

**AN UNSENTIMENTAL JOURNEY:
Surviving Prostate Cancer in the New Millennium
by Jeremiah Healy**

If you had asked me a decade ago to draw a parallel between my father—a retired Army officer from World War II—and Johnny Ramone—a member of the landmark Punk-Rock band that bore his stage name—I would have been hard-pressed. But today, the answer is simplicity itself: They both died from prostate cancer that spread to their bones. And, as an eye-witness to my dad’s passing, I’d recommend against it.

Prostate cancer is the most common cancer in men, with 220,000 of us diagnosed each year. That means one out of every six males will develop it in his life, and those odds darken to one in three if there is a male relative in your bloodline with the disease. Progressing through the statistics, things don’t get better: Next to lung cancer, prostate is also the most deadly form of cancer, with 30,000 men succumbing to it this year alone.

Kind of an attention-getter, wouldn’t you say?

Let me take you back a little. Specifically to November, 2003, when basically I had the world on my string.

By age 55 (okay, 55 and a half), I’d already enjoyed a pretty charmed existence. College at Rutgers, law school at Harvard. Five years of trial practice with a respected Boston law firm followed by eighteen years of teaching at a dynamic Boston law school. While a professor, I saw my first ten mystery novels published, and in 1995, I left teaching to become a full-time writer. Then came winters at a tennis club in Fort Lauderdale, summers at a lakeside house in Maine, and the balance of the year in a three-bedroom condo in the neighborhood of Boston called “the Back Bay.” To top it all off, my wife and I returned from a truly perfect trip through California’s wine country (celebrating our 25th wedding anniversary) to find my most recent book (a legal thriller under the pseudonym of “Terry Devane” and dealing with Boston’s priest/sexual-abuse scandal) had been optioned by Hollywood for feature film [For further details on my writing side, visit www.jeremiahhealy.com].

As I said, overall a pretty charmed existence. In fact, during my annual physical at the Brigham and Women’s Hospital in Boston a few weeks after Thanksgiving, my internist, Dr. Phyllis Jen, and I bantered about my having a life most professionals encounter only in their dreams. When we were finishing, though, she gave me a digital rectal exam, and I gave the lab some blood, as always, toward a simple test for prostate concerns.

When those blood test results came back, my own journey through the crucible of diagnosis and treatment began.

While not exactly a joyride, it has been a perversely intriguing experience, and one that I think you now should take vicariously. For yourself, if you’re a male over 40. Indeed, for any woman with a 40-plus man in her various circles of family and business, lovers and friends. To appreciate the personal side of being a prostate patient, and to learn what the medical community does—and may not—tell you about what lies ahead.

PROSTATE, NOT “PROSTRATE”

And I don’t mean by this just a couple of “twisters” that might pop up in a spelling bee. Perhaps the hardest fact to accept about prostate cancer is that it is asymptomatic in most males. Not only are

we not knocked flat on our backs: We generally don't feel any sensation, much less pain, while the disease is invading the gland.

But nevertheless the tumor (or, more usually, tumors, as they tend to sprout like individual mushrooms) will grow on that roughly walnut-sized organ. And prepare to spread throughout the body (and especially to the bones) long before symptoms of even mild discomfort "down there" lead a typical male to schedule a doctor's appointment. Accordingly, until relatively recently, prostate cancer would not be discovered in a man while it was still curable (A parallel problem exists with women and ovarian cancer—The New York Times, June 9, 2004, the "National Briefing" column). Today, however, there are distant warning signs available that can provide prospective prostate patients with genuine hope for a complete recovery.

First, though, a brief orientation on the prostate gland itself. To give credit where credit is due, much of the following information can be found in DR. PATRICK WALSH'S GUIDE TO SURVIVING PROSTATE CANCER (Warner Books, 2001), co-authored by Janet Farrar Worthington. When I refer to "Walsh, pp. x-z," this is the source that I mean. [Walsh also wrote an earlier book, now out-of-date, so be sure that the copyright on the one you buy is at least 2001; I have the hardcover, but I believe it is now available in trade paperback format as well].

