AUDITÓRIO DO HOSPITAL
DE STO ANDRÉ - LEIRIA

4.11.2017

6OS ENCONTROS DE ANDROLOGIA

SAÚDE MASCULINA

Disfunção Erétil, Masculinidade e Alterações Psicossociais após tratamento do carcinoma da próstata

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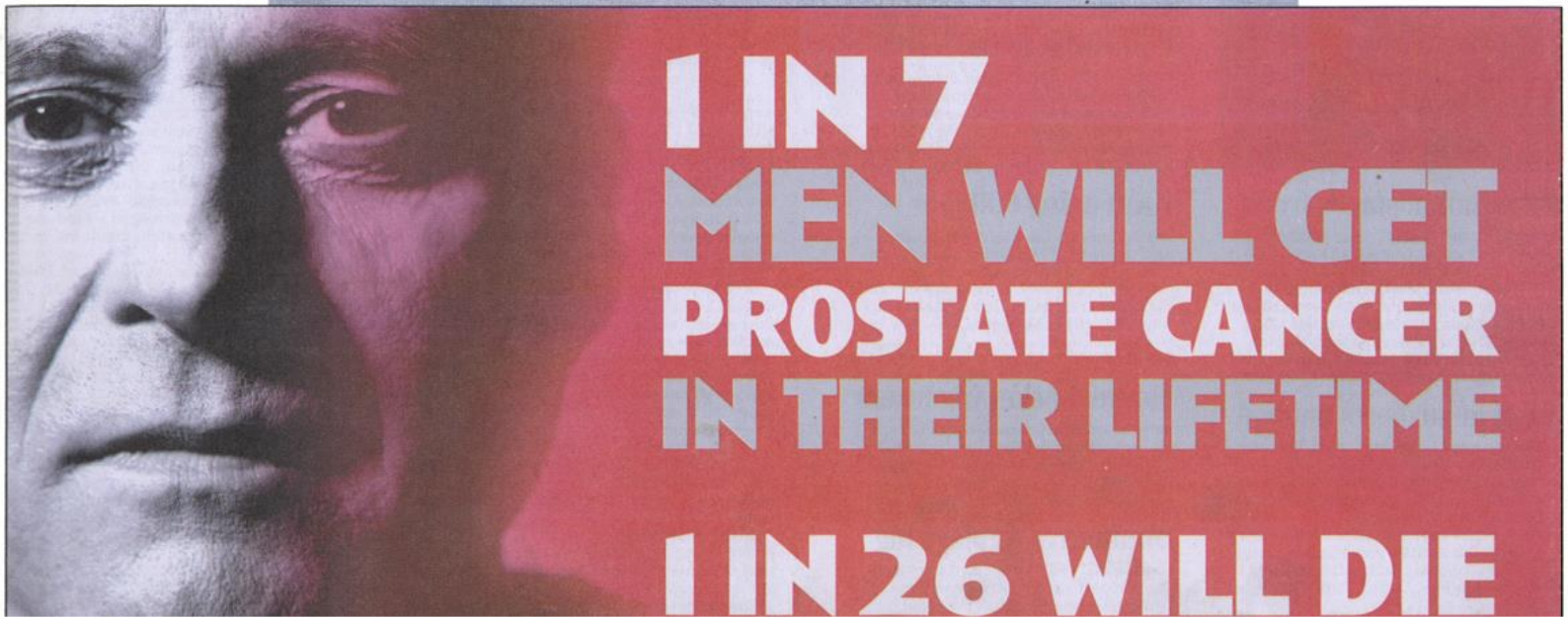
CENTRO HOSPITALAR LEIRIA

The Gazette

MONTREAL | SATURDAY, OCTOBER 15, 2005 | montrealgazette.com | SINCE 1778 | FIRST EDITION



INTRODUÇÃO

- 90% dos doentes tem sobrevivência aos 5 anos e 80% aos 10 anos
- Sobrevivência prolongada: vivência com efeitos 2ários dos tratamentos
- Efeito negativo na função urinária, intestinal, hormonal e sexual
- Efeito adverso na QoL dos doentes
- A DE é o efeito secundário mais frequente do tratamento do CaP

INTRODUÇÃO

- QoL e valores pessoais têm um papel crescente na escolha do tratamento e na avaliação dos resultados na terapêutica do cancro da próstata

- Existem várias opções primárias para tratar o cancro da próstata:
  - prostatectomia radical
  - radioterapia externa
  - braquiterapia
  - criocirurgia
  - terapêutica hormonal
  - (vigilância ativa)

- A escolha é uma tarefa difícil e muitas vezes influenciada pelo médico (e pelas suas próprias convicções)

Objetivos do Tratamento do Cancro da Próstata

- Erradicar o Cancro
- Preservar a Continência
- Preservar a Ereção
- (Prevenir Arrependimentos)

Qualidade de Vida

A Qualidade de Vida é Importante!

- HRQOL é a 1ª preocupação dos homens eleitos para tratamento do CaP (JUrol 2003)

- Inquérito AUA (2000) a 1000 homens
  - 74% dos homens > 50 anos têm receio de realizar o teste do PSA devido aos possíveis efeitos secundários do tratamento do CaP

  - NÃO É DA BIÓPSIA QUE OS HOMENS TÊM MEDO

Incontinência

- Receio real de todos os doentes
- Raramente “comercializada”. Porquê?
  - POUCO COMUM

- Todos os homens ficam incontinentes após a cirurgia
- Continência deve ser recuperada
- Taxa de incontinência após RALP é de 1-3%
- < 10% necessita de penso de proteção

Ereção
“The soul of man”

- O maior conceito errado no cancro da próstata
- O maior alvo comercial
- A única razão para que os homens façam escolhas erradas
  - Durante a vida
  - E no cancro da próstata

Ereção
“The soul of man”

- O impacto da DE nestes doentes ainda é pouco conhecido
- Avaliação da função sexual: focada na função erétil
- Alguns estudos avaliaram o interesse, desejo, satisfação e orgasmo
- Informação escassa sobre as alterações psicológicas na DE
- Sexualidade mantém-se um aspeto significante na vida do homem

O que nos diz a literatura?

