BCAN Patient WEBINAR SERIES

Questions & Answers about Sexuality and Intimacy after Bladder Cancer

A Valentine's chat with Dr. Trinity Bivalacqua

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Part IV: Question & Answer Session

Presented by

Dr. Trinity Bivalacqua *is the Christian Evensen Professor of Urology and Oncology and the Director of Urologic Oncology at the James Buchanan Brady Urologic Institute. He joined the Johns Hopkins Urology Department after completing his general surgery and urology training at Johns Hopkins Hospital. He also completed an American Urological Association (AUA) Foundation Post-Doctoral Fellowship from the AUA Care Foundation. Dr. Bivalacqua has an active clinical practice in Urologic Oncology and Sexual Dysfunction. As a member of the Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, he participates in multidisciplinary approaches to the treatment of a variety of genitourinary cancers. Dr. Bivalacqua has a special interest in cancers of the prostate and bladder with an emphasis on organ sparing therapies, minimally invasive techniques and orthotopic bladder substitution (neobladder). He has recently been acknowledged for his accomplishments in research with several grants including a Career Development Award from the National Institute of Health (NIH), Greenberg Bladder Cancer Institute, and the AUA "Rising Star" Award.*

Question 1: How do you find an expert that deals in sexuality and cancer? Because I know that there are many experts that do deal with sexuality issues, but what about cancer and sexuality?

Dr. Bivalacqua: That's a great question. If you think about it, when you think about men that undergo prostate surgery, sort of all of the prostate surgeons sort of are comfortable and used to talking about this with their patients. I'll tell you that the majority of bladder cancer surgeons are also sort of have experience with prostate cancer patients, are also comfortable doing this. Oftentimes, we forget to talk about it, because the discussion about bladder cancer goes beyond just the surgery, you know? Bladder cancer, as we're all aware, it involves sort of a multidisciplinary approach. You've got a lot of discussion about chemotherapy, radiation. "Do I get chemo prior to surgery? Do I get chemo after? What is my

urinary reconstruction going to be?" This kind of falls down to the bottom of the list for a lot of bladder cancer surgeons to discuss. But what I will tell you is, is that as a patient, you shouldn't hesitate to ask, and if that bladder cancer surgeon, or medical or radiation oncologist can't answer your questions to your liking or to the point where you're satisfied, then every single urology group, doesn't matter if you're a private practice or an academic center, has a sexual medicine specialist that should be called upon to help. If they can't, then you can seek out, for example, a bladder cancer surgeon that has expertise, or that is more comfortable in talking about this.

Question 2: What's the probability of success of nerve-sparing surgery? I know you gave a lot of charts and tables with percentages and those type of things, but could you give an overall sense? Obviously going for the nerve-sparing is going to have a better chance of a positive outcome in terms of sexual function, but what are some ballparks just so that people can keep in the back of their minds?

Dr. Bivalacqua: This is actually an extremely complicated question, because it all depends on the patient. If you remember my chart, there's lots of factors that influence erections as it relates to men, or for women. For example, if I'm seeing a 55 year old man who has no ongoing medical conditions, doesn't have high blood pressure, isn't an active smoker, is an active individual, and they undergo a nerve-sparing operation, well, the chances of them recovering their erection is actually pretty good. It's greater than 50%. It's probably as high as 70% depending on sort of who's doing the procedure. However, if you see a 55 year old man that's already taking Viagra or Cialis or Levitra, any of the medications, is a smoker or a previous smoker, has diabetes, and they have baseline problems with erection, even if I do nerve-sparing in that individual, or even if your surgeon does nerve-sparing, the chances of that individual at the same age recovering erections is less than 30%.

Your baseline capacity and your baseline co-morbidities contribute greatly to your erection recovery, but I think the important thing to keep in mind is that the only way that you're going to be able to recover your erections is if you undergo a nerve-sparing operation. When you look at the study that I showed from the Cleveland Clinic, and I'm not picking on the Cleveland Clinic, because I could show you the same data from Johns Hopkins, a lot of times the surgeons are not necessarily focusing on a nerve-sparing operation. I may sound like I'm being harsh on surgeons, but the reality is, is that I'm trying to make the point that we do need to sort of preach discussion with our patients about recovery of erections.

I just talked to you about a 55 year old, so now let's talk about a 70 year old, right? Let's talk about our average patient diagnosed with muscle-invasive bladder cancer that's 73. The common or average 73 year old is probably going to be on a blood pressure medicine, might be taking medicine for hyperlipidemia. May be a little bit more inactive. Probably already has some baseline erectile dysfunction. If I do a nerve-sparing operation in that individual, their chances of recovering erection is going to be closer to 30%, the 20% to 30%. As you could see, age and preoperative erection capacity is a strong predictor of erection recovery.

Stephanie: Those are really good points, because I think a lot of people think, "Well, if they're going to do nerve-sparing, and then I can take Viagra, I'll be better than ever." You're still going to just go back to where you were. I suppose people don't always realize that.

Dr. Bivalacqua: Yeah, and another thing to keep in mind is that the erection recovery is something that actually takes a significant amount of time. You know, men are not going to be able to see clear erectile function recovery until as early ... It typically takes at least a year. It's probably closer to two years before they may see meaningful erections. That's what I meant about quality of erection. You know, if a man says, "Well, yeah. I have erections, but Trinity, the erection doesn't have a good quality. It's not rigid. I'm not able to penetrate my partner." Well then yeah, they may have an erection, but it's not sufficient for intercourse, so they have severe erectile dysfunction. There's a clear sort of distinction, and that goes with asking the question, "How are your erections? Tell me about the quality?"

