



Educator Module

Prostate Cancer Across the Continuum: From Diagnosis to Survivorship

We've compiled these supplemental Presenter Notes to enhance the content found in many of the slides in the APSHO Educator Module, "Prostate Cancer Across the Continuum: From Diagnosis to Survivorship." We hope you'll find the extra information useful for yourself and/or as a resource as you discuss this important topic with your colleagues.

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- Prostate cancer is the second most common cancer diagnosed in men behind skin cancer, with an estimated 333,830 new cases in 2026.
- One in 8 men will be diagnosed in the United States with prostate cancer.
- Sixty-nine percent are diagnosed with localized disease, and it is the second leading cause of death in American men.
- An estimated 36,320 deaths will occur from prostate cancer in U.S. men in 2026

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Risk Factors

- As men age, they become more likely to get prostate cancer.
- Black men are 60%-67% more likely to develop prostate cancer than white men and twice as likely to die from the disease as other races.
- Close family history of prostate cancer, other cancers associated with hereditary syndromes (breast, ovarian, pancreatic), or known inherited genetic considerations—such as *BRCA* or Lynch syndrome—play a significant role in prostate cancer risk.
- There are also occupational risks and environmental exposures such as Agent Orange, pesticides, and herbicides that affect risk.

Symptoms

- Symptoms in early prostate cancer include changes in urinary function (eg, slow, weak stream), urinary frequency, blood in the urine or semen, and erectile dysfunction.
- In more advanced prostate cancer, pain, weight loss, and fatigue are common symptoms.

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- Prostate cancer screening guidelines are not consistent across organizations and have changed multiple times in the past several years.
- Currently, the American Cancer Society recommends beginning screening men at average risk at age 50. For those at high risk (ie, Black men and those with first-degree relatives diagnosed before age 65), it's recommended that screening begin at age 45. For men at even higher risk (ie, multiple first-degree relatives with prostate cancer diagnosis at an early age), screening is recommended to begin at age 40.
- The U.S. Preventive Services Task Force recommends that the decision to undergo periodic PSA-based screening be an individual one made through a discussion between the patient and clinician, generally between the ages of 55 and 69. They also recommend against PSA-based screening beginning at age 70.
- The National Comprehensive Cancer Network (NCCN) recommends screening between ages 45 and 75 for men at average risk. For men at higher risk, they recommend beginning screening around age 40.
- Screening decisions should take into account the patient's age and individual risk factors, with the timing of when to start and stop routine PSA testing discussed between the clinician and patient.

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- After detection of an elevated PSA, diagnostic workup generally includes a prostate MRI and, when appropriate, a biopsy. The MRI looks for suspicious lesions within the prostate and can help guide the decision about where to biopsy.
- MRI findings are reported using the PI-RADS system, which scores lesions from 1 to 5. A score of 1 indicates a very low likelihood of clinically significant cancer, while a score of 5 indicates a very high likelihood.
- A prostate biopsy confirms whether malignancy is present and also helps determine how aggressive the cancer is using the Gleason score.
- The Gleason score is based on the two most common patterns seen in the tissue sample. The first number represents the most common pattern and the second number represents the next most common pattern.
 - For example, if most of the cancer has a pattern 4 and the remaining cancer is pattern 3, the Gleason score would be $4 + 3 = 7$.
 - It is important to pay attention to the individual numbers and not just the total score (ie, $3 + 4$ and $4 + 3$ are considered different risk categories).
 - These scores are then grouped into five Grade Groups, as seen in the table on this slide.

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- The diagnostic workup also includes staging, which helps determine whether the cancer has spread outside of the prostate.
- Conventional staging can include a CT of the chest, abdomen, and pelvis as well as a bone scan.
- PSMA-PET imaging can identify lymph node involvement and distant metastases earlier and more accurately than conventional CT and bone imaging. Current guidelines support the use of PSMA-PET in patients with unfavorable intermediate-risk and high-risk disease.
- Staging is based on the TNM system. The T describes the primary tumor, N describes lymph node involvement, and M describes whether the cancer has metastasized to other tissues. We use this information to determine whether the cancer has spread and where in the body.

