Bridge to Survivorship: A Conversation with Brittany Sabo and Dr. Thomas Jaffe

Lauren Hixenbaugh (00:02):

Welcome to Living Beyond Cancer. This is a series of podcasts created for cancer patients, survivors, and their caregivers. Hi, I'm Lauren Hixenbaugh, a program manager for mobile cancer screening at the WVU Cancer Institute's Cancer Prevention and Control and I am one of the hosts for today's episodes, and I'd like to introduce my co-host, Andi Hasley.

Andi Hasley (00:24):

Welcome, everyone. I'm Andi. In addition to being the Mountains of Hope coalition manager, I'm a breast cancer survivor myself. Living Beyond Cancer is sponsored by the West Virginia Cancer Coalition Mountains of Hope and is produced by WVU Cancer Institute's Cancer Prevention and Control and we are thrilled to share today's episode with our listeners.

Lauren Hixenbaugh (00:44):

Thanks, Andi. I'd also like to introduce our speakers, Brittany Sabo and Dr. Thomas Jaffe. Thank you both so much for being here today. Could you tell us a little bit about yourselves?

Brittany Sabo (00:57):

Yeah. I'm Brittany Sabo. I've been a nurse practitioner for about eight years. I've been with WVU for the past three years. The full eight years that I've been a nurse practitioner I have been solely focused on urology care. I specifically do a lot of the general urology complaints, male and female, and I've worked most of my time with Dr. Jaffe and have had the pleasure of working with him for the past three years.

Dr. Thomas Jaffe (01:27):

Pleasure. My name's Tom Jaffe. I am a urologist. I've been in practice for 26 years and in addition to training in urology, I did a fellowship and what's called male reproductive medicine and surgery which is in part erectile dysfunction so something I've been concentrating on for my entire career.

Andi Hasley (01:49):

Thank you so much for being with us today and especially for sharing your expertise in this topic. We don't often get a lot of open questions when it comes to the nature of urology and the challenges associated with it so as we get started, could you tell our listeners just in general what you mean when you say urology?

Dr. Thomas Jaffe (02:13):

Well, urology is basically anything involved in the urinary tract. That can be kidneys, it can be your bladder, it can be urinary tract infections, it could be kidney stones. Part of which is also

male sexual dysfunction, such as erectile dysfunction in particular. And there are some other diseases of the genitals that we address as well. But basically, that's kind of it, urination issues with men, difficulty voiding, bladder stones, just anything involved in the urinary tract that's surgical, but we take care of. There are people who have problems with their kidneys from high blood pressure, diabetes. Nephrology doctors take care of that.

Lauren Hixenbaugh (03:03):

Great. Thanks for sharing that with us. So what are some of the procedures that you all commonly do?

Brittany Sabo (03:10):

So some of the urology procedures that we do, we do for prostate procedures, we do what's called a TURP or a transurethral resection of the prostate. We do green light laser, which is a way to reduce the size of the prostate to help men urinate more efficiently. We do kidney stone removal surgeries. There is lithotripsy, which is where we can break up that stone. We also do vasectomies, which for men that do not want to have any more children we do offer vasectomies. Some of the urological cancer procedures that we do are called radical cystectomy and a cystectomy is where we actually remove the bladder and we actually remove the prostate at the same time. And one of the reasons that we do this procedure is for patients that are diagnosed with bladder cancer. Another procedure that we do for an oncology side of things, and oncology means a cancerous source would be what's called a radical prostatectomy, which is where we remove that prostate.

Brittany Sabo (04:18):

And the reason that we do remove the prostate is due to prostate cancer inside of that prostate. Another type of treatment that we do for urological cancers is external beam radiation, and the radiation that is given targets the prostate, and the main focus of that radiation is to shrink or get rid of the cancer inside of the prostate. Another way that we can get rid of cancer is to do what's called radioactive seed implants. And those seeds are placed within the prostate itself and the goal is to get rid of the prostate cancer or shrink it or eliminate that cancer. Those are just some of the procedures that we do see often in clinic.

