Advice for Managing Advanced Prostate Cancer Treatment Side Effects

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Andrew Schorr:
Dr. Catalona, let's talk about some of the typical side effects though. So certainly, with surgery, you can have the risk of urinary problems, erectile dysfunction. You mentioned even there's always the risk in any surgery with the risk of infection. So it starts there, and then you have chemo issues. Maybe you can take us through.

Dr. Catalona:
So most of the issues that I deal with as a surgeon are the issues of urinary incontinence, erectile dysfunction, and infections are usually not a very common problem. But if they occur, I deal with those. And those are relatively straightforward. The patients usually don't hide those from you. They usually let you know, yes, this is a problem and what can be done and what are the options. And so sometimes, they're difficult to manage. But it's not something that the patient keeps from you. So in the same sense, it's not like patients having pain or depression. Some of them do have depression from these side effects.

But in the patients with more advanced prostate cancer, I see two types of problems.

One is that everybody has aches and pains. Everybody sort of wakes up with aches and pains. And the first thing that the cancer patient thinks is oh, my God. This is a new metastasis, or this is something like that. So we often have to sort that out. And if there's any question, we sometimes have to get imaging studies or look at the PSA. And then the other thing that I see in patients with advanced disease is that they may be getting too much pain medication so that they're constipated, mentally they're not clear, sometimes they're sleeping all of the time.

And really, their activities become limited by really the opioid pain medication. So those are the…

Andrew Schorr:
So it's a balancing act.

Dr. Catalona:
Yes.

Andrew Schorr:
So, Judith, so you query people on how they're doing.

I mean, because it could be that they've been prescribed pain medicine. So talk about that, about getting it right, if you will.

Judith Paice:
So Dr. Catalona is exactly right. It's about balance. And you mentioned the words before in cancer treatment the use of multimodal therapy. The same is true for pain management. So it's not just the morphine or other opioids, and morphine is one of the drugs in that class. Also, oxycodone (Oxycontin), hydromorphone (Dilaudid), a wide variety of agents. But we look at non-opioids. For some patients, they can use drugs like ibuprofen (Advil), simple agents that are available over the counter. Those are great for those aches and pains that occur the longer that we're on this planet.

And then, if there is a nerve pain component that would be a tingling or a burning or an electrical shock-like sensation, which sometimes happens when there [are] bone metastases pressing against a nerve, then we've got separate agents that can be used to help with that kind of pain.

So rather than just using higher doses of one medicine, we may be able to use a little bit of each of those different medicines.

Andrew Schorr:
And radiation can be used as well, right?

Judith Paice:
Perfect for…

Andrew Schorr:
So radiation might have a place. Okay. So there may be wives or partners watching. And they say let's say the patient is George, but I don't want George to be a drug addict. And I'm sure you hear that. And, certainly, there's a lot in general communication about pain medicine, the abuse of that, drug addiction. We're talking about a different situation here. Maybe you can talk about that.

Judith Paice:
This has been in the media so much recently, the attention to opioid misuse. So it is true that addiction and misuse of opioids is a horrible public health problem. But I never want to see people who are facing cancer be undertreated because of those misconceptions.

So what do we do? Because people are at risk for addiction, some people, not everybody. So when I'm doing an initial assessment, I'm actually looking for those risk factors. What about their past history? What about their current history with misusing substances? And that can be tobacco and alcohol and recreational drugs. What about their family history? And then we also look at things like past abuse. That is a huge risk factor for people misusing substances. And so then, we take that information, and we stratify it. And it doesn't mean we withhold medicines from someone who has advanced cancer.

But what it means is that we provide those medicines in a safe manner. Some people can't manage a whole month's supply of an opioid. They take too much all at once.

And so we may provide smaller amounts. But that's actually for just a small group of individuals. Most people can actually, with some education, manage their medicines. But it's all about communication and multimodal therapy.

Andrew Schorr:
Okay. We're going to talk about communication. Another issue is fatigue, Dr. Szmulewitz. A lot of people, you say chemo or some of these other medicines. And you talked about many side effects that go along. Fatigue is one, too. I mean, I want to live my life. I want to go do stuff.

Dr. Szmulewitz:
Fatigue is, by far, the hardest one for us as medical oncologists, and in the supportive care and palliative care realm, I imagine it's the same. Fatigue is hard because it's multifaceted. So why are you fatigued? You're fatigued because of the disease that you're fighting. You're fatigued because of the therapy we're giving you to fight that disease. You might be fatigued because of the medicines we're giving you.

So, figuring out the cause of the fatigue. And if we are using medications, maybe we can tweak those to help with fatigue. I think that what I often counsel my patient is the best remedy for fatigue is being active. And so the best way to combat fatigue is to get up and about, to stay occupied mentally, emotionally, and physically because patients often feel more fatigued when they're at home perseverating about their illness and not as engaged. And I know it's really hard. It's really hard when you're suffering, and you don't feel like you have the energy to get up and go to actually do that.

But it, actually, will help stimulate more energy. And, obviously, eating the right foods. And we often have patients see a nutritionist, things like that.

Andrew Schorr:
Judith, and there is research, I know I've seen it at the various conventions that exercise, it seems counterintuitive, but exercise actually helps limit fatigue.

Am I right?

Judith Paice:
Absolutely. And we're always encouraging people within their limits. Maybe they're not going to be running on a treadmill. Maybe they'll just be walking around the block. And helping people to do that a little bit at a time so they don't try to walk 5 miles the first day. Walk around the block the first day. See how you do. And getting outside, getting active, as you say, getting your mind beyond just what's at home is so helpful.

Andrew Schorr:
So I have a pitch for couples. So I used to run marathons. As a two-time cancer survivor and 65 years old, can I still do that? No. But I get out, and I run 30 minutes really slow. But my wife, with me, we go to the gym many days, or we go out for walks. And maybe I can't do as much as before, but at least I'm doing it. And I want to thank you, Esther, for doing that with me. But there's a role for the couples, right?

Judith Paice:
Yes.

Andrew Schorr:
So, Dr. Catalona, do you like seeing men come in with a family member to help facilitate communication and maybe a more positive attitude?

Dr. Catalona:
Yes. I think that's very helpful to me as a physician. And it's kind of beneficial to the patient, because, very often, the patient will want to record the visit or will write down what was said because he said, "As soon as I go home, my wife is going to ask me, and I'm going to forget everything that we said. So it's very nice to have sort of an objective third party there who can make sure that the patient is communicating everything that's bothering them and can also take in what's being recommended by the physician in a more dispassionate way than the patient himself might be able to do.

Andrew Schorr:
Do you have the same feeling about this?

Dr. Szmulewitz:
Yeah, I do. It always is relieving to me when there's another person in the room, because I'm more comfortable knowing that they have an advocate for them, and they have a support at home and outside of this visit.

And it's prognostic. In other words, we know that patients who have a loved one in the home or with them live longer and live better. And I think one of the challenges that we see, especially in my patient population on the south side is a lot of men who don't have that support structure who don't have either a spouse or a partner or even a brother or sister or what have you that comes with them. And I think that's where our support groups, our Us, TOO, can really, really take a leadership role in giving them an environment of support. It's huge.