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- Genetic considerations are important not only when we are deciding who should be screened, but also when we are evaluating a patient at the time of diagnosis and initial staging.
- If someone presents with metastatic disease or localized disease with high-risk features, genetic testing should be part of the initial workup to inform cancer risk and/or treatment.
- Genetic testing is also particularly important in patients with a significant family history or those of Ashkenazi Jewish ancestry. Approximately 1 in 40 people of Ashkenazi Jewish ancestry carry a *BRCA* mutation.
- Some of the important genetic considerations include *BRCA1*, *BRCA2*, and Lynch syndrome.
- Germline and somatic testing can identify different alterations, so it is important to understand the distinction and consider both when appropriate. If a germline alteration is identified, the patient should be referred to a genetic counselor.
- Even if genetic testing was not performed at the time of the initial diagnosis, it should be reconsidered if the patient's disease progresses.

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- For localized prostate cancer, we stratify patients into different risk groups based on their PSA, Grade Group, and clinical stage.
 - Low-risk disease generally includes a PSA <10 , Grade Group 1, and clinical stage T1 to T2a.
 - Intermediate-risk disease includes patients with a PSA of 10 to 20, Grade Groups 2 or 3, or clinical stage T2b to T2c. This group is further divided into favorable and unfavorable intermediate risk based on factors such as PSA, clinical stage, and number of positive biopsy cores.
 - High-risk disease includes patients with a PSA of ≥ 20 , Grade Group 4 or 5, or clinical stage T3.

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- One of the most important things to remember when we are thinking about treatment is that not all prostate cancers require immediate treatment.

- When making an initial treatment decision, consider how aggressive the disease is, including the Gleason score or Grade Group; cancer stage; and the patient's age, life expectancy, comorbidities, and social and lifestyle considerations.
- This is particularly important in prostate cancer because treatment can have significant effects on quality of life and on social and sexual functioning.

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- All localized disease does not need immediate treatment. Active surveillance involves monitoring a known prostate cancer without immediately treating it.
- Patients who are generally candidates for active surveillance include those with low-risk disease and some favorable intermediate-risk disease.
- Surveillance typically includes a PSA every 6 months, a digital rectal examination, periodic prostate biopsies every 1 to 3 years, and prostate MRI annually unless there is a clinical reason to do it more frequently.
- One advantage of active surveillance is that approximately 50% of eligible patients may be able to safely avoid treatment for 10 years. This can help patients avoid or delay treatment-related side effects, which can sometimes be lifelong.
- Active surveillance can also minimize unnecessary treatment for small, indolent cancers that may never progress enough to cause symptoms or spread outside the prostate.
- The limitation is that most patients will ultimately receive treatment by 15 years after diagnosis, and there is always some risk that the cancer could progress to regional or metastatic disease while it is being monitored.
- This can be a difficult conversation because some patients may understandably wonder why they should spend years undergoing surveillance if they may eventually need treatment anyway.

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Favorable Intermediate-Risk Disease

- Patients with an expected survival of more than 10 years can be considered for active surveillance. Definitive treatment options include radical prostatectomy or radiation therapy.
- For patients with an expected survival of 5 to 10 years, radiation therapy may still be considered, but observation may also be appropriate.

Unfavorable Intermediate-Risk Disease

- Patients with an expected survival of more than 10 years typically receive definitive treatment, such as radical prostatectomy or radiation therapy combined with 4 to 6 months of androgen deprivation therapy (ADT). If a patient undergoes prostatectomy and has adverse features or lymph node metastases, adjuvant radiation can be considered.
- For patients with an expected survival of 5 to 10 years, prostatectomy is generally not favored, and options include radiation plus 4 to 6 months of ADT or observation.

