



DR. ASHAMALLA

Know your risk for prostate cancer

By MELISSA BERMAN

mberman@liherald.com

■ Q: What are the biggest risk factors for prostate cancer?

Ashamalla: The three biggest risk factors are age, family history and ancestry. Prostate cancer is uncommon in men younger than 50, and the median age at diagnosis is in the mid-60s. Having a father or brother with prostate cancer can significantly increase a man's risk, particularly if the relative was diagnosed at a younger age or multiple family members have been affected. Certain inherited mutations, including BRCA2, also increase risk. Black men face the highest risk of prostate cancer among racial groups in the United States. For men at average risk, I recommend beginning the conversation about screening around ages 45 to 50. Men at higher risk should begin talking with their doctors around age 40.

■ Q: Can a man have prostate

cancer without experiencing symptoms?

Ashamalla: Absolutely. Early prostate cancer is essentially silent. When prostate cancer is most curable, it usually causes no symptoms. Most localized cancers are detected through a simple PSA blood test rather than because a man feels something is wrong. Men should not assume that having normal urinary function means they do not have prostate cancer. Urinary symptoms that develop with age are often related to an enlarged prostate and are not necessarily caused by cancer.

■ Q: How do doctors determine whether a patient needs active surveillance, surgery or radiation?

Ashamalla: Treatment is based on the individual patient and the characteristics of the cancer. We look at the Gleason score, PSA level and tumor stage to determine the cancer's risk category. For men with low-risk disease, active surveillance is generally

preferred. That means monitoring the cancer with PSA tests, imaging and, when appropriate, biopsies, rather than immediately treating it. For intermediate-, high- or very-high-risk disease, active treatment is generally recommended. Options can include surgery or radiation, sometimes combined with hormone therapy. For localized disease, surgery and radiation have very similar long-term cure rates, so the decision often comes down to the potential side effects and the patient's preferences.

■ Q: How has radiation treatment for prostate cancer changed?

Ashamalla: Radiation has become much more precise. One approach is stereotactic body radiation therapy, or SBRT, which can deliver highly focused treatment in as few as five sessions, with each treatment taking about 10 minutes. It is not appropriate for every patient, but for certain men it can significantly reduce the number of visits compared with traditional radiation schedules. We also have better imaging, implanted markers that help track the prostate during treatment and rectal spacers that create distance between the prostate and rectum. These advances allow us to target the prostate more accurately while protecting surrounding healthy tissue.



Courtesy Episcopal Health Services

Dr. Mark Ashamalla, chair of radiation oncology at the Episcopal Health Services Cancer Center.

■ Q: What should men know about side effects and the importance of screening?

Ashamalla: The side-effect profile of prostate radiation today is dramatically better than it was 10 to 15 years ago. The more precisely we can shape radiation around the prostate and away from healthy organs, the fewer side effects patients experience. Most importantly, men should not wait until they feel sick to get screened. Feeling healthy is

exactly why prostate cancer can be dangerous. When the disease is in its most curable stage, there may be no warning signs at all. For most men, getting started can be as simple as one conversation with a doctor and a PSA blood test. For Black men and those with a family history of prostate cancer, that conversation should begin earlier. Early detection can make a significant difference in treatment and outcomes.

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