ΘΕΡΑΠΕΥΤΙΚΟΣ ΑΛΓΟΡΙΘΜΟΣ ΒΙΟΧΗΜΙΚΗΣ ΥΠΟΤΡΟΠΗΣ

ΙΩΑΝΝΗΣ ΒΑΡΚΑΡΑΚΗΣ

ΑΝΑΠΛΗΡΩΤΗΣ ΚΑΘΗΓΗΤΗΣ ΟΥΡΟΛΟΓΙΑΣ ΕΚΠΑ

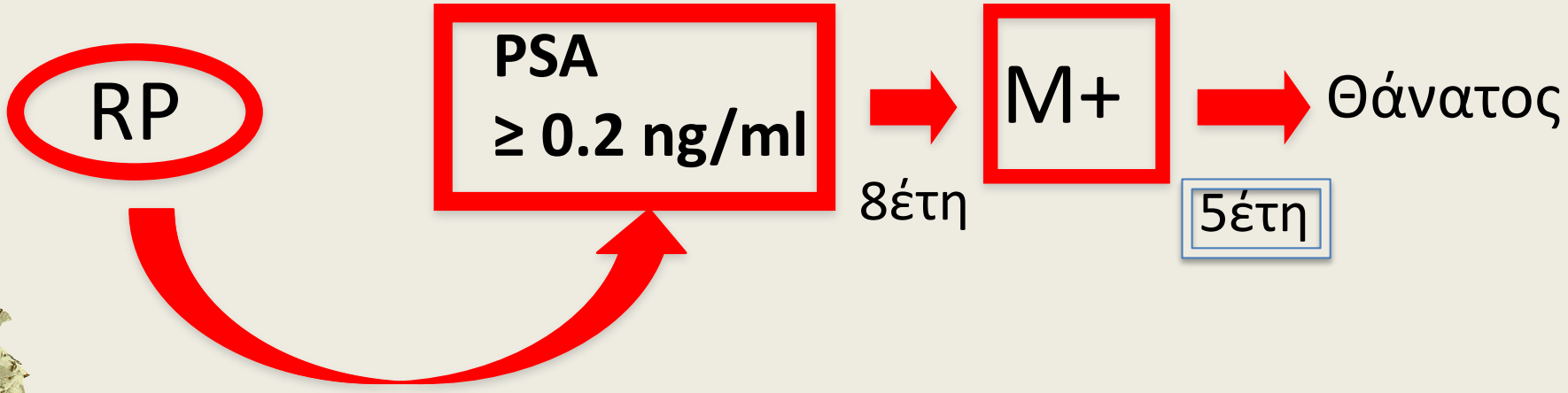
Dept. Urology, Athens Medical School, J. Varkarakis

ΦΥΣΙΚΗ ΙΣΤΟΡΙΑ ΤΗΣ ΒΙΟΧΗΜΙΚΗΣ ΥΠΟΤΡΟΠΗΣ

The Natural History of Men Treated With Deferred Androgen Deprivation Therapy in Whom Metastatic Prostate Cancer Developed Following Radical Prostatectomy 2008

Danil V. Makarov,* Elizabeth B. Humphreys, Leslie A. Mangold, Michael A. Carducci, Alan W. Partin, Mario A. Eisenberger, Patrick C. Walsh and Bruce J. Trock

3096	422/3096	123/422	41/123
RP	**(13.6%)**	**(29%)**	**(33%)**



ΒΙΟΧΗΜΙΚΗ ΥΠΟΤΡΟΠΗ - ΟΡΙΣΜΟΙ

ΒΙΟΧΗΜΙΚΗ ΥΠΟΤΡΟΠΗ	ΟΡΙΣΜΟΣ	
μετά από ΡΙΖΙΚΗ ΠΡΟΣΤΑΤΕΚΤΟΜΗ	2 διαδοχικές αυξήσεις του PSA> 0.2ng/ml (EAU & AUA)[1-2]	
μετά από ΑΚΤΙΝΟΘΕΡΑΠΕΙΑ	RTOG ASTRO Phoenix Consensus Conference	αύξηση PSA 2ng/ml ή περισσότερο πάνω από το nadir