A PLUMBING LESSON

Let's start with something we never learned in high school: the anatomy of the prostate and its important neighbors. And what (relatively little) the gland provides, even before the thing goes haywire. The prostate nests deep inside a man's lower abdomen, near the pubic bone. To picture the beast, imagine there's a baseball magically suspended in front of your chest. Think of this ball also as a spherical clock, with "12" at the top, and "6" at the bottom. Now, reach out your right palm and grasp the baseball underhanded, with your thumb riding at 12, your index finger at 4, and your middle finger at 8. Finally, allow your hand to drop so that the back of your wrist is resting against your belly button.

If that baseball and your hand could be reduced in size and inserted in the nesting place, the ball would be your prostate gland, your thumb would be an important complex of blood vessels for the penis, and your two fingers would be the nerve bundles which control (and are necessary for) both urinary continence and sexual potency.

Another attention-getter, isn't it?

The prostate itself, though, doesn't actually do very much (Walsh, pp. 2-6). Mostly, it serves as a plumbing connection, allowing urine to flow from the large bladder through the medium-diameter prostate to the narrow urethra and out through the penis. The prostate also a) produces about a third of the liquids that comprise semen, and b) protects against certain infections that might threaten a man's fertility (as opposed to virility).

That's about the size of it, in terms of the gland's function. The problem is in the prostate's dysfunction, especially among certain segments of the male population.

AGE, GENETICS, ENVIRONMENT

Prostate cancer is not a "disease of old age." It might seem so, because many of us picture our fathers or even grandfathers being diagnosed. Also, the participants in various medical studies of the illness tend to have an average age in the mid-60's (see the Bibliography at the end of this article), precisely because these men waited until they noticed a problem urinating or complained of lower

back pain. By the time you feel anything from prostate cancer, though, it's probably already migrated to your bone structure, and, realistically, can't be cured. On the other hand, prostate cancer generally consists of slow-growing tumors, making early detection the key to survival. That's why you need to be tested annually—both the digital rectal exam and the PSA bloodwork—beginning at age 40, to establish a baseline of the PSA level that is “normal” for you so that subsequent increases can be intelligently evaluated.

The situation, unfortunately, is worse for African-American men. Black males are 40 percent more likely to develop prostate cancer than white males, and the number of blacks who die from it is almost double the rate for whites (Walsh, p. 52).

There also appear to be quirks of environment, not well understood as yet. Typically, men in mainland China have the lowest incidence of prostate cancer on earth. However, ethnic Chinese from the same gene pool who live in Singapore and Hong Kong have a rate five times higher than their mainland brethren, and moving to Los Angeles produces a rate nearly sixteen times higher (Walsh, p. 55).

There is some thought that diet choices, vitamin D, and regular exercise impact these anomalies. For example, an American Cancer Society study showed overweight men had a thirty percent greater risk of prostate cancer than men at or near their ideal body weight (Walsh, pp. 56-57).

MY OWN JOURNEY THROUGH PROSTATE CANCER

Because I'm not a doctor, I obviously can't give medical advice as part of this article. But I thought it might be helpful for me to devote the balance of it to my own journey through the system, identifying some cross-roads I encountered, and the decisions I made about what paths to follow. First, because of my dad's death from prostate cancer in 1994, I began at age 46—remember: the recommended age now is 40—to have the digital rectal exam as part of my annual physical with my internist. Basically, the doctor inserts a finger into your rectum to “palpate” or touch the prostate. This simple procedure is a rough justice way of determining the size and the relative texture of the gland. The exam is momentarily embarrassing because of the position you the patient must assume, but it is rarely painful. Generally, the smaller and softer the prostate itself is, the less likely the presence of cancer.

However, most doctors today also believe it is vital to have the PSA-level in your blood tested at the same time. “PSA” stands for “Prostate-Specific Antigen.” For our “awareness” purposes here, let's think of PSA as an anti-body specifically produced to deal with problems of the prostate. In addition to cancer, PSA levels tend to rise if your prostate begins to become enlarged (a natural concomitant of growing older) or has a non-cancerous infection within it. So, while an increase in your PSA level from year to year might not automatically mean prostate cancer itself, the increase is a sign that should concern you. As a patient, I was typical: My PSA level stayed at about 1.0 to 1.3 through my forties. By age 52, though, it had climbed to 2.0. The next year: 2.7, then 3.4. When, at age 55—last December—it hit 4.1, my internist, Dr. Phyllis Jen, did not like the “velocity” of these .7, stair-step increases, especially given my dad's history (see Walsh, pp. 117-118). So, she referred me to Dr. Graeme Steele, a urological surgeon at her hospital.

