



GUIDELINES FOR SEXUAL HEALTH CARE FOR PROSTATE CANCER PATIENTS: RECOMMENDATIONS OF AN INTERNATIONAL PANEL

Daniela Wittmann, PhD, MSW
Associate Professor Emerita
University of Michigan Department of Urology



**PROSTATE
CANCER**

Disclosures

Recent contract with Movember

Associate Editor of the Journal for Sexual Medicine

Board member of the Foundation of the Sexual Medicine Society of North America (SMSNA)

Chair of the Oncosexology Committee of the Sexual Medicine Society of North America(SMSNA)

Chair of the Global Outreach Committee of the International Society for Sexual Medicine (ISSM)



Authors and Affiliations

Daniela Wittmann¹, Akanksha Mehta², Eilis McCaughan³, Martha Faraday⁴, Ashley DUBY¹, Andrew Matthew⁵, Luca Incrocci⁶, Arthur Burnett⁷, Christian J. Nelson⁸, Stacy Elliott⁹, Bridget F. Koontz¹⁰, Sharon Bober¹¹, Deborah McLeod¹², Paolo Capogrosso¹³, Tet Yap¹⁴, Celestia Higano¹⁵, Stacey Loeb¹⁶, Emily Capellari¹⁷, Michael Glode¹⁸, Heather Goltz¹⁹, Doug Howell²⁰, Michael Kirby²¹, Nelson Bennett²², Landon Trost^{23, 24}, Phillip Odiyo²⁵, Run Wang^{26,27}, Carolyn Salter²⁸, Ted A. Skolarus^{1,29}, John McPhail²⁰, Susan McPhail³⁰, Jan Brandon³⁰, Laurel L. Northouse³¹, Kellie Paich³², Craig E. Pollack³³, Jen Shifferd³⁴, Kim Erickson³⁴, and John P. Mulhall³⁵.

1. Department of Urology, University of Michigan, USA 2. Department of Urology, Emory University, USA 3. In Memoriam, Ulster University School of Nursing, United Kingdom 4. 4Oaks Consulting, Berryville, Virginia, USA 5. Princess Margaret Cancer Center, Toronto, Canada 6. Department of Radiation Oncology, Erasmus MC Cancer Institute, The Netherlands 7. Department of Urology, Johns Hopkins University, USA 8. Department of Psychiatry and Behavioral Sciences, Memorial Sloan Kettering Cancer Center, USA 9. Departments of Psychiatry and Urologic Sciences, University of British Columbia, Canada 10. Genesis Care, North Carolina, USA 11. Department of Psychiatry, Dana Farber Cancer Institute and Harvard University, USA 12. NS Health Authority and Dalhousie University, Canada 13. Department of Urology, Circolo & Fondazione Macchi Hospital, University of Insubria, Italy 14. Guys & St Thomas' Hospital, United Kingdom 15. Department of Urologic Sciences University of British Columbia, Canada) 16. Department of Urology at NYU Grossman School of Medicine, New York, USA 17. Taubman Health Sciences Library, University of Michigan, USA 18. University of Colorado Cancer Center, USA 19. University of Houston-Downtown, USA 20. Patient with Lived Experience 21. University of Hertfordshire, United Kingdom 22. Department of Urology, Northwestern University Feinberg School of Medicine, USA 23. Brigham Young University, USA 24. Mayo Clinic, Department of Urology, USA 25. Faraja Cancer Support Trust, Kenya 26. Department of Surgery-Urology, University of Texas McGovern Medical School at Houston, USA 27. MD Anderson Cancer Center, USA 28. Madigan Army Medical Center, USA 29. VA Health Services Research & Development, VA Ann Arbor Healthcare System, USA 30. Partner with Lived Experience 31. School of Nursing, University of Michigan, USA 32. Movember Foundation, USA 33. Department of Health Policy Management, Johns Hopkins University, USA 34. Michigan Medicine Therapy Services, USA 35. Department of Sexual and Reproductive Medicine, Memorial Sloan Kettering Cancer Center, USA



External Peer Reviewers

Peer Review and Document Approval

An integral part of the guidelines development process at Movember is the external peer review. The Panel conducted a thorough peer review process to ensure that the document was reviewed by multidisciplinary experts in Prostate Cancer oncological and sexual health care. A call to suggested reviewers was sent out via e-mail on April 8, 2021 to allow interested parties to request a copy of the document for review. The draft guideline document was distributed to 39 interested external reviewers; 28 external reviewers (26 peer reviewers and 2 patients) provided comments. All peer review comments were sent to the Panel leads for review. Following comment review, the Panel revised the draft as needed.



External Peer Reviewers

SOUTH AFRICA

Padaruth (Prithy) Ramlachan,
MD

NIGERIA

Elizabeth Akin-Odanye, PhD

BRAZIL

Sidney Glina, MD

ITALY

Andrea Salonia, M.D., Ph.D.

AUSTRIA

Elfriede Greimel, PhD.

NEW ZEALAND

Erik Wibowo, PhD

AUSTRALIA

Kath Schubach, MSN
Melissa Hadley Barrett, MSN
Sally Sara, MClInN
Victoria Cullen
Vicki Windholtz, MBBS

UNITED KINGDOM

Isabel White, PhD
Lorraine Grover
Will Kinnaird, MS

SINGAPORE

Mark Lin,
Martha Tara Lee, D.H.S.