Objetivos dos estudos randomizados no cancro da próstata

www.impactjournals.com/oncotarget/ Oncotarget, 2017, Vol. 8, (No. 19), pp: 32237-32257

Clinical Research Paper

Robotic *vs.* Retropubic radical prostatectomy in prostate cancer: A systematic review and a meta-analysis update

Kun Tang[1,*], Kehua Jiang[1,2,*], Hongbo Chen[2], Zhiqiang Chen[1], Hua Xu[1] and Zhangqun Ye[1]

[1] Department of Urology, Institute of Urology, Tongji Hospital, Tongji Medical College, Huazhong University of Science and Technology, Wuhan, China

[2] Department of Urology, The Central Hospital of Enshi Autonomous Prefecture, Enshi, China

[*] These authors have contributed equally to this work

CONTEXT: The safety and feasibility of robotic-assisted radical prostatectomy (RARP) compared with retropubic radical prostatectomy(RRP) is debated. Recently, a number of large-scale and high-quality studies have been conducted.

OBJECTIVE: To obtain a more valid assessment, we update the meta-analysis of RARP compared with RRP to assessed its safety and feasibility in treatment of prostate cancer.

METHODS: A systematic search of Medline, Embase, Pubmed, and the Cochrane Library was performed to identify studies that compared RARP with RRP. Outcomes of interest included perioperative, pathologic variables and complications.

RESULTS: 78 studies assessing RARP vs. RRP were included for meta-analysis. Although patients underwent RRP have shorter operative time than RARP (WMD: 39.85 minutes; $P < 0.001$), patients underwent RARP have less intraoperative blood loss (WMD = -507.67ml; $P < 0.001$), lower blood transfusion rates (OR = 0.13; $P < 0.001$), shorter time to remove catheter (WMD = -3.04day; $P < 0.001$), shorter hospital stay (WMD = -1.62day; $P < 0.001$), lower PSM rates (OR:0.88; $P = 0.04$), fewer positive lymph nodes (OR:0.45;$P < 0.001$), fewer overall complications (OR:0.43; $P < 0.001$), higher 3- and 12-mo potent recovery rate (OR:3.19;$P = 0.02$; OR:2.37; $P = 0.005$, respectively), and lower readmission rate (OR:0.70, $P = 0.03$). The biochemical recurrence free survival of RARP is better than RRP (OR:1.33, $P = 0.04$). All the other calculated results are similar between the two groups.

CONCLUSIONS: Our results indicate that RARP appears to be safe and effective to its counterpart RRP in selected patients.

available at www.sciencedirect.com
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European Association of Urology

Platinum Priority – Prostate Cancer

Editorial by XXX on pp. x–y of this issue

Recreational Physical Activity in Relation to Prostate Cancer–specific Mortality Among Men with Nonmetastatic Prostate Cancer

Ying Wang [*], Eric J. Jacobs, Susan M. Gapstur, Maret L. Maliniak, Ted Gansler, Marjorie L. McCullough, Victoria L. Stevens, Alpa V. Patel

Epidemiology Research Program, American Cancer Society, Atlanta, GA, USA

Conclusions: The findings provide additional evidence for prostate cancer survivors to adhere to PA recommendations, and support clinical trials of exercise among prostate cancer survivors with progression or mortality as outcomes.

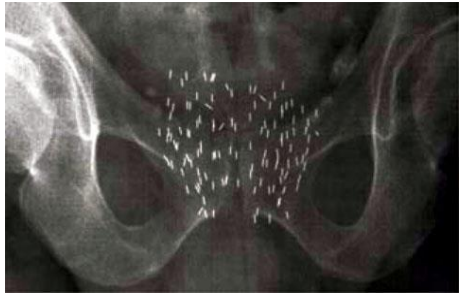
Patient summary: In a large follow-up study of men diagnosed with nonmetastatic prostate cancer, those who exercise more after diagnosis had a lower risk of dying from prostate cancer.

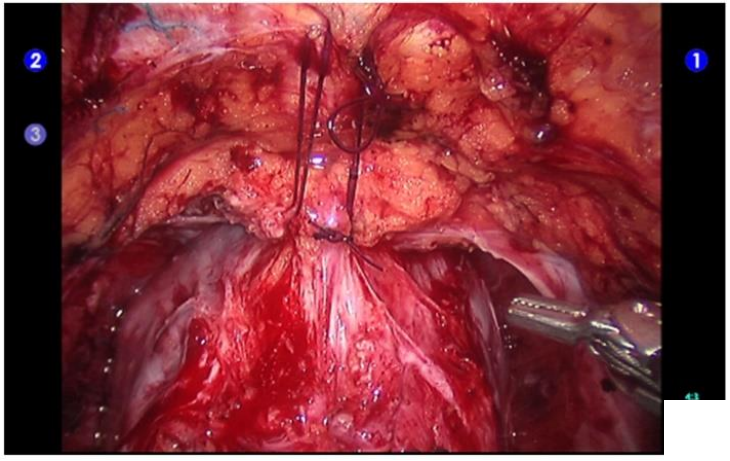
Objetivos dos estudos randomizados no cancro da próstata

