

ZEROPODCAST: PROSTATE CANCER UNCENSORED

Series: 1, Episode 2: Sex After Diagnosis – Guest: Dr. Rachel Rubin

Jamie Bearse: Hello, and welcome to Prostate Cancer Uncensored, a podcast produced by ZERO – The End of Prostate Cancer. I'm Jamie Bearse, CEO at ZERO.

Today's podcast is all about sex. Did you know that 4 out of 5 prostate cancer patients struggle with poor sexual function after treatment? That's a daunting statistic, but there's help and hope as we shed a spotlight on it.

Dr. Rachel Rubin is our guest today. Dr. Rubin is a urologic surgeon who specializes in sexual health. She's with IntimMedicine Specialists in Washington, DC, and she's also a member of ZERO's medical advisory board.

Dr. Rubin, thanks for being with us today. How are you?

Rachel Rubin, MD: Thanks for having me. I'm doing great.

Bearse: Terrific! Thanks for being on. Now, Dr. Rubin, as I just said, 4 out of 5 prostate cancer patients have trouble with sexual function after treatment, and you speak to men everyday about this topic. Give us a little insight into the range of struggles that men with prostate cancer and sexual dysfunction are dealing with.

Rubin: Jamie, thanks so much for inviting me on and for asking. We, in Washington, DC, at IntimMedicine, see men and women for sexual dysfunction. I wish I could say that this is something that just afflicts prostate cancer survivors, but really every one of every gender will have some form of sexual dysfunction at one time or another.

When you're dealing with prostate cancer, I mean, just the word cancer can give you a sexual dysfunction. It is so all-consuming. We know there's increased risks of depression. Cancer diagnoses really can hurt families' communication and intimacy.

So, we see patients who've had surgery who struggle with issues from incontinence to erectile dysfunction. They can get issues like Peyronie's disease, which is curvature of the penis, and they can have pelvic pain issues.

Folks with radiation, they can have urinary problems, erectile dysfunction problems, and we know men with metastatic prostate cancer who are on hormone therapy have significant dysfunction – hot flashes, night sweats, low libido, erectile dysfunction. They can be devastating to deal with.

Bearse: That's right. It's almost an endless list of issues that they struggle with. It's incredible.

Let's talk about the actual physical aspects of prostate removal. I've been working for the cause for coming up on 20 years, and some guys don't even know how to spell prostate let alone know that they have one. So when they get diagnosed with prostate cancer, it really comes as a shock because of the sexual function that is so tied into treatment for it. So, they might be surprised to know that prostate removal does affect orgasms and creates all of these issues that you've outlined.

Rubin: Yeah, it's incredibly frustrating. So usually before I even do a prostate biopsy, I pull up Google Images and I show pictures of anatomy. When you understand your anatomy and you can see it happen, then you can take control of it and you know what you need to do – what treatment can be helpful.

So, a prostate is a walnut-sized organ that lives around the urethra – the tube that you pee through. It's between the bladder and the base of the penis. It is responsible for a lot of the fluid that goes into ejaculation – the fluid that comes out after orgasm. And so, when you remove that prostate, you certainly will no longer have ejaculation.

If you have radiation treatments, a lot of times ejaculate is absent or at least it's significantly diminished. And the nerves that give you an erection – that aid an erection and sexual function – they hug the prostate. They live on the sides of the prostate, and it's really a mesh network of nerves. It's not one single nerve that a surgeon can see and separate off.

So this idea of nerve-sparing prostate surgery can be frustrating because you expect to be fully left intact, but we still see a high rate of sexual dysfunction after any kind of treatment for prostate cancer because it is so linked to sexual function.

Bearse: After hearing all that, it's understandable why men might feel their sex lives might be over after prostate cancer, right?

Rubin: I think it's really unfair that we make men – and we do this to women as well when it comes to any kind of cancer – but we tell them that you have to choose cancer and living versus a good sex life. And that's really an unfair choice that we give to patients. And my point is, you can really have both when you take your quality of life and make it important.

Oftentimes, couples that get a prostate cancer diagnosis, this is the first time they've ever had a sexual challenge. They've ever had to talk about. They've ever had to work through challenges. And I think it's really important to ask these couples... I love meeting with couples before they get prostate cancer treatment to kind of show them what's going to

happen, how we're going to be with them every step of the way, and how they can maintain intimacy during their treatment period and afterwards.

