Autumn | 2022

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A FOCUS ON MEN'S HEALTH

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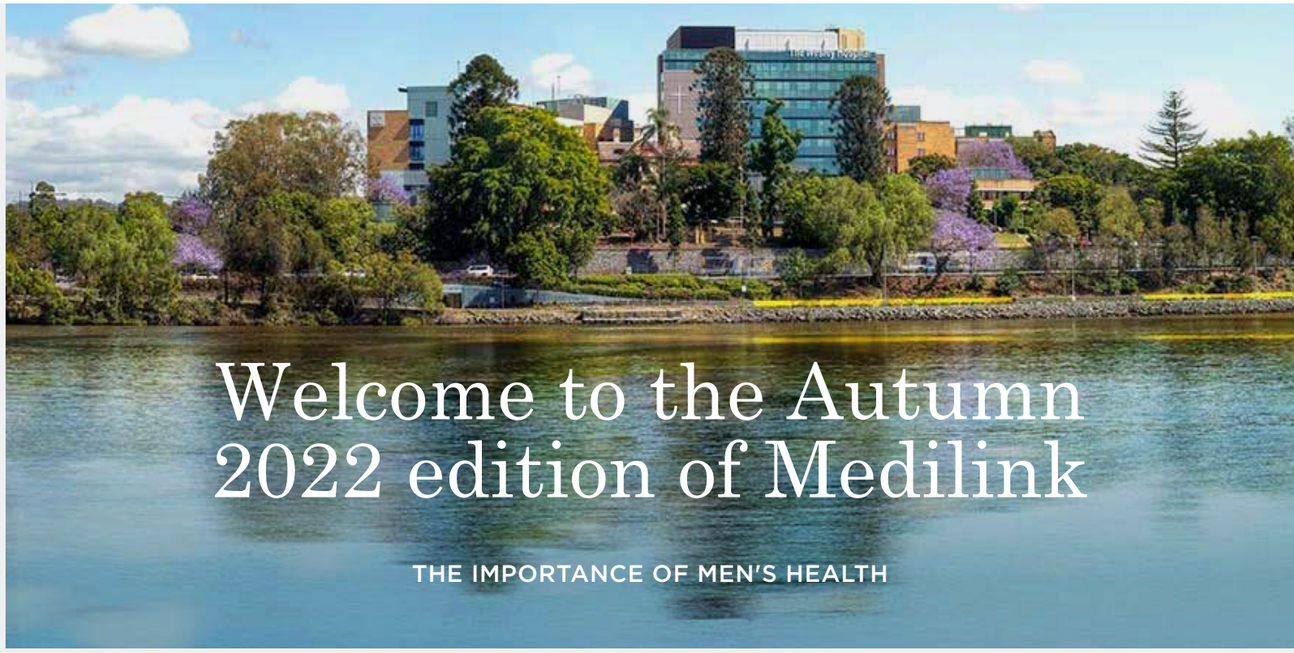

Welcome to the Autumn 2022 edition of Medilink

THE IMPORTANCE OF MEN'S HEALTH

Welcome to our first edition of Medilink for 2022 where we focus on the importance of Men's Health.

I would like to start by thanking our network of GPs who have dedicated their time over the past two years in doing their part in keeping Queensland safe, as well as assisting us where possible to keep our patients safe and cared for.

Our hope is that 2022 will bring us a little bit of calm as we continue to navigate our way through these challenging times whilst keeping our patients as our number one priority.

In 2021 it was wonderful to be able to host some face to face GP education events. I know our team enjoyed being able to network with you, our specialists and our sponsors. It is always good to be able to put names to faces and practices.

However, for the moment, we will be back to running GP events online. This change will allow us to run these events on a more regular basis and include our regional GP network. Take a look at our calendar of online events at Wesley.com.au/for-doctors/for-gps/gp-education-events and book in early to avoid disappointment.

The Wesley Hospital has a history of developing and delivering exceptional care in all it does, but has a particularly strong track record when it comes to men's health. In 2010 The Wesley Hospital's robotics programme began, and has led Australia since then with currently the largest robotics programme in the country. Over the past 12 years since the robotic program's inception, The Wesley has been able to provide over 6000 men minimally invasive, prostatectomies. In 2011 The Wesley Hospital also created Queensland's first dedicated Prostate Nurse role which remains an integral part of our support today. In 2014 The Wesley Hospital was the centre that pioneered a new MRI imaging technique that reduced overtreatment and improved the ability to detect life threatening prostate cancers. In 2018 The Wesley was recognised as a Centre of Excellence for Robotic Surgery, paying tribute to the dedicated team that provides this cutting-edge surgery.

This edition of Medilink is showcasing our continual drive towards providing exceptional care for Queensland men: Our partner in Medical Imaging, I-Med Radiology, here on The Wesley Campus achieved accreditation as Australia's first centre of Excellence in in Prostate Imaging; The work that has been done by Choices, our cancer support charity which has expanded its support to include evidence-based programs for men after cancer treatment; and the continuing work by our Specialists.

We hope you enjoy this edition of Medilink. We look forward to seeing you all throughout 2022, whether that be in person or via video link!

Sean Hubbard
General Manager

Testicular Cancer - Your questions answered

BY DR ADAM PEARCE

Testicular cancer affects mainly young men, with more than 85% of cases occurring between age 15 and 45. It is a highly curable disease with 5-year survival 97% in Australia, but in more advanced cases treatment can be intensive and prolonged. Although it a rare cancer, the number of new diagnoses are steadily rising.

In 2020 there were an estimated 928 new diagnoses in Australia and over 4,000 men living with testicular cancer. Treatment of advanced disease is often complex and requires a co-ordinated, multidisciplinary approach by a team experienced in treating testicular cancers. With excellent cure rates, the focus has shifted in recent years towards cancer survivorship and minimising long-term morbidity from treatment.

