

In men with post-surgical urinary incontinence, conservative management options include pelvic floor muscle training with or without biofeedback, electrical stimulation, extra-corporeal magnetic innervation (ExMI), compression devices (penile clamps), lifestyle changes, or a combination of methods. Uncertainty around the effectiveness and value of these conservative interventions remains [1539]. Surgical interventions including sling and artificial urinary sphincter (AUS) significantly decrease the number of pads used per day and increase the QoL compared with before intervention. The overall cure rate is around 60% and results in improvement in incontinence by about 25% [1540]. Other alternatives, such as the Adjustable Transobturator Male System (ATOMS) and the Adjustable Continence Therapy (proACT) may be an option but seems less efficacious than AUS [1541]. For a more detailed overview of management of urinary incontinence in these men see Chapter 5.6 in the EAU Guidelines for Management of Non-neurogenic Male LUTS [1542].

The use of PDE5 inhibitors in penile rehabilitation has been subject to some debate. A single-centre, double-blind RCT of 100 men undergoing nerve-sparing surgery reported no benefit of nightly sildenafil (50 mg) compared to on-demand use [1543]. However, a multi-centre double-blind RCT (n = 423) in men aged < 68 years, with normal pre-treatment erectile function undergoing either open, conventional or robot-assisted laparoscopic nerve-sparing RP, tadalafil (5 mg) once per day improved participants EPIC sexual domain-scores (least squares mean difference +9.6, 95% CI: 3.1–16.0) when compared to 20 mg 'on demand' or placebo at nine months of follow-up, even though the difference vanished after the end of study [1544]. Therefore, based on discordant results, no clear recommendation is possible, even if a trend exists for early use of PDE5 inhibitors after RP for penile rehabilitation [1545]. A detailed discussion can be found in the EAU Guidelines for Sexual and Reproductive Health [1546].

In a SR of genitourinary cancers with mostly prostate cancers it is evident that sexual well-being concerns for men and their partners are evident from diagnosis and into survivorship. Both (patient and partners) benefited from interventions but many articulated difficulties with initiating the topic due to embarrassment and limited access to interventions in cancer services [1547].

Testosterone supplementation

Although the evidence is limited, men who are managed expectantly for PCa, or who received radical local therapy, do not have worse outcomes when receiving testosterone supplementation [86]. Currently the panel see no contraindication to give testosterone substitution to symptomatic hypogonadal men with prostate cancer where ADT is not the treatment of choice.

8.3.2.2 Men undergoing systemic treatments

Similar to men treated with a radical approach, in men with T1-T3 disease undergoing RT and ADT, a combined nurse-led psychological support and physiotherapist-led multi-disciplinary rehabilitation has reported improvements in QoL. Specifically, this intervention involved action planning around patients' needs related to lifestyle changes, weight control, toilet habits, sexuality, and psychological problems. This was complemented with pelvic floor muscle therapy. Improvements in urinary (adjusted mean 4.5, 95% CI: 0.6–8.4), irritative (adjusted mean 5.8, 95% CI: 1.4–10.3) and hormonal (adjusted mean 4.8, 95% CI: 0.8–8.8) EPIC domains were found up to 22 weeks of follow-up [1548]. In a three-year follow-up with 92% response rate from the initial study, fewer participants had moderate-severe bowel problems in the intervention (n = 2; 3%) vs. control group (n = 10; 14%) (p = 0.016) but the benefits in terms of urinary function were maintained only in those participants with moderate-severe urinary problems at baseline [1549].

Providing supervised aerobic and resistance exercise training of a moderate intensity improves EORTC QLQ-C30 role (adjusted mean 15.8, 95% CI: 6.6–24.9) and cognitive domain outcomes (adjusted mean 11.4, 95% CI: 3.3–19.6) as well as symptom scales for fatigue (adjusted mean 11.0, 95% CI: 20.2–1.7), nausea (adjusted mean 4.0, 95% CI: 7.4–0.25), and dyspnoea (adjusted mean 12.4, 95% CI: 22.5–2.3) up to three months in men treated with ADT [1550]. Such interventions have also reported clinically relevant improvements in FACT-P (mean difference 8.9, 95% CI: 3.7–14.2) in men on long-term ADT [1551, 1552]. These findings are supported by a SR which reported improvements up to twelve weeks in cancer-specific QoL in a meta-analysis of high-quality trials (SMD 0.33, 95% CI: 0.08–0.58) [1501]. Supervised exercise interventions delivered over twelve months are effective in reducing psychological distress; particularly in those men with highest levels of baseline anxiety and depression [1553]. In untrained older men, SR suggests lower volume exercise programs at moderate-to-high intensity are as effective as higher volume resistance training for enhancing body composition, functional capacity and muscle strength and may reduce barriers to exercise and enhance adherence [1554].