

## Chapter 16. Frequently Questions & Answers

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You will receive handouts to prepare you for the specific treatment and recovery process you have chosen, and the pocket behind this chapter is for you to put those handouts in for later reference. Please read those handouts; they contain very valuable information.

In addition to those handouts, many patients we spoke with wanted a Q&A section and had questions about when to call the doctor. The following questions were developed by nurses and are divided into four sections: a) diagnosis; b) decision-making; c) treatment; and d) recovery.

### **Diagnosis**

#### **Q. Why do they ask me those questions every time I come in?**

- Weak or interrupted flow of urine
- Difficulty starting or holding back urination
- Urinating frequently, especially at night
- Pain or burning when you urinate
- Blood in the urine
- Painful ejaculation
- General pain in the lower back, hips, or upper thighs

A. These questions help clinicians evaluate the disease progress and your recovery.

#### **Q. Why does the PSA value go up?**

A. Before treatment, PSA is produced by benign and cancerous prostate tissue, and the level tends to be higher in larger prostates, as the prostate cancer grows or if the prostate is inflamed or irritated. Even sex can increase PSA by 10 percent. If it rises after treatment, the timing and rate of increase, as well as the stage and grade of the prostate cancer are helpful in predicting whether the cancer is recurring where it was or if it has metastasized. (Note: if the PSA doubles over more than one year, the tumor is probably growing slowly.)

#### **Q. How does the doctor know if the cancer has spread?**

A. Radiological tests such as bone scans, CT or MRI scans may be ordered. Pelvic lymph nodes can also be sampled from the pelvis.

#### **Q. What is the difference between the total PSA and free PSA value?**

A. Free PSA is the PSA not bound to proteins. It is often expressed as a ratio of free PSA to total PSA in terms of percent, which is  $(\text{free PSA}/\text{total PSA}) \times 100$ . For each level of total PSA, low levels or free PSA are indicative of a greater risk of prostate cancer. PSA levels alone do not make the diagnosis of prostate cancer or prostate cancer recurrence.

#### **Q. Why does the doctor want me to take additional tests?**

A. Your doctor is trying to determine if your prostate cancer is confined to the prostate gland, and if not, where it may have spread.

**Q. What is involved in a bone scan?**

A. A bone scan involves injecting a small amount of a radioactive chemical through a vein into your bloodstream. The chemical is absorbed by areas of fast bone growth that may be associated with cancer, and then the “picture” shows this to the doctor.

**Q. Am I more at risk if a family member has had prostate cancer?**

A. In certain cases, it seems that the risk for prostate cancer is passed on to males in the family. The younger the family member is when he is diagnosed with prostate cancer, the higher the risk for male relatives to have prostate cancer.

**Q. Are there genetic markers for prostate cancer?**

A. Yes. Some genes appear to increase risk.

**Q. Who gets an MRI using an endorectal coil?**

A. Endorectal coils can be used with an MRI to help your doctor evaluate how advanced your cancer is. The coils are inserted into your rectum during the MRI. This study is available as a supplement to other diagnostic tests. It maybe ordered to determine if the disease has spread outside the prostate, and therefore, may affect the treatment recommendations. Your doctor will discuss with you if this test is recommended in your case.

**Decision-Making**

**Q. Why won't anyone tell me what to do?**

A. Prostate cancer in its early stages can be approached with a number of different therapies, including surgery, radiation, cryotherapy and hormonal manipulation. Within the medical community, there are differences of opinion about which treatment may be superior in an individual case. Unlike some cancers, where there is a clearly superior treatment approach that can be recommended by all physicians, the chance of beating your prostate cancer may be similar with a number of different treatments, depending on your particular disease characteristics. The treatment approaches, however, will each differ in terms of the potential side effects that may occur (sexual dysfunction, urinary issues and rectal issues in particular). It is understood that you may have different concerns about these potential side effects compared to other patients, and you may be willing to accept some risks more than others in order to achieve control of the disease. Therefore, many physicians may give you their opinions of what they think is the best option for you, but the final decision is ultimately yours, based on your understanding of the chance of success and the risks of side effects you are willing to accept.

