

Prostate Cancer Action Plan: Choosing the treatment that's right for you

Segment 1: Introduction

Trust me, there's a better way to choose a treatment for your prostate cancer. Watching this program is a good start. We know you may feel overwhelmed by your diagnosis. You may feel just as overwhelmed by all the treatments you hear about. You may know someone who's had surgery, or someone else who's had chemo, or someone who's had radiation. What goes into choosing one treatment over another? This program will help you talk with your doctor about your treatment options.

We'll start by looking at the prostate itself which sits right in the middle of other organs that affect your sexual, urinary, and bowel functions. Some treatments affect the area more than others, so that could be a factor in the treatment you choose. The treatment you choose also depends on the unique characteristics of your cancer. Is it confined to your prostate or has it spread? Does it grow slow or fast? We can tell a lot about your cancer by looking at three things: your Gleason score, your PSA level, and your tumor stage. Knowing these three things will help you choose a treatment.

We'll look at a number of different treatments to see what's involved and to talk about their various risks and benefits. After you watch this program, you can make a much more informed decision about the next step in treating your cancer.

Many of my patients ask me why are there so many different treatments for prostate cancer? Well it's because every man is different and every prostate cancer is different. Some cancers are aggressive and some aren't. Some cancers are more likely to stay in the prostate whereas some are more likely to spread. We take all these things into consideration when we choose a treatment. We also look at what you want. Some younger healthier men want more aggressive hoping to live many more years.

Older men with other serious health problems may opt to do nothing because it may be possible that they will die from something else and not from their prostate cancer. We certainly don't expect you to make a treatment decision on your own; that's not how it works. You and your doctor will make the decision together. We want you to be comfortable with whatever you and your doctor decide and be confident that it's right for you.

Segment 2: Know Your Prostate

Your prostate is a gland which is part of the male reproductive system. It's about the size of a walnut. It's main job is to make the fluid that's part of semen. The prostate sits between your bladder and penis, underneath the pubic bone and in front of your rectum. It wraps around your urethra, which drains urine from your bladder. Seminal vesicles are behind the bladder and connected to the prostate. These glands add seminal fluid to sperm to make semen. Nerves and arteries are next to the prostate and are necessary for erections.

So your prostate occupies some very important real estate. You can see how treating prostate cancer can affect your sexual, urinary, and bowel functions. We'll talk about some of these side effects when we look at each treatment option. But now you know why some treatments might cause impotence, or incontinence, or give you some bowel or bladder trouble. It's all about location.

One of our major goals in treating prostate cancer is to minimize any damage to the surrounding neighborhood. This isn't always possible simply due to where your prostate is located. For instance, if you have surgery to remove the prostate, there can be damage to nearby nerves that control erections. If you have radiation, the radiation may not only kill the cancer cells but also healthy cells in neighboring organs like the rectum or bladder.

Your doctor will do everything possible to lessen the side effects of whatever treatment you choose. We're also fortunate to have drugs and surgical treatment for incontinence, and drugs like Viagra that can help with erections.

The bottom line is to treat your cancer with minimal impact on the quality of your life.

Segment 3: Three Things to Know in Choosing Your Treatment

There are many things that go into choosing a treatment that's right for you, but there are 3 very specific factors that you and your doctor will use. These are your Gleason score, your PSA level, and your tumor stage. These 3 measures are used to determine the extent and severity of your cancer. Your Gleason score is based on the results of your prostate biopsy. During the biopsy, your doctor takes from 6 to 18 samples from your prostate. A pathologist examines each sample under a microscope. Each sample can have varying amounts of cancer. Some samples may have very few cancer cells, some may have moderate amounts of cancer, some may be full of cancer. The pathologist assigns a number ranging from 1 to 5 to each area of cancer based on the appearance of the cells and how they are arranged. This is the Gleason grade.

