Cancer Survivorship E-Learning Series for Primary Care Providers

GW Cancer Center TAP

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George Washington University Cancer Center TAP. (2020). *Cancer Survivorship Series* [PowerPoint Slides]. GWU Cancer Center TAP. https://cme.smhs.gwu.edu/gw-cancer-center-/content/cancer-survivorship-series

This content was adapted from the GW Cancer Center the Oncology Patient Navigation Training: The Fundamentals (PI: Pratt-Chapman) developed and maintained by CDC cooperative agreements #NU38DP004972, #5NU58DP006461 and #NU58DP007539. The content added, changed, or adapted by our organization do not necessarily represent the views of the GW Cancer Center or the CDC.

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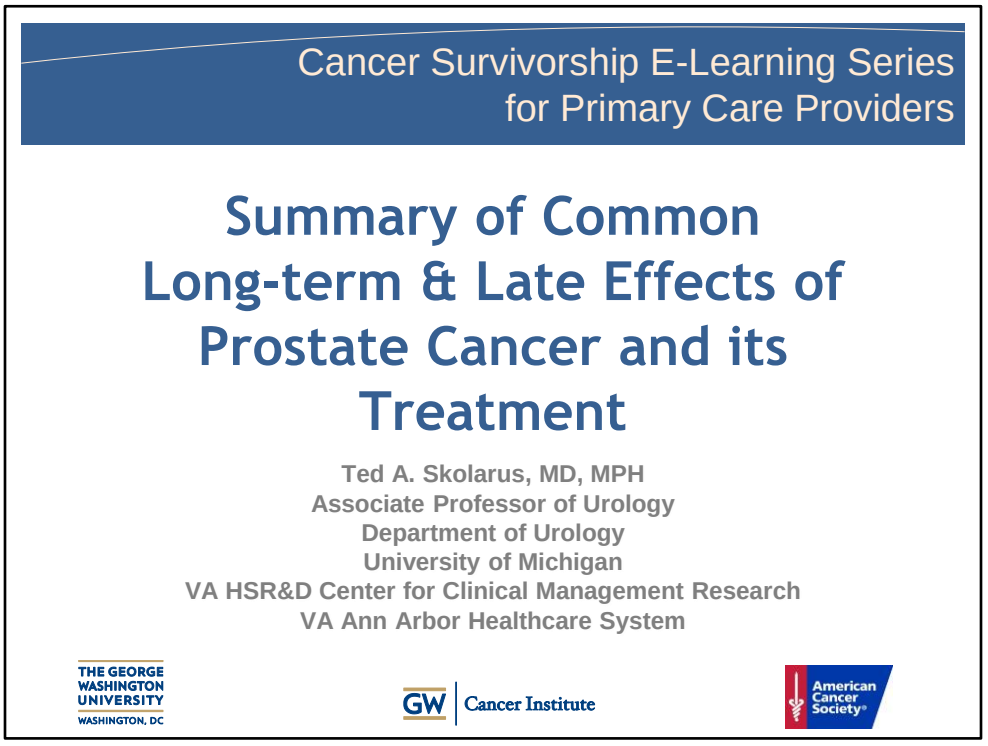

Hello and welcome to a presentation on: A Summary of Common Long-term and Late Effects of Prostate Cancer and its Treatment
I am (Name).
We are pleased to offer this educational session through the National Cancer Survivorship Resource Center, a collaboration between the American Cancer Society and the GW Cancer Institute funded by a five year cooperative agreement from the Centers for Disease Control and Prevention.

Disclosures

- VA HSR&D Career Development Award - 2 (CDA 12-171) for work outside of the current study
- UpToDate™ author royalties for prostate cancer survivorship section

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This presentation was developed from the following manuscript:

Skolarus TA, Wolf A, Cowens-Alvarado, R et al. American Cancer Society Prostate Cancer Survivorship Guidelines. *Cancer*. 2014

Learning Objective

The participant will be able to:

- Describe the common long-term and late effects of prostate cancer treatment.

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Prostate Cancer Survivorship

- 1 in 5 of all cancer survivors
- Over 4 in 10 male cancer survivors in the U.S.
- 170,000 US men are diagnosed each year

Survival Rates (at all stages of Prostate Cancer)	
5 years	99%
10 years	98%
15 years	96%

Source: Siegel R, et al. CA Cancer J Clin. 2012.

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Prostate Cancer Survivorship

- High survival rates are due to a combination of:
  - Early detection
  - Increasingly effective treatment of localized and advanced disease
  - Lead time bias
  - Overdiagnosis

Sources: Siegel R, et al. CA Cancer J Clin. 2012; Ganz PA. Prim Care. 2009; Etzioni R, et al. Cancer. 2012; Draisma G, et al. J Natl Cancer Inst. 2009.

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Each year, approximately 170,000 US men are diagnosed with prostate cancer and begin their journey into prostate cancer survivorship.

