An Optimist's Guide to Your Prostate

Eric Sullivan Esquire.com and magazine May 8, 2018

Here's the bad news: Every man, if he lives long enough, is likely to develop prostate cancer. Here's the good news: Often, you can live with it. But how to go about screening for and treating it—or not—is a source of massive confusion. So we asked Dr. Samir Taneja, a trailblazer in urologic oncology, and a few of his colleagues to share the newest approaches toward beating one of the top killers of men.

Jeffrey Westbrook

SO WHAT'S THE PROSTATE, ANYWAY?

A gland in the male reproductive system the size of a Ping-Pong ball, situated below the bladder and in front of the rectum. Its main purpose is to produce the milky-white part of semen that armors sperm before the big swim.

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Will I Get Prostate Cancer?

Most likely, if you live long enough. Research shows that around 70 percent of men over seventy have at least some cancerous cells in their prostate; they just might not know it. Most men never experience symptoms, and only 11.6 percent are diagnosed at some point in their life. As far as cancers go, this one isn't bad. It's (usually) slow-growing and can remain untreated for years without posing much risk. A common refrain: More men die with prostate cancer than from it.

I've Heard That I Don't Need to be Concerned About Getting Screened. True?

False. But you're forgiven for thinking so. A history lesson: The introduction of new diagnostic tools in the early nineties allowed for cancers to be caught earlier than ever before. Which itself wasn't a problem; where doctors went astray was in assuming most cases required intervention, and swiftly. "We failed to recognize that there were a lot of cancers we were treating that didn't have the potential to harm the patient," says Samir Taneja, director of the division of urologic oncology and codirector of the Smilow Comprehensive Prostate Cancer Center at NYU Langone Health. **"Doctors were ripping up the lawn to pull out the weeds."**

In response, a team of health experts assembled in 2011 by the Department of Health and Human Services recommended a radical shift: Only men at high risk of prostate cancer and those experiencing symptoms needed to be tested. The decision proved so surprising that it made the front page of *The New York Times,* and

with a headline that did not equivocate: "U. S. Panel Says No to Prostate Test for Healthy Men." Last year, as if just to screw with us, the same panel, using the same data, changed its mind. Its draft recommendation (the official release is expected this year) is not so much an about-face as it is a back- pedal: **All men between the ages of fifty-five and sixty-nine should make an informed decision about whether to be screened.** Many urologists believe such considerations should begin at fifty, and forty for men at high risk.

Who's Most At Risk?

Those who...

. . . have a family history. If your father or brother has had it, you're more than two times as likely to have it as the average guy.

. . . are African-American. Black men are 60 percent more likely to develop prostate cancer than other ethnicities; they are diagnosed at a younger age and with more aggressive tumors; and their mortality rate from the disease is 2.4 times higher. (It's unknown why this is so.)

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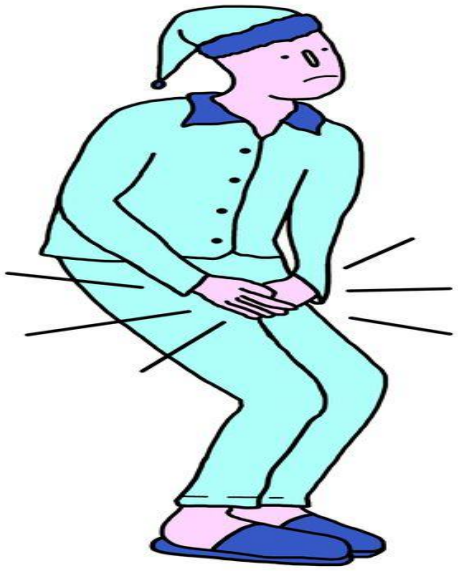
. . . have mutations in any number of genes, including the two linked to breast cancer, BRCA1 and BRCA2. (This appears to be the cause of very few cases.)

. . . are over the hill. Ninety percent of diagnoses are in men fifty-five and above, and your chances of getting it steadily increase with age.

Is There Anything I Can Do to Improve My Chances?

There's no magic bullet. Eat a heart-healthy diet—low-fat, plant-heavy, balanced. Maintain a healthy weight. Exercise. Don't smoke.



