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EXPERT Q &amp; A

**Notes from the Center of an Epidemic**

By ALIYAH BARUCHIN

*Dr. Terry Mason is a urologist, commissioner of the Chicago Department of Public Health, and a leading advocate for African-American men with prostate cancer.*

*Q: African-American men have a 60 percent higher incidence of prostate cancer than white men and are more than twice as likely to die of it. What accounts for those disparities?*

A: Many times, being black or African-American is really a surrogate indicator for access, a surrogate indicator for quality of care. But a [Institute of Medicine](#) report in 2003 indicated that after you corrected for all of those factors -- including socioeconomic, insurance and those kinds of things -- there still seems to be an element of racism that has something to do with differences in outcomes. It is a multifactorial kind of situation.

*Q: African-American men also have the highest incidence of major side effects from prostate cancer treatment. Why?*

A: That is another issue that I think has to be placed in the context of the types of places where African-American men are often treated for prostate cancer, and also of patients' understanding of how to ask about all of the potential side effects and what can be done to mitigate some of them. A study just released from the American Society of Clinical Oncologists showed that if a patient's first and only contact was with a urologist, he was more likely to have surgery. If his point of contact was a radiation oncologist, he was more likely to have radiation therapy.

Certainly, people tend to follow the advice of the person that they see, and since most men are diagnosed with prostate cancer by their urologist, he or she is the first person that they have contact with. Whether or not men have actually been counseled by their urologist to see a radiation therapist would be the question, and it is certainly something that we should look to collect some data on.

*Q: Traditionally, one of the biggest challenges in prostate cancer has been simply getting men to come in for screening. Do you think that this is still the case?*

A: In a career that spans about 25 years, I have seen some change in the attitudes of men with regard to this. Some of that is a function of having, I think, a little bit more faith in and relationship with providers. And, of course, the whole explosion in the erectile dysfunction market also drove men into doctors' offices, where we were able to begin to look at other things like cholesterol and heart disease, and to screen for prostate cancer. Not to mention that there's been a lot of background noise now about prostate cancer, which has also helped men to understand this a bit better.

*Q: Have you seen evidence that the digital rectal exam itself has kept some men from being screened?*

A: Nobody, male or female, likes a rectal exam. The early screening that we used was a combination digital rectal exam and P.S.A. screening. And I've found that the compliance with having men coming in to be screened was far higher when we did a P.S.A.-only screening, which is obviously not as complete. We know that over 80 percent of the prostate cancers now are diagnosed in men with elevated P.S.A.'s, so we felt comfortable offering a P.S.A.-only screening, but with the provision that men understood that they still needed to have a digital rectal exam as well.

*Q: Studies show that African-American men with prostate cancer are the least likely to be satisfied with their doctor's care. What might doctors do differently to gain their support?*

A: That finding doesn't surprise me. If there are support groups that doctors can refer the person to, that's great. If there are support groups where there are other African-American patients, that's even better. If there are other African-American providers, that's a plus as well. But the main thing is, whether African-American or not, to take time and be sensitive. In my own practice, when a man was diagnosed with prostate cancer, I did not rush in to start talking about therapy, because I thought many men needed time to process the idea that they had cancer, decide if they were going to share it with their families, and things of that nature. There needed to be psychological time.

*Q: How can men better explore their options for prostate cancer care?*

A: In our Us TOO support group here in Chicago -- one of the largest predominantly African-American prostate cancer support groups in the Midwest, if not the country -- it was clear that, listening to these men, many of them did not have an adequate opportunity to really look at what their options were. The options were pretty much those presented by the doctor that they were diagnosed by, and they were sometimes made to feel as though there was some urgency in making a decision. Our practice provided a packet of information, and we also created a videotape, "Not By Myself," for those men who did not want to go to a support group -- a videotape of men just talking about the psychological issues. Because people don't realize that cancer is not just a physical diagnosis; it's a psychological diagnosis. And it affects not only the patient, but the partner and family as well.

*Q: What role does a partner or spouse play in prostate care?*

A: The partner role in this whole situation is absolutely critical. And though we're talking about prostate cancer, this is really a larger question about men's health overall, and prostate cancer detection is a subset of that. The partners have typically played a very important role in getting men to be checked not just for prostate cancer, but for everything.

Oftentimes providers are still talking to patients about their disease in the context of the presence or absence of symptoms, which is an archaic way of looking at disease because so many diseases don't produce any kind of symptoms in their earliest, most curable form. So with many men who feel that they didn't need to go to a doctor because they felt okay, their wives were able to get them to see that they didn't need to wait for symptoms, but really needed to avail themselves of some of these early screening modalities.

*Q: Do you agree with the American Cancer Society's screening guidelines?*

A: Yes, except that the ACS guidelines recommend screening African-American men starting at age 45. The urology section at the National Medical Association [which advocates for patients and providers of African descent] suggests that they start at age 40.

*Q: What's the role of diet and exercise?*

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Almost anything that improves your general health will help improve your prostate health as well. So eating a diet that's rich in fruits and vegetables, getting regular exercise, avoiding cigarette [smoking](#) and any other addictive substance — those things that reflect a healthy lifestyle are going to help you keep your prostate healthy, and may indeed help your body do its best to defend you against prostate cancer and any other cancer.

*Q: What do you tell patients about prostate treatment and care?*

A: When and if you are diagnosed, get information that is helpful. There are millions and millions of hits you'll get from the Internet when you put in "prostate cancer," so you want to be sure that you go to nationally recognized centers like the [National Cancer Institute](#), the [American Cancer Society](#), or the [Urological Society](#) or [Radiological Society](#) Web sites.

Also, if you've had a conversation about treatment with a urologist and they're talking about surgery, make sure that you take the time to find a radiation oncologist in your area and talk to them about treatment also. There are no absolutes in the treatment of prostate cancer; I don't think there's clear scientific data that proves, beyond any doubt, what therapy is better. And remember that prostate cancer is not an emergency — you don't have to get diagnosed today and treated tomorrow. You have at least four weeks before you have to think about feeling compelled to make a decision.

Last, when I talk to my patients about how to deal with this, I tell them: number 1, get all the information; number 2, ask all the questions; number 3, sit back down with your provider and discuss the pros and cons of what you've learned. Then, make a decision. And after you've made a decision, you go home and you pray on that decision, and sleep on it. And the next day, when you wake up, if you're still at peace with it, then that's what you do. And don't look back.