JOJ Urology & Nephrology

Juniper Publishers key to the Researchers

Mini-Review
Volume 2 Issue 1 – March 2017
DOI: 10.19080/JOJUN.2017.2.555578

JOJ uro & nephron

Sexual Life After Radical Prostatectomy: Is It Possible?

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Submission: February 11, 2017; **Published:** March 02, 2017

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Abstract

Prostate cancer is the second leading cause of death in men. Radical prostatectomy is an effective weapon in this context, although it is associated with significant negative impact on quality of life, especially regarding sexual function. Sexual function in men is focused on erection and the psychological pain caused by erectile dysfunction can be more disabling than those related to chronic physical problems, affecting their self-esteem and quality of life, and negatively impacting the patient's interpersonal interactions.

Our proposal is evaluate the impact of group psychotherapy and the use of a phosphodiesterase-5 inhibitor in the early rehabilitation stage of patients with prostate cancer undergoing radical prostatectomy.

The studies were conducted in Oenological Urology Clinic of Clinical Hospital of UNICAMP, with men undergoing radical prostatectomy, and were excluded patients in use of nitrate and psychological disorders.

Early integral treatment involving group psychotherapy and PDE-5i, before and after radical prostatectomy, led to less deterioration of erectile function and other domains related to physical aspects (SF-36), with improvement in intimacy with their partner and satisfaction in their sex life, being superior to single treatments.

Keywords: Prostate cancer; Group psychotherapy quality of life; Erectile dysfunction; Radical prostatectomy; Phosphodiesterase-5 inhibitors

Abbreviations: Pca: Prostate Cancer; RP: Radical Prostatectomy; QoL: Quality of Life

Introduction

Prostate Cancer (PCa) is the second most commonly diagnosed cancer in menand representes a significant health problem. The insidence of Pca is continually increasing in developed countries. Because of early detection, the majority of newly diagnosed cancers are organ confined, for which radical prostatectomy (RP) is a curativetreatmentoption. Although the substantial progress made in the detection and treatment of cancer, with a five-year survival of 66% for all cancers [1], the diagnosis of cancer is still assessed as life-threatening and causes more suffering than any other medical diagnosis [2].

In our culture, receiving the diagnosis of cancer brings a whirl wind of emotions and representations - death sentence, mutilation, pain, dependency, impotence, social stigma, andcan cause trauma oranticipatorymourning. Physical and emotional effects not only manifest themselves in thepatient, but can also bring changes in their partners and their families, with an impact on social, Physical and psychological functioning [3].

In this context, the overall goal of psychotherapy is to allow the patient greater pleasure and satisfaction, regardless of the quality of erection. The satisfaction can be enhanced by activities that go beyond the erection, culminating in satisfaction and improved quality of sex life, despite the fact that the male erection problems are not always completely resolved [4]. Additionally, early treatment benefits the sexuality of patients in the short term and may have a positive effect on long term psychological factors.

Staying socially and sexually active is associated with physical and mental health, but sexuality is often neglected by being accepted as an expected problem in elderly men. Thus, it is not uncommon after treatment of the primary focus (PCa) that sexual function is seen as secondary to the overall health of this population [4].

Once prostate cancer, compared to other cancers, has a favorable prognosis, treatment-related morbidity has important implications for life, compromising the quality of life (QoL) [5].

Discussion

The most common strategy used in the treatment of ED post RP is the use of a phosfodiesterase-5 inhibitor (PDE-5i),

represented by drugs such as sildenafil, tadalafil, vardenafil and lodenafil. When this method is ineffective, the intra-cavernous injections of vasodilators or penile prostheses (elongated rigid rods which are inserted surgically into the corpora cavernous of the penis are indicated [6].

Men with sexual dysfunction are less likely to perceive the quality of their overall relationship as relevant to their sexual problems and most patients receive little or no assistance in dealing with the effects of the disease and its treatment in privacy [7].

Integral health care in medicine may be defined as any intervention directed at the "whole person" rather than an organ system. It considers psychological, social, cultural and biological dimensions. Holism and reductionism have been a central problem of western philosophy since at least the 17th century [8]. In the medical realm, these terms express two different ways of understanding the human body. Following Descartes and the approach of science generally, reductionism considers the body through division into manageable parts [9]. Reductionist knowledge is rational, reproducible, and measurable by mathematical physics.

When we look to the human being we have a coin with three faces: biological, psychological and social. The biological, the body, the psychic and the character are not seen alone as autonomous fields, but always subscribe to networks of society, socio-political micro systems such as the couple and the family, and the large groups that are the nation and humanity itself [10]. QoL is defined by the relationship between physical, psychological and social domains. Thus it depends on the ability of each person to accept discomfort and limitations, and is influenced by the individual's satisfaction with his life. The emotional domain is as important as the physical, cognitive or social domains.

Sexual dysfunction, decreased intensity of orgasm, lack of orgasm or pain during orgasm, can cause psychological stress with consequent reduction of QoL [11], low self-esteem [12], poor self confidence and undermine interpersonal relationships [13]. Another important aspect is the educational and informative part of the disease, where we clarify doubts and undo myths, making room for expression and affective contact. The identification of the patient's own needs, managing themselves in search of a better quality of life within their own limitations, and mostly, their potential to become an information tool in the social group to which they belong are fundamental and emphasized at every meeting [14].

The treatment of Pca by means of RP adversely affected notonly erectile and orgasmic functions but also sexual desire, sel-esteem, and masculinity. Our studies, in accordance with several other publications, so we do that a combination of support group psychotherapy and oral medication (PDE-5i) is effective in improving the erectiledys function of patients submitted to RP.

Most studies did not focus on the couple for the intervention and evaluations and, in this regard, themost important and alarming data showed in our studies is that treating the patient is no enough to overcome fundamental aspects of sexual function such as "relationship with the partener" and "in time acy with the partner" that are significantly affected by Pca treatment [10].

Little research has been done in the area of psychosocial interventions in penile rehabilitation, and there are no guidelines for specific recommendations or consensus regarding the optimal rehabilitation protocol or treatment. Future studies with multidisciplinary approaches should define the role of specific psychosocial interventions tailored to the individual personality, and include evaluation of the influence of the partner.

Conclusion

Early integral treatment involving group psychotherapy and PDE-5i, before and after radical prostatectomy, led to less deterioration of erectile function and other domains related to physical aspects (SF-36), with improvement in intimacy with their partner and satisfaction in their sex life, being superior to single treatments. Psychotherapy allowed the identification of the importance of the partner in this scenario.

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How to cite this article: Angela M E P N. Sexual Life After Radical Prostatectomy: Is It Possible?. JOJ uro & nephron. 2017; 2(1): 555578. DOI: 10.19080/JOJUN.2017.2.555578

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DOI: 10.19080/JOJUN.2017.2.555578

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