Nerve-Sparing Prostatectomy Does Not Benefit Everyone
Benefits Limited Mainly to Men with Strong Sexual Function Before Surgery

Bilateral nerve-sparing (BNS) radical prostatectomy (RP) resulted in better sexual and urinary function outcomes than unilateral or nonnerve-sparing (UNS) RP, but the difference reached significance only in men with a high baseline level of sexual function, according to the CEASAR (Comparative Effectiveness Analysis of Surgery and Radiation) study.

“The population-based, prospective, observational study reported that BNS surgery was associated with improved recovery of sexual and urinary function (UF) three years post-RP for localized prostate cancer (PCa, 6.1 points, P=0.004), vs. unilateral nerve-sparing (UNS) RP and NNS RP,” reported Daniel Barocas, MD, of Vanderbilt University Medical Center in The Journal of Urology.

The changes were assessed using patient-reported sexual and urinary functions on the 26-item Expanded Prostate Index Composite (EPIC), with similar changes for both sexual and UF in men with high baseline (8.23 points, a statistically significant difference, P=0.014) but not in those with low baseline function (4.0 points, P=0.090), authors reported.

Final analysis of the study included 991 men diagnosed with localized PCa in 2011 to 2012, who had primary RP treatment with documented nerve-sparing status, and did (Continued on page 4)

EBRT with Brachytherapy Matches Surgery for Prostate Cancer
Worse Survival Without Boost in High-Risk Patients

Men with high-risk localized prostate cancer had similar survival with surgery or with the combination of external beam radiotherapy (EBRT) plus brachytherapy (BT), according to a retrospective review of >40,000 cases.

After adjustment for lymph node status, Gleason score, clinical T stage, and other factors, the resulting survival hazard for radical prostatectomy (RP) vs. combined RT did not achieve statistical significance and numerically favored the nonsurgical approach (Hazard Ratio [HR] 1.17, 95% Confidence Interval [CI] 0.88-1.55). The addition of androgen deprivation therapy (ADT) to RT did not improve survival as compared with EBRT plus BT without ADT.

“Men who had EBRT plus ADT, but no BT, had a significantly greater mortality risk vs. surgery,” reported Ronald D. Ennis, MD, of Rutgers Cancer Institute of New Jersey in New Brunswick, and colleagues in the Journal of Clinical Oncology.

“After comprehensively adjusting for imbalances in prostate cancer prognostic factors, other medical conditions, and socioeconomic factors, this analysis showed no statistical difference in survival between men treated with RP vs. EBRT plus BT with or without ADT,” the authors concluded. “EBRT plus ADT was associated with lower survival.”

“In the absence of randomized trials, these data, in conjunction with patient- (Continued on page 5)
Ultrahypofractionated Radiotherapy for Prostate Cancer is Safe and Effective

Radiotherapy (RT) given in high doses over a shorter period of time is safe and effective for men with prostate cancer, according to research from a phase III trial presented at the European Society for Radiotherapy & Oncology (ESTRO) 37 Conference (Abstract OC-0599). Ultrahypofractionated RT (UHRT) is given every other day in the hospital for 2.5 weeks vs. standard RT where treatment is given every weekday for eight weeks. Researchers say this method of giving RT saves time for patients. It also frees up RT equipment, saving money to benefit other patients on the waiting list for RT.

The study was presented by Anders Widmark, MD, PhD, a senior consultant based in the department of radiation sciences and cancer center at Umeå University, Sweden. He said, “We already know that RT can destroy cancer cells in the prostate, and that it has advantages over surgery and hormone therapy because it is less likely to cause impotence or incontinence. However, RT requires expensive specialist equipment, and patients can end up on a waiting list for treatment. UHRT offers a number of practical benefits to men and time and cost-savings for hospitals, so we wanted to test if it is as safe and effective as standard RT.”

