

January 2013 Speaker . . . Dr. Thomas Morton, Urologist, Lakeridge Hospital

Subject "Open Forum on Prostate Cancer Treatment."

Dr. Morton started his talk by suggesting subjects that are front and centre currently in Prostate Cancer treatment. He then opened the floor for over an hour to questions on anything members had that was troubling or confusing them. Anything they wanted more clarity on. Here's what he had to say in response to some of the questions.



When you talk about Prostate cancer, the opportunities to talk about new things are endless. The last time I was here, we were talking about the growth of active surveillance in early stage prostate cancer. We talked a little bit about where it was three years ago and that's quite different from where it is now.

The treatment and the philosophy on the treatment of prostate cancer and early stage disease has really changed. It's starting to permeate into the communities everywhere. Not just teaching centres but doing it in the major centres and moving it to the smaller centres. Other things we can talk about: there is a lot of conversation about the American task force that came out suggesting that prostate cancer screening was not of value to the patients and then a lot of retort actually in the American political system, because there was a feeling that it was almost a self-interest production by the family practitioners and physicians in the United States and really driven by bias dramatically. American and Canadian urological associations have come up with some thoughts on that and comments in rebuttal. I think those are things that concern a lot of people who are diagnosed with prostate cancer and feel it's very close to their heart and really that perhaps the situation is being ignored. At the end of the day, as physicians, I think we can all recognize that perhaps prostate cancer was over treated for a number of years, particularly south of the border. Perhaps certain types of cancer didn't warrant treatment but that doesn't mean you bury your head in the sand and pretend the disease doesn't exist. It behooves us as physicians to be better at making a diagnosis determining the options for each individual patient and making the right decisions for them. Not turning it into a money making venture, which is what happens south of the border a lot. Robotics: I know you had a talk about it, I have my slant on it, that's something that's new in advanced

disease. There are new techniques in radio therapy. Brachytherapy has been reserved for low risk disease in Canada, in Ontario particularly for the most part. There has been a branching of using a sandwich technique, with high dose Brachytherapy in conjunction with a shorter duration of external beam radiotherapy for intermediate risk disease or high volume, low risk disease. It's important to realize there is another option out there that maybe is not as tried and true but is showing a lot of promise in early stage disease. Then I think one of the things that's really interesting is some of the treatments that have come into play at the end of disease where curative treatment is no longer going to solve the problem alone. We can offer them treatments that can prolong their lives and improve the quality of life, which has dramatically improved over the last three to five years. There are new hormone agents which will block the testosterone better, there are new therapeutic agents that exist that have really helped improve the quality of life and longevity for men in end stage disease, or later on down the road. Aside from treatment, there are complications from treatment. The reality is that not everything goes perfectly, so there are men who have difficulties with incontinence or urinary control issues or erectile difficulties. I am happy to answer questions on any or all of that. I'm going to open up the floor a little bit to questions you may have and then we can expand on things as they are. They can be directly related to decisions that you're making now, concerns that you have, thoughts on anything.

One thing that we have to realize about prostate cancer is, although it's the number one killer of men of all malignancies, it is a chronic disease of your later years. I tell all my patients when they come in, "This isn't lung cancer. This isn't pancreatic cancer. You're not going to be dead in four months or six months". You need to take that concept and idea of cancer and put it aside, because prostate cancer kills men in their later years. There are absolutely aggressive ones of prostate cancer that can be very aggressive but it's rare. Most prostate cancers are slow growing, chronic disease that affects our quality of life, just like diabetes will, like heart disease does, like cerebral vascular disease, which is strokes and the affects of the strokes on our health. The complications to the treatment

of prostate cancer are what drives the task force to look at the disease itself and whether it's been treated too much or who should be treated. If you're 70 years of age and you have a biopsy and you have low risk prostate cancer, we know that, when you're 80, there's a strong chance that you're not going to be impacted by your disease. However, if I take the prostate out, I'm probably going to make you impotent, because you're 70, you're urinary control may take a while to come back, so should you actually be having treatment? I think questions like, "what's the right thing to do for people?" are important things to ask. The C word isn't the same for all types of cancers, we all get kind of scared of it. Just keep it in perspective as to what this disease is. It really is a chronic illness.

Q. *I had good post surgery results but when my PSA started to rise, I had radiation. In the last few years I've been suffering from incontinence, due to radiation scarring, I've been told. Is there anything I can do to improve continence control?*

