

ERECTILE DYSFUNCTION (ED)? – REASONS & POSSIBLE REMEDIES **Compiled by Charles (Chuck) Maack – Prostate Cancer Advocate**

I was reviewing a “Special Report” from the American Prostate Society published way back in the summer of 1996 regarding male impotence. It appears very little has changed over these subsequent years other than PDE-5 inhibitors coming to the fore. I want to share some of the interesting aspects of that report. As far back as the mid 1980s health care professionals had treated impotence as “all in the mind.” Even the men experiencing this problem came to believe that “if I can get my head straightened out” all would return to normal. Shame and embarrassment were so strong men wouldn’t even discuss this most intimate problem with a doctor. It was a no-win situation made worse by the man’s partner justifiably wondering why she was no longer sexually attractive. Does this sound familiar? The report said back then and holds true today that any man who thinks time and hope will take care of his problem is deluding himself. This is one problem that won’t go away; time just aggravates his situation. I found it interesting that the first step in ending male sexual incapability is to stop thinking of it as “impotence.” “Impotence” means a lack of power and strength, and power and strength have nothing to do with making love. Any man who thinks of himself as “impotent” is not just wrong; he is putting himself down. The more accurate term is “Erectile Dysfunction;” what the condition really is: an inability to attain and maintain an erection sufficient to complete sexual intercourse more than half the time sex is desired. This means rigidity as well as duration. Back in 1996 experts believed more than 30 million men in the U.S. were suffering from erectile dysfunction to some degree. This has unlikely changed. Back then, and I would venture to say even now, one man in two experiences this problem to some degree between the ages of 40 and 70. It is an equal opportunity affliction affecting men of every race, religion, and station in life. Even then it was considered that when those numbers are expanded to include women as partners in sexual relationships, that we begin to understand the enormous impact of erectile dysfunction in the United States. The trigger for penile erection is sexual stimulation reaching the brain. The brain responds to the stimulation by signaling the heart to pump more blood into the penile arteries. These arteries promptly dilate to twice normal size. Blood-flow jumps sixteen times normal. As blood-flow increases in the arteries, it partly blocks the veins and traps the arterial blood. The two channels of the penis called “Corpus cavernosa” become so full of blood the penis lengthens and can double its cubic size. All of this can take place in a normal man within 60 seconds! This marvelously elaborate system happens, or it doesn’t, depending on the flow of blood. If any part of the process breaks down, getting or keeping an erection becomes impossible. The system can break down from many causes;

mental/emotional problems, a new partner, stress, anxiousness, fear of sexual failure, disease involving the blood vessels, hypertension, diabetes, elevated cholesterol, some medications for high blood pressure, diffuse arterial disease (blockages in the small penile arteries), venous leak (though blood flows properly into the corpus cavernosa, the veins are not compressed to hold it where it is needed). Age plays a role since as men get older, the corpus cavernosa can lose their ability to stretch. When this happens, the chambers do not enlarge to accept an increase in blood sufficient to squeeze the veins and hold the blood in place. Other causes: low testosterone, damage to the nerves, muscles, or bones in the groin area, and tobacco. Alcohol's impact on the libido and sexual capability is well put in the saying "As whiskey make desire go up, ability goes down." The methods to counter some of these problems are nearly the same today as they were those several years ago. PDE-5 inhibitors were not yet available. Trazadone and Ginseng were sometimes considered as aphrodisiacs that might dilate the penile arteries to an indefinite, varying extent. And then, as now, the use of Muse (not very popular), Vacuum Erection Devices (VEDs), penile injections, and penile implants continue as the few methods to hopefully counter erectile dysfunction. Somewhat a sad commentary that other than PDE-5 inhibitors, nothing has changed. Men experiencing this affliction should be aware that they are not alone. They are rather in company with likely several million other men just here in the United States. And when this occurs and cannot be remedied, I invite your attention to the final paragraph in this paper just prior to the ending disclaimer.