1 EAU guidelines Eur. Urol. 2017
2 Cookson et al. J. Urol. 2007
3 ASTRO guidelines, Int. J. Radiat Oncol. Biol. Phys. 1997
4 Roach et al. Int. J. Radiat Oncol. Biol. Phys. 2006

ΕΚΤΙΜΗΣΗ ΚΙΝΔΥΝΟΥ ΒΙΟΧΗΜΙΚΗΣ ΥΠΟΤΡΟΠΗΣ

Dept. Urology, Athens Medical School, J. Varkarakis

ΕΚΤΙΜΗΣΗ ΚΙΝΔΥΝΟΥ ΒΥ ΠΡΙΝ ΤΗΝ ΘΕΡΑΠΕΙΑ

JAMA®
The Journal of the American Medical Association

«D' Amico RISK STRATIFICATION»

Βαθμός κινδύνου	PSA	cT	GS	Πιθανότητα ΒΥ στη 5ετία
Χαμηλού	<10 ng/mL	cT1-2a	<7	<25%
Ενδιάμεσου	10-20ng/ml	ή cT2b	ή 7	25-50%
Υψηλού	>20ng/ml	ή cT2c	ή >7	>50%

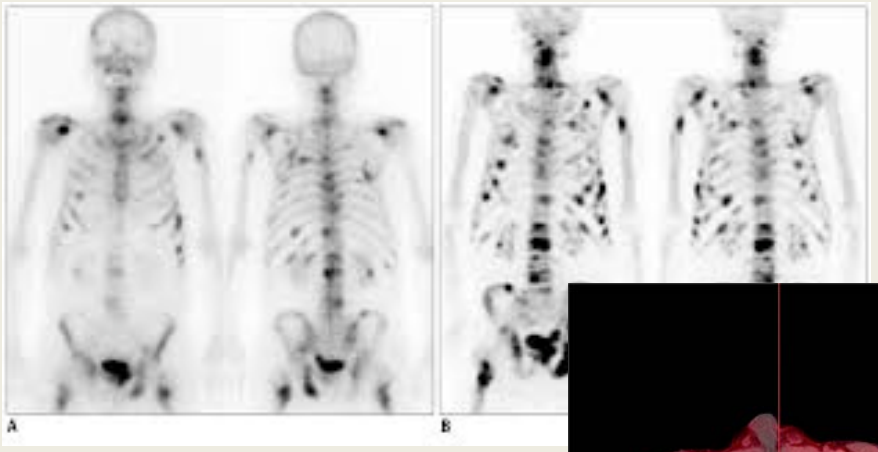
D'Amico, et al. JAMA 1998

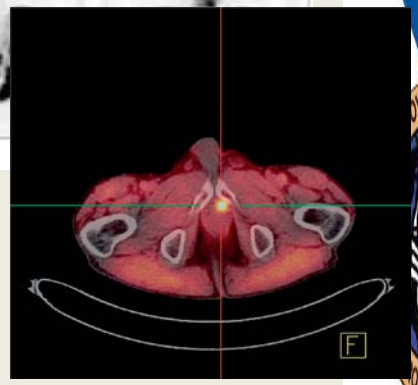
ΕΚΤΙΜΗΣΗ ΚΙΝΔΥΝΟΥ ΒΥ ΜΕΤΑ ΤΗΝ ΘΕΡΑΠΕΙΑ (ΡΙΖΙΚΗ ΠΡΟΣΤΑΤΕΚΤΟΜΗ)