The researchers conducted a trial with 1,200 men who were treated at 12 hospitals in Sweden and two in Denmark between July 2005 and November 2015. All had been diagnosed with medium or high-risk cancer, when clinical factors suggest there was a risk that the cancer could spread if it was not treated. No one had received treatment to block the male hormone testosterone, which can stimulate prostate tumors to grow.

Half of patients received standard RT of 39 treatments, each with a standard RT dose of two Gray (Gy), spread over eight weeks (78 Gy in total). The other half were treated with ultrahypofractionated RT with seven treatments of high-dose RT of 6.1 Gy, every other week-day for 2.5 weeks (42.7 Gy in total). Patients were monitored for an average of five years following treatment to see whether their cancer returned, indicated by a rising PSA level and whether or not they suffered any side effects.

Researchers found that at five years post-RT, 83.8% of men given standard RT had no signs of cancer recurrence. For those treated with UHRT, the figure was 83.7%. Men given UHRT suffered slightly worse side effects at the end of RT, however, long-term side effects were the same as men who were given the standard treatment.

Dr. Widmark added, “Previous research has already shown that it’s possible to increase individual doses and give them over 4 to 5 weeks. Now we have shown that we can condense the therapy further, raising the dose at each hospital visit so that the whole schedule lasts only 2.5 weeks. This is the first large patient trial of this kind, and it shows that ultrahypofractionated RT is just as effective as standard RT at stopping prostate cancer from returning. Importantly, it also shows that men treated in this way do not suffer any more side effects than those treated with conventional RT.”

The ASCO Post, 27 April 2018

Long-Term Outcomes of Adjuvant Treatment in High-Risk Prostate Cancer

As reported by Hussain, et al. in the Journal of Clinical Oncology, long-term follow-up of the phase III SWOG 9921 trial showed that the addition of adjuvant mitoxantrone and prednisone (MP) to androgen-deprivation therapy (ADT) did not improve survival and increased death from other malignancies in high-risk prostate cancer. Outcomes reported with two years of ADT were encouraging. Study accrual was halted in 2007 as a result of a higher leukemia incidence in the group receiving MP. Result of long-term follow-up was initially reported in April at the SWOG (Southwest Oncology Group) Spring 2018 Group Meeting.

In the trial, 961 patients were randomized between October 1999 and January 2007 to receive six cycles of MP plus ADT (bicalutamide and goserelin [Zoladex®]) for two years (n=480) or ADT alone (n=481) after radical prostatectomy (RP). Patients had to have clinical tumor stage cT1–T3N0 disease with ≥ 1 high-risk factor after RP, consisting of Gleason score ≥ 8; pT3b, pT4, or pN+ disease; Gleason score = 7 and positive margins; or preoperative PSA >15 ng/mL, biopsy Gleason score >7, or PSA >10 ng/mL plus biopsy Gleason score > 6. The primary endpoint was overall survival.

Median follow-up was 11.2 years. Estimated 10-year overall survival was 87% in the ADT group vs. 86% in the ADT-plus-MP group (hazard ratio = 1.06, 95% confidence interval = 0.79–1.43). Estimated 10-year disease-free survival was 72% in both groups. Among all deaths, (Continued on page 8)
Doc Moyad’s What Works & What is Worthless Column – Also Known as “No Bogus Science” Column

“The Ripple Effect – Another Reason to Lose Weight?!”

Mark A. Moyad, MD, MPH, University of Michigan Medical Center, Department of Urology

Editor’s Note: Us TOO invites certain physicians and others to provide information and commentary for the Hot SHEET to enrich its content to empower the reader. This column contains the opinions and thoughts of its author and are not necessarily those of Us TOO International.

I can give you 1,000 reasons why you should try to achieve a healthy weight or just pay more attention to your diet and lifestyle, but how about a new one? It’s called the “Ripple Effect.” as you become healthier, the people around you take serious notice! I call it the “Moyad Copycat effect.” And it is annoying!

