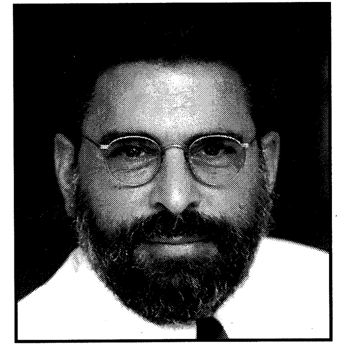
Lawrence D. Mass, MD

Bears&Health

Cancer of the Prostate



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"Prostatism" is the medical term for how you've been conducting your sex life. (LOL) Actually, I don't know where the word originated. Today, it is a relic from the past, like "rheumatism," "lombago" and "neurasthenia," all once commonly used to describe conditions we now have better, more specific and accurate terms for.

Even today, "prostatism" is still sometimes used to describe the condition we offically call BPH: benign prostatic hypertrophy, an enlargement of the prostate gland that is so common a feature of ageing that it can almost be considered normal. Though the natural hormonal changes that take place with ageing are thought to be a factor (no joke - we do undergo menopause), there is no known cause. It's rare for BPH to show up before age 45, but it becomes increasingly common from then on, so common that it should be routinely (at least annually) examined.

What happens in BPH is that the enlargement of the prostate can cause constriction of the urethra, which can make it more difficult to urinate. You start to get literally pissy (another of my lunges at humor, not a medical term). You may notice yourself peeing less in volume and more often, and for it taking longer and requiring more strain to start your stream. This increase in frequency will be especially noticeable if it happens during the night. Many men get up once or even twice during the night to take a leak, but when it's increasing in frequency to several or more times, you need to check it out. The diagnosis of BPH is usually made by your primary physician during a rectal exam that should be part of your routine physical. (Some doctors can be rough and perfunctory. Ideally, your doctor will be this hot bear who will examine you gently, knowledgeably and thoroughly.)

There are a number of different treatments for BPH, ranging from pills such as hytrin proscar and cardura, which can help to shrink the prostate but which must be taken long-term, to various surgical procedures. In light of the triggerhappiness of surgeons, many of whom will urge you to have these procedures with artfully worded claims that they have the most certainty of relief (they definitely have the most certainty of higher remuneration), let me be blunt here and say that anyone contemplating treatment for BPH, especially where the recommendation is for surgery, should seriously consider getting a second opinion, But let me also add here that surgery is often the treatment of choice, especially in more advanced cases, and is usually well-tolerated.

Cancer of the prostate is the second leading cause of deaths from cancer in the U.S. But diagnosing it and deciding exactly what to do about can get complicated. The problem is that the cancers that do develop in many men are very slowly growing. Since this is by and large a disease of older men, the big dilemma is whether to take a chance on letting it be, since it may still be small and inconsequential by the time you die of old age, or opting for treatment which can be expensive and have serious side effects. There is no way of knowing for certain which cancers will grow more aggressively. Here is another situation where a second or even a third opinion is highly recommended.

Because most prostate cancers grow slowly, men aged 50-65 will benefit the most from screening with a digital (finger-up-the-rectum) exam and a blood test called PSA (prostate specific antigen). Because so many men in this age group will also have BPH, there is a circumstantial association, but not an absolute one, of BPH with cancer of the prostate. Other risk factors which may be also be more circumstantial than absolute include a high fat diet; and race and ethnicity (the disease is twice as common among African-American and less common among Oriental males). A family history of cancer of the prostate can also be a risk factor, especially if the relatives were young at the time of diagnosis.

So, if they find a cancer but are uncertain whether it will grow slowly, then the question is raised as to whether or not one should do screening at all. In favor of screening is the fact that most of the prostate cancers that do spread and become incurable before they are diagnosed did so in the absence of screening. The American Urological Association and the American Cancer Society both recommend yearly screening, or at least offering the screening. Against screening, beyond the question of the serious side effects (including loss of sexual functioning) that can result from treatment, is the fact that no one has demonstrated that prostate cancer screening actually saves lives overall. And in fact, the U.S. Preventive Services Task Force and the National Cancer Institute recommend against screening. I am not aware of any information about prostate cancer risk that is specific to gay men.

There are now numerous websites with information about every aspect of health, including conditions and illnesses of the prostate. Just punch in prostatitis or cancer of the prostate or BPH. Although there is not yet to my knowledge any authoratative guide to diseases and conditions of the prostate specifically geared to gay men, there soon will be. This spring, Ballantine will be publishing the GMHC Guide to Gay Men's Health, which will feature a chapter on urology by Dr. Mark S. Litwin, of the UCLA Department of Urology. Another gay phsyician/medical resource is the Gay and Lesbian Medical Association (GLMA), which you can reach via email and the internet (E: info@glma.org and W: www.glma.org) or via telephone: 415-255-4547, or fax: 415-255-4784.