**Q. If they do not get all of the cancer during surgery, can I have radiation afterward?**

A. Yes, postoperative radiation can be given for patients with cancer left behind after surgery. There is, however, an increased risk of side effects such as incontinence and impotence in patients who undergo both surgery and radiation.

**Q. Why can't they do surgery after radiation?**

A. In selected cases, surgery can be performed after external radiation if highly conformal radiation, such as IMRT, has been used. It is not routinely used after brachytherapy (permanent seeds or temporary implants) or after less conformal forms of external radiation. The reason is

that there is a high risk of incontinence and poor wound healing in these patients who undergo surgery after radiation due to the high doses of radiation that these tissues have received.

## **Treatment**

### ***Radiation***

#### **Q. Why does the doctor want me to take hormones before I start radiation?**

A. Two major indications: 1. Part of a protocol in certain stages of disease that combined treatment had been shown to produce better cure rates; and 2. Patients who have very large gland and/or obstructive urinary symptoms may be put on hormones prior and during treatment to shrink the gland in order to decrease treatment related symptoms

#### **Q. What are the chances that I will be impotent?**

A. Incidence rise with age but in general ranges between 35 to 50 percent; half these patients will be helped by Viagra and the rest by other erectile aids.

#### **Q. What are the chances that I will experience incontinence and will it go away?**

A. Long-lasting incontinence is unusual (less than 1 to 2 percent) after brachytherapy or external beam radiation. If it occurs temporarily, it is usually is of limited extent. Incontinence is more likely to occur after prostatectomy or if a procedure is done after radiation therapy in any form.

#### **Q. What if I miss some treatments? Do the treatments have to be consecutive?**

A. It is best if treatment is consecutive, but missing two to five treatments during an eight-week course of treatment can be accommodated by usually adding some additional treatments. Missing treatments unnecessarily should be avoided if possible.

#### **Q. What about three-day weekends?**

A. Missing a day does not interfere in overall success rate. Overall time is important, but treatment protocols takes into account possibility of interruptions of two to five days over a four-to eight-week treatment period. If it extends beyond that timeframe, your doctor can use appropriate formulas to adjust the dose if necessary. However, it is best to keep interruptions to a minimum.

#### **Q. How long will the urinary frequency last? Will it get better?**

A. Acute side effects should decrease over a three-to-six week period. About 10 percent will continue to have problems for another six months, and about 3 to 5 percent may have some continued problems on a chronic basis that are usually mild.

#### **Q. How long will the bowel problems last? Will they get better?**

A. If related to EEBRT, most symptoms are gone three to six weeks after completion of treatment, 10 percent can last up to three to six months, and 2 to 5 percent can be chronic. Symptoms are usually mild but deserve mention to your doctor so they can be properly evaluated.

#### **Q. I am four weeks post radiation. Is it normal to be experiencing frequent urination and bowel problems? Will these things get worse?**

A. Acute side effects should decrease over a three-to-six week period. About 10 percent will continue to have problems for another six months, and about 3 to 5 percent may have some continued problems on a chronic basis that are usually mild.

**Q. Why am I getting that dose of radiation?**

A. Doses are determined by clinical experience and are individualized depending on stage and other factors. The dose is chosen that has the highest chance of cure while causing the least amount of side effects.

**Q. How long do I have to stay on the medication for urinary frequency or diarrhea?**

A. Until symptoms begin to improve.

**Q. Why I am experiencing rectal irritation?**

A. It is due to the effect of radiation on the anal and rectal tissue near the prostate. If it is very uncomfortable, you can sit in a warm tub for five to 10 minutes three or four times a day, especially after bowel movements. Diarrhea during radiation therapy should be reported to your radiation doctor or nurse. It can be managed with diet and medication.