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Localized, High-Risk Disease

- Patients with an expected survival of >5 years or who are symptomatic are generally treated with radiation plus ADT for 12 to 36 months.
- There is a range in the recommended duration of ADT, although typically it is approximately 24 months.

Very High-Risk Disease

- Another option is radiation plus 24 months of ADT with the addition of abiraterone and prednisone.
- Radical prostatectomy can also be considered in selected patients. If there are adverse features or lymph node metastases following prostatectomy, adjuvant radiation should again be considered.

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- For patients who present with regional disease and have an expected survival of >5 years or are symptomatic, treatment generally consists of radiation therapy plus long-term ADT.
- Abiraterone and prednisone can also be used for at least 24 months.
- Radical prostatectomy is generally reserved for selected patients in this setting.

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- PSMA is a cell-surface protein that is highly expressed on prostate cancer cells. With PSMA-PET, a targeted radiotracer is injected and binds to PSMA-expressing tumor cells, allowing us to visualize where the cancer is located and how far it has spread.
- Several PSMA-PET tracers are FDA approved and recommended in current guidelines.
- PSMA-PET is more sensitive and specific for detecting micrometastatic disease than CT, MRI, and bone scans, which is particularly useful for initial staging and evaluating recurrence.

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- With the increased use of PSMA-PET, we are seeing more stage migration. A negative PSMA-PET can provide greater confidence that a patient's disease is truly localized, while a positive scan may identify lymph node or metastatic disease that would not have been detected with conventional imaging.
- PSMA-PET is also used to select patients for PSMA-targeted radioligand therapy.
- PSMA-PET should ideally be performed before starting ADT because ADT can affect the sensitivity of the scan. This can sometimes be challenging when the scan is not immediately available.

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- There are several forms of ADT, including orchiectomy, LHRH agonists, and LHRH antagonists.
- When ADT is being given with definitive radiation, the duration depends on the patient's risk group. For unfavorable intermediate-risk disease, ADT is generally given for 4 to 6 months, while high- and very high-risk disease may require 18 to 36 months.
- When a brachytherapy boost is used, the ADT duration may sometimes be shortened to about 12 months.
- The decision of when to start ADT should be individualized, based on factors such as PSA, PSA doubling time, comorbidities, life expectancy, potential long-term effects of ADT, and patient preferences.
- Some patients are understandably anxious about having known cancer that is not being actively treated, and that can influence their preference for starting ADT sooner.
- ADT may also be used with secondary or salvage radiation after definitive treatment such as prostatectomy, generally for 6 to 24 months.

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- After prostatectomy, it is important to distinguish between PSA persistence and biochemical recurrence.
 - PSA persistence means that the PSA never becomes undetectable after surgery.
 - Recurrence means that the PSA initially becomes undetectable and then becomes detectable or begins to rise on subsequent measurements.
- If there is evidence of PSA persistence or recurrence, imaging (eg, bone and soft-tissue imaging and/or PSMA-PET) can be used to detect evidence of metastatic disease.
- If the disease remains radiographically localized, radiation therapy with or without ADT may be appropriate.
- If there is widespread disease, use the workup and treatment approach for metastatic hormone-sensitive prostate cancer.
- It is important to recognize recurrence early because early salvage treatment may improve outcomes.
- After radiation therapy, biochemical recurrence is defined using the Phoenix criterion (PSA level >2 ng/mL above the patient's nadir).

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- When thinking about disease progression, it's important to first understand whether the patient has metastatic disease and whether the testosterone level is still intact or has been suppressed with ADT.
- A patient who initially presents with metastatic prostate cancer generally has metastatic hormone-sensitive prostate cancer, because their testosterone has not yet been suppressed. These patients can have high-volume, low-volume, or oligometastatic disease.
- A patient who initially had localized disease that was treated and then develops a rising PSA without radiographic metastases has nonmetastatic hormone-sensitive disease.

