



Consensus and Controversies in Cancer of Prostate

BASIS FOR FURTHER STUDIES

5-8 de noviembre de 2017

Main controversies In prostate Cancer:

1-Screening 

2-Management


Observation 

Surgery 

Standard

Laparoscopic

Robotic

Radiation: (no discussion on Cryosurgery-RF etc.) 


Standard

SBRT

Brachytherapy

combination

Systemic

 ADT-Chemotherapy & Immunotherapy

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Screening:

PSA: Old controversies and new Information:

PSA has become the most important issue in men's health, and the most controversial

Controversies: In prostate cancer early detection is the exception to the rule that early detection of cancer saves lives. Some believe that PSA screening may actually do more harm than good.

Some facts:

17 % of American men will be diagnosed with prostate CA

Typically just 3 % will die of cancer (one on every six will be fatal)

Many prostate cancer never will become large to be troublesome.

However PSA early diagnosis of aggressive prostate cancer can improve survival

Cancer diagnosis usually leads to treatment in all prostate cancers, and treatments carry a substantial risk of side effects.

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Screening:

The American prostate, lung Colorectal and ovarian Study: began in 1993 **76,693 men**; Over 8 years.

Randomized to annual PSA for 6 years with DRE. Men with **PSA > 4.0 ng/ml** were advise to get further evaluation (usually Prostate Bx). Men in both groups that were diagnosed with prostate CA were treated by their personal MDs.

After 7 years they found **22 %** more cases of prostate CA in the **PSA screening group**. Even though PSA screening increase the diagnosis of prostate CA It did not improve survival.

There were no real differences in the number of deaths in the two groups.
Results at 10 years are similar to the previous findings. ☀

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Screening:

The European Study ERSPC (European Randomized study of Screening for prostate Cancer):

Similar to the American study it began in the early 1990, enrolled **162,243 men** ages 55-69 randomly assigned to receive PSA screening and the other half the usual medical care. **PSA was performed an average once every four years.** Men with PSA > 3.0 ng/ml had prostate Bxs.

About 9 years of observation there were 214 men in the PSA screening group and 326 in the comparison group that died of Prostate cancer. This mean that the screening reduce the relative risk of dying of prostate cancer by 20%.

Interesting, that means that for Americans the risk of dying from prostate Cancer is 3 in 100 (**3%**) a **20 % reduction means the risks drops to 2.4%**☀

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ACS Screening Guidelines

Men should receive the information starting at the following ages:

- Age 50 for those at average risk of developing prostate cancer
- Age 45 for those at high risk, including African Americans and men with a first-degree relative (father, brother, son) diagnosed with prostate cancer before age 65
- Age 40 for those at higher risk (more than one first-degree relative diagnosed with prostate cancer at an early age)

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AUA screening guidelines

The current recommendations of the AUA date from 2013 and update the Association's 2009, Best Practice Statement on Prostate-Specific Antigen (PSA). ^[2] The guidelines **do not** recommend routine screening for the following groups:

- Any man with a life expectancy less than 10-15 years

- Men under 40 years

- Men between ages 40 to 54 years at average risk

- Men over age 70

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USPSTF screening guidelines

The USPSTF guidelines, which were updated in 2012, **recommend against PSA-based screening for prostate cancer**, while recognizing that **some men will continue to request screening**.^[3] In such cases, **screening should not be ordered prior to shared decision** making that weighs the benefits and risks and takes into account the **patient's preferences and values**.

ESMO screening guidelines (European Society for Medical Oncology)

Like USPSTF, ESMO guidelines **recommend against population-based PSA screening for prostate cancer**, as well as screening of asymptomatic **men over 70 years old**.^[4]

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EAU/ESTRO/SIOG screening guidelines European Association of Urology .Society of Geriatric Oncology

In 2016, revised joint guidelines were issued by EAU/ESTRO/SIOG **with the recommendation that men who are informed and request an early diagnosis should be given a PSA test and undergo a digital rectal examination (DRE)**. PSA testing should be offered to the following groups at elevated risk for developing prostate cancer ^[5] :

Men > age 50

Men > age 45 and a family history of prostate cancer

African-American men > age 45

Men with a PSA level of > 1 ng/mL at age 40

Men with a PSA level of > 2 ng/mL at age 60

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EAU/ESTR/SIOG screening guidelines

The European Randomized Study of Screening for Prostate cancer
ERSPC:

Showed that PSA based Screening results in significant prostate
Cancer Mortality Reduction. Despite some over-diagnosis the
benefits can outweigh the harms if screening is stopped in older
ages to prevent over-diagnosis. To implement Active surveillance
in low-risk tumors, can be cost-saving. Further improvements in
discrimination between indolent and significant disease due to
biomarkers and MRI could justify its use. ***

International Journal of Cancer **2017 Oct 12**

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES April 2017

5-8 de noviembre de 2017

CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

Approved by the AUA Board of Directors April 2017

Purpose: Provide guidelines for the management of localized prostate cancer, provide a clinical framework to stratify by cancer severity, select management options:

Active surveillance Observation, watchful waiting

Prostatectomy

Radiotherapy

Cryosurgery

High Intensity Ultrasound (HIFU)

Treatment for salvage Tx for localized cancer persist o recurs after Primary Tx.

