

ORIGINAL RESEARCH

Quality of life in elderly men after a radical prostatectomy. A qualitative study

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Abstract

Prostate cancer is the second most frequent cancer in Spain. One of its main treatments is radical prostatectomy. This intervention generates a series of physical and psychological consequences in the patient that result in reducing their quality of life. The objective of this study was therefore to explore the experiences and perceptions of older adults about their quality of life after a radical prostatectomy. A descriptive qualitative study was conducted with 18 patients who had undergone a radical prostatectomy, with a mean age of 70.6 years. A focus group of 8 people was formed, and 10 individual interviews were carried out and transcribed in ATLAS.ti for later analysis. The quality of the criteria for qualitative research was guaranteed, and the pertinent ethical aspects were respected. Participants demonstrated worse urinary (incontinence) and sexual (erectile dysfunction) function after radical prostatectomy. Due to these consequences, they manifested shame, despair and relationship problems (lack of communication, absence of sexual life, *etc.*), thus causing a clear decrease in their quality of life. The participants also stated that they did not feel well-protected by the health care received. The physical sequelae on urinary and erectile function of prostatectomized patients decrease the patient's quality of life. These limitations in their sexual life cause them additional psychological consequences that also contribute to a deterioration in the perceived quality of life. In a social environment, patients can find understanding and freedom to share feelings, which contributes to improving their quality of life. However, pressure and lack of communication can appear in the couple, which is perceived as a source of deterioration in quality of life. The care conditions in the health system are not appropriate to address the quality of life of this type of patient in a comprehensive manner.

Keywords

Quality of life; Prostate cancer; Qualitative research; Prostatectomy

1. Introduction

Prostate tumours are fourth in the ranking of the most frequent tumours in the world, with an estimate of 1,414,259 (7.3%) new cases in 2020 [1]. In Spain, prostate cancer ranks second among the most frequent cancers, with 30,884 new cases in 2020 [2]. As there are several therapeutic options with equivalent oncological results, quality of life is an important criterion when selecting a treatment modality [3]. Radical prostatectomy (RP) is one of the main treatment options for these men [4]. The frequency and evolution of intervention have increased rapidly since the 1980s [5]. Among the advantages of robotic-assisted RP (RARP) are that it is precise and minimally invasive [6]. Even so, in comparison with other surgical approaches, such as laparoscopic radical prostatectomy (LRP) and open radical prostatectomy (LRP), it has been a controversial topic in the field of urology [7].

When a man undergoes this type of intervention, his quality of life is significantly affected by negative effects on the urinary function, causing incontinence [8]. Urinary incontinence has a very severe impact on the overall assessment of quality of life: the greater the urine loss, the greater the impact [9]. Among the various dimensions of quality of life, sexual function is one of the most seriously affected by the different treatment modalities for prostate cancer [10]. This has to do with the relationship between surgical treatments and erectile dysfunction [11]. Most patients report that they couldn't have an erection after surgery [12]. These adverse effects have negative psychological and social consequences such as decreased self-esteem [13], irritability or fear [14], not only in patients but also in their partners [15]. A theoretical framework widely used in studies on the quality of life is that of Schalock and Verdugo [16]. This theoretical framework values emotional, material and physical well-being, relation-

ships and personal development, self-determination, social inclusion, and the defense of rights [17].

Health professionals perceive the comprehensive care of this type of patient as a challenge, which demonstrates the importance of training health personnel and caregivers in the management of this condition [18]. Various studies support the benefit of sexual care and education interventions in these patients and the resulting improvement in the quality of life [14, 19].

Until now, the literature has addressed the effects of RP on urinary function [9], sexual function [11], generic quality of life [20, 21], or health-related quality of life [22], and also assesses the latter depending on the surgical technique used [6, 21]. Nevertheless, there is a lack of studies on the perceptions of older adults regarding their overall quality of life in our context [23]. Therefore, the objective of this study was to explore the experiences and perceptions of older adults regarding their quality of life after a radical prostatectomy.

