

Support comes from AstraZeneca, dedicated to providing innovative treatment options for people living with bladder cancer. Learn more at astrazeneca-us.com. Welcome to Yale Cancer Answers with doctors Howard Hochster, Anees Chagpar and Steven Gore. I am Bruce Barber. Yale Cancer Answers is our way of providing you with the most up-to-date information on cancer care by welcoming oncologists and specialists who are on the forefront of the battle to fight cancer. This week it is a conversation about men's health with Dr. Stanton Honig. Dr. Honig is a Clinical Professor in Urology at Yale School of Medicine and director of the Yale Men's Health program. Dr. Hochster is a Professor of Medicine and Medical Oncology at Yale and the Clinical Program Leader of the gastrointestinal cancers program at Smilow Cancer Hospital. Hochster So, tell us a little bit about your background and how you got into men's health? Honig I have been in practice 22 years. I did fellowship training, my residency at Boston University and then an extra time down at Baylor in male reproductive medicine. Since that point in time, we have been taking care of men, specifically their kind of urological complaints. My practice is based mostly on sexual dysfunction, male reproduction and we actually started a transgender program here at Yale over the last year and a half. And we are really interested in making sure that men go to the doctor regularly. Men generally go to the doctor when they are boys, they see their pediatricians and when they get to the maybe 45-50 age group when they start to have some urinary symptoms. We lose them between 18 and 40. And they do not go to the doctor unless they have a problem, and we are just trying to make sure that patients understand that it is important to go to the doctor whether it is a urologist or a primary care doctor just to get checked regularly. Hochster I see. So, any specific advice for that age group, like 20-40, 50-year-olds. Honig Yes. You just want to check in regularly. We know that men who have mild erectile dysfunction, it can be a sign of blood flow problems elsewhere in the body. In fact, we realized that sometimes erectile dysfunction is the first sign of blood flow problems that will show up 5-10 years down the line. So, the blood vessels of the penis are the smallest vessels of the body and you will have abnormalities in the penis that eventually will show up in heart disease and things like that. So, it is important to go to the doctor if you have symptoms like that because you may have some underlying high blood pressure, you may have some underlying coronary artery disease, you may have some high cholesterol and if you smoke, it gives you an opportunity to modify your risk factors. Hochster And also potentially diabetes. Honig Diabetes too. That's correct. 00:03:18 into MP3: https://ysm-websites-live-prod.azureedge.net/cancer/2018-yca-0114-podcast-honig_325492_5_v1.mp3 Hochster So, what kind of areas, I mean is men's health kind of just focused on genitourinary and reproductive issues or do you usually go beyond that? Honig Well, in urology, we focus more on the genitourinary things. So, for instance, we promote the concept of testicular self-exam in men, 18-40. Young men – 18-30 is that population that is most likely to have a testicular cancer. So, self-examination is important. Checking, not necessarily checking but understanding that if you have a sexually transmitted disease, it may result in a problem with fertility down the line and then as men

get older, the concept of just going to the doctor, getting your prostate checked which is somewhat controversial these days, but there are certain subgroups of patients and now the recommendations in terms of AUA recommendations and United States Taskforce now is recommending against screening for prostate cancer in men 55-70. Hochster Okay, so screening for that would be digital exam and a PSA. Honig Well, we recommend having a conversation with either your primary care doctor or urologist and understanding what the risk factors are and what the potential risks and benefits are. So, certain populations are at higher risk for prostate cancer such as a family history of prostate cancer, and that means a first-degree relative, so a father or a brother. African-Americans are also at a higher risk for prostate cancer and more aggressive prostate cancer. So, we tend to recommend screening earlier in them, but men who we think have at least a 10-year life expectancy, between the ages of 55 and 70, and even beyond that since we are living much older, that those patients get screened as well, and that would involve a blood test and a rectal exam. Hochster Right. So, men are kind of reluctant to go to the doctor as you kind of said. Why do you think that is and what is the best way to address that? Honig Well, I think a couple of things: #1 they are afraid that they are going to be hurt by some type of exam that is done, especially in the young men – 99% of the time there is no discomfort