You know, important questions like what do you want sex to look like? How do you want to feel at the end of it? How do we work through those challenges and maintain pleasure and intimacy because really sex is not just about erections? It's about pleasure and intimacy, and how do we keep that conversation going before treatment, after treatment, and even during treatment?

Bearse: Now, you said you talk to couples about what you want to sex to look like after prostate cancer. Do you also pull up Google Images for that too?

Rubin: Absolutely! No, not always. We didn't have that middle school class where they taught us how to talk about sex. None of us had good sex education. And it's really, really challenging to talk about it.

And so, making it medical. Explaining the anatomy. Those Google images showing what happens and getting you to talk about sex like we do blood pressure and diabetes, it takes some of the pressure off. It takes some of that discomfort and shame off, and we can have an honest conversation about what intimacy is going to look like.

Bearse: Intimacy is a critical part of all this, and we'll get into that in just a minute. I wanted to hit you up with a couple more questions.

We all know about the blue pill. We hear about implants, and there's a range of treatments that are available to men depending on what issues they're dealing with. Can you tell us some more about that? I know there's quite a few options, but can you run through a few of them for listeners?

Rubin: Absolutely! Like I said, if you understand how the anatomy works, you then know how we can alter it and change it to have better function. So it's really helpful to explain to couples that the penis is just a muscle. It's a muscle that contracts and relaxes just like your biceps. It's just that you don't have full control over it. It's a little bit from the fight or flight perspective.

For example, if you have a tiger chasing after you – I use this example often – do you want to have an erection Jamie? If a tiger is chasing you.

Bearse: Probably not.

Rubin: Probably not, right. So when you're running away from a tiger, evolution has said that muscle needs to be contracted, and you've got to get blood flowing into other places or you're going to get eaten.

So if your muscles are relaxed, that's when erections happen. And so anything we can do to relax muscle is what aids us in erectile function. So the little blue pill, everyone knows about

it, but very few people know how it works. Viagra, Cialis, Stendra, Levitra (8:05) are muscle relaxers.

And so, if you're taking your muscle relaxer so you can get a good erection, that feels a whole lot different than if you say I have to take my erection pill.

So in terms of other treatments, anything you can do to get muscles to relax is going to help with erectile function. That includes injections that we put directly into the penis to relax the muscle, vacuum pumps which help to bring blood flow to the penis and aren't medication, and we'll even use things like sex therapy which is a great treatment to get your brain to relax and to get better communication with your partner, which is going to aid in erectile function.

And there are specialized physical therapists called pelvis floor physical therapists which help with all sort of muscle. So they can help you with incontinence if you have incontinence after prostate surgery. They can help you with sexual function as well and pelvic pain because your pelvis is just full of muscles that can be affected after prostate cancer treatment.

Bearse: Now, with thinking about sex, do you guys actually use a tiger to chase some guys around to make them get panicked and then relax, and then, you can talk about sex with them?

Rubin: I do have quite a few patients who get tiger imageries in their head quite often.

Bearse: As a guy, that's probably the last thing you want the tiger after. Do you find that simply hearing that there are so many options out there that it gives men hope that they might resume sex life after prostate cancer?

Rubin: Absolutely! I think the key is we don't talk about it enough. Everyone's worried about cancer and death, and we don't spend the time talking about quality of life. And so, it's really important – for at least the cancer docs that I work with – is that I see patients for the quality of life side of things. We're not talking about your Gleason score. We're not talking about all the treatments for prostate cancer. We're talking about how you live with prostate cancer.

When you make it a medical problem, and you make it easy to talk about, and you give time to those conversations, people really do get hope because you get to redefine what your goals are. You get to redefine what it is you want out of life and what you want out of whatever life you have left fighting the cancer.

What a better way to fight cancer than to live your best life and to improve your quality of life as much as possible.

Bearse: That's great. Now, let's get into talking about intimacy, but before I do that I think that intimacy is connected with being vulnerable and having courage. I think vulnerability

and courage go hand in hand, and it doesn't have to necessarily happen in the bedroom. It really happens with relationships, no matter what kind of relationship you're talking about.

At ZERO and building a cohesive team with lots of great relationships within the organization, I stress having that courage to be vulnerable because it builds trust among two people or even among teams.

