Male Incontinence After Prostate Surgery

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Introduction

Andrew Schorr:
When it comes to treating prostate cancer, surgery can be the recommended approach. Unfortunately, urinary incontinence can be a side effect of surgery. What are the best ways to deal with this uncomfortable condition? Coming up, Dr. John Hairston from Northwestern Memorial Hospital will discuss treatment options, and a patient will share his own story—next on Patient Power.

Andrew Schorr:
Hello and welcome to Patient Power sponsored by Northwestern Memorial Hospital. I'm Andrew Schorr.

Well, I am almost 61 years old and as I get older I recognize that many men, and it happened to my father, can develop prostate cancer. It is not uncommon. And then you look into what treatments are right for you and one of them, of course, for some men can be prostate surgery or prostatectomy—whether it's radical prostatectomy or nerve-sparing prostatectomy— and a side effect that can happen is urinary incontinence, and that gives men pause.

So what we're going to talk about in this program with a specialist who helps men who are dealing with incontinence is how you manage that side effect. First of all, how common is it, and how do you manage it, and are there are options? So joining us to help us understand that is Dr. John Hairston. He's a urologist on the medical staff at Northwestern Memorial Hospital in Chicago. He's also an associate professor of urology at Northwestern University's Feinberg School of Medicine, and he is a subspecialist when it comes to dealing with incontinence and helping men and women with this issue.

Dr. Hairston, thank you for joining us.

Dr. Hairston:
Thank you for having me on, Andrew. I sure appreciate the opportunity.

Andrew Schorr:
Well, let's talk about this as a worry for men who have prostatectomy. I know that at Northwestern Memorial there are many, many surgeries done to help to men with this concern. When it comes to the side effect of incontinence, how common is it?

How Common Is Incontinence After Surgery

Dr. Hairston:
Well, incontinence, it's an interesting point, and I think what I want the program to really be about is the options that men have when they do confront this problem. I think it's important to say up front that there's a little bit of misperception in the public arena. I think in the media and amongst the community of men that this is just inevitable, you know, after prostate cancer surgery, and that's really not true. So I think it's really important up front to sort of make that point.

But for those men who do end up with the problem there certainly is help, and there are definitely options so men don't have to suffer with the problem.

Andrew Schorr:
We're going to talk about those options along the way. Now, just one question about incontinence: when we talk about incontinence this is where you have the inability to hold urine in your bladder so you may have leakage, you may cough or sneeze or laugh and some may dribble out, or it could be more extreme where you just can't hold at all, and some men in this extreme case might even be wearing some kind of diaper?

Dr. Hairston:
Correct. Yeah, the definition of incontinence is just the inability to control the urine. But that's a good point. There are two types of incontinence, and this really holds true for men and women. There's one that's called urge incontinence, and that has to do with the inability to hold urine when you have an urge to go. Overactive bladder is the term you hear about, and it kind of makes more sense to most people. But that's when you have frequent urination—urgency—and you can't hold it.

Particular to prostate surgery what most men end up with is what's called stress incontinence—and women have that too—but that's when you have loss of control with increased abdominal pressure or physical activity such as lifting something or coughing and sneezing, as you say, or for many men it's playing tennis or golf or activities like that. That's an important distinction because there is to some degree, a component of overactive bladder that can occur in men, either prior to surgery and in some men after surgery, but that's something that usually can be culled out with a quick history, just asking the men questions. And that's treated differently. We can treat some men with medicines for that problem, but the vast majority of men after prostate surgery with significant urine control problems have the stress incontinence component, and that's kind of what we're here to talk about.

Augusto's Story

Andrew Schorr:
All right. Well, let's meet one of your patients, Augusto Agner, from the

Lincolnwood area of Chicago. Augusto is 67, and going back to 2007 because your PSA had been rising, you had positive biopsies and then you had prostatectomy surgery. We're aware, Augusto, that there could be incontinence, but you had pretty significant incontinence. How bad was it?

Augusto:
Well, it was pretty bad. I was wearing at least 8 to 10 pads per day.

Andrew Schorr:
Eight to 10 pads per day, and here you're trying to do your work and everything. So you maybe didn't even know. Could you just be sitting there, maybe in a business situation, and then your pants would be wet?

Augusto:
Yes. It was horrible because I was so depressed, and when I was sitting in front of my desk and I realized that I was all wet, and that was embarrassing in front of my co-workers, you know, and after that I was very depressed.

Andrew Schorr:
And it was not getting better.

Augusto:
Not at all, not at all.

