# Prostate Cancer Discussion for VCH Family and Community Practice Rounds
# Jan 7, 2026

- 3/3 Session- Following 2 Sessions by Dr. Gleave
- Patient Perspectives & Questions: Chris Rauscher (No Disclosures)
- Patient Support- Prostate Cancer Supportive Care Program: Monita Sundar
- Group Discussion- What Does This Mean For Your Patients and Practice?: Led by Judith Hammond

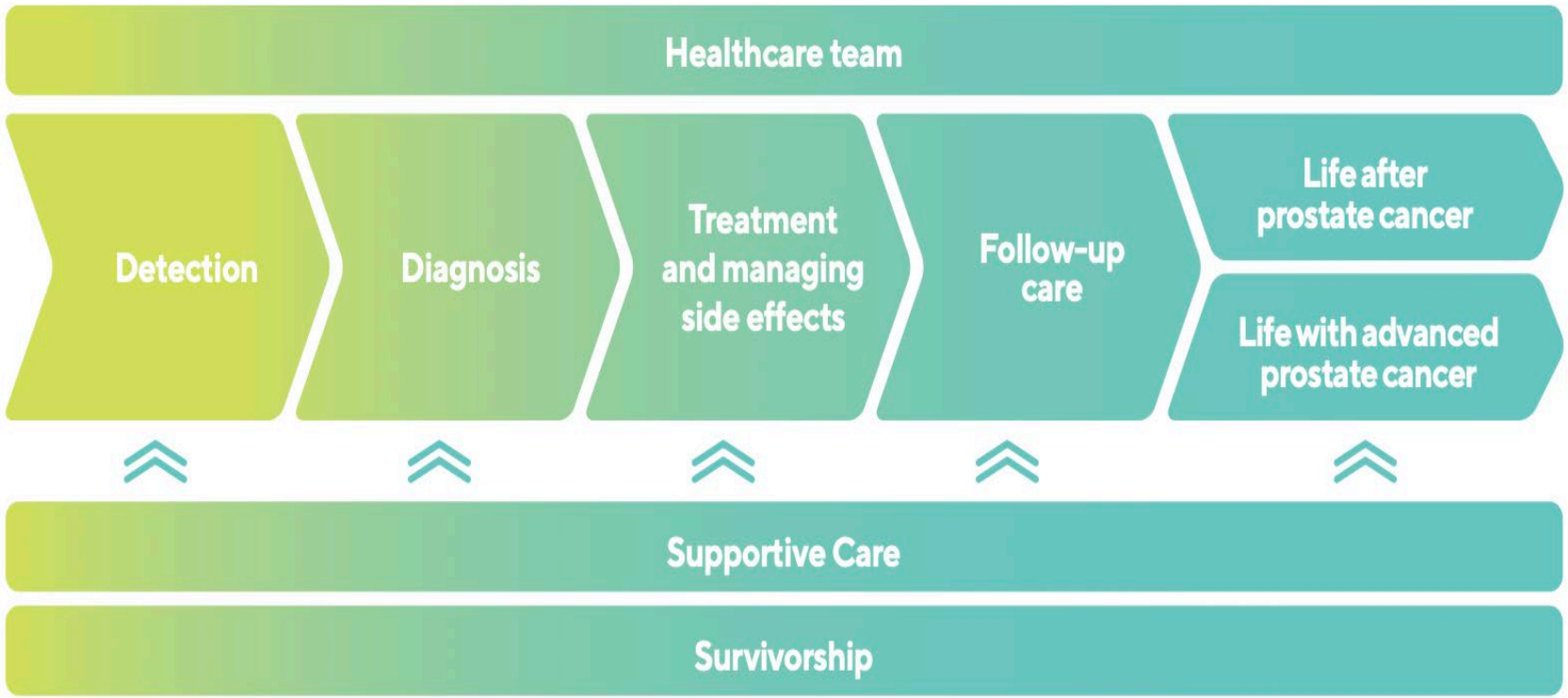
# Supporting the Patient's Prostate Cancer Journey- A Patient Perspective- Objectives

- Build upon your understanding of patients' needs across the patient journey
- You will better understand key supports that are available for prostate cancer patients
- The group will strategize how to best support patients