GETTING SERIOUS ABOUT THE SITUATION: HAVING A BIOPSY

Prior to meeting Dr. Steele, I didn't know any urologists personally, so I talked with a few other doctors—three white males—I knew socially. They all said, “Don't worry, Jerry: You jog and swim, you bike and kayak, you play singles tennis and do Nautilus weight-training. No way does somebody as healthy and fit as you are have prostate cancer.” However, Dr. Steele at our initial appointment in late December, 2003, performed a second digital rectal exam on me himself. While he agreed the size and texture of the gland seemed normal, my dad's history and my PSA level of over 4.0 suggested to him that a biopsy was highly advisable, and we scheduled it for mid-January, a few days before I was to fly down to Fort Lauderdale for my annual three months of winter in the sunshine.

The preparation for a prostate biopsy is less than enjoyable.

Basically, you eat normally, but on the morning of the biopsy you give yourself a rectal enema with a product made by the Fleet company. The purpose of the enema is to clean out your bowel so that the doctor can first insert a long, horse-hair like needle up your rectum and locally numb the prostate. Then the urologist takes a device that can shoot a retractable dart into your prostate itself to get core samples for later pathological examination. It sounds pretty horrible, but actually the experience, thanks to the local anesthetic, was more like hearing a staple gun go off ten times behind you, and a sensation internally of a dentist tapping a mirror on a novocained tooth to be sure it was numb. Side-effects of the biopsy: minor and very few. Once the anesthetic wore off, there was some soreness inside my butt for the balance of that day, and a little blood in my urine through the next day. I saw a lot of blood in ejaculated semen, though its color went from burgundy to milky within two weeks.

The results of the biopsy were more troubling. The night before my flight to Florida, I got an e-mail from Dr. Steele: The pathology report on the biopsy said there was prostate cancer in two of the ten core samples taken. From that e-mail onward, though, my urologist always talked in terms of “cure,” not just “treatment.” However, because the cancer is a slow-growing one, and Dr. Steele was confident it had been detected years before it would migrate outside the prostate gland itself, he advised me to go to Florida, read up on the illness, and discuss my situation at an appointment in late February, when I would visit Boston anyway to do tax returns, etc.

So I began reading, especially that terrific book by Dr. Patrick Walsh that I mentioned earlier. Another physician/friend sent me via e-mail an article from *The New England Journal of Medicine* (www.nejm.org), about a recent study on men with prostate cancer. The Journal is a terrific resource as well, because—even without subscribing to it—lay-person patients like me can plant what a lawyer would call a “Shepardization flag.” Basically, if any other medical journal at a certain level of quality publishes a subsequent article citing that initial article, the Journal automatically sends you an e-mail containing a link to the subsequent, presumably relevant article so you can read it online or print it out for later review. This amazingly generous practice on the part of the Journal made me feel a lot more in control of my situation. (See the Bibliography at the end of this article).

After doing all the reading, and speaking with a number of male friends who had been diagnosed with prostate cancer and underwent respectively different treatments, it seemed that there were four major possibilities for me:

1. Radical retropubic prostatectomy: surgical removal of the prostate gland itself (Walsh, pp. 205-258);

2. External source radiation: A rotating ray-gun with no actual intrusion into the body of the patient (Walsh, pp. 410-411);
3. Radioactive seeds implanted in the prostate permanently or radioactive bars inserted in the prostate and then retracted quickly (Walsh, pp. 270-281);
4. "Watchful waiting:" delaying any treatment while monitoring the PSA level at frequent intervals to see how fast the cancer may be growing when weighed against the risk of dying first from something other than prostate cancer (Walsh, pp. 178-192).

There are other possible treatments, including a laparoscopic removal of the prostate, freezing the prostate, ingesting hormones, etc., but the radical operation, the external radiation, and the internal radiation options are the most typical.