involved in any type of exam, especially if you are having some sexual issues. The other thing is that, men like to know if they find something bad that it is treatable; for instance, testicular cancer, one of the most treatable cancers known to man. So, the earlier that you go to a doctor, get examined and things like that, the more likely you are to require less treatment. Similarly, prostate cancer is a very treatable disease if caught early. So, I think the important points are: #1 – most of the time the exam is benign, harmless, usually just involves a discussion. Secondly, most of the problems involved are treatable, curable things like that. And lastly when it comes to sexual problems per se, this is a fixable problem. Men like to fix things and that is how we are kind of wired. We do not discuss things, we just like to know that we can fix things. When it comes to sexual dysfunction, especially things like erectile dysfunction when a patient comes in, I tell them every one can be fixed, it is just a matter of how you go about treating you. 00:07:18 into MP3: https://ysm-websites-live-prod.azureedge.net/cancer/2018-yca-0114-podcast-honig_325492_5_v1.mp3 Hochster Well, that is very reassuring to hear as a male. I mean, my wife says if men had to go for mammograms, like they never show up. So, you know it is actually not as painful as some of the things that women are accustomed to doing every year. Honig Well, I would also reach out to the partners of men regarding this as well because especially wives are the gatekeepers for men, so it is really important that if you are a wife or you are a partner of a male out there, it is important that you get your significant other or partner to the doctor and these are the messages that you can relate to your partner: #1 - most of the time it is a harmless exam, #2 – fixable problems, #3 – if something is found, it is most of the time when it comes to cancer, it is curable. Those are the things that men like to know when they go to the doctor and they are more likely to go if they have an understanding

that that is how it is going to result. Hochster So, for symptoms related to prostate enlargement or prostate cancer, what should our listeners be looking for and what should trigger them going to the doctor if it is not one of these regular yearly exams? Honig So, the typical symptoms of an enlarged prostate are urinary symptoms and they usually tend to be a decreased force of stream when you urinate, it usually involves getting up 2-3 times at night and that is usually the type of thing that will bring the patient to the doctor or it will be the wife nagging the husband, hey you are getting up a couple of times at night, maybe you need to get checked. Sometimes, it will involve sleep issues and things like that. 20-30 years ago, the only treatments that were available were surgical and most of the time now #1, men want to know that if they are having those urinary symptoms it is not anything serious, right. I would point out that generally speaking, these urinary symptoms are not a sign of prostate cancer. It is more a sign of just a prostate enlargement. But it is important to get checked, it is important to have a PSA if you have these symptoms that is prostate-specific antigen, which is just a simple blood test that is the best test that we have to check for prostate cancer. And we have excellent medical therapy, we have new procedures that are available that are minimally invasive that we are doing here at Yale. So, there are a lot of things that are available for men. Hochster And you are talking about for benign prostate enlargement. And most of the time when people have this kind of trouble with their stream or getting up frequently at night, it is not prostate cancer most of the time, it can still be fixed and you can sleep better. Honig Not only can it be, it is fixable with medical things, minimally invasive options – prostate cancer generally speaking is silent. It is usually picked up on the blood test or physical exam. Hochster Okay. And when it comes to erectile dysfunction, what are the kind of things that people might notice to bring them to attention or that they should go see the doctor about, what kind of symptoms? 00:11:08 into MP3: https://ysm-websites-live-prod.azureedge.net/cancer/2018-yca-0114-podcast-honig_325492_5_v1.mp3 Honig Usually it comes down to being intimate with your partner and men will first notice that their erections may not be as hard as they used to be or they will get hard and they will lose it before they have an orgasm and it is important to differentiate the difference between problems with erections, meaning getting hard and problems where you let us say come too quickly like premature ejaculation, which is actually very, very common as well. And so, generally speaking, men will find that their erections are not as good as they used to be, they will have weaker erections and we really have outstanding treatment options available, and that usually starts with medications such as drugs like Viagra, Levitra, Cialis which are probably some of the safest drugs out there. And I would say that most men who have mild-to-moderate problems with erections will respond nicely to what they are called PDE5 inhibitors, phosphodiesterase inhibitors and they work by blocking the breakdown of the important substances that are important for erections. Hochster And so, is that kind of normal thing with aging that people will get this to a certain extent, men will get this? Honig Well, I would say the following: It is not a normal step in aging, we have