WHAT TYPES OF CANCER ARISE IN THE TESTICLE?

This article will focus on Germ Cell Tumours (GCT) which account for the vast majority of testicular cancers. These are sub-classified as either pure seminoma or non-seminomas which include the variants embryonal carcinoma, yolk sac tumour, choriocarcinoma and post-pubertal teratoma. One or more of these tumour types may be present and men with both seminoma and non-seminoma elements are managed as non-seminomas.

Other rarer testicular cancers are sex cord stromal tumours such as Leydig cell or Sertoli cell tumours. 90% of these are benign, but malignant sex cord tumours are aggressive and resistant to chemotherapy.

The most common testicular tumours in elderly men are haematological cancers such as lymphoma or plasmacytoma.

The para-testicular structures may also give rise to rhabdomyosarcomas in children and young men, or liposarcomas in older men.

HOW DO TESTICULAR GERM CELL TUMOURS PRESENT?

The most common presentation is with a solid painless intra-testicular mass. Occasionally they may present with acute pain due to a bleed into the tumour. Less commonly men may present with symptoms of metastatic disease such as back pain from retroperitoneal lymph node metastases, cough, chest pain or haemoptysis from pulmonary metastases, or a left supraclavicular mass. These men may have a “burnt out” primary in their testicle, or rarely present with a primary GCT of the mediastinum.

HOW SHOULD A TESTICULAR MASS BE INVESTIGATED?

Scrotal ultrasound has a sensitivity of almost 100% for testicular cancers and if this is confirmatory, the patient should be referred for urological assessment urgently. Serum tumour markers beta-HCG and alpha-fetoprotein (AFP) are often elevated. Lactate dehydrogenase (LDH) is less specific but often also elevated. The levels of these markers can be used to for prognostic purposes and followed to monitor response to treatment. AFP is never elevated in the case of pure seminomas and normal tumour markers certainly do not exclude a GCT.

HOW ARE GERM CELL TUMOURS TREATED?

A solid intratesticular mass and consistent ultrasound findings are sufficient to proceed with a radical orchidectomy. Prior to surgery, consideration needs to be given to the quality of the contralateral testicle and if there are concerns about this, men should be offered semen cryopreservation prior to orchidectomy. Patients will also require staging with a CT chest, abdomen and pelvis to assess for metastatic disease, most commonly seen in the left para-aortic (left-sided primaries) or inter-aorto-caval lymph nodes (right) just inferior to the renal vessels. I prefer to do this before surgery, in case any wound related issues cause confounding lymphadenopathy. In men with high volume symptomatic metastases, orchidectomy is deferred until after completing chemotherapy

Radical orchidectomy is performed through an incision in the inguinal region and involves excision of the testicle encased in the surrounding tunica vaginalis, as well as the spermatic cord as far superiorly as the deep inguinal ring. If patients wish, a testicular prosthesis can be placed in the scrotum to preserve cosmesis.

HOW ARE GERM CELL TUMOURS STAGED?

The absence of metastases on CT, and rapid normalisation of tumour markers following orchidectomy confirms Stage I disease (confined to the testicle). Persistently elevated or rising markers are indicative of occult metastatic disease and treated as such.

Retroperitoneal metastases on CT are Stage II disease, whereas metastases beyond these lymph nodes is Stage III.

WHICH MEN WITH STAGE 1 DISEASE SHOULD HAVE ADJUVANT TREATMENT?

Approximately 18% of men with Stage I seminomas will relapse on surveillance. The risk is higher with larger tumours and in those with tumour invasion of the rete testis on histopathology. Men have the option of a single dose of carboplatin chemotherapy which reduces the risk of relapse by approximately 6-10% and is generally well tolerated. Equally, surveillance alone is entirely reasonable for all men with Stage I seminomas who are willing to comply with surveillance protocols. These consist of regular tumour markers and physical examination as well as around seven CT scans for at least 5 years. The protocols are a little less strict for those who choose adjuvant carboplatin.

Non-seminomas are more aggressive tumours and have a higher chance of relapse of up to 50% if lymphovascular invasion is present on histopathology. Men with Stage I non-seminomas have the option of a single cycle of multi-agent chemotherapy or surveillance. This chemotherapy is more toxic, but equally the benefits are greater. Surveillance protocols are far more stringent than those for seminomas. Whether adjuvant chemotherapy is chosen or not, the overall survival remains excellent at 97%

TREATMENT OF RELAPSED OR METASTATIC GCT

More than 80% of men with metastatic disease can be cured. Prognosis is based upon the IGCCCG classification which uses histological type, disease location and tumour marker levels to allocate men good-, intermediate- or poor-prognosis group.

The mainstay of treatment is multi-agent chemotherapy with BEP (bleomycin, etoposide, cisplatin) with three cycles for good-prognosis disease, or four for intermediate- or poor-risk disease. Each cycle last three weeks. Common side effects are nausea and vomiting, alopecia, fatigue, rashes and skin pigmentation and patients must be monitored for myelosuppression and pulmonary toxicity. Cisplatin

can cause neuropathy, tinnitus, loss of high-tone hearing or nephropathy. Chemotherapy also causes azoospermia which usually recovers. Nonetheless, men are recommended to cryopreserve semen beforehand if they didn't do this prior to their orchidectomy.

Men with Stage II seminoma (confined to retroperitoneal lymph nodes) may be suitable for radiotherapy. There is also growing evidence for the utility of surgery as an alternative to chemotherapy for these men.

THE ROLE OF SURGERY FOR RESIDUAL POST-CHEMOTHERAPY MASSES

Residual masses following chemotherapy may contain necrosis/fibrosis only, residual chemo-resistant germ cell tumour or teratoma. It is recommended they undergo resection as imaging modalities cannot reliably differentiate between these disease entities. Teratoma is not itself biologically aggressive, but is resistant to chemotherapy and radiation and has the potential to de-differentiate into highly aggressive somatic malignancies such as sarcoma or adenocarcinoma.