2. Materials and Methods

2.1 Design

A descriptive qualitative study was carried out. These studies are characterized by requiring less abstraction in data analysis, which allows us to describe more intimate details [24]. The approach of this study is based on the principles of naturalistic research, which allows researchers to describe phenomena by focusing on how participants see, interpret, or experience a particular phenomenon in its natural state [23]. To prepare the report for this study, the recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ) [25] were followed.

2.2 Participants and Setting

The participants were 18 patients who had undergone a radical prostatectomy. The study was conducted in southeastern Spain from October 2020 to May 2021. Convenience sampling was used due to the ease and availability of access to participants. The inclusion criteria to participate in this study were: (1) men who had undergone a radical prostatectomy; (2) being an older adult (over 65 years). Exclusion criteria were: (1) refusal to participate (2) not speaking Spanish. The main researcher contacted the participants who met the inclusion criteria by telephone through the professionals of a local branch of the Spanish Association Against Cancer (AECC). A total of 24 participants were invited to participate in the study, of whom 6 refused to participate, alleging lack of time (2) or that it was not comfortable for them to talk about their intimate details (4). The mean age of the participants was 70.6 years, and standard deviation 4.61. The sociodemographic data of the participants can be seen in Table 1.

2.3 Data Collection

Ten in-depth individual interviews were carried out, and a focus group with 8 participants was held. Both the interviews and the focus group were recorded, with the prior consent of the participants. First, the focus group was held, lasting 90

minutes, to facilitate the exchange of ideas, experiences and anecdotes about the phenomenon from the interaction between the members [26]. The focus group was led by a moderator (male), who had a series of topics to be introduced if they did not arise spontaneously in the discussion. Another researcher acted as an observer, taking notes on non-verbal elements of the conversation and keeping an eye on the recording systems. After the preliminary analysis of the focus groups, ideas were noted down to include in the question script for the individual interviews. The interviews lasted an average of 55 minutes. The interviews were conducted by a male researcher after an initial meeting in the Association to build up trust with the participants. The interviewing researchers had received training in qualitative research methodology and had a master's degree. Furthermore, there was a protocol and interview guide that was rehearsed prior to the interviews (Table 2). Data collection was stopped when the interviews no longer provided new information (data saturation was reached).

2.4 Data Analysis

All the recordings were transcribed and incorporated into a hermeneutic unit of ATLAS.ti 9 (Thomas Muhr, Scientific Software Development GmbH, Berlin, Germany) for analysis, along with the annotations and observations of the interviewers and observers. The data analysis followed the thematic analysis procedure described by Braun and Clarke [27, 28]: (1) Familiarization with the data was made through the complete reading of all the transcripts to extract the general meaning followed by a rereading in which annotations were written in ATLAS. ti Memos. (2) For the systematic coding of the data three researchers selected the important citations and assigned them codes to capture their meaning. Codes that did not reach the consensus of at least two researchers were rejected. (3) To generate the initial themes, rooted codes (with many citations) were grouped into themes that represent patterns of shared meaning, joined by a central concept or idea. (4) The development and review of the themes were carried out by checking that the themes developed were consistent with the codes they group together and with the coded quotations. In this phase, networks were generated with ATLAS.ti and represented conceptual maps of the analysis. (5) Then themes were refined, defined and named, improving the analysis and denomination of each theme. (6) Finally the report was written, and the most illustrative quotes were selected, examples of articulate summaries were produced, and the analysis was again related to the research question and the literature.

2.5 Rigour

The quality of the Guba and Lincoln [29] criteria for qualitative research was guaranteed. Credibility: to guarantee credibility, parallel triangulation was carried out with the rest of the researchers and included in their training (each one carried out an analysis, and then they all exchanged experiences). Transferability: the experience of the subjects and the context were both described in detail. Dependency: an exhaustive description was made in the methodology section. Confirmability: our analysis of the data was returned to the participants to clarify the final data and confirm the use of the participants'

TABLE 1. Sociodemographic profile of the participants.

