of prevalence rates, from about 20% to 88%. To help further clarify this issue, Timothy Siegel, MD, and colleagues from the Center for Prostate Disease Research, Rockville, MD, compared erectile function in patients receiving radical prostatectomy, external beam radiation, or watchful waiting.

Siegel et al. used data on more than 800 prostate cancer patients that had been collected prospectively as part of the Department of Defense Center for Prostate Disease research program. Prior to treatment, 69% of the men reported normal erectile function. At an average of 53 months after treatment, 10% of men who had undergone radical prostatectomy and 15% of those treated with external beam radiation had intact erectile function.

In contrast, 38% of the men who chose watchful waiting had adequate erections after six months. Overall, more than 80% of the men who were treated by prostatectomy or external beam radiotherapy developed ED during the study, regardless of age.

ED Should Be Expected with Active Treatment

“Patients who elect non-nerve sparing radical prostatectomy or external beam radiation therapy should expect a high incidence (greater than 85%) of erectile dysfunction after therapy,” the authors wrote. “In our experience, erectile dysfunction did not develop based on the type of therapy received, but only whether a patient received active therapy for prostate cancer.”

In an accompanying editorial, Ian Thompson, Jr., MD, University of Texas Health Sciences Center at San Antonio, commented that, “These sobering results disagree with the common perception that erectile dysfunction is nonexistent with surveillance, and is infrequent after radiation and slightly greater with surgery.”

In a second editorial, Irwin Goldstein, MD, Boston University School of Medicine, focused on the importance of outcomes studies in urological oncology that use well-validated survey instruments for assessing sexual function, and of collecting and analyzing data on physiological and psychological variables relevant to sexual function.

SMOKERS AT HIGHER RISK OF COMPLICATIONS FROM BREAST RECONSTRUCTION SURGERY

Women who quit smoking for at least three weeks prior to breast reconstruction surgery after a mastectomy may significantly reduce their risk of complications, according to a report in Plastic and Reconstructive Surgery (2001;107:342-349). In many cases, the risk can be reduced to that of nonsmokers, according to the study.

The study is based on records of more than 700 women who had undergone breast reconstruction surgery with either an implant or a TRAM (transverse rectus abdominis musculocutaneous) flap.

Of the participants, 155 were current smokers at the time of the procedure, 76 were ex-smokers, and 517 were nonsmokers. Women who had quit as recently as three weeks prior to undergoing either type of surgical procedure were classified as ex-smokers.

The fact that the former smokers’ overall complication risk was similar to that of nonsmokers surprised investigators, said Randall Yetman, MD, co-author and plastic surgeon at the Cleveland Clinic. Almost 40% of the smokers experienced complications, such as

“I routinely tell my breast cancer patients that smoking might increase their risk of complications and that most of these complications detract from the appearance and feel of the reconstructed breast.”
mastectomy flap necrosis, fat necrosis, abdominal wall necrosis, seroma, wound dehiscence, and infection, compared with about 25% of nonsmokers and ex-smokers.

**Smoking Impairs Wound Healing**

During the surgery, blood supply to the tissue at the reconstruction site is reduced. Smoking causes constriction in blood vessels that impairs wound healing and reduces oxygen delivery to the tissues. Therefore, women who smoke are even more vulnerable to tissue necrosis and other complications in the area of the reconstruction. Wound dehiscence, fat necrosis, and lumpiness of the reconstructed breast, for example, were all about three times more common among smokers than among nonsmokers.

Jeanne A. Petrek, MD, director of the surgical program at the Evelyn H. Lauder Breast Center at Memorial Sloan-Kettering Cancer Center, New York City, notes that although the results of a single study cannot be considered definitive, “It is intuitive that because smoking decreases blood supply and can lead to surgical complications at other sites, it would be expected to increase the risk of the complications noted in this study.

Based on these considerations, I routinely tell my breast cancer patients that smoking might increase their risk of complications and that most of these complications detract from the appearance and feel of the reconstructed breast. And, I offer appropriate pharmacological agents and counseling to help these women stop smoking for as long as possible before surgery.”

Debbie Saslow, PhD, director of breast and cervical cancer at the American Cancer Society, agrees that, “although there are limited data, women could be told that one study indicates that complications might be increased if they continue to smoke, but that if they stop smoking for three weeks before the surgery, it could make a big difference in their results. However, many women in this situation are already experiencing tremendous fear and stress, so we should make sure that the issue is approached in a supportive and sensitive way.”

**Erratum**

In the January/February 2001 issue, in the article, “American Cancer Society Guidelines for the Early Detection of Cancer: Update of Early Detection Guidelines for Prostate, Colorectal, and Endometrial Cancers” (Smith RA, von Eschenbach AC, Wender R, et al. CA Cancer J Clin 2001;51:38-75), an error occurred in the text on page 43. The PSA and PSA-free levels are given in nanograms per deciliter (ng/dl), but should be given in nanograms per milliliter (ng/ml). We apologize for the error and any confusion this may have caused.