Commentary (Boxer): Management of Sexual Dysfunction After Prostate Brachytherapy

By Richard J. Boxer, MD [5]

The current ONCOLOGY article by Drs. Merrick, Wallner, and Butler is a valuable addition to the literature. An estimated 189,000 American men were diagnosed with prostate cancer in 2002, and 30,200 died of the disease, making it the most common cancer among men, and the second most common cause of cancer death.[1] The treatments have led to a high rate of cure, but the results of treatment often cause a reduction in quality of life.

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The goal of any therapy is to maximize the benefits and minimize the side effects. However, we must not lose sight of the fact that prostate cancer is a serious health problem and will commonly lead to death if left untreated. We must strive for better therapies that improve both the quantity and quality of life. That said, I have never heard a man say he would rather have one more sexual experience than see his daughter's wedding or his grandchild's next birthday.

Late Effects

The contribution of this paper to the understanding of brachytherapy for prostate cancer is that it focuses on the late effects of treatment. American society generally celebrates immediate gratification, and oncologists tend to describe the immediate effects of a particular therapy. However, long-term effects may result in serious and debilitating problems or have a negative impact on quality of life. For example, cystitis may become a serious complication years after the completion of radiation therapy.

The reduction in erectile function may be the result of many factors- vascular, neurologic, psychological, a myriad of health problems and pharmaceutical effects, the "aging process," the relationship with a partner, and the partner's desire and health. It is expected that erectile function will diminish years after therapy is completed. Thus, a study must correct for age, illness (eg, vascular disease or diabetes), and the other variables that would affect an aging man and his partner. This would require an enormous clinical trial effort, a large number of patients, and honest assessments by patients and their partners. Nonetheless, it would finally answer the question of the short- and long-term effects of prostate cancer treatments.

Choice of Therapy

Patients demand and deserve knowledge of the benefits and risks of any therapy. In standard discussions with patients, radiation oncologists and urologists explain that radical prostatectomy has a far greater chance of causing erectile dysfunction than radiation therapy, and that seed implantation has less of a chance of causing erectile dysfunction than external radiation. Reported data along these lines[2] provide the patient, his family, and physician with valuable information to foster a discussion of long-term effects, which may alter the chosen mode of treatment. The young patient who chooses radiation based solely on his desire to maintain sexual activity may be gaining very little in the long run, and may be choosing an inferior therapy based upon incomplete information. If the patient has a better chance of survival at 10, 15, or 20 years with radical prostatectomy, but chooses seed implantation to reduce the risk of erectile dysfunction, he may still find that there is a significant reduction in erectile function at 3 to 6 years posttherapy. The trade-off may not be worth it to him and his family, and they may ultimately believe the short-term gain was not worth the long-term pain.
Effects of Adjuvant Therapy

Androgen ablation therapy is commonly used in conjunction with external-beam or seed implantation radiation therapy. The powerful negative impact on erectile function lasts for months following the last injection of a luteinizing hormone-releasing hormone agonist. Patients report that months after the discontinuation of hormone ablation they continue to have hot flashes. This is a certain indicator that their androgen level has not returned to normal. In fact, depending on the patient's age, reduced libido due to hormone ablation may never return to normal (again, this is a multifactorial problem).

Therefore, a patient may choose radiation over surgery as a primary form of cure for prostate cancer, but suffer from the deleterious effects of the adjuvant therapy. The bottom line for the patient is erectile dysfunction for at least a year, and then a 3- to 6-year reduction in erectile function as described in this study.[3]

Conclusions

So where does that leave the patient, his family, and the doctor? Obviously honest, forthcoming, and evidence-based information leads to greater understanding among the discussants. Patients depend upon unbiased data, and therefore, whether the physician is a radiation oncologist or a urologist, the short-term and long-term effects of therapy must be conveyed to the patient. Quality-of-life issues are critical, but reasonable people define quality of life in a myriad of ways. Sexual activity is important, but there are other equally or more important aspects of life-including life itself-and this involves a very personal decision. The doctor's role is first to be educated, then to educate, and always to be compassionate and sympathetic to those in her/his trust and care.

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