Systematic Review and Meta-Analysis of the Use of Phosphodiesterase Type 5 Inhibitors for Treatment of Erectile Dysfunction following Bilateral Nerve-Sparing Radical Prostatectomy

Xiao Wang[1], Xinghuan Wang[1]*, Tao Liu[1], Qianwen He[2], Yipeng Wang[3], Xinhua Zhang[1]*

1 Department of Urology, Zhongnan Hospital of Wuhan University, Wuhan city, Hubei province, P. R. China, **2** Department of Cardiology, Zhongnan Hospital of Wuhan University, Wuhan city, Hubei province, P. R. China, **3** Department of Anesthesiology, Zhongnan Hospital of Wuhan University, Wuhan city, Hubei province, P. R. China





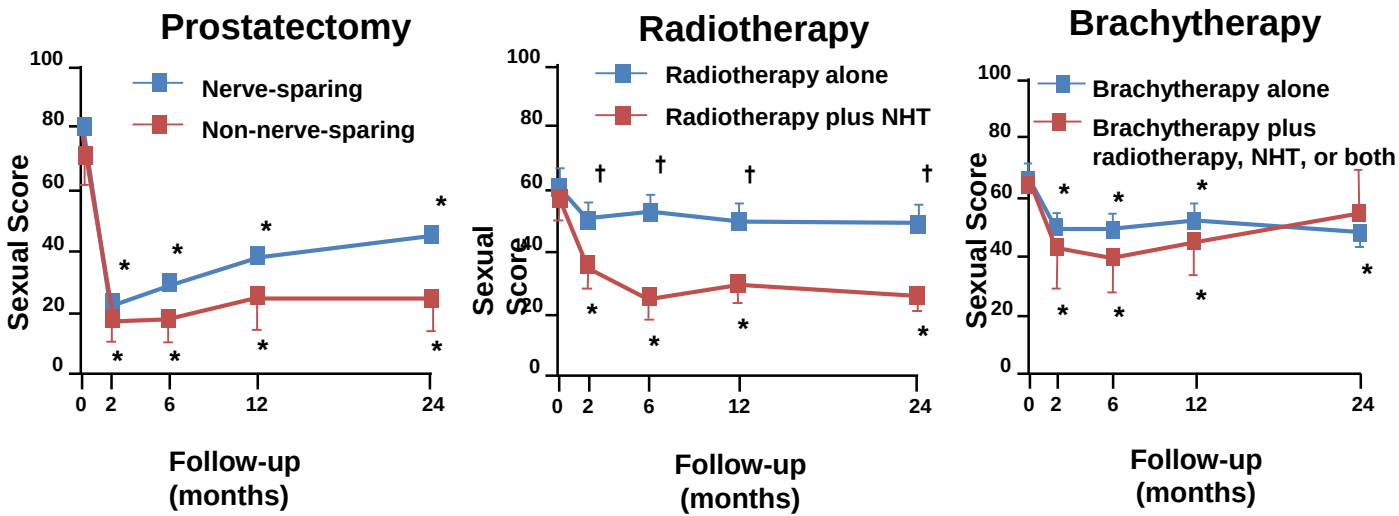
Qualidade de Vida e Oncologia

Qualidade de Vida

- O conceito de QoL é subjetivo
- Estudos com doentes oncológicos: questionários próprios
- PROMs: patient-reported outcome measures
- Difícil a avaliação
- Perceção do impacto na QoL

The substantial incidence of erectile dysfunction in men treated for early prostate cancer is well described, as is its pathophysiology, but the impact of erectile dysfunction on men's lives has been less well explored.

Qualidade de Vida depende do procedimento

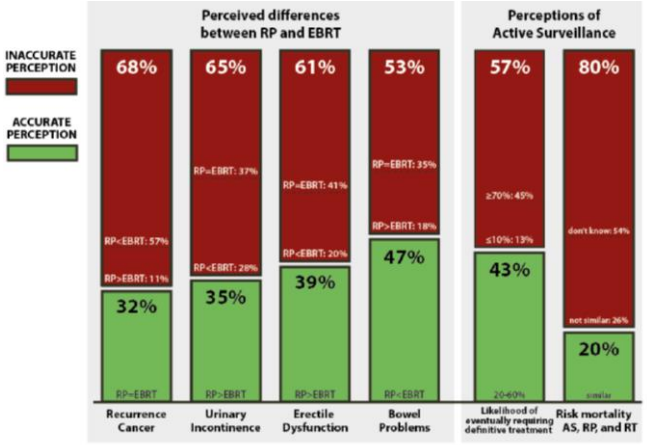


N=1201

*P<0.01
†Significant, but below the threshold of clinical relevance
NHT = neoadjuvant hormone therapy
Scores based on the Expanded Prostate Cancer Index Composite (0-100)

Sanda MG, et al. *N Engl J Med.* 2008;358:1250-1261.

The accuracy of patients' perceptions of the risks associated with localized prostate cancer treatments



- 68% dos doentes não compreendem que risco de recorrência é semelhante entre RT e PR
- > metade não percebe que PR tem > risco de IUE (65%) e de DE (61%) e < risco de problemas intestinais (53%)

CONCLUSION

The results of this multi-center study emphasize the need for health professionals involved in the treatment and care of prostate cancer patients to be aware that many of their patients may have inaccurate ideas about the risks associated with the various treatment options, and thus may make choices that are less than well-informed and that may lead to unexpected or disappointing outcomes. Efforts are needed to better understand why these misperceptions occur, their impact on outcomes and, most importantly, how they can be corrected prior to patients' choosing a treatment.