Andi Hasley (05:04):

So one of the challenges of course with neurological cancer, we heard you mention prostate a lot and the majority of this podcast of course is going to be focused on the challenges with that and the big challenge that we always hear about from people that have been affected by prostate cancer in their life is erectile dysfunction. So could you give a little bit of information as to why that might happen and even maybe speak about how a patient is diagnosed before we get into-

Lauren Hixenbaugh (05:40):

And how patients end up in your care.

Brittany Sabo (05:44):

In general, that's a very broad topic because I mean, they can come to us for a kidney stone and we do a PFA and find out they have prostate cancer. There's a thousand avenues that we could go down, but specifically, they get referred from the urology oncology team to Dr. Jaffe and myself for ED, erectile dysfunction.

Andi Hasley (06:01):

So what causes a man to get erectile dysfunction?

Brittany Sabo (06:06):

To understand this we must first understand what allows a man to achieve an erection. There are two nerves that supply the penis nitric oxide. The nerves are located at the five and seven o'clock position of the prostate. Nitric oxide causes smooth muscles to relax, which allows blood to enter the corpora cavernosum. The corpora cavernosa are hollow sponge-like tubes that form most of the shaft of the penis and they contain blood vessels. These blood vessels fill with blood that help a man to achieve an erection. When erectile dysfunction occurs it is due to the damage of the nerves and therefore nitric oxide cannot be supplied and smooth muscles do not relax so blood cannot enter the corpora cavernosum, therefore, no erection can occur.

Andi Hasley (06:54):

As you mentioned before, after a person sees their oncologist and then they have these symptoms of erectile dysfunction they're then referred to your office. This may sound like a crazy question, but before they end up in your office post-procedure, are they given specific symptoms or conditions to look for, things to be aware of, or is this something that is post-procedure is like, oh, this is happening or this isn't happening and then that's what happens next.

Dr. Thomas Jaffe (07:33):

Yeah. So usually we're referred patients from mainly the urology cancer surgeons, the one who removed the prostate or removed the bladder and prostate together. When those procedures are done they try to what we call spare or leave alone those nerves that Brittany was talking about. If you think of the prostate like an apple, at five and seven o'clock of that apple are these two big nerves, if they're damaged everything downstream from those nerves also don't work. So what the big revelation and prostate cancer surgery was, and this was a number of years ago, was the ability to identify where the nerves were. Again, these erection nerves and kind of push them out of the way while the prostate was being removed so they were still present and functioning. So in regard to cancer surgery when you remove the bladder you have to take out the prostate because they're kind of together.

Dr. Thomas Jaffe (08:38):

And when you take out the prostate, obviously you're talking about the nerves. That's where you have to be careful. That's where you have to go to prostate cancer surgeons who really do a lot of this type of surgery so they know where the nerves are. They know how to push them away. They know how to stay out of them. So when we see a patient it's mainly from those guys, the guys who do urology cancer surgery, but we can also see them from primary care doctors and

they might have had prostate cancer surgery somewhere else outside of our system and they end up with erectile dysfunction and then we see them or they might be, have nothing to do with cancer and they have diabetes, high blood pressure, those types of diseases that cause erectile dysfunction or are a symptom of erectile dysfunction or symptom of those particular diseases.

Dr. Thomas Jaffe (09:32):

So if you're looking specifically at cancer, generally what happens is more often than not patients just come in with having no treatment. Now normally depending on what you believe, after prostate cancer surgery or bladder and prostate surgery where the nerves are impacted in some way it can take up to anywhere between a year or two before you see spontaneous return of erections, meaning that you can just get an erection without any medications or anything else. Now, there are studies that have been done where people who have those types of surgeries will be given medication either Viagra or Cialis on a relatively routine basis, weekly, and over the course of three to six months. The hope is that it will improve the health of the penis and I'll explain that in a second and resolve their erectile dysfunction or at least improve the health of the erectile tissue so when they get to us we can do things that are less invasive to help someone get an erection.