RP **Gleason** sum		0.0008
- 5-6 vs 7	2.60 [1.34-4.58]	0.004
- 5-6 vs 8-10	**4.55** [2.19-9.42]	<0.0001
Extracapsular extension		0.0019
- Focal vs none	2.17 [1.20-3.92]	0.011
- Established vs none	2.72 [1.56-4.74]	0.0004
Seminal vesical invasion	**4.37** [2.90-6.58]	<0.0001
Lymph node metastasis	2.61 [1.70-4.01]	<0.0001
Positive surgical margins	**3.31** [2.11-5.20]	<0.0001

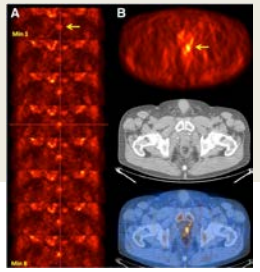
Hull et al. J. Urol. 2002

ΤΟΠΙΚΗ
ή
ΑΠΟΜΑΚΡΥΣΜΕΝΗ
ΥΠΟΤΡΟΠΗ





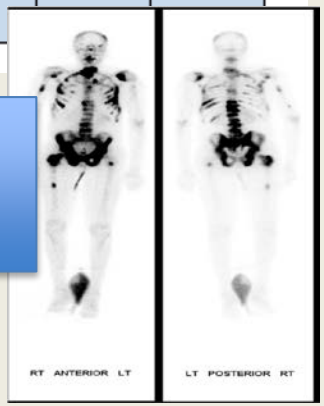
ΑΠΕΙΚΟΝΙΣΤΙΚΟΣ ΕΛΕΓΧΟΣ ΜΕΤΑ ΒΥ



6.9.4.6 Guidelines for imaging in patients with biochemical recurrence

Prostate-specific antigen (PSA) recurrence after radical prostatectomy	**LE**	**GR**
PSA < 1 ng/mL: no imaging is recommended.	3	A
PSA ≥ 1 ng/mL: positon emission tomography PET /computed tomography (CT) imaging is recommended using choline or prostate-specific membrane antigen (PMSA).	2b	A
Perform bone scan and/or abdominopelvic CT only in patients with PSA > 10 ng/mL, or with adverse PSA kinetics (PSA doubling time (DT) < 6 months, PSA velocity > 0.5 ng/mL/month).	3	A
PSA recurrence after radiotherapy		
Perform prostate multiparametric magnetic resonance imaging (mpMRI) only in patients who are considered candidates for local salvage therapy, use mpMRI to localise abnormal areas and guide biopsies.	3	B
Choline PET/CT imaging is recommended to rule out lymph nodes or distant metastases in patients fit enough for curative salvage treatment.	2b	B
Perform bone scan and/or abdominopelvic CT only in patients with PSA > 10 ng/mL, or with adverse PSA kinetics (PSA-DT < 6 months, PSA velocity > 0.5 ng/mL/month).	3	A