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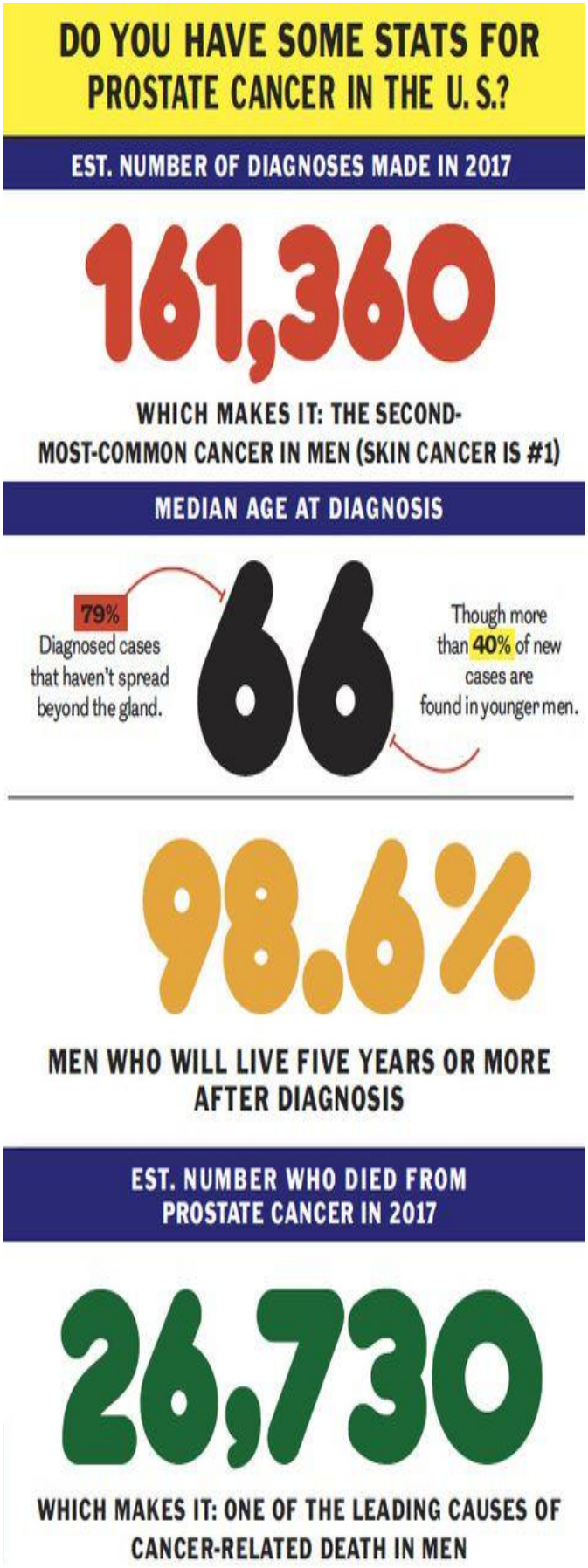
What Symptoms Should I Look Out For?

Mostly Pee-Related: Your bathroom breaks become more frequent; or your stream is weak; or you strain to push it out; or you feel like you haven't fully emptied the tank; or you wake up in the middle of the night more often than usual.

But just because you woke up four times instead of three to take a leak, that doesn't mean you have cancer. Our prostate enlarges as we age, which can lead to a condition with similar symptoms known as benign prostatic hyperplasia. Or maybe you had one too many negronis last night.



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Why Don't I Know Any of This?

You're not alone in **ignoring your own well-being.** According to a recent Cleveland Clinic survey, one-fifth of American men said they only see a doctor when prompted by their significant other, and 7 percent never go to the doctor, no matter how sick they become.

Do I really Need a Finger Stuck Up My Keister?

AFRAID SO. Despite thirty years of groundbreaking medical advancements, the digital rectal exam (DRE) is still a valuable way for your doctor to take a quick-and-dirty assessment of your prostate. They're looking for a spot that's firmer than the tissue around it, sort of like finding a rock in dirt. The test is crude, and a negative result doesn't rule out cancer. But if your doc feels a suspicious bump, the need for further inquiry shoots up exponentially. Some cold, lubricated comfort: The exam takes just ten seconds.

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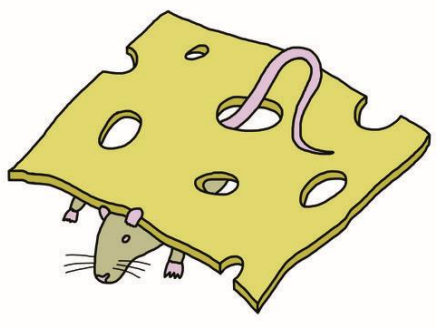
What's This PSA Blood Test I Keep Hearing About?