The most common location for residual masses is the retroperitoneum. Surgery involves resection of the residual mass, along with the lymph node tissue surrounding the great vessels between the level of the renal arteries and the common iliac bifurcation. Occasionally resection of involved adjacent vascular structures or organs is also required.

WHAT ARE THE LONG-TERM SEQUELAE OF TESTICULAR CANCER?

With excellent cure rates and many decades to live with the side-effects of treatment, cancer survivorship has shifted into focus in recent years. Most survivors will regain a good quality of life. Those treated with orchidectomy have an increased risk of hypogonadism and infertility. Whilst the chemotherapy side-effects listed above will often recover within 2 years of treatment completion, including recovery of spermatogenesis, peripheral neuropathy, Raynaud's phenomenon and auditory changes can be permanent. Additionally, those treated with chemotherapy have double the risks of both cardiovascular disease and of developing non-germ cell malignancies. Depression, anxiety, fear of relapse, alcohol or substance misuse, body image issues, financial and sexual difficulties are all more common in testicular cancer survivors than the general population, highlighting the need for appropriate awareness and support from the health care network.

WHAT CAN MEN DO TO REDUCE THEIR RISK?

Whilst there is not anything that can be done to reduce the risk of developing testis cancer, it is recommended men and adolescent males self-examine their testicles to familiarise themselves with their anatomy, and present early for evaluation should any abnormalities develop, thus reducing the risk of presenting with disseminated disease, improving prognosis and minimising the treatment required.

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Advances in the treatment of prostate cancer – striving to improve quality-of-life for patients

BY DR JAMES MACKEAN

Recent years have seen substantial developments in the treatment of prostate cancer. From improvements in radiation treatment techniques, to rectal spacing gels that reduce toxicity to organs at risk (OAR), science and technology has come a long way, striving to improve men's quality-of-life throughout and after treatment.

DEVELOPMENTS IN RADIATION TREATMENT

There have been significant advancements in the way radiation therapy is delivered and a shift from conventional radiation therapy to shorter treatment schedules, known as hypofractionated radiation therapy (HypoRT).

Advancements in treatment delivery and planning software have led to more focussed and accurate radiation therapy techniques, including intensity modulated radiation therapy (IMRT), image guided radiation therapy (IGRT) and HypoRT.

A recently published, first real-world study in Australia & New Zealand highlights the rapid uptake in the last 5 years of shorter radiation therapy schedules for men with prostate cancer.[1]

HypoRT involves the use of fewer, larger doses of radiation therapy directly to the tumour, minimising exposure to surrounding healthy tissue.[1] For prostate cancer, HypoRT is typically delivered as twenty sessions over four weeks, compared to ~40 sessions over eight weeks required with conventional radiation therapy, halving the number of visits patients need to make to clinic.

Globally, several randomised clinical trials have confirmed HypoRT is as effective as conventional radiation therapy for patients with localised prostate cancer.[1]

The recent JAMA study showed an increase from 2.1% to 52.7% over a three-year period - remarkable as behaviour change in medicine is challenging, and it can often take many years to see meaningful changes in clinical practice.[1]

In addition to tracking the utilisation of HypoRT across Australia and New Zealand, the study also recorded patient-reported outcomes (PRO) of men receiving either HypoRT or conventional radiation therapy. Patient reported outcomes included urinary control, and changes in bowel and sexual function.[1]

Promisingly, the study found no clinically meaningfully differences in PROs between HypoRT and conventional radiation therapy, which is consistent with previous international studies from the United Kingdom and the United States.[1]

STEREOTACTIC RADIATION THERAPY

With further developments in technology, radiation therapy has become even more sophisticated, with the introduction of stereotactic body radiation therapy (SBRT), allowing for even shorter treatment times (~5 sessions) where suitable.

Prostate SBRT has substantial prospective evidence supporting its use, with favourable tumour control, patient-reported quality-of-life, and levels of toxicity demonstrated. SBRT has sufficient evidence to be supported as a standard treatment option for localised prostate cancer while ongoing trials assess its potential superiority.[2-4]

SPACERS TO REDUCE RECTAL TOXICITY

The clinical problem in prostate radiation therapy is the rectum. It becomes a major OAR due to proximity to the prostate, and therefore high dose radiation therapy becomes unavoidable. This can cause, (dependent on area and volume of rectum receiving radiation) a myriad of complications including rectal bleeding, frequency, urgency and mucous.

There is high level evidence showing rectal spacing improves separation of the rectum (from 2mm to 12mm), reducing significant toxicity to the area by upwards of 70%.[5]

Barrigel® was introduced in Australia approximately 12 months ago. It is a hyaluronic acid material inserted into the tissue planes between the prostate and the rectum, pushing the rectal wall away from the prostate, helping to reduce unwanted radiation doses to the front rectal wall. Barrigel is a natural, biodegradable material that stays in place for 6 to 9 months and is then broken down by the body over time.

The spacer procedure is usually performed under a light general anaesthetic. The Barrigel is injected into the space between the rectum and the prostate to increase the area. The gel is sculpted to fit, so each insertion is individualised. The procedure takes between 15-30 minutes.

Barrigel assists clinicians in treating the prostate to the highest curative doses with less potential for untoward side effects to the bowel.[5]

CONCLUSION

With the many advances in treatment design and delivery, alongside a multidisciplinary team approach to care including clinical and allied health teams, the improvements seen in patient's quality-of-life both through and after prostate cancer treatment are encouraging.