Participant	Age	Educational level	Civil status	Number of years since prostatectomy	Type of participation
P-01	78	Basic	Married	4	Interview
P-02	69	No studies	Married	10	Interview
P-03	67	Medium level	Married	8	Interview
P-04	67	No studies	Widow	3	Interview
P-05	72	Medium level	Married	10	Interview
P-06	66	Basic	Married	5	Interview
P-07	66	Medium level	Married	3	Interview
P-08	70	Medium level	Widow	7	Interview
P-09	66	University	Married	6	Interview
P-10	74	Medium level	Single	8	Interview
P-11	69	Medium level	Single	7	Focus Group
P-12	73	Basic	Married	12	Focus Group
P-13	67	University	Single	5	Focus Group
P-14	68	Basic	Married	3	Focus Group
P-15	75	Medium level	With partner	11	Focus Group
P-16	70	Basic	With partner	13	Focus Group
P-17	71	University	Married	9	Focus Group
P-18	83	Basic	Widow	13	Focus Group

Age: Average = 70.6 years. standard deviation = 4.61. Years of evolution: Average = 7.6, standard deviation = 3.4.

TABLE 2. Interviews protocol.

Fase	Título	Contenido
Introduction	Motives	Your experience provides information that should be known by all.
	Objectives	The results of the research will be published.
Beginning	General Introductory Question	Explanation of the study and ethics.
		If you agree, let's start by telling me how your quality of life has changed since the intervention.
Development		How has the prostatectomy influenced you on a physical level?
		How has this affected you emotionally?
		How has it influenced your social and family life?
		What is your biggest concern?
Closure	Final Question	Is there anything else you would like to say on the topic?
	Thanks	We appreciate the time you have dedicated to us. Remind them that their accounts will be very helpful.

citations.

3. Results

From the analysis of the data, two main themes were extracted that characterize the quality of life in the process of a prostatectomy (See Table 3).

3.1 Theme 1. Physical and Psychological Repercussions after a Prostatectomy

The participants discussed the consequences of a prostatectomy on a physical level and how these consequences have an important psychological impact, thus affecting their perceived

quality of life. Within this theme, two sub-themes emerged:

3.1.1 Subtheme 1. Physical Sequelae: Impact of Urinary and Sexual Dysfunction on the Perceived Quality of Life

Along with the immediate consequences of radiotherapy and surgery (burns, pain, itching, bleeding, loss of strength, *etc.*), long-term patients continued to be able to perform basic activities of daily living (BADLs) although other types of consequences appeared with respect to urinary and sexual functions. The patients reported difficulty or impossibility of erection and ejaculation, thus causing sexual dissatisfaction and having a significant negative impact on their quality of life.

TABLE 3. Themes, subthemes and units of meaning.

THEME	SUBTHEME	UNITS OF MEANING
Physical and psychological repercussions after a prostatectomy	Physical sequelae: Impact of urinary and sexual dysfunction on perceived quality of life	Compromised urinary function. Compromised sexual function. Difficulty in erection. Ejaculation difficulty. Urinary incontinence. Recurrent urine infections. Inability to work. Negative impact on quality of life. Burning when urinating before the intervention.
	Shame and sexual impotence on perceived quality of life	Concern about the couple's sexual life. Anxiety. Shame. Feelings of impotence. Feeling of loss of manhood.
Quality of life and context of the prostatectomy patient	The family and social dimension of quality of life	Influence of family and friends. Absence of sexual life. Family pressure to have surgery. Impotence is a taboo subject among men. Not satisfying partner. Partner provides understanding. Low sexual activity before the intervention. Lack of interest in sex. Lack of communication with family. Lack of communication with partner.
	Limitations of the health system in the approach to total quality of life	Lack of support from health professionals. Lack of medical support. Lack of doctor-patient relationship. Poor perception of health care. Lack of information. Lack of knowledge of other types of interventions. Fear of treatment for erectile dysfunction. Bad experience with treatment for erectile dysfunction.

“It leaves you unable to function. Come on, it won't get up or get stiff or anything” (P-01).

“Yes, quality of life, yes, because I have lost what, because first you lose...it's just the impotence” (P-03).

“(…) when one reaches an age one is not there to do fancy stuff, do you know what I mean? That's tricky, and look I've tried and everything but no... I didn't think it was going to go down so soon but look where it is” (P-04).

In terms of urinary function, incontinence and recurrent urinary tract infections generate great discomfort among patients, and they even have to abandon their work or leisure obligations due to the urgency to urinate.