Andrew Schorr:
All right. So you go back to your urologist, and I understand you had one of the procedures that can work for some men, and that was the sling procedure. Did that make a difference?

Augusto:
Well, unfortunately, it did not work at all, and then to be honest with you, you know, I was kind of so frustrated that I went into a very bad depression. I didn't want to see anybody, I didn't want to go anywhere. I was in my room for six long months being treated with depression--

Andrew Schorr:
Oh, my.

Augusto:
--due to this problem.

Andrew Schorr:
Oh, my. Quite, quite bad. Well, through someone you met it was recommended that you see specialists at Northwestern Memorial Hospital, and you actually connected with our guest, Dr. Hairston, who is a specialist in incontinence. And you'd been doing your research as well and understood there was an additional option, a pump that could basically allow you to control the sphincter of the bladder and when urine would flow. So you go to see him and what happened? You had

the pump implanted?

Augusto:
Yes, I did. I had the pump implanted, and I'll tell you something, I think it was sent by God.

Andrew Schorr:
Wow.

Augusto:
And it was a miracle.

Andrew Schorr:
It was a miracle. So you went from eight pads a day to afterwards with the pump implanted and giving you back control of your urine flow, any wetness, dry, what?

Augusto:
A hundred percent dry.

Andrew Schorr:
Oh, my, and I know how emotional it is for you, Augusto. That's an example of how bad it could be and how getting to the right specialist and the right procedure can be life changing. And it was life changing for you, getting this problem handled.

Augusto:
A hundred percent because, you know, it brought new life again. I always enjoy my family and my life.

Andrew Schorr:
Right.

Augusto:
The experience was so successful that we went out celebrating with my family, and I'm a different person again. I became the same person I used to be, a happy man, you know, getting up in the morning, going to work, you know, and doing my hobbies, you know, enjoying my family, my grandchildren. And life is totally back again thanks to the pump.

Andrew Schorr:
And you're very grateful for Dr. Hairston.

Augusto:
My goodness. I don't think—I don't have the words to thank this gentleman. Dr. Hairston did something to me that, you know, I couldn't believe that I was going to find somebody on the face of the earth to give me such a break in my life.

Andrew Schorr:

What a great story. Okay, Augusto, we're going to be back to you shortly.

Dr. Hairston, so, first of all, Augusto's case seems pretty interesting. He first had one intervention, and then had another, and I guess the way I think of it is there must be a continuum of options so that in a man—an individual's case maybe there's one thing that seems like maybe it would be right. Or maybe there could even be a difference of opinion if you seek a second opinion, but you try to get the best option for the patient, but all hope is not lost if that doesn't work, right? You may have something yet to try?

Dr. Hairston:
Absolutely, and that's the important point is that there's a plethora of options, and you're absolutely right, there is a continuity or a continuum of the options that we may give any individual. Mr. Agner had a robotic prostate surgery actually back in 2007 and it was organ confined, and he was doing great, and his PSA is undetectable. And we have to remember with all of this—and I tell every patient that walks in the doors—is keep in mind that you are cancer free and that's the most important part, and we can help you with the rest of it.

But he developed a problem with his urine control, and it didn't come back as quickly as he would have liked, and he ended up having another minimally invasive procedure called a male sling, which is also an option for many men. It didn't quite do the job for him, and then he kind of continued on and then got to me. We evaluated him and then we went on to what's called an artificial urinary sphincter, which is ultimately sort of the gold standard everything else is measured against.

And he's done quite well. He's very pleased, and so he's a good example of how there's a continuum of options, and when one option doesn't work you can move down the line to further options.

Andrew Schorr:
All right. Let's step through this. So, first of all, with the typical man who might have some incontinence after surgery, in many cases does it resolve itself, and if so, how significant is it and then what time frame does it get better? Tell us about the recovery process from prostatectomy when incontinence shows up just right when the catheter comes out and you're right at the starting line.

Recovery After Surgery

Dr. Hairston:
Right. And that's an important point as well. So, many men, when the catheter comes out initially after surgery, will have some degree of urine control problems, and it's usually very mild. And most men when they undergo the process they're counseled on that as part of the surgical process, and that's accepted. The deal is that most men recover function over a period of time, and that can range from three months to one year.

But that first year is critical and for men with milder degrees of urine control problems, you know, maybe they wear a pad a day right after the catheter comes out at most, or maybe they just have a little bit of urine control problems. There is a period of time that you need recovery and the pelvic floor needs to rehabilitate, so to speak. And so we don't get very excited and we don't get up front after surgery. Men need time to improve, and that has been shown for years now with our literature.