The Gleason score represents the sum of the 2 most common patterns, or the 2 most common Gleason grades. For instance, let's say most of the samples in your biopsy get a grade of 3, the second most common pattern gets a grade of 4. Add them together and your Gleason score is 7. Gleason scores range from 6 to 10. Clinically speaking, Gleason scores of 1 and 2 are no longer used. A score of 6 or less may mean that your tumor is less likely to grow rapidly or spread. A score of 7 means the tumor is potentially more dangerous in terms of faster growth and potential spread. A score of 8 to 10 implies a high likelihood of an aggressive cancer, which has a greater potential for rapid growth and possible metastasis.

Knowing your PSA level can also give you more information about your cancer. Prostate-specific antigen or PSA is a protein produced exclusively by prostate cells. PSA is found in higher levels in men with prostate cancer because more PSA finds its way into the blood where it is measured. The same thing happens in some men with benign prostate enlargement or prostate infections. Interpreting PSA levels is complicated. Your doctor will help you understand your particular PSA levels. There are a lot of factors that go into how the PSA levels are used in explaining treatment options. Tumors are assigned a stage from 1 to 4 based on the size of the cancer or the volume of the cancer, whether or not it can be felt on a digital rectal exam, and whether or not the extent of the cancer can be seen by any number of imaging tests, including ultrasound, CT scans, and MRI. There are times when these imaging tests are necessary and there are other times when these imaging tests are not helpful in terms of staging. Let's talk about the various stages of prostate cancer. To re-emphasize, current practice and decisions are mainly based around Gleason score and tumor stage. PSA can help, but it can be misleading and subject to misinterpretation.

Stage 1: the cancer is small and confined to the prostate. It cannot be felt on a digital rectal exam. Cancers of this stage are usually detected because an elevated PSA led to a biopsy. Stage 2: the cancer is larger than in stage 1 and can be felt on rectal exam as a nodule. The cancer cannot be detected outside the prostate. Stage 3: the cancer has spread outside the confines of

the capsule that surrounds the prostate. It can be detected in the seminal vesicles either by biopsy or palpation. Stage 4: the cancer has spread to other organs, lymph nodes, or bones. You might see your tumor stage written with an A, B, C, or D next to it, such as Stage 2a or Stage 2b. These letters add more detailed information about your cancer and you can ask your doctor to explain them to you.

It's really important for you to ask your doctor what your particular Gleason score and tumor stage are. Of course, there are many other factors that go in choosing a treatment, but these 2 - Gleason score and tumor stage - are the most important. Sometimes PSA and the imaging tests that we've discussed are also important. These variables will help you choose a treatment and understand why your doctor may guide you in one direction rather than another.

Segment 4: Risk Assessment

We've talked about how your cancer grade, tumor stage and PSA can help you and your doctor make a decision about your treatment. It's also helpful to know what we call risk assessment and risk groups. We all know about risk. Every time we get on the freeway or climb a ladder, we risk having an accident. It's the same with prostate cancer. There's the risk that the cancer will grow or spread or even cause death or it may not do any of those things. Knowing your risk can help you make a treatment decision. Some urologists will assign you to a risk group based on your grade, stage and PSA.

Risk groups are useful in letting you know if your cancer is at low or high risk of growing, spreading or causing problems. Your treatment decision may well depend on the level of risk you face. Your doctor may also use nomograms to assess your risk and help you choose a treatment. A nomogram is a mathematical tool used to make predictions. In the case of prostate cancer, nomograms are useful to predict the risk that your cancer will spread or recur after treatment.

A nomogram is based on detailed information about your cancer, including your grade, stage, PSA and biopsy results. It can predict your individual risk better than assigning you to a risk group. A nomogram can be very useful in helping you and your doctor determine a treatment approach that may give you the greatest benefit.