**Q. How will my diet have to change during my radiation treatments?**

A. You will want to eat a low-fiber diet for a while. Call the Health Education Department and ask if they have a nutrition class related to prostate cancer.

**Q. How much diarrhea is OK?**

A. Anything more than four loose stools a day. Call us, and we can recommend some over-the-counter drugs or prescribe a medication.

**Q. How many fiducial seeds are used, and how are they placed?**

A. Doctors use between three to five fiducial markers. They are usually inserted a couple weeks before treatment starts so the tissue has a chance to recuperate from the procedure.

**Q. When are fiducials used with radiation therapy? Who gets fiducials and who does not?**

A. Fiducial seeds are used in cases where it is felt the anatomy allows one to place the seeds safely and effectively, and is often used when it is felt that daily reproducibility could be a problem for various reasons.

**Q. Will you take the fiducial seeds out?**

A. Fiducial seeds are inserted and non-radioactive and remain permanently.

***Radiation: Permanent (Low-Dose) Seeds***

**Q. Is there anything I should worry about having permanent seed implants?**

A. Your physician should discuss with you the risks of the procedure and expected radiation effects. In the 24 hours after the permanent seed brachytherapy procedure, fevers, inability to urinate or severe pain are unusual and should be discussed with the physician or nurse right away. There may be some small amount of blood in the urine for three to four days after the procedure, which is normal. Difficulty with urination (more frequent urge to urinate, increased nighttime urination, some burning on urination and slowing of the stream) is common over the

next three months after an implant. Some difficulty achieving an erection may also occur during this time due to the swelling from the implant.

**Q. Can I pass the radiation to my sexual partners?**

A. During the act of intercourse, it is possible that a stray seed could be passed in the ejaculate. It is therefore recommended that a condom be used for the first three months after a permanent seed implant has been performed.

**Q. I am having some burning with urination after surgery or radiation implant (permanent seed or HDR brachytherapy procedure). Is this normal?**

A. It is normal for the first 24 to 48 hours after brachytherapy or surgery. It is from the manipulation of the prostate and is from the urinary catheter. If it lasts longer than 48 hours, or the pain is intense, call your physician. In the next several months after an implant, burning on urination can occur due to irritation of the urethra in or around the prostate or sphincter muscle. It can be treated with medicines as needed.

**Q. What counts as frequent urination?**

A. Urinating more than every two hours.

**Q. I have to urinate frequently. Is this normal?**

A. It is common to experience some frequent urination immediately after permanent seed implantation or HDR brachytherapy. It will improve significantly during the next seven to 14 days. Over the next three months, frequent urination can occur due to the effect of the radiation on the urethra and bladder base. It is usually most intense for the first month, and then begins to diminish. It should be discussed with your physician, as it can be treated with medicine.

**Q. My scrotum is bruised. Is this normal?**

A. There can be some bruising of penis, scrotum and the perineum (the space between the anus and the scrotum) due to needles that were used to implant the seeds. This will heal normally, usually after a week, and is usually painless. If there is pain associate with this, you should discuss it with your physician.

**Q. I am having some blood in my urine. When do I worry and call someone?**

A. Passage of dark blood clots or bright red bleeding with urination occurs after permanent seed or HDR brachytherapy. It is due to the irritation of the bladder and urethra from implant needles or the urinary catheter. When the bleeding is extensive (more than just blood tinged urine), please contact your physician. It may be necessary to place a catheter or (on some occasions) to look in the bladder to find the source of bleeding.

**Q. I cannot seem to urinate. Should I call the nurse?**

A. If you cannot urinate, especially if you have been unable to urinate for over four hours and are having pain or discomfort, call us immediately, and we will ask you to come in to see us or we will direct you to go to the emergency room.

