

# Prostate Cancer



## Treatment options challenge physicians and patients

by Marilyn Thordarson

*It's a summer evening and my husband Bill and I are entertaining new acquaintances at our home—Rotarians from the surrounding area attending a district meeting in Spokane. As we talked and discovered experiences in common, the three men find they have all had prostate cancer, fortunately diagnosed early, yet treated differently. Very recently, Bill had laparoscopic surgery; another of our guests, conventional radical surgery; and the third, radiation therapy.*

Since Bill's bout with prostate cancer, we are wiser and have learned a great deal from other men who have candidly shared their experience. The most common observation is not whether you'll have the disease, only when; if you live long enough, it most likely will happen.

We've also learned there are a surprising number of viable treatment options with good outcomes. That fact is one of the more challenging aspects of the disease.

### Prostate, small but susceptible to cancer

The prostate is a gland, about the size of a walnut, and it contributes nutrients and fluid to sperm during ejaculation. We don't specifically know what causes prostate cancer, but male hormones—especially testosterone—stimulate cancer cell growth in the gland.

Risk factors include age (over 70 percent of all prostate cancer cases are diagnosed in men over 65), ethnicity and family history.

The gland's location, from a treatment point-of-view, is problematic. It is nestled beneath the bladder and wraps itself around the neck of the bladder leading into the urethra. During treatment, tissue and nerves close to the prostate may be temporarily or permanently damaged.

Other than skin cancer, prostate is the most common cancer for men. During their lifetime, 50 percent of men will have cancer, 30 percent of which will be prostate cancer.

The good news is that, thanks to prostate-specific antigen (PSA) testing, mortality rates are down 40 percent, says Michael Oefelein, MD. "With early detection, we get ahead of the disease by five or six years; men are more likely to die from diseases other than prostate cancer."

## Treatment choice is difficult

Dr. Oefelein says the big “C” has unique issues for men as they make treatment decisions. Some, like my husband, want the cancer removed—and the sooner the better. Others have a different view; they see the potential risks of temporary or permanent incontinence and/or impotence as worse than the disease. They may elect to do nothing if, for them, “watchful waiting” is an acceptable option. The risks of incontinence and/or impotency with all treatments are a major concern.

“Cancer is a huge issue and a patient’s treatment decision depends on how he reacts to the diagnosis and how he processes the information. There are no rights or wrongs,” says Michael Henneberry, MD.

Thomas Fairchild, MD, says talking with patients and spouses about treatment choice is challenging. “I am sympathetic; as a specialist, I know there are a number of acceptable options.”

“The fact is, when you look years down the road, regardless of the treatment choice, cure rates are equivalent,” adds Dr. Henneberry.

Physicians agree that patients should do research, talk honestly and openly with their families and doctors and seek second opinions if helpful.

## New technology expands options

Advancements in radiation technology have expanded treatment options for all stages of prostate cancer, says Gary VanHeuvelen, MD, radiation oncologist. Radiation therapy essentially kills the cancer cells and disables the prostate gland. An enhancement of the conventional external beam radiation, called IMRT (intensity modulated radiation therapy), uses advanced planning technology to focus the radiation precisely, better protecting normal tissue.

Brachytherapy treatment—implanting radioactive seeds in the prostate—is a newer therapy, but has good results. Its advantage is that it requires only one treatment session, compared to multiple visits required by external beam radiation therapy.

## Less invasive surgery

Laparoscopic prostatectomies, recently introduced in American medical centers, access and remove the gland through small “ports” rather than a larger incision.

Since 2004, local urologists/surgeons have been using the laparoscopic procedure enhanced by robotic technology.

The advantage of the robotic technology, says David Mikkelsen, MD, is that it offers more freedom of movement for the surgeon’s hands and wrists, allowing fine maneuvers in the tightly-confined space occupied by the prostate gland. The surgeon’s view is three-dimensional and can be magnified up to 10 times its actual size, plus the view angle can be changed.

Thirty-two robotically-assisted laparoscopic prostatectomies have been performed at Sacred Heart. Operative time has decreased from six to 3.5 hours, says Dr. Mikkelsen, comparing favorably with a typical surgery. Other physicians performing the procedure include Drs. Fairchild and Craig Whiting.

## And still more options

Additional types of treatment, depending on the stage of cancer, include hormonal and cryotherapy therapies. Because the growth of cancer cells in the prostate is stimulated by testosterone, the organ may be treated with agents that block the production of testosterone and the hormone’s action on cells. Cryotherapy, which literally freezes the prostate so it is no longer functional, is another viable option.

Watchful waiting can sometimes be appropriate. “A man in his 70s with early-stage cancer probably has 10 years average survival without any intervention. Many men die, not from prostate cancer, but with it,” says Dr. Oefelein.

Generally, surgery (laparoscopic and open), radiation therapy (including brachytherapy) and cryotherapy may be used for early-stage prostate cancer. Hormonal therapy, chemotherapy and radiation (or combinations of these treatments) are used when the disease has spread to other parts of the body. These latter treatments may also supplement other therapies for early-stage disease.

## All things considered

The good news about prostate cancer is that survival rates are markedly improved; over the past 20 years, the five-year survival rate for all stages combined increased from 67 percent to 98 percent. In addition, as my husband and I discover, there is a wealth of information available for those making decisions about treatment choices.

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## Treatment Options

All available in the Spokane medical community

All treatment options, with the exception of “watchful waiting,” have some risk of temporary or permanent incontinence and sexual impotence. Erectile dysfunction is a major issue, but surgical procedures have become increasingly refined, with a significant reduction in potential damage to nerves and other areas.

Procedure	Pros	Cons
“Open” surgery: perineal or retropubic prostatectomies	surgeons can see and feel the prostate and surrounding area.	large incision; more trauma to the tissue; 3-4 hospital days and a Foley catheter for approximately two weeks.
Laparoscopic or robotically-assisted laparoscopic prostatectomy	small incisions, less blood loss and need for transfusions; less chance of post-surgical complications; catheter needed for 10 days or less.	inflating the abdomen with carbon dioxide gas to improve the visual field causes some post-surgical discomfort.
Radiation therapy (external beam/IRMT)	avoids surgery and with newer technologies, radiation is very precise. For patients with other health issues, may have less risk than surgery.	8 weeks of treatment, five days a week for 15-20 minutes each. Bowel irritation may occur.
Brachytherapy	one treatment, versus multiple visits.	possible bowel irritation.
Hormone therapy	non-invasive.	patient may have unpleasant symptoms of menopause, including hot flashes and weight gain.
Cryotherapy	a minimally-invasive procedure with short recovery time. May be repeated if unsuccessful.	may damage some healthy cells and long-term outcomes not known.
Watchful waiting	avoidance of risks involved in surgical or radiation treatment.	requires close monitoring by physician.

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