Finally, a word about tumor staging and how it relates to risk assessment. Chances are you already know your tumor stage: 1, 2, 3 or 4. Tumor stages are usually determined either before surgery or after surgery or both. Staging before surgery is called the clinical stage. Staging after surgery is called pathologic stage. You'll see clinical stage written like this, with a lower case C before an upper case T. Clinical stage is based on a rectal exam and imaging studies like ultrasound, CT or MRI.

You'll see pathologic stage written like this with a small P before the capital T. This is the cancer stage after surgery when the prostate and surrounding tissue are removed and examined by a pathologist. Knowing your clinical stage is particularly useful when discussing treatment options. Knowing your pathologic stage is helpful in talking about outcomes following surgery. As you've seen we use various tools to determine the risk that your cancer may or may not spread or reoccur. Knowing your risk may help you and your doctor determine the next steps in your treatment.

Segment 5: Treatment Options for Stage 1 Prostate Cancer

Low risk prostate cancers are generally stage 1 in Gleason score of 6 or less. These are usually, but not always low volume cancers. They're localized to the prostate. If you have low or very low risk prostate cancer, you have a number of treatment options. You could choose active surveillance. We have specific criteria for patients who qualify for active surveillance. If you are a candidate and choose active surveillance, we will closely monitor your PSA levels at specific intervals. You will also need to have repeat biopsies at specific intervals to be sure that your cancer is not growing or changing. Approximately a third of patients who initially elect active surveillance will experience a change of progression of the cancer and will then benefit from definitive treatment. Other patients with low risk cancer may not be candidates for active surveillance and would be better served by surgery, radiation, or cryotherapy.

Please watch the segment on each type of treatment for a description of the treatment and the risks and benefits. The treatment you choose may depend on your age and your overall health. If you're older or have other serious medical problems, it could be made worse by surgery or radiation. Active surveillance may be a good choice for you. If you're younger and healthy or have a family history that suggests the possibility of a more aggressive cancer, you may want surgery or radiation as your initial treatment. Some treatments may have distinct advantages over others. It all depends on the unique characteristics of your particular cancer and your personal preferences. When it comes time to choose your treatment, you and your doctor will decide together.

Segment 6: Treatment Options for Stage 2 Prostate Cancer

Stage 2 cancers are cancers that can be felt on rectal exam, or can be seen on imaging studies.

These cancers are still confined to the prostate.

If you have clinical stage 2 prostate cancer, you have a number of treatment options available to you depending on which risk group you are in.

Most active surveillance protocols exclude patients with stage 2 disease, however, if you are elderly and or, if you have multiple medical problems, watchful waiting and monitoring of your cancer may be the best option. Surgery is a good option for most stage 2 cancers. Other options for stage 2 prostate cancer include radiation, or freezing to destroy cancer cells. Hormone therapy is not an option for stage 2 tumors, however a short course of hormone therapy is sometimes necessary to shrink the prostate prior to radiation or freezing. Please watch the segment on each type of treatment for a description of the treatment and the attendant risks and benefits.

The treatment you choose may depend on your age, and your overall state of health. If you're older or have other serious medical problems that could make surgery or radiation dangerous, watchful waiting and monitoring of your cancer could be a good choice for you. This would be particularly true for example if you are eighty years old, have heart disease, diabetes and high blood pressure and a Gleason score six tumor that happens to be a palpable nodule, yet confined to the prostate. If, however you're younger and healthy, you may want surgery, radiation or cryoablation as your initial treatments. Some treatments may have distinct advantages over others. It all depends on the unique characteristics of your cancer and your personal preferences. Your doctor can help you decide.

Segment 7: Treatment Options for Stage 3 Prostate Cancer

Clinical stage 3 prostate cancer has spread outside the prostate. Sometimes it can be felt or seen in the seminal vesicles. Most clinical stage 3 cancers are rarely cured, but these cancers are treatable and can sometimes be put into remission or even cured. Surgery is usually not done for clinical stage 3 cancers with intensive care but in some specific circumstances it may be an option. External beam radiation therapy is usually the treatment of choice for stage 3 cancers and it's often combined with hormone ablation and/or Reiki therapy. Hormone therapy shrinks the tumor, slows or temporarily stops its growth, and makes radiation more effective. Please watch the segment on each type of treatment for description of benefits and risks.