5-8 de noviembre de 2017

CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

Some Guidelines

Share Decision Making:

- Encourage patients to seek a 2nd opinion
- importance of health related behaviors and risk factors
i.e.: obesity
- Requires clinicians to inform patients about short and long term side effects
- Inform patients about suitable clinical trials

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Consensus and Controversies in Cancer of Prostate

TABLE 3: Risk Stratification for Localized Prostate Cancer

Very Low Risk	<u>PSA <10 ng/ml AND Grade Group 1 AND clinical stage T1-T2a AND <34% of biopsy cores positive AND no core with >50% involved, AND PSA density <0.15 ng/ml/cc</u>
Low Risk	<u>PSA <10 ng/ml AND Grade Group 1 AND clinical stage T1-T2a</u>
Intermediate Risk	PSA 10-<20 ng/ml OR Grade Group 2-3 OR clinical stage T2b-c <ul style="list-style-type: none"> Favorable: <u>Grade Group 1</u> (with PSA 10-<20) OR Grade Group 2 (with PSA<10) Unfavorable: <u>Grade Group 2</u> (with either PSA 10-<20 or clinical stage T2b-c) OR Grade Group 3 (with PSA < 20)
High Risk	PSA ≥20 ng/ml OR Grade Group 4-5 OR clinical stage ≥T3*

*Clinical stage T3 cancer is considered locally advanced and, therefore, outside the scope of this guideline.

Group 1 3+3, G 2=3+4, G3= 4+3 G 4=4+4 G5=4+5

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

VERY LOW-/LOW-RISK DISEASE:

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

VERY LOW-/LOW-RISK DISEASE:

-Clinicians should not perform abdomino-pelvic CT or routine bone scans in the staging of asymptomatic very low- or low-risk localized prostate cancer patients. (Strong Recommendation; Evidence Level: Grade C)

-Clinicians should recommend active surveillance as the best available care option for **very low-risk** localized prostate cancer patients. (Strong Recommendation; Evidence Level: Grade A)

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

VERY LOW-/LOW-RISK DISEASE

Clinicians may offer definitive treatment (i.e. radical prostatectomy or radiotherapy) to select low-risk localized prostate cancer patients who may have a high probability of progression on active surveillance.*** (Conditional Recommendation; Evidence Level: Grade B)

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

VERY LOW-/LOW-RISK DISEASE

-Clinicians should not add ADT along with radiotherapy for low-risk localized prostate cancer with the exception of reducing the size of the prostate for brachytherapy.

(Strong Recommendation; Evidence Level: Grade B)

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

VERY LOW-/LOW-RISK DISEASE

-Clinicians should inform low-risk prostate cancer patients considering whole gland **cryosurgery** that consequent side effects are considerable and survival benefit has not been shown in comparison to active surveillance. (Conditional Recommendation; Evidence Level: Grade C)

-Clinicians should inform low-risk prostate cancer patients who are considering focal therapy or **high intensity focused ultrasound** (HIFU) that these interventions are not standard care options because comparative outcome evidence is lacking. (Expert Opinion)

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES VERY LOW-/LOW-RISK DISEASE

- Clinicians should recommend observation or watchful waiting for men with a life expectancy ≤ 5 years with low-risk localized prostate cancer. (Strong Recommendation; Evidence Level: Grade B)
- Among most low-risk localized prostate cancer patients, tissue based genomic biomarkers have not shown a clear role in the selection of candidates for active surveillance. (Expert Opinion) ***

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CLINICALLY LOCALIZED PROSTATE CANCER:

AUA/ASTRO/SUO GUIDELINES

INTERMEDIATE –RISK DISEASE

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

INTERMEDIATE –RISK DISEASE

-Clinicians should consider staging unfavorable
intermediate-risk localized prostate cancer patients with
cross sectional imaging (CT or MRI) and bone scan. (Expert
Opinion) **PET/CT**

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

INTERMEDIATE –RISK DISEASE

-Clinicians should recommend :[Prostatectomy or Radiotherapy plus Androgen Deprivation Therapy \(ADT\) as standard treatment](#) options for patients with intermediate-risk localized prostate cancer. (Strong Recommendation; Evidence Level: Grade A)