“The problem is that sometimes you are in such a hurry that you pee in your pants, you pee then you have to go. It's not that you pee just once... You continually pee... All those little things” (P-02).

“They told me that in the operation there was a twenty-five percent chance of leaking urine, but I was more than leaking, you know? Total helplessness” (P-03).

The patients experience an improvement with respect to the urinary situation that they had before the surgical intervention as the pain when urinating disappears, but the fact of having to start using absorbent pads for urine loss means a significant decrease in their independence.

“And then urine appears, which isn't great, you have to wear pads, but you also pee quickly and lightly, making life normal” (P-03).

3.1.2 Subtheme 2. Shame and Sexual Impotence on Perceived Quality of Life

The patient undergoes a period of adaptation due to a series of changes, in which various insecurities and concerns arise, including a mixture of feelings of impotence from the belief that they cannot improve their sexual life with their partner and a sense of the loss of manhood from not being able to

maintain an erection. This situation ends up discouraging them and generating anxiety. Patients become used to thinking that their sexual life is hopeless.

“She also says she has fun, but not being able to do that properly makes me feel... anxiety, right? Like you don't feel the same anymore. But it's the same with everything. The subject of the bedroom becomes almost avoided” (P-03).

“You really end up avoiding relationships. It's what I said before, it's anxiety and the fear of failing in terms of masculinity that is always lurking over you. But deep down I don't want to avoid it because I feel desire, you know?” (P-08).

Added to this cocktail of emotions is the embarrassment they feel when they have to deal with these issues in the consultation. Privacy in medical consultations is not always guaranteed. This is not because of the presence of other patients or various professionals but rather because they do not have the tact to leave the patient alone with the doctor, without family members.

“Also, my daughter was there, and if the doctor asks me with her there, and if I'm asked, I say no. And my daughter always comes with me, so you can imagine” (P-01).

“We talk about it among ourselves, but not at the doctor's. I know colleagues from the Association who are waiting to be operated on for the second or third time, and they close up, and it's as if they were embarrassed” (GF).

They also reported feelings of modesty and having lost their masculinity when breast growth becomes more noticeable.

“And on top of all that, your chest becomes almost like a woman's, it's painful and it's grown... And of course all of that is embarrassing” (P-03).

3.2 Theme 2. Quality of Life and Environment of the Prostatectomized Patient

The influence of the environment on the quality of life of these patients is decisive. As they are elderly patients for whom sexuality is still a taboo subject, it is difficult for them to communicate openly with their partners, friends, or health professionals in order to express how they feel and be able to help them increase their quality of life.

3.2.1 Subtheme 1. The Family and Social Dimension of the Quality of Life

Some patients understood sexual practice exclusively in terms of intercourse, and since this was not possible, they had a total absence of sexual life with their partner, which ended up causing disinterest in both. Still, they showed a willingness to learn how to improve their sex life in another way if they were taught. During the interviews, they stated that they felt supported by the understanding of their partners and did not feel pressured by them, although they indicated a lack of communication and confidence to be able to talk about their sexuality with them.

“Well, I think she’s really trying to avoid it. I think she sees how nervous I get, how this affects me so deeply... And I think this creates a communication barrier between us. I think she does want to keep our sex life active” (P-08).

“I am lucky with my wife in that she understands that we cannot have sex like we had before, that this was something that could happen when I had surgery and well... well, it is what it is” (P-03).

Some patients were interested in learning how they could improve their sex life while others felt embarrassed trying to talk to them about it. During the focus group, some technical terms were not understood by the participants, so they did not generate responses.

“When the moderator asks something related to intercourse, some participants remain silent. They don’t seem to know what intercourse is. When the moderator clarifies the meaning, some participants come across as very tense” (Observation note—GF).

“Well, I, if you give a talk right here on the ground floor, we would have no problem saying well, come on, let’s see what he has to tell us, come on. Let’s solve the problem of the fallen dick! (laughs)” (P-01).

Several patients mentioned that their social life had been impaired after the intervention. The fact that they have had to stop working and very often feel tired has caused them to go out less now than before. Although talking about problems of sexuality between men is still a very sensitive topic, many recounted how they talked about it openly with acquaintances who had been through the same thing.