With stage 3 cancer, treatment is less about cure and more about control. Some treatments may have distinct advantages over others in controlling your cancer. It all depends on the unique characteristics of your tumor and your personal preferences. You and your doctor can decide together.

Segment 8: Treatment Options for Stage 4 Prostate Cancer

Stage 4 prostate cancer has spread outside the prostate to other organs, lymph nodes, or bones. Like stage 3 cancers, stage 4 cancers cannot be cured, but these cancers can be treated to slow their growth and relieve symptoms. Hormone therapy may shrink your tumor, slow its growth, or even stop its growth. It can also have similar effects on the cancer if it is spread to lymph nodes and bones. Please watch the segment on hormone ablation therapy, also known as androgen deprivation therapy, for a description of how this is done as well as the benefits and risks. With stage 4 cancer, treatment is less about cure and more about control. Some treatments may have distinct advantages over others in controlling your cancer. It all depends on the unique characteristics of your tumor and your personal preferences. You and your doctor can decide together what's best.

Segment 9: Active Surveillance

Active Surveillance is a management option where your doctor closely monitors you for any sign that your cancer is growing or changing. The purpose of Active Surveillance, is to help you avoid unnecessary treatment of a cancer that may never harm you. Active Surveillance involves having a PSA blood test, generally every 6 months depending on the protocol.

Additionally a repeat biopsy is usually done, the timing of the repeat biopsy or biopsies varies and is dependent on the protocol your urologist is using. If your PSA rises a repeat biopsy usually necessary.

Deciding on who goes on Active Surveillance, is not set in stone. You may want to think about this treatment if you have stage one prostate cancer, and a Gleason score of 6 or less. Active Surveillance or Watchful Waiting may also be a good choice for older men with a life expectancy of less than 15 years, or for men with other serious medical problems.

A risk of Active Surveillance is the unpredictable nature of prostate cancer. There's a 30% chance of that tumors with a Gleason score of 6 or less will progress to a higher grade or stage. This is something we can't yet predict although researchers are currently working on trying to predict this. Some cancers also progress before PSA levels change, there's always the chance that a small slow growing cancer will grow more quickly than we expect, and become more difficult to treat.

The upside to Active Surveillance is that you might be able to avoid other treatments, which carry a risk of incontinence or impotence. Your cancer may never become a problem.

The more we learn about prostate cancer, the more Active Surveillance is becoming an accepted practice. The fact is that some prostate cancers grow more slowly than others. More than half of all American men have some cancer in their prostates by the age of 80. These cancers are small, and are of low volume. These cancers do not cause systems, and some of them do not result in age adjusted elevation of PSA. Most of these cancers never cause a problem, and men with this type of indolent prostate cancer, do not die from the disease.

I hope you have a better idea of what Active Surveillance involves, and if this might be the right treatment for you. Talk with your doctor and make the decision together.

Segment 10: Surgery: Radical Prostatectomy

Surgery for prostate cancer is called a radical prostatectomy. This procedure removes the prostate and seminal vesicles with the goal of also removing all the cancer. Surgery can be a very effective treatment for prostate cancer that is not spread. In that case, there's a greater than 95% chance that surgery will cure your cancer. If your cancer has spread beyond the capsule of the prostate, surgery is not a cure, but may be an option to relieve the symptoms of more advanced cancer such as urinary obstructions. There are three ways to perform a radical prostatectomy: open radical prostatectomy, laparoscopic radical prostatectomy, and robotic-assisted laparoscopic radical prostatectomy.