CHINA

Angela Ng, MD

JAPAN

Daisaku Hirano, MD
Takahiro Osawa, MD, PhD
Shunichi Namiki, MD

CANADA

Gerald Brock, MD
John Oliffe, PhD
Ken Noel, Lived Experience

UNITED STATES

Maurice Garcia, MD, MAS
Mohit Khera, MD
B. R. Simon Rosser, PhD, MPH,
LP
Lawrence Jenkins, MD
William West, PhD

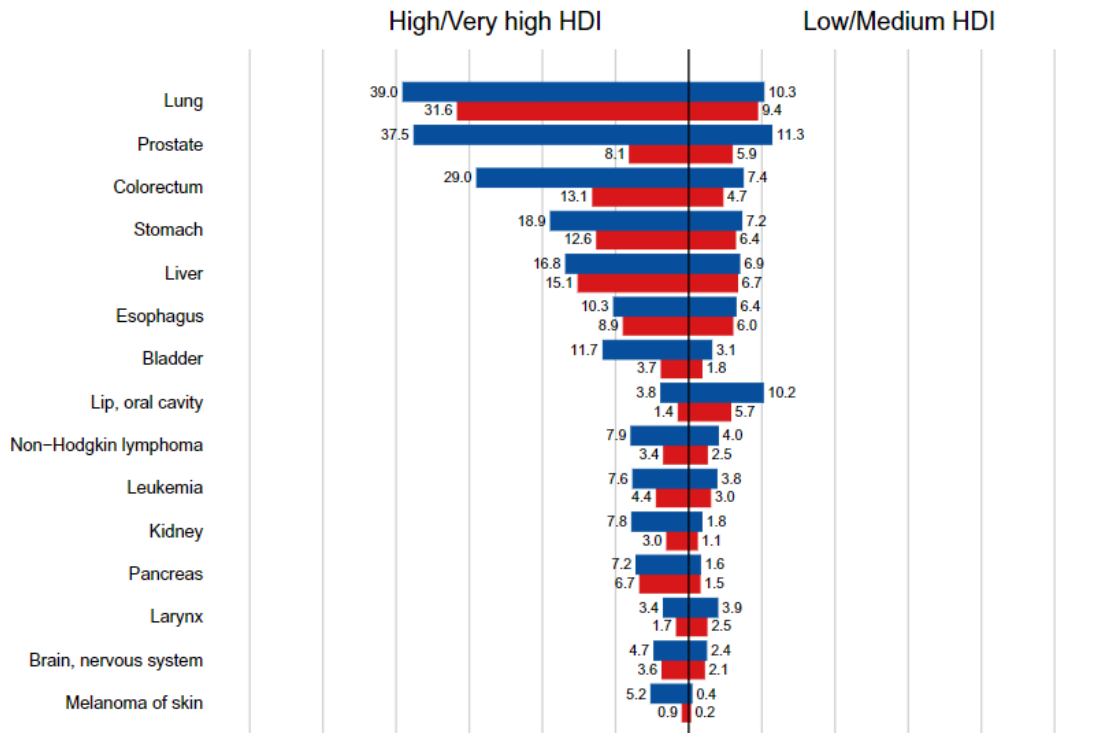




GUIDELINES PURPOSE

GLOBAL PROSTATE CANCER INCIDENCE AND MORTALITY

Male



Background

- Sexual dysfunction is the most commonly reported health-related quality of life outcome following therapies for prostate cancer, affecting men, partners and their relationships. Sexual health care should therefore be central to prostate cancer survivorship care.
- National origin, ethnicity, and race affect perspectives on gender roles, sexual orientation, relationships, health beliefs, disparities in access to healthcare, and uptake of healthcare offered. Help-seeking may be impeded by men's culture-driven discomfort about discussing sexual side-effects of treatment – a topic considered embarrassing and intensely private.