There are very few things that actually annoy me about my wife/girlfriend/soulmate/best friend/lover... However, I can give you one thing about her that makes me crazy. Regardless of what I do, I cannot keep up with her attention to her health, including her diet and exercise routine. She, non-arguably, has some of the healthiest behaviors in a human being I have ever met! Drink too much? Nope! Eats unhealthy meals once in a while? Nope! Misses her exercise class? No! It is disgusting!

However, over the years I’ve realized that being around her has forced me to step up my game and take better care of myself. This is an example of the “Ripple Effect.” And, it exists throughout all medicine. For example, in a recent study of a famous weight loss program (aka Weight Watchers), around one-third of the spouses that were not involved in the program achieved clinically meaningful weight loss! In other words, when one spouse is losing weight and becoming healthier, the other spouse becomes motivated to become healthier! This “two for one effect” not only results in more healthy individuals, but it does so at a lower cost (two for the price of one). Even in the study’s control group, where individuals were given “self-guided” advice (aka just four pages of healthy advice) the spouses of these individuals also lost weight! WOW! WOW spelled backwards! Thus, weight loss occurs with couples in structured and non-structured weight loss programs. The best line in this study is this: “This study adds to growing literature suggesting that weight and weight change within married couples is highly interdependent.” And, in my experience, I agree! Regardless, I am still annoyed by my wife and hope to manipulate the “Ripple Effect” in my superficial favor soon. How? I am going to show her that massive/big screen televisions we can purchase for our home (including the bathrooms) solely for the purpose of watching exercise classes (aka “pro/college sports”) will lead to our becoming a healthier couple! GENIUS!

Reference:


Gleason 4+3 vs. 3+4 Prostate Cancer Tied To Higher Risk of Metastasis at Diagnosis

Men with Gleason score (GS) 4+3 prostate cancer (PCa) have a three-fold higher risk of distant metastases at diagnosis than men with GS 3+4 PCa, according to a study published in Urology Annals (Vol. 10, pp. 203-208, 2018).

Mohamed H. Kamel, MD, of the University of Arkansas for Medical Sciences, et al. retrospectively reviewed 1,402 medical records of men presenting to five Veterans Affairs hospitals with GS 7 PCa. The cohort consisted of 1,050 and 352 men with GS 3+4 and 4+3 prostate cancer, respectively.

The two groups were similar with respect to sociodemographic and clinical characteristics. The mean ages of the GS 3+4 and GS 4+3 groups were 63.6 and 65.4 years, respectively. The racial composition was 49.5% white and 49.4% black vs. 45% white and 53% black in the GS 3+4 and GS 4+3 groups, respectively.

A significantly higher proportion of men in GS 4+3 group than the GS 3+4 group had distant metastases at diagnosis (2.8% vs. 0.9%), the investigators reported. In addition, the study found that average PSA levels were significantly higher in the GS 4+3 group than the GS 3+4 group (18 vs. 11.4 ng/mL). Dr. Kamel’s team found no statistically significant difference in overall survival.

The study was limited by its retrospective, non-randomized approach to the review of medical information, the authors noted.

Prostate Cancer Advisor
3 May 2018

Predictors Identified of Adverse Pathology After Radical Prostatectomy for Prostate Cancer

“Higher PSA levels and a larger number of positive prostate biopsy cores are associated with adverse pathologic features following radical prostatectomy (RP) for low-risk prostate cancer (PCA),” according to investigators.

In a study of 546 patients who underwent RP for low-risk PCa, investigators concluded that a PSA level greater than 4.5 ng/mL and the presence of more than two positive biopsy cores are the optimal values for predicting adverse pathologic features (APFs) – positive surgical margins (PSMs) and extracapsular extension (ECE)/seminal vesicle invasion (SVI) – following RP.