Importance of ACS Cancer Survivorship Clinical Practice Guidelines

- PCPs inevitably participate in the care of prostate cancer survivors.
- It is often unclear who has principal responsibility for prostate cancer survivorship care and what it entails.
- The ACS guidelines provides focused recommendations on the role of PCPs in the treatment of patients experiencing the long-term and late effects of prostate cancer.

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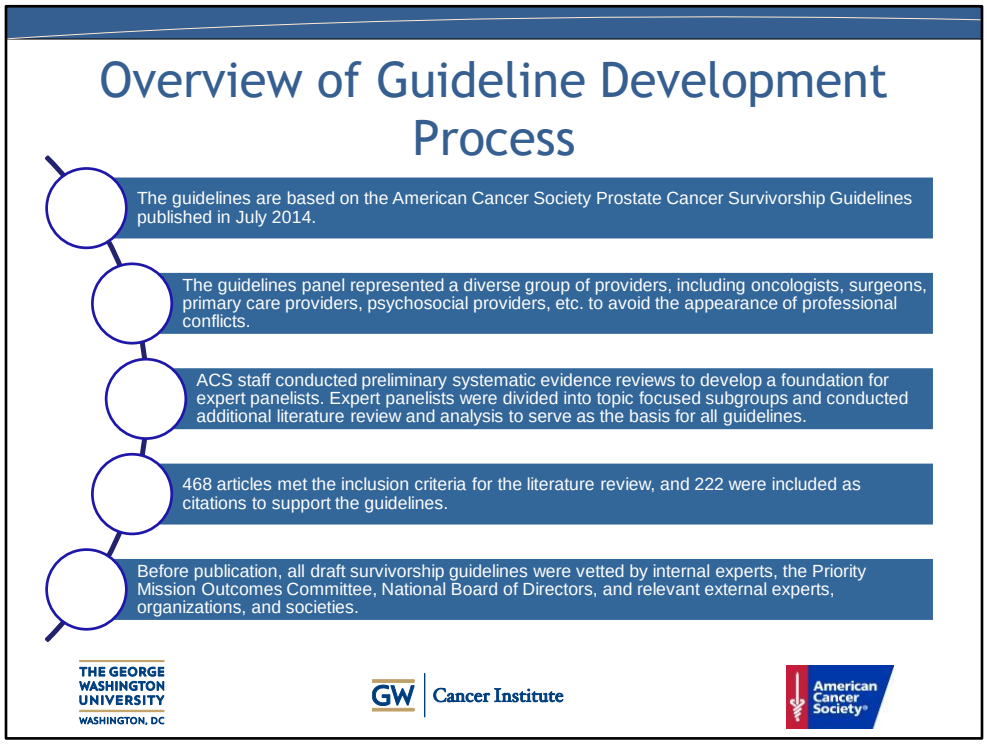

The guidelines featured in this module are based on the American Cancer Society Prostate Cancer Survivorship Guidelines published in July 2014.

The guidelines panel represented a diverse group of providers, including oncologists, surgeons, primary care providers, psychosocial providers, etc. to avoid the appearance of professional conflicts.

ACS staff conducted preliminary systematic evidence reviews to develop a foundation for expert panelists. Expert panelists were divided into topic focused subgroups and conducted additional literature review and analysis to serve as the basis for all guidelines.

Where applicable, existing guidelines for health promotion, screening, surveillance, and psychosocial care were leveraged.

468 articles met the inclusion criteria for the literature review, and 222 were included as citations to support the guidelines.

Before publication, all draft survivorship guidelines were vetted by internal experts, the Priority Mission Outcomes Committee, National Board of Directors, and relevant external experts, organizations, and societies.

Moving forward, ACS survivorship guidelines will be briefly updated as needed including an annual online update with relevant new studies. Guidelines are schedule to be rewritten every 5 years.

Prostate Cancer Diagnosis and Treatment

- Treatment type may vary based on different factors such as comorbidity, patient and provider preferences, disease progression, patient's age, race, ethnicity, access to care, and socioeconomic status.
- Treatment options include:

Sources: Dall'era MA, et al. J Urol. 2009; Cooperberg MR, et al. J Clin Oncol. 2010; Latini DM, et al. Cancer. 2006; Porten SP, et al. J Urol. 2010.