And it is somewhat relative. So if a man has a significant problem right after surgery, you know, you can kind of get an idea that well, he may not recover as quickly. But all men we absolutely give time to recover in a conservative fashion, and then usually at six months or certainly at a year is when we start to get more concerned that they may need something done, or most men by that time are concerned as well themselves.

Andrew Schorr:
All right. So they may then be referred to you as a subspecialist in urology helping men and women with incontinence—but for the men, they come to you. So where do you start? So they've been living with this maybe for many, many months or even a year, and they say, okay. How do you assess their situation and then begin to talk about options?

Dr. Hairston:
Right. Well, the first thing, like you said, sort of depends on the time frame of when they get to me. If it's still within that first year, say it's, you know, in the six-month range to a year and the urine control is not that severe—you know, a lot of time I give reassurance and I counsel them, you know, on the things we just discussed. You know, it's a good opportunity to talk about pelvic floor muscle training, because that's kind of something that's talked about quite a bit.

Training The Pelvic Floor

You know, training the pelvic floor is very important after prostate surgery. The literature goes on both sides of the fence over the utility of it. However, I'm a proponent of it, and I think it's a good idea in all men to explore that at least. So if a man gets to me early on and has sort of milder degrees, absolutely the first thing we'll do is refer him to our pelvic floor team for our pelvic floor muscle training and exercises.

Andrew Schorr:
All right. Help us understand that for a second. I have an idea of like your pelvis going to the gym, you know. So these muscles—and we're aging often as we deal with prostate cancer surgery anyway—what are you trying to do?

Dr. Hairston:
Well, the sphincter, the urinary sphincter is a muscle. It's a muscle that's a little bit

different than—it's a smooth muscle, so like a bowel and it's not under direct voluntary control, but the continence complex in men is sort of a combination of smooth muscle, the urinary sphincter and sort of the pelvic floor as a whole. So similar to women with stress incontinence problems and strengthening the muscle, the bed of the pelvic floor, we can do that in men and achieve continence and achieve improvement at least in their urinary control.

You know, typically what we'll do is we'll send them to a therapist, and they'll have weekly sessions for about six weeks initially and then sometimes they can, you know, move on from there. Kegel is the word you hear, so people know or people often hear about Kegel exercises, and so that's just simply the means of strengthening the pelvic floor.

In milder degrees it can actually cure the problem and it can solve the problem all together. So I have men, like I said, who just wear hardly a pad a day, just a little bit, and they're concerned, and we send them to pelvic floor therapy and they come back and they're doing just fine. And so that's certainly the initial approach. If a man—you know, if you have significant problems I think the chances of that curing the problem are less, although it might improve it, and it's certainly a good adjunct if you're going to move on to other types of surgical therapy because it's been shown that men generally do better with that.

Andrew Schorr:
Okay. I just want to understand what they do. So you send them to the Kegel gym, if you will. What are they doing? Is it biofeedback? I've even heard of certain kind of electrostimulation techniques. What do you do at Northwestern?

Dr. Hairston:
Generally the therapists are going to want to work with the muscle strengthening. So they can work either externally or sometimes they do internal work by simultaneously doing a rectal exam, for instance, and telling a man, 'I want you to tighten up your sphincter, ' and so they learn control. And they teach the man exactly what muscles to use to strengthen. And then you do exercises and a patient can take that information and then utilize it at home to do those strengthening exercises. So it's kind of really focused on strengthening of the pelvic floor and the muscles.

You know, biofeedback and electrostimulation has been talked about. It certainly has a utility in some of the overactive bladder syndromes that I spoke about earlier in men and women and urge and continence problems. I think for—you know, the jury is certainly still out for those kind of techniques for prostate or problems after prostate cancer surgery. They don't have as much utility, so we're simply talking about the strengthening exercising of the pelvic floor, or Kegels, if you will.

Other Options

Andrew Schorr:

Okay. So hopefully that works for a man, and as you said many it helps, but then they come back to you and say, 'well, no, this didn't quite get it,' or 'I still have the problem.' What's next?

Dr. Hairston:
Right. So at that point then you certainly move on to sort of evaluating for other, more invasive options. And usually a history and a physical are certainly important, but at that point there are a couple of issues. One is we generally move on to what's called urodynamic testing, which is a physiologic test where we have to put small catheters in the bladder. It's done in the office setting. It's not generally particularly uncomfortable. We put a tiny catheter in the bladder, and we actually fill the bladder up to sort of recreate a full bladder, and we can see many things.

