PROSTATE CANCER
THE EMOTIONAL EXPERIENCE

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Charles Huggins was born in Nova Scotia in 1901. He attended Harvard Medical School in the early 1920’s. He trained as a general surgeon in Michigan. In 1927, at the age of 26, he was appointed to the faculty of the University of Chicago as a urological surgeon. He was less a surgeon and more a physiologist interested in glandular secretions. He became interested in studying prostatic fluid—a runny, straw colored mixture of salt and sugar meant to lubricate and nourish the sperm.
Because of the connection of estrogen with the growth of breast cells, Huggins wondered if testosterone had similar effects on prostate cells.

By the late 1920’s Huggins had devised a device to collect prostatic fluid from dogs.

He discovered that prostate cells were dependent on the hormone testosterone for their growth and function.

One obstacle that occurred was that some of his experimental dogs had prostate cancer. This effected his study of prostatic fluid, however inspired the question of whether depriving these dogs of testosterone would effect the growth of the cancer cells.

It did.
He extrapolated from that experiment and wondered if confusing the body in believing that it was female would suppress the growth of prostate cells.

So he used synthetic estrogens to induce a chemical castration.

It worked. Until there was a relapse.

Most significant was that it taught us that we had other options to create cancer remission then using toxic, cellular poisons used in chemotherapy.
NUMBERS

- Most common non-skin cancer in males.
- 186,320 new cases in 2008.
- 65% of new cases occur in men over the age of 65.
- Second leading cause of cancer death in men.
- Incidence and mortality is twice as high in men of African descent.
- Psychological reactions can be affected by marital status, retirement, supports, loss of friends or family to death.
- 5-10% are due to genetics.
- A diet high in saturated fats has been connected with a higher incidence of prostate CA.
ACS recommends a yearly digital rectal exam for men above 50 along with a PSA test.
Individuals with greater risk should begin screening at the age of 45.
It can not be said with certainty whether early screening and or treatment is of benefit, especially when considering the impairments caused by treatments.
PSA levels can be normal in the case of cancer being present.
It can also be high in prostatitis, BPH, and when a procedure has been performed in the area.
PSA levels can also vary with age and other medical issues.
For this reason there is considerable anxiety around test taking time.
A lot of emotional significance is placed on whether the PSA level is changing.
Options include:
- Watchful waiting, active surveillance, surgery, radiation and cryotherapy.
- Most definitive choice in the past has been an open radical prostatectomy.
- There is a newer “nerve sparing” procedure that decreases the incidence of impotence and urinary incontinence.
- Currently options of laparoscopic and robotic prostatectomies apparently lead to less bleeding, less risks for infection, and less time in the hospital.
- Radiation therapy may have decreased and or delayed issues with impotence. However the bowel is effected more. Because PSA levels take a while to decrease, anxiety is more prevalent.
Hormone manipulation is also used. This decreases the synthesis of testosterone and thus the growth of prostate cancer cells.

This is preferred over orchiectomy due to effects on body image.

Side-effects of reducing hormone can include:

- ED, loss of libido, hot flashes, gynecomastia, irritability, anxiety and depression (more common if there is a hx of depression).
PSYCHOLOGICAL EFFECTS

- Due to uncertainty about treatment decisions, outcomes and side-effects there is potential for anxiety, irritability, anger, and depression.
- Information overload (having control VS not knowing what to do with the information).
- Surgery
  + tumor is out and pathology can help “see” cancer more clearly
  - fear of anesthesia, infections, stay in hospital
- Radiation
  + no surgery
  - side-effects (GI)
- Diet/exercise
  + feel more in control
  - can get obsessive of what to eat and what not to in fear of recurrence.
SEXUAL ISSUES

- Can be due to aging, cancer, surgery, radiation and hormonal treatments.
- This can cause stress in a relationship.
- Feeling less like a man.
- Therefore discussions prior to treatments are important.
- Treatments include drugs, penile injections, vacuum erection devices, penile prostheses, sex therapy.
Complication of surgery and radiation.

Due to embarrassment, social events are avoided.

It is important to determine cause and educate on treatment options.

These include pelvic muscle reeducation, bladder training, anticholinergic medications, and urinary sphincter implantation.

Therapy and or medications of anxiety and depression can also be of help.
Symptom of advanced disease.
It results from local growth, inflammation, and mets to the bone.
This will lead to depression and anxiety.
Men likely not to take adequate amounts of pain medication.
WEAKNESS AND FATIGUE

- More challenging if one has lived an independent and active life style.
- Due to illness, hormone therapy, radiation, pain meds, and steroids.
- Psychostimulants may help counter effects of opioids, increase motivation, appetite, and elevate mood.
- Wellbutrin (no sex side-effects) and prozac (help fatigue) are also used.
- Exercise, hydration, good diet and adequate sleep are crucial.
HOT FLASHES

- Caused by medical and surgical androgen ablation.
- Leads to sweating, feeling “hot”, and chills.
- Hormone therapy may need to be stopped in certain extreme cases.
- SSRI/SNRI/and seizure meds can be helpful.
- Decreasing caffeine, alcohol, hot beverages, and stress management can be helpful.
Lack of both physical and emotional communication.

Significant others have a greater level of distress.

Counseling individually and together can be very helpful.

Patients usually feel the need to protect their spouses from their emotional struggles.

Spouses also feel this and can feel overwhelmed with the level of caretaking needed. Therefore support for them is important.
Usually these fears are denied or not spoken of.
Hearing of other’s recurrences can offer both hope and dread.
Monthly testing/scanning is a time of great uncertainty.
Topics of death are avoided. As both patient or family member can feel that talking about “it” will most definitely lead to death.
Talking about the reality of death (whether cancer leads to it is never known for certain) can be freeing.
Prevention with 10-20mg of lexapro.

Incidence of depression was less

However greater dropout due to side-effects

Usually not given preventively unless strong history of depression and or patient request.

Collaborative care with primary care clinician, case manager, and psychiatrist.

Research has shown benefit.

Antidepressants

Chosen based upon type of depressive symptoms, current medical issues, and side-effect profiles.
Pt with agitation or insomnia ~TCA, trazadone, remeron
Pts with fatigue or psychomotor slowing ~SSRI’s or stimulants
Pts with pain ~TCA
Pts with heart issues ~prozac, sertraline (less effects on BP)
Pts with slow gut or urinary retention ~SSRI (<anticholinergic effects)
Pts with seizure risk ~wellbutrin
Pts who can not take whole pills ~liquid formulations are available.
PSYCHOTHERAPY OPTIONS

- Individual
- Group
- Support, educational, coping skills, self exploration, existential issues
- Couples
- Family
- For health care providers
ANXIETY

- Relaxation techniques ~ guided imagery/meditation
- Psychotherapy
- Medications
INTEGRATIVE APPROACH

- Can be helpful for physical symptoms of cancer treatments
- Can help with depression and anxiety
- Include nutrition, exercise, stress management
- Acupuncture, reiki, homeopathy, supplements, Chinese medicine and other non-western modalities of medical treatment.
RESOURCES

- ME!
- IHM program
- Spiritual care
- Social work
- Nutritionist