In the open radical retropubic prostatectomy, the surgeon makes an incision about 4 or 5 inches long between your belly button and your pubic bone. In very rare cases the incision is made between your scrotum and rectum. This is called a perineal radical prostatectomy. The most common procedure done today is the robotic-assisted laparoscopic radical prostatectomy. During all radical prostatectomies, the surgeon removes your entire prostate and seminal vesicles and might also take some lymph nodes and other tissues so they can be tested for cancer.

While you're still under anesthesia your surgeon will put a catheter in your penis to empty your bladder and allow the hook up known as the anastomosis between the bladder and the urethra to heal. You'll likely have the catheter for one to two weeks. Then, you should be able to pee on your own after it's removed. You'll probably stay in the hospital for a few days after an open prostatectomy and will need about 3 to 5 weeks before you feel like getting back to your normal activities. Most laparoscopic RRP's are done with robotic assistance. One difference between the open prostatectomy and the robotic-assisted laparoscopic procedure is the size of the incision.

To perform a laparoscopic radical prostatectomy, your surgeon makes several small incisions in your belly. The incisions are just big enough to insert a small video camera and long instruments that the surgeon manipulates to remove your prostate. Even though the robotic-assisted procedure sounds like a robot is in charge, it's still your surgeon who's in control. The only difference between the two laparoscopic procedures is who's actually holding the instruments: your surgeon or robotic arms. With laparoscopic surgery, recovery and return to usual activity is faster. Chances are you'll stay overnight in the hospital rather than a couple of days. You'll probably also have less pain, but you'll still go home with a catheter and need it for a week versus 2 to 3 weeks with the open procedure.

What's better? An open prostatectomy or a robotic-assisted laparoscopic procedure? Early studies show that the results are about the same. The biggest difference is that you may have less pain and faster recovery with a laparoscopic procedure, but sometimes the size of your

prostate, your weight, and the shape of your pelvis makes you a better candidate for an open procedure. Also, the size of the prostate and the stage of the cancer may play a role in deciding between the open prostatectomy or a robotic-assisted laparoscopic procedure.

Like any operation, all prostate surgery carries some risks and there may be side-effects. Some short-term side-effects include bleeding that requires transfusion, infection, urinary and bowel problems, and blood clots in the legs or lungs. Two significant long-term potential side-effects are incontinence and erectile dysfunction. However, there are effective treatments to help with both conditions. The primary benefit of surgery is that it can give you a greater than 95% chance of being cured if your cancer is confined to your prostate and has not spread.

In some cases surgery may be your best option. Especially when you start looking at the risks and benefits and the chance for a cure. Patients with Stage 1 or Stage 2 disease benefit greatly from surgery. Particular if you're younger than 70 and don't have other serious medical problems like heart disease or diabetes. With any treatment, including surgery, there's always the chance that not all the cancer will be treated or fully removed. In some cases your doctor may combine surgery with another treatment like radiation therapy to increase your chances of a cure. I hope you have a better idea of what surgery involves and this might be the right treatment for you. Talk with your doctor and make the decision together.

Segment 11: Radiation Therapy

Radiation Therapy uses high doses of radiation to kill cancer cells or to keep them from growing. Radiation is an option as primary option for Stage 1, 2 and 3 cancers. Sometimes radiation is given to men after surgery to destroy any stray cancer cells. Radiation is also used along with hormone therapy for tumors that have grown into nearby tissues, also known as Stage 3 Disease. Radiation can be used to reduce the size of an advanced tumor or metastatic prostate cancer in bones or lymph nodes. In this scenario, radiation provides local control and/or symptom relief.

There are 2 types of Radiation Therapy: External Beam Radiation and Internal Radiation, or placement of radioactive seeds otherwise known as Brachytherapy. Your doctor may use both types of radiation or along with other treatments like hormone deprivation.