“Physicians should be aware of these parameters, which can predict APFs, and should avoid under-treatment of these patients,” Jae Won T, et al. Obesity 26: 499-504, 2018

Renal and Urology News
14 May 2018
Nerve-sparing RP Does Not Help Everyone

(Continued from page 1)

not have androgen-deprivation therapy (ADT). Overall, 80% of the men underwent robotic RP — while 19% and 1% were treated with an open RP or other approach. The analysis grouped 11 men treated with UNS and 75 men with NNS RP, the group noted. The response rates at six, 12 and 13 months were 98, 96 and 88%, respectively, and were similar in the two groups.

Study limitations included potential misclassification of nerve-sparing status from medical reports, and the limited number of men who underwent NNS or UNS.

In a contemporary practice, BNS appeared to have the most benefit in men with high baseline sexual function: “Men with anything less than excellent erectile function (EF), i.e. initially in the top quartile, did not have a good outcome,” stated Barocas.

“That tells us that maybe it’s not appropriate to raise the hopes of those men that they will have good EF... it is not worth the incremental risk of positive margin — although we failed to find one.”

“In addition,” he said, “it is important to acknowledge that 44% of the men who underwent RP did so for low-risk disease, which could have been observed or undergone active surveillance instead.”

Barocas stated that the findings reflect those of the PROSTQA (Prostate Cancer Outcomes and Satisfaction with Treatment Quality Assessment) study, although results did not reach statistical significance, and CaPSURE (Cancer of the Prostate Strategic Urologic Research Endeavor) study, which only found statistically significant EF recovery from BNS RP in men with high baseline sexual function.

Based on a follow-up study of PROSTQA and CaPSURE data, a predictive model was developed that identified patient age, baseline sexual function, and nerve-sparing status as predictors of EF recovery. “We found that these characteristics, as well as comorbidity, predicted BNS response,” Barocas said. Multivariable analyses found that younger patient age and lower comorbidity were significantly associated with higher three-year sexual domain scores, while race, D’Amico risk, and surgeon case volume were not.

Younger age, non-black racial group, and BNS were associated with better UF scores three years after BNS RP vs. UNS or NNS surgery but, as with sexual function, the benefit of BNS was limited to men with high baseline sexual function (7.5 points, a statistically significant difference, P=0.015), but was not significant in men with low baseline sexual function.

“That nerve-sparing was not associated with improved UF outcomes in men with low baseline sexual function runs counter to previous studies including CaPSURE, which showed improved UF scores with BNS in men in the lowest quartile of baseline sexual function,” the researchers noted. Barocas said “while this finding is hard to explain ... and further study is needed, currently, the hope to preserve UF doesn’t seem to justify nerve-sparing in men with low sexual function at baseline.”

Scott Shello, MD, of Cancer Treatment Centers of America in Metro Atlanta, who was not involved in the study, opined. “It is very important that men are informed about the benefits and harms of screening, and that their preferences are taken into consideration.”

The Task Force’s widely debated 2012 guidelines recommended against screening men ages 55 to 69 (grade D). In 2013, the American Urological Association (AUA) and the American College of Physicians (ACP) recommended a shared decision-making approach for men ages 55-69 and 50-69, respectively.

“Although PSA is not a perfect test, there are many new testing options that can be used in men with an elevated PSA to help make decisions about biopsy” said Loeb. “These include more specific biomarker tests for clinically significant PCa and MRI.”

USPSTF described the number of harms and benefits with PSA screening, which can be quantified over a 10- to 15-year period. They estimate that if 1,000 men were offered a PSA test, 240 would screen positive, leading to positive biopsies in 100. But 20.7% to 50.4% of these men will actually have indolent disease that never grows or metastasizes, according to the evidence report.

Of the 100 men with biopsy-positive PCa, 80 will opt for definitive treatment with surgery or radiotherapy (RT) immediately or after a period of active surveillance (AS). Post-treatment, 50 men will experience long-term erectile dysfunction (ED) and 15 will experience long-term urinary incontinence (UI).

And while 1.3 PCa deaths would be prevented, five men would still die from PCa despite definitive treatment. Krist said that one of the most “critically important” points amidst the data is “whether or not screening is right for man really depends on how he values the potential benefits and harms.”