I leaned toward the radical operation for a number of reasons. First, my urologist, Dr. Steele, was fairly certain the cancer could be completely cured by the operation with no further treatments of radiation or chemotherapy necessary. Second, I knew personally two men ten years older than I who'd had the operation respectively seven years and four years before, and they'd remained cancer-free ever since; in addition, a friend of a friend my own age who preceded me through the surgical process by just a few months generously volunteered to steer me via e-mail through my own. Third, I knew personally two other men, one ten years older than I who'd had the radioactive seed implant, and the other twenty years older who had had the retractable radioactive bar, and both had seen their PSA levels begin to rise again after a few years of apparent "cure." Fourth, once radiation is tried but fails, the subsequent "salvage" surgery nearly always results in urinary incontinence and sexual impotency. Fifth, I was relatively young, even at 55, and in good physical condition to survive the operation and manage the convalescence. And finally, honestly, I still had the images of my father near the end of his long battle with prostate cancer, breaking bones every time he tried to move in his bed.

My wife and I discussed the matter between us at different intervals, and we both agreed that the operation was the way to go. And that meant it was wise for me, with a relatively rare blood-type of A, Rh negative, to stockpile some of my own blood over a few months span for possible use during my surgery. I also had to have a prostate M.R.I., or "Magnetic Resonance Imaging," a month before the actual surgery, to give the doctor the best, current view of the prostate he would be removing. The M.R.I. involved lying on my back on a table with a metal coil positioned up my rectum, which frankly was uncomfortable more than painful for the forty or so minutes involved. Then I was strapped down to stay still for the "photo opp," and slid into what I pictured as a tunnel but others have characterized as a coffin. The competent technicians told me the photos were nice and clear, but the doctor was the one who had to read them toward the radical retropubic surgery. Now, obviously, any time the word "surgery" is modified by the adjective "radical," things begin to sound scary. Let's return briefly to our earlier "baseball" metaphor to understand what's really involved in the operation itself.

Imagine again that baseball in the pitcher's upturned hand. The dorsal vein to the penis is the thumb at twelve o'clock high, the two nerve bundles represented by the index and middle fingers at four and eight respectively. The surgeon makes a five-inch, vertical incision, from just below the navel to near the base of the penis. The abdominal muscles are not severed, but rather pried apart, creating a "window" for the surgeon to see and to touch the prostate gland. He or she then cuts the core out of the baseball while (hopefully) leaving a margin of horsehide around the prostate and not severing any of the nerve-bundle fingers. This cutting "trick" is the so-called "nerve-sparing" procedure that Dr. Patrick Walsh and others have developed over the last ten to fifteen years to

preserve urinary continence and sexual potency post-surgery. The complication?: We're talking in the real world not about a sphere the size of a baseball but rather a gland the size of a walnut, so the surgery is delicate and lengthy.

My operation was scheduled for June 3, 2004, at noon, which meant I had to go through a "pre-test" two weeks before at the hospital (basically to ensure that I was healthy enough to survive surgery). The timing of the operation also allowed my wife and me to take a great business trip to the country of Iceland for the annual conference of the Scandinavian Crime Writers Association. Two days after returning to Boston, with twenty-four hours of no food and the inevitable Fleet enema, I was being wheeled into the operating room, and that's the last I remember until waking up in the recovery room five hours later. They had me on designer drugs from an IV drip, so there was no pain.

After being transferred to a normal hospital room, I realized I had a Jackson-Pratt drain (a clear plastic container shaped like a Dunkin' Donut) trailing from my incision to take away operation-induced fluid. I also had a Foley catheter up my penis and attached by a clear plastic tube to a catheter bag to take my urine directly from the bladder to the penis, there no longer being the "plumbing connection" provided by the now-removed prostate gland until the surgical grafting of bladder to urethra healed. My wife visited with me until she could tell that the drugs were making me even less lucid than usual.

Thereafter, I lay flat on my back in the hospital bed there, wearing bulbous, ankle-to-thigh pneumatic "boots" (like an astronaut's spacesuit) on both legs that would pulsate intermittently to stimulate blood circulation. Unfortunately, that first night, for some reason I decided to unbuckle the boots, get up, and walk the ten feet to my bathroom toward attempting a bowel movement. Bad decision: Not only had I not eaten for 36 hours, the enema early that day had cleaned out whatever was in my digestive system. Also, anesthesia doesn't just "put you under;" it also paralyzes the large intestine to the point that the "tube" loses its motility—the ability to move waste through it toward the anus. Accordingly, all I accomplished was inflicting pain on myself from the surgical incision I'd experienced on the operating table that afternoon.