Now, why I say that is because you spoke at our summit. I'm going to share something that's sort of vulnerable about myself and maybe you'll reciprocate. Now, you spoke at our ZERO Prostate Cancer Summit which we have every year in February, and that summit is meant for educating prostate cancer patients and their caregivers and their families about the disease to help inform them about their journey and then to also bring in advocates from around the country to talk to elected officials about protecting and growing prostate cancer research funding and improving access to care for prostate cancer treatment and screening and more.

So, when we brought you into the summit, I thought the conversations that you had with our attendees were just fascinating. And I think the statistic that you shared was – and this might be helpful for some prostate cancer patients to hear – that women orgasm with penetration about – is it 12% of the time?

Rubin: Less than 18% of the time.

Bearse: So less than 1 in 5 do. And hearing that statistic and bringing it home, I think was very helpful. So having you come to the summit and just sitting in and listening to some of the things that you had to say. And not being a prostate cancer myself. But even that kind of information to go back home with was incredibly helpful. So I have to thank you for that. And that's my little bit of vulnerable moment to you.

Rubin: It's not just prostate cancer that affects sexual function. We don't talk enough about female sexual function. We don't talk enough about male sexual function. And everyone feels so alone.

Sex is this magical thing that everyone's having and no one's talking about. You don't have to be coupled in order to have a satisfying sex life. You don't have to be in a heterosexual relationship to have a satisfying sex life. And it can be very isolating and feeling alone because you are only speculating what kind of sex other people are having. You're using pornography to give you what the measure of success is. You're using these unrealistic expectations.

So patients get to decide what kind of sex they want. And if have a prostate cancer diagnosis and you just avoid any intimacy or conversation about it, you're wasting a lot of really fun experiences. And you're not living the life that you could be living.

Bearse: I think that less than 20% would resonate a lot with prostate cancer patients because I hear guys talk about when they're going through their prostate cancer journey that they

can't achieve an erection, their partners are on them of hey, are you just not into me anymore, am I not attractive enough? And it just creates this sort of spiral effect of not being able to achieve the right level of intimacy.

Even to the point where I hear some prostate cancer patients are almost telling themselves a narrative in their own head about that without even having a conversation with their partner about it. So it creates, what you had said a few minutes before, of the tiger chasing them. You can't really relax.

Rubin: Yes, if you're always thinking about that tiger, you get that adrenaline surge, it's really hard to be in the moment and to be intimate. And if you're not used to talking about it, then when things go wrong, it's even harder to talk about these problems.

And you know, women and partners – it doesn't have to be a heterosexual relationship – people do well with communication. They do well with talking about things. Both sides of the couple often have trouble saying what feels good or what they want, but the only endgame is that both of you have pleasure. That's the rule of sex – it's fun, it feels good and you enjoy it.

None of what I just said was erection. None of what I said was orgasm. None of what I said was it had to look a certain way. And so that's where the conversation needs to shift – is being able to change that dance and focus on what feels good.

Bearse: Well said. Well said. Now, let me through it to you to share something. There probably aren't many people that grow up and go to school whether they're in grade school or high school or whatever and say hey I want to be a sex doctor when I grow up.

Rubin: Every little girl's dream.

Bearse: Yes, every little girl's dream. What personal experience made you want to be a sex doctor? Was there a relationship at some point where you were like, um hey buddy, you're doing it wrong, and it just sort of stuck in your head and that's how you ended up here? Tell us about that.

Rubin: You know, I would say that I grew up among people where it wasn't so hard to talk about sex. It was easy to sort of talk about with your friends, but yet, a lot of people had problems. Guys and gals would complain of issues – pain with sex, inability to have an orgasm, couldn't put tampons in, needing surgery in order to be able to be sexually active.

So I had these experiences watching people around me have issues, and it was easy for us to talk about. And then when I found urology – and maybe that's what drew me to the field of urology – is because these kinds of issues weren't hard for me to talk about.

And so, I found that my mentors or the people who were training me weren't that good at it. They could counsel you on prostate cancer. They could talk about your robotic

prostatectomy. They could give you statistics. But they wouldn't ever ask you about your sexual function, or they would spend 5 minutes throwing a Viagra prescription at you.

And I wanted more for my patients. I wanted to be able to have those difficult conversations. I wanted to work within a multidisciplinary way to deal with what we call a biopsychosocial approach. The biology, the psychology, and really that quality of life issue.