Prostate-specific antigen (PSA) is a slippery protein that, true to its name, is produced in the prostate. It's also a biomarker: a measurable medical sign that indicates something about your health. The amount of PSA in your blood is like a litmus test for how the gland is doing. (Anything above 2.5 ng/mL is worth further testing.)

My PSA is High! Does That Mean I Have Cancer? Holy Shit Holy Shit Holy Shi...

Calm down. It's way too early to make that call. There was a time when a high PSA was a one-way ride on the road to biopsy, surgery, or radiation, and finally, to add insult to injury, flaccidity. But it's now understood that the PSA is far from a perfect test. "PSA is specific to prostate diseases but not specific to prostate cancer," says Eric Klein, chairman of the Glickman Urological and Kidney Institute at the Cleveland Clinic. "So it has many false-positive results"—meaning a high PSA score in a guy without cancer, which occurs in a whopping 75 percent of cases. More troubling, some studies have put the rate of false negatives—a low PSA score in a guy with cancer—at 20 percent. And the same guy getting the same test three times in the same week might show three different results. Get retested.



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My PSA is S*till* High. What's Next?

Historically, a biopsy of twelve tissue samples. Though this is the only way to confirm prostate cancer, it's not airtight; after all, you're sampling less than 1 percent of the prostate. Why not do another? Because biopsies are like a **Swiss-cheesing of the gland**. Blood may appear in your stool, urine, and ejaculate for a few days or more; infection is common. What's needed: more nuanced assessments.

What New Technologies Have Improved Screening?

I. A Better Biomarker

Because a high PSA score isn't specific to prostate cancer, the race is on to identify scores that are. New biomarker tests come out all the time, with acronyms that sound less like medical terms than programming languages—PHI, 4Kscore, SelectMDx, TMPRSS. Some analyze urine while others analyze blood. They each measure something different, but **their objective is the same: refining the assessment of whether a guy has cancer or is likely to get it.** (Certain genetic tests have the added benefit of helping predict his family members' susceptibility.) It should be noted that the FDA requirements for such lab tests aren't nearly as rigorous as those for new drugs, so be sure to ask your doctor about whether a test is widely accepted or if you're the guinea pig.

II. A Prostate Pic

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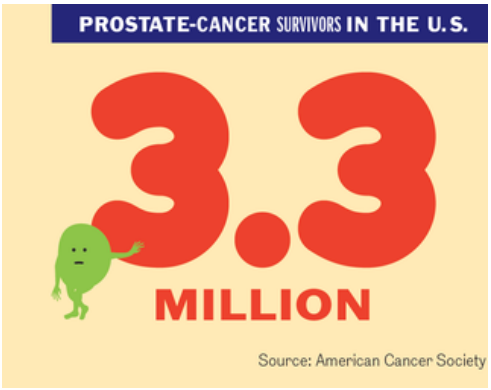
You've probably heard of magnetic-resonance imaging (MRI). **Think of it as a high-tech Live Photo of your organs' inner workings.** New types of MRI have allowed doctors to view the prostate like never before. Taneja, a pioneer of the technique, has built his clinical practice at NYU around its use. "Tumors we see with MRI tend to be higher-grade, meaning more aggressive, larger in volume, and more often associated with bad clinical

outcomes," he says. **"Imaging allows us to selectively identify cancers that we want to treat and avoid detecting cancers we don't want to find."** In other words, it helps mitigate the over- diagnosis and overtreatment of low-grade tumors—the same issue health experts tried to resolve in their 2011 recommendation—effectively **reducing the number of biopsies by as much as 28 percent.** Further, if tissue sampling is required, MRI can be used to help guide the procedure, thereby improving accuracy. All this, and without abandoning screening for all healthy men.

MRI has its limitations: The machines are expensive and not as available as, say, a urologist's pointer finger. Insurance companies don't like covering scans for men who haven't yet been biopsied. The scan needs to be read by a radiologist with extensive training. Plus, imaging isn't foolproof, and a false negative for high-grade cancer, however unlikely, is possible. Remember, MRI isn't a replacement for the old ways of screening and treatment, but a refinement.