External Beam Radiation uses a machine to send radiation to the cancer. It's like getting X-ray. It's painless and lasts just a few minutes. You'll usually get external radiation for 5 days a week as an outpatient for 7-9 weeks. There are also short term and more intensive forms of External Beam Radiation Therapy that are available. If you are a candidate for Radiation Therapy, your doctor will refer you to a radiation oncologist, who is an expert in all forms of radiation therapy. The good thing about any radiation is that it kills cancer, but it also zaps healthy tissue too.

Before your first radiation session, your doctor inserts 3-5 tiny gold seeds into the capsule. It's a lot like having a biopsy. These seeds mark the exact location of your prostate so the radiation beam has a very precise target. This minimizes the amount of radiation that hits surrounding tissues. Gold seed placement is used for IGRT, or Image Guided Radiation Therapy, and IMRT, known as Intensity Modulated Radiation Therapy.

Brachytherapy is a way to deliver radioactive seeds inside your prostate. Brachytherapy is done as an outpatient procedure under general anesthesia. Special computer programs calculate the exact dose of radiation these seeds give off for weeks or months. An advantage of Brachytherapy is that the radiation from the seeds doesn't travel far, so there may be less damage to nearby healthy tissues.

Radiation can have both short and long term complications. Short term complications of radiation therapy can include fatigue and bowel problems, such as diarrhea, bleeding, or pain. You might have some urinary symptoms such as urgency, frequency, or painful urination. Other complications might show up 10 to 20 years later, when you start to see more bowel and urinary problems and erectile dysfunction. There is also an increased risk of bladder and rectal cancers in men having radiation, although these are rare and somewhat controversial complications.

A key benefit of radiation is that it's an effective treatment for prostate cancer and may be easier on you than surgery. It may also be a good choice if you're an older man with other medical problems that could be made worse by having surgery.

My patients often ask me, "what's better? Radiation or surgery?" I tell them that it depends on the tumor stage, gleason grade, their general state of health, and the potential side effects that they are willing to deal with. Very generally speaking, for certain grades and stages, the cure rate when comparing radiation to surgery is about the same.

Another thing to consider is if the radiation does not eradicate the cancer, having surgery after radiation is much more complicated. However, if surgery does not eradicate the cancer, doing radiation after surgery is usually well tolerated. I'm also asked about External Beam Therapy, also known as IMRT or IGRT versus Brachytherapy, which is the placement of radioactive seeds into the tissue of the prostate.

What's the best way to go? Well, it depends. A possible advantage of Brachytherapy is that it lets your doctor deliver high doses of radiation directly into the prostate without damaging nearby healthy tissues.

External Beam Radiation is often combined with Brachytherapy, or radioactive seeds, to produce maximal cancer control and chance for cure. But for men with large prostates, this treatment may not be as effective because it can be difficult to place the radioactive seeds into the right places. In that case, we might opt for external radiation or use hormone therapy to shrink the prostate before radiation.

Segment 12: Cryoablation

Cryoablation is a treatment that involves freezing all or a part of your prostate to kill cancer cells. You might also hear this procedure called cryosurgery or cryotherapy. Cryoablation is typically used to treat patients who have failed radiation. However, it is also an option for a few select patients with stage 1 or stage 2 cancers. It is also effective against cancers with a high Gleason score. Cryoablation might also be a good choice if you're unable to have surgery or radiation because of your age or other medical problems. Additionally, an important use of cryoablation therapy is for patients whose cancer returns after radiation.

Cryoablation is done under general or spinal anesthesia. Your doctor will place 6 to 8 probes in your prostate. Very cold gases are then passed through the probes. A ball of ice crystals forms around each probe to freeze and kill the nearby cells. After cryosurgery, the frozen tissue thaws and the leftover debris either dissolves or is absorbed by your body. After the procedure, you may have some bruising and soreness where the probes were inserted between the scrotum and anus. 80 to 90 percent of cryoablation procedures are done as outpatients.