Questionários de avaliação da qualidade de vida em doentes com cancro da próstata

Questionnaire	Domains / items
Functional Assessment of Cancer Therapy-General (FACT-G) [866]	Physical well-being, Social/family well-being, Emotional well-being, and Functional well-being.
Functional Assessment of Cancer Therapy-Prostate (FACT-P) [867]	12 cancer site specific items to assess for prostate related symptoms. Can be combined with FACT-G or reported separately.
European Organisation for Research and Treatment of Cancer QLQ-C30 (EORTC QLQ-C30) [868]	Five functional scales (physical, role, cognitive, emotional, and social); Three symptom scales (fatigue, pain, and nausea and vomiting); Global health status / QoL scale; and a number of single items assessing additional symptoms commonly reported by cancer patients (dyspnoea, loss of appetite, insomnia, constipation and diarrhoea) and perceived financial impact of the disease.
European Organisation for Research and Treatment of Cancer QLQ-PR 25 (EORTC QLQ-PR 25) [869]	Urinary, bowel and treatment-related symptoms, as well as sexual activity and sexual function.
Expanded prostate cancer index composite (EPIC) [870]	Urinary, bowel, sexual, and hormonal symptoms.
Expanded prostate cancer index composite short form 26 (EPIC 26) [871]	Urinary, sexual, bowel, and hormonal domains.
UCLA Prostate Cancer Index (UCLA PCI) [872]	Urinary, bowel, and sexual domains.
Prostate Cancer Quality of Life Instrument (PCQoL) [873]	Urinary, sexual, and bowel domains, supplemented by a scale assessing anxiety.
Prostate Cancer Outcome Study Instrument [874]	Urinary, bowel, and sexual domains.

EORTC QOQ-PR25

EUROPEAN JOURNAL OF CANCER 44 (2008) 2418–2424

available at www.sciencedirect.com

ScienceDirect

journal homepage: www.ejconline.com

An international field study of the EORTC QLQ-PR25: A questionnaire for assessing the health-related quality of life of patients with prostate cancer

George van Andel[a], Andrew Bottomley[b], Sophie D. Fossâ[c], Fabio Efficace[b], Corneel Coens[b], Stephane Guerif[d], Howard Kynaston[e], Paolo Gontero[f], George Thalmann[g], Atif Akdas[h], Sven D'Haese[b], Neil K. Aaronson[i,], on behalf of the EORTC Genito-Urinary Tract Cancer Group and the EORTC Quality of Life Group*

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[i]Division of Psychosocial Research and Epidemiology, The Netherlands Cancer Institute – Antoni van Leeuwenhoek Hospital, Plesmanlaan 121, 1066 CX Amsterdam, The Netherlands

Conclusion: In general, the QLQ-PR25 demonstrates acceptable psychometric properties and clinical validity. Some caution should be used in interpreting the bowel function and side-effects of hormonal therapy scales; results can be reported at the individual item and scale level.

US1	Have you had to urinate frequently during the day?	3162	94.4	186	5.6
US2	Have you had to urinate frequently at night?	3143	93.9	205	6.1
US3	When you felt the urge to pass urine, did you have to hurry to get to the toilet?	3120	93.2	228	6.8
US4	Was it difficult for you to get enough sleep because you needed to get up frequently at night to urinate?	3140	93.8	208	6.2
US5	Have you had difficulty going out of the house because you needed to be close to a toilet?	3143	93.9	205	6.1
US6	Have you had any unintentional release (leakage) of urine?	3164	94.5	184	5.5
US7	Did you have pain when you urinated?	3062	91.5	286	8.5
IA1	Has wearing an incontinence aid been a problem for you?[a]	668	20.0	2680	80.0
US8	Have your daily activities been limited by your urinary problems?	2895	86.5	453	13.5
BS1	Have you daily activities been limited by your bowel problems?	2865	85.6	483	14.4
BS2	Have you had any unintentional release (leakage) of bowel stools?	2904	86.7	444	13.3
BS3	Have you had any blood in your bowel stools?	2918	87.2	430	12.8
BS4	Did you have a bloated feeling in your abdomen?	2911	86.9	437	13.1
TS1	Did you have hot flushes?	3118	93.1	230	6.9
TS2	Have you had sore or enlarged nipples or breasts?	3068	91.6	280	8.4
TS3	Have you had swelling in your legs or ankles?	3090	92.3	258	7.7
TS4	Has weight loss been a problem for you?	3111	92.9	237	7.1
TS5	Has weight gain been a problem for you?	3076	91.9	272	8.1
TS6	Have you felt less masculine as a result of your illness or treatment?	3073	91.8	275	8.2
SA1	To what extent were you interested in sex?	3024	90.3	324	9.7
SA2	To what extent were you sexually active (with or without intercourse)?	2951	88.1	397	11.9
SF1	To what extent has sex been enjoyable for you?[b]	937	28.0	2411	72.0
SF2	Did you have difficulty getting or maintaining an erection?[b]	948	28.3	2400	71.7
SF3	Did you have ejaculation problems?[b]	919	27.4	2429	72.6
SF4	Have you felt uncomfortable about being sexually intimate?[b]	934	27.9	2414	72.1

US urinary symptoms, *IA* incontinence aid, *BS* bowel symptoms, *TS* treatment symptoms, *SA* sexually active, *SF* sexual functioning