Dr. Thomas Jaffe (10:46):

So specifically what these pills do that you hear about Viagra, Levitra, and Cialis, they are smooth muscle relaxants. So what does that mean? What your penis, the erection tissue in the penis is made up a smooth muscle, and the difference between smooth muscle and skeletal muscle, skeletal muscles like your bicep so you control it. You can do whatever you want with it, but with smooth muscle, your body controls it due to signals, be it hormones, whatever it might be. So the erection tissues in the penis respond to nitric oxide like Brittany was talking about. So when a patient, so when before intercourse patient stimulated those nerves release nitric oxide, and when nitric oxide gets to the smooth muscle or the erection tubes of the penis that's when those tubes dilate.

Dr. Thomas Jaffe (11:41):

So the theory is, if you give somebody who's had prostate cancer surgery, you might have some damage to the nerves, you want to keep the nerves well oxygenated and the tissue well oxygenated, you give this medication Viagra or Cialis mainly and that dilates the blood vessels, the corpora cavernosum erection tube so more oxygen gets to the tissue and the hope is that you'll improve the health of the penis. So that usually is tried for about three to six months to see what happens. And obviously, if it's successful we don't see the patient. If it's not successful we do see the patient. So the whole idea again is just trying to get oxygen to the tissue and just improve the overall general health and blood supply of the penis in the hopes that the erectile dysfunction that results from a procedure is less severe.

Lauren Hixenbaugh (12:41):

So you've kind of talked about that. It's not just cancer or it's not just prostate cancer or bladder cancer that causes erectile dysfunction. There's some other things that could cause it and I

wondered if you wanted to mention what those were just for maybe other people listening that have went through the erectile dysfunction before we kind of talk about the treatment of it.

Dr. Thomas Jaffe (13:03):

Well, it's an important question regardless because a lot of people who have prostate cancer surgery also have these other problems, right.

Lauren Hixenbaugh (13:12):

Okay.

Dr. Thomas Jaffe (13:12):

And so they might go into the prostate cancer surgery with erectile dysfunction or some degree of it. The most common things we see are diabetes and high blood pressure and those would be the two major medical problems that we see.

Brittany Sabo (13:27):

Obesity and smoking is also very prevalent in the state of West Virginia as well.

Dr. Thomas Jaffe (13:32):

Smoking's the worst.

Brittany Sabo (13:33):

Yes.

Dr. Thomas Jaffe (13:34):

That is probably the number one cause of erectile dysfunction, but the bottom line, like you add all those things together the state is filled with patients who had the potential to have a erectile dysfunction based on those things, bad habits, and or medical problems.

Andi Hasley (13:52):

I feel like the world needs to get that information out more, that smoking is a cause of erectile dysfunction.

Dr. Thomas Jaffe (13:58):

That's the only way you can get people to stop smoking in this office, to be honest.

Andi Hasley (14:01):

Absolutely.

Dr. Thomas Jaffe (14:03):

You can tell them they're going to die from bladder or kidney cancer they don't care about that at all. As soon as you tell them you can't have an erection the cigarettes are gone like that second.

Andi Hasley (14:12):

Well, sure. I mean, it's important. It's an important part of our lives as humans and it's a part that people enjoy and value. So I would imagine it is a huge incentive for people to eliminate that habit.

Lauren Hixenbaugh (14:25):

Well, and I was also thinking many of these things that you're talking about, smoking history, obesity, hypertension are all also contributors to cancer, many different types of cancer.

Dr. Thomas Jaffe (14:37):

Yeah. For urological cancer, smoking is important for certain types of kidney cancer and bladder cancer, mainly so and if you look at the number one cause of those cancers, that's what it is, smoking tobacco. Number one through a hundred. I mean there are other reasons that are kind of less common nowadays, but smoking is really the reason why most of these cancers occur, not prostate cancer, but certain kidney cancers and bladder cancer.

Andi Hasley (15:09):

You spoke a little bit about treatment options, specifically medications. How do you determine what treatment option would be best for the patient that you see?