You'll get antibiotics and pain meds, although most men are pleasantly surprised at how little pain they have. You'll go home with a catheter that you'll wear for about a week. You might also experience some swelling of the penis or scrotum, blood in the urine, or a feeling that you need to empty your bladder or bowels often. These side effects are usually temporary. The most common complication is erectile dysfunction, which occurs in more than 50 percent of men who were potent before cryoablation. You might also have some problems with incontinence, but this is generally rare. A benefit of cryoablation is that it's a minimally invasive procedure, so recuperation is fairly fast and easy. The procedure can be repeated if the first cryoablation has not completely killed the cancer.

Cryoablation is a relatively new treatment, so we don't have a lot of data showing how men do 10 or 15 years after the treatment, but we do have studies that show that 60 to 80 percent of men with smaller, less aggressive cancers are disease-free 5 years later. 40 percent of men, with more aggressive tumors, are cancer-free at 5 years. These results are similar to those found in radiation therapy studies. There are also some studies that suggest cryoablation may be a better treatment option than radiation for men with Gleason scores in the range of 8 to 10. However, cryoablation is not suited for everyone, and many patients are better off considering surgery or radiation as a primary option. I hope you have a better idea of what cryoablation involves, and if this might be the right treatment for you, talk with your doctor and make the decision together.

Segment 13: Hormone Therapy

Prostate cancer needs the male hormone testosterone to grow. The purpose of hormone therapy is to stop your body's ability to make or use testosterone. 85% of prostate cancers respond to hormone therapy and will slow down or even shrink, but hormone therapy does not cure cancer and it will eventually stop helping. Hormone therapy is usually reserved for men whose cancer has spread outside the prostate or to other organs like bone or lymph nodes. Hormone therapy is sometimes used in combination with radiation. For example, you may receive hormone therapy before undergoing radiation to shrink your tumor and increase the chance of a successful treatment.

There are 3 ways to do a hormone ablation therapy. One injections to stop your body for making testosterone. Sometimes combined with oral medications that block testosterone from getting to the cancer cells. Two, surgery to remove both testicles which are the main source of testosterone. Three, oral blocking medication that blocks any residual testosterone that comes from the adrenal glands. Surgery to remove both testicles is usually a simple outpatient procedure, but many men find it very difficult to accept.

For most men the biggest downside of hormone therapy is sexual dysfunction. Without testosterone, you will lose your desire for sex and your ability to perform. Your testicles and penis may shrink. There is an increase risk of bone weakness, fatigue, weight gain, hot flashes, and breast enlargement and tenderness. Hormone therapy has been linked to an increase risk of high blood pressure, diabetes, stroke and heart attack. The good news is that some of these side effects can be prevented or treated with medication.

Side effects from hormone ablation therapy are significant and can be serious. Why do it at all? Well, complications related to metastatic disease such as urinary obstruction or pathologic bone fractures are far more serious than the side effects from hormone ablation therapy. Also for patients with locally advanced prostate cancer, hormone ablation therapy combined with radiation produces better survival results in either therapy alone.

I hope you have a better idea of what hormone therapy involves and if this might be the right treatment for you. Talk with your doctor and make the decision together.

Segment 14: Talking with your Doctor

I'm a big believe that knowledge is power. I hope that what you've learned in this program makes you feel that you're ready to go talk with your doctor about a treatment option for your cancer. Not all prostate cancers are alike. One size does not fit all. Your cancer may be very different from your neighbor's and the guy down the street. That's the reason we did this video so that you can make a joint decision with your doctor about your very unique cancer.

If you don't already know your Gleason score, PSA level, and tumor stage, as your doctor. Also it may be helpful for you to know about your specific risk group. Nomograms and tables can help you identify your specific risks and chances. All of this information along with your personal preferences and lifestyle will hopefully help you decide with your doctor what's right for you. With this information in line, you now understand the treatments available to you.

Once again it's important to emphasize that your cancer is unique just as your treatment options are going to be unique. Go see your doctor ready to talk about the treatment options you've seen so you can come to an informed decision together. Good luck with whatever you decide.