An important paper titled "Persistent Erectile Dysfunction Following Radical Prostatectomy: The Association between Nerve-Sparing Status and the Prevalence and Chronology of Venous Leak" describes reasoning for difficulty regarding erectile function. Certainly worth a read to have some idea why you may be experiencing this difficulty. Go to: www.pubmed.gov then enter 19686421 in the search box).

The below URL takes you to an abundance of information regarding Erectile Dysfunction (ED). Be sure to take your time and read everything pertaining to ED including medications, alternative medications, herbs, testosterone replacement, and the side effects and other warnings provided:

<http://www.nlm.nih.gov/medlineplus/erectiledysfunction.html>

It appears from the below, that we should all be adding "Saving Your Sex Life: A Guide for Men with Prostate Cancer" to our home libraries. Dr. Mulhall is well

known as likely the most experienced physician in the nation in treating sexual dysfunction. Take particular note where he remarks “It takes 18-24 months for most men to reach maximal recovery of sexual function after radical prostatectomy.” The last paragraph is of particular importance.

John P. Mulhall, MD, director of the Male Sexual and Reproductive Medicine Program at Memorial Sloan-Kettering Cancer Center in New York City, has written a new book titled [Saving Your Sex Life: A Guide for Men with Prostate Cancer](#) (Hilton Publishing Company, Chicago, 2008). In it, Dr. Mulhall discusses male sexual anatomy and sexual function; how prostate enlargement can cause sexual dysfunction; the effects of radical prostatectomy, radiation, and hormone therapy on sexual function; and strategies for recovering some or all of the patient's pre-surgery sexual function. It is the first book written exclusively for men with prostate cancer about sexual function.

The interview was conducted by Rosemary Frei, MSc, a Toronto-based medical journalist.

“Who is your main audience?”

Patients as well as urologists. There are plenty of physicians out there who are going to get prostate cancer. Everybody knows someone who's got prostate cancer.

What was your primary objective?

I realize doctors are uncomfortable with sexual issues, so I'm trying to empower patients to feel comfortable asking their physicians about this. Prostate cancer is a slow-growing cancer. So it's not as if men are diagnosed this week and need surgery the next. Men are not going to get the best treatment if they don't know what questions to ask, and they have time to do research and figure out what those questions should be. So there's a chapter about deciding on which treatment to have. I try to tie the decision in with sexual function—one of the topics for questions you should ask your [doctor](#). For example, just because a doctor is a urologist doesn't mean he's an expert on radical prostatectomy—maybe he only does one a year. And we know that surgeon [procedure] volume is a predictor of success. So men need to ask how many he does.

Why was your book necessary? Do most urologists fail to discuss with prostate cancer patients the effects of treatment on their sex lives?

For physicians who manage prostate cancer patients, their first focus is oncologic—prostate-specific antigen measurements, etc. Their next concern is [restoring] continence. Sexual function isn't near the top of the list. And they often don't have the comfort level to talk to patients about it either. There's a famous slide I often use during talks—it shows a patient on a bed beside the doctor and both have “thought bubbles” that say, “I hope he brings up the topic of erection problems.” So it's usually on people's minds but rarely discussed. In addition, we only get one or two hours of sex [medicine](#) information in medical school. There's more time spent on tropical medicine.

How should urologists counsel prostate cancer patients?

The most important thing is to convey realistic expectations. I tell all the patients who come to see me the same thing: Don't base your decision [on which treatment to opt for] on sexual function. After three years, the outcomes from all the procedures are the same. Patients need to make an informed decision. If they don't know what questions to ask and the physician doesn't bring up sexual function, they're going to make an ill-informed decision. Every day I have a man sit in front of me with tremendous regret—with tears in his eyes—who tells me, “If I had known it was going to be like this, I would have never opted for that treatment.” Such patients weren't given realistic expectations.