Avaliação da Masculinidade

Bem Sex Role Inventory

Conformity to Masculine Norms Inventory

SANDRA L. BEM

TABLE 1

ITEMS ON THE MASCULINITY, FEMININITY, AND SOCIAL DESIRABILITY SCALES OF THE BSRI

Masculine items	Feminine items	Neutral items
49. Acts as a leader	11. Affectionate	51. Adaptable
46. Aggressive	5. Cheerful	36. Conceited
58. Ambitious	50. Childlike	9. Conscientious
22. Analytical	32. Compassionate	60. Conventional
13. Assertive	53. Does not use harsh language	45. Friendly
10. Athletic	35. Eager to soothe hurt feelings	15. Happy
55. Competitive	20. Feminine	3. Helpful
4. Defends own beliefs	14. Flatterable	48. Inefficient
37. Dominant	59. Gentle	24. Jealous
19. Forceful	47. Gullible	39. Likable
25. Has leadership abilities	56. Loves children	6. Moody
7. Independent	17. Loyal	21. Reliable
52. Individualistic	26. Sensitive to the needs of others	30. Secretive
31. Makes decisions easily	8. Shy	33. Sincere
40. Masculine	38. Soft spoken	42. Solemn
1. Self-reliant	23. Sympathetic	57. Tactful
34. Self-sufficient	44. Tender	12. Theatrical
16. Strong personality	29. Understanding	27. Truthful
43. Willing to take a stand	41. Warm	18. Unpredictable
28. Willing to take risks	2. Yielding	54. Unsystematic

Note. The number preceding each item reflects the position of each adjective as it actually appears on the Inventory.

Table 1
Masculine Norms Assessed by the Conformity to Masculine Norms Inventory (CMNI)

Subscale name	Description	Sample item
Emotional Control	Emotional restriction and suppression	"I tend to keep my feelings to myself"
Winning	Drive to win	"In general, I will do anything to win"
Playboy	Desire for multiple or noncommitted sexual relationships and emotional distance from sex partners	"If I could, I would frequently change sexual partners"
Violence	Proclivity for physical confrontations	"Sometimes violent action is necessary"
Self-reliance	Aversion to asking for assistance	"I hate asking for help"
Risk-taking	Penchant for high-risk behaviors	"I frequently put myself in risky situations"
Power Over Women	Perceived control over women at both personal and social levels	"In general, I control the women in my life"
Dominance	General desire to have personal control over situations	"In general, I must get my way"
Primacy of Work	Viewing work as a major focus of life	"My work is the most important part of my life"
Pursuit of Status	Being pleased with being thought of as important	"It feels good to be important"
Disdain for Homosexuals[a]	Aversion to the prospect of being gay, or being thought of as gay	"I would be furious if someone thought I was gay"

[a] Considerations regarding renaming the "Disdain for Homosexuals" subscale to "Heterosexual Self-presentation" are described in the Discussion section.

Avaliação da Masculinidade

Sexual Self-Schema Scale for Men

Appendix B

Describe Yourself (Form M)

Directions: Below is a listing of 45 adjectives. For each word, consider whether or not the term describes you. Each adjective is to be rated on a 7-point scale ranging from 0 = *not at all descriptive of me* to 6 = *very much descriptive of me*. Choose a number for each adjective to indicate how accurately the adjective describes you. There are no right or wrong answers. Please be thoughtful and honest. Question: To what extent does the term_____describe me? Rating scale:

Not at all descriptive 0 1 2 3 4 5 6 Very descriptive

1. humorous	16. *open-minded*	31. *sensitive*
2. *conservative*	17. sloppy	32. responsible
3. smart	18. *feeling*	33. *reserved*
4. *soft-hearted*	19. *arousable*	34. *experienced*
5. unpleasant	20. rude	35. good natured
6. *powerful*	21. *broad-minded*	36. *romantic*
7. *spontaneous*	22. *passionate*	37. shy
8. shallow	23. wise	38. *compassionate*
9. *independent*	24. *aggressive*	39. *liberal*
10. *inexperienced*	25. polite	40. kind
11. *domineering*	26. *revealing*	41. *individualistic*
12. healthy	27. *warm-hearted*	42. *sensual*
13. *loving*	28. stingy	43. *outspoken*
14. helpful	29. *exciting*	44. lazy
15. passive	30. *direct*	45. excitable

Note. Scoring instructions: The 27 Men's Sexual Self-Schema Scale items are in italics. Factor scores are calculated by summing ratings on the items listed below. Items 2, 10, and 33 are reverse keyed. Factor 1 = 4, 13, 18, 19, 22, 27, 31, 36, 38, and 42; Factor 2 = 6, 7, 9, 10, 11, 24, 26, 29, 30, 33, 34, 41, and 43; Factor 3 = 2, 16, 21, and 39. Men's Sexual Self-Schema Scale score: Total = Factor 1 + Factor 2 + Factor 3.