ΑΠΕΙΚΟΝΙΣΤΙΚΟΣ ΕΛΕΓΧΟΣ ΜΕΤΑ ΡΠ ΔΕΝ ΓΙΝΕΤΑΙ ή ΕΙΝΑΙ(-) ΑΦΟΥ ΧΒRT ΣΕ ΤΙΜΕΣ <1ng/ml

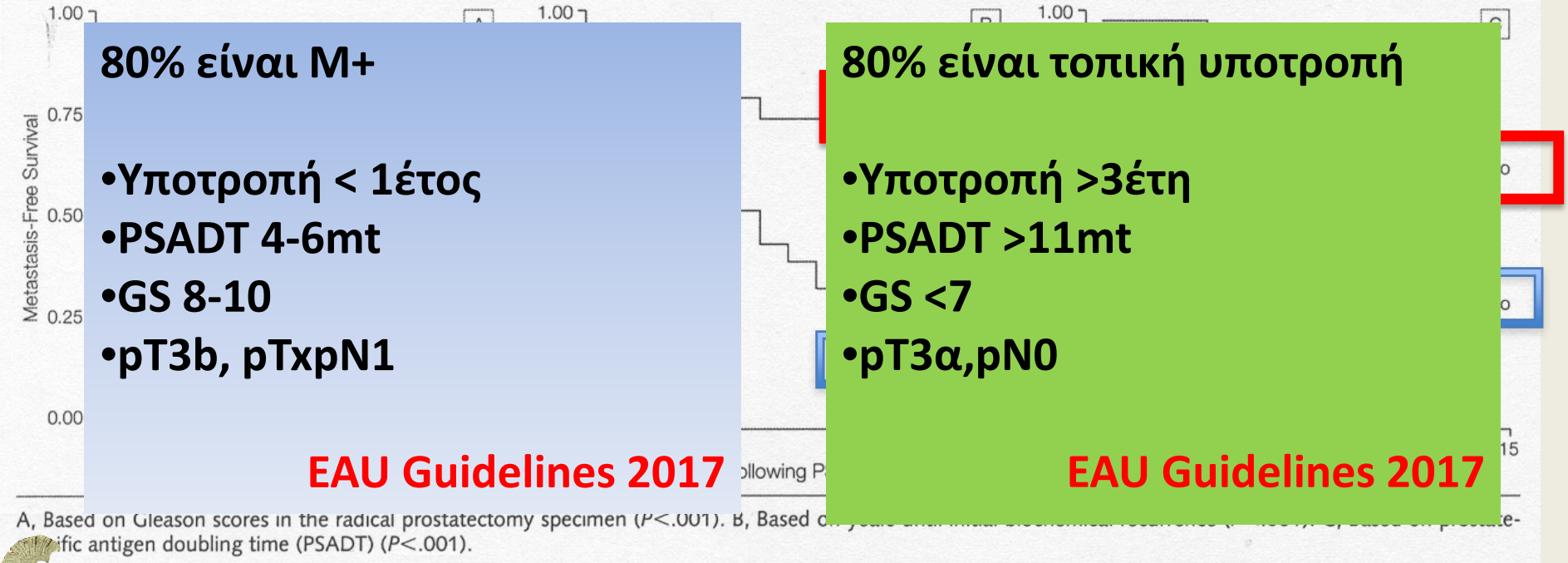


Dept. Urology, Athens Medical School, J. Varkarakis

Natural History of Progression After PSA Elevation Following Radical Prostatectomy

Πιο πιθανή η M+

Figure 3. Actuarial Likelihood of Metastasis-Free Survival in 304 Men With Prostate-Specific (PSA) Antigen Elevation After Radical Prostatectomy



A, Based on Gleason scores in the radical prostatectomy specimen ($P<.001$). B, Based on ... ific antigen doubling time (PSADT) ($P<.001$).