Brittany Sabo (15:19):

So typically we start off patients, like Dr. Jaffe had talked about, specifically after having their prostate removed and or bladder removed they do that trial period of that three to six months with any of the oral medications, such as Viagra or Cialis. We typically get the patients after they've already done what's called penile rehab therapy and that's where they are on, three to five days a week of one of the medications. Some patients, depending on if they did have a nerve-sparing procedure, they may have better success with these medications. If they weren't able to have the nerve-sparing procedure they may not be as responsive to this medication. If the medications are not working for the patient we do have what's called a vacuum erection device. This can be used in addition to the oral medications and this is an external device that is placed on over top of the penis which creates a suction to the base of the pubic area.

Brittany Sabo (16:23):

And there's a pump that will pull essentially the blood into the penis to create an erection and there's an elastic band that is placed at the base of the penis to allow that blood flow to stay within the penis to allow a man to have sexual intercourse. If those two options do not work for the patients, meaning the medication and the vacuum erection device, the third option would be

what's called intracavernosal injections and this is where we actually inject medication into the patient's penis directly. The medications are called Trimix or [inaudible 00:17:03]. We do a demonstration here inside of our office with one of the other nurse practitioners. We will have the patient actually demonstrate to us that they're able to draw up the medication and inject that medication into their penis. They do a self-demonstration. This injection is injected into the base of the penis so it's where there's less nerves.

Brittany Sabo (17:26):

Patients do tolerate this procedure very well and the benefit to this injection is it's about an 85% success rate in achieving an erection with this medication. Some side effects with the medication is there's minimal bleeding and bruising and what's really good about it is they usually do get an erection within 15 to 20 minutes. So it is relatively quick after you do inject yourself that you can have sexual intimacy at that time. If that option either is not well perceived by some patients, because it is an injection, we do use a very small needle though, the next option would be what's called an inflatable penal prosthesis, which I will let Dr. Jaffe go into detail about because that's what he does specialize in.

Dr. Thomas Jaffe (18:13):

So what Brittany says is a hundred percent the truth. We try not to do an implant. That's kind of the last stop on the train and there are a number of reasons we'll get into. One of the things that we can do sometimes is combined therapy so if you take one of the erection pills like Viagra and you're 85% there and don't want to do injection therapy, certainly don't want to do an implant, you can add to that the vacuum erection device so you can do both together and you can do that also with the injection therapy. So basically we can kind of combine stuff to get patients to where they want to be, as it relates to the quality of their erections. If you look at injection therapy, just to go back with that, it's delivered with a diabetes-type needle so it's a very small needle.

Dr. Thomas Jaffe (19:03):

And as Brittany said it's the base of the penis so where it actually leaves the body. So there's very little discomfort with the injections and they're basically used when you want to have intercourse right then and there. And you can use it three days in a week and once on the day that you use it. Now it's filled with medications that are smooth muscle relaxers and those smooth muscle relaxers don't depend on the nitric oxide or nerves. So for example, if you have a patient who has diabetes and patients with diabetes have basically horrible nerves so they barely release nitric oxide and sometimes their erection tissue is not very good either so you need to bypass the normal pathway to get an erection, meaning stimulation, nerves releasing the nitric oxide need to bypass that system because it's just not working well and that's what do the injections do.

Dr. Thomas Jaffe (19:57):

So imagine if you have diabetes and or prostate cancer surgery, and the nerves are not allowing release of nitric oxide, these pills are likely not going to work and even if you spare the nerves, one nerve 25 to 50% will respond to medications, two nerves 50 to 75%. So it's not a hundred percent guarantee that if the nerves are spared that you're going to have normal erections, at least erections without some type of intervention. The point being is you have to really evaluate

everything that's going on with the patient, what they were like before and what they were like after the procedure, if they were completely normal, they were diabetic and had erectile dysfunction, hypertension all the way you think about how to get patients back to where they want to be. That's, everybody's kind of put in different categories in regard to how we can treat them.

Dr. Thomas Jaffe (20:52):

We always start out noninvasive but depending on what their comorbidities are, meaning what problems they had going in, how many nerves they had spared during the surgery, that kind of portents what will end up happening in the long run. Now if they do get to the point where they have implant surgery there're basically two types of implants. But the point is this, implant surgery basically means that we with a device, which is all internal, nothing can be seen, it mimics your ability to have an erection. What I mean is basically this machine allows your erection tubes to dilate so you get length and girth of an erection like you normally would and that's the advantage of it is basically you can have intercourse whenever you want, and there are no medications involved. So the point is, is that everything that we do somehow either causes the normal pathway of erections to get better, like the pills increasing the nitric oxide, the injections allowing the smooth muscle in the penis to relax.

