# Erectile Dysfunction In Patients With Prostate Cancer And Metabolic Syndrome Transcript

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## Introduction to Dr. Valenzuela

Hello, everyone. Welcome once again to the Prostate Cancer Summit. I'm your host, Doctor Geo Espinosa, and it is my great pleasure to introduce to you Doctor Robert Valenzuela, who specializes in prosthetic urology, sexual dysfunction, post prostatectomy, urinary incontinence, BPH, and Peyronie's disease.

He's one of the most prolific implementers of penile prostheses, artificial urinary sphincters, and male slings in the northeast region. He's former assistant clinical professor at Squall Urological Clinic at New York Presbyterian, and he's the former director of the penile prostheses surgery at the Icahn School of Medicine at Mount Sinai here in New York.

He's also the co-director of the fellowship program at Mount Sinai as well. He's a good friend. And honestly, guys, there is no Doctor Geo Espinosa without Robert Valenzuela because he got me started over 20 years ago in Washington Heights, New York, right, Robert J.

Washington Heights. That's the best place to be. So I have a lot of love and affection for for Doctor Valenzuela because, those were my starting roots as a, as a, as an unconventional physician and natural pelvic medicine.

So I really, I really I always. Oh, I owe a lot to to Doctor Valenzuela. Robert, thanks for for being on this summit. I could not think of. You know, we have, quite a few experts in sexual dysfunction for this summit, and I just felt like it would be incomplete if I didn't speak to one of the best in this area.

So thank you for being on on this late day. What a great introduction. Thank you so much. Listen, it is my pleasure. And I love working with people. And I think, you know, my track.

I have to what? I used to be pretty much an oncologist, so I used to do a lot of oncology. I remember. And as I transitioned to being more into sexual medicine, there's a lot that I learned along the way in terms of managing these patients.

And what is important. And I think the natural graphic aspect of it is extremely important. And that's where you came along. And I thought that was great to have you on board.

Yeah, that started everything for me. I remember doing, prostate exams and, and in this weird way, I never even expressed it to you as a guy. I love doing this, you know? Oh, man.

You know, I used to come back home to my wife. Oh, man. I had the greatest day. I felt, you know, 15 prostate with Doctor Valenzuela. And I learned that this means that and that means the other.

And so, yeah, I know that's the part of the quirkiness of maybe my own head. Urology of urology if.

## From Prostate Cancer Surgery to Sexual Medicine

So let's so, you know, you do bring actually, I have to say, and I'm glad you mentioned that you do bring a special set of experience to the table, because unlike many trained fellows in sexual dysfunction and penile prostheses, you performed, I remember quite a lot of prostatectomy and you treated a lot of prostate cancer back in the day.

So talk a little bit about that. How many prostate cancer surgeries that you do? I there were quite a few when we worked together. So I can only imagine the whole time that you, you work with prostate cancer.

How many did you do and and what what got you to transition to specialize primarily into sexual dysfunction and penile prostheses. So, you know, I trained at Beth Israel, which at that time we were associated with, Mountain View and, Einstein School of Medicine.

And so we had an extremely good training in general urology. And so coming out of that program, I felt like, you know what? I could just hang up my shingle and go out there and practice.

But what I did was I joined a group of private physicians that, focused on prostate cancer and focused on, oncology and stones. I was there for two years, and then I moved out into Washington Heights.

And when I joined Doctor Contreras, that was there, as well as, general Urologist. And the experience that I brought with me in terms of doing taking care of the patient as a whole, not just taking care of one aspect of their treatment, but seeing the patient as a whole.

And so when we began seeing patients, you know, my practice was built on prostatitis. So a lot of these patients presented with irritated voiding symptoms and symptoms of prostatitis.

And this is what brought them in. What brought them was all these lower urinary tract symptoms. And along those lines you wound up doing their PSA. You wind up diagnosing prostate cancer.

And not only did I specialize, I did a lot of prostate cancer. But I don't know if you remember that background buff and I heard of Washington Heights.

We used to do between 100 to 125 radical prostates a year. So we were very busy, and that went on for about 7 or 8 years. And so at the same time, not only was I taking care of the prostate cancer, but I wanted to take care of them as a whole, take care of them post-op.

I was able to take care of their incontinence, take care of their erectile dysfunction and manage them all along. And some of these patients are still my patients today, which is great.

And like I said, unlike, people who have been trained specifically in sexual medicine, they miss out on that aspect. Seeing these patients pre-op before what they were like, what what their experiences were like, what do they bring to the table and how to help them overcome that problem, how to overcome the prostate cancer, and then what's to come afterwards?