men in their 80s who have good erections and most men in their 40s who will have good erections. However, over time, men will have a deterioration in their erections, and usually it is from a blood flow problem and the risk factors are the ones that we started to talk about earlier, which is smoking, high cholesterol, diabetes, coronary artery disease, high blood pressure and things like that. Some men who have had prostate surgery who have had effects on their nerves, some people who have other neurological conditions, but about 70% of men will have a good response to these particular drugs, so they shouldn't be afraid to go to their doctor. Now, one of the problems with these drugs is that they are very expensive. And there are generics now that are becoming available, so there are ways to kind of make it work a lot more inexpensively with respect to these particular medications. But we have excellent treatment options above and beyond the pills as well. And we can get into that as well. Hochster Okay. Well, I have this impression that there are also issues with testosterone as men age and some people have even talked about "male menopause." So, we will come back and talk about that more. We are going to take a short break now for a medical minute. Please stay tuned to learn more information on men's health with Dr. Stanton Honig. Medical Minute Support comes from AstraZeneca, a global biopharmaceutical company that has developed 3 FDA-approved cancer medicines in the past 3 years for a variety of tumor types. Learn more at astrazeneca-us.com. 00:14:25 into MP3: https://ysm-websites-live-prod.azureedge.net/cancer/2018-yca-0114-podcast-honig_325492_5_v1.mp3 Genetic testing can be useful for people with certain types of cancer that seem to run in their families. The patients that are considered at risk for a familial or hereditary cancer receive genetic counseling and testing so informed medical decisions can be based on their own personal risk assessment. Resources for genetic counseling and testing are available at federally designated comprehensive cancer centers such as Yale Cancer Center and at Smilow Cancer Hospital. Smilow's genetics and prevention program is comprised of an interdisciplinary team that includes geneticists, genetic counselors, physicians and nurses who work together with the goal of providing cancer risk assessment and taking steps to prevent the development of cancer. More information is available at YaleCancerCenter.org. You are listening to WNPR, Connecticut's public media source for news and ideas. Hochster Welcome back to Yale Cancer Answers. This is Dr. Howard Hochster, and I am joined tonight by my guest, Dr. Stanton Honig from the Yale Urology Department and the Director of Men's Health. So, we were just talking about erectile dysfunction, drugs like Viagra, phosphodiesterase inhibitors and I wanted to ask you about testosterone. So, there is some evidence that males produce less testosterone as they get older and there may be an aging effect of that as well. Honig Right. So as men get older, their testosterone goes down, and that does not mean you necessarily need replacement. In fact, the endocrine guidelines recommend that you only screen for low testosterone if you are "symptomatic." So, if you have decreased energy, if you have loss of libido, some erectile dysfunction, some fatigue and things like that, so we are not recommending screening for low testosterone in all men and that is not

the recommended way to approach this. But in a male who is over 50, who has these signs and symptoms, it is reasonable to check a testosterone. Now I will say that testosterone is more of a libido, meaning interest drug than it is for erectile dysfunction. A lot of times, you treat their low libido and they also have associated erectile dysfunction, they will actually get more frustrated because their libido will improve but they will not have an improvement in their erectile function. So, it is usually a combination of treatment of low testosterone in addition to treatment of their erectile dysfunction. Hochster So, they may go together but not necessarily. Honig Correct. So, in a man who has erectile dysfunction alone, it is probably not just a testosterone issue. Testosterone may modulate your sexual response, but it is probably not the major issue here. I think one thing that is important to stress here is that a lot of people think that if the pills do not work, that