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

INTERMEDIATE –RISK DISEASE

-Clinicians should inform patients that favorable intermediate-risk prostate cancer **can be treated with radiation alone, but that the evidence basis is less robust** than for combining **radiotherapy with ADT**. (Moderate Recommendation; Evidence Level: Grade B)

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

INTERMEDIATE –RISK DISEASE:

-In select patients with intermediate-risk localized prostate cancer, clinicians may consider other treatment options such as cryosurgery. (Conditional Recommendation; Evidence Level: Grade C)

-Active surveillance may be offered to select patients with favorable intermediate-risk localized prostate cancer; however, patients should be informed that this comes with a **higher risk of developing metastases** compared to definitive treatment. (Conditional Recommendation; Evidence Level: Grade C)

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

INTERMEDIATE –RISK DISEASE

-Clinicians should recommend **observation or watchful waiting**
for men with a life expectancy ≤ 5 years with intermediate-
risk localized prostate cancer. (Strong Recommendation;
Evidence Level: Grade A)

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CLINICALLY LOCALIZED PROSTATE CANCER:

AUA/ASTRO/SUO GUIDELINES

HIGH –RISK DISEASE

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

HIGH –RISK DISEASE

-Clinicians should stage high-risk localized prostate cancer patients with cross sectional imaging (CT or MRI) and bone scan. (Clinical Principle) *** PET/CT

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

HIGH –RISK DISEASE

-Clinicians should recommend **radical prostatectomy or radiotherapy plus androgen deprivation therapy as standard treatment** options for patients with high-risk localized prostate cancer. (Strong Recommendation; Evidence Level: Grade A)

-Clinicians **should not recommend active surveillance for patients with high-risk localized prostate cancer.** Watchful waiting should only be considered in asymptomatic men with limited life expectancy (**≤5 years**). (Moderate Recommendation; Evidence Level: Grade C)

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

HIGH –RISK DISEASE

- Cryosurgery**, focal therapy and **HIFU** treatments are not recommended for men with high-risk localized prostate cancer outside of a clinical trial. (Expert Opinion)
- Clinicians should not recommend primary **ADT** for patients with high-risk localized prostate cancer unless the patient has both limited life expectancy and local symptoms. (Strong Recommendation; Evidence Level: Grade A)

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

HIGH –RISK DISEASE

-Clinicians may consider referral for genetic counseling for patients (and their families) with high-risk localized prostate cancer and a strong family history of specific cancers (e.g., breast, ovarian, pancreatic, other gastrointestinal tumors, lymphoma). (Expert Opinion)

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**CLINICALLY LOCALIZED PROSTATE CANCER:
AUA/ASTRO/SUO GUIDELINES
ACTIVE SURVEILLANCE:**

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

ACTIVE SURVEILLANCE:

-Localized prostate cancer patients who **elect active surveillance should have accurate disease staging including systematic biopsy with ultrasound or MRI-guided imaging.**

(Clinical Principle)

-Localized prostate cancer patients undergoing **active surveillance should have routine surveillance PSA testing and digital rectal exams.** (Strong Recommendation; Evidence Level: Grade B)

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINE

ACTIVE SURVEILLANCE:

Localized prostate cancer patients undergoing active surveillance **should be encouraged to have a confirmatory biopsy within the initial two years and surveillance biopsies thereafter.** (Clinical Principle)

Clinicians may consider multiparametric prostate MRI as a component of active surveillance for localized prostate cancer patients. (Expert Opinion)

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

ACTIVE SURVEILLANCE:

Clinicians should offer **definitive treatment to localized prostate cancer patients undergoing active surveillance who develop adverse reclassification.** (Moderate Recommendation; Evidence Level: Grade B)

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Active Surveillance of prostate Cancer: Advances for more Accurate Risk assessment:

Active surveillance of prostate cancer is being increasingly utilized with low risk cancer, but there are some men with potentially life-threatening cancers that are inadvertently enrolled in active surveillance.