I want to know where you came from. I want to know where you want to go. And I want to help increase people's quality of life. That's really why I went into this field. And it is so incredibly rewarding because not a lot of people do what I do. And hopefully, more will as we go ahead. But it's incredibly rewarding.

Bearse: And I'm sure being able to delve into the intimacy aspect is also important as well because that, as we've been talking about, really sort of clear your mind and just be in the moment to be able to have sex.

Rubin: I want to tell a story real quick. Can I tell a story?

Bearse: Yeah, tell a story.

Rubin: So, let me tell a story that I think really highlights the issue. I saw a couple recently where they had been married for 7 years, and they have not been able to have penetrative sex. He has erectile issues, and she has such tight pelvic floor muscles that she can't tolerate penetration either.

And they came to see me just completely feeling like failures being so upset that they couldn't have that relationship with each other. And everyone was mad. They want children which I understand. That's an important part of this.

But they came to see me, and they're sitting in front of me. And I asked him if he could have an orgasm. And he looked at me. And he says yes of course, my wife is always there with me. I'm able to have a very pleasurable orgasm, and it feels great.

I said, okay, and I looked at her. And I said, well, can you have an orgasm? And she got blushed in the face, she started giggling, and she said, Dr. Rubin, I can have 10 orgasms in a row and he's there with me and we have a great time. And they're looking at each other and they're laughing, and they have this intimate connection that's just amazing.

And I look at them, and I said, well shit, you guys have better sex than most patients that I see every day, right? You have great sex. But they were looking at themselves as complete and total failures.

And by telling them that, by giving them permission to see what intimacy and pleasure look like, what the goal of sex is, it took a weight off of their chest as we work towards penetration and getting them to improve upon whatever sexual experience they want. You know, the idea that they're going to feel a different pleasure with penetration – I'm not sure they will.

And so, it's really understanding what is the goal, and what are we all trying to achieve.

Bearse: Our women listeners especially, their ears just perked up over that. Dr. Rubin, what's the secret to 10 orgasms?

Rubin: I think normalizing, as you said, that most women can't have an orgasm with penetration – that more than 50% of women have vibrators that work for them to improve their orgasm. It doesn't necessarily matter who's giving you the pleasure as long as you get pleasure as a couple.

So normalizing some of these things in sexuality I think can be extremely helpful.

Bearse: Absolutely. I love this story. Now, back to prostate cancer. And some prostate cancer patients and survivors with their partner may need to redefine intimacy. Is that right? Tell me about that.

Rubin: Yeah, I think we just talked a lot about that – that too often I'll see couple who have been going through prostate cancer treatments for 2 years, and they've completely avoided any kind of intimate conversation. So because they don't think they can get erections, they've stopped holding hands. They've stopped hugging. They've stopped kissing. They've stopped talking about it because they know that it won't end in a penetrative relationship.

And so, the problem is, maybe 2 years goes by and they're ready to start up again. Just getting a hard erection still makes it really hard to rebuild that intimate connection with their significant other if they have one or even with yourself.

And so, as I said, what better way to fight cancer then to try to achieve intimacy during that whole experience, whatever intimacy might look like. And having those conversations that just because you're cuddling or just because you're holding hands doesn't mean it's going to end in penetration. And being able to talk about it is going to make you have a more intimate relationship with your family. It's going to make you feel more human. And it's really going to make you give a big middle finger to cancer and say cancer's not going to get my whole life.

And that's the whole point of treating cancer anyway. We want you around for as long as possible. And we have to decide what that life looks like.

Bearse: I love it. Let's flip off cancer, and one of the best ways to do that is to have a pleasurable and intimate sex life.

Now, you had talked about a partner. So when it comes down to whether we're talking about your wife or your husband or girlfriend or partner, they're a vital part of the sex discussion. Can you talk us through some of the doubts or fears or anxiety that they go through when you counsel them as you're treating a prostate cancer patient?

Rubin: Absolutely. I mean, cancer is a couple's problem. It's a family problem. You see this all the time when you're dealing with caretakers and families. It affects everybody. Your quality of life affects your partner's quality of life. Your ability to feel intimate and to feel good about yourself affects your partner.