Dr. Thomas Jaffe (22:16):

What the implants do is the body has not been able to respond to anything else we've tried so we have to get those erection tubes to dilate somehow to cause an erection and so that's what implants do. The inflatable implants do it with a little pump that we put in the scrotal sac that when you squeeze it it draws fluid into these what we call cylinders. The cylinders are the tubes that we place on either side of the penis into the erection tubes, that when fluid gets into those tubes they dilate just like a normal erection. If you look at the other types of implants we typically put in, one's called a semi-rigid implant or malleable implant and that's basically a rod which is put in on both sides of the penis in the right erection tube and the left erection tube.

Dr. Thomas Jaffe (23:19):

So the advantage to that is that you don't have to do any pumping or anything like that. The penis always has rigidity to it. So whenever you want to have intercourse, you bend it up. When you don't want to have intercourse, you bend it down. But the other type of implant, the inflatable device, you pump the pump and it draws fluid into those cylinders and you get an erection that way. So it's more natural to have an inflatable implant, but both accomplished the goal, which is to have intercourse. So it's a surgical procedure. It's typically something that the patient has to stay in overnight afterwards for antibiotics. There is obviously some discomfort associated with the procedure. There's a catheter placed in the bladder that wouldn't come out until the next morning. There are medications that have to be taken specifically antibiotics because there's a risk of infection with implant surgery. Give pain medication obviously because there can be significant discomfort with this type of surgery. The main reason we try not to do it is typically with prostate cancer surgery there's slight decrease in the length of the penis.

Dr. Thomas Jaffe (24:33):

Just imagine you're taking out the prostate. Now you have to reconnect the bladder and the urination tube together. So imagine having to sew those two things together, it's going to kind of decrease the length a little bit, right? So when you talk about putting in an implant, the length of the penis with an implant is if a patient gets in front of a mirror and takes his flaccid penis and pulls it, that's how long it would be with an implant. So that's one of the reasons why some people won't go forward with one because it's not your normal erection length. It's flaccid length on stretch. So if they don't like that length, they don't want an implant because once an implant goes in, that's it you're done. Nothing else will work. So it's really kind of last stop on the train and we would do it through an incision, one incision typically right below the pubic bone, which is kind of right above the penis or where the penis and scrotal sac connect either way. But we can get everything in through that one incision. It's certainly very aggressive.

Lauren Hixenbaugh (25:44):

So what is the recovery time for that typically? And then is there any kind of pain associated with this, obviously the surgery, but after that?

Dr. Thomas Jaffe (25:54):

Yeah. So recovery, basically you stay in the hospital overnight. Reason for that is for pain medication and IV antibiotics because again, one of the major risks is infection. Which is pretty rare unless a patient's diabetic, for example, then the risk goes up. But regard recovery in general about a five to seven out of 10 pain-wise, pain usually gets better around seven to 10 days, although some people can be in all lot of discomfort for up to six weeks. They usually have to sponge bath for four days and on day five they can actually take a real shower. When they get out of the hospital there's rarely any swelling, believe it or not, but by the time they get home, there's definitely going to be some and maybe some black and blue.

Dr. Thomas Jaffe (26:41):

Everybody's really different there. It's typically not a lot. Those are just kind of in general terms on average how people are afterward. I mean, honestly, if you spend the time to talk to somebody about what they can expect, most guys really do tolerate it really, really well. I mean we kind of tell them exactly the course of everything that's going to happen, both pre and postoperatively and so their expectation going in is pretty clear. So nothing kind of happens that we haven't already spoken to them about. Now if they know that you have absolutely no pain tolerance this is really not an operation for them.

Lauren Hixenbaugh (27:20):

And you mentioned that this is kind of the last stop. So this procedure would be for life.