A. First of all, if your PSA is failing after your surgery, one of the advantages of having surgery first is you can have radiation after it. It's not without potential complications but it can control the disease for an extended period of time. If you didn't have the radiation, your PSA would have likely climbed to varying degrees and you might have needed hormone therapy at an earlier stage. So it's delaying the need for another type of treatment with its potential side effects. The decision to have radiation sounds very sound and appropriate on your part. You didn't jump the gun, you did what sounded reasonable at the time. There are a couple of things about incontinence after surgery and radiation. Certainly, radiation makes continence troubles worse and it can do it in a variety of different ways. The first thing is that, when you have surgery as a younger man, you recover your urinary control quicker and you bounce back to close to 100% fairly well. What does happen as we get older, our muscle tone, things sag a little bit perhaps. When your muscle tone is good you can maintain your urinary control because you could almost voluntarily tighten your muscles and you were fine. When you lose that tone, we do find that as men reach their later years they become a little less able to control their urine, just from the surgery alone and loss of muscle tone. Radiation impacts healing, so if you had radiation too early after surgery, usually that means before your urine control recovers fully, then sometimes it prevents the healing completely and you continue to have that stress or exertion type of leakage. I'm always reticent to offer radiation right

after surgery until people recover well. The other issue is radiation increases scarring, so your bladder neck can narrow down, which would require you to have surgery to open it up. It also really has an impact on the natural elasticity of your bladder, so your bladder capacity actually shrinks. Your bladder muscle gets thickened, you lose some of that natural compliance. When you get urgency, you pee more often, you get up more at night. Much of this can be controlled by medications. There are different things that can be done. There are medications to help relax your bladder and allow you to hold on a bit better because of what I would call instability of your bladder. There are definitely options and, if you are having control issues and you're not satisfied with what you're getting from your radiologist, go back to your urologist. This is their speciality.



Q. *I was put on hormone treatment after surgery and, in the last few months, I have experienced joint pain, calf pain and when I get up, I'm not steady.*

A. I'm not sure why you're on hormone treatments so soon after surgery, other than saying you probably have fairly high grade, high risk disease in your PSA. You have cancer in the lymph nodes and you're not that old? If you have disease in your lymph nodes at the time of the surgery, unless it's a tiny, microscopic amount, you should be placed on hormone therapy after it because you have systemic disease which has spread. In order to control the disease properly, you need to block the testosterone. There are a couple of things. First of all, if you did well for six to nine months and now you're having these symptoms, those symptoms don't sound typically related to hormone therapy. There may be other reasons for why you're feeling the way you are not related to your hormone therapy. Hormone therapy, as everyone knows, can do lots of "fun" things but yours aren't typical. Sex drive can go, you can put on weight, you can have hot flashes, you can lose a little bit of body hair, you can lose

quality erections, there are lots of other things — bone density is very important, you should be on vitamin D and calcium. Your symptoms could suggest that you're calcium levels are low. Talk to your family doctor and let him/her know what is happening. It's not that your symptoms couldn't be related to hormone treatment, because we often get weird side effects to medications but it's not typical. There's a possibility that intermittent hormone therapy would help if you are suffering from reaction to hormone therapy. Intermittent therapy isn't for everyone. We know that you can be put on hormone therapy intermittently and your PSA can go down to very low numbers. The standard of care of treatment is you stay on hormone therapy forever or until the disease starts to grow in spite of hormone therapy. With intermittent treatment we can withhold some treatments. When you're on it, it affects your bone density and all the other things I mentioned. When your PSA goes down, you can go off it for a time, until your PSA starts to elevate again. That period of time can be different for everyone. It can be five years or six months, depending on the aggressiveness of your disease. When your PSA starts going back up, you go back on hormone therapy. This way you get off-treatment breaks, which makes you feel better. Your side effects can be longer lasting than just stopping the medication. The testosterone can take a while to bounce back but, if you get off it for three or four years, you get your testosterone closer to normal and you feel a bit more like yourself. You may not live as long if you get intermittent therapy. The actual difference is not dramatic. It becomes, do I want to live 15 years and feel crappy for 12 of them, or do I want to live 14 years and four months and feel better for a greater period of time. If your side effects from your hormone treatment are intolerable, then talk to your urologist about going off them intermittently.

Q. *Should everybody have radiation after surgery?*

A Every treatment has some side effects. I would say to you that there's no evidence that giving radiation after surgery is going to benefit everybody who has their prostate out. So why have the side effects of treatment if there's no benefit? There is evidence, particularly with hormone related disease, e.g. breast cancer, that there is a benefit to have radiation following surgery. There's also evidence that if you radiate the lymph nodes there are better long term results. I think for all comers, unless there's evidence that radiation will be beneficial, the side effects don't make it worth while. Then the question is, if you have high risk disease

should you have radiation after the surgery, or should you wait until your PSA rises? There are studies looking at that right now to define who is high risk and when it would benefit them to have radiation. Only 40% develop PSA recurrence. 60% of these people never get a recurrence. I personally believe unless somebody tells me that it's better for patients to have it up front, I'd rather avoid the side effects of the treatment and going for six weeks of radiation treatment. The jurie's out on that and the answer will come back.

Q. *I had radiation about eight years ago and about a year and a half later, I started having problems with my urethra, which was blocked by scar tissue. I had surgery to correct that. This has recurred about every six months and I've had to go back in to have the blockage opened up. Is this ever going to end or am I going to have to live with it forever?*

A. I would say to you that it should get better. Radiation can do some significant things to humans. I don't know what's being done to open up your stricturing but I know the guys at Southlake are very capable.