Background

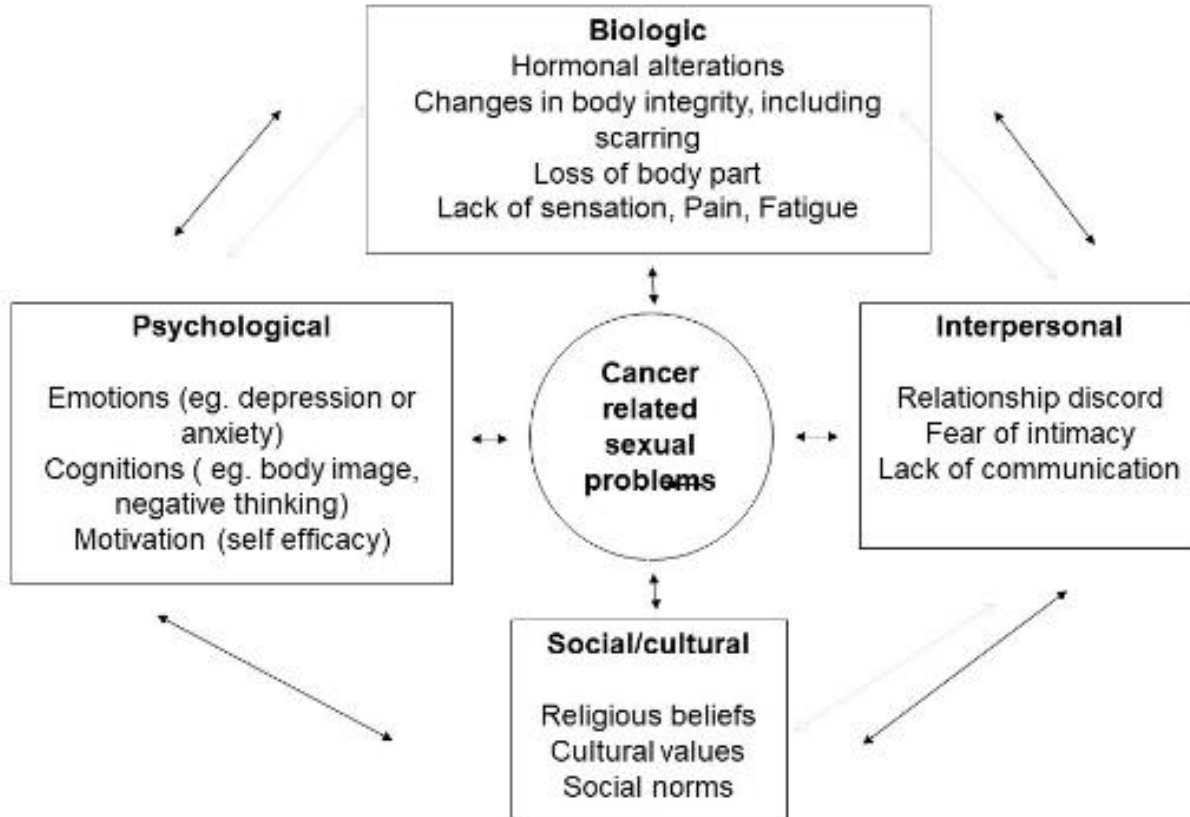
- The guidelines are a part of a broader TrueNTH Movember initiative to provide maximum support for men and their partners in prostate cancer survivorship to enable them to have the highest possible level of quality of life.
- The key audiences for the clinical care guidance are primary care providers, urologists, radiation and medical oncologists, sexual health counselors/therapists, nurses and others providing pre-treatment preparation and post-treatment follow-up care to prostate cancer survivors and their partners as well as patients and partners





THEORETICAL MODEL AND GUIDING PRINCIPLES

Theoretical Model



Guiding Principles

- 1) The healthcare provider plays an active role in routinely addressing sexual concerns in prostate cancer survivorship.
- 2) Sexuality and sexual recovery are multi-dimensional.
- 3) The role of grief and mourning in couples' recovery of sexual intimacy has emerged as a path towards a new sexual paradigm despite sexual dysfunction.
- 4) Men rarely return to baseline sexual function after prostate cancer treatment.
- 5) Including the partner in sexual health counseling, if both partners agree, is preferable when men are partnered.
- 6) Support by a multidisciplinary team of healthcare providers is needed to best assist support men and their partners who desire to recover sexual intimacy after prostate cancer therapy.





METHODS

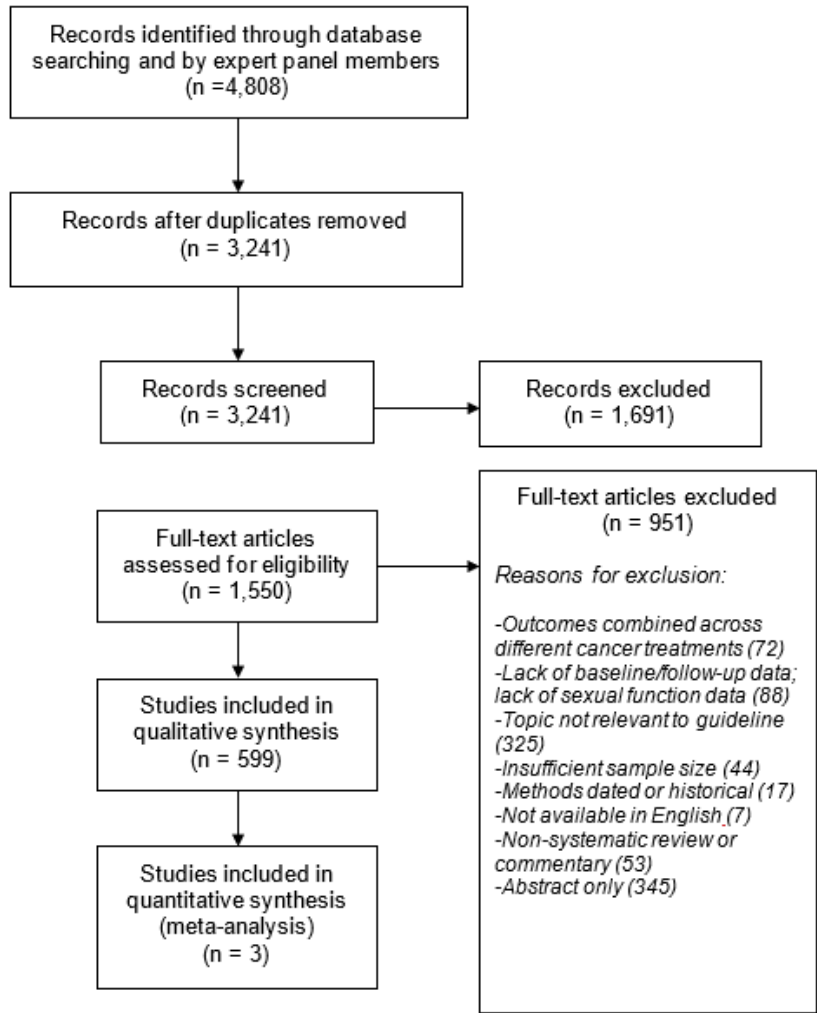
Systematic Literature Review

- The guidelines were developed by an international expert panel and a guideline methodologist – Martha Faraday, PhD.
- A systematic literature review, designed to reflect the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)[4] (Figure 2), using the Ovid MEDLINE, Scopus, CINAHL, PsychINFO, LGBT Life, and Embase databases (search dates 1995 through 2022) was conducted to identify peer-reviewed publications relevant to the impact of prostate cancer treatment, assessment of prostate cancer treatment consequences for sexuality, and treatments for sexual sequelae of PCTs.



