PROSTATE CANCER

A fatigue-friendly nursing study guide

Screening • Diagnosis • Treatment • Post-op Care • ADT

EXAM PROMISE The transcript is reorganized into short, testable sections without dropping its key points. Gold boxes preserve course wording. Pink boxes identify urgent nursing action. Clinical updates are labeled so you can separate a lecture answer from current practice.

Your color map

Color	Meaning
BLUE	Core concept / foundation
PINK	Priority action / complication
GREEN	Expected finding / patient teaching
GOLD	Lecture-specific item—memorize, then verify clinically

Low-energy route

Read the pink spinal-cord-compression and post-op boxes first → compare BPH with cancer → master PSA logic → finish with androgen-deprivation effects and the one-minute review. Stop after one sprint if your focus drops.

1 The Big Picture

STUDY SPRINT · 8 MIN Connect anatomy, growth pattern, and hormone sensitivity

CORE IDEA Most prostate cancers are adenocarcinomas. Many grow slowly and are androgen sensitive, but behavior varies: some remain localized for years while others invade or metastasize. Treatment depends on risk group, stage, life expectancy, comorbidities, and patient goals.

Prostate cancer versus BPH

Feature	Prostate cancer	BPH
Usual origin	Often peripheral zone	Usually transition/central periurethral zone
Early symptoms	Frequently none	Lower urinary tract symptoms are common
DRE	Hard, irregular, nodular or asymmetric may be suspicious	Smooth, rubbery, symmetrically enlarged
PSA	May rise, but is not diagnostic	May also raise PSA
Major late concern	Local invasion and metastasis, especially bone	Obstruction, retention, infection, renal effects

LOCATION MEMORY Cancer likes the PERIPHERY; BPH crowds the PIPE. A peripheral tumor may not obstruct the urethra early, which helps explain why early prostate cancer can be silent.

2 Risk & Screening Conversations

STUDY SPRINT · 9 MIN Know the lecture ages and the shared-decision principle

Risk factors to assess

- Increasing age; risk rises substantially with age.
- Black/African ancestry and family history, especially an affected first-degree relative at a younger age.
- Inherited cancer-predisposition variants or a strong family pattern; ask about prostate, breast, ovarian, pancreatic, and related cancers.

LECTURE AGE PATTERN The transcript teaches discussion around age 50 for average risk, age 45 for African American men or one first-degree relative diagnosed before 65, and age 40 for multiple first-degree relatives with early disease. Remember 50 → 45 → 40 as risk rises.

CURRENT-PRACTICE LENS PSA screening is not an automatic one-size-fits-all test. Current organizations use shared decision-making and differ somewhat on starting age, interval, and stopping. Use your course ages for the exam, but verify the current guideline and individual risk in practice.

Why screening requires discussion

Possible benefit	Possible harm
Earlier detection of clinically important cancer	False-positive PSA and anxiety
Lower chance of metastatic disease for some screened groups	Biopsy bleeding, pain, or infection
Opportunity for curative treatment when localized	Overdiagnosis and treatment of indolent disease
Risk-adapted follow-up	Urinary, bowel, and sexual effects from treatment

3 Clinical Manifestations & Focused Assessment

STUDY SPRINT · 9 MIN Recognize late/local disease and metastatic red flags

Finding	Nursing meaning
Often asymptomatic early	Screening or incidental evaluation may detect disease before symptoms.
Weak stream, hesitancy, frequency, nocturia, retention	Can occur with local obstruction but is not specific; BPH is a common alternative.
Hematuria	Gross blood in urine can occur with advanced/local disease; assess amount, clots, retention, and hemodynamics.
Hematospermia or pelvic/perineal discomfort	Requires evaluation but is not diagnostic by itself.
Bone/back/hip pain	Possible osseous metastasis; prostate cancer commonly spreads to bone.
Weight loss, weakness, anemia	Possible advanced systemic disease or treatment effect.

ASSESS FIRST Urinary pattern, bladder distention/retention, pain location, hematuria or clots, infection signs, renal function, mobility, neurologic status, medication/supplement use, sexual concerns, and the patient's goals and support system.

ONCOLOGIC EMERGENCY New severe back pain plus leg weakness/numbness, gait change, saddle anesthesia, or bowel/bladder dysfunction suggests metastatic spinal cord compression. Limit unsafe movement, perform a focused neurologic assessment, and notify/activate the urgent pathway immediately.

4 PSA, DRE & Diagnostic Workup

STUDY SPRINT · 11 MIN Separate suspicion, confirmation, grading, and staging

PSA logic

Truth	What it means for questions
PSA is prostate-specific—not cancer-specific	Cancer, BPH, prostatitis/infection, retention, and recent prostate manipulation can affect it.
No single PSA value proves cancer	Interpret age, trend, medications, risk, exam, imaging, and follow-up testing.
Finasteride/dutasteride lower PSA	Document 5-alpha-reductase inhibitor use so the clinician interprets the value correctly.
A rising trend after treatment matters	Repeat and evaluate; one isolated result does not automatically prove clinical recurrence.