Disclaimer: *Any medical procedure or treatment involving the use of radiation carries risks, including skin irritation and associated pain. Before proceeding with treatment, all patients should discuss the risks and benefits of the treatment with an appropriately qualified health practitioner. Individual treatment outcomes and experiences will vary.*

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Bowel Cancer - The Conversation

BY DR CARINA CHOW

Last holiday, I had the good fortune to visit Winton at the time of their biennial Outback Festival. The highlight of this 3-day festival was the Dunny Derby which are hotly contested races between teams of 4 with a home built port-a-loo and starting with a competitor with their undies around their ankles running to the loo.

In amongst the hilarity, I hear the local GP being interviewed about bowel cancer in Australia, how common it is in Queensland. "Things to look out for are bleeding with your bowel motions or changes in your bowel habit like becoming constipated or going multiple times a day". "The perfect poo is a soft sausage". I thought this was a funny conversation for such an event but in reality, this was exactly the conversation all Queenslanders need to hear.

Bowel cancer is the third most common cancer in Australia with a 1 in 13 chance of developing a bowel cancer before the age of 85yrs. It also remains the second most common cancer killer.

Rates of bowel cancer had been slowly rising until the mid 2000s, but since this time, there has been a slight decline in incidence. This most likely can be attributed to the National Bowel Cancer Screening Program (NBCSP) which was introduced to Australia in August 2006.

The National Bowel Cancer Screening Program involves a faecal occult blood test (FOBT) test which is sent home biennually to people between the age of 50 and 74 yrs. This tests for microscopic blood in the stool and a positive test should prompt a colonoscopy. Currently, ~7% of people who submit their test will have a positive result. 1 in 11 of these patients will have a significant adenoma and 1 in 41 will have a cancer. Screen detected cancers are more likely to be stage I or II compared to equivalent non-screen detected counterparts, and thus carries a better prognosis. Pleasingly, now 20% of colorectal cancers detected are from FOBT tests. Early detection and removal of adenomas is likely the reason behind the slow decline in the incidence of colorectal cancer since the inception of the NBCSP.

However, in patients under the age of 50, there has been a rapid increase in incidence of bowel cancer.

This is not only in Australia, but across many western nations. Colorectal cancers in people under 50 now make up 10% of all colorectal cancers diagnosed. Scarily, now, a person born in the 1990s is 4x more likely to get a rectal cancer and 2x more likely to get a colon cancer than a person born in the 1950s. The incidence of colorectal cancer in persons aged 15-24 has increased by 186% in the last 30 years and every age group less than 50 years has also increased. Bowel cancer has now become the deadliest cancer in persons aged 25-34yrs.

Why this is the case remains unclear and subject of much research. In response, the American Society of colorectal surgery has decreased their screening age to start at 45yrs and Bowel Cancer Australia has is advocating the NBCSP to do the same.

What we can do now is exactly what is happening in Winton. We can improve the awareness amongst the community and encourage everyone to actively seek attention if they have worrying symptoms like changes in bowel habit, per rectal bleeding, unexplained weight loss and iron deficient anaemia. As a medical community, we all must remember that no one is too young for bowel cancer.

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https://www.bowelcanceraustralia.org – #N2Y

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Benign Prostatic Hyperplasia

EPIDEMIOLOGY

Benign prostatic hyperplasia (BPH) is a *common condition* affecting most men over the age of 50. It is a common cause of lower urinary tract symptoms (LUTS), previously known as prostatism, in men. It is due to stromal (fibroblasts and smooth muscles) and glandular epithelial cell proliferation in the peri-urethral transitional zone (TZ) of the prostate gland [1]. This causes bladder outflow obstruction (BOO) and changes in the bladder which in turn causes LUTS.

It is important not to confuse BPH with prostate cancer as most men presenting with LUTS may think they have prostate cancer and vice versa. Most prostate cancers occur in the peripheral zone of the prostate gland and do not cause symptoms associated with BPH. Most prostate cancers are detected through PSA screening.

As the world and Australian population ages, the burden of disease is expected to ***increase***. Studies have demonstrated a linear association between increasing age and development of LUTS [2,3,4]. Some studies have shown the prostate volume to increase by 2-2.5% per year [5].

PATHOPHYSIOLOGY

The pathophysiology of LUTS from BPH is not fully understood. LUTS can occur in patients without significant enlargement of the prostate gland. Studies have shown a "***static***" as well as a "***dynamic***" component to the bladder outflow obstruction from BPH [6].

The static component is due to peri-urethral compression from the increase in size of the transitional zone leading to increased resistance to outflow and increase in bladder pressure. The dynamic component is due to increased tension within the prostate smooth muscles in the stroma of the prostate gland. Medications, such as five alpha reductase inhibitors (5-ARIs), target the static component, whereas alpha-blockers target the dynamic component of the obstruction.

ASSESSMENT

The aims of treatment are to improve patient quality-of-life by reducing bothersome symptoms and to prevent BPH-related complications, such as chronic renal insufficiency, bladder diverticular, bladder calculi, urinary tract infection, acute urinary retention, chronic urinary retention and long-term bladder dysfunction due to chronic and untreated bladder outflow obstruction.

Assessment of LUTS begins with a good ***history*** of symptoms. Symptoms are divided into voiding (or obstructive) and/or storage (or irritative) symptoms. Validated questionnaire such as International Prostate Symptoms Score (IPSS) [7] provide a good guide. The questionnaire also includes a Quality-of-Life score due to urinary symptoms and is a good indicator of how bothered the patient is by his symptoms.

Physical examination should include a focused urological examination of the penis, urethral meatus, testes, inguinal and suprapubic area. Digital rectal examination (DRE) of the prostate is useful to determine volume and consistency of the prostate gland. Neurological examination may be required if there are associated symptoms, such as significantly altered bowel habits or neurological symptoms suspicious for cauda equina.