Systematic Literature Review

Identification
Screening
Eligibility
Included



Evidence Statements

Nomenclature Linking Statement Type to Level of Certainty, Magnitude of Benefit or Risk/Burden, and Body of Evidence Strength (Reproduced with Permission of the American Urological Association)			
	Evidence Strength A (High Certainty)	Evidence Strength B (Moderate Certainty)	Evidence Strength C (Low Certainty)
Strong Recommendation (Net benefit or harm substantial)	Benefits > Risks/Burdens (or vice versa) Net benefit (or net harm) is substantial Applies to most patients in most circumstances and future research is unlikely to change confidence	Benefits > Risks/Burdens (or vice versa) Net benefit (or net harm) is substantial Applies to most patients in most circumstances but better evidence could change confidence	Benefits > Risks/Burdens (or vice versa) Net benefit (or net harm) appears substantial Applies to most patients in most circumstances but better evidence is likely to change confidence (rarely used to support a Strong Recommendation)
Moderate Recommendation (Net benefit or harm moderate)	Benefits > Risks/Burdens (or vice versa) Net benefit (or net harm) is moderate Applies to most patients in most circumstances and future research is unlikely to change confidence	Benefits > Risks/Burdens (or vice versa) Net benefit (or net harm) is moderate Applies to most patients in most circumstances but better evidence could change confidence	Benefits > Risks/Burdens (or vice versa) Net benefit (or net harm) appears moderate Applies to most patients in most circumstances but better evidence is likely to change confidence
Conditional Recommendation (No apparent net benefit or harm)	Benefits = Risks/Burdens Best action depends on individual patient circumstances Future research unlikely to change confidence	Benefits = Risks/Burdens Best action appears to depend on individual patient circumstances Better evidence could change confidence	Balance between Benefits & Risks/Burdens unclear Alternative strategies may be equally reasonable Better evidence likely to change confidence
Clinical Principle	A statement about a component of clinical care that is widely agreed upon by urologists or other clinicians for which there may or may not be evidence in the medical literature		
Expert Opinion	A statement, achieved by consensus of the Panel, that is based on members' clinical training, experience, knowledge, and judgment for which there is no evidence		



GUIDELINES STATEMENTS



PART I

Counseling Patients about the Impact of Prostate Cancer Therapies on the Biopsychosocial Aspects of Sexuality

STATEMENT 1: A clinician-initiated discussion should be conducted with the patient and the partner (if partnered and culturally appropriate), to educate them about realistic expectations of the impact of prostate cancer therapy on the patient's sexual function, the partner's sexual experience, and the couples' sexual relationship. The clinician should promote openness and inclusivity, consider cultural context, and tailor counseling to the specific needs of patients who are heterosexual, gay, bisexual, or identify as men who have sex with men, and of transgender women and gender non-conforming patients. *(Strong Recommendation; Evidence Strength Grade C)*

STATEMENT 2: Patients and partners should be advised that biopsychosocial treatment for sexual problems can mitigate sexual dysfunctions and lead to the recovery of sexual intimacy. *(Strong Recommendation; Evidence Strength Grade C)*

STATEMENT 3: Patients and partners should be advised that psychological distress, including grief and mourning about sexual losses, resulting from the sexual side-effects of prostate cancer therapies, can be experienced by patients after prostate cancer therapy and by their partners and that this distress can be mitigated with appropriate biopsychosocial rehabilitation strategies. *(Strong Recommendation; Evidence Strength Grade C)*





PART II

Counseling Patients on the Impact of Individual Prostate Cancer Therapies on Sexual Function

STATEMENT 4: Patients and partners should be counseled that all therapies for prostate cancer have the potential to result in short-term and long-term erectile dysfunction. *(Strong Recommendation; Evidence Strength Grade B).*

STATEMENT 5: Patients and partners should be counseled that patients treated with radical prostatectomy have different trajectories of sexual function decline and potential recovery compared to patients treated with radiotherapy. *(Moderate Recommendation; Evidence Strength Grade C)*

STATEMENT 6: Patients and partners should be counseled that after prostate cancer therapies, most patients do not return to their pre-treatment erectile function levels. *(Strong Recommendation; Evidence Strength Grade B).*

STATEMENT 7: Patients and partners should be advised that pre-existing erectile dysfunction is associated with a higher risk of post-treatment erectile dysfunction after radical prostatectomy regardless of the surgical technique used and after radiotherapy regardless of the type of radiation employed. *(Strong Recommendation; Evidence Strength Grade B)*



STATEMENT 8: Patients and partners should be informed that there is no clear evidence supporting an advantage of robotic, laparoscopic or open radical prostatectomy in terms of post-operative erectile function outcomes. (*Moderate Recommendation; Evidence Strength Grade C*)