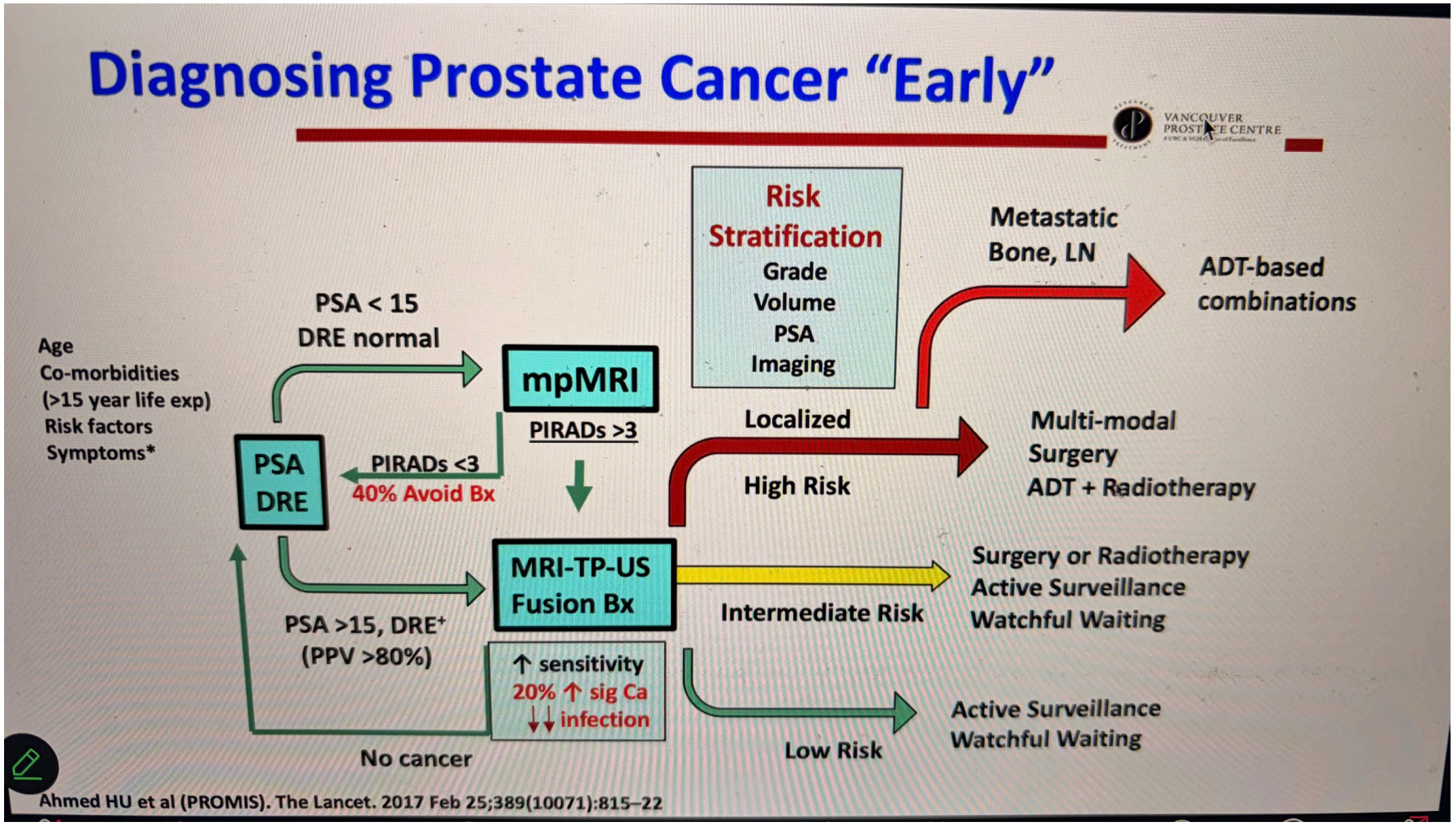
# Patient Perspectives Come From:

- Personal perspective
- Support group participant perspectives
- Various websites and videos

## Your prostate cancer experience



# Diagnosing Prostate Cancer "Early"




Ahmed HU et al (PROMIS). The Lancet. 2017 Feb 25;389(10071):815–22

# You don’t have to answer every question

- Deal with the initial stress: prostate cancer is usually slow growing so you have time to make decisions (+ epidemiology)

- Direct to best information sources for patients:
  - Canadian Cancer Society- well described, somewhat clinical
  - Prostate Cancer Support Care Program (in the Diamond Centre)
  - Prostate Cancer Foundation Canada: *Vancouver Prostate Cancer Support Group*
  - (Prostate Cancer Research Institute- US, videos break out by Gleason score, can ask questions directly and responses from trained patients)