You know, we also forget that most men who have prostate cancer are diagnosed and treated during a time where most women are going through or are already well into menopause. And they have their own sexual problems and sexual complaints of low libido or painful intercourse happens. And so that's a conversation that needs to be happening because not a lot of people know about how women are affected by menopause which is actually very similar to how men are affected by hormone therapy for metastatic prostate cancer. And so, having those discussions is very important.

Bearse: Now, for us guys that are out there listening tell us a little bit about that. You said that going through menopause has a little bit of similarity to going through hormone treatment for prostate cancer.

Rubin: So when you give a guy Lupron for metastatic prostate cancer – another medication that stops his androgen function – you take away all the hormones in his body. And men feel awful. They get hot flashes. They get night sweats. They get low libido. They get erectile dysfunction. They get an increase in cardiovascular disease. I mean, these are very serious and very life-changing medications that we give to save your life from prostate cancer.

Usually around age 52, all women's ovaries stop producing estrogen, testosterone, progesterone. They stop producing hormones. And so, what happens to women? They get hot flashes. They get night sweats. They get low libido. They get arousal problems. So pain with intercourse, dryness. They get can urinary tract infections, increased risk of cardiovascular disease. And this isn't just women with cancer. All women experience it.

And so, all of the side effects that you see in men on androgen-deprivation therapy happens to many women if not all women in some capacity who stop producing hormones in menopause.

Bearse: Thanks for shedding a light on that. When it comes to treatment for sexual dysfunction, it's important for both partners to be on the same page and of course the same rhythm. You shared the example of a couple who thought that they were maybe going through some sexual dysfunction, but it turns out they're the envy of 99% of people who hear that story.

But could you share a story about what's it like when a couple's not aligned over sexual dysfunction and are trying to get their sex life back or improve it after prostate cancer?

Rubin: I see this all the time. You see people who come in with libido mismatch, and it's not just a man whose libido is higher than a woman. A lot of women have higher libidos than their male partners. You certainly see it in same-sex couples as well. You get these libido mismatches.

I think it really all comes down to communication issues. If you can't talk about sex with your partner, who can you talk about sex with? No wonder people don't talk about it with their doctors because you can't even talk about it when the lights are off and you're having sex.

And so, it really comes down to communication. And if partners aren't on the same page, we're never going to get anywhere. So when I see patients, I always encourage the partners to come in because understanding the medical condition of their partners can be incredibly therapeutic. If you understand that the erection isn't hard because of a muscle problem and a blood flow problem, it feels a lot less sad than saying, oh I can't get an erection because you're not attractive anymore.

As I said before, you can take it very personally. You know, taking that Viagra pill and saying this is my muscle relaxer as opposed to this pill will make it so that I can pretend to be attracted to you. I think people build it up in their heads instead of actually talking about it out loud and working through it with their partners.

And the time to talk about sex is actually not while you're having it. You know, we never give feedback. We never have an after-action report. We never do a pre-brief. And I think changing that, planning sex, talking about it, scheduling it, those things can all be very helpful.

I work very closely with sex therapists who really can work with couples as a coach really to help you regain intimacy into your life. As I say, you want to go to sex therapy not when your relationship is bad but actually when it's good because how do you make it better. Nobody is so good at sex that they can't make it better, that they can't improve communication. And so, really working with that consultant to work with them on improved communication, everybody benefits from that.

Bearse: Now, Dr. Rubin, can you share a story from your experience when a couple isn't aligned as they go through prostate cancer? What I'm trying to get at is that they will be listeners out there that aren't quite sure that they should be seeing a sex therapist or talking to a doctor further about sexual dysfunction. So if there's a story that they can hear. And there's part of it that maybe a light bulb goes off over their head, and they're like, hmm, that kind of sounds similar to what I might be going through with my partner. So maybe I should talk to a sex therapist or at least talk to my doctor to see if I can get some help in the bedroom.

Rubin: I think one thing we assume – certainly have a lot of stories – but one thing we assume is that our partner isn't interested, or our partner doesn't want sex. And sometimes it's the intimacy people are afraid of.

I had a couple in here the other day where he had prostate cancer, and they hadn't had any kind of discussion about intimacy. They hadn't had any intimate time together for about 2 years. And I asked him, I said, well, how are your erections? And he said, well, they're not as hard as they used to be. I don't think they're hard enough for penetration.