Table 4

Pearson Product–Moment Correlations of Factor and Total Male Sexual Self-Schema Scores With Sexuality and Relationship Criterion Measures for Undergraduate Men (n = 84 and n = 86)

	Male sexual self-schema score			
Dimension measure	Factor 1: Passionate–Loving	Factor 2: Powerful–Aggressive	Factor 3: Open-Minded–Liberal	Total
Sexuality: attitudinal–evaluative				
Sex Without Commitment Index (SOI)	.14	.36***	.18	.35**
Hostility Toward Women Scale	.00	.13	.03	.06
Sexuality: behavior				
SES: Lifetime	.33**	.49****	.30**	.48****
SES: Current	.30**	.26*	.25*	.33**
No. of sexual partners	.21	.34**	.24*	.38***
No. of one-night stands	.25*	.35**	.24*	.41***
Sexual coercion	.14	.43****	.29**	.36***
Sexuality: affects				
Sexual Arousability Index	.36***	.28*	.28*	.40***
Romantic involvement				
Passionate Love Scale	.48****	.20	.42***	.47****
No. of prior love relationships	.05	.18	−.07	.12

Note. SOI = Sociosexual Orientation Inventory; SES = Sexual Experience Scale.
* $p < .05$. ** $p < .01$. *** $p < .001$. **** $p < .0001$.

ESTUDOS – MASCULINIDADE E ALTERAÇÕES PSICOSSOCIAIS

ESTUDOS – MASCULINIDADE E ALTERAÇÕES PSICOSSOCIAIS

- Maioria com nível baixo de evidência
- Populações mistas de doentes
- Avaliações distintas (urologistas, radioterapeutas, psicólogos, enfermeiros)
- Objetivos diferentes das avaliações
- Fronteira entre avaliação médica e psicológica

Sexualidade após tratamento do cancro da próstata localizado

JGIM

ORIGINAL ARTICLES

Sexuality after Treatment for Early Prostate Cancer

Exploring the Meanings of ''Erectile Dysfunction''

Barbara G. Bokhour, PhD, Jack A. Clark, PhD, Thomas S. Inui, MD, ScM, Rebecca A. Silliman, MD, PhD, James A. Talcott, MD, SM

Table 1. Domains of Quality of Life Affected by Erectile Dysfunction

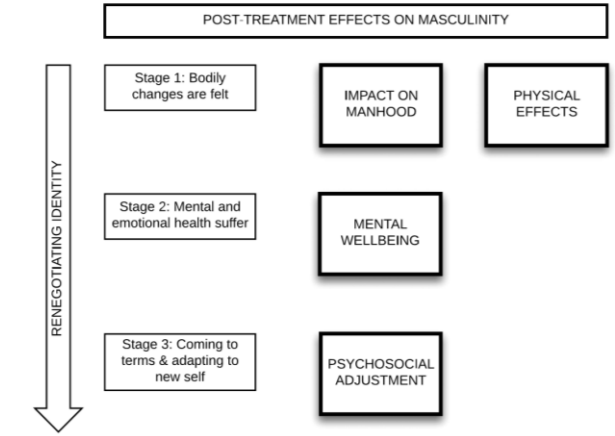
Sexual performance
Anxiety about satisfying a partner and oneself
Hesitation in initiating physical intimacy
Feeling that sex is awkward and unnatural
Relationships with women
Awareness of loss of potential for sexual intimacy
Disquieting absence of a sexual element in everyday interaction
Qualitative shift in interactions with women
Sexual imaginings
Distressing lack of physical or emotional response to attractive women
Loss of pleasant pastime: fantasizing about sexual intimacy
Masculinity
Sense of oneself as a man is diminished
Loss of sexual function means loss of a defining feature of manhood

- Significado da DE: implicações psicossociais
- Além da possibilidade de obter ereção
- Domínio das relações
- Dificuldade em envolver com parceira sexual
- Interações com mulheres
- Fantasias sexuais
- Modo de rever como homens

Perceção da masculinidade após tratamento de CaP

Obrey Alexis, PhD, MSc, BSc, RN
Aaron James Worsley, BA

A Meta-Synthesis of Qualitative Studies Exploring Men's Sense of Masculinity Post–Prostate Cancer Treatment



■ Theoretical model of stages in renegotiating masculine identity.

Implications for Practice

We would like to recommend that communicating the adverse effects of prostate cancer treatment by healthcare professionals to patients with prostate cancer should be more forthcoming because this may prepare patients for changes that may affect their perceived masculinity. Some patients were not adequately apprised of the adverse effects, and unduly, the transition period became a struggle for some of them. If communication from healthcare professionals is more conspicuous, perhaps this could help in men's adjustment to the changes that may result from prostate cancer treatment.

Review Article

Erectile dysfunction, masculinity, and psychosocial outcomes: a review of the experiences of men after prostate cancer treatment

Suzanne K. Chambers[1,2,3,4,5], Eric Chung[6,7], Gary Wittert[8], Melissa K. Hyde[1,2]

[1]Menzies Health Institute Queensland, Griffith University, Gold Coast, QLD, Australia; [2]Cancer Council Queensland, Fortitude Valley, QLD, Australia; [3]Exercise Medicine Research Institute, Edith Cowan University, Perth, Australia; [4]Prostate Cancer Foundation of Australia, St Leonards, NSW, Australia; [5]The University of Queensland Centre for Clinical Research, The University of Queensland, Brisbane, Australia; [6]Department of Urology, Princess Alexandra Hospital, University of Queensland, Brisbane, QLD, Australia; [7]AndroUrology Centre, St Andrew's War Memorial Hospital, Brisbane, QLD, Australia; [8]Freemasons Foundation Centre for Men's Health, School of Medicine, University of Adelaide, Adelaide, South Australia, Australia

Contributions: (I) Conception and design: SK Chambers, E Chung, MK Hyde; (II) Administrative support: All authors; (III) Provision of study materials or patients: All authors; (IV) Collection and assembly of data: MK Hyde; (V) Data analysis and interpretation: All authors; (VI) Manuscript writing: All authors; (VII) Final approval of manuscript: All authors.