You know, nowadays medicine is so compartmentalized. You have specialists with specialists for everything. So you had you guys would see the BPH, they diagnose the prostate cancer, they send them over to the oncologist.

The oncologist has the radical prostate, sends them to the sexual medicine. Well, you know what I felt like at that point I was doing everything, which was great.

But then robotics came along and ruined everything for me. That was it. That was it. And, to me, it's funny because Doctor Gallbladder, I remember where he critiqued it, critiqued it vehemently initially when you I remember I remember him saying, well, when you have all these scars and you put them together, it's the same.

It is the same size, right? And then later on he was like, well, if you can't beat them, join them. And he started crying. He started doing robotics. Well, you know, Carlson actually asked me a medal.

He didn't ask me. He told me, you got to go to California. You got to go and train. You got to come back ready to do a robotic prostate. And I was like, man, I'm too old.

What happens is in private practice, you age out very quickly. You don't have the patience to spend 4 or 5 hours doing a procedure that you do in an hour and a half, right.

So a typical day for me on a Tuesday should do to radical prostate superior procedures. I was home by 330.

Meanwhile, these guys were doing one radical prostate from 730 in the morning to 4:00 in the afternoon.

And so what happened? You know, those who are not academics can spend the time doing it. Those that are in training can spend the time doing it. I couldn't afford to do that. I had, a large patient population and I had a lot of people to set up.

And so, you know, as I saw that prostate cancer who radical prostate used in the robot became very safe and effective and patients were doing well. I transitioned to sending those patients out to somebody who could do a better job, because I really believe that you got to provide the best possible care for your patients, right?

You know, there were patients who would come to me and say, no, no, I want it done by you. And I would say, but and I would send somebody who could do it with the robot.

And I think that's the right way to treat your patients. If you can't do it, send it to somebody who could do the right thing for your patients. Yeah. And the evidence was there or at that point.

So the evidence was was there and it was obvious that the robot, you know, less blood loss, less pain and those kinds of things that got better, faster recovery, faster recovery work, less pain, no hospitalization.

And oftentimes, I mean, there's a lot of benefits. So you think about a radical prostate. These patients needs to stay in the hospital for three days to four days.

Then they had a catheter. And then oftentimes they were out of work for about three months. Just recovering from the from the scar from the incisions in some institution, some places they go home same day if they do it early enough.

Yes, yes, they used to do it. They they're doing it same day surgery. That's right. So and that goes along with the fact I mean as well. So a lot of the other procedures.

So it's definitely much superior around that time. However it's not like you were did 100 prostatectomy a year and that's it. You did quite a lot of penile implants back then as well.

Maybe hundreds as well. I mean, you one of the top guys in New York and, so, so and again, it's it's, I think remarkable.

## Evaluating Post-Prostatectomy Erectile Dysfunction

It's almost like I spoke to, recently to, Doctor Easton from Memorial Sloan-Kettering. And, you know, he has this wonderful, wonderful experience in doing open prostatectomy.

Right? He did, you know, several hundred, if not a thousand of those before transitioning to the robot. And he finds that that combination that now the current automated decisions don't have they don't have that training and open.

And he finds that there's value there. He says, I still have to do about ten a year because there's a lot of, he call it a hostile abdominal environment where you still have to do an open and a new trainees don't.

I find it fascinating that you have this experience which is so useful in prostate cancer, prostate cancer surgery? Well, now solely focusing on male sexual health, particularly post, post prostate cancer treatment.

So, tell us, tell us about that. So here we have, a patient that, you know, under regardless of what he's trying to do after he prostatectomy, it's not happening.

He he's not he he's not getting it up. He's not getting it, an erection where he's satisfied he and his partner are satisfied. Yeah. My first question is, it used to be that, you had a whole protocol, and it seems as I speak to different experts.

You don't need a protocol if you are qualified for a for prostheses, you get it. In other words, you don't have to try cialis. Okay, I didn't try. Try and mix. Okay.

You don't have to go through that process. So go ahead. Speak on that. In terms of your process before they go ahead and get an implant. So my practice is a little bit different.

It has evolved to where I am, what you would consider a super specialist. Right. So you have a specialist and then there's a subspecialty within the specialty.

So basically a lot of the patients who come through my door now are ready for prostheses. I don't have to sell to them. I don't have to convince them of it.

All I have to do is present them the data. Most urologist I would they will practice some level of sexual medicine because it's easy. You can do testosterone replacement.

