PRACTICES IMPORTANT TO BEGIN PRIOR TO AND CONTINUING BEYOND SURGICAL REMOVAL OF THE PROSTATE GLAND OR RADIATION THERAPY TO THE PROSTATE GLAND

Compiled by Charles (Chuck) Maack – Prostate Cancer Advocate/Mentor

DISCLAIMER: Please recognize that I am not a Medical Doctor. I have been an avid student researching and studying prostate cancer as a survivor and continuing patient since 1992. I have dedicated my retirement years to continued research and study in order to serve as an advocate for prostate cancer awareness, and, from a activist patient's viewpoint, to voluntarily help patients, caregivers, and others interested develop an understanding of prostate cancer, its treatment options, and the treatment of the side effects that often accompany treatment. There is absolutely no charge for my mentoring – I provide this free service as one who has been there and hoping to make your journey one with better understanding and knowledge than was available to me when I was diagnosed so many years ago. Readers of this paper must understand that the comments or recommendations I make are not intended to be the procedure to blindly follow; rather, they are to be reviewed as my opinion, then used for further personal research, study, and subsequent discussion with the medical professional/physician providing your prostate cancer care.

Erectile Dysfunction (ED) can occur with surgical removal of the prostate gland or radiation to the gland and its periphery. Of importance is that with lack of natural erection and/or lack of stimulating erection corporal fibrosis and subsequent venous leak can occur if penile rehabilitation is not begun early on.

A Cleveland Clinic study a few years ago used an injection program in combination with early (meaning NOW, before the intended treatment, and continuing through and beyond) daily sildenafil (Viagra). They combined daily sildenafil (50 mg) to promote daily vasodilatation with either penile injections of PGE1injections (mean 4 mg/2–3 times/week) or 30U of low-dose Trimix (1 ml contains PGE1 5.88 mg, phentolamine 0.19mg and papavarine 17.65 mg/2–3 times/week) to provide the strongest pharmacological stimulus to the penis and to stimulate sexual activity. Their early combined program showed 100% compliance and had 50% return of spontaneous natural erections at 6 months. Injection of vasoactive agents provides the strongest stimuli to the neurovascular network of the penis. Their use of sildenafil combination with injection allowed them to reduce the injection dose of PGE1 and lower penile pain considerably. The

combination of daily sildenafil with penile injections appears to be safe and should prove to be effective early penile rehabilitation strategy.

One of the top physicians regarding penile rehabilitation and sexual issues, John Mulhall of Memorial Sloan Kettering Cancer Center in New York City, recommends a PDE5 inhibitor (Viagra, Levitra, or Cialis) on a daily or at least every-other day protocol to begin a week or more before surgical removal of the gland or radiation to the gland and its periphery. This should be continued following surgery or during and beyond radiation therapy. If a natural erection does not occur by four weeks post the end of treatment, he recommends the penile injections (PGE1) noted in the foregoing paragraph. Both the PDE5 and PGE1 inhibitors provide arterial blood flow as well as oxygenation to penile tissue that are both necessary to penile rehabilitation. Sexual intercourse should not begin until at least six weeks post treatment allowing for appropriate prostatic bed recovery despite hopefully noting an erection capability earlier.

A recent report (February 2015) http://tinyurl.com/n47lfzu using patient results from 2008 and 2009 came to this conclusion regarding erectile dysfunction as well as incontinence following surgical removal of the prostate gland and should serve as your forewarning that either may not return as rapidly as you might expect:

Results

- The study showed that before radical prostatectomy, urinary incontinence of various severity grades was reported in 18.8, postoperatively in 63.0% ($p < 0.001$) and erectile dysfunction of various degrees was reported in 39.6 at baseline compared to 80.1% 12 months postoperatively ($p < 0.001$).

Important in the foregoing information is for you to recognize that the more you put into return of erectile function (as well as continence), the more likely it will occur earlier than later.

This Medscape paper regarding tadalafil/Cialis concludes: **"**These results suggest that chronic dosing of tadalafil improves QoL of patients post-nsRP. The improvement of urinary incontinence in elderly patients randomized to tadalafil OaD may contribute to this effect." (post-nsRP means following nerve sparing Radical Prostatectomy). Another remark in the same paper taking 5mg tadalafil daily: "sexual domain-scores improved significantly with tadalafil."

http://tinyurl.com/pcx3yba (if the abstract won't open, you can subscribe to Medscape at no cost in order to read this and future reports)

Please review a paper I compiled offering what I hope might help some men gain an earlier return of erectile function following surgical removal of the gland or radiation therapy: http://tinyurl.com/3oz7u8l

Early Kegel exercises should also be practiced beginning prior to and beyond surgery or radiation to enable earlier return of continence, with incontinence a side effect that often follows either of the foregoing treatment options. Here is information in that regard: http://tinyurl.com/6ng8o6t