COURSE SEQUENCE The transcript says to draw PSA before the DRE because prostate stimulation may raise PSA. For an exam asking sequence, choose PSA first. Clinically, also ask about infection, retention, ejaculation, instrumentation, biopsy, and medications that may alter interpretation.

From suspicion to diagnosis

Step	Purpose
PSA ± DRE	Identifies concern; neither alone confirms cancer.
Repeat PSA / risk tools	Confirms persistence and refines the need for further evaluation.
Multiparametric MRI	Locates suspicious lesions and helps guide biopsy decisions.
Prostate biopsy	Obtains tissue—the diagnostic confirmation.
Gleason score / Grade Group	Describes microscopic aggressiveness; higher grade means less differentiated and generally more aggressive disease.
TNM + PSA + Grade Group	Defines stage/risk and guides treatment; imaging is selected according to risk and symptoms.

EXAM PEARL PSA raises suspicion. Biopsy confirms. Grade predicts aggressiveness. Stage describes extent. Do not let one test perform all four jobs.

5 Treatment Map

STUDY SPRINT · 10 MIN Match treatment intensity to cancer risk and patient goals

Approach	Core purpose / nursing focus
Active surveillance	Curative intent remains possible; scheduled PSA, exams, imaging and/or repeat biopsy watch for progression.
Watchful waiting	Less intensive symptom-guided approach, often when life expectancy/comorbidity makes curative treatment less useful.
Radical prostatectomy	Removes prostate, seminal vesicles, and selected surrounding tissue/nodes; monitor urinary and surgical complications.
External-beam radiation	Treats localized/locally advanced disease or relieves metastatic symptoms; monitor urinary, bowel, skin, fatigue effects.
Brachytherapy	Radioactive sources placed in/near prostate; follow radiation-safety and urinary teaching.
Androgen-deprivation therapy (ADT)	Lowers testosterone or blocks androgen action; used in several advanced/high-risk or combined-treatment settings.
Chemotherapy / newer systemic therapy	Used in selected metastatic or treatment-resistant disease; regimen is stage- and biology-dependent.
Cryotherapy/focal therapy	Freezes selected prostate tissue; may be considered in selected primary or recurrent settings, not a universal first-line treatment.

CORRECTION Surgery is not automatically the most common or best treatment for every patient. Low-risk disease may be monitored, and advanced disease often needs systemic therapy. The plan is individualized rather than chosen by diagnosis alone.

6 Radical Prostatectomy: Nursing Care

STUDY SPRINT · 12 MIN Protect urinary drainage, circulation, healing, and function

Immediate priorities

- Assess airway, pain, vital signs, bleeding, incision, drains, urine output/color, and catheter patency.
- Maintain the indwelling catheter exactly as ordered; avoid traction, kinks, dependent loops, and unapproved irrigation or removal.
- Expect some pink-tinged urine early if ordered parameters allow; report bright-red bleeding, large clots, falling output, bladder distention, severe spasms, or hemodynamic change.
- Prevent atelectasis and VTE with coughing/deep breathing, incentive spirometry, early ambulation, leg exercises, and ordered prophylaxis.

CATHETER PRIORITY Low or absent urine output after prostate surgery is not "just expected." Check the patient and tubing for kinks or obstruction, assess bladder discomfort/distention, and notify according to orders—do not force irrigation unless specifically prescribed.

Discharge teaching

Teach	Key points
Catheter care	Closed system, bag below bladder, secure tubing, hygiene, output tracking, and removal appointment.
Activity	Walk regularly; avoid heavy lifting/straining and driving until cleared; prevent constipation.
Pelvic-floor recovery	Perform pelvic-floor exercises as instructed after the surgical team approves timing.
Sexual function	Erectile dysfunction and fertility changes may occur; offer factual teaching, privacy, referrals, and partner-inclusive support if desired.
Report	Fever, worsening pain, foul/cloudy urine, blocked catheter, large clots/bright bleeding, calf pain, chest pain, or dyspnea.

7 Androgen-Deprivation Therapy (ADT)

STUDY SPRINT · 11 MIN Understand mechanism, forms, and long-term effects

MECHANISM Many prostate cancers use androgens as growth signals. ADT reduces androgen production or blocks androgen action; it controls disease but is not the same as physically removing the prostate.

