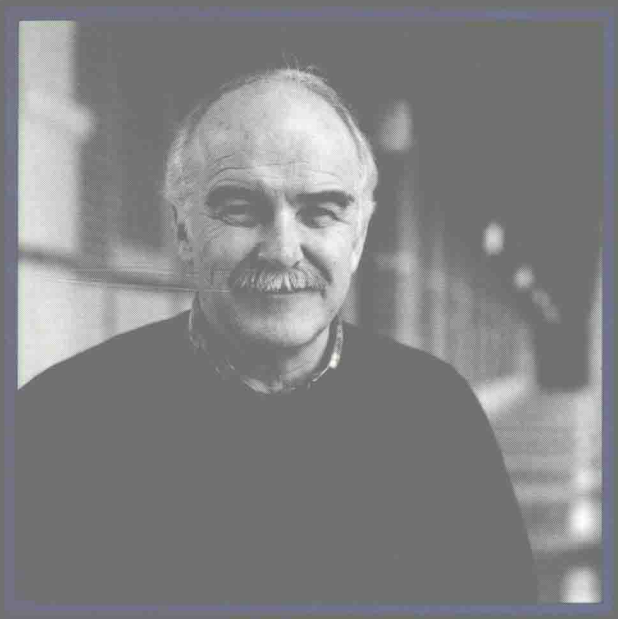
WILLIAM MARTIN

MY PROSTATE AND ME



Dealing with Prostate Cancer

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My Prostate and Me

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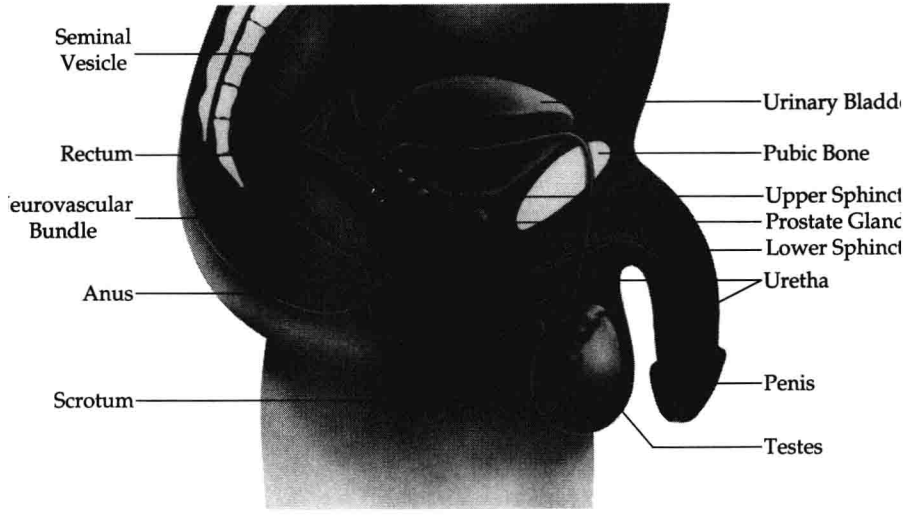
Seminal Vesicle
Rectum
eurovascular Bundle
Anus
Scrotum
Urinary Bladd
Pubic Bone
Upper Sphinct
Prostate Glanc
Lower Sphinct
Uretha
Penis
Testes

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CHAPTER 1

My Walnut

My prostate and I were not exactly strangers. At first, I hardly noticed its enlarged role in my life. I had always drunk large quantities of liquids, with the consequent need for frequent trips to the rest room. But about ten years ago, when I was still in my mid-forties, the interval between trips began to grow shorter and the urgency a bit more pressing. I was aware that this was a common side effect of aging, without knowing precisely why, and managed to take it with some good humor. Around the time I turned fifty, a birthday that has a way of impressing one with the fact that the road ahead is likely to be shorter than the one behind, I typically responded to how-does-it-feel-to-be-fifty questions by saying that although my sight and memory were fading, I could pee more often than ever, even at night, when younger men were sleeping. Inevitably, the laughter broke clearly along age lines, with men over fifty in the lead, followed closely by their wives.

Not long afterward, in the course of a regular physical examination, my internist, David Bybee, asked, as part of a long series of questions, if I was

noticing any changes in my pattern of urination, such as greater frequency, having to get up one or more times during the night, difficulty in starting, diminished stream, a sensation of not quite finishing, or occasional dribbling. I registered a perfect score. He then performed that highlight of every middle-aged man's physical, the digital rectal examination, identified in urological literature simply as a DRE.