And I said, well, can you have an orgasm? And he said, yes. And I said, does the orgasm feel good? He said, yes, the orgasm feels great. I said, well that's wonderful. I said, are you having regular orgasms?

And he looked at me – and his wife was sitting next to him – and he said, yes, I do have regular orgasms with masturbation. And that was fine, and he was able to talk about that. And I asked her, I said, well, have you been having orgasms?

And he started talking. He said, well, I just told you we haven't had any intimate time in 2 years. And she looked at me, and she said, yes, Dr. Rubin, I've been having orgasms. I have regular orgasms from masturbation.

And you saw his face of just complete and total surprise and shock and also just amazement, right? There was something this woman he'd been married to for 40 years, and he had no idea that she was able to have an orgasm through masturbation.

And I often see this with couples of all ages where they will know more about each other's bowel movement habits than they know about their own masturbation habits. And I know religion plays a role, and certainly, there's a wide audience that's going to listen to this, but we have to have the conversation of is there something so shameful and wrong about a reflex that makes you feel good?

And if you can have them together, great. But a lot of people are having them separate. And so, is that a horrible thing to talk about? Can you have intimacy together and pleasure separately?

I see that all the time where couples are not having conversations about these things.

Bearse: And communication is the key. I can imagine that going a couple of years of orgasming separately through masturbation and one not knowing about the other would also come down to communication too. There has to be some improvement there, I can imagine, in the room for this particular story. I just can imagine the shock or even one of the partners may be feeling betrayed that the other one hadn't talked to the other one about their masturbation habits.

Rubin: That's what makes my job so much fun and wonderful is that I have to take the whole couple in to consideration. I have to get them talking to each other. I have to get them being honest with themselves. And I have to ask hard questions of things that they've never had to verbalize out loud.

But again, when you make it medical, when you explain to them how prostate cancer affects their body, when you explain to their partners how prostate cancer affects their body, it becomes manageable. It becomes easier to talk about. You take that shame away from it.

Bearse: Yeah, most definitely. So one of the takeaways here is to talk with your partner about sex and what you had said before – in being able to really define what you want to get out of it and really be an attentive listener to what your partner wants to get out of it.

Rubin: And again, those conversations are important to happen over the breakfast table or over dinner. They're not supposed to happen while you're engaged in that vulnerable act because feelings can get hurt, and it can be difficult to have those conversations in those vulnerable moments.

And so, making it easy to talk about at other times, I think will really be beneficial for the couple.

Bearse: And just to be in the moment when you're trying to relax, have fun, and have a pleasurable moment having sex, what should couples talk about to kind of heighten that?

Rubin: That is a great question, and I'm going to say there's no one-size-fits-all with sexual medicine.

Bearse: All right, so they can talk about anything while getting it on?

Rubin: Each couple is going to have their own things that get them excited or get them relaxed or get them in the moment, right? Some people like chocolate ice cream. Some people hate chocolate ice cream. And so, you've got to figure out what your ice cream flavor as a couple is.

And it may be different within each side of the couple, which is again what makes it really fun because you have to constantly communicate and alter your preferences based on what your partner wants. And that may change even from experience to experience.

Bearse: That's right. When you work with couples, I'm guessing that you have to take into account what sex was like before prostate cancer in order to be able to treat the couple after prostate cancer. Tell us a bit about that.

Rubin: So I think this is not a specific thing to cancer. I think very often I'll see couples who have a sexual dysfunction, and their goal is to get back to 10 years ago when they were different people. And that's the marker of success. And anything less than that is not successful.

And I think the issue is really getting people to talk about what is the goal of sex. What does feel good? What kind of pleasure are they having with their partners? And maybe that's trying to get to some level that they were before, but also, we have to live going forward.

What do we want it to look like? What are things we can change? And what are things that we cannot change?

If you're someone who can only get an erection by putting an injection into their penis, but you are terrified of needles, and you're going to pass out every time you do that, well that is not going to work for you. And we're going to have to find a different treatment strategy that's going to help you.

And so, again, it's not that one-size-fits-all approach. I have to get to know you and work with you and whoever's with you if there is someone with you and figure out how are things going to look like going forward not going backwards.

Bearse: That's right. Has a prostate cancer patient ever felt as though they've returned to full 100% function of how they were like before prostate cancer?