- If imaging subsequently identifies metastatic disease while the patient remains hormone-sensitive, that becomes metastatic hormone-sensitive prostate cancer.
- If the PSA begins to rise despite a suppressed testosterone level, we consider the patient to have castration-resistant prostate cancer (CRPC). This can be either metastatic or nonmetastatic. When the PSA is rising, testosterone remains suppressed, and there is no radiographic evidence of metastases, this is nonmetastatic CRPC.

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- When choosing treatment and discussing sequencing, the patient's goals of care must be considered. The aggressiveness of the cancer should be balanced with the patient's quality of life, as well as how much treatment and how many clinic visits the patient is willing or able to manage.
- Comorbidities are also important because some treatments can affect cognition, cardiovascular health, and diabetes.
- Patients need to be educated about the potential side effects of treatment.
- Financial toxicity also matters. The cost of medications and the need to miss work for appointments or treatment can affect a patient's ability or willingness to continue therapy.

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- For metastatic hormone-sensitive prostate cancer, ADT is the foundation of treatment. Timing and duration of ADT should be individualized based on the patient's disease and overall situation.
- ADT may be given continuously or intermittently, depending on the clinical circumstances and treatment goals.
- For patients with high-risk biochemical recurrence, we can add an androgen receptor pathway inhibitor (ARPI) such as enzalutamide. In some patients, it can be used as monotherapy when the potential side effects of ADT are a concern. Apalutamide can also be combined with an LHRH agonist or antagonist in appropriate patients.
- For non-metastatic hormone-sensitive biochemical recurrence, treatment can include ADT plus an ARPI.
- In patients with high-volume metastatic disease, treatment can be intensified with ADT, an ARPI, and docetaxel. Radiation to the primary tumor may also be considered in selected patients.
- For patients with a *BRCA2* mutation, the treatment approach may include ADT with niraparib and abiraterone.
- In patients with oligometastatic disease, local treatment of metastatic sites can be combined with ADT and an ARPI.
 - Radiation can also target specific metastatic sites. Treatment directed at metastatic sites is generally not considered curative, but it may delay the need for additional systemic therapy and can improve progression-related outcomes.
- Patients receiving indefinite ADT in the metastatic hormone-sensitive setting must be monitored regularly, including a physical examination and PSA every 3 to 6 months, with imaging when new symptoms develop and to assess treatment response.
- Even when the PSA remains undetectable, ongoing monitoring is important. A rising PSA despite a castrate testosterone level signals progression to castration-resistant disease and the need for additional treatment.

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- Several ARPIs can be used in metastatic hormone-sensitive prostate cancer, including abiraterone with prednisone, enzalutamide, apalutamide, and darolutamide.
- Abiraterone works by inhibiting androgen production, but it can also cause mineralocorticoid excess. Therefore, it is given along with prednisone.
- Darolutamide is unique among these agents in that it does not cross the blood-brain barrier to the same extent, which contributes to differences in its side-effect profile.
- When choosing among these agents, consider the patient's comorbidities, potential adverse effects, and overall treatment goals.

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- Once a patient develops metastatic CRPC, treatment options depend on what they have already received and on the molecular characteristics of their disease.

- For a patient who has not previously received an ARPI, options include abiraterone with prednisone, enzalutamide, or docetaxel.
- Biomarker testing is particularly important because patients with *BRCA* or other HRR mutations may be candidates for PARP inhibitor-based treatment.
- For patients with bone-predominant metastatic disease, radium-223 can be considered in the appropriate clinical setting.
- If a patient has already received an ARPI but has not yet received docetaxel, docetaxel is generally preferred as the next line of treatment.
- Disease-specific treatments include lutetium for patients with PSMA-positive disease, and cabazitaxel with or without carboplatin.