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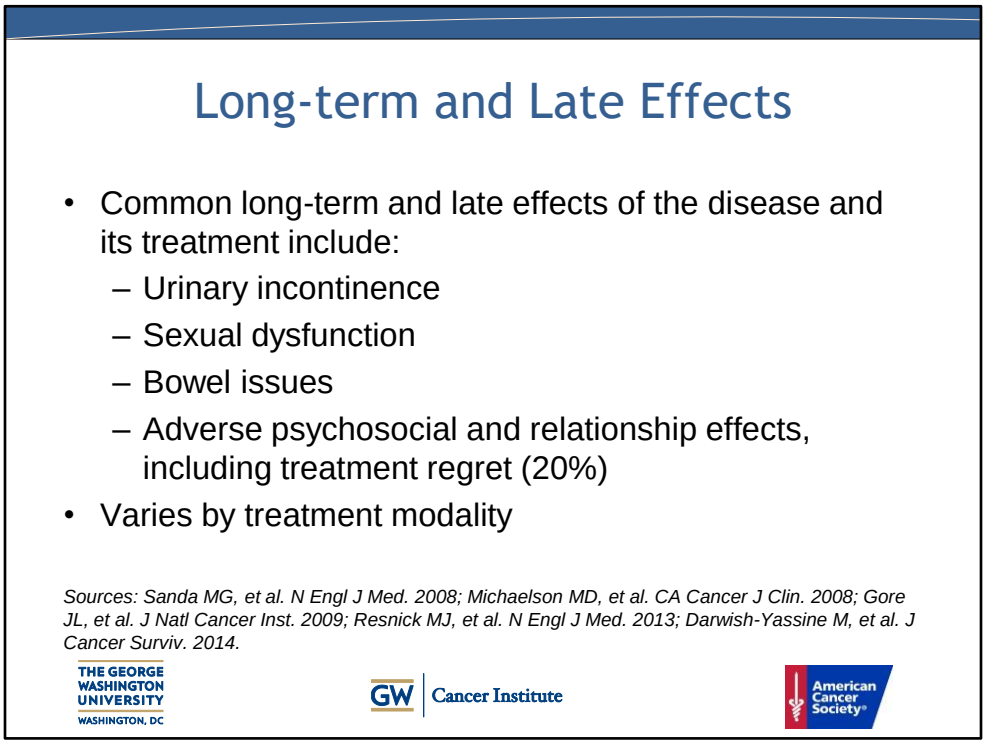

Many prostate cancer survivors experience long-term and late effects of the disease and its treatment, including:

Urinary incontinence
Sexual dysfunction
Bowel issues
Adverse psychosocial and relationship effects, including treatment regret (20%)

Comorbidities may further influence these long-term and late effects.

Surgery

- Radical prostatectomy (open, laparoscopic, or robotic-assisted)
  - PSA drops to an undetectable level within a 2 month period.
  - Results in neurovascular injury and fibrosis.
- Many men do not return to their prior level of sexual function after surgery. Those at greater risk include:
  - Older men
  - Those w/ preexisting ED
  - Patients who do not have nerve-sparing surgery
- Early penile rehabilitation after prostate cancer surgery may improve sexual function outcomes.

Sources: Stephenson AJ, et al. J Clin Oncol. 2006; Morgan TM, et al. Prostate Cancer Prostatic Dis. 2014; Akbal C, et al. Int Urol Nephrol. 2008; Stember DS and Mulhall JP. Brachytherapy. 2012.

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Surgery

Long-term Effects (lingering)
Urinary Dysfunction • Urinary incontinence (stress) • Urinary symptoms (urgency, frequency, nocturia, dribbling) • Urethral stricture formation (scarring at the urethra) Sexual Dysfunction • Erectile dysfunction (ED) • Lack of ejaculation • Orgasm changes (w/o erection, associated w/incontinence) • Penile shortening

Sources: Michaelson MD, et al. CA Cancer J Clin. 2008; Radomski SB. Can Urol Assoc J. 2013; Kopp RP, et al. Eur Urol. 2013.

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Radiation

- External Beam or Brachytherapy
- PSA slowly falls; reaches lowest level after 6 months to several years.
- “PSA bounce” may occur within 2 years.
- Small increased risk for secondary malignancies compared to men receiving surgery (bowel, bladder).

Sources: Roach M 3rd, et al. Int J Radiation Oncology Biol Phys. 2006; Crook J, et al. Int J Radiat Oncol Biol Phys. 2007; Thompson A, et al. Int J Radiat Oncol Biol Phys. 2010; Mehta NH, et al. Int J Radiat Oncol Biol Phys. 2013; Sountoulides P, et al. Ther Adv Urol. 2010; Musunuru H, et al. Clin Oncol (R Coll Radiol). 2014; Murray L, et al. Radiother Oncol. 2014.

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Radiation

Long-term Effects (lingering)	Late Effects (delayed)
Urinary Dysfunction • Urinary incontinence • Urinary symptoms (dysuria, urgency, frequency, nocturia, dribbling) • Hematuria • Urethral stricture Sexual Dysfunction • Progressive ED • Decreased semen volume Bowel Dysfunction • Fecal urgency, frequency, incontinence • Blood in stool • Rectal inflammation, pain	Urinary Dysfunction • Urethral stricture • Hematuria due to small blood vessel changes Sexual Dysfunction • ED can be delayed in onset 6-36 months after therapy Bowel Dysfunction • Rectal bleeding secondary to thinning/small blood vessel changes of anterior rectal wall mucosa

Sources: Richter JM, et al. Aliment Pharmacol Ther. 2012; Do NL, Gastroenterol Res Pract. 2011; Hampson NB, et al. Cancer. 2012.