You can do, pde5 you can do injectables, all these things. So they exhaust all those resources before they ultimately send them out because they're not doing the surgery.

So for me, most of these patients that come to me, not only do I look for whether they have a right down dysfunction, but I also focus on the urinary symptoms.

And sometimes physicians, they don't really capture that because they're so focused on, well, how are you doing? And you're not getting erections. But you mentioned nuances such as, you know, climactic area, lots of area with orgasm.

While they don't have an erection, well, they may not wear a diaper. They may be still able to masturbate, and then they may leak urine at that time. So it's something I try to identify at every level with every one of my patients.

The other thing is penile anatomy. We know that penile of that, which significantly changes with the duration of erectile dysfunction. So these patients that come in with a record dysfunction, I take into account one, what type of therapy did they have?

Did they have just a radical prostate and they go on to do a radiation therapy? Did they have hormone therapy? Because each one of those are considered insults to the penile anatomy.

You can lead. That leads ultimately to one a rectal genic. Silence. The longer your therapy, the longer your penis is going to be out of circulation. Is that going to get that nutrient that against those nocturnal erections?

Number two, oftentimes these patients are put on daily medication like Sally's daily tadalafil. Well guess what. They take it in the morning. Do you think that's going to do anything for them now when did these patients wind up having any kind of stimulation without in fact having stimulation, which means that they're having increased, stimulation of the cavernous soft.

It's usually at nighttime during REM sleep cycle, what we call nocturnal penile, to my sense, are nocturnal erections. Well, if you're giving them the medication in the morning, you're giving them a low dose.

This medication is not really going to make much of a difference for them. It's been shown that it will help, but I find that giving them to them at the right time makes a bigger difference.

So being out of atom is very important. Their response, to penile duplex. Not only do they have large vessel disease venous leak A penile duplex is an ultrasound right to to the penis to see them.

There is circulation to the penis. Right. So even though these patients oftentimes come prepared already, they may have had a duplex at another place.

I want to see if I perform it either myself or one of my staff members, and either walk in or have one of my members look at it and see what the anatomy is like.

Is there any curvature, is there any angulation, is there any fibrosis? Because that's also going to help me map out the surgery, is that you're going to walk them blindly, just put in a procedure on anybody you really want to plan things out properly in order to give them the best result.

So it's a step it seems very simple. They come in, they're ready for prostheses, you book them and you get them done. But it's not as simple as that because the patient's expectations, you know, they don't see their prostate cancer.

They don't see their scars. But believe me, they do look at their penis. They they they can appreciate or they complain. The loss of length, loss of girth, angulation, all these other things that come along with this type of treatment.

Well, a few of the others mentioned, and maybe you can expand on it. So we know that after, let's say, surgery, they lose about two centimeters up their length.

A peanut prostheses does not elongate their penis. Or is there an approach where you can kind of do both, kind of elongate the penis and at the same time and insert the the penile prostheses.

Okay. So the penile process is meant for function. It is strictly function. It is not like a breast implant that you can make it any size that you want.

It does not work that way. So all of these patients, yes, on average will lose a certain amount of length about two centimeters of length after their radical prostate or after radiation.

So there are techniques, but these are highly specialized techniques and not everybody performs them. And then it, all the so, certain kinds of procedures that you can do at the time of penile prostheses to try to restore some of the length.

And I'm very careful to tell my patients, we try to penile length preservation or restoration. We do not do penile a large amount because your anatomy cannot be altered.

What you have is what you have. You cannot go beyond that because there are limiting factors. You have the urethra that only has a certain amount of elasticity.

You have the neurovascular bundles that have a same amount of elasticity and can stretch. But so much, you know, the nerves of the penis are undulating nerves, and they're meant to be that way because when you get an erection, these fibers stretch out.

That means the nerves have to, accommodate for that. But they cannot accommodate beyond a certain level without causing shearing forces and leading to disastrous complications such as loss of sensation or high paresthesia of the penis.

So what's the use of having a penis if you have no sensation? So you have to be very careful about those things. So you're right, lots of length is probably one of the biggest complaints.

You know, I've looked at some of these patients while I was treating them pre-op for radical prostate. I always took into account what the post-op is going to be like.

And I started them on therapy immediately after the surgery and while I was at Sinai. Part of the program is still is to try to maintain function and get them back into a rehab mode as quickly as possible.