Dr. Thomas Jaffe (27:29):

Yes. Now, so that's a good question because the inflatable, so we put these cylinders in each erection tube, the one that you have to pump a pump to get fluid into. There's a pretty significant failure rate with those. So about 25% and seven to 10 years will have some component of that inflatable device not work any longer and they would need to have a replacement of the implant.

That's the only way you can treat that, you can't fix that. The semi-rigid or rods, they last forever. So they never have to be replaced.

Andi Hasley (28:08):

If a patient no longer was interested in this aspect of their life, is this something that they would have removed or would need to have removed or how does, how does that work for the long term?

Dr. Thomas Jaffe (28:19):

That's a good question. It does not have to be removed. The only time you have to remove an implant is if someone's just having a lot of pain from it, discomfort, it just never gets any better for them or it gets infected otherwise there's no reason to ever remove one, because they're sterile and they don't affect urination at all, which I didn't mention before, but they don't affect how someone voids. They don't affect anything really. So it never has to be removed unless again, it doesn't function or, and the patient wants to continue to have intercourse or if they have an infection, which is typically pretty much close to the surgical procedure. So, but otherwise, it can stay in.

Lauren Hixenbaugh (29:03):

So my follow-up question to that would be we're seeing people at younger rates, if they still want to bear children is there something, is there an option that is a better choice? And do you send people to, I don't know, what are the options if people still want to bear children?

Dr. Thomas Jaffe (29:23):

It's really rare that we see anybody who's interested in fertility after these types of surgeries. We do see it, but it's probably less than 5% of what we see for infertility for example. The answer is though they can. What you're removing when you do radical prostatectomy or radical cystoprostatectomy where the bladder and prostate are both removed is basically the mechanism for delivery of sperm. So basically the vas deferens is removed. The seminal vesicles are removed. So sperm move from the testicle into epididymis, which are the tubes behind the testicle then into the vas, then into the seminal vesical, and out through the prostate. So all that's gone. So you're still making sperm. The way you would have a child would be in vitro fertilization basically. You can actually remove sperm from the testicular tissue itself or get sperm from epididymis again, which is like a reservoir for sperm because that's where the sperm moves into once it's matured from the testicle. So you'd have to do in vitro fertilization, but you can do it.

Andi Hasley (30:31):

That's really interesting and it goes along with what I was going to ask next too, throughout this, the whole conversation that you've had with the implants and fertility and your options you kept saying the phrase with whatever outcome the patient desires. So how does it affect their overall well-being? Do you see their choices driven more toward the relationships that they're in? Maybe

just share a little bit about what, how you navigate the patients. I would imagine broad variances and what their end game would be.

Dr. Thomas Jaffe (31:13):

Yeah, it's kind of, it's so variable from person to person. So some people, let's say someone had severe diabetes and they weren't having erections prior to going into the surgery. They might have no interest at all in trying to get that part of their life back. They might be single and have no interest in having relationship after. They didn't have real interest before or after. It could be that they're kind of on the fence about it, depending on what you can do for them, they'll either go forward or not. Everybody's so different. It's so hard to say. I think Brittany would agree with me that most people, we see a lot of people so most people want to get that part of their life back to certain extent. Now how farther they're willing to go is another story.

Brittany Sabo (32:08):

Right and I think that I usually initially will see these patients and then I will talk to Dr. Jaffe about what their wishes are and I think that the biggest thing that patients need to understand is just to be open and honest with your provider and to let them know what you and your partner, or even if you are single and you still want to have a relationship, you have to be open and honest with your provider because we can't read your minds. We don't know what you want. Yeah, we have a pathway that we follow, if this fails and we do the next step, but we have to know what you are looking for, what your health history is.

Brittany Sabo (32:42):

So for the patients to come in and give us a good health history, what surgeries have they had? What medications are they on. Having all up-to-date information, it makes our process or your urology team's process easier to be able to treat you. Even if you don't know what options are out there you don't have to at the initial consultation that you see your urology provider, you don't have to know right then and there what you want to do. You can take some time to think about it and then set up another appointment to discuss it in further detail.

Andi Hasley (33:10):

Do you have a specific patient success story that you would like to share with our listeners?