Translational Andrology and Urology
Indexed in PubMed

Transl Androl Urol 2017;6(1):60-68

- Muitos homens conseguem ultrapassar as dificuldades relativas à idade, ao aumento da sobrevivência, parceira, sexualidade e virilidade.
- Para outros esta tarefa é árdua e desafiante.
- Papel dos profissionais de saúde: identificar estes homens e parceiras e ajudá-los nesta etapa.

EUROPEAN UROLOGY XXX (2017) XXX–XXX

available at www.sciencedirect.com
journal homepage: www.europeanurology.com

European Association of Urology

Platinum Priority – Review – Prostate Cancer

Editorial by XXX on pp. x–y of this issue

Quality of Life Outcomes after Primary Treatment for Clinically Localised Prostate Cancer: A Systematic Review

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Conclusions: This is the first systematic review comparing the impact of different primary treatments on cancer-specific QoL for men with clinically localised prostate cancer, using validated cancer-specific patient-reported outcome measures only. There is robust evidence that choice of primary treatment for localised prostate cancer has distinct impacts on patients' QoL. This should be discussed in detail with patients during pretreatment counselling.

Patient summary: Our review of the current evidence suggests that for a period of up to 6 yr after treatment, men with localised prostate cancer who were managed with active surveillance reported high levels of quality of life (QoL). Men treated with surgery reported mainly urinary and sexual problems, while those treated with external beam radiotherapy reported mainly bowel problems. Men eligible for brachytherapy reported urinary problems up to a year after therapy, but then their QoL returned gradually to as it was before treatment.

Diminuição do risco de suicídio

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UROLOGIC ONCOLOGY

Review article

Decreasing suicide risk among patients with prostate cancer: Implications for depression, erectile dysfunction, and suicidal ideation screening

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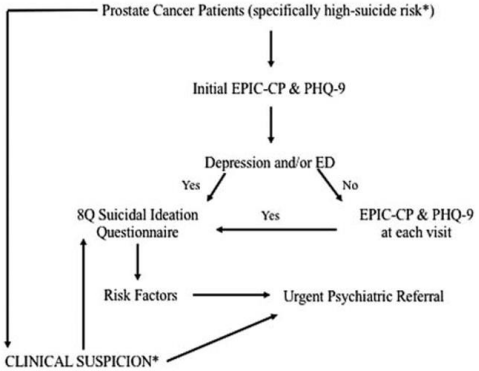
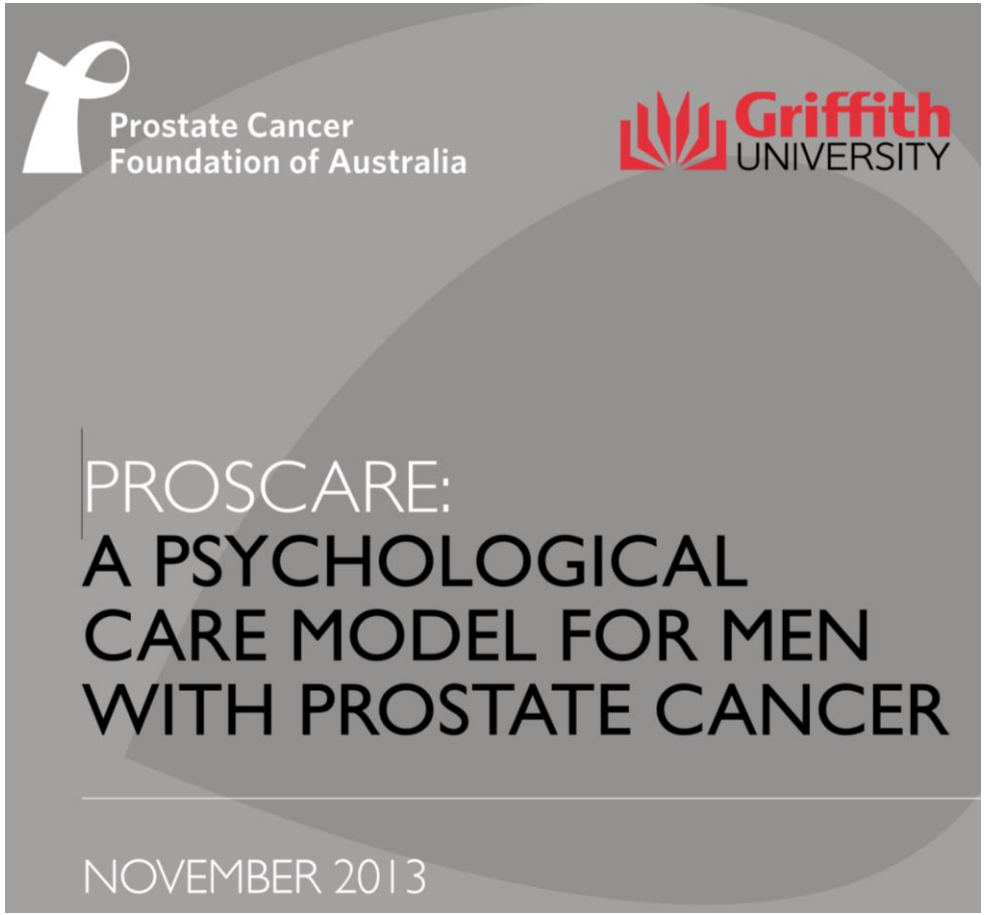


5. Conclusion

Suicide in patients with prostate cancer is not an uncommon event and may occur many years after diagnosis. Up to 5%–12% of patients may have suicidal ideation, particularly those who are white, unmarried, elderly and have distant disease. Approximately 60% of patients with prostate cancer will develop depression or mental health illness and there appears to be an association between erectile dysfunction and depression that is compounded in patients with prostate cancer. The burden of screening for erectile dysfunction, depression and suicidal ideation lies with the entire health care team. The screening algorithm using EPIC-CP, PHQ-9, and an 8-question suicidal ideation questionnaire should assist with guiding timely and appropriate psychiatric referral to optimize outcomes in these high-risk patients.