## Penile Prosthesis, Length, and Timing Considerations

And in fact, for me, if a patient has a detectable PSA, let's say you have prostate cancer, you have a radical prostate, and now you go back to your doctor and said, oh, by the way, your PSA still detectable.

That means that you may still have disease. You may get a Pet scan. The Pet scan shows that there's still disease. How are we going to treat that? I'm going to treat it with radiation and oftentimes with androgen.

That provision. Well guess what. Those two hits are going to be on the erectile function and on the penis. That could cause further shrinkage. So what I always tell my patients is if you're going to go that route, sometimes the best thing is to get the penile procedures before getting the radiation while your penis is still pliable, while you still have that elasticity, so that while you get your hormone therapy and your radiation therapy, your penis doesn't suffer for it.

But we're so focused, as you can imagine. I mean, you could just imagine if you have prostate cancer, you're going to be focused on I need to get rid of this sexual function is secondary, but the reality is we see what comes afterwards.

So we need to be aware of these things. You know, that's a great point and might be the first time I hear this. Right. So this is a situation where you have a guy who had, his prostate removed and now he has a recurrence of his PSA because his he has some level of relapse.

He may have to undergo radiation therapy and hormonal deprivation therapy or chemical castration. And you're suggesting right before you do that, get the penile implant so that it's already, you know, it's sort of it's sort of already there when you're able to function.

Interesting guys on ADT, hormonal deprivation therapy, they some of them still have a desire to be sexually active. They can't because of the insults that you are teaching us about.

But they so they have sexual dysfunction. There's no circulation going on around the pelvic area. But some of them. So if they have an implant, they'll still look.

They're still able to enjoy the quality of life. You know, I think that the patient is funny. I wonder who drives is the physician or the patient. There are many patients.

You know, I remember, working at Columbia after I work with you and and the conversation was, well, you know, don't think sexuality. Think of what's going to cure you first.

And I think that the tide has changed a little bit, where now we can talk. We can have the discussion about both. Yeah. Who try to cure you. But, you know, let's talk about quality of life, and that's probably patient driven.

So I love the idea of but that seems to, you know, like you said, it's like okay. No the cancer. So then people, you know, and and also their physician oncologists, I know we need to get you going, get you going right away though.

There's a period of time where they go on ADT. I'm actually probably thinking out loud here. There's a period of time where they're, about two months before they go on ADT, that maybe they can have their penile implant.

How many patients have you seen have opted for that? Oh, I see quite a few. So I see a lot of post radical prostate patients. Not only do I see a lot of these patients who come in have to they're having prostate. And I detected the PSA.

I test for their PSA in the PSA slightly elevated or it's detectable and I'm the one that I'll send them for. For radiation or send them back to their physician, letting them know that their PSA salivate.

So, and I'm also getting more and more referrals like that. I think the word's getting out. I think you're right. It's patient driven. The physician is sitting there is like, well, I'm focusing on the cancer.

We need to get this taken care of. But I think the physicians are beginning to listen to beginning to understand the needs of our patients. And they understand that life goes on.

You can treat the cancer, you can cure them, but now you want to enhance their quality of life afterwards. Yeah. And so, you know, these patients who have gotten radical prostate radiation, hormone therapy, now they're undetectable, no evidence of disease.

Their testosterone still is slowly coming up, you know, at Memorial. And, they looked at replacing testosterone in some of these patients after radical prostate model.

One of the one of the, you know, big professors of sexual medicine. They said it's almost like a test of cure. If you're undetectable, you get testosterone replacement and you become detectable.

Then there's something wrong, right? So yeah, we know that patients with prostate cancer can be treated with testosterone replacement in the right setting, with the appropriate follow up.

That goes to show you that physicians are listening, they're paying attention to the patients and understanding that quality of life is just as important as surviving your cancer.

I love it. I see a lot of these patients, and I tell you that it's disheartening to see them. You know, it's almost like they lost a zip to their step.

And, and, you know, I try to pump them up and it's like, yeah, this is they're not buying. They it's just chemical race biochemistry. At the end of the day, especially testosterone comes back.

That's when it really, really hits them. That's when depression sets in that marital problems, they have relationship problems that only with their spouses but with their family in general.

That's I think that's where the expression angry old man comes from. Yeah. Exactly. Exactly. And you know, and these these are angry old men that are in their 50s sometimes.

Sometimes. Yeah. So biochemically, you know, they, they, they are a little bit older, a great group of people to my heart goes out to them. And so, so the idea is.

Right. So this so the patient had a prostatectomy, prostate removed. They were on ADT radiation. Now they got it off ADT. Testosterone comes back. The erections are not working.