USPSTF acknowledges in their recommendations that certain groups of men are at higher risk of developing PCa — African Americans (AA) and those with a family history of PCa. However, due to a lack of evidence in their trials, the Task Force doesn’t suggest a different approach for these men. Instead, they suggest that these risk factors be discussed with men during the conversation about risks and benefits of screening.

“The Task Force found itself in this position that we really couldn’t say whether AA men would get any greater benefit from screening, and we really don’t know if they’ll have any greater harms from screening,” said Krist. “We need more studies to understand the benefits and the harms so that clinicians can better counsel patients.”

The new USPSTF guidelines still recommend against screening for men ages 70 and older (grade D). AUA President J. Brantley Thrasher, MD broadly commended the new guidance, however touched upon the guidance for this age group.

“While we agree that a number of older men are not candidates for PCa testing, we believe that select older, healthier men may garner a significant benefit,” he said. (Continued on page 8)
EBRT with Brachytherapy Matches Surgery for Prostate Cancer (Continued from page 1)

reported quality of life, should be shared with patients to help guide their individualized treatment decisions,” they added.

“Though not a randomized trial, the study added to a growing volume of evidence that RT and RP lead to similar survival for men with localized prostate cancer,” said Jeff Michalski, MD, of Washington University in St. Louis. A large British study showed no difference in survival among men with low- and intermediate-risk prostate cancer randomized to RT, RP, or active surveillance. A randomized Canadian study showed a reduced risk of biochemical relapse, but not a survival benefit, with EBRT plus BT vs. dose-escalated EBRT for men with intermediate- and high-risk disease.

Most recently, data from another retrospective review, involving 1,800 men with localized prostate cancer and Gleason score 9-10, showed significantly better five- and 7.5-year prostate cancer-specific mortality with EBRT plus a BT boost vs. EBRT alone or RP.

“I think we’re starting to see that RP isn’t offering much of an advantage over an RT approach,” Michalski stated. “The caveat is that these aren’t prospective studies looking at these high-risk groups of men. It is conceivable that subtle selection differences exists, which we may never be able to control outside the context of a randomized study.”

“The study’s failure to show an additional survival benefit with ADT should be interpreted cautiously,” Michalski added, noting that multiple trials of high-risk patients have demonstrated a benefit with hormone therapy.

“It’s hard to abandon the benefit that treatment (ADT) provides,” he said.

Based on 2004 to 2013 data from the National Cancer Data Base, the study included 42,765 men with localized but high-risk prostate cancer, defined as clinical stage T3-T4, biopsy Gleason score 8-10, or pretreatment PSA >20 ng/mL. The cohort comprised 24,688 men who underwent RP, 15,435 who had primary EBRT plus ADT, and 2,642 who had EBRT plus BT with or without ADT.

The authors reported that 2,342 men died, and median follow-up among survivors was 36.3 months and ranged from days to almost 12 years. In addition to the primary analysis, investigators performed three sensitivity analyses: EBRT plus ADT stratified by total RT dose (<7,920 cGy vs ≥7,920 cGy); EBRT plus BT with or without ADT; and interaction between comorbidity score and the type of treatment.

The data showed no difference in survival for men treated by RP vs. those who had EBRT plus BT. The addition of BT did not change the results. Men who had EBRT with ADT but no BT had more than a 50% increase in the survival hazard vs. RP (HR 1.53, 95% CI 1.22-1.92). The sensitivity analysis showed that an EBRT dose ≥7,920 plus ADT reduced, but did not eliminate, the increased survival hazard vs. RP (HR 1.33, 95% CI 1.05-1.68).

The author of an accompanying editorial reiterated the limitations of retrospective analyses and encouraged clinicians to recognize personal biases when interpreting such data.

“For each clinician interpreting retrospective results along with, or in absence of, clinical trial data, recognizing our own biases ... to assess the quality and believability of each study can potentially remove the greatest confounder of all,” wrote Ronald Chen, MD, of University of North Carolina at Chapel Hill.