It takes 18-24 months for most men to reach maximal recovery of sexual function after radical prostatectomy. The problem is that if patients are told they will recover [sexual function] in six months and erections haven't come back after nine months, they get depressed and stop doing anything [sexual]. Another consequence of unrealistic expectations is demonstrated in a European paper that was published earlier this year and looked at satisfaction with open vs. robotic-assisted prostatectomy. Satisfaction was lower with the robot because patients undergoing robotic prostatectomy are given unrealistic expectations, and their urinary and sexual outcomes are no better than with the non-robotic laparoscopic or open approach.”

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OTHER ERECTILE DYSFUNCTION SPECIALISTS (Please note: I have no idea of their expertise)

<http://pcai.pbwiki.com/PCAI%20List%20of%20ED%20Specialists>

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MUSE is occasionally recommended by physicians, but reports I continually read are that not only does it not work very well, but has caused discomfort and even pain to some patients. More reasonable would be to try a Vacuum Erection Device (VED) because it certainly helps bring blood into the penis as well as an erection. Very possibly you will then be able to maintain an erection either with or without the rubber rings that accompany the device to keep the blood in the penis. Alternatively, injections certainly work well and do not hurt. Many men reject the idea because they think sticking a needle into their penis would hurt. The needles are very thin and your urologist should provide you a prescription for the mix along with instruction on the appropriate place to inject. The only downside is going through the motions to bring on the erection while the partner is all primed for intercourse. The "upside" (pun intended) is that very good erections result.

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VACUUM ERECTION DEVICE (VED)

Osbon VED info (also recognize that in recovery, the VED is used to keep the penis oxegenated and the connectile tissue elastic):

<http://www.timmmedical.com/patients/>

Another source is Encore Deluxe VED around \$121.00

<http://tinyurl.com/q7e7st>

You can also find other brands on the internet by entering Vacuum Erection Device in the search box.

INJECTIONS (PAPAVERINE/BIMIX/TRIMIX)

The following websites describe penile injection therapy for erectile dysfunction:

<http://www.infertility-male.com/erectdys/injxn1.htm>

Successful Self Penile Injection
Hints, Questions, and Answers:

<http://www.ustoo.com/PDFs/Injection.pdf>

Patient Guide to Penile Injections:

http://www.ucsfhealth.org/adult/medical_services/urology/male_sexual/injections.html

John Mullineaux, a prostate cancer survivor/advocate advanced the following information learned during a presentation regarding what occurs that brings about an erection and how this can be enhanced.

"I am not a doctor. Last year, I was fortunate to hear a presentation by the Director of Men's Sexual Health of a regional medical center in our area. He explained the mechanism of erections and why it is a use it or lose it proposition. Here is what I heard.

The outer layer of the two corpora cavernosa is a form of smooth muscle cells. These cells can stretch and expand in both length and width during sexual arousal. They get "exercise" and additional blood supply from our nightly erections.

There is an artery that runs down the center of each cavernosa. This supplies the blood flow necessary for an erection. The veins that return that blood run on outside of the smooth muscle tissue with very tiny vessels that enter the cavernosa between the smooth muscle cells.

When a man becomes aroused, those nerves that the doc's try and spare send a signal to the arteries to open up. If they do, the penis starts to lengthen and thicken. However, that is only part of the process. As those smooth muscle cells start to expand, they constrict the veins. It is that venous

constriction that generates the penile blood pressure necessary for an erection.

After a prostatectomy, if those nerves are traumatized, nightly erections do not occur. Deprived of their exercise and additional blood supply, the theory says those smooth muscle cells begin to develop a plaque like substance that prevents them from stretching and expanding in the future. If this happens to enough of those cells, impotence is the result. Even with injections, the resulting erection will be smaller because some of those cells will not stretch.