The 4Kscore test: for men with elevated PSA the role of 4ksocre has stablished role to identify those at low risk harboring a high-grade (Gleason 7 of higher)

Patients with intermediate –risk tumors (**Gleason7**) **are more likely to metastasize on active surveillance**. In this groups the decision on immediate TX or active surveillance is particularly difficult. The 4Kscore can be helpful in predicting the risk that these patients harbor a high grade cancer (Gleason 7 o higher)

MSKCC Peter Scardino October 12, 2017

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Active Surveillance of prostate Cancer: Advances for more Accurate Risk assessment:

The 4KScore Test:

The **4KScore** algorithm incorporates **four protein biomarkers in blood PSA, Free PSA Intact PSA and Human Kallikrein 2 along with age DRE and history and prior biopsy results.**

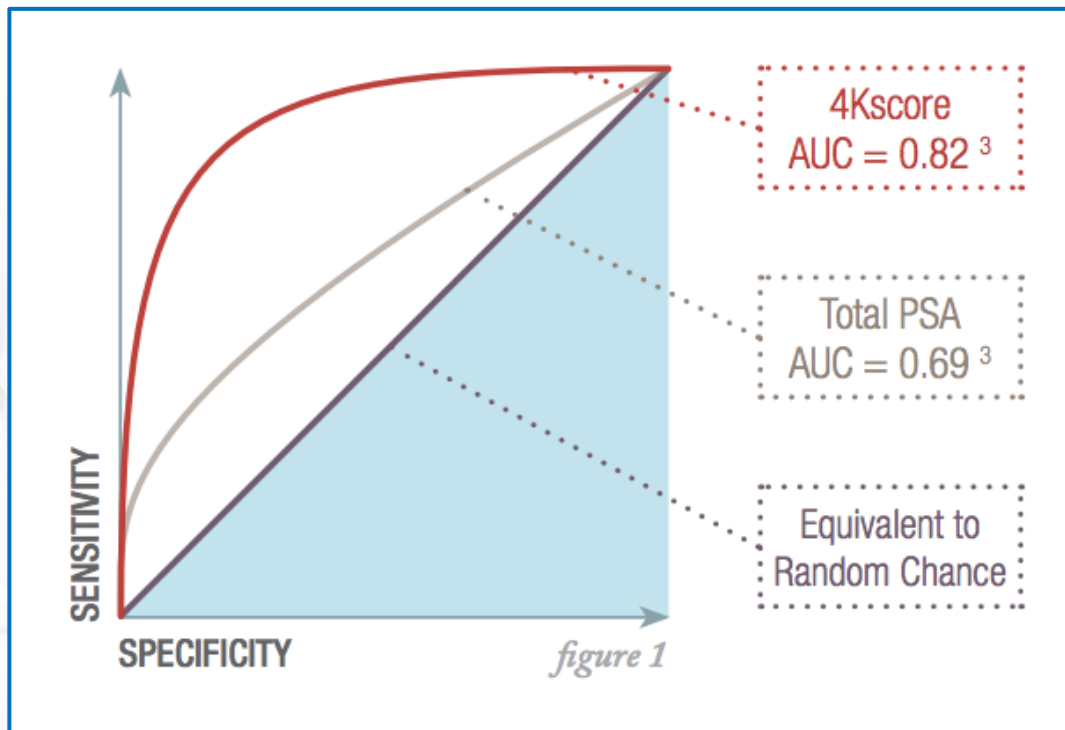
The results provides the probability that a patients has a Gleason 7 or higher prostate cancer

Results: **Prospective US Clinical Trial. 1.012** men schedule for prostate BX because of abnormal PSA. **The study demonstrated that a 30 to 58 % of biopsies could have been eliminated if the 4Score test had been used as diagnostic tool prior to the Biopsy.**

Future **Advances LIQUID Biopsies**

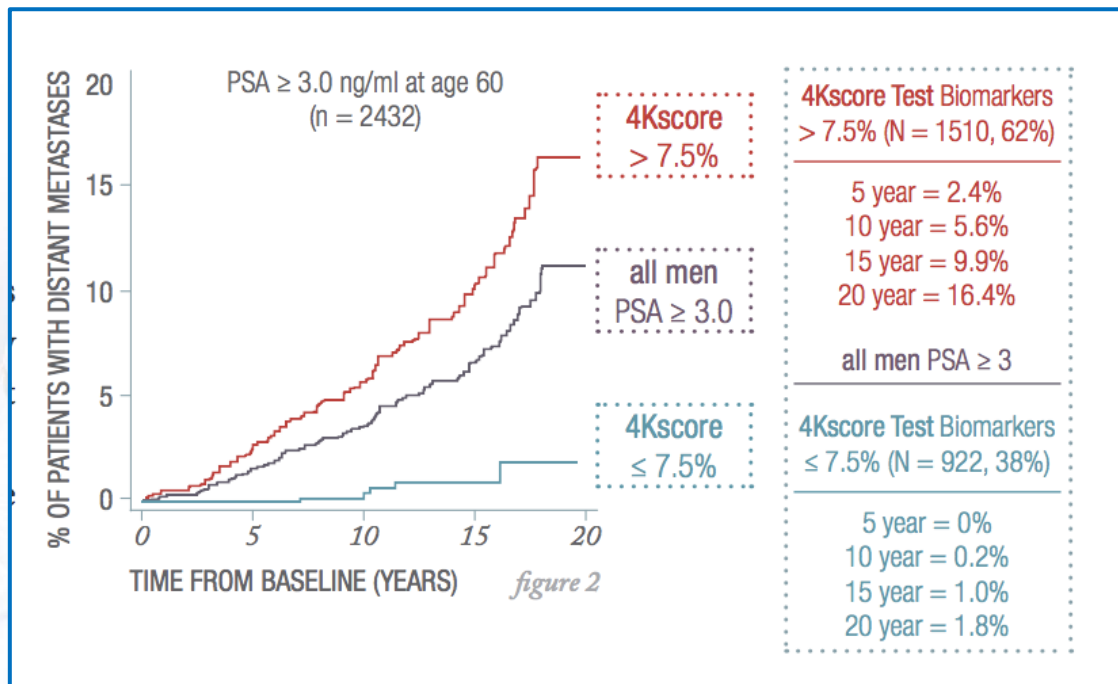
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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