MedPage Today
25 April 2018

Prostate and Lung Cancers Are Expected to Be the Most Common Cancer Types Among HIV-Infected Adults by 2030

While effective antiretroviral therapy, which suppresses HIV replication and improves immune function, has resulted in increased longevity for people living with HIV and reduced the risk of certain cancers, including Kaposi sarcoma and non-Hodgkin lymphoma, other cancers are expected to become more common as this patient population ages.

According to a population-based study investigating the projected cancer incidence rates among adults living with HIV, by 2030 prostate and lung cancers are expected to be the most common cancers in this population. The study findings show that cancer will remain an important comorbid condition as people with HIV live longer and age, highlighting the need for expanded access to HIV therapies and cancer prevention, screening, and treatment. The study by Shiels, et al. is published in Annals of Internal Medicine.

The researchers used population-based data on HIV and cancer to project cancer incidence rates in the adult HIV population and the HIV Optimization and Prevention Economics (HOPE) model to forecast the number of people living with HIV through 2030, and then calculated projected cancer burden.

Cancer incidence in this population was estimated from the National Cancer Institute’s HIV/AIDS Cancer Match Study. The researchers applied those rates to projections of the number of HIV-infected people from the Centers for Disease Control and Prevention to estimate the future cancer burden.

According to the study findings, by 2030, the proportion of adult people living with HIV in the United States aged 65 years or older is projected to increase from 8.5% in 2010 to 21.4% in 2030. Age-specific rates are projected to decrease through 2030 across age groups for Kaposi sarcoma, non-Hodgkin lymphoma, cervical cancer, lung cancer, Hodgkin lymphoma, and other cancer types combined, and among those aged 65 years or older for colon cancer.

However, prostate cancer and lung cancer rates are projected to increase. The estimated total cancer burden in people living with HIV will decrease from 8,150 cases in 2010 (2,730 of AIDS-defining cancer [ADC]) and 5,420 cases in 2010 (2,730 of AIDS-defining cancer [ADC]) to 6,690 cases in 2030 (720 of ADC and 5,980 of NADC). In 2030, prostate cancer (n = 1,590) and lung cancer (n = 1,030)

(Continued on page 6)
Men Much Less Likely Than Women to Get BRCA Testing, Despite Risks

Although BRCA1/2 mutations put men at increased risk of breast, prostate and other cancers, they are significantly less likely than women to have genetic testing for these variants, studies show. “We often hear about the risk of breast and ovarian cancer in women with BRCA1/2 mutations, but what is less often appreciated are the cancer risks to men with BRCA1/2 mutations,” Dr. Christopher Childers of the University of California, Los Angeles and Kimberly Childers of Providence Health and Services Southern California told Reuters Health in a joint email.

“Men with BRCA1/2 mutations – primarily BRCA2 – have a 100-fold higher risk of breast cancer than average; they are also at increased risk of often aggressive, early-onset, prostate cancers, as well as pancreatic cancer and melanoma,” they said.

“Once a mutation carrier is identified, an important next step is to help identify other individuals in the family who may have the mutation and encourage them to get tested,” they note. “Male relatives are equally as likely to carry a mutation as are their female relatives.”

The two researchers and their colleagues analyzed data from the 2015 U.S. National Health Interview Survey, which involved a representative sample of adults age 18 or over. Those who received genetic testing were asked if their test was for breast, ovarian, colon, rectal or other cancer.

As reported online, April 26 in JAMA Oncology, 378 adults reported a history of genetic testing for cancer, representing 2,498,842 people in the weighted subsample.

Compared to the overall sample, the genetic testing subsample included a lower proportion of Hispanics (10% vs. 16%), uninsured individuals (2% vs 10%), and subjects with only high school or General Educational Development diplomas (30 vs. 44%).

Close to three times as many women were tested as men (73 vs. 27%). The disparity persisted for unaffected men, who tested at half the rate of unaffected women (relative risk, 0.51).