The speaker's recommendation was men should take daily viagra a month preceding surgery and start injection therapy (but not sexual intercourse) as soon as the catheter is out. The injections only have to produce the lengthening and thickening initially. As healing progresses, the dosage can be increased to produce full erections. He was not convinced of a VED's ability to preserve potency.

As I mentioned at the beginning. This is what I heard the doc say. You can take it with as many grains of salt as you choose.”

For an understanding of Penile Injection for an Erection,

Recommend visiting <https://pcai.pbwiki.com/> then clicking On the folder index “Injections” where Michael Holland Has provided the results of his research and experience.

If not subscribed to pcai@prostatepointers.org, you may Have to subscribe before being able to then also subscribe To the pcai.pbwiki site. PCAI is a mailing list for frank and open discussion of the sexual issues surrounding PCa. To subscribe, go to:

<http://www.prostatepointers.org/mailman/listinfo/pcai>.

PDE5-inhibiting drugs (Viagra, Levitra, Cialis)

There are now three oral ED drugs: Viagra ([sildenafil](#)) by [Pfizer](#), Levitra ([vardenafil](#)) by [Bayer](#) Pharmaceutical and Glaxo-Smith-Kline-Beecham/Schering Plough, and Cialis ([tadalafil](#)) by Lilly-ICOS.

For all practical purposes, these drugs are the first line of oral [treatment](#) for [males](#) with erectile dysfunction. In certain circumstances in which the males are young, no comorbidities are recognized, and laboratory tests are normal one should look for the etiology of their erectile dysfunction before instituting treatment since the disease process may be more serious than the symptoms, i.e., the ED itself. In some cases, treatment of the primary disease may in fact resolve the [sexual dysfunction](#). However, most men have a cause for their ED as noted by the history and physical examination and the laboratory tests and PDE-5 inhibitors are the first line of choice.

Viagra (Sildenafil)

Discovered by Pfizer, Sildenafil is a potent and selective inhibitor of cGMP-specific phosphodiesterase type 5 (PDE5), which is responsible for degradation of cGMP in the corpus cavernosum in the penis. This means that, when sildenafil is present in the organism, normal [sexual](#) stimulation leads to increased levels of cGMP in the corpus cavernosum, which leads to better erections. Without [sexual stimulation](#) and no activation of the NO/cGMP system, sildenafil should not cause an erection.

Viagra (Sildenafil) is a member of a family of drugs called PDE5 inhibitors. Viagra was the first PDE5 inhibitor on the market. FDA approved Viagra on March 27, 1998. [Viagra®](#) contains sildenafil citrate packaged as a [pill](#).

Patients receiving sildenafil had a significant improvement in the erectile function

http://www.urotoday.com:80/index.php?option=com_content&task=view_ua&id=2216042

or if won't open, try <http://tinyurl.com/5moca9>

Particular caution should be used when prescribing PDE5 inhibitors for [erectile dysfunction](#) for patients receiving [protease inhibitors](#), including [Reyataz](#). Coadministration of a protease inhibitor with a PDE5 inhibitor is expected to substantially increase the PDE5 inhibitor concentration and may result in an increase in PDE5 inhibitor-associated adverse events, including [hypotension](#), visual changes, and [priapism](#).

PDE5-inhibiting drugs are very effective. PDE5 inhibitor drugs appear to work in men regardless of why they have erectile dysfunction — including vascular [disease](#), nerve problems, and even [psychological](#) causes. PDE5 inhibiting drugs can cause a number of minor [side-effects](#), including [headache](#), lightheadedness, [dizziness](#), flushing, and change in [vision](#). A few men choose not to use one of these drugs because they are bothered by these side-effects.