OTHER IMPORTANT RECOMENDATIONS: **RADIOTHERAPY**

Clinicians may offer single modality external beam radiotherapy or brachytherapy for patients who elect radiotherapy for low-risk localized prostate cancer. (Clinical Principle)

Clinicians may offer external beam radiotherapy or brachytherapy alone or in combination for favorable intermediate-risk localized prostate cancer. (Clinical Principle)

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

OTHER IMPORTANT RECOMENDATIONS: **RADIODTHERAPY**

Clinicians should offer 24-36 months of ADT as an adjunct to either external beam radiotherapy alone or external beam radiotherapy combined with brachytherapy to patients electing radiotherapy for high-risk localized prostate cancer. (Strong Recommendation; Evidence Level: Grade A)

Clinicians should **inform** localized prostate cancer patients that use of ADT with radiation increases the likelihood and severity of adverse treatment-related events on sexual function in most men and can cause other systemic side effects. (Strong Recommendation; Evidence Level: Grade B)

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

OTHER IMPORTANT RECOMENDATIONS **RADIOTHERAPY:**

Clinicians should consider moderate hypofractionation to localized prostate cancer patient (of any risk category) and clinician should decide on external beam radiotherapy to the prostate (**without nodal radiotherapy**). (Moderate Recommendation; Evidence Level: Grade B)

For localized prostate cancer patients with **obstructive**, non-cancer-related lower urinary function, surgical approaches may be preferred. If radiotherapy is used for these patients or those with previous significant transurethral resection of the prostate, low- dose rate brachytherapy should be discouraged. (Moderate Recommendation; Evidence Level: Grade C)

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

OTHER IMPORTANT RECOMENDATIONS **PROSTATECTOMY:**

- Clinicians should inform localized prostate cancer patients that **younger or healthier men** (e.g., <65 years of age or >10 year life expectancy) are more likely to experience cancer control benefits from prostatectomy than older men. (Strong Recommendation; Evidence Level: Grade B)
- *Clinicians should inform localized prostate cancer patients that open and robot-assisted radical prostatectomy offer similar cancer control, continence recovery, and sexual recovery outcomes*.** (Moderate Recommendation; Evidence Level: Grade C)
- Clinicians **should not treat** localized prostate cancer patients who have elected to undergo radical prostatectomy **with neoadjuvant ADT** or other systemic therapy outside of clinical trials. (Strong Recommendation; Evidence Level: Grade A)

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

OTHER IMPORTANT RECOMENDATIONS: **PROSTATECTOMY**

Clinicians should inform localized prostate cancer patients with unfavorable intermediate -risk or high-risk prostate cancer about benefits and risks related to the potential option of **adjuvant radiotherapy when locally extensive prostate cancer is found at prostatectomy**. (Moderate Recommendation; Evidence Level: Grade B)

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Consensus and Controversies in Cancer of Prostate

Table 4. Care Options for Localized Prostate Cancer by Level of Evidence and Strength of Recommendation¹

Evidence Level/ Recommendation Strength	Prostate Cancer Severity/Aggressiveness				
	Low Risk		Intermediate Risk		High Risk
	Very Low Risk	Low Risk	Favorable	Unfavorable	
A / Strong	Active Surveillance	NA	Radical Prostatectomy OR Radiotherapy ² with Androgen Deprivation Therapy	Radical Prostatectomy OR Radiotherapy ² with Androgen Deprivation Therapy	Radical Prostatectomy OR Radiotherapy ² with Androgen Deprivation Therapy
B / Moderate	NA	Active Surveillance	Radiotherapy ² without Androgen Deprivation Therapy	NA	NA
B / Conditional	NA	Radical Prostatectomy OR Radiotherapy ²	NA	NA	NA
C / Conditional	NA	Cryosurgery (whole gland)	Active Surveillance OR Cryosurgery (whole gland)	Cryosurgery (whole gland)	NA
No evidence / clinical principle or expert opinion	NA	Focal Ablative Therapy OR High Intensity Focused Ultrasound	Focal Ablative Therapy OR High Intensity Focused Ultrasound	Focal Ablative Therapy OR High Intensity Focused Ultrasound	NA