One of the things that I try to do, and I'll tell you, I'm also at fault of this sometimes as well, is that when you see your patient at their six week followup, their three month followup, you're talking about their ... You know, for example, their continence, if they have an orthotopic diversion. Talking about their CT scan, looking for cancer recurrence. You're talking about their problems with their appliance, you know? You've got all these other issues. Sometimes you forget to bring up that aspect of it. It's important that we do this, and if a patient and their partner want to be sexually active, and especially if it's a man, for example, you could do injection therapy immediately. You can do it as soon as they're ready, as early as six weeks after surgery. You'll be able to give that individual a good enough erection for penetrative intercourse, and that's something that I try to do in my patients and discuss with them early on.

Question 3: Should female urethra be spared to minimize impact on ability to have orgasms during a cystectomy?

Dr. Bivalacqua: Right. Great question. The urethra is spared, obviously, if you get an orthotopic diversion. However, if you undergo an incontinent diversion, like an ileal conduit, we typically don't leave the urethra behind, because it could be a harbinger of cancer, right? You could develop a recurrence in the urethra, and it's extremely challenging to survey. It's not like putting a cystoscope into the urethra. We will routinely remove the urethra. The nerves that innervate the clitoris actually run lateral to the urethra, so if you perform a nerve-sparing operation, you can actually ... The nerves are lateral to the urethra, and they won't necessarily be injured when the urethra is removed.

Now, if the surgeon has to remove the nerves or the anterior portion of the vagina and the entire urethra, unfortunately the nerves will be removed, the vagina will be shortened and may become difficult for penetrative intercourse. That's why we try, in our young patients, to preserve the anterior portion of the vagina, and also preserve the uterus and ovaries, because there's less chance of injury of those nerves if they run lateral to the uterus and ovaries.

Question 4: This one is a two-part question. We get this request for information often at BCAN. The first part is, "My husband is receiving BCG. How dangerous is BCG for me in between the treatments, in terms of sexual contact, for a female partner?"

Dr. Bivalacqua: Right. Once again, great question. The answer is, I don't know. What I will tell you is that what we do know is that BCG is, as long as the male partner is having erections and there is no spillage of urine, for example, then the BCG treatment should not affect the partner woman at all, because the BCG is in the urine, and obviously it's being, when the patient voids or goes to the bathroom, it's being released. What I tell patients is, is try to stay away from sexual intercourse for 24 to 48 hours. It's sort of my rule of thumb. I think at that point, I think there's very, very little risk on the partner.

Question 5: The second part of this person's comment, he also had a loss of interest, and he's 73. He's had some problems with urinary leaks, and she's had some atrophy after lack of use post-menopause and uses [inaudible 00:51:25], but the husband doesn't even want to try, so what are your suggestions for them, as far as as a couple? They just went on to say he's tried Viagra, but that no longer works, and he's very active and works out at the gym. Do you have any suggestions about what they could do?

Dr. Bivalacqua: I think that is ... Just hearing the question, if they were in my office, the first thing I would ask the man, the gentleman is, "Why are you not interested in trying?" You know, "Do you need to speak with someone about coping with the ongoing treatment, and what effect that may have on you and your wife or partner?" Right? This is a perfect scenario where speaking with someone, a counselor, about this is actually ... Could help out tremendously. Because it would allow both the couple to discuss this freely and kind of go over their concerns, or really the anxiety that's associated with it. If it is just simply the man is unable to obtain an erection, and that's why he is anxious about doing it and doesn't want to do it, then the next step is actually very simple. It's intracavernous injections, where we teach the man how to inject into the penis a medication that will give him an erection. It will bring the blood flow in to allow him to have a rigid erection.

Another option is something called a vacuum erection device, which is a little bit of ... It's an artificial erection. I could tell you most men and their partners are not very satisfied with this treatment, and once again, I'm not trying to be critical of a vacuum erection device. I could just tell you in my experience, this hasn't been very satisfying, whereas injection therapy is more of a natural erection, and it allows for a better, more rigid erection for intercourse.

Question 6: What about GainsWave treatment and the priapus shot for ED? Do you know anything about that? Is that beneficial for bladder cancer patients?

Dr. Bivalacqua: Right. I don't know what Gains Way treatment is, unfortunately. I'm sorry. I think the priapus shot is what the intracavernous injection therapy is. The priapus is actually the Greek god that was ... He was a Greek god that had a large phallus, and if a man has a prolonged erection, it is called a priapism, an acute priapism. Injection therapy gives men a good, rigid erection, so it has been termed a priapus shot, so I think that's what this caller or question is related to.

Stephanie: Yeah. I think it's GainsWave. W-A-V-E, so it's probably got something to do with ultrasound or some other ...

Dr. Bivalacqua: Oh, I see. I think what they're asking is a penile duplex doppler ultrasound. What that is, is where the patient is given an injection into the penis, injection therapy, and what it does is it induces an erection, and then a radiologist or even a urologist can use an ultrasound to look at how well there is blood flow into the penis, so how well is the blood flow going in, and then how well is the blood staying in the penis? How well is it being trapped into the penis? That sometimes can help us determine if injection therapy may or may not work. The reality is, is that if you had a doppler, most patients are just going to try the injection. The doppler doesn't help it as much as you may imagine. We sometimes use it to help us determine the cause of the lack of erection.

Stephanie: Excellent. Thank you so much. That pretty much wraps up all the questions that came in. I think that they were real excited about some of the studies that you're working on to look at sexuality issues with intravesical therapy. I think that there's a lot of curiosity about that and what that means for patients, so we'll look forward to finding out some of those results a little bit later on.