Method	High-yield distinction
Bilateral orchiectomy	Permanent surgical reduction of the testicular testosterone source; systemic/palliative cancer control, not tumor excision.
GnRH/LHRH agonist	Initially may cause a testosterone "flare" before suppression; flare prevention may be ordered in patients at risk.
GnRH antagonist	Suppresses testosterone without the initial agonist flare.
Androgen-receptor inhibitor	Blocks androgen signaling at the receptor; drug-specific adverse effects and interactions vary.
Androgen-synthesis inhibitor	Reduces androgen production; some regimens require a corticosteroid and close lab monitoring.

Nursing surveillance during ADT

Effect	Assessment / teaching
Hot flashes, fatigue, sexual changes	Normalize discussion, assess distress and sleep, and offer symptom-management resources.
Bone loss/fracture risk	Weight-bearing activity, fall prevention, calcium/vitamin D plan if prescribed, and bone-density monitoring.
Loss of muscle / increased fat	Resistance activity and nutrition support; monitor function and fall risk.
Metabolic/cardiovascular effects	Monitor weight, blood pressure, glucose/lipids and cardiovascular symptoms; reinforce risk reduction.
Mood/cognitive concerns	Screen for depression, coping difficulty, and cognitive change; escalate suicidal thoughts immediately.

FLARE ALERT After a GnRH agonist, new/worsening bone pain, urinary obstruction, weakness, or neurologic symptoms can signal tumor flare. Patients with vertebral metastases are especially vulnerable—report promptly.

8 Radiation & Systemic Therapy

STUDY SPRINT · 10 MIN Anticipate toxicities without mixing treatment types

Therapy	Common nursing concerns
External-beam radiation	Fatigue, urinary frequency/urgency/dysuria, bowel irritation/diarrhea, skin changes, and later sexual dysfunction.
Permanent seed brachytherapy	Urinary irritation/retention; follow facility-specific time/distance precautions and instructions around children/pregnant people.
Chemotherapy	Myelosuppression/infection, fatigue, nausea, neuropathy, fluid retention or other drug-specific effects.
Corticosteroid-containing regimen	Hyperglycemia, infection risk, mood/sleep changes, fluid effects, and GI protection considerations.
Bone-directed therapy	Pain/function, calcium status as ordered, renal considerations, and dental evaluation/osteonecrosis teaching for selected drugs.

REGIMEN NUANCE The transcript links metastatic chemotherapy with prednisone. That may fit selected regimens, but chemotherapy is not always paired with prednisone. Learn the specific ordered regimen and monitor its actual toxicities.

9 Metastasis & Palliative Priorities

STUDY SPRINT · 9 MIN Recognize predictable spread and protect function

SPREAD PATTERN Prostate cancer commonly spreads to regional lymph nodes and bone—often spine, pelvis, ribs, and proximal long bones. Bone metastases are usually osteoblastic, but they can still cause pain, fracture, marrow problems, and cord compression.

Problem	Priority nursing response
Bone pain	Assess location, severity, movement effect, neurologic symptoms, and function; administer multimodal analgesia and coordinate radiation/systemic care.
Pathologic fracture risk	Fall precautions, safe handling, assistive devices, and urgent evaluation of sudden focal pain or inability to bear weight.
Spinal cord compression	Urgent neurologic assessment and escalation; preserve safety and prepare for rapid imaging/treatment.
Urinary obstruction	Assess retention, output, renal function, infection and pain; catheter/procedure only as ordered.

Problem	Priority nursing response
Whole-person needs	Palliative care, symptom control, sexuality/body-image support, advance-care planning, caregiver support, and hospice when appropriate.

10 PSA After Treatment & Recurrence

STUDY SPRINT · 8 MIN Use trends and treatment context—not a memorized deadline

After treatment	Expected monitoring logic
Radical prostatectomy	With prostate tissue removed, PSA should fall to a very low/undetectable level over the follow-up interval. Detectable or rising PSA prompts repeat testing and evaluation.
Radiation	The prostate remains, so PSA usually declines more slowly and may not reach zero; interpret nadir and trend.
ADT/systemic therapy	PSA response helps monitor disease but must be interpreted with symptoms, testosterone when relevant, imaging, and other findings.

TRANSCRIPT CORRECTION The lecture says PSA should drop within a few days after prostatectomy and that a rise several weeks later usually means recurrence. Safer exam reasoning: PSA is followed after an appropriate postoperative interval, and recurrence is based on a confirmed pattern/threshold—not one isolated early result.

11 Saw Palmetto: Herbal-Supplement Safety

STUDY SPRINT · 8 MIN Ask, document, verify—never assume “natural” means harmless

WHAT THE LECTURE EMPHASIZES Ask specifically about saw palmetto. The transcript warns about taking it with finasteride (Proscar), anticoagulants/antiplatelets, hormonal medicines, and possible interference with iron absorption.