80% είναι M+

- **Υποτροπή < 1έτος**
- **PSADT 4-6mt**
- **GS 8-10**
- **pT3b, pTxpN1**

EAU Guidelines 2017

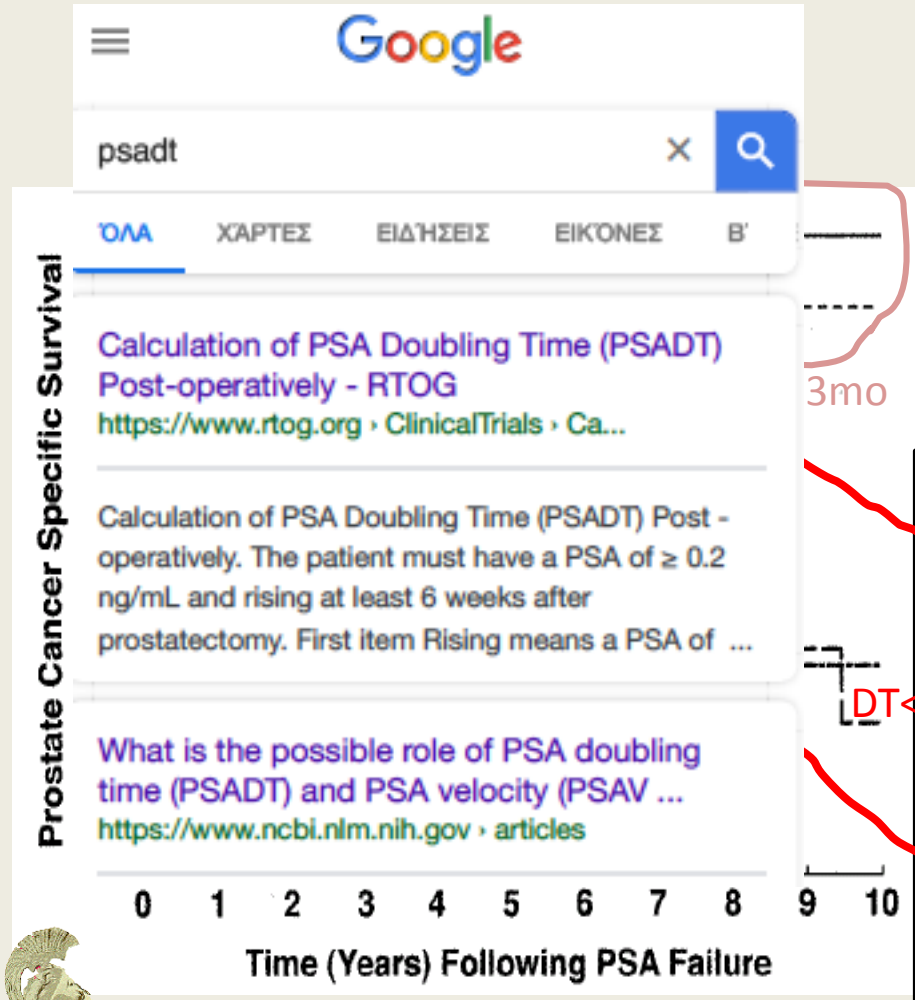
80% είναι τοπική υποτροπή

- **Υποτροπή >3έτη**
- **PSADT >11mt**
- **GS <7**
- **pT3α,pN0**

EAU Guidelines 2017

Pound et al. JAMA 1999

PSA DT predicts cancer-specific mortality after surgery or radiation therapy



$$PSA(t) = PSA(0)e^{\lambda t + \gamma t^2}$$

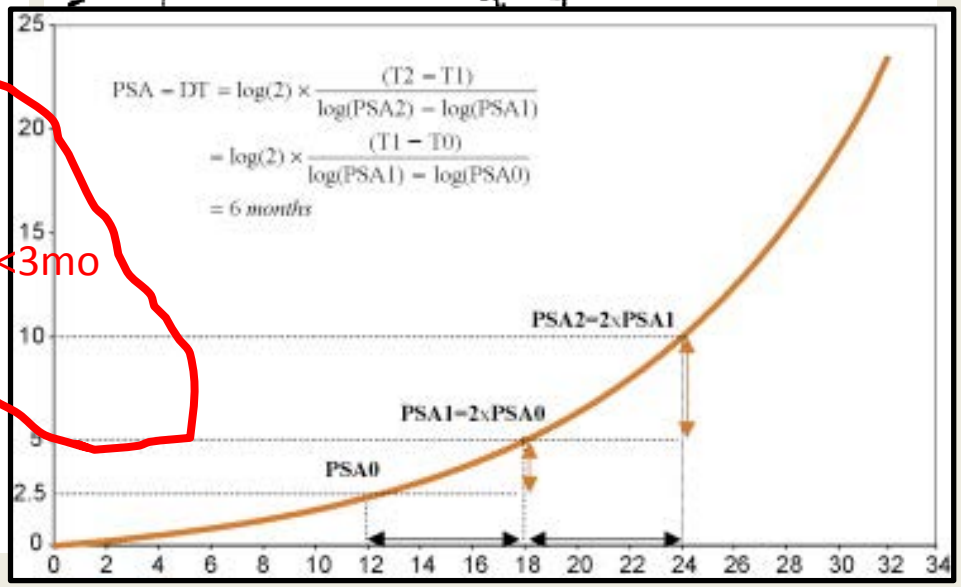
$$\ln PSA(t) = \ln PSA(0) + \lambda t + \gamma t^2$$