CAMPANHAS DE SENSIBILIZAÇÃO - PROSCARE



Summary of Recommendations

Assessment and management of physical and psychosocial effects of prostate cancer and treatment

Cardiovascular and metabolic effects (specific risk for men receiving ADT)

- Follow USPSTF [US Preventive Services Task Force] guidelines for evaluation and screening for cardiovascular risk factors, blood pressure monitoring, lipid profiles, and serum glucose (uspreventiveservicestaskforce.org/uspstopics.htm).

Distress/depression/PSA anxiety

- Assess for distress/depression/PSA anxiety ***at initial visit, at appropriate intervals, and as clinically indicated***. (Note. The Panel removed wording that recommended assessment should occur "periodically, at least annually" and removed the suggestion that a "simple screening tool" be used "such as the Distress Thermometer.")
  - ***ASCO Qualifying Statement: Physicians should refer to ASCO's Screening, Assessment, and Care of Anxiety and Depressive Symptoms in Adults With Cancer guideline (www.asco.org/adaptations/depression) for more information on management of this important problem.***

Distress/depression/PSA anxiety (con't)

- Manage distress/depression using in-office counseling resources or pharmacotherapy as appropriate.

- If office-based counseling and treatment are insufficient, refer survivors experiencing distress/depression for further evaluation and or treatment by appropriate specialists.

Fracture risk/osteoporosis - specific risk for men receiving ADT

- Assess risk of fracture for men treated with ADT or older radiation techniques through baseline DEXA [dual energy x-ray absorptiometry] scan and calculation of a FRAX [WHO fracture risk assessment] score.

Sexual dysfunction/body image

- Discuss sexual function with survivors.
- Use validated tools to monitor erectile function over time. (Note: The ASCO Panel removed the reference to “the SHIM” tool)
- Erectile dysfunction may be addressed through a variety of options, including penile rehabilitation or prescription of phosphodiesterase type 5 inhibitors (eg, sildenafil, vardenafil, tadalafil).
- Refer men with persistent sexual dysfunction to a urologist, sexual health specialist, or psychotherapist to review treatment and counseling options.

Sexual intimacy

- Encourage couples to discuss their sexual intimacy and refer to counseling or support services as appropriate.
- Prescribe medication as described above to address erectile dysfunction.
- Instruct couples on use of sexual aids to improve erectile dysfunction for men/male partners as well as postmenopausal symptoms for women. Refer to mental health professional with expertise in sex therapy.

Urinary dysfunction

- Discuss urinary function (eg, urinary stream, difficulty emptying the bladder) and incontinence with all survivors.

- Consider timed voiding, prescribing anticholinergic medications (eg, oxybutynin) to address issues such as nocturia, frequency, or urgency. Consider alpha-blockers (eg, tamsulosin) for slow stream.

- Refer survivors with postprostatectomy incontinence to a physical therapist for pelvic floor rehabilitation; at a minimum, instruct survivors about Kegel exercises.

- Refer men with persistent, ***bothersome*** leakage or other urinary symptoms to a urologist for further evaluation (eg, urodynamic testing, cystoscopy) and discussion of treatment options including surgical placement of a male urethral sling or artificial urinary sphincter for incontinence.

8. QUALITY OF LIFE OUTCOMES IN PROSTATE CANCER

This chapter is presented in two parts. The first will summarise consequences of therapies for PCa. Based on two SRs, the second will evaluate the evidence for adverse effects of treatments over the longer-term (twelve months +) and also make evidence-based recommendations for supportive interventions aimed at improving disease-specific QoL across all stages of disease.

European Association of Urology

8.3.1.1 Guidelines for long term quality of life in men with localised disease

Recommendations	LE	GR
Advise eligible patients for active surveillance, that global quality of life is equivalent for up to five years compared to radical prostatectomy or radiotherapy.	1b	A
Discuss the negative impact of surgery on urinary and sexual function, as well as the negative impact of radiotherapy on bowel function with patients.	1b	A
Advise patients treated with brachytherapy of the negative impact on irritative urinary symptomatology at one year but not after five years.	1b	C

8.3.2.1 Guidelines on improving quality of life in men who have been diagnosed with prostate cancer

Recommendations	LE	GR
Offer men on androgen deprivation therapy, twelve weeks of supervised (by trained exercise specialists) combined aerobic and resistance exercise.	1a	A
Offer men with T1-T3 disease specialist nurse led, multi-disciplinary rehabilitation based on the patients' personal goals addressing incontinence, sexuality, depression and fear of recurrence, social support and positive lifestyle changes after any radical treatment.	1b	A

CONCLUSÕES

- O dx de CaP é uma experiência angustiante para a maioria dos homens, para as suas parceiras e familiares
- Problemas psicológicos importantes num nº significativo de doentes: ansiedade, depressão, sintomas *trauma-like*
- Doentes com CaP têm risco > suicídio
- Angústias, alterações psicossociais e necessidades são heterogénas
- Promoção do rastreio destas situações e referenciação precoce para acompanhamento psicológico / psiquiátrico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