Three-quarters of genetic testing was for BRCA-related cancers, 24% for colorectal cancer, and 22% for other cancers. Among the unaffected population, men underwent testing for BRCA mutations at one-tenth the rate of women (RR, 0.10).

However, there were no gender disparities for colorectal or other cancer testing.

“This latter point suggested to us that it is not that men are overall less likely to obtain genetic testing, but rather that men are getting tested specifically for (BRCA mutations) much less often,” Childers said.

“Future research needs to focus on why men are not getting genetic testing, and more importantly, to find ways to increase testing in men,” they conclude.

“Previous studies have shown that men don’t necessarily understand the importance of a breast/ovarian cancer gene mutation — that it is more of a ‘feminine’ issue — but this couldn’t be further from the truth.”

Dr. Marleen Meyers, director of the Perlmutter Cancer Center Survivorship Program at NYU Langone Health in New York City, told Reuters Health, “Men with genetic mutations may have a higher than average lifetime risk for breast, colon and prostate cancer among others. Their children may also have a significantly increased risk of...”
P1, “Nerve-Sparing...” A major advance in the surgical management of prostate cancer was the development of the nerve-sparing radical prostatectomy (RP). Since then, men have been told that they have an excellent chance of regaining spontaneous erections with nerve-sparing surgery without a consideration of the pre-op level of sexual functioning. The report by Barocas and colleagues illustrates that point, although the study is not randomized and only a small number of men had unilateral or non-nerve-sparing surgery. Going forward, men need better counseling when weighing their options. A simple questionnaire (IEFF) can give a numerical value to a man’s erections with the score ranging from 0-25. The likelihood of regaining erections declines as the score declines. Although not studied adequately, men with a score under 20 have a very small chance of resuming normal sexual function. One suggestion is before a man decides to have surgery, the IEFF score should be done and the result used to provide more truthful odds that erections will return.

The Bottom Line: The success of nerve-sparing RP greatly depends on a man’s preoperative function. More accurate information about his risk should incorporate an assessment of his function.

P1, “USPSTF: Prostate...” What to do about screening? The USPSTF has issued yet another set of recommendations, which are more in line with the small but statistically significant benefit. They now recommend that men ages 55-69 have a discussion with their doctors about the risks and benefits and then make an informed decision. They are fairly detailed about the risks and benefits and that information could easily be provided in a one-page document read by patients before their exam. It is highly unlikely that many men have been given this information, but it is extremely important for men to make an informed decision. Without those numbers, men are deciding in the dark. Guidelines for high-risk groups like African-Americans acknowledge the lack of data, which means those men do not really know if they have different risks from treatment or greater odds of benefitting from being screened. The suggestion for older men to individualize their decision based on their life expectancy can also be helpful.

The Bottom Line: Screening recommendations have been updated but still require a shared decision after being informed of the numerical odds of benefit and risk.

P1, “EBRT with...” How should we counsel men with high-risk prostate cancer about their treatment options? Can we say whether RP, radiotherapy (RT) with androgen deprivation therapy (ADT), or RT with brachytherapy with or without ADT is best? New data from a large, but uncontrolled study suggests that EBRT plus brachytherapy matches the survival with RP. The question is whether the result is reliable? The problem is that they found no survival advantage using ADT despite several well-done randomized trials showing the opposite. For now, men should not be told the survival is the same but rather they should be counseled about the risks of each approach. Until a randomized study is done, caution is needed in what men are told.

The Bottom Line: Without a randomized study it is not appropriate to tell men that EBRT plus brachytherapy is an equivalent therapy to RP or RT plus ADT.

P2: “Ultrahypofractionated” Is ultrahypofractionated RT as good as standard dosing for intermediate and high-risk disease? That question was addressed in a prospective, randomized trial involving 1,200 men. They received either 78 Gy of RT in 39 treatments or 42.7 Gy in 2.5 weeks. With five years of follow-up, disease-free survival was not significantly different. Short-term side effects were higher with the new approach but long-term results were similar. Though randomized, neither group received ADT, despite randomized studies proving a survival benefit in these risk groups. Why that was not included is unclear but it weakens the study significantly. Furthermore, without assessing survival it is premature to conclude the treatments are equally effective.