“I no longer feel able to go out with friends or any of those things. I was always there with a glass of wine in the bar, and now all my friends ask: where are you? Where have you gone? And me? My goodness, I just don’t feel like it any more” (P-04).

However, some participants have identified patient associations as sources of quality of life since they allow them to

discuss their concerns and complications with other patients or friends.

“There (in the Association) we don’t hide anything, we tell each other that this happens to me and that happens to me. This is also quality of life because it leaves you feeling calmer” (P-01).

Specifically with regard to sexual sequelae, talking amongst peers gives them the freedom to talk about their experiences or limitations without feeling judged and to be understood, which helps to improve their quality of life.

“He says the same thing ‘that I can’t get it up’. And me neither, what can we do? And then we burst out laughing, and he says, ‘No, and the baker too, what a situation, I saw him the other day and he tells me, “Now that I’ve retired to be with my wife every day, I can’t get it up, damn it!” And we take it like that, as a joke, that’s what it is” (P-07).

3.2.2 Subtheme 2. Limitations of the Health System in the Approach to the Total Quality of Life

During the interviews, the lack of psychosocial support from health personnel for these patients was clear. They did not have a professional-patient relationship in which enough trust is generated to talk about what concerns them or ask for advice to improve their quality of life. Lack of information about the problem, the intervention, and short- and long-term sequelae were also noted. This generates a poor perception of the health care received by patients.

“The oncology nurse told us something about that, but they didn’t tell us much” (P-03).

“The doctor gave me treatment options, they told me that this could happen but at no point has he been concerned about how this is going. I guess they also have priorities and don’t have much time. But, they have not offered me alternatives or anything at all other than pills or injections” (P-08).

Many of the patients interviewed agreed that they did not know where to obtain information and advice about their problems in order to improve their quality of life and expressed feelings of helplessness.

“Sure, having someone to lean on because I’m not the only one, I know. There is no one in the hospital to go to for advice. Everyone is always busy, and it’s not their priority, I can understand that. This is not the time to talk about this, but I can’t pick up information out and about either. So who is my support in this?” (P-08).

When they talked about the treatment for erectile dysfunction (phosphodiesterase-5 inhibitors), they expressed fear and rejection of the drug, since they had not been duly informed about it either, and they only commented on other people’s experiences that they had heard about. In addition, the doctor offered them this as the only way to recover their sexual life, without informing them of different alternatives such as being able to carry out non-coital sexual practices.

“But wow, in my case, the pills, could they work? I don’t know if I would take them because they say they cause problems... Once, I think, now that you mention it, that the doctor told me something about Viagra, but it was a thing of the past” (GF).

4. Discussion

This study aimed to explore the experiences and perceptions of older adults regarding their quality of life after a radical prostatectomy. The adoption of a descriptive qualitative approach allowed us to explore the phenomenon under study from the point of view of the patients who experience it [23]. The data and opinions collected focused on two main issues: the consequences, both physical and psychological, generated by this condition, and the impact of the social and healthcare environment on the patient's quality of life.

The main finding of this research was that sexual function is the most compromised and has the greatest impact on quality of life, as seen in various studies [20, 30, 31]. The ability to achieve an erection is greatly reduced in these patients but improves when they attend psychotherapy [11]. Post-surgical urinary incontinence was observed as another key factor in the decrease in quality of life [5, 12]. Having to urinate constantly makes it impossible to maintain a normal life [8]. Quality of life decreases even more when the incontinence is almost total, and pads have to be worn [9]. The patients showed hopelessness due to their situation, even going so far as to stop working even though it is known that a specific care plan for this type of patient improves urinary function [14]. Participants were concerned about the loss of quality of life following a prostatectomy. Maintaining quality of life is a main aim when choosing one therapy or another in elderly men with prostate cancer [32].

As for relationships between couples, sexual contact is limited, which worsens over time, even reaching the total absence of sexual life, in line with other studies [15]. Sexual dysfunction is common, and most men are not offered helpful intervention or support. Other studies have also pointed to the need for improvements in services linked to sexual rehabilitation and measures to reduce the effects of androgen deprivation therapy [22]. Health professionals should consider the different domains of quality of life, without forgetting sexuality, one of the most affected [10]. In fact, a recent study suggests that testosterone replacement therapy could improve erectile function as well as reduce libido. Furthermore, it can be carried out on patients who have undergone prostate cancer interventions [33].