there are no other good options for patients. And I would say, just the opposite. We have outstanding treatment options for men who do not respond to the pills. For instance, we have the option of injecting a tiny amount of medicine with a tiny needle into the side of the penis, which works incredibly well in men who do not respond to pills and I would like to compare it to the flu shot. So, I say to patients – have you ever had a flu shot and usually they say yes, and I say did that hurt? and they say no, and I will say well that is what it feels like. I know the thought of putting a needle into your penis than to put in your arm... 00:18:15 into MP3: https://ysm-websites-live-prod.azureedge.net/cancer/2018-yca-0114-podcast-honig_325492_5_v1.mp3 Hochster It is a different place as I recall in my anatomy... Honig Right, but actually you will barely feel it and I would say 7/10 men who do not respond to pills will have an excellent response to these penile injections. We also have options called vacuum erection device. It is a device that you put over the penis, you pump it up and it creates a vacuum around the penis, it draws blood in to help you get hard and also works well. And for those that do not find this something that would work or something that they would consider palatable, we also have penile implants, which is a surgical procedure, but actually if you look at the satisfaction rates and the success rates with penile implants is probably higher than anything else out there including pills. There is about a 50% dropout rate in patients who just use pills for a number of reasons – it could be cost, it could be efficacy and things like that. So, I would just stress to people listening tonight that if they do not respond to pills, there are multiple minimally-invasive, excellent options that can fix this problem and make a man allowed to be intimate again with his partner. Hochster I see. And if that is the case, I mean there are a lot of primary care doctors, etc., that may give out the phosphodiesterase inhibitor-type drugs, but then if that is not really working, see a urologic specialist who specializes in this kind of issue. Honig Exactly. Because there are really outstanding treatment options available. Hochster It is very reassuring to know. And what about fertility in general? You deal with issues of male infertility. Honig Right. So, one of the things I would like to stress is a man if he is checked and has an abnormality in his sperm, should be checked by a urologist, a reproductive urologist. A lot of times this is driven

by women, the women partners, because they are the gatekeepers not only for health but also for pregnancy. So, if you have had some kind of underlying abnormality when you are younger, let us say an undescended testicle, sexually transmitted disease, if you are trying to get your wife pregnant and you have been unsuccessful, generally speaking the recommendation is to wait a year. But in men who have had some underlying problem, the earlier you get this checked out, the better. And #1, it is important to be examined because about once or twice a year, I will pick up a testicular cancer in a man who presents with male factor infertility. So, there can be not only abnormalities of the sperm, but there can be physical conditions that are treatable that can be the cause of these underlying problems, and not only can there be underlying causes, but there are things that are treatable. There are certain things called varicoceles, they are enlarged veins around the testicles that can heat up the testicles. They probably occur in about 18% of all men. If you have lined up 100 men in a locker room, you find that 18% have these enlarged veins. But if you lined up 100 men who had fertility problems, that incidence would go up to about 35-40%. So, not everyone who has these enlarged veins necessarily have a fertility problem but in certain men, this can affect their fertility and this is again a treatable, reversible cause for male factor infertility. 00:22:08 into MP3: https://ysm-websites-live-prod.azureedge.net/cancer/2018-yca-0114-podcast-honig_325492_5_v1.mp3 Hochster I see. And so, one of the things you look at is a sperm count and then urologic exam, urologic evaluation, and it is possible to bank sperm for people who have low sperm counts, is that right? Honig Well, generally speaking, sperm banking is recommended for those who are undergoing some type of treatment. So, for instance, if a patient is newly diagnosed with a testicular cancer or a lymphoma or leukemia, these are the types of tumors that will see in reproductive age, we recommend that you freeze some sperm before you consider any type of oncological therapy. An oncological therapy could be either chemotherapy, which kills cancer cells but it also kills actively dividing cells which are sperm cells. Same thing is true for radiation or any type of surgical procedure that may affect things like ejaculation and things like that. So, fertility preservation is an