### ***High Dose Rate (HDR) Brachytherapy***

**Q. What is HDR brachytherapy (temporary seeds)?**

A. It is computer directed precision directed placement of a tiny Iridium 192 radiation source temporarily into the prostate.

**Q. How does high-dose radiation (HDR) work? How does it kill the cancer and what does it do to normal tissue?**

A. It is similar to all forms of radiation in that it causes disruption of the cancer cell DNA.

**Q. What are the side effects of HDR brachytherapy?**

A. The potential side effects of HDR are similar in nature to all forms of radiation, namely rectal, bladder, and erectile dysfunction. The rectal complication rate with HDR, like other forms of brachytherapy, is extremely low. Urination problems are often a consequence of pre-existing benign prostatic hypertrophy (BPH). The rapid delivery of HDR reduces the duration of the acute side effects after treatment. The urologist and radiation oncologist should manage any late urinary problems together and urinary procedures kept to the necessary minimum because they often resolve without surgery. The incidence of erectile dysfunction depends upon baseline status and can be treated in a variety of ways described elsewhere.

**Q. How is it different from seeds?**

A. Permanent seeds are inserted by hand directly into the prostate tissue. HDR is inserted by a computer control device called an “afterloader.” The size of the radiation source size is about the same, but with HDR the “seed” is attached to the end of a fine wire that is inserted for about 20 minutes, in several separate sessions, into a hollow catheter scaffolding in and around the prostate. Both procedures are usually performed as an outpatient without a surgical incision.

**Q. Why don't people know about HDR brachytherapy and use it more? Is it new?**

A. HDR requires complex equipment and facilities. There are fewer physicians trained in HDR and it is newer than seeds. Ten-year outcome data has been published for both forms of brachytherapy showing excellent cancer control and few major side effects has been published for both forms of brachytherapy. HDR may be applied to cancer that has extended beyond the prostate as well as organ confined disease.

**Q. Has HDR been shown to be safe and effective treatment for prostate cancer?**

A. Ten-year outcome data published for HDR brachytherapy shows excellent cancer control and few major side effects for all stages and grades of cancer. HDR may be applied to organ confined disease cancer or to cancer that has extended beyond the prostate.

**Q. Can I work during treatment?**

A. Except for the several days during the treatment, and depending upon the type of work, most patients are able to function immediately upon completion of the implant.

**Q. How long will I have to be out of work?**

A. You will not be able to work during the day of the procedure or the next day. There are usually two implants procedures separated by one week. You may or may not be able to do some work in between sessions.

**Q. Do I need disability?**

A. You do not generally need disability for prostate brachytherapy seeds or HDR, but some patients prefer to take one month off during the treatment process.

**Q. How long do treatments last? When I am actually in the booth?**

A. Treatments typically last 20 minutes in the treatment room. You will be fully monitored during treatment.

**Q. Can I exercise between treatments?**

A. Exercise within your comfort zone and within the range of recent previous experience is not a problem. Start slowly, and work up to your usual activity. Do not ride a bike for at least one month after any form of prostate brachytherapy. Discontinue the activity if discomfort or urinary symptoms develop and consult your physician.

**Q. How do I know if I am cured and if the cancer is gone?**

A. The word “cure” is not easy to define for prostate cancer patients because the disease can be extremely slow to progress. However, with radiation therapy (unlike radical prostatectomy, where it is hoped that there will be no detectable PSA), reduction of PSA to low but still detectable levels is the goal of therapy. There are many definitions of PSA progression and the PSA level may vary from patient to patient. It may take many years for the PSA to reach its lowest point (nadir) after radiation therapy. Consultation with your radiation oncologist is very important *before* a diagnosis of recurrent or persistent disease is made. Regular PSA tests and digital rectal exams (every three to six months) are the primary means of follow up. Other tests may be ordered as needed. A large percentage of patients with prostate cancer have long-term control or “cure” of their disease.