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- After a patient has received both an ARPI and docetaxel, cabazitaxel is generally the preferred chemotherapy option. Docetaxel rechallenge can be considered in selected situations.
- For patients with *BRCA* or other HRR alterations, biomarker-directed treatments such as olaparib or rucaparib are options depending on the specific mutation and disease setting.
- Lutetium can be used for patients with PSMA-positive disease, and cabazitaxel can also be combined with carboplatin in selected patients with more aggressive disease.
- Sipuleucel-T is another option for selected patients, particularly those with asymptomatic disease and no visceral metastases.
- For patients with oligoprogressive disease, metastasis-directed therapy can sometimes be used to treat individual progressing sites.
- Radium-223 can be considered for patients with symptomatic bone-predominant metastases without visceral disease.
- Pembrolizumab is an option for patients whose tumors have specific biomarkers such as MSI-high disease.
- Genetic and biomarker testing is important in advanced prostate cancer, as it can identify treatment options that would not otherwise be apparent.

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- If a patient has received an ARPI but has not previously received docetaxel, docetaxel is generally the preferred chemotherapy option.
- Monitor closely for treatment-related toxicities, particularly peripheral neuropathy, as well as the other expected chemotherapy adverse effects.
- Cabazitaxel, with or without carboplatin, can be considered for patients who are fit for chemotherapy and have more aggressive disease or unfavorable genomic features.
- Pembrolizumab is an anti-PD-1 therapy that can be considered for patients with metastatic CRPC whose tumors are MSI-high. Tumor mutational burden can also be relevant when considering this treatment.
- PARP inhibitors are another important treatment option for patients with HRR mutations.
- As with all of these treatments, we need to monitor side effects and consider practical issues such as gastrointestinal symptoms, treatment costs, and adherence.

Slide 31

- Multiple PARP inhibitors are FDA approved for specific prostate cancer disease states and specific HRR mutations.
- Both germline and somatic testing can identify mutations that may be relevant to treatment.
- It is important to match the specific mutation and the patient's disease state to the appropriate treatment indication because the approvals are not interchangeable.
- Examples include olaparib, olaparib in combination with abiraterone, and rucaparib, depending on the patient's specific molecular findings and clinical situation.

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- Radium-223 is administered intravenously every 4 weeks for up to 6 cycles.
- It is used in patients with metastatic CRPC who have symptomatic bone metastases without visceral metastases. Patients should also not have bulky lymph node disease.
- Radium-223 is associated with a risk of fractures, so a bone-strengthening agent is recommended when appropriate.
- Because radium-223 is a radioactive treatment, patients also need education about radiation precautions and handling bodily fluids during the first few days after treatment.

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- Lutetium is approved for patients with PSMA-positive metastatic castration-resistant prostate cancer who have progressed on an ARPI. It may also be used before docetaxel in patients who have already received and progressed on an ARPI.
- Lutetium is administered intravenously every 6 weeks for up to 6 cycles.
- Imaging is conducted after several cycles to assess the patient's response. If a patient has a good response and the disease becomes less PSMA-avid, treatment may be paused and then resumed if the cancer progresses again.
- Because lutetium emits gamma radiation, patients need clear instructions about limiting close contact with others after treatment.
 - This includes avoiding close contact within about 3 feet with household members for the first 2 days and sleeping more than 3 feet away from others for at least 3 days.
 - Patients should avoid close contact with children and pregnant people for 7 days and should wash soiled laundry separately. When possible, using a separate toilet is also recommended.

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- Urinary incontinence is a common concern following prostate cancer treatment, particularly radical prostatectomy and radiation to the prostate.
- The severity of incontinence varies depending on treatment type, patient characteristics, and how incontinence is defined and measured. In general, mild incontinence is about 1 to 2 pads used per day, moderate is 2 to 4 pads, and severe is 5 or more pads.
- Management should be individualized based on the severity of the incontinence, how long it has been since treatment, the underlying cause, and how much it is affecting the patient's day-to-day life.
- Pelvic floor physical therapy is an important part of management and can be started early after surgery or even before a radical prostatectomy. Patients can learn how to identify and properly use their pelvic floor muscles, perform exercises, and use those muscles during activities that tend to trigger leakage.
- Behavioral strategies can also be helpful. These include bladder retraining and timed voiding, such as trying to urinate every 2 hours while awake.
- Patients should also identify and avoid individual bladder triggers when possible. These may include caffeine, certain foods, or other dietary factors. Constipation is another important factor because it can make urinary incontinence worse.
- Medications have a limited role when the primary problem is stress incontinence. Pharmacologic treatment is more useful when there is also an overactive bladder or urge incontinence component.
- For patients whose symptoms persist despite conservative measures and significantly affect quality of life, surgical options such as an artificial urinary sphincter or sometimes a male sling can be considered.
- Urinary incontinence should be assessed proactively and addressed early.