We can see, you know, how much the bladder holds, how it's behaving, whether there's an overactive bladder component, but particularly we want to look at the sphincter complex and the strength of the sphincter. So we have a man cough and push down, and so we can certainly measure certain things, but basically look at the strength of the sphincter and the outlet. And we do that, and that helps sort of determine the severity of the problem.

The other thing that I do which I think is very important is trying to objectively quantify urine loss because that has an impact on what we might offer to a patient. We spoke about earlier I think, you know, that there's a continuum of options, but any given patient, one option may be better in my opinion.

We've struggled a little bit in trying to objectively quantify the problem because you can imagine a man comes in, well, I wear one pad a day, and another man may wear three pads a day because he just doesn't like to have a moist pad, so you've got to be very careful when you go by how many pads a day do you use. It's very difficult.

So one thing I do is what's called a pad test. We will weigh the pads. You weigh them dry and then you weigh them wet, and you do it for a 24-hour period, and that has been shown, at least in my opinion and my practice, to be the best objective quantifier of urine loss. And then we take that information together with that urodynamic study and with the man's clinical history and certainly his wishes, and that's when I kind of put him into the algorithm, and at that point I discuss all the options and we try to figure out the best approach.

Andrew Schorr:
Now, one thing I want to jump in with is that I've read that what you might put in the category of supportive care can make a difference. In other words, if the man is overweight, could losing weight help, or not drinking as much before bed? I mean, are there things like that that make a difference here?

Dr. Hairston:
There's no doubt. I mean, there's so many variables which is one reason why there are specialists like me to try to cull through all that. I think, you know, all of those

things impact voiding functions, so we kind of take all of that into perspective. And the urodynamic testing—there's a thing called a voiding diary we sometimes do where you have a man jot down, you know, how much he urinates, when he's doing it, and you look at variations and things like that. Absolutely. They all make an impact and so you try to fix all those up front as best you can, and many men you can certainly improve the problem. And you do the best you can.

But if it gets down to it where you've done all of those things and the man still has a problem, then we're going to move on to the more invasive options.

Andrew Schorr:
All right. Let's step through those. So where do you start when you say an invasive option?

Dr. Hairston:
So I always tell a man there's really three options, and they run the continuum between the least invasive to the most invasive. The least invasive option from a surgical standpoint is what's called urethral bulking agent, and that's where we go in with a scope through the urethra and we actually (with a small needle) inject material under the lining of the urine channel there to actually—it's called a bulking agent. That agent will actually sit in there and bulk up the urethra and sort of close it off. That has really been taken from the female realm, so to speak. That's been done in females for many years now—decades—and has been shown to be effective.

I talk to men about that as an option. To be honest with you, it's not a good option. If you look at the literature, the results, certainly the longevity of it is pretty poor, you know, on the order of 20 to 30 percent success. In fact, at the most recent International Consultation on Incontinence, it was mentioned that it's probably not a good option. But I certainly talk about it because men may hear about it, and that may be an option for instance for a man who has a lot of other problems and not really a good surgical candidate. For instance, he has a lot of cardiac problems or cannot tolerate anesthesia, so that's a very minimally invasive thing that really can almost be done in the office. So it's something I talk about.

The next two options then are what we call minimally invasive slings and then an artificial sphincter, as I said before, which Mr. Agner had. It’s easier to go to the other end of the spectrum, which is the artificial sphincter. That's a mechanical device which is an inner tube that surrounds the urethra, and there's a pump that goes in the scrotum. The inner tube is filled with fluid and goes around the urethra and closes it off, like an inner tube that's filled up. When a man wants to urinate he simply pushes the pump in the scrotum three or four times. It's very innocuous. Pump the pump and it releases the fluid from the cuff, the little inner tube opens and the man urinates freely, and then it self-times and it closes back up.

So that's kind of the Cadillac. That's been around for almost three decades now, has a very long track record for success, and that's kind of the gold standard which everything else is measured against. So it's kind of easier to talk about that, and

generally men with more severe problems and severe degrees of leakage will really probably do better with that.

Andrew Schorr:
Wow. So it's sort of a mechanical way of what we do naturally when we've not had this problem—sort of on demand urination?