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Androgen Deprivation Therapy (ADT)

- 'Hormone treatment', testosterone suppression or blockade
- PSA rate of decline and nadir varies with the patient.
  - Overarching PSA goal is <0.05 or 0.1 ng/dl.
  - Decline within 6-8 weeks, depending on the level at ADT initiation
- Results in a normochronic normocytic anemia and rapid loss in bone density.

Sources: Roach M 3rd, et al. Int J Radiation Oncology Biol Phys. 2006; Grossmann M and Zajac JD. Asian J Androl. 2012.

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Hormone (ADT)

Long-term Effects (lingering)	Late Effects (delayed)
Sexual Dysfunction • Loss of libido • Erectile dysfunction Other • Hot flushes/sweats • Weight gain, abdominal obesity • Change in body image • Excessive emotional reactions and frequent mood changes • Depression • Fatigue/decreased activity • Gynecomastia • Anemia • Body hair loss • Dry eyes	• Osteoporosis, fractures • Metabolic syndrome • Cardiovascular disease – possible increased risk of myocardial infarction • Diabetes; decreased sensitivity to insulin and oral glycemic agents • Increased cholesterol • Increased fat mass and decreased lean muscle mass/muscle wasting • Venous thromboembolism • Vertigo • Cognitive dysfunction

Sources: Ahmadi H and Daneshmand S. BJU Int. 2013; Levine GN, et al. CA Cancer J Clin. 2010; Eastham JA. J Urol. 2007; Choong K and Basaria S. Aging Male. 2010; VanderWalde A and Hurria A. CA Cancer J Clin. 2011; Saylor PJ and Smith MR. J Urol. 2013.

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Active Surveillance

Active surveillance may avoid or delay the need for radiation or surgery.
It is used to find early signs that the condition is getting worse.
During active surveillance, certain exams and tests, including biopsies, are done on a regular schedule.

Watchful Waiting

Sometimes used in conditions that progress slowly.
Also used when the risks of treatment are greater than the possible benefits.
Patients may be given certain tests and exams.

Long-term Effects of Expectant Management

- 30% of prostate cancer patients experience clinically relevant general distress.
- 25% have increased anxiety.
- 10% experience major depressive disorder.
- Distress may diminish in the first five (5) years after treatment for some patients.

Sources: Carlson LE, et al. Br J Cancer. 2004; Korfage IJ, et al. Br J Cancer. 2006; Jayadevappa R, et al. Psychooncology. 2012; Punnen S, et al. BJU Int. 2013.

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Expectant Management

Long-term Effects (lingering)	Late Effects (delayed)
• Stress, anxiety, worry • Risks associated with repeat biopsy (active surveillance), PSAs, and DREs • Symptoms associated with disease progression	• Disease progression

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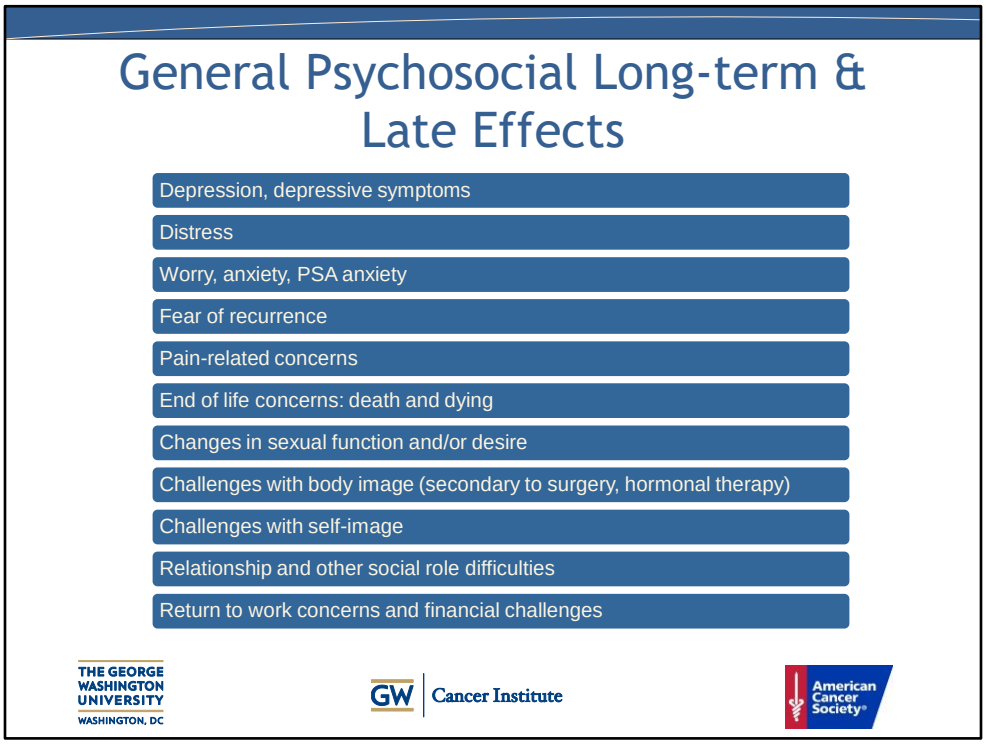