**Q. How long do I stay on hormone therapy after the treatment?**

A. The need for hormone therapy may vary according to the type of prostate cancer. Patients with favorable or low-risk group cancer probably do not need hormone therapy in most cases. Patients with intermediate- and higher-risk group disease may have hormone therapy for variable periods from four months total to indefinitely. In general, high-risk group patients receive two years of hormone treatments when receiving external radiation therapy without brachytherapy. The value or lack of value of hormone therapy with HDR is currently under investigation.

**Q. During treatment, do I need to be following a special diet? Are there supplements I should take?**

A. There is no special diet associated with HDR or permanent seed brachytherapy if it is used without external beam radiation therapy. If external beam is used, the recommendations listed elsewhere in this guide should be followed.

***Hormones***

**Q. How many people do hormone therapy?**

A. Depending on stage of disease and extent of symptoms hormones may be prescribed. In cases where metastases have developed, most patients will be treated with androgen deprivation therapy (ADT) i.e. hormone therapy. For patients receiving external beam, about 10 to 20 percent of patients receive ADT as part of their treatment. Overall, about 15 to 20 percent of patients have ADT, but it depends on the type of presentations.

While we often refer to patients being treated with hormones, the actual goal is androgen ablation or removal either surgically by removal of the source of testosterone by removing the testicles, or anti-androgen medications described elsewhere in this guide. The oral (pills) agent is often given for 10 to 30 days prior to Lupron to avoid an inflammatory reaction in the cancer that is sometime seen with injections alone.

**Q. What are hot flashes? Why am I getting them?**

A. Hot flashes result from withdrawal of hormone, and in this case, it is related to testosterone withdrawal. Hot flashes are felt to be complex in origin but probably reflect autonomic nervous systems response to the withdrawal of hormones.

**Q. Once I start hormones, will the hot flashes be the worst at the beginning, middle or end of the treatment?**

A. It is variable but occurs most prominently early in the course of treatment (first few months).

**Q. What can I do about the hot flashes?**

A. Taking vitamin E, soy, and Effexor seems to work. Talk to your doctor because there may be some restrictions with radiation therapy.

**Q. Why is one hormone therapy chosen over the other?**

A. Doctors may use monotherapy (one therapy) or combination therapy (several different therapies at the same time), or intermittent therapy (on and off). The decision about which medications are used is based on possible side effects, chance of a testosterone flare (temporary surge) and preference (e.g., as a temporary treatment until another therapy begins, while a patient makes a decision about surgery or radiation), and for other reasons.

**Q. I feel like I am gaining weight. Is it the hormone therapy?**

A. Chances are that you are not really gaining weight, but your body is changing because of the hormone therapy. You may be feeling a little softer and rounder around the abdomen than usual.

**Q. Are the impotence and lack of libido due to hormone therapy permanent?**

A. No, these side effects should disappear within three to four months after stopping treatment if the course of treatment is less than six months. Long-term hormone therapy (> one year) may be associated with a higher risk of failure to recovery libido and sexual function. It takes from three to six months after cessation of hormone therapy to recover.

**Q. Is penis shrinkage related to my dwindling testosterone level?**

A. Yes. Normal penis size should return slowly if androgen blockade is stopped.

### ***Recovery: Surgery***

#### **Q. After surgery, when should I call the nurse (talk with a urology nurse)?**

A. Recovery after surgery will take at least four weeks. You will spend a few days in the hospital with a drain that removes the lymph fluid or urine that may temporarily leak into your pelvis, and then go home with a catheter for one to two weeks. Your urine may be a little bloody for several days, which is fine. If it stays bloody longer a few days, or is dark red, bright red, or you find clots in it, call the nurse. You should also call the nurse if:

- There are any blood clots in the catheter;
- You have any leg swelling, especially if the swelling is sudden, significant or limited to one side of your leg;
- You have pain, tenderness or redness on your leg;
- You have sudden chest pains, shortness of breath, a cough, bloody saliva or mucus;
- You see signs of infection (e.g., if wound is red or pus comes out, or you have a fever and chills);
- You are constipated (i.e., no bowel movement for two or more days); or
- After the catheter is removed, you have trouble urinating or if there is a gradual weakening of your urine stream. This may be a sign of bladder neck contracture.