$$DT = \frac{-\lambda + \sqrt{\lambda^2 + 4\gamma \ln 2}}{2\gamma}$$

Overall survival

3mo

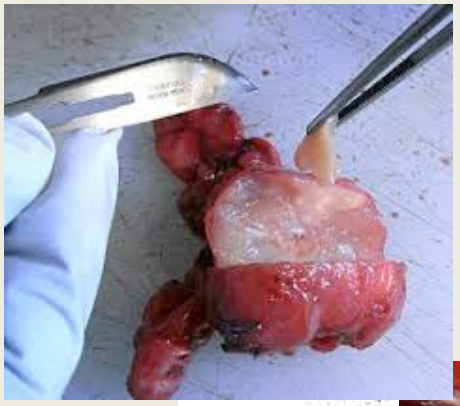
DT<3mo



Dept. Urology, Athens Medical School, J. Varkarakis

D'Amico et al. J. Urol. 2004

ΡΙΖΙΚΗ ΠΡΟΣΤΑΤΕΚΤΟΜΗ



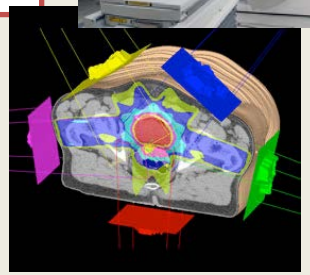
ΚΑΚΑ ΠΡΟΓΝΩΣΤΙΚΑ ΣΗΜΕΙΑ

- Εξωκαψική νόσος
- (+) χειρουργικό όριο
- Διήθηση ΣΚ
- >GS 8

PSA recurrence
PSA persistence

ΑΝΤΙΜΕΤΩΠΙΣΗ;

NCCN Clinical Practice Guidelines in Oncology: Prostate Cancer



XBRT

Dept. Urology, Athens Medical School, J. Varkarakis

ΠΟΤΕ ΚΑΤΑΛΛΗΛΟ TIMING?
ΕΠΙΚΟΥΡΙΚΗ vs. ΑΚΘ ΔΙΑΣΩΣΗΣ

ΕΠΙΚΟΥΡΙΚΗ XBRT
"adjuvant"

XBRT ΔΙΑΣΩΣΗΣ
"salvage"

RP
+sm
+Sv
+cap
GS8

BY

64Gy 1.5-4 mo

ΥΠΕΡΘΕΡΑΠΕΙΑ

ΤΟΞΙΚΟΤΗΤΑ

ΑΠΩΛΕΙΑ ΘΕΡΑΠΕΥΤΙΚΟΥ ΠΑΡΑΘΥΡΟΥ

Dept. Urology, Athens Medical School, J. Varkarakis

ΕΠΙΚΟΥΡΙΚΗ ΑΚΘ vs. ΠΑΡΑΚΟΛΟΥΘΗΣΗ

3 RCTs– LEVEL 1b

Study	N	Inclusion criteria	Randomisation	Definition of BCR	FU (mo)	BFS @10y	OS @10y
SWOG 8794 Thompson et al J Urol 2009	431	pT3 cN0 R1	60-64Gy vs Observation+SRT	>0.4	152	53 vs 30% (P<0.05)	74 vs 66% (P=0.023)
EORTC 22911 Bolla et al Eur Urol 2012	1005	pT3/pT2 pN0 R1	60Gy vs Observation+SRT	>0.2	127	60.6 vs 41% (p<0.01)	81 vs 77% NS
ARO 96-02 Wiegel et al Eur Urol 2014	385	pT3 pNo R1 PSA<0.1	60Gy vs Observation+SRT	>0.05+ confirmation	112	56 vs 35% (p=0.0001)	82 vs 86% NS

ΕΠΙΚΟΥΡΙΚΗ ΑΚΘ ΚΑΛΥΤΕΡΟ BFS (LE1) & OS (?)