(Comment from the audience): *That's a little bit of my journey. I finally talked to my urologist about self-catherization. Going into that solution I was in fear of it. It turned out to be absolutely no big deal. I was probably self-cathing maybe once a week in the beginning. I now self-cath maybe once every two months, so it has become a whole lot better. Prior to self-cathing I was having to go back to the urologist every six months and have it opened up, because that seemed to be where the stricture was in my world.*

A. Yes, it depends where the problem is. Depending on where your scarring is, we do not have great treatment for scarring in the urethra. When it's at the bladder neck, often times we use cauterizing and we're able to cut back to normal blood vessels and tissues. The bladder is a really good vascular organ, so then you get blood supply and it will stay open enough to help the symptoms. If it's the urethra, the blood supply in the urethra stinks. When it's injured or damaged or scarred, we often cut it with a knife or dilate it. For some people with good blood supply it solves the problem and they only need to do it once or a couple of times. Then there are people like yourself, who are having trouble because, probably, there is very poor blood supply in the urethra where the scar is and it can't heal properly, so it just scars down again. When that happens, you start to look for alternatives. If it's happening that often, depending on where it is, self-catherization is a reasonable alternative, there

are lots of men who have non-cancer related strictures of the urethra, who have to do the same thing. Sometimes there are open procedures that can be done, where a special urethra expert can take a piece of your urethra and put, basically, a substitute urethra in, which I think is worthwhile but it depends on where the stricture is.

Q. *General comments on HDR and Brachytherapy.*

A. There are a lot of factors to consider in making a decision. Your Gleason 9 indicates an aggressive disease. The problems with one form of treatment is that, I tell people with higher grade or higher risk disease, a Gleason score of 8, 9 or 10 indicates high risk regardless what your PSA is or what your prostate feels like, certainly you're the type of person who would need a bone scan and a cat scan to make sure that you have disease that is grossly outside your prostate gland. If all that is clear, then what you're left with is "How do I manage my disease and can I be cured?" The answer is Yes, you can but for most people with the type of disease that you have, there is a certain understanding that you will probably require multi hormonal therapy to control your disease. What I mean by that, is it's not very common to get away with one treatment alone. You might and that would be fantastic if you did but you also have to recognize that your risk of recurrence is higher than the average guy because of what you have. Having said all that, if you understand that component of the disease, then what you have to decide in your mind is what works best for you? The treatment options in that situation are surgery, removal of the prostate gland, versus standard external beam radiation, where they zap the prostate as best they can, and they will talk to you about shrinking your prostate gland with hormones for a period of time, perhaps; and then the third option which is HDR with Brachytherapy. The radiologists feel very good about that treatment in comparison with what they've been doing before. If you look at the short term results, it looks better. That's encouraging. So, if you're comparing two radiation techniques and one looks better than the other, then I think that option seems more appealing, accepting that you're happy with the process and procedure and the side effect profile and all that stuff.

Q. *Can you explain benefits of minimally invasive surgery versus open surgery?*

A. Minimally Invasive surgery means basically with telescopes. With telescopes, laproscopically, you have a couple of holes and you do the surgery inside the abdominal cavity, you can tie up blood vessels, you can use clips, you can use

staples, everything on the inside and then you take the offending organ out through a small incision of some kind. An open procedure is an incision of some kind. So when we're just talking prostate cancer, the gold standard is a radical prostatectomy, which is what I do and what I've done for a long time and still continue to do because of resource issues and because there's no evidence that robotic prostatectomy is better for patients in terms of the things that really matter at this stage of the game. I do the incision about 2/3 up the way of the belly button and remove the prostate that way. Prostate is a main sexual unit, it produces semen. If you don't have a prostate, you don't produce semen. That doesn't, in itself, cause erectile difficulties but it ends ejaculation. The problem with the prostate is the nerves that control erections run right beside the prostate and are basically tethered to it. We have to identify the nerves, move them out of the way if you want to spare the nerves, before we take the prostate out. There are a couple of reasons that is problematic. One: prostate cancer spreads along the nerves, so when it gets outside the prostate one of the ways in which it metastasizes is along nerve fibres and blood vessels. If you have a bigger tumour, it has a greater chance of being outside the prostate gland. If you try to spare the nerves and take the prostate out, you may leave some of the cancer behind. If they are small tumours and low grade and confined and you feel there is low risk of it being outside the prostate gland, then you can get closer to the prostate and get the nerves out of the way on one or both sides to get the prostate out and feel comfortable that you're not leaving cancer behind. Number two is, even if you spare the nerves, nerves are very sensitive, so when you're cauterizing things or squeezing tissue or pulling on things, parts of the nerve fibre can be torn or irritated and you can have damage to the nerves, which are not only sensitive but take a long time to recover. You can have recovery of your function up to two or three years after an injury. If we can spare the nerves on one side, you can get erectile function from 50 to 70%; if we can spare the nerves on both sides the chances of success are even higher.

Dr. Morton also talked to several individuals during our break, helping them with some of the problems they preferred discussing directly with him.