Dr. Hairston:
Right. Exactly. And that's the important point. Really, really with any of these treatment options, what we're talking about is the sphincter control most of the time—I mean, the bladder generally is fine. It's not a bladder issue, so regardless what you choose what's important in this is men urinate naturally. You just, you know, if it's the artificial sphincter the cuff opens and you urinate naturally, and then the cuff closes again, compressing the urethra. If it's a male sling, that provides a little compression support, but the man urinates naturally, and that's the important part in all this.

The Sling vs The Pump Procedure

Andrew Schorr:
All right. Let's back up. Now, you said that the sling works for many men without putting in a pump. So what do you do? I know that Augusto tried that and it didn't end up working as effectively as he wanted for him, so he went on to the pump. But for some men the sling will work. What is that procedure?

Dr. Hairston:
Right. So the sling is also something that—we seem to take a lot from the female and learn a lot from the female realm. But a sling, people probably heard the term sling. We use it a lot in females. Sling is a general term for basically putting anything underneath the urethra that provides support, somewhat like a hammock or a back stop, if you will. And we've done it in females for many decades now, which is kind of the gold standard as well. It was applied to men early on, but the man's anatomy is a little bit different.

But basically the concept is we can do this through a tiny, you know, a few-inch incision beneath the scrotum, and we put a piece of material in there. It's synthetic material, like a little strip of material, and if goes underneath the urethra and just compresses it and provides support. These are minimally invasive surgeries that take about an hour—45 minutes or an hour. They're outpatient. The man generally goes home either without a catheter or may have a catheter for a day or so. So we've made great strides.

Those, we've changed the way we do them a little bit, and it's a little bit of a work in progress. The concept has been around for a while. What I tell men, there's two things with that. We do not have the long-term literature to support the long-term efficacy of that. We've got good two-year data now and going on to three-year data where the results are very good. But what I tell men is that I just don't have

the track record that we have with an artificial sphincter—which we have, you know, going back 20 or 30 years. So that's something I think important for men to learn. You might hear about these slings. They're done a lot. I do them. I think they're great. They're not for every man. But we just don't know the long-term outcome.

The beauty of it is it's easier to do. It's quicker. The men do great postoperatively with regard to pain. And you can always move onto a sphincter, and Mr. Agner is a good example of that. The sling didn't work out for him, we moved on to a sphincter, and he's doing great.

Andrew Schorr:
Now a question about the pump, if you will, of the sphincter and the durability of that.

Dr. Hairston:
That's a good question. The beauty of it is we have a long track record with it. You know, it's a mechanical device and as such the—to put it in perspective, the patient satisfaction rates with an artificial sphincter is on the order of 97 percent, and that's been well proven. Because it's a mechanical device, it's going to work. If you put it in, it's going to work.

Because it's a mechanical device you can have malfunction, but these devices last quite a long time. What I quote men, and we've looked at this in the literature, is, you know, over a 10- or 15-year period about 15 percent or so of men might need a type of revision surgery to say, for instance, replace the pump, or the tubing has a leak and you have to go replace some of the tubing. And those are generally pretty easy surgeries. So, you know, I tell men about one in seven over a lifetime of 10 or 15 years may have to have a revision surgery for something like that. So the durability has been well proven over time.

Andrew Schorr:
And just so we have everybody at least think about this and they've had prostatectomy surgery, there is always other risks of complications such as infection, but with minimally-invasive surgery it is much less. But always whenever you consider surgery you want to go into it with your eyes open, discuss your own personal situation and understand the risks and the benefit. But it sounds like here if a man has come to you and he's had more severe incontinence the benefit may be high.

Possible Complications

Dr. Hairston:
Absolutely. And that's usually the case, particularly with the patients with the sphincter, as I said. The satisfaction rates are extraordinary. But, as you said, you know, with every benefit come a risk, and that's an important point we should discuss. The main risks are with really either the male slings or the artificial

sphincter, because both of them are foreign bodies. The artificial sphincter is a component with a pump and a cuff, but these are all synthetic materials and they've been used for many, many years. The body doesn't reject them, so to speak. And the slings are made of synthetic material as well.

So the main risks that we discuss are infection of the device or the mesh, or erosion. And erosion means that the device or the mesh will go into an area where it shouldn't be, such as the urethra—it will erode into the urethra. Those are the two main problems you discuss with this.

If you look at all comers, the artificial sphincter device has an infection rate of around five percent or so. So it's certainly not the majority of men. When it does occur it's a problem. You have to remove the whole device. It's rarely life threatening but unfortunately with it being a foreign body, the body can't fight off the infection as well, so when that does occur you have to remove it. Now, you can always go replace one later once there's recovery, but certainly that's an issue.