A good friend once mentioned to me that when she was pregnant with her first child, medical professionals failed to tell her certain things about the birthing process and its aftermath because, "We didn't want to scare you." Well, here's the prostate surgery equivalent from my experience: Laughter is definitely not "the best medicine." Essentially, you're a jack-knife with a very sore hinge. If you laugh—or sneeze, or cough—your abdominal area invariably, involuntarily spasms really painfully. I found that clutching a pillow to my tummy and praying helped a bit. However, if you're suffering from a cold or allergies when your operation date rolls around, I'd seriously consider postponing the surgery, not just because of the aforementioned pain but also because of the risk of tearing your internal sutures and the resultant internal bleeding and possible infection.

I slept fairly well that first night, probably thanks to the Planters' Punch of drugs dripping into my arm. However, the next morning, I made another bad decision. Ravenously hungry, I asked the "resident on rounds" if I could eat. She said that so long as I felt well, I could have a "house" breakfast: effectively, a "farm-hand's" breakfast without the hash browns or grits. It tasted great, but guess what?: The pain-killers in my IV drip also paralyzed the large intestine, so when I later felt pressure building up inside my digestive tract and wanted to have a bowel movement, I had insufficient motility for one. That pressure made my second afternoon in the hospital (= the day after surgery) pretty miserable, though I did get up and walk around the room some more, as recommended to avoid blood-clotting and muscle atrophy. Friday afternoon, my internist, Dr. Phyllis Jen, and my urologist, Dr. Graeme Steele, both visited me to be sure all was well. In addition to my

wife, I even got a visit from one of my doctor friends who'd told me pre-biopsy that I was too healthy and fit to have prostate cancer.

Thereafter and through dawn, a remarkably caring, rotating cast of nurses aides and technicians came through at various intervals to monitor my vital signs, check my IV drip, and empty my catheter bag of accumulated urine. Then, Saturday morning, another pair of aides explained to me how to operate the bag myself, including exchanging it for a "walk-around" bag, easily hidden under sweatpants or dress slacks. A little after twelve that afternoon—or about forty-two hours after I left the operating table—I walked out of the hospital with my wife to a friend's car and went home to a light but delicious meal.

Sunday morning, I experienced my first post-op bowel movement, followed by a in-person call from the visiting nurse association to check on my incision and catheter bag. On Monday afternoon, I walked a mile and a half along the Charles River in Boston, and by Thursday—exactly a week after the surgery—I was walking six miles a day. Which is what you are encouraged to do, because of the aforementioned blood-clot and atrophy risks. At Operation-plus-ten-days, the Foley catheter was removed, and I was continent immediately, in that I could stop and start the flow of my urine on command. However, I would still wear an absorbent, adhesive pad in my Jockey briefs during the day, as coughing or sneezing could cause a spurt of several drops. I also wore a Men's Depends disposable diaper at night, since any alcohol or sleeping pill tends to make the sphincter muscle controlling urinary continency relax.

By Operation-plus-one-month, I was back to distance swimming. By Operation-plus-two-months, I was back to all my physical exercising, including stomach crunches. Now, at Operation-plus-five-months, I have some sexual potency back as well, and that factor is improving noticeably, thanks in part to the once-a-week dose of Cialis that my urologist has me taking.

All Dr. Steele's subsequent monitoring (the pathology report on my prostate itself once removed, the quality-control PSA blood tests) indicate I am now cancer-free. Or at least, "prostate" cancer-free. I still go for a colonoscopy every three years, because both my mother and father had colon cancer as well. But, so far as medical technology can determine, I'm now healthy again. And likely to live well into my seventies, with prostate problems of any kind a ghost from the past at most.

THE LESSONS LEARNED?

- 1) Have your PSA level checked at each annual physical, beginning at age 40. This way, the doctor can establish a baseline of "normal" PSA level for you, and be positioned to notice in later years any stair-step rise in PSA over several physicals or an increase in the velocity of the rise, or even a real "spike" in the PSA level.
- 2) Listen to your doctors and do what they suggest. A rise in PSA might be due to routine, age-related enlargement of the prostate, or a non-cancerous infection in the gland, or prostate cancer. The only way to know is a prostate biopsy, and, as I said earlier, that procedure ain't so bad.
- 3) If the biopsy comes back cancerous, first—however oxymoronic this sounds—relax. By beginning your PSA testing at age 40, you've caught the slow-growing tumors well before they've migrated outside the prostate, and you have months to investigate and evaluate the various treatments to find the one that's right for you.
- 4) If you decide on the surgery, be sure to have it done at a major teaching hospital and by a urological surgeon who has performed a lot of them. Dr. Graeme Steele, my surgeon, had