# FAMILY PRACTICE ONCOLOGY NETWORK- BC Cancer

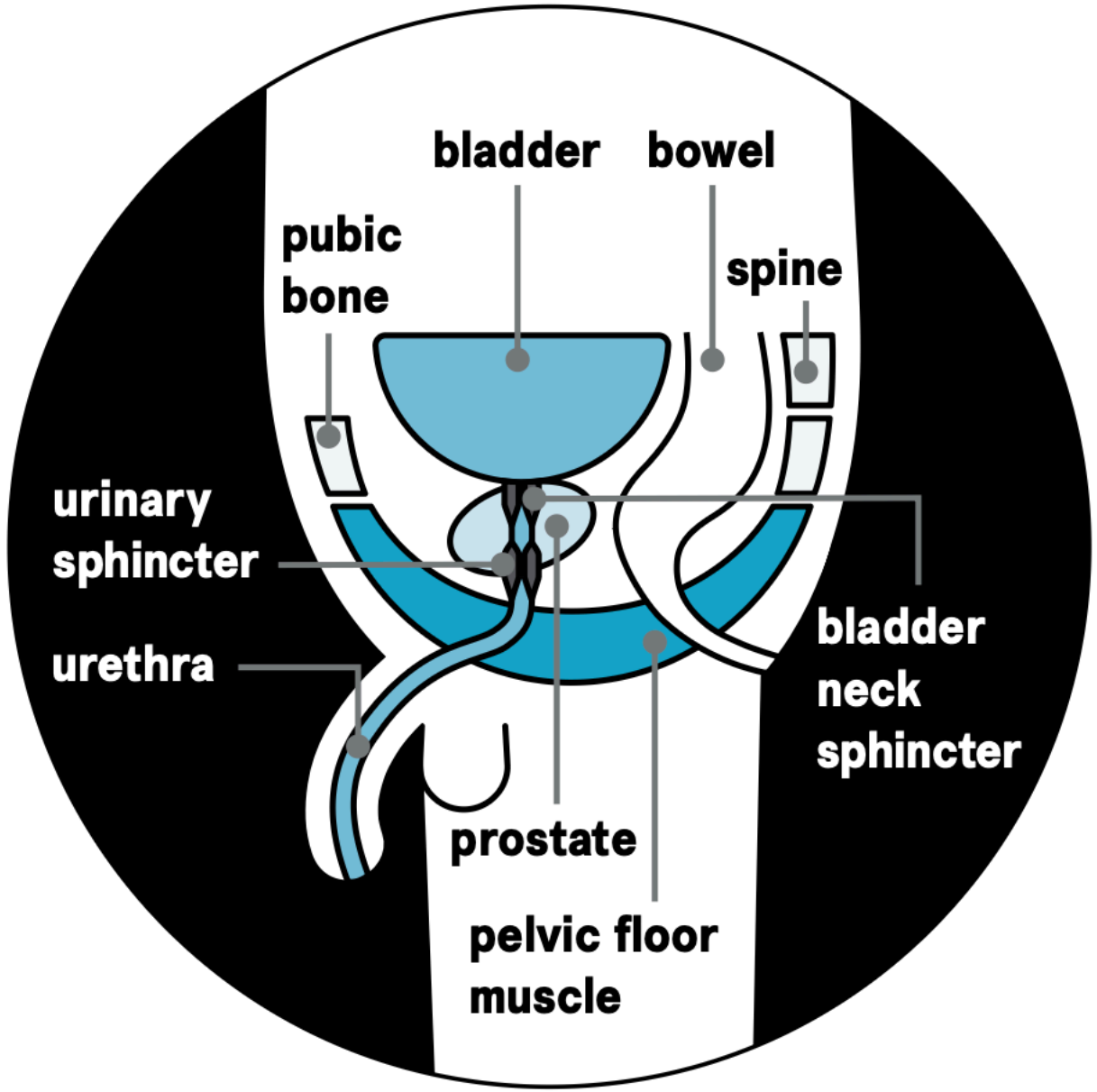
- FP Oncology Network Primary Care Needs Asst- 2018
- Journal of Family Practice Oncology
- Education: Annual Edn Day, Webinars, Modules
- Clinical Resources: Guidelines, Clinical Care Pathways, Supportive Care
  - GPAC Guidelines part 1 (diagnosis and referral) and part 2 (follow up in primary care)

# Shared Decision-Making

- Patients need information leading understanding
- Address questions along the cancer journey
- “TRADEOFFS!!”
- Do specialists outside the Prostate Centre and BC Cancer provide sufficient information and support??
  - E.g. For localized PC, options can include active surveillance, surgery or radiation therapy, often with similar outcomes, so decisions are often patient preferences in relation to anxieties and side effects….

# Prevention-Risk-Screening

- The literature isn't strong on advice for prevention- general health and diet, especially if cancer develops
- Risk: family 1st degree: Genomics: https://www.bccancer.bc.ca/our-services/services/hereditary-cancer
- Screening:
  - "The decision to use PSA testing for the early detection of prostate cancer should be individualized. Patients should be informed of the potential risks as well as the potential benefits of PSA testing." (GPAC)
  - What does my PSA result mean?
  - What is next?


bladder
bowel
pubic bone
spine
urinary sphincter
urethra
bladder neck sphincter
prostate
pelvic floor muscle

