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Sexual rehabilitation or penile rehabilitation – do we have an optimal post-prostatectomy regimen?

Marta Skrodzka

Department of Urology, University Hospital of Białystok, Poland

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Prostate cancer, as the most common tumor in the European population of elderly males, has become one of the most important problems faced by public health [1]. Advances in diagnostics have resulted in an increasing numbers of patients qualified for radical treatment, an option with potential complications and sequelae. Oncological efficacy is our main priority, but these days it's not enough.

With regards to radical prostatectomy, a widely used option for localized prostate cancer, we should think of minimizing potential impairment of erectile function and urinary continence. The authors emphasized that post-prostatectomy sexual dysfunctions not only include erectile dysfunction (ED), but also ejaculatory and orgasmic dysfunction, penile shortening and deformations, psychosexual disturbances in: desire, body image and partner relationship intimacy, not mentioning depression and anxiety. According to published data, sexual dysfunction has an even stronger adverse impact on quality of life than urinary incontinence [2]. The issue that deserves the most attention of clinicians is that postoperative erectile function is affected by many factors including: patient's age, comorbidities, prostate cancer attributes, preoperative erectile function, but also surgical technique and the surgeon's level of experience [3]. One needs to match the proper patient, proper timing and treatment technique to optimize the functional outcome and strive for excellence to improve quality of life for of our patients.

Over recent years, we have observed increasing interest in ED after diagnosis and treatment of prostate cancer, with an accumulation of research and media attention on the subject. This has provided us with a detailed pathophysiological background (postoperative compromised cavernous oxygenation, with secondary apoptosis and erectile tissue fibrosis) and resulted in rehabilitation investigations [3]. Applicable modalities include phosphodiesterase type 5 inhibitors on demand or as daily regimen, vacuum devices, vasoactive agents as intracorporal injections or intraurethral gels, penile implants or combinations of the above according to the patients' preferences [3, 4, 5].

Even today with many therapeutic options available, there is no standard rehabilitation protocol that we could rely on [3]. Moreover, we lack proper evidence for rehabilitatory efficacy in clinical settings, but any rehabilitation is undoubtedly better than no action at all. Most of the published algorithms suggest penile rehabilitation instead of a holistic approach of sexual rehabilitation including a psychotherapeutic contribution [3, 4].

Despite importance of psychological and sexual counseling, there is limited research in this field and this fact makes the presented data particularly valuable. The authors have not only shown better functional outcome with the aide of a psychosocial therapist, but also stressed the patients' need of it (over 40% of patients and their partners asked for additional visits to the sex therapist beside the program).

An aspect that has to be considered is that this multimodal approach offers better patient acceptance and compliance, which also contributes to better therapeutic result [5, 6]. What we have also learnt is that sexual rehabilitation and erectile function restitution are options not only applicable to patients after nerve sparing radical prostatectomy, but also after non-nerve sparing procedures [3, 6, 7]. Recent studies have shown this to be an alternative for selected patients with high-risk, localized prostate cancer, who are not eligible for nerve sparing radical prostatectomy. It draws our attention to a few aspects: 1) efficacy of penile rehabilitation procedure is a "back to the baseline"

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option and one of the most important prognostic factors is erectile function before surgery; 2) sexual rehabilitation should be offered to all preoperatively potent patients, bearing in mind that inferior results would be expected after non nerve sparing procedures; 3) treatment should start as soon after surgery as possible (removal of the catheter or within one month after surgery) not only to prevent development of penile fibrosis, but also to minimize potential psychological detrimental effects; 4) sexual rehabilitation may be of more importance and profit for the patients after non nerve sparing procedures, which has been confirmed by the authors' results [3, 4, 6, 7].

Eighty-seven percent of physicians administer some form of accessible rehabilitation after RP, e.g. phosphodiesterase type 5 inhibitors, intracavernosal injections, vacuum devices or intraurethral prostaglandin, but one must not forget the importance of psychosexual support in the preoperative period (regarding education and awareness of possible complications, appraisal of available therapies, encouragement to undergo early treatment and comprehension of its importance) [3].

Combining excellence in treatment technique with emotional support brings prostate cancer survivor as close as possible to a state of well-being as opposed to just "getting rid" of the disease.

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Correspondence
Marta Skrodzka M.D, Ph.D.
martaskrodzka@gazeta.pl