Rubin: So, what I would say is that certainly you can get good erectile function back after prostate cancer treatment. Certainly, urination issues can be improved and do well. But you're never going to be the same person after you've had a diagnosis of cancer. And so, assuming that that just doesn't exist, I think is unfair.

You're always going to have something that's going to be different, or as people age, they become more mature. As people age, they become more confident. As people age, lots of changes are happening.

So the cancer aspect, you have to expect some change, and you have to be able to change the dance a little bit I think is a really important point. Don't stop dancing. Just change your steps.

Bearse: That's right. I don't even think prostate cancer has to play a factor in that. That just comes with age or getting older or how you're likes change, too, right?

Rubin: Absolutely! Seventy percent of 70-year-olds have erectile dysfunction; 60% of 60-year-olds. And it can feel very isolating – well, I have cancer, and this is why this is happening to me. But this is happening to a lot of couples that don't have cancer. But we never talk about it, and so, people feel very alone.

Bearse: I heard you say that a couple's sex life may not be the same after prostate cancer. Obviously, we talked about this through the whole podcast. And it can be a new journey for them. Can you continue to explain what you mean by that?

Rubin: Yeah, I think it can bring you a lot closer as a couple. If you've improved your communication. If it makes you realize that life is short and you have to live it to the fullest, then that's a good change that you can make in your life. What better way to fight prostate cancer than to live and to live to you fullest?

And so, hugging your family a little tighter. Communicating a little bit more. Being vulnerable. Showing cancer that it's not going to get you.

As I just said, everyone should keep dancing. The dance steps might change. You may have to change the moves a little bit, but don't sit on the sidelines. Don't just sit there and regret how you used to be able to be a great dancer. Continue that dance!

Bearse: Yeah, I hear you. Me personally, I used to be able to breakdance and do the windmill on a cardboard on the floor and all that. But now, it's sort of more of a waltz, I would say.

Rubin: You're way too old for that.

Bearse: That's right. I was going to say I don't recommend that prostate cancer patients try to the breakdance windmill on the floor, but they may be up for it.

Rubin: Exercise is very good for erectile function. So I have to promote exercise and eating right.

Bearse: And what's the top exercise that comes to mind? What do you get asked about?

Rubin: You know, sex is a great exercise. You can burn a lot of calories in the bedroom.

Bearse: That's true. And then, I can imagine that some of the listeners are also asking after prostate cancer – since we're getting so intimate in the details – what's the best thing that they can do to achieve sexual function?

Take me through a couple of the steps of rebuilding sexual function after prostate cancer. Do you know what I mean by that?

Rubin: Yep. It's a great question. You're really going to want to work individually with your doctors to figure out what is it that's the main complaint that you have. Is it leakage during intercourse? Urinary leakage. Is it leakage throughout the day? Is it a problem with the erection itself? Is it is problem with your libido or your interest in sex?

And each treatment is going to change depending on what your biggest complaint is. We've got lots of treatments for erections ranging from pills, injections, suppositories, vacuum pumps, penile implants. And as I said before, there's even some alternative treatments like pelvic floor physical therapy or sex therapy that are incredible treatments to improve communication and help with the muscle relaxation that we talked about.

And so, when you do have a diagnosis or after treatment of prostate cancer, there is hope. There are so many things that we can do to get you having a more fulfilling sex life.

Bearse: Thanks, Dr. Rubin. I can also imagine that prostate cancer patients are also asking when they get back in the saddle, when they're back in the bedroom, and it comes to sex, what's the best position to make sure that everything's working smoothly?

I think it goes back a little bit to the dance analogy that we used. Do you ever get asked that?

Rubin: What I would say to that is that in sexual medicine we don't get it right every time, but you bet your butt we have fun trying, you know. And so, it's a matter of figuring out with your partner what is working for you. And it's going to be a different position, a different angle because you've got different people with different body habitus and different erections.

You've got to figure out what works for the couple.

Bearse: Now, is there like a catalog or something that you hand out at IntimMedicine to couples that they can look each page?

Rubin: No, I don't, but that's something we should commission. We should think about that.

Bearse: Maybe. I'm going to call the New York Times after this and tell them we have a new best seller coming. That could be a page turner.

Rubin: There you go.

Bearse: Well, great. Now, with prostate cancer patients and their partners, tell me what are some top, frequently asked questions that come from couples that we haven't covered?