It's a little bit higher in patients that are high risk such as diabetes or patients who have had radiation for instance, and then maybe they've had prostate surgery and then they had adjuvant—what we call adjuvant radiation. The risks are a little bit higher, maybe double that, so that's certainly something we take into account.

The risk of infection with male slings is very low, on the order of probably less than two percent or less than one percent. That's pretty rare. Again, if it does occur you might have to remove the device, but the infection rates are certainly a little bit lower with the male sling, so that's certainly an advantage to that.

Likewise, the risk of erosions is similar. The risk of erosion is a little bit higher with an artificial sphincter. When that does occur, you have to remove the device but it kind of goes in line. I mean, it's like the incontinence after prostate surgery. Those things do occur and you hear about them and they're bad problems, but they're actually the vast minority of patients where that occurs in. Erosions with male slings are very uncommon as well, on the order of one percent or so, so it's something to discuss. I discuss it with all my patients.

Andrew Schorr:
Thank you explaining that. One other question that some men may wonder about because they see TV ads and maybe it's not about after prostate cancer surgery but it relates somehow to incontinence. So there's no pill, you've found. There's no magic bullet, if you will, that a man could take, to avoid these other interventions and all is well?

Dr. Hairston:
Yeah, you know, that would obviously be nice. There's certainly no magic pill or medication that's going to help stress incontinence. The same holds true with women with this problem. If it's pure stress incontinence, which is a problem with the sphincter or a problem with the control of the sphincter, we just don't have pills that are going to help that, unfortunately, as yet and nothing in the pipeline that

I'm aware of.

But that's an important point. So we talked earlier about men with the overactive bladder component, and so there are some men that come to me with that problem and you know, if we sort that out then occasionally we will put a man on a medication for overactive bladder, and they will improve. So I've seen some men that have come to me with urine control problems after prostate surgery that's presumed to be a problem with the sphincter, when in fact really it's the overactive part. So you can help a subset of men with that. But as far as the other component unfortunately, yeah, there's no pill.

Andrew Schorr:
So, Doctor, just summing up from your point of view, you're a specialist in this area. Men come to you and they are not happy and want a higher quality of life. It sounds like you have a broad range of options to help men like Augusto do better.

Dr. Hairston:
Yes, and again that's the key. I think, you know, we just don't want people to suffer. I think it's an awareness issue. I think in particular with prostate cancer, the man's already had to go through the whole, you know, the issue of being diagnosed with cancer and all that comes with that, and then they go through surgery and they may have this problem and they just sort of assume that's part of the situation, and that's not really true. And so, you know, I just want men out there to know that there certainly are options. There are numerous options, and they don't need to suffer.

Closing Comments

Andrew Schorr:
Dr. John Hairston, thank you so much for explaining this. Thanks for your devotion to men and women dealing with incontinence and explaining how there are options, as you said, for men who may be dealing with incontinence after prostate cancer surgery. Thanks for being with us.

Dr. Hairston:
Well, I appreciate you having me on, Andrew. I'm always happy to talk about this.

Andrew Schorr:
All right. Let's give the final word to Augusto Agner and what he'd say to other men who may be on the sidelines thinking they just have to suffer.

Augusto:
Well, my main recommendation is, please, go after a specialist, you know, an incontinence specialist. I understand all the doctors they try their best to help you, but if you go after a specialist it's a different story because sometimes urologists don't tell that they're not trained for it, but they don't know and to the point where some doctor that they've spoken with—they don't even know that this type of

device would do so good for a person like it did for me. So I recommend that everyone suffering for incontinence, go see a specialist on incontinence.

Andrew Schorr:
Right. And find out all your options.

Augusto:
Right, because they can help us. That's for sure, a hundred percent.

Andrew Schorr:
Okay. Augusto Agner, all the best to you, sir. I'm glad you got your life back.

Augusto:
Thank you. I really appreciate your call.

Andrew Schorr:
Augusto, thank you for telling your story and inspiring other men—and of course, thanks again to Dr. Hairston. As you can see as men age, sometimes younger men, too, we have this concern and it may happen to us: prostate cancer. And then the question is what to do. If we proceed to surgery, some of the time incontinence may be another shoe that drops but, as you heard, many times that will resolve itself in the short term. But if it doesn't there are specialists like Dr. Hairston who can help and see what your own personal situation is and then a range of options that can be brought to bear to bring you a higher quality of life.

Thanks for joining us. Be sure to share this program with people you may know who may have this concern. I'm Andrew Schorr. Remember, knowledge can be the best medicine of all.