STATEMENT 9: Patients and partners should be counseled that both prostatectomy and radiation therapy may be associated with orgasmic pain, decreased sexual desire, and changes in ejaculatory function. Prostatectomy results in an immediate and complete loss of ejaculate volume, while radiation therapy is associated with a more gradual decline and variable reduction in ejaculate volume. (*Moderate Recommendation; Evidence Strength Grade C*)

STATEMENT 10: Patients and partners should be counseled that sexual incontinence (including sexual arousal incontinence and climacturia) may occur after radical prostatectomy and has the potential to recover with the recovery of urinary control. (*Strong Recommendation, Evidence Strength Grade C*)

STATEMENT 11: Patients and partners should be counseled that penile length and girth/volume loss may occur after radical prostatectomy. (*Moderate Recommendation, Evidence Strength Grade C*)



STATEMENT 12: Patients and partners should be informed that radical prostatectomy may be associated with an increased risk of the development of penile curvature (Peyronie's disease; PD). *(Conditional Recommendation, Evidence Strength Grade C)*

STATEMENT 13: Patients and partners should be counseled regarding the diverse impacts of androgen deprivation therapy (ADT) (as a primary or as an adjuvant therapy) on sexual desire, erectile function, penile girth and length, ejaculatory function, orgasmic function and couples' intimacy. *(Strong Recommendation; Evidence Strength Grade C)*

STATEMENT 14: Patients and partners should be counseled that patients treated with combined ADT and radiotherapy are at risk for the cumulative sexual side effects associated with both ADT and radiotherapy. *(Strong Recommendation, Evidence Strength Grade C)*

STATEMENT 15: Clinicians should routinely ask prostate cancer patients, regardless of age, and their partners if future fertility is desired prior to undergoing prostate cancer therapies. *(Moderate Recommendation, Evidence Strength Grade C)*



STATEMENT 16: Patients interested in future fertility should be counseled that prostate cancer therapies may negatively affect their fertility potential so that they could consider pre-treatment sperm banking and referral to a reproductive specialist as availability of assisted reproductive techniques and financial and cultural considerations allow. (*Moderate Recommendation, Evidence Strength Grade C*)





PART III

Assessment of Sexual Dysfunction and Sexual Distress

STATEMENT 17: Clinicians should offer screening and assessment regarding sexual function and sexual concerns to patients, partners, and couples prior to prostate cancer therapy and regularly throughout follow-up, tailored to cultural, ethnic and racial context, sexual orientation and gender identity. (*Clinical Principle*)

STATEMENT 18: In both pre and post prostate cancer therapy assessments, health care providers should pay attention to the presence of erectile dysfunction, low sexual satisfaction, low desire, orgasmic dysfunction [including altered orgasmic sensation, lack of orgasm (anorgasmia), painful orgasm (dysorgasmia) and orgasm-associated urinary incontinence (climacturia)], sexual arousal incontinence, changes in penile size or curvature, anodyspareunia, couples' sexual concerns, inclusive of avoidance or cessation of sexual activity, and couples' sexual concerns. (*Strong Recommendation, Evidence Strength C*)



STATEMENT 19: Patients and partners should be counseled that an assessment of the partner's sexual function can help plan treatment designed to support couples' recovery of sexual intimacy. (*Clinical Principle*)

STATEMENT 20: Clinicians should use validated Patient Reported Outcome measures whenever appropriate or possible, to assess patients' sexual function and possibly partners' sexual function, as well as sexual distress, based on a clinical assessment of the patients' and partners' goal for sexual recovery. (*Clinical Principle*)





PART IV

Lifestyle Modification

STATEMENT 21: Lifestyle modification should be recommended to patients to optimize their overall and sexual health, including avoiding smoking, engaging in physical activity, increasing consumption of healthful plant-based foods, and reducing consumption of red and processed meat. (*Clinical Principle*)





PART V

Psychosexual Treatment

STATEMENT 22: Clinicians should provide education and individualized sexual rehabilitation and psychosexual support to patients and partners across the entire to survivorship continuum, tailored to: prostate cancer therapy type; partnership status; cultural, ethnic, and racial context; sexual orientation; and gender identity. *(Strong Recommendation; Evidence Strength Grade C)*

STATEMENT 23: Clinicians should normalize grief as a typical reaction to sexual losses and encourage patients and partners to whom sexual recovery is important to pursue sexual viability despite sexual losses. *(Strong Recommendation; Evidence Strength Grade C)*

STATEMENT 24: Clinicians should include the partner, if both the patient and partner agree, and provide support for couples coping with the sexual side-effects of prostate cancer therapy both directly and through referral for psychosexual treatment. *(Strong Recommendation, Evidence Strength Grade C)*



STATEMENT 25: Clinicians should support patients who are gay or bisexual, men who have sex with men, as well as transgender women and gender non-conforming patients and their partners with information relevant to their sexual experience, and guide them towards finding meaningful support resources. (*Expert Opinion*)

STATEMENT 26: Clinicians should refer patients, partners and couples for whom education and support are insufficient for specialty psychosexual treatment. (*Clinical Principle*)

STATEMENT 27 Clinicians should make patients and partners aware of group interventions and digital health/telemedicine methodologies that can increase access to sexual health support in prostate cancer survivorship. (*Moderate Recommendation, Evidence Strength Grade C*)





PART VI

Biomedical Treatment

STATEMENT 28: Clinicians should consider nerve-sparing surgical treatment options, when available and oncologically safe, irrespective of baseline erectile function. (*Strong Recommendation; Evidence Strength Grade C*)