So thus maybe it's the penis has gotten shorter. Yeah it's Jesus. So yeah the right time is probably between one and the other. That would be that would be the ideal time.

That's that's amazing. I found that with these cases that they do very, very well and they tolerate the radiation well. And after that, you know, I mean, these guys who come to me at the radiation, I wait at least six months after the radiation for penile prostheses because, you know, it's just I'd rather wait until they heal properly from that.

Yeah. If I go ahead and put in a procedure so it takes. It's a wait. It's a loss, a significant loss of time. So let me ask. So they had a, they had a they had their prostate removed and, but they're still incontinent.

So if they're incontinent, they're not even thinking sexual activity. They're thinking, you know, and they can actually if they get an erection big, if they have a fear of leaking into their partner.

Sure. What do we do there? And that's well, that's why that's why, like I said, medical history is very important. You want to determine if there's any level of incontinence, including climax to it, because that's going to affect their their ability to have intercourse.

And there are things that we can do for them to take care of that. So basically, the beauty of robotic prostate

cancer, as opposed to, hope and prostate cancer, we used to have about a 15% incontinence rate.

We are now down to about less than 5% incontinence rate and not only not only are we down to less than 5%, but the level of total incontinence is probably even lower than that.

And that's a testament to the technique and the visibility and all these things. I mean, we've got they've gotten so good at doing it. So these patients, it all depends on the level of incontinence.

There are treatments for that. There's a male sling. There's a male sling by Boston Scientific called the advanced. There's another I, male sling called the virtue male sling.

## Incontinence Solutions and Surgical Combinations

And then for those guys who are not candidate surgical can I mean, I should go back and say first is medical therapy. Want to evaluate the bladder, make sure they don't have an overactive bladder, which can happen from the procedure and everything.

But if you're talking in the surgical realm, we have male slings. You have large artificial urinary sphincters. And for those guys with mild urinary incontinence and erectile dysfunction and climbing or and climb Victoria, we can do a penile prostheses in a sling.

At the same time, I developed a sling called a mini male sling, which is what it does. It supports the urethra when they get an erection, so it tightens up the cylinders, and then it lifts up the urethra to block it off to prevent leakage during sexual activity, which is key.

It's very important to these patients. That's excellent. Wow. How often things go wrong, doctor Valenzuela with penile prostheses, whether in the middle of the procedure afterwards, it seems like I remember the infection rate being a bit higher than it is right now, but I'm not really on top of the literature as much as you are.

So what can go wrong? And I know that infections is one of the things that can happen. And, where are we with that at this point? Well, what I always tell my patients is, look, penile procedures is just like any other surgery.

There's always a risk of infection, bleeding, pain, malfunction. All of these things can happen in the immediate post-op period. And that's normal. Just like a radical prostate.

I like to compare it to crossing the street. You can cross the street, you can get hit by a car. You can look up, you look down, and you take every precaution.

But somebody still comes and hits you. Same thing with penile prostheses. We as surgeons try to take, make, take every single precaution to try to prevent it from happening.

But it can still happen. Historically, penile prostheses infection rates are about three, 3%, which is, you know, not terrible considering if you don't have any function whatsoever.

And you can take that risk. But that's all comers. If you go in, you look at it specifically, an implant is high volume implanted, their infection rate goes on.

Guys who implant more than 50 implants a year, you're looking at an infection rate of less than, let's say, 1 to 2%. If you go above that, guys should do 100 to 200 implants a year.

You're looking at infection rates of less than 1%. Now, out of all everybody that I know French wide is it was a well known, you know, procedures implant to and sexual medicine surgeon.

He has rate of infection is about point 4 or 5% which is amazing. I mean my infection rate I tell my patients is less than 1%. But again, it all depends on who's doing your surgery.

Take drains and somebody with those ten and 20 year and get to one infection. He's got a 10% infection rate right. You got a guy who has 100 implants a year.

He gets one infection. You got 1%. Yeah. So it's all relative. Not only that, what do you bring to the table? The experience, the ability to take care of any intraoperative complications that can happen because that can happen.

You know, you could get into the urethra. You can perforate the corpora, you can perforate the bladder. There's organs all around. These things can happen.

Just like with a radical prostate. You can perforate the intestines, you can perforate the bladder. You can do all kinds of havoc that can happen. But it's not that we do it on purpose.

These are things that can happen, and we disclose that to our patients. It looks like the like the satisfaction rate is pretty high after a guy's got a penile prostheses.