Slide 36

- ADT side effects vary widely, so it can be difficult to predict which effects a particular patient will experience.
- Education is important, but it can easily get lost in the amount of information patients receive at diagnosis.
- A standardized EMR resource can be useful for documenting education and providing patients with information through the after-visit summary or patient portal.
- The following slides will highlight several individual side effects in more detail.

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- This chart highlights some of the more common toxicities we see with advanced prostate cancer treatments, although it is not an exhaustive list.
- Routine laboratory monitoring is important with these therapies.
- With abiraterone, liver function and potassium should be monitored frequently during the first 3 months.
- ARPIs require blood pressure monitoring, and a home blood pressure cuff and log can be helpful.
- With chemotherapy, assess for neuropathy before each cycle because it can become dose limiting.

Slide 38

- Fatigue is one of the most common cancer treatment side effects and can significantly affect quality of life.
- Physical activity is an effective management strategy, but patients should start small and gradually increase activity. For example, someone who is inactive might start with a 10-minute walk 3 times a week and build from there.
- A combination of aerobic and strength training appears to be most helpful.
- Sleep hygiene and mindfulness practices can also help, while medications such as dexamethasone or methylphenidate have more limited evidence and require a risk-benefit discussion.

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- Up to 80% of men may experience hot flashes with ADT. They are often self-limited and may not require medication.
- Venlafaxine or clonidine may help some patients, while physical activity, avoiding triggers, and acupuncture are other options.
- Cognitive effects such as memory problems and brain fog can also occur with ADT.
- Physical activity, mindfulness, mental stimulation, and activities such as reading or puzzles may help.
- Cognitive behavioral therapy can provide strategies for managing both cognitive changes and the emotional distress associated with them.

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- Cardiovascular and metabolic health is important because some prostate cancer treatments can contribute to cardiovascular risk.
- Risk is also influenced by factors such as age, obesity, family history, tobacco use, diabetes, and sedentary lifestyle.
- A meta-analysis of 24 randomized trials found approximately a twofold increase in cardiovascular morbidity with an ARPI plus ADT compared with ADT alone, although the difference was less pronounced when adjusted for time on study.
- With abiraterone, prednisone helps reduce the compensatory mineralocorticoid effects caused by cortisol suppression.

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- Patients with preexisting cardiovascular disease may benefit from follow-up with cardiology or cardio-oncology.
- The ABCD framework—which stands for awareness and aspirin, blood pressure, cholesterol and cigarettes, diet and diabetes, and exercise—is a systemic approach to cardiovascular risk reduction.
- This framework can help guide lifestyle counseling and coordination with the broader care team.
- Although there is no single consensus approach to cardiovascular screening and risk reduction, this provides a useful structure for discussion.

Slide 42

- Apalutamide is associated with rash in about one-quarter of patients. It can usually be managed with topical corticosteroids or antihistamines, although treatment interruption or dose reduction may occasionally be needed.
- Abiraterone can cause mineralocorticoid-related effects, including edema, hypertension, and hypokalemia, so monitoring is important.

- Frequent laboratory monitoring is especially important during the first 3 months of abiraterone therapy and can generally be spaced to every 4 to 6 weeks afterward.
- Chemotherapy-induced peripheral neuropathy can cause numbness, burning, or tingling, so baseline assessment is particularly important in patients with diabetes.
- Duloxetine can help with painful neuropathy, although there are limited options for numbness and tingling without pain.
- Lutetium also requires specific education about radiation and contact precautions, including precautions related to close contact and sexual activity.