- done 50-75 per year over two decades: Enough to be sharp, not so many as to become jaded.
- 5) Also, if you decide on the surgery, consult the Shopping List at the end of this article. Plus, lose some weight, especially around the middle. As indicated above, the procedure pushes the abdominal muscles aside rather than severing them, but the less fat the doctor has to cut through first, the less tissue has to heal, and you'll return sooner to normal physical activities. Also, pre-operation, improve your sphincter control by performing so-called "Kegel" exercises that your doctor can explain.
 - 6) Read up on the available literature about prostate cancer (see the Bibliography at the end of this article), visit the websites (see the Press Release on my own website), and learn the jargon and current trends toward questioning your doctors.
 - 7) Obtain your doctors' e-mail addresses, and try to bunch any questions in omnibus e-mail messages toward the various stages of your treatment ("Do I need to fast before a PSA blood test?" or "Do I need to use a Fleet enema before the prostate M.R.I?"). This is a lot more convenient and time-efficient for the doctor than telephoning back and forth, and you'll have some record of what the doctor responding did—or didn't—tell you about risks and outcomes.
 - 8) After returning home from the hospital, don't be a hero. While I found simple Excedrin to be sufficient for pain management until the pain went away a week after surgery, you may need to take some of the higher-octane stuff your doctor might prescribe. However, do remember the "constipation" affect some heavier drugs can have. Also, don't drive with the catheter still in place, and don't lift anything more than ten pounds for a good month.
 - 9) When your tummy will let you, begin to laugh and joke about the illness with your family and friends. Prostate cancer is like any other risk in life: You'll handle it better with a positive, rationally defiant response to this new bump in your road. Try also to worry the fewest people pre-operation but reassure the most people post-operation. I found creating an e-mail list and sending out one comprehensive post-operation e-mail followed by shorter update e-mails worked well.
 - 10) Have some consideration for your "care-giver." It isn't easy on a domestic partner to have to go through prostate cancer with you when he or she has no control over the illness, either. Try to inject little interludes of normalcy, like having a drink together after work or going to a museum for a few hours.
 - 11) Pay it forward. You can't really "pay back" somebody who's already had the surgery and then helped you deal with your prostate cancer. But you can "pay it forward" by being a willing listener/advisor to men newly diagnosed, to orient them and re-assure them that life does return to normal post-operation, even if it might take some months.

And, meanwhile, thanks for letting me "pay it forward" by reading this article I've written for you and your loved ones.

Jeremiah Healy

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SHOPPING LIST FOR PROSTATE CANCER (SURGERY)

- 1) Health Care Proxy: Depending on the state law where you live or will be treated, this is a document that deputizes someone else to make health care decisions for you should you be incapable of doing so for yourself.
- 2) Living Will Declaration: Again depending on the state law where you live or will be treated, this document permits doctors to withhold or even withdraw life-prolonging treatments for a terminal condition should you be incapable of communicating such a desire yourself.
- 3) Fleet Enema: one for prostate biopsy, a second for prostate surgery.
- 4) Bacitracin: for disinfecting the tip of your penis while the Foley catheter is still inserted.
- 5) Diapers: Men's Depends, enough for two to four weeks, post-operation.
- 6) Adhesive pads: After most urinary continence is regained, to be worn inside underwear toward absorbing small spurts of urine.
- 7) Lotrimin Cream: For any chafing around penis and testicles.
- 8) Overnight Catheter bag: For indoors and sleeping (hospital will provide one, but ask for a back-up, particularly if your doctor says the catheter must stay in for as much as two weeks, as these bags can be hard to find in even a large pharmacy).
- 9) "Walk-around" Catheter bag: For wearing under sweatpants or dress slacks outside (same advice on back-up as for overnight bag).
- 10) Water pistol and Listerine: Put a solution of 20% Listerine and 80% water into the pistol to shoot disinfectant into the walk-around bag after each use.
- 11) Loose-fitting sweatpants and dress slacks, preferably dark in color and with pockets large enough to carry some water bottles for the long walks post-operation, the only exercise you'll be able to do for a while.