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**Stephanie Chisolm:**

Actually, this was fabulous. I think you guys covered so much in terms of not only the sexuality and intimacy, but also the impact, not just from the normal treatments that don't seem quite as drastic as having your bladder removed, but all of the treatments that impact bladder cancer. I think there's just so many things. This was such a comprehensive program. It was fabulous. I really appreciate it.

And I'm just thinking, we have a couple of questions that were in there... But you mentioned something, Dr. Avulova, about women often going to the gynecologist to deal with sexual function stuff. I know that there is such a specialty of being a urogynecologist. So you've done your urology training, you've done your gynecological training. Would that be the type of a person to say a woman who has issues with sexuality as a result of having their bladder removed or other aspects, that they should seek a urogyno that was able to help address both the bladder cancer issues and the sexual function issues?

**Dr. Svetlana Avulova:**

That's a really good question, Stephanie. So urogynecologists, they mostly deal with benign urologic issues. So urinary incontinence, pelvic prolapse. And oftentimes, when a patient has a diagnosis of bladder cancer, they're immediately sort of shuttled to the urologic oncologist. Although, I would say that there are some folks out there that may be sub subspecializing in sexual health and improving sexual health for women.

So what I would say is, unfortunately, it's not a straightforward answer, I guess, is my answer. And I think it's important for us to provide a multidisciplinary approach. So I think as a urooncologist, if you don't feel comfortable addressing the sexual health issues, then figure out who within your practice or institution is available, whether it is a gynecologist or a urogynecologist. And sometimes, it could be internal medicine providers that deal with menopause. For example, at certain centers, they have robust menopausal clinics, where they refer patients to. And maybe that would be the pathway.

**Stephanie Chisolm:**

For so many patients, sometimes the bladder cancer diagnosis sort of fits that second half of life, where perhaps menopause is hitting at the same time. And erectile dysfunction also might be coming into play, just because of their age, and then the disease just compounds that. So Melissa, any other thoughts on that?

**Melissa Donahue:**

There are definitely some physicians that are also trained in sexual medicine with gynecology or urology, that are listed in AASECT. Sometimes, they're listed under sexual counselors or educators because of the certain educational component. In order to be a therapist, you need to have a certain state licensure. So there are some physicians that are on the lister that do have those distinctions, so they can speak with patients and be listed on their website. But most doctors in medical school unfortunately are not trained in sexual medicine. It's specialty that gynecology or urology really gets a lot of, unfortunately, in just even general practice, without the oncology piece attached. So it's definitely a need and it's a place of research that I've been doing in my doctorate, about sexual medicine and dealing with sexual pain. And noticing that there's such a loss of education there.

But to speak to the other organization, the STAR organization, their focus is a lot on research, which is why I didn't necessarily mention them in my presentation, because I find they are a wealth of information for research, but I don't know how many of the people there are necessarily practitioners or are solely therapists or educators. They might be more academic related or there might be a cross membership with ASSECT.

**Stephanie Chisolm:**

Sure. I think it's within urology, I think mostly, but there is a sub professional group called the Sexual Medicine Society of North America. And so, I do believe that they have a website where you can look for physicians that are in the SMSNA, the Sexual Medicine Society of North America. Those are people that have gone on for additional training and they do research in that area. So when you're looking for somebody, if you're not finding it at the AASECT site... Which by the way, I did drop that full address into the chat box, so that you had it handy for everybody if you were interested.

So let's get to some of the questions. And remember, we do have a little more time for questions, so if you want to submit your question, now is the time. The first question was, "Do you have a list of doctors who can help female bladder cancer patients with sexual function, especially after cystectomy?" So I think we've just covered that.

And then, "Are there any good supplements for men with erectile dysfunction, that show any promise?" You talked a little bit, Dr. Avulova, about not using some of the pills like Viagra or Cialis, that they don't necessarily work. So you'd have to go with more of a physical thing, whether it was Caverject. Which, can you explain that to people? Because when people here about Caverject, which is an injection directly into the penis, that increases the blood flow, which causes the penis to become erect, people think, "Oh my goodness, I'm going to put a needle in what?" And they get really nervous. And from what I understand, it's a very tiny needle, correct?