Distress – multi-factorial unpleasant experience of psychological, social, and/or spiritual nature

Key Risk Factors for Distress in Men

- Being single/unmarried
- Low education
- Advanced disease
- Low physical or cognitive functioning
- Younger age
- Medical comorbidities
- Psychiatric history
- Poor coping skills

Source: Nelson CJ, et al. J Sex Med. 2011.

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Conclusion

- Long-term and late impacts of cancer vary for prostate cancer survivors.
- Providers should screen for and provide support for urinary, sexual, psychosocial, bowel and overall general health issues.
- Coordination of care between primary and specialty care providers is critical to quality cancer survivorship care.

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Acknowledgment

We are grateful for the support of CDC cooperative agreement #5U55DPOO3O54.

Thank you (Presenter) for your presentation and for sharing your expertise on this important topic.

This concludes this section of this lesson.

Cancer Survivorship E-Learning Series
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Prostate Cancer Survivorship Guidelines for Primary Care Providers

Andrew M.D. Wolf, MD
Associate Professor of Medicine
University of Virginia School of Medicine

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Disclosures

- Dr. Wolf served on the ACS Prostate Cancer Survivorship Guidelines Committee
- No financial disclosures

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This presentation was developed from the following manuscript:

Skolarus,T., Wolf, A., Erb, N., et al. (2014), American Cancer Society Prostate Cancer Survivorship Care Guidelines. CA: A Cancer Journal for Clinicians. doi: 10.3322/caac.21234

Learning Objectives

The participant will be able to:

- Describe how to care for prostate cancer survivors as outlined in the new American Cancer Society-approved Survivorship Center Prostate Guidelines.
- Demonstrate understanding of a PCP's role in providing follow-up care to prostate cancer survivors.

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American Cancer Society Prostate Cancer Survivorship Guidelines

- Health Promotion
- Surveillance for Prostate Cancer Recurrence
- Screening and Early Detection of Second Primary Cancers
- Assessment and Management of Physical and Psychosocial Long-Term and Late Effects
- Care Coordination

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Guidelines for Health Promotion

- The following recommendations address:
  - Meeting information needs
  - Obesity and weight management to improve health outcomes
  - Physical activity
  - Nutrition and alcohol consumption
  - Smoking cessation
- Assess information needs related to prostate cancer and treatment, side effects, other health concerns, and available support services, and provide or refer survivors to appropriate resources to meet these needs.

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Weight Management and Physical Activity

- Counsel survivors to achieve & maintain a healthy weight by **limiting intake of high-calorie foods and beverages and increasing physical activity**.
- **Educate survivors** regarding the association between physical activity and lower overall prostate cancer-specific mortality.
- Counsel survivors to **engage in at least 150 minutes per week of physical activity**, which may include weight-bearing exercises.

- Provide **regular evaluation** to determine appropriate levels of participation, health promotion, and lifestyle modification programs.

Sources: Rock CL, et al. CA Cancer J Clin. 2012; Chan JM, et al. Curr Opin Urol. 2014; Kenfield SA, et al. J Clin Oncol. 2011; Demark-Wahnefried W, et al. J Clin Oncol. 2012; Santa Mina D, et al. J Cancer Surviv. 2013.

Burger image from: http://www.foodielovesfitness.com/2013/07/29/revamping-fast-food-san-diegos-natural-selections/

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Nutrition

- Counsel survivors to achieve a dietary pattern that is high in fruits and vegetables and whole grains.
- Refer survivors with nutrition-related challenges to a registered dietitian.
- Dietary recommendations:
  - Micronutrient-and phytochemical-rich vegetables and fruits
  - Low amounts of saturated fat
  - At least 600 IU of vitamin D per day
  - Adequate dietary calcium (not to exceed 1,200 mg/day)
  - DASH diet contains these elements

Sources: Rock CL, et al. CA Cancer J Clin. 2012; NHLBI. www.nhlbi.nih.gov/health/public/heart/hbp/dash/dash_brief.pdf. 2006.

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Alcohol and Tobacco Use

Alcohol consumption should be limited to no more than 2 drinks per day.

Survivors should avoid tobacco products or be referred to cessation counseling and resources.