Basic ***investigations*** including a urine MCS, FBC, ELFT and PSA are generally performed as a baseline measure. A renal tract ultrasound would provide information on the prostate volume, absence or presence of median lobe of the prostate gland, bladder wall trabeculation, diverticular or calculi, post-void residuals and upper tract status. A urinary flow rate study and post-void residual can be done in the urological office. Bladder diaries may be helpful to assess storage symptoms, such as urinary frequency and nocturia. Formal urodynamics studies are often not necessary, unless there is suspicion of a neurogenic bladder. Flexible cystoscopy may be required to assess the lower urinary tract or to exclude a urethral stricture.

MANAGEMENT

It is important to note that ***not all*** men with LUTS need medical treatment. Men with mild, uncomplicated and non-bothersome LUTS can be monitored. Changes to lifestyle habits, such as weight loss, increase physical activity, reducing or stopping caffeine and alcohol intake, reducing fluid intake at night should be advised. They should be monitored annually as studies have shown that progression of LUTS occur as one ages, usually with associated increase in prostate volume [8,9,10].

Men with bothersome symptoms, who wish to be treated, can be commenced on herbal medications containing saw palmetto (sereneo repens), alpha-blockers (prazosin, tamsulosin, silodosin), 5-ARIs (finasteride, dutasteride) or a combination of 5-ARIs and alpha-blockers (tamsulosin & dutasteride).

In general, saw palmetto and ***alpha-blockers*** work best in smaller prostate volumes (<60 mL) due to higher stromal/glandular ratio in the prostate gland. Although the relative degree of stromal and epithelial hyperplasia is variable, in general, approximately 80% and 20% of the hyperplastic nodule is composed of stromal and epithelial elements respectively [11]. The efficacy and tolerability of alpha-blockers are dose-dependent. Studies have shown that most long-acting alpha-blockers have the same efficacy. Side-effects include asthenia/fatigue, postural hypotension and dizziness, nasal congestion/rhinitis, anejaculation and intraoperative floppy iris syndrome (IFIS). Saw palmetto and finasteride can also cause IFIS [12].

5-ARIs block the conversion of testosterone to biologically active dihydrotestosterone in the prostatic epithelial cells [13]. This leads to involution of the prostatic epithelium and slowing the progression of BPH. As PSA is secreted by the prostatic epithelial cells, 5-ARIs can reduce the prostate volume by approximately 30% and a PSA by about 50% after six months or more of continuous treatment. Studies (PLESS [14], MTOPS [15], CombAT [16]) have shown treatment with 5-ARIs either alone or in combination with alpha-blockers to be effective in improving symptoms and reducing the risk of acute urinary retention and the need for surgery especially in those with larger prostate volumes (>40 mL). Some studies, including the Veteran Affairs (VA) [17] trial and PREDICT 18 study did not show superiority of combination therapy over alpha- blocker alone, especially in patients with smaller prostate volumes and shorter duration of treatment. Side-effects of 5-ARIs include asthenia/fatigue, decreased/loss of libido, erectile dysfunction, ejaculatory disorders and gynaecomastia in up to 16% of patients 19.

Surgery for BPH has evolved from monopolar TURP using glycine irrigations to a safer form of bipolar TURP using saline irrigations. There are new procedures being introduced to treat BPH. Most of them are aimed at reducing the side-effect of retrograde or anejaculation commonly associated with a TURP. They include Urolift, Rezum and prostate artery embolization (PAE). Laser vaporisation and/or enucleation of the prostate using laser of different wavelengths (holmium, thulium, greenlight PVP) is an alternative

to a TURP. It does not confer any significant advantage over a well performed TURP, unless the patient is anti-coagulated and it cannot be temporarily withheld due to a medical condition. Although there is short-term data to suggest efficacy of Urolift and Rezum in treating smaller prostate glands (<60 mL), they do not have the data to match the superiority of a TURP in larger prostate glands and in the longer term. Furthermore, there is no head-to-head trials comparing Urolift or Rezum to a TURP. In contrast, PAE can be utilised to treat prostate gland of any size and there is a head-to-head trial against TURP20. In the trial, TURP was shown to be superior to PAE in symptom improvement, flow rate, lower post void residual and lower remaining prostate volume. PAE had less anejaculation than TURP in the trial.

SUMMARY

BPH is a common condition and will remain so with an ageing population. Treatment is indicated in a select group of patients. Medical treatment is generally considered to be the first line of treatment, unless there is a surgical indication or medical treatment has failed. As with all surgical procedures, optimal outcome relies on careful patient selection. TURP remains the gold standard surgical treatment for BPH, unless the patient is concerned about the risk of anejaculation.

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Choices Cancer Support Centre: Support for men with cancer

JANINE PORTER-STEELE RN PHD AND LEONIE YOUNG DUNIV

The long-term survival of patients diagnosed with cancer has risen significantly in the last few decades. This has been a result of new techniques in surgery and more effective treatments as well as newer approaches to early detection.

However, the same treatments that have enabled long-term survival can also create potentially debilitating side effects ranging from disruptions in day-to-day activities to ongoing chronic illness such as cardiac issues. In addition, the impact of enduring effects of cancer treatment can have a significant effect on health related quality of life. These can range from physical impairment from amputation, the functional changes that may occur around continence or sexual function, the emotional effects of a cancer diagnosis and treatment, and the uncertainty and fear for the future [1,3,4]. It is also recognised that men can experience a range of unmet supportive care needs with the most frequently reported being concerns related to intimacy and informational physical and psychological needs[1] however men being less likely to report or discuss those concerns when compared to women[2].

Whilst age does not define distress for people diagnosed with cancer, those who identify as younger adults certainly do have to deal with quite specific concerns and for men, this can occur up to 50 years of age. This may be because of what is happening in their lives such as having dependent children, having financial responsibilities, looking for a long–term partner, looking ahead, having a longer life expectancy and a greater need for independence. Younger men's treatment decisions are also influenced by the onset of long-term treatment related side effects.