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- Bone health should be addressed in all patients receiving ADT.
- Important lifestyle measures include weight-bearing and balance exercise, smoking cessation, and limiting alcohol.
- Patients should maintain adequate calcium and vitamin D levels.
- Antiresorptive therapy can be considered based on individual fracture risk.
- In patients with castration-resistant disease and bone metastases, higher-dose denosumab or zoledronic acid can help prevent symptomatic skeletal-related events.
- Assess bone health early and continue prevention strategies throughout ADT.

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- All prostate cancer treatments can affect sexual health, including erectile dysfunction, penile shortening, and decreased libido.
- Although sexual health has been studied, it remains an under-addressed aspect of cancer care.

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- We should educate patients and partners about expected sexual health changes and help manage them.
- Avoid assumptions about sexual interest based on age, sexual orientation, or relationship status.
- The Sexual Health Inventory for Men, or SHIM, can assess erectile function, but it does not address all aspects of sexual health.
- There are also communication models to help aid providers in having these conversations with patients, including BETTER, PLISSIT, and EX-PLISSIT
- Patients want clear, specific language with minimal medical jargon, repetition and teach-back, and involvement in decision-making.
- When appropriate, partners should also be included in these conversations.

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- These are the aforementioned communication models that can help guide conversations about sexual health.
- BETTER is a model of sexual dysfunction assessment. PLISSIT stands for Permission, Limited Information, Specific Suggestions and Intensive Therapy. There is also the Extended PLISSIT model.

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- Erectile dysfunction is the most commonly reported sexual function side effect of prostate cancer treatment, and there are several treatment options.
- Treatment should be individualized based on the patient's goals, baseline function, and preferences.
- PDE5 inhibitors are typically the initial pharmacologic option when appropriate, although their effectiveness can be limited early after prostatectomy.
- Vacuum erection devices can produce an erection mechanically and can be used alone or as part of penile rehabilitation.
- Intracavernosal injections are another nonsurgical option and generally provide more reliable erections, but patients need education on administration and potential adverse effects.

- An inflatable penile prosthesis is a definitive surgical option for patients with persistent ED or those who prefer a surgical approach.
- The key is to set expectations early, discuss options, and reassess regularly because recovery can take time.

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- Sexual health extends beyond erectile dysfunction and can include low libido, changes in ejaculation, climacturia, and psychosocial or relationship concerns.
- After prostatectomy, men can no longer ejaculate, and some may experience urine leakage during orgasm.
- For men with low testosterone after treatment for localized disease, the risks and benefits of testosterone replacement should be considered based on symptoms and cancer characteristics.
- Testosterone replacement is generally not recommended for men with high- or very high-risk disease, and men receiving ADT should not receive testosterone replacement.

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- Survivorship encompasses a person's health and well-being from diagnosis throughout the rest of life.
- It includes the physical, psychological, social, and economic effects of cancer and its treatment, along with ongoing care and surveillance.
- Patient-centered survivorship care requires collaboration among multiple members of the healthcare team.

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- Survivorship in advanced disease is increasingly important as more patients live with incurable cancer.
- Establish goals of care early and reassess them as the disease progresses, while documenting those goals clearly for the care team.
- Address symptom burden, treatment and travel burden, and the emotional impact of living with incurable disease.
- We also need to support caregivers and discuss end-of-life care and hospice when cancer-directed treatment is no longer available or desired.

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- Social determinants of health include conditions such as economic stability, housing, and social support that can significantly affect health and quality of life.
- If these needs are not addressed, they can limit the effectiveness of our clinical interventions once patients leave the clinic.
- Oncology APPs are in a unique position to connect clinical care with community health workers, social workers, and local resources.
- We should normalize screening for social needs as part of survivorship assessments and use multidisciplinary teams to extend care beyond the healthcare system.