Most men do not enjoy this part of their visit to the doctor. Some, in fact, decline their physician's offer to perform a DRE. I tend to accept official procedures without much resistance and acceded to Dr. Bybee's request that I drop my trousers and bend over, facing away. In addition to being my primary physician, he is also my friend, so I was relatively relaxed. He inserted a gloved and well-lubricated finger into my rectum and began to feel, quite diligently, my prostate gland. I grimaced, my eyes watered, and I hoped he would hurry. Finally, after a long twenty or thirty seconds, he removed his finger, stripped off his glove, and gave me a brief lesson in anatomy.

The prostate gland, he explained, is attached to the base of the bladder, in front of the rectum. At orgasm and ejaculation, it produces the fluid that carries the sperm (produced by the testes) through the penis to whatever happens to be waiting for it nearby. This mingling of substances takes place in

the urethra, a tube that runs right through the prostate on its way from the bladder to the end of the penis. That little bit of plumbing is the problem. In a perfectly healthy gland, which is about the size of a walnut, the urethra has plenty of room to perform its small repertoire of tasks. When the prostate starts to grow, however, as it does in most middle-aged men, it typically constricts the urethra, creating some or all of the symptoms to which I had just confessed. This condition has a name: benign prostate hyperplasia (or hypertrophy) or, more simply, BPH. My growth, he said, was a little larger than normal for my age—the *plasia* was more *hyper* than he had expected—but nothing to be too concerned about. As its name indicates, BPH is benign. It isn't cancer and it doesn't turn into cancer. If the gland were cancerous, he explained, he would probably be able to feel a lump or a ridge or some other kind of hardness or irregularity. He had felt nothing unusual other than the enlargement. He would keep an eye on it, so to speak, and if my symptoms got worse, we could talk about what to do then.

I wasn't worried. My symptoms weren't extreme, and I knew that treatment existed, though I was not clear about details. I remembered that my father, when he was about 70, had undergone a surgical procedure known popularly as "a Roto-Rooter job," and that he had pronounced it a great

success. On the second day of his recovery, he boasted that he "could pee over a ten-wire fence" and allowed that, had he known about this operation, he would have had it done years earlier. Now, I knew about it years earlier than he had, and I would be ready when the time came.

With the exception of some common allergies, which I keep under control with biweekly self-administered injections, and stomach pains that strike in times of stress, I have enjoyed almost perfect health throughout my adult life. In my first twenty-five years of teaching at Rice University, I missed class only three times because of illness. Given that record, I have often stretched the time between physical exams longer than perhaps I should have, and an unbroken string of satisfactory results on the standard battery of tests had made me quite complacent. Thus, on the occasion of my next exam, in 1990, about two years after the one just described, I was mildly surprised when David Bybee told me I had scored a bit higher than normal on a relatively new blood test he had given me. It was called a PSA, for prostate specific antigen, and it seemed to be useful in giving an early warning sign that a man might be developing cancer of the prostate. The normal range was 0-4. My score was 6.4. (I would later learn that this figure reflects nanograms, or billionths of a gram, per milliliter.) Some urologists,

he said, didn't think there was much reason to worry until the score got up to around 12 or so. The test is prostate-specific, but not cancer-specific. An enlarged prostate can raise the score even when no cancer is present, but cancer tissue causes it to zoom upward much more rapidly than does normal tissue. His digital examination had indicated nothing more than slight continued enlargement, but he felt it would be worthwhile for me to have an ultrasonic examination of my prostate, just to play it safe. He could arrange to have it done at the Department of Urology at the Baylor College of Medicine.

I didn't know what such an exam would cost, but I assumed my insurance would pay for most of it and I could afford the rest. I have long taken some comfort in living just five blocks from the Texas Medical Center, with its collection of world-famous hospitals, medical schools, and research institutions. No matter how long a shot it was, it didn't make sense to turn down a chance to use some of that collective expertise to check on the possibility that I might have cancer.

A transrectal ultrasound (TRUS) is not nearly as much fun as a DRE. After removing my trousers, I crawled up on a table and lay on my side while the technician operated the machine and discussed what he saw with a young urology resident. Though it is sonic rather than optical, the

sensation is rather like having a TV camera—with knobs removed—poked into one's rectum and aimed here and there for ten or fifteen minutes, producing shadowy images on a little Sony monitor that I was invited to watch. Having never seen anyone's prostate nor, for that matter, an ultrasound image of anything other than a fetus of one of my granddaughters, I couldn't make much of what I saw. The technician said my prostate was more pear-shaped than round, but that this was a normal variation. Other than that, he and the resident saw nothing to indicate the presence of any kind of cancerous growth. Just as I thought.