Studies have shown that exercise may be helpful in improving cancer specific fatigue, improve fitness and function and quality of life in men with cancer [3] and that men are more likely to engage in exercise interventions[4]. Yates et al; (2022) [4] examined a multicomponent survivorship program with men with prostate cancer. Their findings highlighted that survivorship care interventions are relevant to men at all stages of disease and treatment plan. They conclude that survivorship care interventions for men with prostate cancer and their carers should be tailored to individual needs, include a focus on improving exercise and nutrition behaviours to promote health and quality of life. There should also be a focus on provision of specific services such as psychological supports and sexual counselling. They also discuss and advocate the use of telehealth counselling, particularly pertinent given the issues of access no longer just around living rurally or remotely but also due to the Covid Pandemic.

The Wesley Hospital Choices Cancer Support Centre (Choices) commenced in 1998. Since 2015, Choices has been developing and broadening its services to support not only women but affected by any cancer. In doing this, Choices' programs aim to respond to the evidence above and change the state of play for men with cancer.

Choices provides an appropriate space for men to make valuable networks and connections in ways they feel comfortable doing so. With appropriate evidenced based, expert clinical and peer support, throughout the treatment phase and beyond Choices can help decrease stress and enhance well-being.

CHOICES PROGRAMS TO SUPPORT MEN

+ The More Choices Gym Program runs for 6 weeks and incorporates an individualized exercise gym program by an Exercise Physiologist and undertaken in the Wesley Hospital Gym. This program utilises the benefits of exercise following a cancer diagnosis as well as the benefits of connection with others who have similar experiences
+ Through specialist nursing, peer support and counselling services addressing the psychosocial needs of people dealing with the impact of cancer
+ Choices also offers other exercise programs including yoga and pilates all designed to assist both mental and physical well-being
+ Choices Complementary Therapies include Reiki, Reflexology, and Indian Head Massage which promote well-being and improve quality of life
+ Assistance in making important decision about surgery and treatment
+ Assistance in managing treatment side-effects
+ Advice about broader life-related topics including stress management, intimacy, sexuality,

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The Wesley Hospital Choices Cancer Support Centre

The Wesley Hospital Choices
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Male persistent pelvic pain

CHERYL ZEELIE

Chronic pelvic pain syndrome (CPPS) is a distressing condition that has a significant effect on quality of life. CPPS has a multifactorial etiology and seems to respond best to multi-disciplinary management.

The UPOINT system is a clinical phenotyping system useful to classify patients with urologic pelvic pain to help understand the etiology and guide therapy. The clinical domains are urinary, psychosocial, organ specific, infection, neurologic/systemic and tenderness of skeletal muscles in the abdomen and pelvic floor, *(Shoskes et al, 2009).*

Pain is defined as "An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage", IASP 2020. Common symptoms of CPPS include deep pelvic, penile, perineal and groin pain; urinary symptoms; dysejaculation and obstructed defecation. A biopsychosocial approach is essential when managing persistent pelvic pain.

Pathology should be excluded by the treating medical team, but the pelvic floor physiotherapist has an important role to play in assessing for increased pelvic floor muscle tone/tenderness which can contribute to pelvic pain. Increased pelvic floor tension also leads to problems with bladder, bowel and sexual function. Many of these men will have developed peripheral/ central sensitisation and as such, multi-disciplinary management is essential.

Possible causes of Pelvic and Sexual Pain:

+ Increased tension in pelvic floor muscles
+ Irritation, injury or compression of a nerve
+ Overtraining of core/ abdominal muscles
+ Psychological factors such as mood, high stress, relationship issues or past abuse

At The Wesley Women's and Men's Health Outpatient clinic, our pelvic health Physiotherapists have a special interest in the management of CPPS. A physiotherapist will perform an individualised assessment, focussing on each patient's individual circumstances and current level of function. We work collaboratively with GPs and other health professionals to assist in patients achieving their goals. Treatments for men with pelvic pain are varied and may include strategies for pelvic floor and whole-body relaxation, pain education, paced and gradual return to exercise, stress and lifestyle modifications, home exercise/ stretching programmes, advice on a healthy diet and education on improved bladder and bowel functioning.