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

OTHER IMPORTANT RECOMENDATIONS: **RADIOTHERAPY**

Clinicians should inform localized prostate cancer patients who are considering **proton** beam therapy that it offers no clinical advantage over other forms of definitive treatment.

(Moderate Recommendation; Evidence Level: Grade C)

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

OTHER IMPORTANT RECOMENDATIONS: **RADIODTHERAPY**

Important new issues in Prostate Cancer:

1-Management of Oligometastasis

2-Role of Molecular Biology in Prostate Cancer

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Active Surveillance of prostate Cancer: Advances for more
Accurate Risk assessment:

METHOD Total PSA and Free PSA are measured using FDA-
approved kits from Roche Diagnostics which uses quantitative
electrochemiluminescence (ECLIA) methodology. The
BioReference proprietary assays, Intact PSA and hK2, are
laboratory developed tests validated by BioReference and are
run on the auto-DELFI by Perkin-Elmer and uses DELFIA
(dissociation-enhanced lanthanide fluorescent immunoassay)

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Oligomestasis

Meaning to have less than 3-5 metastasis:

General concept: Patients with localized disease could be cured by surgery or Radiation and patients with metastatic disease are treatable but not Curable with current therapies.

There there however some provocative new data, generally lower level of evidence – retrospective data- and recent prospective trials _high level of evidence- that suggest of given local therapy to those with few metastasis may increase survival. Long time without disease progression and/ or be cured.

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Oligomestasis

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINE

Care options by cancer severity/Risk Group:

Very low/Low-Risk Disease:

- Not perform CT, o routine BS in staging**

- Recommend active surveillance (Grade A)**

- Recommend definitive TX to who may have probability of progression on active surveillance. (Grade B)**

- Should't add ADT along with RT, except to reduce size for BQT.**

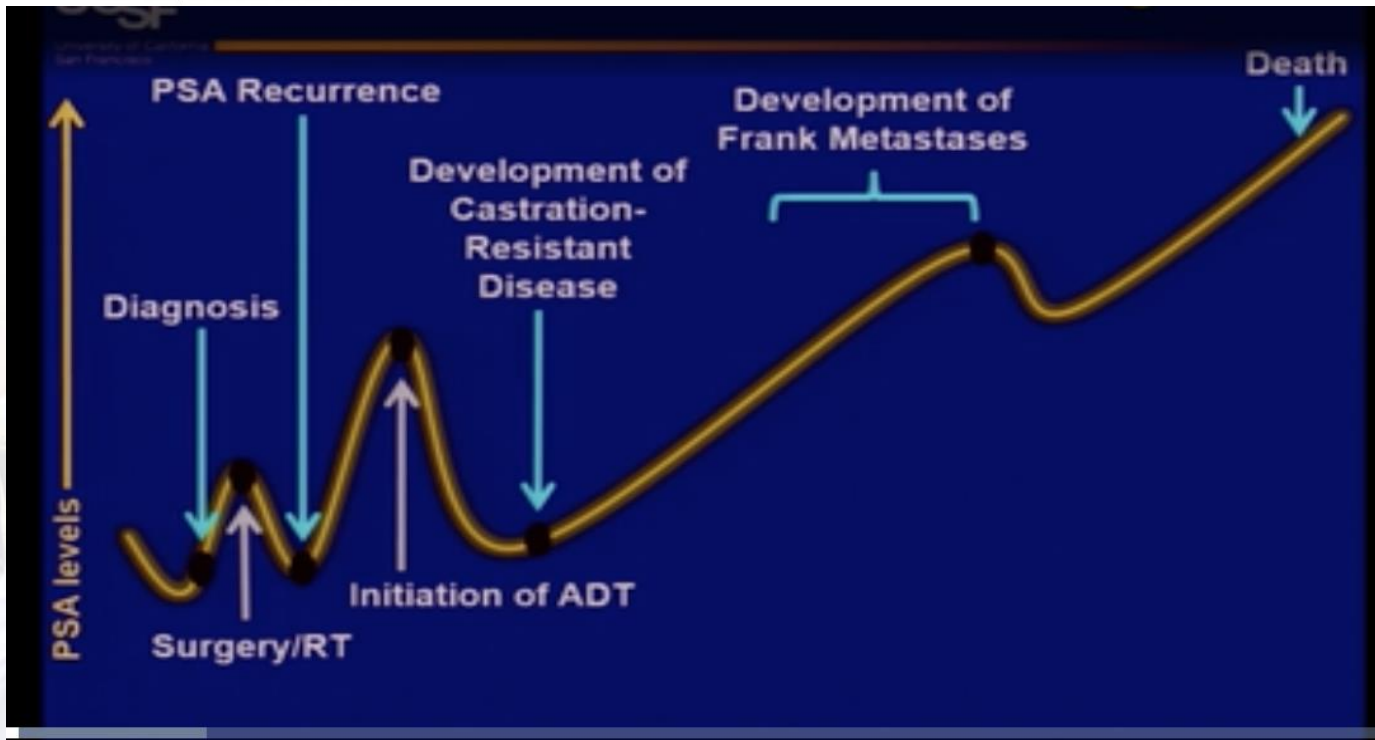
- should informed pts that consider Cryosurgery may have side effects and survival benefits are unknown. (Grade C)**