Not quite a year after that exam, my wife Patricia and I flew to California to visit our son Jeff, his wife Suzanne, and daughters Samantha and Jenna, the latter of whom was brand new. We spent a night in Santa Barbara at that charming "small hotel with a wishing well" where Charlie Chaplin and Fatty Arbuckle used to carouse, I gave a lecture at Pepperdine University, and Jeff showed us around Twentieth-Century Fox studios, where he worked as a writer for "The Simpsons." It was an entirely satisfying interlude. Then, on the last day of our stay, as if contemplating silent movies and watching my grown son pursue a successful career had somehow reminded a sensitive prostate of the rapid passage of

time, I was suddenly stricken with the worst urinary discomfort I had ever experienced. The need to urinate was truly burning, voiding brought as much pain as relief, and what relief ensued was dismayingly short-lived. I was relieved that the flight back to Houston was on a DC-10, which enabled me to alternate aisles on my way to the toilet, in an effort not to call attention to the frequency of my trips.

The first night at home, I made eleven trips to the bathroom, about nine more than usual. The next morning, I called Dr. Bybee's office, described my symptoms, and managed to get an afternoon appointment. He listened to my symptoms and performed a DRE that was not only eye-popping but produced a small amount of milky discharge, which he collected on a glass slide. He smiled and rendered his verdict: a classic case of prostatitis. My walnut-sized nemesis had developed an infection. Prostatitis typically occurs in younger men and can bear some relation either to lack of sexual activity or to a sudden burst of activity after a period of abstinence. None of those conditions fit my case, but none were required. Sometimes it just happens, and I clearly had it. Fortunately, it was curable, though not overnight. He prescribed a six-week regimen of an antibiotic especially formulated to penetrate into the prostate, and he invited me to return

every few days for a week or two to have my gland hand-milked. He drew blood for another PSA test, just as a precaution. Then, as a parting shot, he suggested that I try to have sex as often as possible. Throw me in the briar patch.

On my next visit a few days later, Dr. Bybee told me my PSA count was up to about 8, approximately 25 percent higher than my previous test. That was not good, but neither was it alarming. Just as enlargement can raise the score, so can prostatitis. My score would probably go down when the infection subsided. I acknowledged my relief at learning that my new intense discomfort was traceable mainly to an infection, but volunteered that the normal state of affairs was no picnic. I asked whether he thought I ought to consider the Roto-Rooter procedure, which a recent consultation with my Modern Home Medical Adviser had taught me to identify as a transurethral resection of the prostate (TURP).

David Bybee is a bright, compassionate, and thoroughly honest man, but he is not what one would describe as earthy. He said, "Oh, I don't think I'd rush into that. One of the things it does is to send the ejaculate back into the bladder, so that your orgasm is dry. And that...well...it might not be as much fun. As long as your symptoms are not bothering you too much, I'd put that off as long as I could. We're both just getting older."

Happily, the prostatitis subsided and disappeared as predicted, but over the next eighteen months, my prostate gradually but perceptibly got a tighter grip on my urethra. I added a trip or two to my nighttime routine, the interval between voidings diminished to less than an hour during the day, and my body's announcement of the need to urinate sometimes came so suddenly and with such intensity that a wait of as little as ten minutes was simply out of the question. I seldom made it through a meeting of any consequence without having to excuse myself at least once. I dared not try to teach on Tuesdays and Thursdays, when classes run 80 minutes, and standing around to talk to students after a 50-minute class was often a major challenge. During the 1992-93 academic year, the Rice sociology department sponsored a series of public lectures on urban issues. As one of the organizers of the series, it often fell to me to introduce the speaker and to sit either on the dais or the front row. Without exception, the question-and-answer session following the speeches provided my bladder with a severe test. On more than half of those occasions, I had to leave my seat and walk the length of the auditorium to reach a rest room, typically returning just in time to bring the evening to a close. I could joke with myself that "I'm a big guy with a big prostate," but it really wasn't much fun.

Increasingly, strategic planning for urination became a conscious part of my routine. I learned to void just before leaving the house and then again upon arriving at almost any destination—church, a restaurant, my office, a friend's home—in the hope, often vain, that I would not have to excuse myself more than once during an average sojourn. At a concert or theater, I tried to arrange for seats on the aisle, and at intermission I tried to use a closed stall rather than a urinal, to avoid having some young man in line behind me ask if he could "play through." At public gatherings, I ignored requests to move toward the center. At movies, I learned that episodes of high excitement or intense emotion are typically followed by slow spots that allow a quick trip to the toilet. (Scenes beginning with a shot of a car or bus on a long, straight highway are ideal.) I began to select supermarkets and video stores less for their stock and prices than for their provision of public rest rooms, though I quickly learned that one can find an unadvertised rest room in most grocery stores simply by walking through the swinging doors next to the meat counter.

Eventually, I learned the location of the john in virtually all the places I frequented. At the Brazos Bookstore near the university, you go straight back through the open door at the rear of the display area. In the sprawling Bookstop at Alabama