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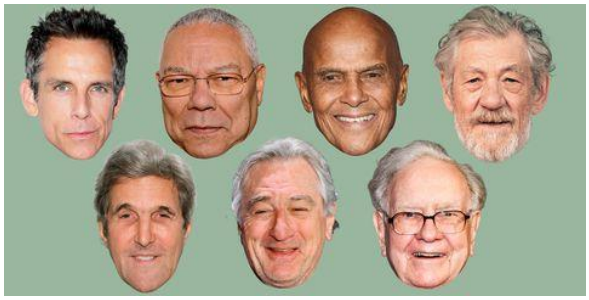
It's Official: I Have Prostate Cancer. Whose Company Am I In?

Men who've been diagnosed with and treated for prostate cancer include: Ben Stiller, Colin Powell, Harry Belafonte, Ian McKellen, John Kerry, Robert De Niro, Warren Buffett, and Robert Mueller.



THAT Robert Mueller?

Yup. In fact, in 2001, he had surgery on the very same day the Senate unanimously confirmed him as the next director of the FBI. Most patients take up to four weeks to recover. Mueller, who was then fifty-six, was back at work in four days.

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What Advice Can the Doc Who Treated Robert—Can I Call Him Robert?—Impart?

Peter Carroll, chair of the department of urology at the University of California, San Francisco, who performed Mueller's surgery, provides these tips to all of his patients, not just FBI directors. (And it's Mr. Mueller to you.)

- Get a second opinion.
- Seek out experienced providers, especially those who are part of multidisciplinary teams.
- Form a "support" team of friends and loved ones (or join an actual support group).
- Don't rush treatment.

But I Should Still Get Treated, Right? Cancer is Cancer.

Not necessarily. The decision hinges on how nasty the tumor might be. “When men are newly diagnosed with prostate cancer,” says David Penson, chair of the department of urologic surgery at Vanderbilt University Medical Center, “the most important thing they can do is work with their physicians to figure out whether the cancer is aggressive or slow-growing.”

To determine your risk profile, a urologist looks at a few facets of the tumor, calculated through a combination of imaging and biopsy. The first is its aggressiveness, most commonly measured on a scale known as the Gleason grading system. The second is its stage, measured on the TNM system, which uses similar data to ascertain where the tumor resides in the prostate (T), if it’s spread to nearby lymph nodes (N), and if it has metastasized to other parts of the body (M).

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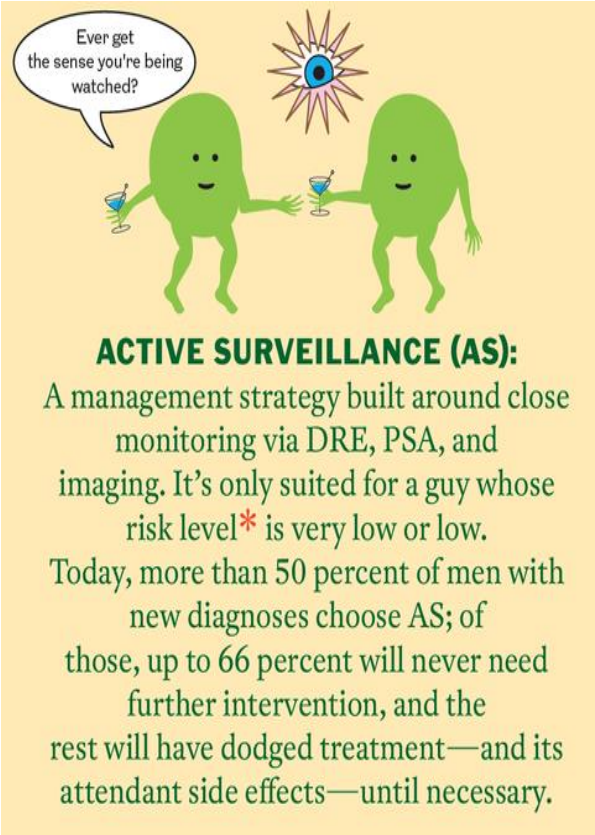
A high Gleason grade and/or advanced stage grouping correlate with a strong chance that the cancer has or will spread. The most likely path forward involves the most severe interventions, such as chemotherapy and hormone therapy. (Because of the complexity of these treatments, we won’t address them here.)

If you have a localized tumor, your treatment options are plentiful, and your chances of a positive outcome are high. To best guide you, your doctor will take into account additional factors such as your age, overall health, and willingness to risk the side effects of a given treatment. Each option will cause collateral damage, and you have to decide where to hedge your bets.

What Are My Treatment Options?