The Bottom Line: A better and longer study is needed to assess the value of ultrahypofractionated RT for intermediate- and high-risk prostate cancer.

P2: “Long-Term Outcomes...” Can mitoxantrone plus prednisone improve survival of high-risk men following RP? That question was evaluated in a randomized trial comparing ADT alone to ADT plus the adjuvant therapy. Sadly, the addition of mitoxantrone did not improve overall survival and it caused more non-prostate cancer deaths. This is a good example of why randomized trials are needed because without them, early benefits are often suggested from phase I, II trials. Furthermore, it illustrates that sometimes more therapy can do more harm than good.

The Bottom Line: Adding mitoxantrone plus prednisone to ADT following RP causes worse overall survival compared to ADT alone in high-risk patients and should not be used.

Resources Address Anxiety, Depression and Prostate Cancer

Many men who are diagnosed with prostate cancer, or are managing the disease, experience some level of anxiety and/or depression. Caregivers may also be affected. The psychosocial challenges surrounding treatment choices and side effect management can have a negative impact on the prostate cancer journey. Anxiety and depression aren’t always effectively treated, in part because the symptoms may not be recognized.

We encourage you to visit the Us TOO web page for information on recognizing and managing anxiety, depression and prostate cancer.

www.ustoo.org/anxiety-and-depression
Meyers concluded. “There are National Comprehensive Cancer Network (NCCN) guidelines for genetic testing that include men, and coverage for testing is often linked to these guidelines.”

“At this time,” she added, “not all men need genetic testing, but it is always important to take a detailed family history, review guidelines and consider genetic testing particularly in multiple cancer families with younger onset of cancer, families with Ashkenazi heritage, and families with male breast cancer.”

“Clinicians should evaluate and screen any male with the above history and refer him to a genetic counselor, as above history and refer him to a genetic counselor, as above history and refer him to a genetic counselor,” Dr. Meyers concluded. “At this time,” she added, “not all men need genetic testing, but it is always important to take a detailed family history, review guidelines and consider genetic testing particularly in multiple cancer families with younger onset of cancer, families with Ashkenazi heritage, and families with male breast cancer.”

“Clinicians should evaluate and screen any male with the above history and refer him to a genetic counselor, as discussion of mutations may be complex. As more men are screened, we will learn more about their risk and prevention options,” Dr. Meyers concluded.

Long-Term Outcomes

(Continued from page 2)

18% in the ADT group vs. 22% in the ADT-plus-MP group were due to prostate cancer and 18% in the ADT group vs. 36% in the ADT-plus-MP group were due to other types of cancers. The investigators concluded, “MP did not improve [overall survival] and increased deaths from other malignancies. The [disease-free survival] and 10-year [overall survival] in these patients treated with two years of ADT were encouraging compared with historical estimates, although a definitive conclusion regarding value of ADT may not be made without a non-treatment control arm.”

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Nerve-Sparing

(Continued from page 4)

study, was asked for comment. “If there is a risk of positive margins with nerve-sparing, is the risk-to-benefit ratio worth it? In this study, the positive margin rates were similar in the two groups – 22.4 vs. 21.8% – but this can be highly influenced by the surgeon’s clinical judgment regarding to whom he offers nerve-sparing based on risk stratification,” he stated.

MedPage Today
25 April 2018

Let Us Help You Plan Your Path Through Every Step of Your Journey...

Us TOO Presents:
Prostate Cancer Pathways for Patients & Caregivers

a New Educational Event and Webcast Series

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9:00 am - 3:30 pm
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(Red Auditorium)
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Kirkland, WA 98034

- Men’s health risks
- Prostate cancer awareness
- Treatment options
- Management of side effects

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