Dr. Thomas Jaffe (33:17):

I mean, we have a lot of them, fortunately, and whether it's through kind of being persistent with the rehab therapy, we talked about meaning in the taking of Viagra or Cialis for extended periods of time, whether it be that plus a vacuum erection device, whether it be injection therapy or whether it be people who go on to implant surgery, it's not just one. It's just a lot of patients who are very successful in helping. One of the things that we kind of talk about, there is certain level of frustration with patients who don't respond to certain things, and sometimes that gets in the way of us kind of going to the ultimate or most aggressive approaches and probably some of that's due to whatever relationship they're in and how sexually they are, to begin with. Maybe they don't want to get too, too aggressive.

Dr. Thomas Jaffe (34:14):

But the bottom line is regardless of what we do there will be success at each step somehow. So if the medications don't work, literally like Brittany said 85% of patients will respond to the injections. The injections people get really scared about obviously right off the bat, but when you kind of sit down and explain exactly what it is, a lot of people go forward with it, especially when they find out kind of the pros and cons of an implant and if the injection don't work, an implant 100% will work. So you're talking about you're going to have success. It just depends on how far you want to go to get that success. So I think we have a lot of pretty happy patients in general.

Brittany Sabo (34:59):

Definitely, I agree with everything, Dr. Jaffe said a hundred percent. Especially with the injections. They're kind of, it's a happy medium. If the oral medications don't work and they don't want to do the implant, if they get over the fear that yes, they are going to be injecting themselves with a needle, they do have great success rate. And when they come back and they say, "Wow, Brittany, you were right. It wasn't painful and I can reestablish this relationship with my partner." Just seeing the smiles on their face. I mean, they are really, really, really happy about that and it's good to know that there is that happy medium between pills and surgery that can help patients.

Dr. Thomas Jaffe (35:37):

Well said.

Lauren Hixenbaugh (35:38):

Well, it's good to hear some positivity at the end of this for you all and for your patients. And as we begin to wrap up today, if listeners were to remember one point from today's episode, what would you hope it would be?

Dr. Thomas Jaffe (35:52):

I would hope it would be that there are treatments available, that generally, we can be successful in helping them with getting that part of their life back by a number of different means, whether it be extremely non-aggressive or aggressive, depending on kind of how interested they are in being able to have intercourse again, we can be successful. I mean, we listen to the patients, we hear what they want and we can offer them a therapy based on that desire and so it really is something that they don't have to kind of eliminate from their lives or relationships because we can really do something to help them.

Brittany Sabo (36:47):

And I think that my hope is that patients make that phone call or ask their primary care provider or their urology oncology team to ask for a referral to see a urology team member that specializes in erectile dysfunction, to not be afraid to discuss it because we do have a lot of patients that do tell us I wish I would've made this appointment sooner. So never be afraid to

make that appointment, to open up to your healthcare provider, to let them know that you are having erectile dysfunction because like Dr. Jaffe said there are a lot of treatment options out there and we, your providers are willing to help you. You just have to make that first step to get that appointment.

Lauren Hixenbaugh (37:27):

Great. Thank you guys so much. We appreciate it. Yeah. Obviously, as you both said, there are lots of different topics that we continue to discuss past just erectile dysfunction, kind of thinking about the overall being of the person. So as we wrap up today what I wanted to say is if you want to find out more and you have additional questions for Dr. Jaffe or for Brittany, you can always go to Living Beyond Cancer or the Mountains of Hope website, which is the West Virginia State Cancer Coalition and that could be found at moh.wv.gov or you can go to wvucancer.org. We do have a Facebook support group. You just go to Facebook, type in the search bar Living Beyond Cancer and you'll find us there. We have a really supportive community where people can share their experiences and stories. Living Beyond Cancer would like to thank our speakers, Dr. Jaffe and Brittany Sabo for joining us today, as well as our listeners. We hope that you'll continue to be with us.

Andi Hasley (38:32):

Thanks for joining us.

Brittany Sabo (38:33):

Thank you.

Dr. Thomas Jaffe (38:35):

Thanks a lot.