ΜΕΙΟΝΕΚΤΗΜΑΤΑ ΕΠΙΚΟΥΡΙΚΗΣ ΑΚΘ: ΚΙΝΔΥΝΟΣ ΥΠΕΡΘΕΡΑΠΕΙΑΣ

Adjuvant radiotherapy after radical prostatectomy shows no ability to improve rates of overall and cancer–specific survival in a matched case–control study

Christopher R. Porter, Umberto Capitanio*, Paul Perrotte*, Jochen Walz*, Hendrik Isbarn*, Koichi Kodama, Robert P. Gibbons, Roy Correa Jr and Pierre I. Karakiewicz*

Table 2 10-Year Probability of an Undetectable PSA after Radical Prostatectomy Alone

Prostatectomy Gleason Score 6	
Capsular penetration, negative margin	90%
Capsular penetration, positive margin	75%
Prostatectomy Gleason Score 7	
Capsular penetration, negative margin	62%
Capsular penetration, positive margin	35%

ΤΙ ΓΙΝΕΤΑΙ (-) ΧΟ & ΕΡΕ;

ΒΥ 25%

Β.Υ όχι σίγουρη σε (+) ΧΟ

ΒΥ 65%

The Impact of Anatomical Radical Retropubic Prostatectomy on Cancer Control: The 30-Year Anniversary

Jeffrey K. Mullins, Zhaoyong Feng†, Bruce J. Trock, Jonathan I. Epstein, Patrick C. Walsh, Stacy Loeb

- The **most common finding** among the 3 adverse pathologic findings for XBRT (SV, EPE, +SM) is the presence of **-SM & EPE**

Immediate Adjuvant Radiation Therapy Following Radical Prostatectomy Should Not Be Advised for Men with Extraprostatic Extension Who Have Negative Surgical Margins

Patrick C. Walsh [a,], Nathan Lawrentschuk [b]*

- **SWOG subanalysis** of pt EXP & (-) SM **never performed**
- **ARO 96-02** pt EXE & (-) SM received **no significant benefit** from ADJ XBRT
- **EORTC 22911** significant **reduction of BFS** but **no reduction in OS**

EXPERT OPINION

James Buchanan Brady Urological Institute

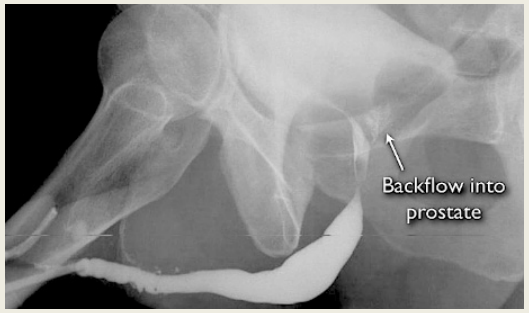
BRADY

ADJUVANT XBRT : WHO SCHOULD RECEIVE IT

NO	YES	Marginal Benefit
• **EXE & (-) SM** • **Bladder neck contraction** or significant **incontinence** and marginal indications • **>70y** (unless very healthy & HG on (+) SM)	**GS≥7 & (+)SM**	**+SV** *ARO-9602 NO benefit BFS* *EORTC better BFS NO OS*

Δόση **μέχρι 66Gy** στην προστατική κοίτη + SV με την επαναφορά της **εγκράτειας**.