Sources: Rock CL, et al. CA Cancer J Clin. 2012; Chan JM, et al. Curr Opin Urol. 2014.

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Guidelines for Surveillance for Prostate Cancer Recurrence

- Measure serum PSA level every 6 to 12 months for the first 5 years, then recheck annually thereafter.
- Refer survivors with elevated PSA level back to the primary treating specialist for follow-up and, if indicated, further treatment.
- Perform an annual DRE in coordination with cancer specialist to avoid duplication.

Sources: National Comprehensive Cancer Netowrk, Inc. http://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf; Stephenson AJ, et al. J Clin Oncol. 2006; Morgan TM, et al. Prostate Cancer Prostatic Dis. 2014.

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Guidelines for Screening and Early Detection of Second Primary Cancers

- Adhere to American Cancer Society screening and early detection guidelines.
- For survivors presenting with hematuria:
  - Perform a thorough evaluation to rule-out bladder cancer which includes urologist referral for cystoscopy.
- For survivors presenting with persistent rectal bleeding, pain, or other symptoms:
  - Refer to the appropriate specialist as well as the treating radiation oncologist to conduct a thorough evaluation for rectal cancer.

Source: American Cancer Society Prevention, Early Detection, and Survivorship Guidelines. http://www.cancer.org/healthy/informationforhealthcareprofessionals/acsguidelines/index.

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Physical and Psychosocial Assessment

- Assess for physical (e.g., urinary, sexual, bowel) and psychosocial effects of prostate cancer and its treatment.
  - Tailor to the type of cancer treatment received and current disease state to trigger appropriate self- and clinical management strategies for support and therapy.
- Use validated surveys and more comprehensive measures of prostate cancer health-related quality of life (HRQOL) such as the Expanded Prostate Cancer Index Composite (EPIC).

Sources: Szymanski KM, et al. Urology. 2012; Chang P, et al. J Urol. 2011.

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Assessing baseline patient-reported health-related quality of life (HRQOL) and tracking this measure over time is an important element of high quality survivorship care.

While varying levels of evidence exist to demonstrate the presence of these effects during survivorship, there is limited information on the time interval post-treatment or the prevalence of these effects among survivors.

The guidelines combine available evidence with expert consensus to assist PCPs in managing prostate cancer survivorship.

Physical and Psychosocial Longterm & Late Effects

The following may be experienced by prostate cancer survivors:

- Anemia
- Bowel Dysfunction
- Cardiovascular Metabolic Effects
- Distress/ Depression/ PSA Anxiety
- Hip Fracture And Osteoporosis
- Sexual Dysfunction/ Body Image
- Urinary Dysfunction
- Vasomotor Symptoms

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Anemia

- Common complication of androgen deprivation therapy (ADT).
- Perform annual complete blood count (CBC) to monitor hemoglobin levels.
- Evaluate with focus on potential causes other than ADT.

Sources: Grossmann M and Zajac JD. Asian J Androl. 2012; Grossmann M and Zajac JD. Endocrinol Metab Clin North Am. 2011.

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Bowel Dysfunction

- Discuss bowel function and symptoms (e.g., rectal bleeding, urgency, frequency, incontinence) with survivors.
- For mild-moderate symptoms of chronic radiation proctitis, prescribe stool softeners +/- prn hydrocortisone enemas or suppositories.
- Refer survivors with persistent or severe rectal symptoms to the appropriate specialist.

Sources: Richter JM, et al. Aliment Pharmacol Ther. 2012; Do NL, et al. Gastroenterol Res Pract. 2011.

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Cardiovascular and Metabolic Effects

- PCPs should be aware of the effect of ADT on cardiovascular disease and diabetes in prostate cancer survivors.
- Periodic evaluation and screening is recommended for:
  - Cardiac risk factors
  - Blood pressure monitoring
  - Lipid profiles
  - Serum glucose or hemoglobin A1c
- Follow USPSTF guidelines for evaluation and screening for cardiovascular risk factors, blood pressure monitoring, lipid profiles, and serum glucose.

Sources: Grossmann M and Zajac JD. Clin Endocrinol (Oxf). 2011; Levine GN, et al. CA Cancer J Clin. 2010; U.S. Preventive Services Task Force. Screening for Coronary Heart Disease: Recommendation Statement. 2004.

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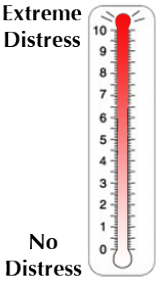
Distress/Depression/PSA Anxiety

- Assess for distress/depression/PSA anxiety at least annually using a simple screening tool, such as the NCCN Distress Thermometer, across all stages of survivorship.
  - Partners & family members often provide valuable insights into survivor distress.
- Manage distress/depression using in-office counseling resources or pharmacotherapy as appropriate.
- If office-based management is insufficient, refer survivors experiencing distress/depression to appropriate specialists.