# From Screening to Diagnosis

- The Biopsy
  - A fearful prospect
  - Do you address questions or defer to the urologist? Patients often don't feel prepared, especially for pain during and after
- After the Biopsy
  - Patients are anxious to get the result- do they wait until they see the urologist again?
  - If the biopsy is positive for PC, do you rely on the urologist to:
    - Explain what the results mean and next steps?
    - Refer to supportive care services (Prostate Cancer Supportive Care Program)

# RISK GROUPS

| Risk | T stage, Gleason Group, PSA | Treatment options |
|---|---|---|
| Very low | T1c + Grade Group 1 + PSA < 10 + fewer than 3 biopsy cores with ≤ 50% involvement + PSA density < 0.15 | Active surveillance, preferred<br>Prostatectomy or radiation are also options |
| Low | T1-2 + Gleason Group 1 + PSA < 10 | |
| Intermediate | No high or very high-risk features + has one or more intermediate risk factors:<br>T2b-c, Grade Group 2-3, PSA 10-20 | Prostatectomy or radiation<br>Active surveillance |
| High | T3 OR Gleason Group 4 or 5 OR PSA > 20 | Radiation or prostatectomy +/- ADT |
| Very high | T3b-T4 OR primary Gleason 5 OR more than 4 cores with Grade Group 4 or 5 | Prostatectomy or radiation with ADT or ADT alone (not preferred) |

# From Diagnosis to Treatment

- This is confusing time for patients as there appear to be many treatment options for localized PC, although those options may have similar cancer outcomes- it's more about patients understanding the side effect profile of the various options for the particular specialist they will be involved with
- Do the urologists discuss the various options in that context? Do they refer to a radiation oncologist for an opinion on those treatments as an option?
- Patients may hear about new treatments, even robotic techniques, but in reality, such treatments may only be available on an investigation stage at the Vancouver Prostate Centre

| Treatment | Urinary (Continence) | Erections | Bowel | Recovery Time |
|---|---|---|---|---|
| Surgery (Prostate Removal) | Leakage at first, improves in months. Some men need pads long-term (14%). | Often affected. Nerve-sparing may help, meds/devices often needed | Rarely affected. | Hospital stay 1–2 days. Catheter ~1 week. Back to work 4–6 weeks. |
| External Beam Radiation | Less leakage than surgery. May cause urgency/frequency. need pads long-term (5%). | Gradual decline over months–years | May irritate rectum (loose stools, urgency).<br>10 year study- 8% bleeding/urgency | Daily treatments for weeks. Energy improves in weeks after. |
| Brachytherapy (Seed Implants) | Irritation early (urgency/frequency). Leakage uncommon | Some effect, usually milder than surgery/radiation. | Rectal irritation possible, usually mild. | Outpatient or short stay. Back to normal in days–1 week. |
| Focal Therapy (HIFU, Cryo, IRE) | Mild urinary issues. Low risk of long-term leakage. | Often better preservation than other treatments | Minimal bowel side effects. | Quick recovery (days–1 week). Less long-term data. |

# Sexual Experience of MSM with PC

- Loss of role-in-sex identity, confidence, relationships, being single
- Libido;  difficulty  reaching orgasm
- Loss of the prostate +/- seminal vesicles
  - Prostate as source of sexual pleasure
  - Sources of fluid for semen- ‘anejaculation’ with ‘dry’ orgasms, semen as part of the sexual experience
- Penis
  - Shrinkage (+ testicles), especially with ADT
  - Not getting erection or penis not hard enough for penetration
- Receptive issues, above plus
  - ‘Anodyspareunia’/pain, irritation, bleeding
- ‘Climacturia’- urinary incontinence during sex

# Follow-up in Primary Care

- GPAC guideline- Part 2

- Survivorship: “the link between treatment and recovery, and a key point of continuity of care bridging the connections between the patient, BC Cancer, and the patient’s primary care team”

- Surveillance for recurrence:
  - Side effects/symptom table
  - PSA Profile Indicating Possible Recurrent Disease-Biochem recurrence

- Palliative Care and Advance Care Planning

# NEW- PROTOTYPING AN AI NAVIGATOR

# Prostate Cancer Supportive Care Program:

Monita Sundar

# Group Discussion

From FB Newly Diagnosed PC site:

“I have a question about how involved my Primary Care Physician should be in my cancer care?”

“You should be consulting specialists (urologic surgeon, radiation oncologist, other oncologists) who deal a lot with prostate cancer patients.

Your PCP has access to tests results, including labs and scans,

biopsy results and consult notes but the specialists give advice related to your cancer, including treatment options.”

# GROUP DISCUSSION

- What is your approach to screening? What do you do if the PSA is increased?
- Do you stay involved once a referral is made to urology for biopsy? How?
- Do you support your patients through their cancer journey?:
  - Treatment side effects
  - Co-morbidities mgt
  - Post-treatment- recurrence monitoring, survivorship end-of-life??
- How do you see you could involve the Prostate Cancer Supportive Care Program to support your patients?

# FINAL QUESTIONS??