- That HIFU are not standard (Grade B)**

- Genomic biomarkers have not shown a role in selectintion of care**

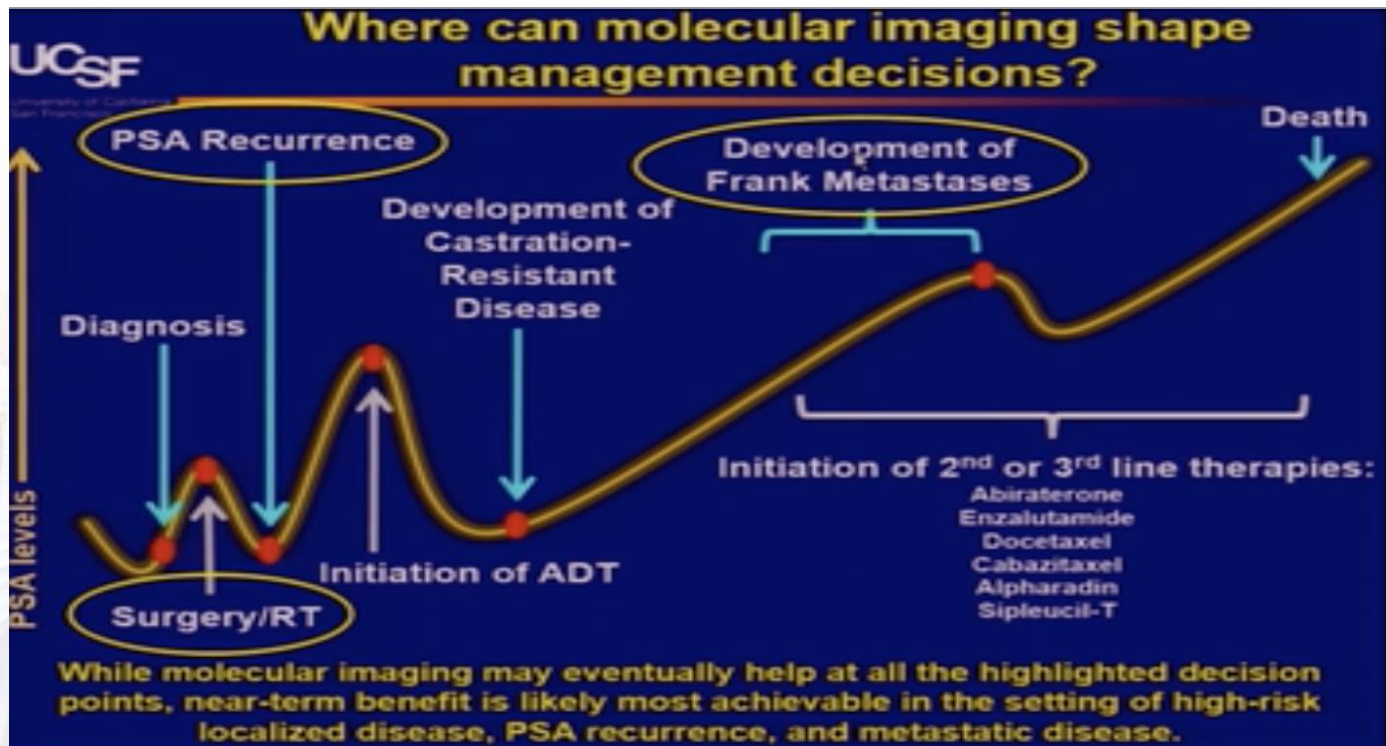
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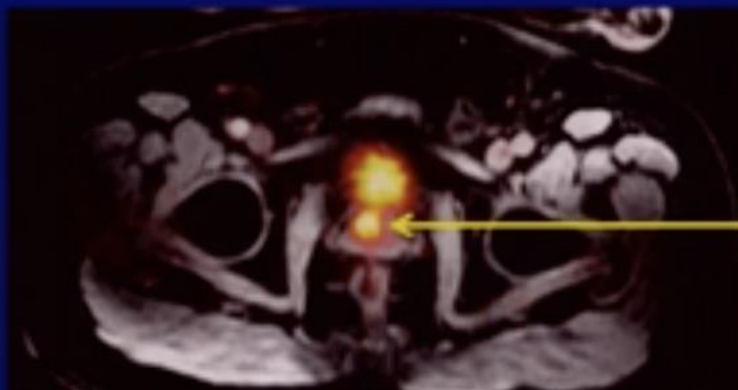
Consensus and Controversies in Cancer of Prostate