Studies in vitro have shown that sildenafil is selective for PDE5. Its effect is more potent on PDE5 than on other known phosphodiesterases (10-fold for PDE6, >80-fold for PDE1, >700-fold for PDE2, PDE3, PDE4, PDE7, PDE8, PDE9, PDE10, and PDE11). The approximately 4,000-fold selectivity for PDE5 versus PDE3 is important because PDE3 is involved in control of cardiac contractility. Sildenafil is only about 10-fold as potent for PDE5 compared to PDE6, an enzyme found in the retina that is involved in the phototransduction pathway of the [retina](#). This lower selectivity is thought to be the basis for abnormalities related to color vision observed with higher doses or plasma levels.

Levitra (vardenafil)

[Levitra](#) was the second oral PDE-5 inhibitor for erectile dysfunction to be [Food and Drug Administration](#) (FDA) approved approximately two years ago. Studies done on Levitra have excluded patients that failed Viagra, and, therefore, the efficacies are somewhat shifted toward the positive. In general, the feeling is that Levitra is more potent and efficient than Viagra as demonstrated by the hard-to-treat groups of [patients](#).

Cialis (tadalafil)

[Cialis](#) has an estimated effective duration of 36 hours; however, there are studies showing high efficacy up to 100 hours. It is not affected by any food whatsoever, and in fact can be taken with pure [fat](#). Viagra, on the other hand, is impeded by any type of food, and Levitra absorption is impeded by a high-fat [diet](#) in which more than 62% of the fat and the [food energy](#) are from fat.

An interesting article regarding PDE-5 efficiency:

Phosphodiesterase Type 5 Inhibitors in the Management of Erectile Dysfunction Secondary to Treatments For Prostate Cancer: Findings from a Cochrane Systematic Review

<http://tinyurl.com/4amxbl>

More good advice from PC survivor/advocate John Mullineaux for those experiencing a problem with their health insurer covering PDE-5 inhibitors:

“My insurance is with CIGNA. My script had been denied as it was considered a "lifestyle" drug.

I wrote the highest level female executive I could find. I told her I thought CIGNA had a problem with "gender parity". I further said I knew CIGNA covered hormone replacement therapy for menopausal females and I didn't see how that was less of a "lifestyle" issue than surgically induced impotence.

It seemed to work as they agreed to cover 8 pills a month.”

Here are ailments identified by Johns Hopkins health alerts that may be contributing to the problem:

Two Studies Link Erectile Dysfunction with Cardiovascular Disease

http://www.johnshopkinshealthalerts.com:80/alerts/prostate_disorders/JohnsHopkinsProstateDisordersHealthAlert_1808-1.html?ET=johnshopkins:e4627:18985a:&st=email&st=email&s=W3R_080308_005

If that doesn't open, try: <http://tinyurl.com/2clr5k>

AND, there is information regarding most any question regarding prostate cancer and its side effects by visiting the Prostate Cancer Research Institute (PCRI) website www.pcri.org the clicking on either “PCRI Papers” or “Newsletters.” Here is an article regarding erectile dysfunction:

http://www.prostate-cancer.org/education/sidefx/Auerbach_ErectileDysfunction.html

WHEN ALL ELSE FAILS, AN ERECTILE IMPLANT MAY BE CONSIDERED:

Erectile dysfunction (ED) implants:

You can watch the procedure on-line and find out for yourself exactly what's done. They simply install two inflatable tubes in your penis (that parallel your corpus cavernosum), a pump in your scrotum and a reservoir in your abdomen. The video of the procedure is at:

<http://www.or-live.com/coloplast/1908/event/webcast.cfm?>

Two types of erectile dysfunction penile implants:

Titan

<http://tinyurl.com/3y7dcp>

Excel

<http://tinyurl.com/38fpxa>

Obviously it is important that you determine a physician with much experience and expertise in the penile implant procedure.

Comprehensive information regarding penile implants:

<http://www.medscape.com/viewarticle/584818?src=mp&spon=17&uac=113983MZ>

or:

<http://tinyurl.com/8jxes3>

If not subscribed to Medline, you can subscribe for free.