Penile Rehabilitation

STATEMENT 29: Clinicians should define the intent and goals of penile rehabilitation strategies on an individualized basis, including preservation of penile length, maintenance of corporal tissue quality, and early patient engagement in sexual recovery. Penile rehabilitation should not be equated with treatment for the recovery of unassisted erectile function. (*Clinical Principle*)

STATEMENT 30: Clinicians should counsel patients that use of phosphodiesterase type 5 inhibitors (PDE5i) for penile rehabilitation in the early post-prostatectomy period (up to 45 days post-surgery) does not improve rates of unassisted and PDE5i-assisted erectile function recovery at 12 months compared to placebo. (*Moderate Recommendation, Evidence Strength C*)



STATEMENT 31: Clinicians should advise patients that there is limited evidence to determine the benefit of non-PDE5i approaches for penile rehabilitation in order to promote recovery of erectile dysfunction. (*Moderate Recommendation, Evidence Strength Grade C*)

STATEMENT 32: Patients and partners should be counseled that there is not enough evidence to definitively support penile rehabilitation with PDE5 inhibitors in the prevention of penile volume loss. (*Conditional Recommendation, Evidence Strength Grade C*)

STATEMENT 33: Clinicians should counsel patients that there is insufficient evidence to determine the benefit of PDE5i use after radiation therapy as a strategy for penile rehabilitation. (*Conditional Recommendation, Evidence Strength C*)




Erectile Dysfunction Treatments

STATEMENT 34: Clinicians should provide support for patients' use of pro-erectile aids as well as non-penetrative sexual activity if they wish to continue to engage in sexual activity. (*Strong Recommendation; Evidence Strength Grade C*)

STATEMENT 35: Clinicians should discuss all available erectile function treatment options with patients following all modalities of prostate cancer therapy, including PDE5i, intraurethral suppositories, intracavernosal injections (ICI), vacuum erection devices (VED), penile implants, and tailor recommendations based on patient preference, efficacy, and phase of sexual function recovery. This discussion should address benefits, risks, and contraindications associated with each option as well as patient and partner goals. (*Clinical Principle*)

STATEMENT 36: Clinicians should inform patients with persistent erectile dysfunction after completion of definitive therapies for prostate cancer about the potential benefits and risks of penile implant surgery. (*Strong Recommendation, Evidence Strength Grade C*)



Additional Sexual Dysfunction Treatments

STATEMENT 37: If identified, altered orgasmic sensation, difficulty reaching orgasm or anorgasmia can be managed using a biopsychosocial approach. *(Expert Opinion)*

STATEMENT 38: Persistent, bothersome dysorgasmia may be treated using alpha-adrenergic blockers. *(Moderate Recommendation, Evidence Strength Grade C)*

STATEMENT 39: Patients and partners should be counseled regarding management strategies for bothersome sexual incontinence (including sexual arousal incontinence and climacturia), including psychological reframing. *(Clinical Principle)*

STATEMENT 40: Patients should be counseled that there are insufficient data regarding the efficacy of pelvic-floor rehabilitation, penile tension loop, a male sling operation or placement of an artificial urinary sphincter for the management of sexual incontinence (including sexual arousal incontinence and climacturia). *(Conditional Recommendation, Evidence Strength Grade C)*



STATEMENT 41: Clinicians may discuss the risks and benefits of testosterone therapy to improve low sexual desire in hypogonadal men following prostate cancer treatment. (*Moderate Recommendation, Evidence Strength Grade C*) related to ADT. (*Moderate Recommendation; Evidence Strength Grade C*)

STATEMENT 42: Clinicians should counsel patients that there are inadequate data to quantify the risks versus benefits regarding testosterone therapy to treat low sexual desire in men with treated or active non-metastatic prostate cancer. (*Conditional Recommendation, Evidence Strength Grade C*)





Part VII

Lifestyle Modification Strategies

SSTATEMENT 43: Patients and partners should be informed about the importance of and benefits of exercise for sexual health as a component of medical management related to ADT. (*Moderate Recommendation; Evidence Strength Grade C*)





Part VIII

Clinician Education

STATEMENT 44: Clinicians should be provided with sexual health education in interprofessional groups using case based/reflective learning approaches, adopting a biopsychosocial lens and incorporating attention to diversity and sexual minorities. (*Strong Recommendation; Evidence Strength Grade C*)





Part IX

Healthcare Programs and Systems

STATEMENT 45: Providers and healthcare systems should develop culturally appropriate materials for counseling regarding to the impact of prostate cancer treatment on sexual health. (*Strong Recommendation; Evidence Strength Grade C*)