important concept that we are trying to get out to the general public. In addition, the State of Connecticut... Hochster But not everybody who get, young men who get chemotherapy for the diseases you mentioned, they are not going to be permanently infertile? Honig Well, it depends. And what I would like to say is you never know what is going to happen down the line. So for instance, in a man who has testicular cancer, he may undergo a course of chemotherapy and he may go from having tons of sperm to having no sperm, and then he may bounce back, but he may be one of those men that has initial chemotherapy and does not respond and then needs a more aggressive chemotherapy regimen, at which point he may not be able to bounce back. So, some chemotherapy regimens will allow you to bounce back, others do not. The only issue really that would negate freezing sperm ahead of time as I see it is cost, and that is one of the main points I wanted to make here, which is Connecticut is actually the first state in the United States to pass a law stating that insurance carriers must cover fertility

preservation prior to oncological therapy. And I would also mention that it is not only cancer therapy, it may be patients who have rheumatological diseases like arthritis or other things that may undergo treatments for let us say methotrexate or Cytoxan, it is not just the cancer patients, it is other patients. In fact, we have started a transgender program here in Yale and one of the things that we focus on is fertility preservation. So, before let's say a male to female undergoes gender-affirming surgery and remove the gametes, we offer cryopreservation of sperm prior to that so if they wanted to have a biological child, that this would be an option for them down the line. Hochster And this is covered by insurance, all that, in terms of the original preservation and also yearly maintenance fees or whatever is involved? Honig Well, as we speak, the answer is no, but as of January 1st when the law goes into effect, Connecticut is the first to pass a law stating that insurance must coverage cryopreservation of sperm. I am not sure of the specific details of long-term coverage and things like that, but it has really been a historic step in the Connecticut legislation moving forward in this area of fertility preservation. 00:26:06 into MP3: https://ysm-websites-live-prod.azureedge.net/cancer/2018-yca-0114-podcast-honig_325492_5_v1.mp3 Hochster And that will start on January 1st? Honig I believe it is January 1st. It was put into law and signed by Governor Malloy, I believe in September (2017). Hochster I see. Well, that is very interesting. And so, I guess the last thing that maybe we could talk about for a minute would be prostate cancer screening. So, there is a lot of news in the press about should you get your PSA done or should you not get it done and which organization is recommending do it or not, can you give us some advice on that. Honig Well, I think the current guidelines are that men between the ages of 55 and 70 should be screened for prostate cancer, and I think that involves a decision-making process between the patient and his doctor whether it be his primary care doctor or a urologist. I practice what I preach, I get PSA screening, I have a digital exam, I have a PSA because the only way you can find something is if you check for it. And if you do not check for it, you may end up with advanced cancer. Now, having said that, we have taken a much less aggressive approach to low-grade prostate cancer. So, people who have screening, who have a low-grade cancer, lot of them are on what is called active surveillance, meaning they do not even need treatment but they are watched regularly with some kind of screening -- PSA, biopsy, etc., to make sure there is not progression to aggressive disease. So, historically 15 years ago, if you had prostate cancer, it was like you are pregnant or you are not. If you had it, you had to have treatment. Now, we realized that there are those that are very aggressive, that need treatment and there are those that do not need treatment. Hochster And I think one of the issues with PSA screening is that since with prostatic hypertrophy, enlarged benign prostate enlargement, you can have a somewhat elevated PSA and then there a lot of extra biopsies in those situations. Honig Well, it depends. I think we have a lot of different tools now. So, for instance, the MRI over the last 3-5 years has become a much more valuable tool in identifying abnormalities, so it is not just biopsy, biopsy, biopsy... Dr. Stanton Honig is a Clinical Professor in Urology at Yale

School of Medicine and Director of the Yale Men's Health Program. If you have questions, the address is canceranswers@yale.edu and past editions of the program are available in audio and written form at YaleCancerCenter.org. I am Bruce Barber reminding you to tune in each week to learn more about the fight against cancer. You are on WNPR, Connecticut's public media source for news and ideas.