



FACTORS THAT DETERMINE YOUR RISK:

- Prostate-Specific Antigen
- Digital Rectal Exam
- Clinical Stage Gleason Score
- Number of Positive Cores
- Location of Positive Cores
- Tumor Size
- Tumor Genetics



TOOLS TO HELP DETERMINE YOUR RISK:

- Advanced Prostate Imaging: Multiparametric MRI Study
- Computerized Robotic MRI-Guided Targeted Biopsy
- Genetic Test for Tumor Cell Growth



YOU DO NOT HAVE TO NAVIGATE PROSTATE CANCER ALONE.

Vituro Health's patient ambassador program offers patients the opportunity to be paired with a peer who has been through treatment. These ambassadors are trained volunteers who will offer peer support to individuals and families by sharing firsthand about their own experience with prostate cancer.

The team of volunteers in Vituro's patient ambassador program honor confidentiality, promote what is in the best interest of each patient and share personal treatment and recovery experience. If a patient is seeking medical advice, ambassadors will direct patients back to their own physicians.

TO LEARN MORE ABOUT VITURO HEALTH'S PATIENT AMBASSADOR PROGRAM OR AVAILABLE TREATMENTS, PLEASE CONTACT:



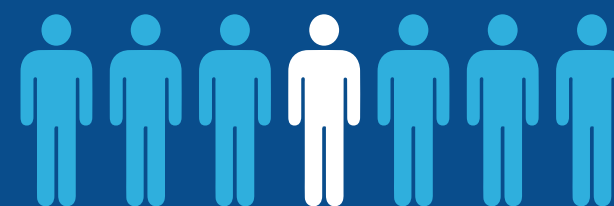
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HEALTH**

1.866.4VITURO (848876)

OR VISIT VITUROHEALTH.COM

1 IN 7

MEN WILL GET PROSTATE CANCER



KNOW YOUR TREATMENT OPTIONS



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WHAT IS THE RISK CATEGORY OF YOUR PROSTATE CANCER?



**LOW
RISK**



**HIGH
RISK**

YOUR IDEAL TREATMENT MATCHES THE RISK OF YOUR CANCER WITH THE INVASIVENESS OF THE TREATMENT.



ACTIVE SURVEILLANCE

**SURGERY
(RADICAL PROSTATECTOMY)**

RADIATION THERAPY

**HIFU
(HIGH INTENSITY FOCUSED ULTRASOUND)**

OVERVIEW

- Actively follow the cancer but avoid actual treatment
- Treatment is initiated if the cancer shows signs of progression
- Periodic MRI and targeted biopsy is recommended to ensure accurate staging
- Indicated for clinically insignificant cancers
- Close routine follow-up includes:
 - PSA periodically
 - MRI occasionally
 - Repeat MRI-guided targeted biopsy every 12 months is strongly encouraged
- Talk to a healthcare professional on a regular basis

- Definitive removal
- 2 hour operation, typically performed via robotic approach
- 5-6 small ‘keyhole’ incisions made in lower abdomen versus one incision
- 1-2 day hospital stay

- Brachytherapy (“Seeds”): Outpatient procedure performed in a hospital or surgery center; seeds are placed with needles through the perineum (space under the scrotum) with transrectal ultrasound guidance; performed by radiation oncologist and urologist together
- External Radiation (IMRT/IGRT): Lay on radiation table for ~40 treatments over 8 weeks Monday-Friday, each treatment lasting 12-15 minutes
- For moderate and high-risk disease, patients are often given hormone therapy for 6 months to 2 years in conjunction with radiation treatments (literature shows better oncologic outcomes)–intramuscular injections given every 3 months (Eligard, Lupron, Trelstar) plus possible anti-androgen given daily for first month to avoid testosterone flare (Casodex)

- Ablative therapy
- Controlled thermal energy delivered through a rectal ultrasound probe to precisely destroy prostate cancer tissue while minimizing treatment-related side effects
- Over 50,000 cases performed throughout the world since 1998
- 2-3 hour procedure performed in a hospital or surgery center
- Outpatient procedure
- General anesthesia

BENEFITS

- Avoid any treatment side effects if managed properly with active follow up - recommend an active navigation and prostate management organization

- Excellent long-term oncologic outcomes
- Minimal post-op pain
- No radiation effects
- PSA should be zero post-op, so recurrences are easily detected
- Recurrences can be treated with radiation therapy with good outcomes

- Excellent long-term oncologic outcomes
- No surgery
- No stress incontinence
- No foley catheter
- Minimal to no pain

- Excellent oncologic outcomes, comparable to surgery and radiation
- Minimal-to-no incontinence, especially with focal therapy
- Minimal-to-no erectile dysfunction, especially with focal therapy
- No effect on ejaculatory function with focal therapy
- Minimal discomfort
- No pain
- Outpatient procedure
- No radiation effects
- Repeatable
- Can perform focal therapy

RISKS / DRAWBACKS

- Requires close follow-up with periodic repeat MRI and repeat biopsy
- Only indicated for clinically insignificant cancers
- Psychological burden
- Potential for cancer progression
- Only appropriate for select patients:
 - Stage T1c (nonpalpable)
 - Gleason score 6 or less, some Gleason 3+4
 - Better for low volume, low-risk disease

- Surgical risks: bleeding, infection, cardiovascular risks of anesthesia
- Stress incontinence – loss of urinary control; typically recovers over 6-12 months post-op; or <5% long-term risk
- Erectile dysfunction – reduced with nerve-sparing technique
- Foley catheter about 7 days post-op
- Penile numbness, shortening – 1cm
- Loss of ejaculate

- Radiation cystitis – irritative voiding symptoms (pain or burning with urination, urinary urgency and frequency, urge incontinence, blood in urine)
- Radiation proctitis – irritative rectum symptoms (rectal urgency and frequency, blood in stool, painful bowel movements)
- Urinary retention
- Obstructive voiding symptoms
- Erectile dysfunction (same risk as surgery at 5 years post-treatment)
- PSA never goes to zero so recurrences are a little more difficult to detect – PSA trend is followed
- Treatment failures can be difficult to treat – HIFU or cryosurgery are typically best options
- Cannot undergo surgery after radiation – “bridge is burned”; significantly increased risk of surgical complications
- Increased risk of secondary malignancies (bladder, rectal)
- Loss of ejaculate

- Transient post-op irritative urinary symptoms (~10%)
- Development of urethral stricture (5-15%, reduced with focal therapy)
- Cost (not covered by insurance) – currently \$25,000
- Foley or suprapubic catheter about 5-7 days postop