Evidence-based correction

- Current NIH information says saw palmetto alone provides little or no benefit for BPH urinary symptoms and does not appear to alter PSA readings.
- The specific claims that it must never be combined with finasteride, routinely causes clinically important bleeding, or interferes with iron absorption are not firmly established in the current NIH summary.
- The safe nursing action is still to reconcile all supplements, document brand/dose/frequency, and have the prescriber or pharmacist check product-specific interactions before surgery or alongside anticoagulants, hormones, or prostate medicines.

EXAM VS PRACTICE If the test asks directly from this lecture, recognize its stated interaction warnings. In practice, do not independently stop a prescribed medicine or make a definitive interaction claim without checking an authoritative interaction resource and the patient's clinician/pharmacist.

12 Lecture Statements Decoded

STUDY SPRINT · 9 MIN Learn the rationale behind the likely answer

Prompt	Best exam reasoning
Cancer versus BPH location	Cancer: peripheral zone. BPH: central/transition periurethral zone.
Suspicious DRE	Stony-hard, irregular, nodular, asymmetric, or indurated gland.
Can PSA diagnose cancer alone?	No. It is a risk/suspicion marker and can rise in benign conditions.
PSA and DRE sequence	For this course: draw PSA before DRE.
Why orchiectomy?	Removes the major testicular testosterone source to suppress androgen-driven cancer.
Cryotherapy	Freezes tissue; selected use, often discussed for recurrence—not universal first-line care.
Metastatic red flag	New back pain with weakness or bowel/bladder change = possible cord compression.

13 Exam Traps & Memory Hooks

STUDY SPRINT · 8 MIN Replace shortcuts with complete nursing reasoning

Trap	Correct it
Urinary symptoms prove prostate cancer	No—BPH, infection, and other disorders can cause similar symptoms.
High PSA equals cancer	No—PSA is not cancer-specific; biopsy confirms histology.
All prostate cancers need immediate surgery	No—risk, stage, life expectancy, goals, and comorbidities guide treatment.
Watchful waiting = active surveillance	No—active surveillance is structured monitoring with curative treatment if progression; watchful waiting is symptom-guided.
ADT removes the prostate	No—it reduces or blocks androgen signaling.
No urine after surgery is expected	No—assess for obstruction, retention, bleeding, and catheter problems.

Trap	Correct it
One rising PSA proves recurrence	No—evaluate timing and confirm a trend/accepted threshold.

MEMORY STRING P-R-O-S-T-A-T-E: Peripheral origin • Rising PSA needs context • Obtain biopsy to confirm • Slow often, not always • Testosterone can feed growth • Assess urine after surgery • Track bones/neurologic status • Explain sexual/continence effects.

14 Retrieval Practice

STUDY SPRINT · 10 MIN Cover the right column and answer aloud

Question	Answer / rationale
1. Where does prostate cancer usually begin?	Peripheral zone; BPH commonly affects the central/transition periurethral area.
2. Does PSA alone diagnose cancer?	No. It raises suspicion; tissue biopsy confirms.
3. What DRE finding is suspicious?	Hard, irregular, nodular, asymmetric, or indurated prostate.
4. What four items help define risk/stage?	TNM extent, PSA, Grade Group/Gleason information, and clinical context.
5. Active surveillance versus watchful waiting?	Structured monitoring with possible cure versus symptom-guided palliation.
6. First priority with absent catheter output post-op?	Assess patient, bladder, catheter and tubing; do not force unprescribed irrigation.
7. Major long-term ADT concerns?	Bone loss, metabolic/cardiovascular effects, body-composition change, sexual changes, fatigue, and mood.
8. What suggests spinal cord compression?	Back pain with weakness/numbness, gait change, saddle anesthesia, or bowel/bladder dysfunction.
9. What does a rising post-treatment PSA require?	Repeat/trend-based evaluation in the context of the treatment received.

15 One-Minute Review

IF YOU REMEMBER ONLY 10 THINGS 1) Cancer is usually peripheral; BPH is periurethral/transition-zone. 2) Early cancer may be silent. 3) PSA is not cancer-specific. 4) Biopsy confirms cancer. 5) Grade predicts aggressiveness; stage describes spread. 6) Treatment is individualized—surveillance is a real option. 7) Protect catheter drainage after prostatectomy. 8) ADT threatens bone, metabolic, cardiovascular, sexual, and emotional health. 9) Bone/back symptoms require focused neurologic assessment. 10) Back pain plus weakness or bowel/bladder change is an emergency.

Four short study passes

Pass	What to do	Time
1 Pink scan	Read cord-compression, catheter, flare, and recurrence boxes.	6 min
2 Compare	Review cancer versus BPH and surveillance versus treatment.	8 min
3 Trace	Say PSA → MRI/risk workup → biopsy → grade/stage → plan.	6 min
4 Retrieve	Answer all nine questions; revisit only the misses.	10 min