Rubin: So, I think sexual education is a really important...these are really important questions. Questions like how long are you supposed to last as a man. So this idea of premature ejaculation. Or if you orgasm too quickly or it takes you too long to have an orgasm. It's a little like Goldilocks. I see people who orgasm too quickly, and I see people who have really delayed orgasm. And they all want treatment. And so the idea is normalizing it and really letting people know what is "average."

And it's always surprising to people what those answers are.

Bearse: Not to interrupt you, but as a guy, we sort of all know this reputation that Sting has, which is doing this tantric sex act that can last like 3 to 4 hours. So, us guys, get it in our head of hey, that's the standard that we need to reach for.

Rubin: So, let me ask you, Jamie – and this is how studies are done in sexual medicine – if a man enters a woman, and she clicks the stopwatch on, man orgasms and she clicks the stopwatch off, how long is average if we look at the entire world? What's average?

Bearse: That is a good question.

Rubin: Putting you on the spot. Give me a number.

Bearse: I would say it would depend on the age, wouldn't it? But just overall, regardless of age, I'm going to say 7 minutes.

Rubin: About 5.5. And so, 7 minutes that's the US data. So 5.5 minutes throughout the world. If it's average, that means that half are below that, and half are above that.

And how long does it take a woman to orgasm? Remember we said most orgasm from penetration. But it can take a woman up to 15, 20 minutes to have an orgasm in a lot of research studies. And so, you do the math.

Women are not only having orgasms from penetration, and you've got to spend the time before or after really focusing on a partner. Obviously, this is a heterosexual conversation. And women can have multiple orgasms. Remember that story I said.

So the idea that sex is over and intimacy time is over when the man has an orgasm really doesn't take into consideration female pleasure. So it's something to think about.

Bearse: Yeah, and an old way to think about it because you want to make sure that both partners end up having a good time.

Rubin: Absolutely!

Bearse: What's something that every guy and woman end up asking you as they come into meet with you?

Rubin: It's completely different. My youngest patient is a 14-year-old with pelvic pain, and my oldest patient is a 94-year-old with various issues. And so, I see all ages and all genders and all sexual orientations.

And I think the universal thing is how little we are taught about anatomy and sexual function. And how, teaching – you know, in my office, I'll show you PowerPoint presentations and pictures and we talk about the physiology. And again, when you understand it, you feel like you can control it. And then, we have options for treatment.

I think when it's this unknown, scary thing that we don't understand it's really hard to understand the treatments and to stick to them.

Bearse: Great. And, I've seen repeated surveys and studies that men when faced with prostate cancer are more concerned over sexual dysfunction than they are of actually dying from the disease. Now, are you finding that in your conversations as well?

Rubin: I will say it is incredibly frustrating because when they're being treated for prostate cancer, you're hearing all of the cancer death, dying on the operating table. You're hearing statistics, and you're having to listen to all of that. And somewhere in there your doctor may have mentioned erectile dysfunction, incontinence, libido issues. But you don't hear it.

If they say it, you don't hear it. And if they don't say it, you definitely don't hear it. But if you've never had those problems, you can't even fathom what they're going to feel like. And so, often when men are on the other side of it, they say, well if I had only known this, I never

would have done X, Y, and Z. But it's really hard to explain to someone something they've never experienced before.

And so, it can be incredibly challenging. But the key is working with a team that takes your quality of life into consideration and makes it a priority.

[music]

Bearse: Dr. Rubin, thank you for joining us today and all of your radical candor and honesty around the topic. I want everybody to know that Dr. Rubin is a urologist at IntimMedicine. And she is one of the few urologists that has a fellowship trained in sexual medicine out of San Diego. And she's the person to go to especially with the radical candor that I love so much that's coming from you, Dr. Rubin. To be able to just get to the root of the problem and solve it, especially when it comes to such a sensitive topic as sexual health. Thank you for joining us today.

Rubin: Thank you so much, and hopefully, we'll see everyone at the Prostate Cancer Summit.

Bearse: Absolutely, and I look forward to seeing you there, too.

Now, for our listeners, this podcast is just one of a series of podcasts about sex. Head over to zerocancer.org to listen to our other podcasts. And again, I'm Jamie Bearse, your host and CEO at ZERO – The End of Prostate Cancer.

Thank you for listening to Prostate Cancer Uncensored.