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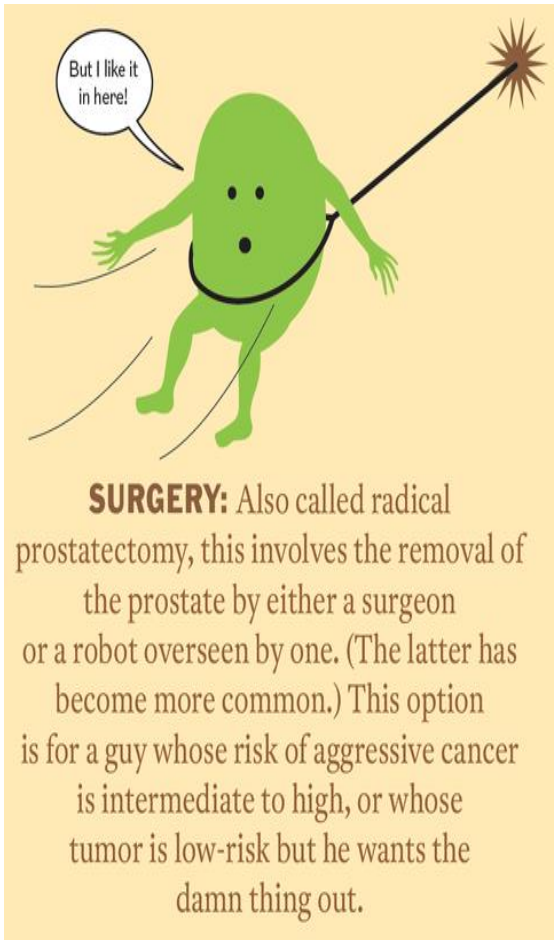
** Using a simplified version of the risk-stratification system developed by the National Comprehensive Cancer Network. For more, go to nccn.org.*



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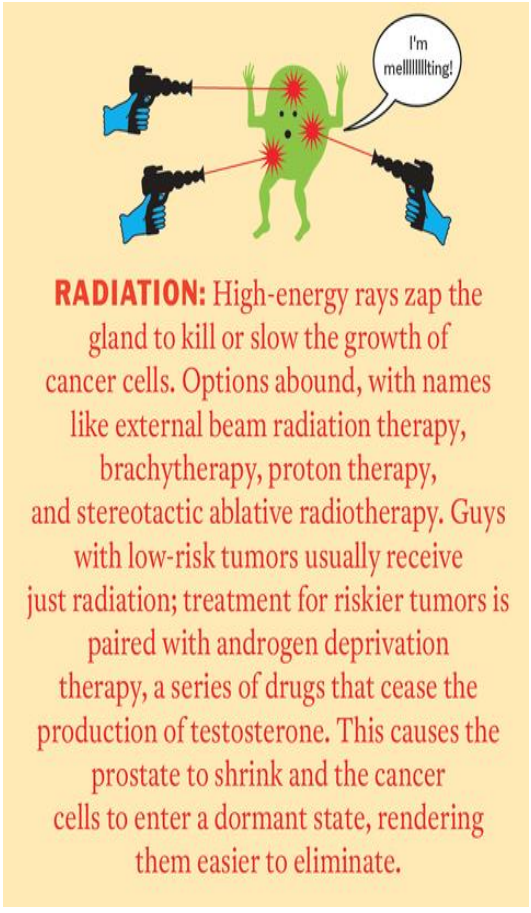

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If I'm Treated, Will I Ever Get an Erection Again?

Perhaps. Though the common side effects of both surgery and radiation—incontinence and erectile dysfunction—last for weeks or even months, they are often temporary or fixable. Most men will experience both; their severity is dictated by, among other things, the stage the cancer is in and the intensity of the treatment. Active surveillance—in essence, watching and waiting—carries risks, too. There's a chance a tumor can grow or spread in unexpected ways. The upshot: Know the risks of each treatment before you choose.

I Want to Know More. What Should I Google?

Trust the Internet at your own peril, and not just because of shoddy intel. Take the new treatment approach known as focal therapy. The idea—targeting the tumor, not the whole prostate—is compelling, and the data is promising. But while many believe this is the next treatment frontier, we're years away from it becoming a standard of care. Unless your doc is at a major research hospital, don't assume it'll be an option. For reliable and up-to-date information, visit reputable sources, starting with the National Cancer Institute, the Urology Care Foundation, and the American Cancer Society.