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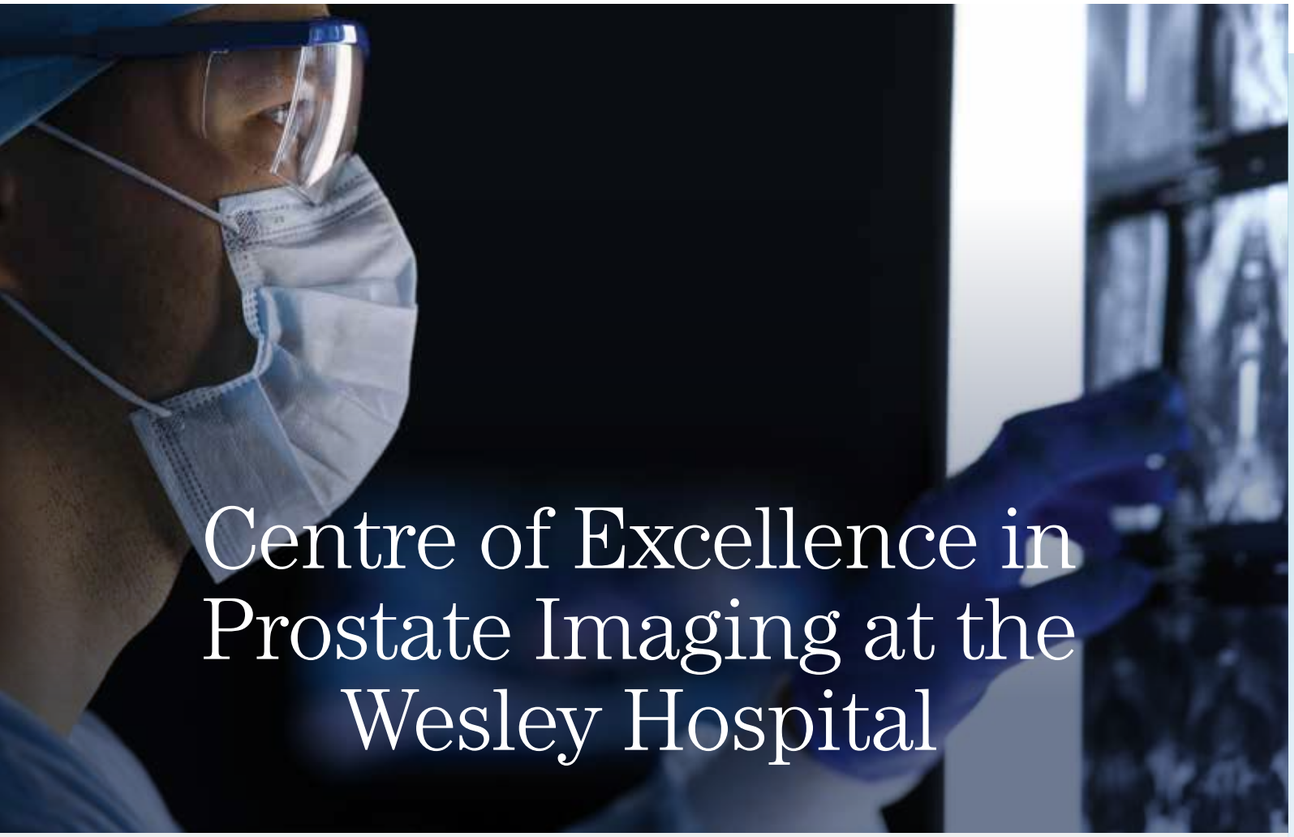

Centre of Excellence in Prostate Imaging at the Wesley Hospital

The radiologists at the Wesley Hospital have recently been awarded the internationally recognised accreditation from Radboud University in Holland as Australia's First Centre of Excellence in Prostate Imaging.

Recognised as the most experienced and trusted experts in clinical prostate radiology, our team provide unique confidence, insight and pathological feedback within an extensive network of multi-disciplinary teams across South East Queensland. Working collaboratively with the Wesley Hospital oncologists and the Wesley Hospital urologists, who in 2018 were recognised as Australia's first Centre of Excellence in Robotic Surgery, the multi-disciplinary team of experts are able to provide unparalleled treatment and diagnosis of prostate disease in Queensland.

The Wesley radiology group was a world leader in MRI prostate in 2012 and has since developed a reputation as one of the most comprehensive prostate diagnostic centres in the country. This is evident through pioneering the detection and biopsying of prostate cancer using MRI scans, including a world-leading trial in 2013, followed by introduction of Ga68 PSMA PET PSMA in 2014 and Lutetium 177 PSMA Therapy in 2017.

Radboud University Medical Centre (RUMC) headed by Professor Jelle Barentsz is the world leader in prostate imaging and research. It is the recognized global training centre for prostate imaging. Radboud CEO accreditation radiologists need to successfully complete a rigorous training program and minimum hands-on experience supervised by Prof Barenstz and his team at Radboud. After extensive training and assessment through RUMC the Centre of Excellence certification is recognition of the Wesley's expertise and leadership in prostate diagnosis.

The Wesley Radiology team have unparalleled experience and scan numbers across Prostate diagnosis – performing more than 17000 Prostate MRIs, 7000 Ga68 PSMA PET PSMA, 1000 MRI prostate biopsies and 300 Lutetium 177 PSMA Therapy.

For further information visit https://i-med.com.au/read-more-about-wesley-hospital

I-MED Radiology Network
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New Visiting Medical Practitioners

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Dr David Fraser is a Queensland trained orthopaedic surgeon specialising in hip and knee arthroplasty.

Having completed a dual Bachelor of Science and Bachelor of Commerce at The University of Queensland in 2005 followed by a Bachelor of Medicine/Bachelor of Surgery in 2010. He subsequently completed Orthopaedic training in Queensland and was awarded a Fellowship of the Royal Australian College of Surgeons in 2021 and Fellow of the Australian Orthopaedic Association also in 2021.

Dr Fraser has completed further subspecialty training in primary and revision hip and knee replacement with a strong focus on the usage of robotic technology under the supervision of Dr William Donnelly and Dr Hugh English.

Dr Fraser maintains a public appointment at the Prince Charles Hospital where he is involved in training future orthopaedic surgeons. In addition to hip and knee arthroplasty he also manages sports injuries of the knee including ACL and meniscus pathology, hip arthroscopy as well as general lower limb trauma.

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Dr Masa Kudo is a Queensland trained Respiratory and Sleep Physician. After graduating from University of Queensland, Dr Kudo completed dual training in Respiratory medicine and General medicine at the Prince Charles Hospital and the Mater Hospital.

He then completed fellowship in Sleep medicine at the Princess Alexandra Hospital, gaining further expertise in management of complex sleep disorders including neuromuscular disease, refractory insomnia and central hypersomnia.

Dr Kudo has an interest in looking after patients with undifferentiated problem and complex medical needs. He has expertise in managing wide range of respiratory and sleep disorders including asthma, chronic cough, interstitial lung disease, bronchiectasis, sleep apnoea and non-respiratory sleep disorders. Dr Kudo has admitting rights at the Wesley Hospital and the Mater Private Hospital.

Dr Kudo offers rapid-access consultations for any respiratory or sleep conditions. He is fluent in English and Japanese.