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1) Is there a large dominant nodule in the prostate? More than one? Bilateral?

- This may have implications for if and how we intensify local therapy with a brachytherapy boost



If we treat with brachytherapy, we would tailor a plan to increase the radiation dose in this area

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Consensus and Controversies in Cancer of Prostate

- **When patients have a PSA recurrence after prostatectomy or RT, the clinician does not know where the prostate cancer is**
 - For post-prostatectomy PSA recurrences, patients are often treated with RT to the surgical bed, for presumptive local recurrences – with failure rates of >50%, likely because there was distant disease outside of the RT field.

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NCCN Screening guidelines

The NCCN recommends performing a baseline evaluation, with a history and physical examination that includes the following:

- Family history
- Medications
- History of prostate disease and screening, including prior PSA and/or isoforms, exams, and biopsies
- Race
- Family or personal history of *BRC1/2* mutations

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

Care options by cancer severity/Risk Group:

Intermediate-Risk Disease:

Should stage with CT and BS

Recommend Radical S or RT plus ADT as standard TX. (Grade A)

Could be Treated with RT alone but evidence is less robust than combined with ADT. (Grade B)

may consider other Tx. such as Cryosurgery (Grade C)

Recommend WW for men with life expectancy ≤ 5 years

That focal therapy or HIFU are not standard.

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

Care options by cancer severity/Risk Group:

High Risk Disease:

Stage with CT, or MRI and BS

Recommend RP or RT plus ADT as standard options for localized
Disease

Do not recommend active Surveillance

Cryosurgery or Focal Tx HIFU are not recommended

Should not recommend primary ADT unless patient has both limited
life expectancy and local symptoms

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Active Surveillance of prostate Cancer: Advances for more Accurate Risk assessment:

Recent Active Surveillance Trials Results:

Report on 731 men randomly assigned to Radical Prostatectomy or observation for nearly 20 years.

Overall those assigned to prostatectomy had similar risks of death from any Cause of from prostate cancer as the observation group. However for men with the intermediate-risk cancers surgery led to 14.5 % fewer deaths from all causes than observation.

MSKCC Peter Scardino October 12, 2017

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

Radiotherapy:

May offer single modality EXBRT or BQT for low risk localized Pts

EXBRT or BQT or in combination for Intermediate Risk Pts.

Should offer ADT 24-36 months as adjunct to the above

recommendation

5-8 de noviembre de 2017

CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

Radiotherapy:

-Informed Pts. that ADT increase likelihood of severity of Side effects

Consider moderate Hypofractionation for localized (for any Risk).

*Clinician decide on EXBRT to the prostate (without nodal RT)

Pts. With obstructive symptom's surgery may be preferred.

Protons offers no clinical advantage over other forms of Rt

Consider BQT has similar effects as EXBRT with regards to ED, proctitis and exacerbate urinary symptoms

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CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

OTHER IMPORTANT RECOMENDATIONS: **RADIODTHERAPY**

Clinicians should inform localized prostate cancer patients considering brachytherapy that it has similar effects as external beam radiotherapy with regard to erectile dysfunction and proctitis but can also exacerbate urinary obstructive symptoms. (Expert Opinion)

5-8 de noviembre de 2017

CLINICALLY LOCALIZED PROSTATE CANCER: AUA/ASTRO/SUO GUIDELINES

INTERMEDIATE –RISK DISEASE

-Clinicians should inform intermediate-risk prostate cancer patients who are considering focal therapy or **HIFU** that these interventions are not standard care options because comparative outcome evidence is lacking. (Expert Opinion)

5-8 de noviembre de 2017