Sources: Carlson LE, et al. J Clin Oncol. 2010; Mitchell AJ. J Natl Compr Canc Netw. 2010; NCCN Guidelines for Distress Management. http://www.nccn.org. 2013; Chamers SK, et al. Psychooncology. 2014; Hart SL, et al. J Natl Cancer Inst. 2012.

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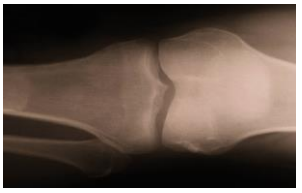
Hip Fracture/Osteoporosis

- Assess risk of fracture, for men treated with ADT or older radiation techniques with a baseline DEXA scan and calculation of a FRAX score.



- For men determined to be high risk, prescribe weekly bisphosphonate therapy (oral alendronate 70 mg) or annual intravenous zoledronic acid 5 mg to increase bone density.
- Further guidance is available through the NCCN's Bone Health in Cancer Care report and the Endocrine Society's Guidelines for the management of osteoporosis in men.

Sources: Gralow JR, et al. J Natl Compr Canc Netw. 2009; Saylor PJ, et al. J Urol. 2010; Freeland SJ, et al. JAMA. 2005; Saylor PJ, Prostate Cancer Prostatic Dis. 2010; Watta NB, et al. J Clin Endocrinol Metab. 2012.

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Sexual Dysfunction/Body Image

- Screen all survivors for sexual dysfunction.
- Ideally, use validated tools, such as the Sexual Health Inventory for Men (SHIM), to monitor erectile function over time.
- Erectile dysfunction may be addressed through a variety of options, including prescription of phosphodiesterase type 5 inhibitors or penile rehabilitation.
- Refer men with persistent sexual dysfunction to a urologist, sexual health specialist, or psychotherapist to review treatment and counseling options.
- Assess for distress due to sexual changes and make appropriate referrals for managing the psychosocial aspects of sexuality.

Sources: Cappelleri JC and Rosen RC. Int J Impot Res. 2005; Yuan J, et al. Int J Impot Res. 2010; Pahlajani G, et al. J Sex Med. 2012; Brison D, et al. J Sex Med. 2013. Porst H, et al. J Sex Med. 2013; De Sousa A, et al. Prostate Cancer Prostatic Dis. 2012.

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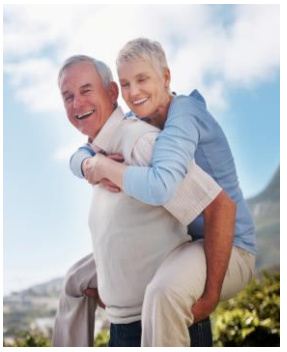
Sexual Intimacy

- Both the patient's *and* partner's sexual concerns should be considered during survivorship care.
- Encourage couples to discuss their sexual intimacy and refer to counseling or support services as appropriate.
- Instruct couples on the use of sexual aids to improve erectile dysfunction for men/male partners and to address post-menopausal symptoms for women.*



*More research is needed to understand and address the unique needs and concerns of same-sex couples.

Sources: Ko CM, et al. Support Care Cancer. 2005; Reese JB, et al. Support Care Cancer. 2010; Couper J, et al. Psycho-oncology. 2006.

Image Source: http://motionmedication.com/Stock-Images/Older%20Couple%20Piggyback.jpg

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Urinary Dysfunction

- Screen all survivors for urinary dysfunction and incontinence.
- Consider timed voiding, or prescribing anti-cholinergic medications to address issues such as nocturia, frequency, or urgency. Consider alpha-blockers for slow stream.
- Refer survivors with post-prostatectomy incontinence to a physical therapist for pelvic floor rehabilitation; at a minimum, instruct survivors about Kegel exercises.
- Refer men with persistent leakage or other urinary symptoms to a urologist for further evaluation and discussion of treatment options, including surgical placement of a male urethral sling or artificial urinary sphincter for incontinence.

Sources: Goode PS, et al. JAMA. 2011; Campbell SE, et al. Cochrane Database Syst Rev. 2012; Comiter CV, Curr Opin Urol. 2010; Rai BP, et al. Cochrane Database Syst Rev. 2012; Chung E and Cartmill R. BJU Int. 2013; Herschorn S. Can Urol Assoc J. 2013.

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Vasomotor Symptoms

- ADT is associated with a number of adverse physical effects including vasomotor symptoms (e.g., hot flushes), fatigue, sexual dysfunction, and decreased libido.
- Although not FDA-approved for this indication, prescription of selective serotonin or noradrenergic reuptake inhibitors or gabapentin may offer symptom relief.

