer. This type of radiation therapy minimizes the damage to healthy tissue next to the tumor.

L

Laparoscopic Prostatectomy: Surgery to remove the prostate gland using instruments inserted through several small cuts in the abdomen. Laparoscopic radical prostatectomy is minimally invasive and relies on modern technologies.

Laser Prostatectomy: A procedure using laser energy to treat Benign Prostatic Hyperplasia (BPH).

Libido: Desire or interest in sexual activity. Prostate cancer diagnosis and its treatment can affect this.

Lymph: A fluid that carries disease-fighting cells through the lymphatic system.

Lymphatic System: A variety of tissues and organs that produce, store and transmit disease-fighting cells. This system includes the spleen, thymus, bone marrow and thin lymph tubes called “lymphatic vessels.”

Lymphocyte: A type of white blood cell that produces antibodies and other disease and infection-fighting substances.
Magnetic Resonance Imaging (MRI): A technique using magnets to build detailed pictures of areas inside the body. It is most commonly used in radiology to visualize the internal structure and function of the body. This procedure may be used to look for metastases.

Malignant: A medical term used to describe a cancerous tumor that has the ability to spread.

Marker: A tumor marker is a substance found in the blood, urine, or body tissues. There are many different tumor markers, each indicative of a particular disease process, and they are used in oncology to help detect the presence of cancer.

Metastasis: The spread of cancer from one area of the body to another.

Morbidity: A term used to describe a disease or the incidence of disease within a population or to the degree that the health condition or treatment for the condition affects the patient.

Neoadjuvant: Preliminary cancer therapy, usually chemotherapy or radiation therapy, which precedes a necessary second type of treatment modality of treatment.

Neoplasia: Abnormal or uncontrollable cell growth.

Neoplasm: An abnormal mass of tissue. Neoplasms may be benign, pre-malignant or malignant.

Nerve Sparing: A surgical technique during a radical prostatectomy where one or both of the neurovascular bundles, a term applied to the body nerves, arteries, veins and lymphatics that tend to travel together in the body controlling erections, are not cut or severed. The aim of this technique is to avoid damaging the nerves that help control erections and continence.
GLOSSARY

N
Nocturia: The need to urinate at night, thus interrupting sleep.
Non-Steroidal Anti-Inflammatory Drug (NSAID): A drug that decreases fever, swelling, pain, and redness.

O
Oncology: The branch of medicine dealing with cancer.
Orchiectomy: A type of hormone therapy for prostate cancer where one or both testicles are surgically removed to reduce testosterone.
Orgasm: The peak conclusion of the plateau phase of the sexual response cycle, characterized by an intense sensation of pleasure.

P
Palliative Care: Form of medical care or treatment that concentrates on reducing the severity of disease symptoms, rather than striving to halt, delay, or reverse progression of the disease itself or provide a cure. The goal is to prevent and relieve suffering and to improve quality of life for people facing serious, complex illness.
Pathologist: Pathologists are physicians who diagnose and characterize disease in living patients by examining biopsies or bodily fluid. The vast majority of cancer diagnoses are made or confirmed by a pathologist.
Pelvis: The lower portion of the abdomen located between the hip bones.
Penis: An external male reproductive organ which carries semen and urine through a tube called the urethra. It is the male sexual organ.

Perineum: The area between the anus and the scrotum.

Proctitis: Inflammation of the rectum caused by radiotherapy.

Prognosis: A term to describe the likely outcome of an illness or course of a disease as well as the probability of recovery or recurrence.

Prostate: A gland of the male reproductive system that produces a milky, white fluid.

Prostatectomy: See Radical Prostatectomy.

Prostate-Specific Antigen (PSA): An enzyme present in very small amounts in men that helps to liquefy semen. It is produced by the prostate and is found in higher amounts in the blood of men with prostate cancer, benign prostatic hyperplasia, or infection or inflammation of the prostate.

PSA Density: A means of measuring PSA level in relation to the size of the prostate gland.

PSA Test: A blood test to measure prostate specific antigen that can supplement other tests to help diagnose problems with the prostate gland.

Quality of Life Measurement: A measure of a person’s overall satisfaction with life and their ability to successfully cope with the full range of challenges associated with the pain and symptoms after a particular treatment.
GLOSSARY

R

Radical Perineal Prostatectomy: Surgery to remove the entire prostate gland. It is used to treat cancer that is localized within the prostate gland. The incision is made in the perineum, midway between rectum and scrotum.

Radical Retropubic Prostatectomy: Surgery to remove the entire prostate gland. It is used to treat cancer that is localized within the prostate gland. The incision is made in the lower abdomen.

Radiotherapy: The use of high-energy radiation to kill cancer cells and shrink tumors.

Remission: The decrease or disappearance of indications and symptoms of cancer. Cancer may still be in the body even if no indications or symptoms are present.

Recurrence: Cancer that has returned after treatment.

Robotic Prostatectomy: Laparoscopic prostatectomy, when it is carried out with the assistance of a robot. Laparoscopic robotic arms are controlled by a surgeon.

S

Scrotum: The pouch of skin (sac) containing the two testicles and their accessory organs.

Semen: Fluid discharged at ejaculation in the male. It consists of sperm from the testes and fluid from the prostate and other sex glands.

Seminal Fluid: Also known as semen.

Seminal Vesicle: A pair of simple tubular glands that secrete a significant proportion of the fluid that ultimately becomes semen.
Sexual Health Inventory for Men (SHIM): A validated questionnaire designed to help you and your health care provider identify if you are experiencing erectile dysfunction and if you are, to what degree.

Sphincter (Urinary): A collective name for the muscles surrounding the urethra used to control the flow of urine from the urinary bladder.

Secondary Cancer: Also called metastases, it is cancer that has spread from its origin to another part of the body.

Stage, Staging: The extent to which cancer has spread throughout the body.

Steroid: A type of drug used to control swelling and inflammation.

Stricture: A closing or narrowing of the urethra. Can be caused by benign prostatic hyperplasia (BPH) or prostate cancer (PCa).

Stress Urinary Incontinence (SUI): It is the loss of small amounts of urine associated with coughing, laughing, sneezing, exercising or other movements that increase intra-abdominal pressure and thus increase pressure on the bladder. It is not uncommon after prostate surgery.

Testes: The male gonads. Two reproductive glands located inside the scrotum that are the main source of testosterone and sperm.

Testicle: A single testis or male gonad.

Testosterone: The principal male sex hormone that promotes the development and maintenance of men’s sex characteristics.

Three-Dimensional (3D) Conformal Radiotherapy: Treatment that uses 3D images to conform the radiotherapy beams to the shape and size of the prostate.

Transrectal Ultrasound (TRUS): A procedure used to formulate an image of internal body tissues. It involves the insertion of a sound-wave emitting probe into the rectum. (Also called an endorectal ultrasound.)
GLOSSARY

U

Ureter: The tube carrying urine to the bladder from the kidney.

Urethra: The tube that carries urine and semen out the body.

Urgency: An imminent need to urinate.

Urinary Bladder: The organ that collects urine excreted by the kidneys prior to urination.

Urinary Incontinence: Any unintentional or involuntary leakage of urine. It can range from a few drops to no control at all of your urine.

Urination: Also known as micturition or voiding is the process of urine from the urinary bladder traveling through the urethra to the outside of the body.

Urology: The medical specialty concerned with diagnosing and treating diseases of the urinary system, including the prostate gland.
BIBLIOGRAPHY


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INSIGHTS TO HELP YOU LIVE LIFE RESTORED

after prostate cancer surgery

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