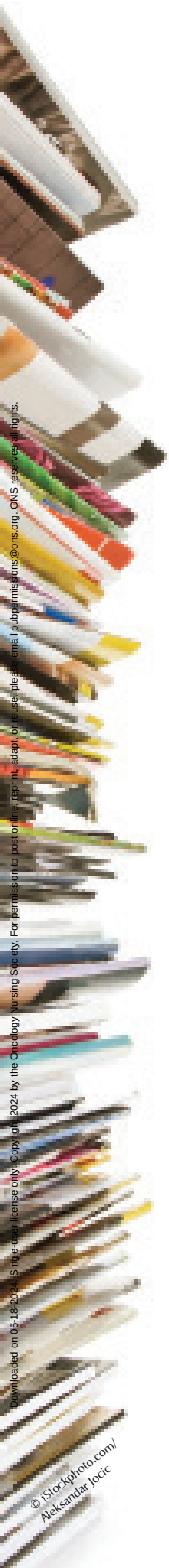

The More Things Change, the More They Stay the Same—Or Do They?

This is the first of a retrospective series in 2013 celebrating 40 years of the Oncology Nursing Forum. *Each feature will focus on a single cancer and discuss the changes to the diagnosis and treatment of the disease since the 1970s.*

Prostate cancer continues to be a disease that affects many men and has a profound effect on their quality of life, as well as that of their partners. Controversy exists over the role of prostate-specific antigen screening in identifying men with the disease (Carlsson et al., 2012), as well as heated debate over the most appropriate treatment for men with low-risk disease (Bill-Axelson et al., 2011; D'Amico, 2011). Treatment for prostate cancer has always been known to cause erectile problems and, in searching the archives of the *Oncology Nursing Forum*, two articles of interest on this topic were found.

In a 1987 article, Heinrich-Rynning described the effects of treatment for prostate cancer on sexual functioning. The author compared the most common treatments of the time—surgery (e.g., perineal, retropubic, transurethral), radiation (e.g., external beam), hormone manipulation (e.g., orchiectomy, estrogen therapy), and chemotherapy—and their effects on sexuality. Of note was the author's contention, based on the evidence at the time, that erectile dysfunction (ED) after treatment might be psychogenic as well as physiologic. Today, we assume that the ED resulting from treatment for prostate cancer is mostly physiologic and scant attention is paid to the psychogenic. The author also pointed out the concurrent changes associated with ageing, something else largely ignored in present-day practice.

Six years later, an article by Waxman (1993) showed the influence of the work of Patrick Walsh on the understanding of sexual functioning. Walsh pioneered the nerve-sparing procedure for radical prostatectomy and, because of using a carefully selected population in his study, was able to show vastly improved erectile functioning using his technique (Walsh, 1988). The promise was gradual return of erections in the first postoperative year. Waxman pointed out that, although nursing interventions cannot restore erectile functioning, we can provide emotional support to the man and his partner during these difficult times.

Both of these articles were published before the introduction of a new class of drugs in 1998, the PDE5 (phosphodiesterase type 5) inhibitors, which have revolutionized the field of male sexual health and have changed the way we approach ED after treatment for prostate cancer. Today, penile rehabilitation has become the accepted standard of postoperative care for men with prostate cancer (Mulhall, 2009; Mulhall, Land, Parker, Waters, & Flanigan, 2005; Padma-Nathan, McCullough, & Forest, 2004). Briefly, penile rehabilitation involves a daily low dose of sildenafil, hypothesized to prevent damage to penile tissues from hypoxia caused by praxia of the penile nerves. But even with good nerve-sparing techniques, the return of erections is not guaranteed; rates of erectile functioning range from 13%–86% after surgery (Borchers et al., 2006). Only one-third of men were reported to return to their preoperative level of erectile functioning in another study (Levinson, Lavery, Ward, Su, & Pavlovich, 2011).

So what can nurses do? Heinrich-Rynning (1987) and Waxman (1993) recognized the important role for nursing in the care of men with prostate cancer. Suggestions for nursing interventions in both articles stress the importance of assessment by the nurse in a nonjudgmental manner, anticipatory guidance about new ways of expressing sexuality, and referrals for counseling as needed. This remains true today, but is still an area where improvements can occur.

Some nurses remain reluctant to talk about sexuality with patients, despite having in our arsenal the tools and skills to help these men (Olsson, Berglund, Larsson, & Athlin, 2011). In a review of the literature on cancer and sexuality, Hordern (2008) suggested that the BETTER Model (Mick, Hughes, & Cohen, 2003) provides a broad perspective to base a discussion about sexuality on, using quality of life as the context for a detailed discussion about the sexual side effects of treatment, timing of interventions, and need for additional information on the part of the patient. The acronym BETTER stands for **B**ringing up the topic, **E**xplaining that sexuality is part of quality of life, **T**elling the patient about resources that can be accessed by the nurse or patient to help, **T**iming the discussion for when the patient is ready to talk, **E**ducating the patient about the sexual side effects of treatment, and **R**ecording in the notes that a discussion has taken place.

So, what has changed and what has stayed the same for men after prostate cancer treatment? Although advances have been made in treating the side effects, much suffering continues for these men and their partners. Nurses have