A Urologist with experience and special expertise in the installation of penile implants for those willing to travel to get the best in treatment is David R. Paolone,

M.D., Assistant Professor of Urology, One South Park Street, Madison, WI 53715,
Tel: 608-287-2900, email: david.paolone@uwmf.wisc.edu

The following is a lengthy, but worth reading, article regarding the importance of finding a physician with much expertise in surgically installing a penile implant that will provide an erection suitable for intercourse. I have included this because of the importance that is described:

NEW YORK, NY, USA (Press Release) - March 9, 2009 - After years of testing, Dr. J. Francois Eid, director and founder of Advanced Urological Care in New York City, has refined an innovative "No-Touch" surgical technique that has caused penile implant infection rates to plummet to near zero. Infection rates for the infrequent penile implanter are over TWELVE TIMES as high as Dr. Eid's rate, which is less than 1%. Unlike many infections, which require treatment, healing time, etc., an infected penile prosthesis must be completely removed and replaced. Penile shortening, fibrosis and loss of sensation commonly occur after an infection. Subsequent attempts at re-implantation are extremely difficult with an increased risk of urethral and penile perforation that often requires additional surgery in the future.

For this reason, post-operative infection of a penile prosthesis implant remains one of the most dreaded potential complications of this procedure.

Dr. J. Francois Eid, also a Clinical Associate Professor of Urology at The Weill-Cornell Medical College, has performed more internal penile prosthesis surgeries than anyone in the world. His worldwide reputation for excellence in the treatment of erectile dysfunction (ED) is built on innovations in patient care such as his No-Touch Technique.

Specialized Experience Leads to Breakthrough in Penile Prosthesis Implantation

Doctors that perform fewer than 3 penile implants per year account for 70% of all implants currently inserted in patients in the United States. Dr. Eid attributes his ability to conceptualize, develop, and implement the No-Touch Technique to his extensive experience performing penile implantations, over 300 per year. Despite stringent precautions, many experienced urologist infection rates are 5%, and some institutions are as high as 50%. Dr. Eid's No-Touch success rate speaks for itself, with infection rates near zero.

Dr. Eid's No-Touch Technique

Dr. Eid believes the best way to eliminate infection is through prevention of exposure to bacteria and normal skin flora. Because skin organisms (e.g. staphylococcus epidermis, staphylococcus aureus, candida albicans) cause most infections, Dr. Eid reasons that eliminating direct AND indirect contact (for example, through surgical equipment or gloves) between the prosthesis and the skin will most effectively reduce infection rates. In addition, pre-operative antibiotics and antibiotic coating of the implanted device (the routinely used strategy for eliminating skin bacteria), is ineffective against fungi, such as candida albicans, which account for 10% of post-operative infections. Furthermore, during the surgery, adjustment or even removal and repositioning of the cylinders, pump and/or reservoir is often necessary. When performed without the No-Touch Technique, this results in additional direct contact of the device with skin, thus increasing exposure to skin bacteria and increasing post-operative infection rates.

Experience with Replacements of Infected Penile Prosthesis further supports No-Touch Technique

Salvage procedures, where an infected implant is removed and a new device immediately inserted, have been successful in the past even though the new implant is inserted in an infected tissue bed. Dr. Eid believes that "it is the decrease of total bacterial count and exposure to skin, rather than the complete elimination of bacteria from the procedure, that accounts for the success of penile prosthesis implantation." It is crucial to understand this reality because it gives the implanting physician the tools to further reduce and eliminate infections.

About J. Francois Eid, M.D, and UrologicalCare.com

Dr. Eid is the director and founder of Advanced Urological Care in New York City. He is also a Clinical Associate Professor of Urology at Cornell University. Dr. Eid is one of the foremost specialists in urological prosthetic reconstruction and performs over 300 internal penile implants per year with zero, or minimal complications. Dr. Eid leads workshops on penile prosthesis surgeries worldwide. More information about Dr. Eid and his expertise with erectile dysfunction treatment, penile prosthesis implantations urinary dysfunction treatment, and ejaculation dysfunction treatment can be found on his website, <http://www.UrologicalCare.com>, or by telephone 212-535-6690.