#### **Q. When do the drains come out?**

A. The drains usually come out one to three days later, before you leave the hospital.

#### **Q. Catheter questions?**

A. If your penis gets sore, make sure the bag is stabilized. If the catheter falls out, call the nurse and go into your doctor's office to have it replaced.

#### **Q. What if surgery does not work? What if the PSA does not fall to undetectable?**

A. Radiotherapy with or without androgen ablation is an option.

#### **Q. What if PSA starts rising again after falling to undetectable?**

A. Radiotherapy with or without androgen ablation is an option.

### ***Recovery: Radiation***

#### **Q. If you have had IMRT, can you then do proton therapy?**

A. No, the M.D. Anderson Information Line said that proton therapy would not be appropriate for a previously treated patient. The doses of radiation with IMRT are too high to allow further treatment with protons. Brachytherapy may be an option if the interval from treatment is long (measured in years).

#### **Q. I had radiation and do not seem to be having any problem with impotency. Will I have any future problems?**

A. Impotence may gradually get worse over time. Sexual function may also decline as a result of other illnesses and with age.

### ***Recovery: Brachytherapy***

**Q. I am having some burning with urination and trouble starting my stream. Is this normal?**

A. Burning with urination or inability to get stream going is fairly common three to four months after brachytherapy. Talk to your doctor about options.

**Q. How will I know if I can stop taking the Flomax?**

A. To know if you still need it, you can try not taking it for a few days. Such a trial such is done in conjunction with consultation with your doctor.

**Q. I have decided to have brachytherapy and EBRT. How long will I wait between having the implant and starting the EBRT?**

A. Usually patients with permanent seed implants wait three to six weeks (depending upon the radionuclide being used and recovery from the procedure) before starting the EBRT. The seed implant can also be done after the EBRT. With HDR brachytherapy, the preferred approach is to have the implant first and then start the EBRT about two week later. EBRT can be given first as well. Discuss the reasons with your doctor.

**Q. I have a dry, irritated area on my butt cheek. What is that?**

A. Some men get a rash, and it should go away in a few days. It may be due to the sterile preparation solution or a medication. Keep it dry, clean, and put Neosporin on it (if necessary), and baths might help. Notify your doctor if it blisters or gets worse.

**Q. I have hemorrhoids. Is it from the radiation?**

A. Yes, you can temporarily use over-the-counter creams and baths to help with burning and itching.

**Q. My penis is a little numb in one spot (or on one side). Is it from the radiation?**

A. There may be a little nerve irritation that occurs (more commonly with brachytherapy). It may take a month or year, but it will likely go away.

**Q. Will I become impotent with radiation therapy?**

A. Radiation therapy has a low rate of impotence (less than 30 percent), and 15 percent of those can have improved erections with medication or other aid.

***Recovery: PSA***

**Q. How fast will my PSA value drop?**

A. It is variable and depends on the treatment. It drops quickly after surgery, but slowly after external beam and brachytherapy. The lowest value may not be reached until two to four years after completing treatment. There is often no major change for three months after radiation. Hormone therapy (ADT) causes a rapid decrease in PSA within a month.

**Q. Why don't they check my PSA on the last day of treatment?**

A. Results are variable and can be misleading. The PSA can actually rise immediately after EBRT because of inflammation and deposition of PSA into blood.

**Q. How often will my PSA be monitored?**

A. The first PSA test is usually done four to six weeks after treatment, and then every three months for the first year or two, and then every six months thereafter.

