Sexual Function Similar After Prostate Cancer Tx

BY JEFF EVANS
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ORLANDO, FLA. — Posttreatment sexual function in prostate cancer patients differs initially between the various primary treatments, but becomes nearly equal among all modalities after 4 years, Joycelyn L. Speight, M.D., reported at a symposium on prostate cancer sponsored by the American Society of Clinical Oncology.

Still, some data on patients in a prostate cancer registry suggest that brachytherapy may offer modest advantages in preserving sexual function, at least for some patients, said Dr. Speight, of the University of California, San Francisco.

Sexual function after radiation- and brachytherapy (BT)–based treatment regimens tends to be highest immediately after treatment, then declines slowly during the ensuing 4 years. After radical prostatectomy, sexual function is lowest immediately after treatment and then slowly improves during the next 4 years, she reported.

"All of the treatments for prostate cancer can have an impact on health-related quality of life, and this often influences the patient's treatment choice," she said.

The findings were obtained from self-reports of sexual function and quality of life submitted by 2,903 patients in the CaPSURE registry (Cancer of the Prostate Strategic Urologic Research Endeavor) every 6 months for up to 4 years after treatment.

The validated questionnaires consisted of the Rand 36-item health survey, the UCLA prostate cancer index, and a 12-item medical health checklist.

In patients who received 6 months or less of neoadjuvant androgen deprivation therapy (ADT), brachytherapy (BT) was associated with the least change and decline in sexual function and significantly better overall sexual function 4 years after treatment than other treatment modalities.

But in patients who received more than 6 months of neoadjuvant ADT, all therapies provided similar levels of sexual function 4 years after treatment.

Patients who received external beam radiotherapy (EBRT) alone, BT alone, or EBRT plus a BT boost were significantly older on average than were patients who received nerve-sparing or non-nerve–sparing radical prostatectomy (70 years vs. 63 years), and were significantly more likely to have at least one comorbid condition such as diabetes, hypertension, or coronary artery disease (82% vs. 53%). The group treated with EBRT and/or BT also was significantly more likely to have received neoadjuvant ADT for more than 6 months prior to treatment, compared with the prostatectomy group (38% vs. 8%).

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Regardless of treatment, all patients who received more than 6 months of neoadjuvant ADT showed clinically significant improvement in sexual function between treatment and year 1.

After the first year, sexual function levels reached a plateau for all groups that received more than 6 months of neoadjuvant ADT, Dr. Speight said at the symposium, which was cosponsored by the Society of Urologic Oncology and the American Society for Therapeutic Radiology and Oncology.

By year 4, patients who received EBRT, BT, or EBRT plus BT had the same level of sexual function regardless of whether they received more than 6 months of neoadjuvant ADT. But patients who received nerve-sparing or non-nerve–sparing radical prostatectomy with more than 6 months of neoadjuvant ADT had significantly better sexual function after 4 years than those who had 6 months or less of neoadjuvant ADT.

Sexual function was evaluated on a scale of 0 to 100, with higher scores meaning better function. At 4 years after treatment, no group scored higher than 34 on average.

Immediately after treatment, no group had an average score lower than 12. No data were available on sexual function prior to treatment. ■

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