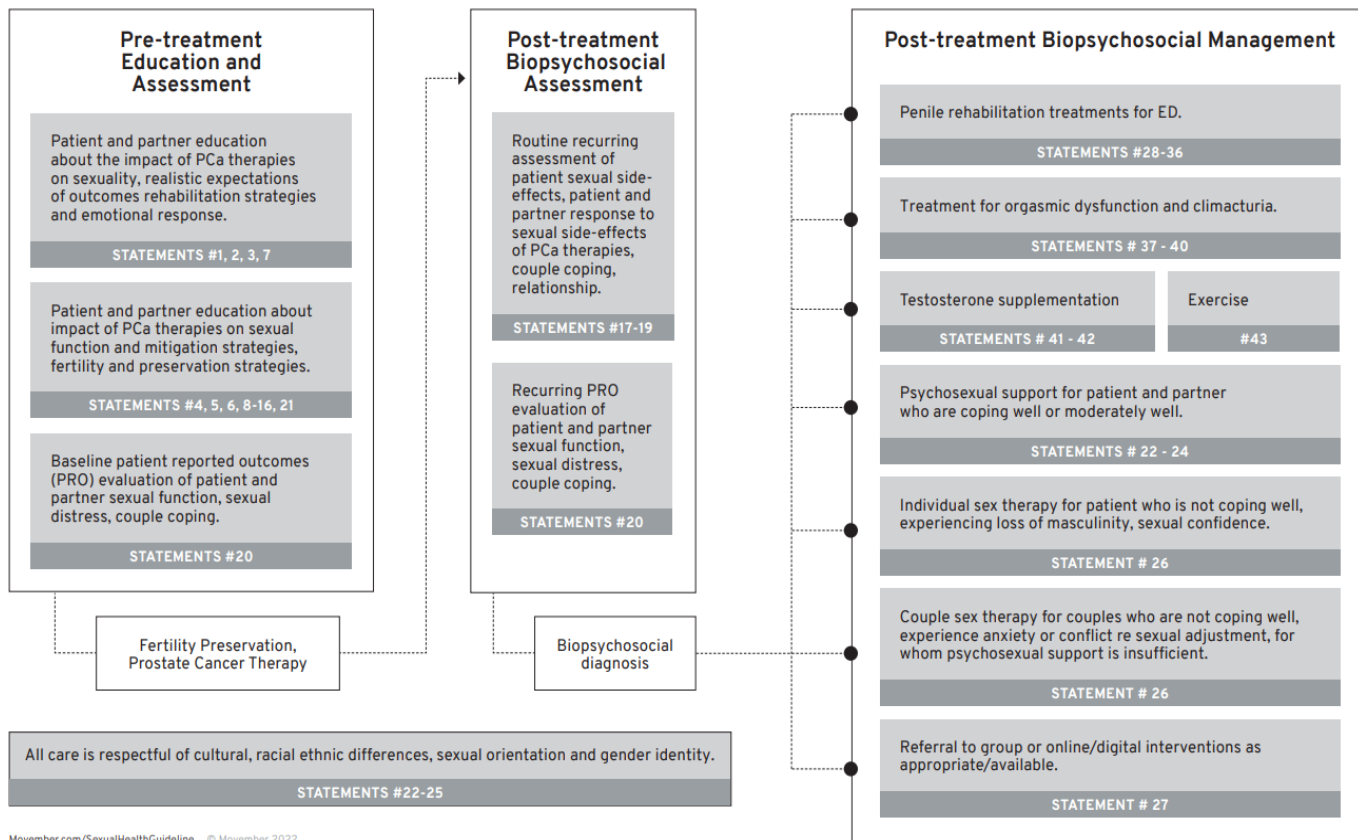
STATEMENT 46: The development of programs should be based on the recognition that culture influences the conceptualization of sexual recovery and of the priorities and resources available in that region. (*Expert Opinion*)

STATEMENT 47: Insurance coverage for the treatment of sexual dysfunctions secondary to prostate cancer therapies should become universally available in order to recognize the validity of this aspect of prostate cancer care and to reduce disparities in access to care. (*Clinical Principle*)