**Q. Will my PSA keep dropping?**

A. Sometimes there is a bounce or temporary rise in PSA. In other words, the PSA level may rise and fall for the first several years after radiation. Although no one is quite sure why, it is a common occurrence and should not cause alarm. After surgery, if the disease is eradicated, your PSA will be 0.1 ng/dL or less. A diagnosis of progression of prostate cancer requires that the PSA rise be sustained over a period of observation (many months) and that it be confirmed by repeated testing. It is the long-term trend that counts and not a single rise that leads to the conclusion of persistent prostate cancer. There are many ways to define PSA progression, so discuss the PSA values with your surgeon (if you have a prostatectomy) and your radiation oncologist (if you have EBRT or brachytherapy *before* a conclusion of disease progression is made.

***Recovery: Impotence***

**Q. Is there anything I can do to prevent future impotence?**

A. After the first month of treatment, some people prescribe low-dose Viagra or Levitra or injection therapy on a regular basis to increase blood flow and oxygen to the tissue and prevent impotence.

**Q. How are Viagra or Levitra usually prescribed?**

A. These drugs are to be taken by mouth one hour before intercourse.

**Q. What are the differences between Cialis, Levitra and Viagra?**

A. All of these drugs have the same mechanism, but some work better than others. If you take nitrates, you should not take Viagra, Levitra or Cialis. For Viagra, doses above 25mg should not be taken within four hours of taking an alpha-blocker. Consult with your physician before taking these medications.

**Q. Why won't the insurance company pay for more than six pills a month?**

A. You will need to ask your insurance company.

***Follow-Up***

**Q. If I have any urological problems in the future, should I call you?**

A. Yes, if there is a problem, it is important that the doctor talk to us as procedures can damage tissue after they received radiation. We will encourage them to avoid instrumentation in the urethra or bladder. A thorough discussion that includes input from the radiation oncologist is helpful before proceeding with procedures. Some radiation-associated problems may occur many months or years after treatment. They frequently resolve with patience and conservative medical management.

**Q. Will I have to have repeat bone, MRI or CT scan?**

A. You will only need to have these scans if there is a rise in PSA that is interpreted by your doctor as suspicious for persistence of the cancer. The bone scan is often positive long after the initial rise of the PSA in cases where the cancer recurs.

**Q. Who will follow my care – the urologist or the radiation oncologist?**

**A.** Both. You will probably be seen by both specialists. The emphasis may vary in different medical communities and it may depend on what kind of treatment you have received.

**Q. There is a little bit of blood in my ejaculate. Should I worry or call?**

**A.** Hematospermia (blood in the ejaculate) can occur for some time after treatment (even up to a year or more after treatment). It is usually of no significance, but it should be reported to your doctor.

**Q. I seem to have less ejaculate. Is it related to treatment?**

**A.** Ejaculate fluid decreases after radiation because the prostate and seminal vesicles are not making as much fluid as before, and the consistency may be more watery.

**Q. The doctor told me to stop taking my vitamins and antioxidants before I started radiation treatment. When can I go back on them?**

**A.** You can resume your regimen three weeks after your last treatment.

**Q. When can my diet go back to normal?**

**A.** You can resume a normal diet right after completion of radiation treatment. You can start adding things slowly. Stop if the diarrhea starts up again.

**Q. When can I expect my urinary function will be back to normal?**

**A.** Urinary function will usually be back to normal by three months after treatment ends.

**Q. What happens if I have blood in my urine months or years after radiation treatment or brachytherapy?**

**A.** Bleeding in the urine should be evaluated by your urologist. Occasionally, many months or years after radiation therapy, a small blood vessel may break and spill blood into the urine. On the other hand, it is important to rule out unrelated serious problems unrelated to the prostate cancer or treatment. There also may be bleeding from an area of radiation injured bladder or urethra. The urologist will perform cystoscopy (look into the bladder) or order various radiological studies as needed. Again, a conservative approach to management of radiation effects may avoid complications.