Referrals can be made via:

+ Medical Objects
+ Fax – 07 3123 5338
+ www.respirologist.com.au/referral (secure electronic referral portal)

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Dr Ross Tomlinson is a clinical haematologist at Icon Cancer Centre, Wesley and Toowoomba. He is experienced in caring for a wide range of malignant and non-malignant blood disorders including lymphoma, leukaemia, multiple myeloma, myelodysplastic syndromes, thrombosis and haemostasis.

In 2012 he completed his Bachelor of Medicine, Bachelor of Surgery (MBBS) at Bond University. Dr Tomlinson subsequently commenced clinical and laboratory haematology specialist training at the Royal Brisbane and Women's Hospital and Toowoomba Base Hospital.

Dr Tomlinson maintains a strong interest in clinical trials, clinical research and medical education in both his private practice and roles at Princess Alexandra Hospital. He has published several clinical research articles in leading peer-reviewed journals and is a regular presenter at national and international haematology conferences.

Dr Ross Tomlinson is a strong advocate for clinical trials and local research, ensuring regional patients have access to the latest treatment options. He is committed to providing individualised, patient-centred care, and works collaboratively with his patients, their loved ones and general practitioners to achieve the best possible outcome.

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Dr Martin Hanson is an Otolaryngology Head & Neck surgeon with advanced training and subspecialty interests in Facial Plastic Surgery (particularly rhinoplasty and reconstruction of the nose and ears), Thyroid & Parathyroid Surgery, and Head & Neck Cancer Surgery.

He is one of a select group of Australian surgeons to be dual subspecialty trained in the USA, having completed accredited fellowships at Memorial Sloan Kettering Cancer Center (Thyroid and Head & Neck Cancer) and the University of Virginia (Facial Plastic and Reconstructive Surgery). Marty was offered an academic faculty position at UVA and worked as an Attending Surgeon in the Division of Facial Plastic Surgery in 2020 and 2021 prior to returning to Australia with his young family.

Dr Hanson has refined technical expertise in, and regularly sees patients for, cosmetic rhinoplasty, functional nasal reconstruction (for trauma, nasal obstruction and sleep apnoea), blepharoplasty, otoplasty and the resection and reconstruction of complex cutaneous malignancies of the face, nose, ears, eyelids and neck. He has performed clinical research focused on areas where he has high-volume surgical experience, namely thyroid, salivary and laryngeal disease and sinus surgery (including pituitary procedures). Marty was in the first cohort of surgeons to be certified by the American Head & Neck Society in their Trans-Oral Robotic Surgery (TORS) Fellowship training program and is one of the only surgeons in Queensland to receive formal fellowship training in the performance of surgical facelift.

Marty is committed to providing his patients with optimal treatments while also focusing on maximizing their quality of life. Marty believes that surgeons need to be sensitive to all issues affecting their patients and wishes to be seen as someone who cares about his patients and their families as people.

Dr Pranavan Palamuthusingam
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Dr Pranavan (Pran) Palamuthusingam is a Consultant General and Hepato-Pancreatic-Biliary (HPB) Surgeon at the Royal Brisbane & Women's, and Wesley Hospitals.

He graduated from James Cook University medical program in 2008 and finished General Surgery training in 2015, obtaining Fellowship with the Royal Australasian College of Surgeons (FRACS). He then completed further years of subspecialty training in HPB Surgery Oncology at the Royal Adelaide Hospital and the prestigious St James University Teaching Hospital in Leeds, United Kingdom. He is a certified HPB Surgeon with ANZHPBA (Australia, New Zealand, Hepato-Pancreatico-Biliary Association).

Dr Pranavan was the Clinical Lead for Liver and Pancreas Surgery in North Queensland (2018-2022) and has created a multidisciplinary tertiary referral service based out of the Townsville University Hospital and Mater Hospitals- enabling high quality service to be provided to a catchment area extending from the Cape York to Mackay. He is still actively involved in supporting the service.

He was the former Supervisor of General Surgery Training at the Townsville University Hospital and is the Clinical Lead for the North Queensland Foregut Research Collaborative (NQFRSC) that fosters research in Liver and Pancreas Surgery in conjunction with James Cook University. He is also Senior Lecturer in Surgery with the James Cook University Medical School and University of Queensland.

He performs the full breadth and complexity of HPB surgery services for both benign and malignant conditions with a particular interest in complex cancer surgery.

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Dr Philip Rowell was raised in Brisbane's western suburbs. He completed his undergraduate Science degree in 2003 and successfully completed post graduate medicine through the University of Queensland in 2008. He concluded his Orthopaedic training in Queensland in 2018 and was awarded a Fellowship of The Royal Australasian College of Surgeons (FRACS).

Since 2019 he has held a position as an Orthopaedic Specialist at The Princess Alexandra Hospital, where he specialises in Orthopaedic Oncology and contributes to Orthopaedic Trauma management. Since 2019 he has also held an appointment at The Prince Charles Hospital, a tertiary level arthroplasty centre where he specialises in arthroplasty of the hip and knee and General Orthopaedics. He was an early adopter of robotic joint replacement technology through The Prince Charles Hospital in January 2019 and continues to contribute to research in this developing area.

In 2020 his family of six moved to Canada to complete further sub-specialty expertise in one of the world's most prestigious Orthopaedic Oncology (musculoskeletal tumour) units at Mount Sinai Hospital, Toronto. During this time, Phil held a joint appointment at Princess Margaret Cancer Centre, one of the largest cancer centres in the world and a world leader in cancer research. Additional time was spent at the renowned Hospital for Sick Children (SickKids) in Toronto.

Dr Rowell and presented research locally and internationally in the areas of sports medicine, paediatric orthopaedics, arthroplasty and orthopaedic oncology. He has an ongoing interest in musculoskeletal tumour and arthroplasty research.

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