Do you know what those numbers look like? How many you know are satisfied versus, dissatisfied after? Man, this was the. This was the worst decision I've ever made.

How many of those guys out there? I mean, I can't see it, but who knows? Yeah. So highly satisfied. They've actually looked at the literature on women and men and women.

It's about 85% satisfaction rate with the the penile process. Probably. It was a lot less before the peanut trust. Yeah. That's right. And then for the men it can be as high as 90%.

Wow. Okay. These men are very satisfied. I mean, when you're talking about highly satisfied, you're looking at about 86 to 90%. And when you're looking at satisfied for these patients, you're looking at about 95% satisfaction rates.

So it's very, very high. I mean, one of the comments I get from a lot of my patients is, I wish I would have done this. I would have done this a lot sooner.

And it's consistently across the board. They wish they would have done it sooner. Why? Because if free, it frees them up. You know, they actually did a study where they looked at men who got a penile processes.

They're about 20 to 30% of men who got penile procedures were never used a lot of time.

## Penile Implant Risks, Satisfaction, and Final Advice

But 100% of them said they would do it again, because psychologically, it frees their mind from having to think, I cannot get an erection or engaging in any kind of sexual situation due to the fear that they can't perform or engaging in any social event because they feel out of place, or they feel like they can engage a partner or another person because they feel, what if it comes to that and I can't do anything about it?

So I really frees up the individual significantly. No issues with orgasms, right? They they get they feel the same type of orgasm. And some after prostatectomy is claim that they're even more inclined to orgasm.

Yeah, that's true. And that makes total sense because you're removing the prostate and they're merging still there. But now you get a little fibrosis and they get an intense orgasm.

They may not ejaculate, but they have an intense orgasm. No there is we do not disrupt any of the, nerves of the penis. So no, it does not affect the orgasm.

And if they are premature ejaculation, they still are premature ejaculation. So I like to compare it to a breast implant. Breast implant? A woman can get it in their teens and or in the 20 years old.

And yet they can have kids and they can still lactate and breastfeed. Well guess what? The sensation everything is still there. Just the same. The only difference is, is that you still have rigidity.

Now you have rigidity. Okay, now you can control the rigidity of the penis. Now one of the things that I like to do to my patients is what I call corporal sparing.

You know, the penis has two chambers and those chambers are full of spongy tissue. The teaching was that we used to use these instruments that they dissect into the penis and and in essence, destroy all that tissue.

Well, it's been shown that if you preserve that cavernous tissue that tissue is still functional. You can actually do a sonogram of that tissue and see the circulation of the penis.

Not only that, when patients become sexually aroused, they get a little fullness of their penis and almost feel like they're getting an erection. They may not get the rigidity that they need for intercourse, but that's compensated by filling the procedures.

So that's very important. And I do that across the board with all my patients, because I find that their level of satisfaction is significantly better.

Wow. This is great. All right. That's all I have for you. Doctor Valenzuela, a final thoughts. And, where can people find you? I think, you know, my final thoughts on this is, you know, cancer. Yes.

I always tell my patients when you hear the diagnosis of cancer, the beauty about prostate cancer is that if you catch it on time, it's not going to kill you.

It is very good. And it can be cured. It can be eliminated. And yes, even if it comes back after surgery, it can still be treated and you can have a very long life.

And so not only do you have to think of the immediate treatment, but you also have to think of your quality of life in the future. You have to think about what's to come after that.

You still want to continue having your relationship, your partner, your family and all those things. Believe it or that can be significantly affect. Be affected by your lack of surgery, by the lack of your sexuality.

So I think to me, it's very important that you keep that in mind, because testosterone is what drives man's libido and tries and tries men in a lot of ways.

And so you begin to notice that when you don't have that erection, it really affects you in a negative way. You know, it's easy to find the balance. While urology can't get easier than that.

You can just Google me, find balance. Well, neurology talks about all the things that I do, so I like to keep it simple. valenzuelaurology.com. That's right.

All right brother, thanks so much for joining us. And thanks for enlightening us on, you know, something a very important topic. Sexual health and penile prostheses after prostate cancer treatment.

Thanks so much for geo. It's a pleasure being here. Thank you for inviting me. My congratulations on your summit. I think this is a great idea. Thank you.

Thank you. I'm super excited. Hey, everyone. Thanks again for watching. I promised you right from the beginning. I'm only bringing the best to this summit, and I will continue to do so, so stay tuned. There's more to come.

This is Doctor Geo Espinosa signing off, and I'll see you next time.