Our participants reported that they can discuss their limitations with each other even more confidently than with their partners. However, they did not report their participation in formal support groups. Other authors have emphasized that patients should be encouraged to participate in support groups, exercise programs, and health education [32]. Another study [29] concludes that patients could benefit from a health system that evaluates the patient's sexual function with a partner after prostatectomy beyond the ability to penetrate, and take interest in other aspects such as sexual intimacy, sexual confidence, and masculine self-esteem. The nursing staff can also help the patient when they observe deficits in these areas. The interviews also mention the lack of a relationship of trust with health professionals and a lack of information about the magnitude of the consequences of the intervention, when advice should be given on the different treatment routes, and how each one will affect their quality of life [5].

Other studies have reported that the quality of life of elderly men with CP is clearly influenced by one's financial situation [21, 34], which conditions accessibility to health services. However, this does not occur in contexts such as that of our study, where access to health care is free [10].

The main limitations of our study are that it was carried out in a specific geographical area of Spain, which could limit the generalization of our conclusions. Ideally, a broader range of scenarios would be included to assess the perceptions and experiences of prostatectomy patients. For example, Moss *et al.*, [31] found differences in HRQoL between urban and rural areas. The study of the Cv of patients undergoing other therapeutic options such as RT [35] could also yield different results. A further limitation is the sample size, given that it is so small, it may not be considered as representative of the wider population.

5. Conclusions

The physical sequelae in the urinary and erectile function of prostatectomized patients leads to a decrease in their quality of life, according to our participants. These limitations in their sexual life cause additional psychological consequences such as shame or fear, that also contribute to a deterioration in perceived quality of life.

In the intimate social environment (family, friends, patient association) patients can find understanding and the freedom to share experiences and feelings, which contributes to improving well-being and quality of life. Pressure and lack of communication between partners can also appear in the family environment, which is perceived as a source of deterioration of one's quality of life.

The participants highlighted that, despite the potential of and need for comprehensive care, the care conditions in the health system are not sufficient to address quality of life in a comprehensive manner, which, for example, includes sexual topics.

AVAILABILITY OF DATA AND MATERIALS

Data of this study are audio recordings and their transcripts of the interviews and focus group. These contain confidential data (*e.g.* full names). The analyzed data is found in an Atlas.ti software project, which is required to access it. Likewise, all of this is in the possession of the Main Author (AMB).

AUTHOR CONTRIBUTIONS

CFS and JMHP designed the research study. AMB, APPM and LVGR performed the research. JMHP, APPM and MMJL provided help and advice on critical review of the manuscript. LVGR, MMJL, CFS analyzed the data. LVGR, AMB, CFS wrote the manuscript. All authors contributed to editorial changes in the manuscript. All authors read and approved the final manuscript.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

This research was carried out following the ethical principles of the Declaration of Helsinki. Permission was obtained from the Ethics and Research Commission of the Department of Nursing, Physiotherapy and Medicine of the Faculty of Health Sciences (Code: ENFISMED-09/16). The participants were informed of the objective of the research, the methodology, and their rights (voluntary nature of participation and the possibility of withdrawing at any time, the right to request psychological support if they considered it appropriate, *etc.*). The confidential treatment and anonymity of the data was guaranteed according to the European Data Protection Law. Informed consent was obtained from all participants before starting the research.

ACKNOWLEDGMENT

The authors would like to express their gratitude to all the participants in this study, to John Milton for his linguistic services, and to the CTS-451 Health Sciences Research Group, belonging to the CEINSA (Health Research Center) of the University of Almería.

FUNDING

This research received no external funding.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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How to cite this article: Lucía Victoria García-Rodelas, Álvaro Martínez-Bordajandi, Ana Patricia Puga-Mendoza, José Manuel Hernández-Padilla, María del Mar Jiménez-Lasserrotte, Cayetano Fernández-Sola. Quality of life in elderly men after a radical prostatectomy. A qualitative study. *Journal of Men's Health*. 2023; 19(1): 7-14. doi: 10.22514/jomh.2023.004.