Despite the difficulty you may be experiencing in gaining the return of an erection, it is important that you continue concern for that of your partner. There is no excuse for any man to clam up and come near to shunning his partner because of

possibly feeling inadequate because of this hopefully temporary setback. Love and intimacy are more than sexual intercourse. Though sexual intercourse is a comforting and exciting coming together of those who love and care for each other, it is not the entirety of intimacy. Intimacy has so many other acts that express love, care, concern, and need for the other as well as needs of the other. We read recommendations of seeking counseling but that, too, is easier said than accomplished. The questions posed are first, who in the community (pastor, physician, counselor) is experienced in this type of counseling and could adequately address what is occurring sufficiently to understand and want to do something about it? And secondly, likely more important, are you willing to participate in such counseling? When the first question cannot be answered because such professionals are not available, it then becomes paramount that we work with our partner to resolve the intimacy issue in other ways. Obviously those of you caught up in this uncomfortable and for many almost unbearable situation are dealing with much frustration. I wish I had the answer, but I'm only a sixteen year survivor and twelve year androgen deprivation continuing patient myself probably as inadequately addressing this situation as well as I should in my own wonderful marriage continuing since 1954. Here is something that was brought to my attention and is so important and will most certainly help any couple:

In an email, I had remarked "From past experience in reading many such issues between couples, this is a subject that has so many variables that it is difficult to come up with a simple conclusive recommendation. The key word is "communication." With communication and regular discourse between couples, the effects of androgen deprivation therapy are much more easily resolved."

And in regards to that remark, a woman provided likely the best perspective of what the partner/caregiver is experiencing emotionally while trying to comfort and show understanding:

"Sometimes I think that talking is the most evil form of communication there is. We take such comfort in it, yet we can undo everything we've said in one gesture or in one look, or even in one misinterpretation. Show me. Take me outside and let's watch the sunset together. Put your arm around me and pull me to your side for a long hug that tells me I'm treasured. When you wake up in the morning and meet my eyes, smile when you see me there. Surprise me with a picnic you've made for two, or arrange dinner for four with my friends at a cheerful place that won't mind if we linger until closing time. Send me happy-to-be-with-you messages. Join me in the shower and let me wash your back after you've washed

mine. Touch me, even if it's just a gentle hand on my shoulder, or on my leg beneath the table. Work your way to "bolder" but ease off at the first sign of resistance. I will do the same, always respecting the signals you give, whether you utter them or not. Show me. Discover me. Rediscover us.

Show me what you are saying is true. Then I'll listen to what you need to say.”

What a powerful rendering regarding what many (most?) of we men fail to recognize; fail to act on! I was so impressed and told her so as did several others. In my reply I added “I still believe communication is vital, but you alluded well that words used in communication and gestures that accompany those words must be considered carefully so that a remark is not perceived as hurtful.” I would encourage all men reading this paper to re-read what this woman provided for our recognition; then take that advice and act on it.

In closing, for men and their wives/partners experiencing difficulty with intimacy as the result of treatment, an excellent book is "INTIMACY WITH IMPOTENCE – THE COUPLE’S GUIDE TO BETTER SEX AFTER PROSTATE DISEASE" by Ralph and Barbara Alterowitz, both certified sexuality counselors (AASECT). This book can be purchased at www.renewintimacy.org.”

Disclaimer: Please recognize that I am not a Medical Doctor. I have been an avid student researching and studying prostate cancer as a survivor and continuing patient since 1992. **The comments or recommendations I make are not intended to be the procedure for you to now follow; rather, they are to be reviewed along with the comments or recommendations of others for your own further research, study, and discussion with the physician providing your prostate cancer care to come to your own, personal conclusion.**