Sources: Grossmann M and Zajac JD. Clin Endocrinol (Oxf). 2011; Saylor PJ and Smith MR. J Urol. 2013; Ahmadi H and Daneshmand S. BJU Int. 2013; Fisher WI, et al. CA Cancer J Clin. 2013; Alekshun TJ and Patterson SG. Support Cancer Ther. 2006.

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Guidelines for Care Coordination

- PCPs should maintain their role as general medical care coordinator throughout the spectrum of prostate cancer detection, treatment, and aftercare.
- When survivorship care is transferred to the primary care provider, the primary treating specialist is encouraged to:
  - Provide a treatment summary and survivorship care plan to the PCP.
  - Clarify the need for and frequency of PSA monitoring.
  - Establish thresholds for referral back.
- Annually assess for the presence of long-term or late effects of prostate cancer and its treatment. Refer survivors to appropriate community-based and peer support resources.

Sources: Hewitt M, et al. Washington, DC: National Academies Press. 2006; American College of Surgeons. Commission on Cancer. Cancer Program Standards 2012. http://www.facs.org.

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Conclusion

- PCPs should play an active role in the care coordination of survivors by:
  - Promoting healthy behaviors,
  - Assisting in the surveillance for cancer recurrence and second primary cancers,
  - Assessing and managing physical and psychosocial long-term and late effects,
  - Clarifying care roles when needed with other members of the prostate cancer treatment team.
- The ACS guidelines provide recommendations on the role of PCPs in caring for prostate cancer survivors.

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Case Study

You are seeing a 73 year old African American man now 3 years out from external beam radiation for locally advanced prostate cancer.

- PMH: Hypertension, knee osteoarthritis
- Medications: ADT (Lupron) from his urologist, hydrochlorothiazide, amlodipine, acetaminophen
- Social History: married for over 40 years; no tobacco or alcohol
- Review of Systems positive for urinary urgency with occasional leakage, erectile dysfunction
- Blood pressure 134/92, BMI 28

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Case Question #1

Which of the following health promotion interventions would you recommend?

A. walking 30 minutes 3 days a week

B. the DASH diet

C. calcium carbonate 750mg twice daily

D. Vitamin D 400 International Units daily

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Case Question #1 Discussion

Which of the following health promotion interventions would you recommend?

A. walking 30 minutes 3 days a week

- A minimum of 150 minutes of physical activity weekly or 30 minutes daily is recommended

✓ B. the DASH diet

- The DASH diet is rich in fruits, vegetables, whole grains and legumes, has been shown to help lower blood pressure, BMI, waist circumference as well as other risk factors associated with metabolic syndrome*

C. calcium carbonate 750mg twice daily

- Calcium should be obtained through dietary sources, not supplements (due to concern re increased coronary risk); the recommended maximum is 1200mg/d

D. Vitamin D 400 International Units daily

- The recommended amount of Vitamin D is at least 600 IU/d

**Sources: Appel LI, et al. JAMA 2003; NHLBI. www.nhlbi.nih.gov/health/public/heart/hbp/dash/dash_brief.pdf. 2006.*

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Case Question #2

For the patient's genitourinary symptoms, which of the following could be appropriate interventions?

A. a phosphodiesterase type 5 inhibitor

B. testosterone replacement therapy

C. urology referral for alternative erectile dysfunction management strategies

D. A or C

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Case Question #2 Discussion

- For the patient's genitourinary symptoms, which of the following could be appropriate interventions?

A. a phosphodiesterase type 5 inhibitor

- Most men on ADT experience both loss of libido and erectile dysfunction (ED). Some men & their partners wish to continue sexual activity while on ADT. The PDE-5 inhibitors may be effective in managing ED in these men.

B. testosterone replacement therapy

- Testosterone replacement is both ineffective and contraindicated for men on ADT

C. urology referral for alternative erectile dysfunction management strategies

- For men in whom PDE-5 inhibitor treatment is inadequate, urology referral is appropriate to explore alternative management strategies.

✓ D. A or C

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Case Question #3

Which of the following tests is recommended for this patient?

A. Cardiac stress testing
B. DEXA
C. Abdominal aortic aneurysm screening
D. All of the above

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Case Question #3 Discussion

Which of the following tests is recommended for this patient?

A. Cardiac stress testing

- Although patients on ADT are at increased cardiovascular risk, there is no evidence for testing asymptomatic men

✓ B. DEXA

- Men on ADT are at significant risk for osteoporosis and should undergo DEXA scanning; a FRAX score should be calculated and men at high risk should be offered bisphosphonate therapy

C. Abdominal aortic aneurysm screening

- Per USPSTF guidelines, only male ever-smokers 65-75 years should undergo AAA screening

D. All of the above

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Acknowledgment

We are grateful for the support of CDC cooperative agreement #5U55DPOO3O54.

Thank you (Presenter) for your presentation and for sharing your expertise on this important topic.

This concludes the webinar, please continue to explore the remaining sections of the cancer survivorship e-learning series for primary care providers.
Thank you.