SUMMARY OF GUIDELINES STATEMENTS

Sexual Health Care for Prostate Cancer Patients



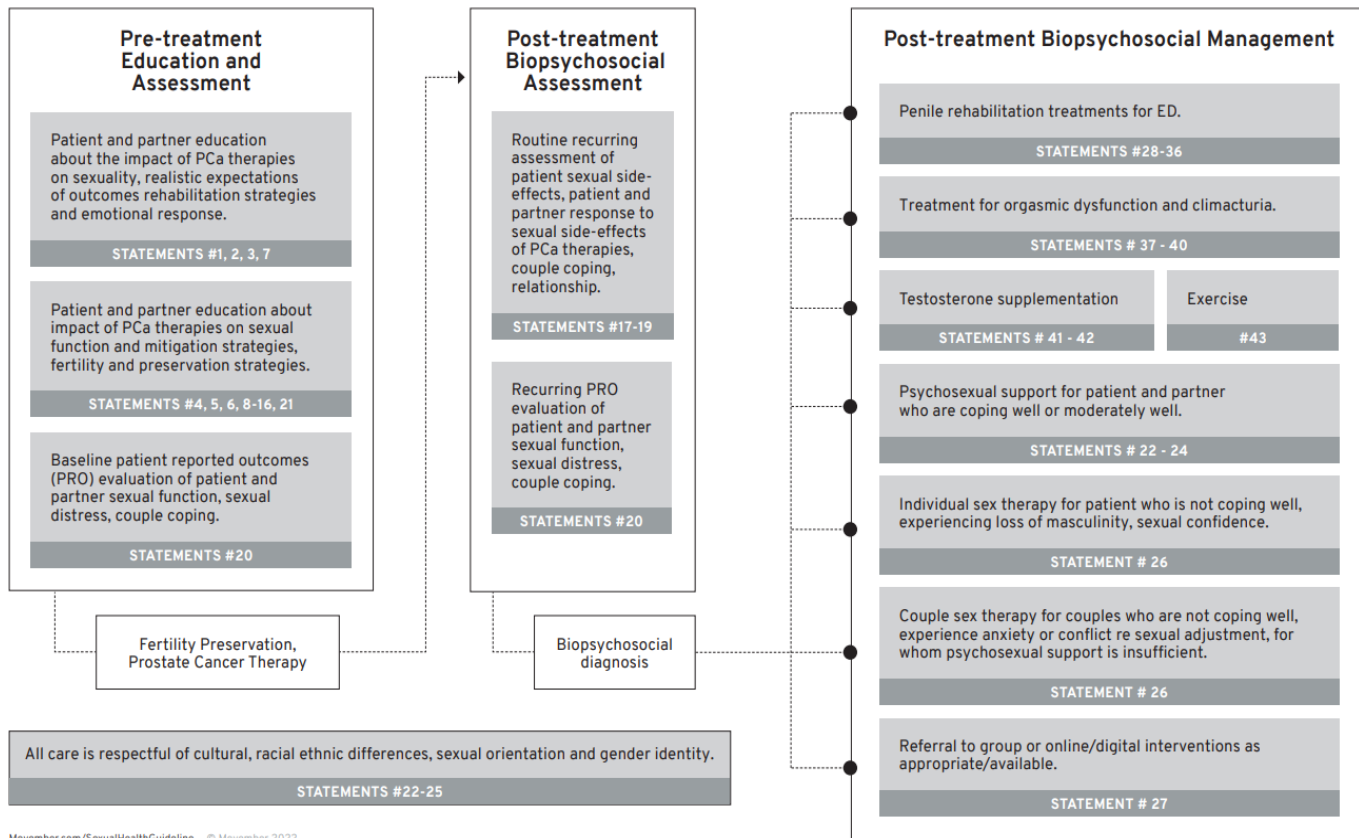


SUMMARY OF GUIDELINES STATEMENTS

Sexual Health Care for Prostate Cancer Patients



Linking Guidelines Statements to Clinical Practice



The Guidelines are Published on the Movember Website



Our website uses cookies to bring you an easy and personalised browsing experience. By continuing, you consent to our cookie policy on this device. For more info, please see our [Privacy Statement](#)

[Accept Cookies](#)

Clinical Guidelines for Sexual Health and Prostate Cancer

An evidence and expert opinion-based framework to help clinicians assess and manage the sexual side-effects of prostate cancer therapies, and facilitate shared decision-making between clinicians, patients and partners.

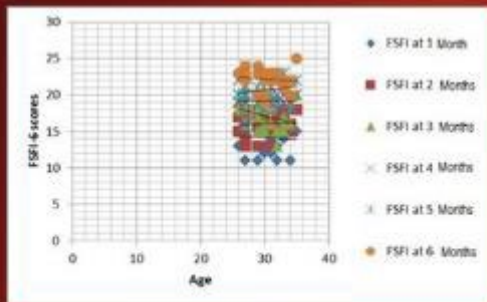
These Guidelines are intended for use by clinicians. If you are a person with prostate cancer or their partner, please note that these Guidelines does not replace individual medical advice. [Read more.](#)

[DOWNLOAD GUIDELINES](#)

Why these Guidelines exist



Publication



ONCOLOGY

Guidelines for Sexual Health Care for Prostate Cancer Patients: Recommendations of an International Panel

Check for updates

Daniela Wittmann, PhD, MSW,¹ Akanksha Mehta, MD,² Eilis McCaughan, PhD, RN,³ Martha Faraday, PhD,⁴ Ashley DUBY, MS,¹ Andrew Matthew, PhD,⁵ Luca Incrocci, MD,⁶ Arthur Burnett, MD,⁷ Christian J. Nelson, PhD,⁸ Stacy Elliott, MD,⁹ Bridget F. Koontz, MD,¹⁰ Sharon L. Bober, PhD,¹¹ Deborah McLeod, PhD,¹² Paolo Capogrosso, MD,¹³ Tet Yap, MD,¹⁴ Celestia Higano, MD,¹⁵ Stacy Loeb, MD,¹⁶ Emily Capellari, MLIS,¹⁷ Michael Glodé, MD,¹⁸ Heather Goltz, PhD, MSW,¹⁹ Doug Howell,²⁰ Michael Kirby, MD,²¹ Nelson Bennett, MD,²² Landon Trost, MD,^{23,24} Phillip Odiyo Ouma, MS,²⁵ Run Wang, MD,^{26,27} Carolyn Salter, MD,²⁸ Ted A. Skolarus, MD, MPH,^{1,29} John McPhail,³⁰ Susan McPhail,³⁰ Jan Brandon,³¹ Laurel L. Northouse, PhD, RN,³² Kellie Paich, MPH,³³ Craig E. Pollack, MD, MHS,³⁴ Jen Shifferd, MPT,³⁵ Kim Erickson, PT,³⁵ and John P. Mulhall, MD³⁶





Endorsements



International Society for Sexual Medicine



Sexual Medicine Society of North America



Society of Urologic Nurses and Associates



American Psychosocial Oncology Society



Presentations

2023

- Australian and New Zealand Urologic Nurses Society Annual Meeting, Melbourne
- American Urological Association-Society for Urologic Oncology Annual Meeting, Chicago
- Erasmus Medical Institute, Rotterdam, The Netherlands
- 20th Scientific Congress of International Surgeon-Experts at Binh Dan Hospital, Hanoi, Vietnam





MOVEMBER®

THANK YOU

dwittman@med.umich.edu



@DrWittmann