**Dr. Svetlana Avulova:**

It is a very tiny needle. So first of all, I'll back up. So I think it depends on where you start off. And as urologists, we're actually really good at treating erectile dysfunction. And so, it depends on where you're starting off. And this is before bladder cancer diagnosis. So if you already have erectile dysfunction beforehand, and usually there are other markers of... For example, cardiovascular issues, erectile dysfunction is often the first sign of a cardiovascular issue. So if you already have issues, you can try Cialis or Viagra. So those are the pills that would increase blood flow to the penis. What I meant to say was that once the bladder is removed, and even in the best nerve sparing, oftentimes, those medications no longer work. Even if you never needed them before surgery, after that surgery, it is unlikely that they will work. However, if you are talking about, if you're being treated with just TURBTs, those can definitely work.

And going back to the supplements, there are some men that look at saw palmetto to help with their prostate health. But the studies to date haven't really shown any benefit in terms of potency, so meaning erections. And the FDA studies behind those are not very robust. So would recommend going with the FDA approved medications like Cialis and Viagra, that we know exactly how they work. But if you are interested in additional supplements, you could look. So Memorial Sloan Kettering, they have a very good website for integrative medicine and you can look at the different supplements.

And then, as far as your question, Stephanie, about the intra-cavernosal injections, yes, the needle is very small. It's about the same size as an insulin needle. And believe it or not, men do fairly well with using that. And what we do is we do a test run in the clinic. We show them exactly how to do it, and we do it at a dose that's half the usual dose, so that you can go home without having a full blown erection. And then, make sure that that erection goes down appropriately. And most men, they do really well. And then, the vacuum assist device, oftentimes, you can combine that with the pills, like Viagra or Cialis, which basically manually brings the blood flow to the penis.

And some men use that in addition to the pills, to bring blood flow to the glands of the penis, that oftentimes may not be engorged with just the pills. So to answer your question, men are able to do it. Yes, it's a scary thought in the beginning, but we do walk you through it in the clinic, and make sure that you're comfortable with it.

**Stephanie Chisolm:**

Got you.

**Melissa Donahue:**

The other piece about using those devices, I try to remind people all the time, is that's just a physical aspect of the erection. And to make sure that there is a mental component or a desire or interest. Very frequently with men, they get concerned and they overthink their erection. And if you're worried, "Is it going to happen? Am I going to get an erection?" And we keep thinking about it, "Because last time it didn't happen." And start doing some type of circular thinking and circular obsessing.

**Stephanie Chisolm:**

Right. Don't they call that spectatoring?

**Melissa Donahue:**

Yes. Even with all of the devices, the medicine, the pumps, the erections do still fail because the medicine just brings the blood flow. But if the brain is not coming along in the experience of pleasure, it does not work. And I tell people all the time, "It doesn't just give you an erection, it makes it available for the blood flow to go in. You need to bring your brain and be present in the sexual experience too."

**Stephanie Chisolm:**

The sexuality is truly a mind-body. If your brain is thinking about the grocery store and what you left behind and what you forgot to buy, it's really hard for the body to get back into the swing of things. And I know, Dr. Avulova, you mentioned vaginal dilators and things like that. So men are encouraged to do penile rehabilitation if they've had nerve sparing removal of the bladder, so that they can kind of keep things going. What's the usual timeframe for erections to occur again? And then, I wanted to ask about women, is there something women should consider doing as vaginal rehabilitation or something else like that?

**Dr. Svetlana Avulova:**

That's a really good question. So most people, I would say at six weeks for penile rehabilitation. And I usually lean on my partners in men's health where I practice, and they say at the very least, six weeks would be helpful to start the penile rehabilitation. But most patients that undergo this surgery, they're not thinking about this. And sometimes, it can be three months. And sometimes unfortunately, it could be six months. And the longer you wait, the more sort of fibrosis and scar forms. So the earliest you can do it, the better. And it's safe. I would say at six weeks would be the earliest. And as far as for women, I think you bring up a really good point. So one of the things that often happens with women, is they have vaginal leakage, especially if part of the vagina was removed and you had to sew the rest of it. So that sort of drainage from the scar, from that repair, often, is pretty bothersome to women and they have vaginal drainage. It takes a few months for that to go away. But what I would say they should be doing is applying vaginal estrogen. And around six weeks, I would do that as well. And oftentimes, I encourage women to do that. And vaginal dilators, again, at six weeks, especially if we've spared the entire vaginal canal and didn't require any extensive reconstruction.

**Stephanie Chisolm:**

Thank you all so much and we look forward to seeing you on the next patient insight webinar.

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