ΜΕΙΟΝΕΚΤΗΜΑΤΑ ΕΠΙΚΟΥΡΙΚΗΣ ΑΚΘ ΤΟΞΙΚΟΤΗΤΑ



- SWOG 8794
  - **Urethral stricture** 24% vs. 12%
  - **Total incontinence** 6.5% vs. 2.8%
  - **Rectal complications** 3.3% vs. 0%

x2

- EORTC 22911
  - **More** frequent **grade II** toxicity
  - Marginally more grade III toxicity 4.2% vs. 2.6%
  - **No grade IV toxicity**
- ARO 96-02
  - **Only 1 grade III** bladder toxicity (3D conformal planning)

ΜΕΙΟΝΕΚΤΗΜΑΤΑ ΕΠΙΚΟΥΡΙΚΗΣ ΑΚΘ: ΤΟΞΙΚΟΤΗΤΑ

Toxicity	Grade 2	Grade 3	Grade 4	Any significant >G2
Overall GU toxicity	12.4%	2.3%	1%	15.9%
Cystitis	4.7	0.5	0	
Hematuria (14%)	4.7	0	0	
Urinary stricture	4.7	1.3	1	
Urinary incontinence	4.7	0.5	0	
Overall GI toxicity	9.5%	0.2%	0%	9.8%
Proctitis	8.2	0	0	
Chronic diarrhoea (9%)	3.7	0	0	
Small bowel obstruction	0.2	0.2	0	
Leg oedema	1.5%	0%	0%	1.5%

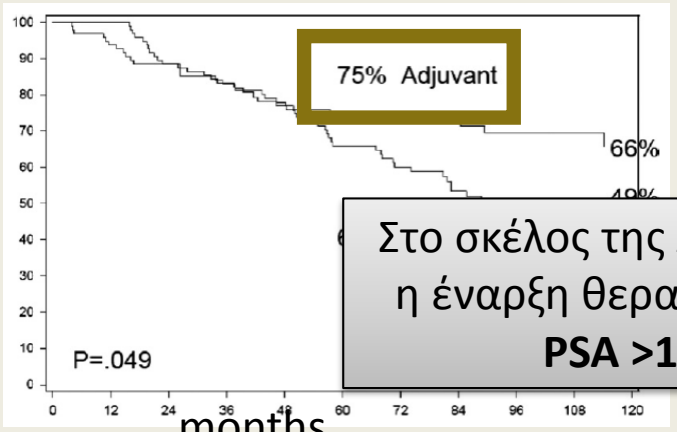
EAU Guidelines 2010
Sanda et al N Engl J Med 2008
Nieder AM et al J Urol 2008

ΕΠΙΚΟΥΡΙΚΗ ΑΚΘ VS ΑΚΘ ΔΙΑΣΩΣΗΣ

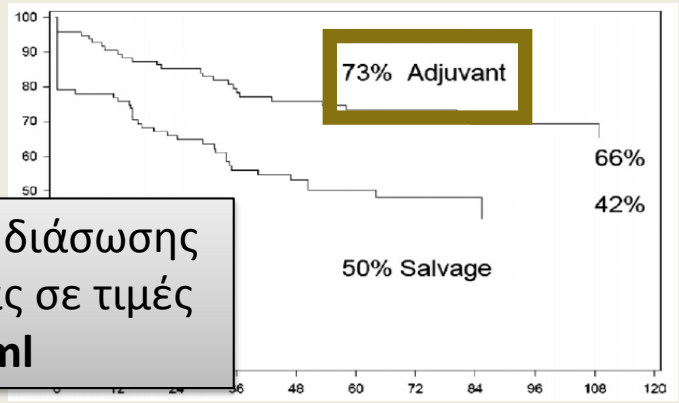
A Multi-Institutional Matched-Control Analysis of Adjuvant and Salvage Postoperative Radiation Therapy for pT3-4N0 Prostate Cancer

Edouard J. Trabulsi, Richard K. Valicenti, Alexandra L. Hanlon, Thomas M. Pisansky, Howard M. Sandler, Deborah A. Kuban, Charles N. Catton, Jeff M. Michalski, Michael J. Zelefsky, Patrick A. Kupelian, Daniel W. Lin, Mitchell S. Anscher, Kevin M. Slawin, Claus G. Roehrborn, Jeffrey D. Forman, Stanley L. Liauw, Larry L. Kestin, Theodore L. DeWeese, Peter T. Scardino, Andrew J. Stephenson, Alan Pollack

From date of surgery



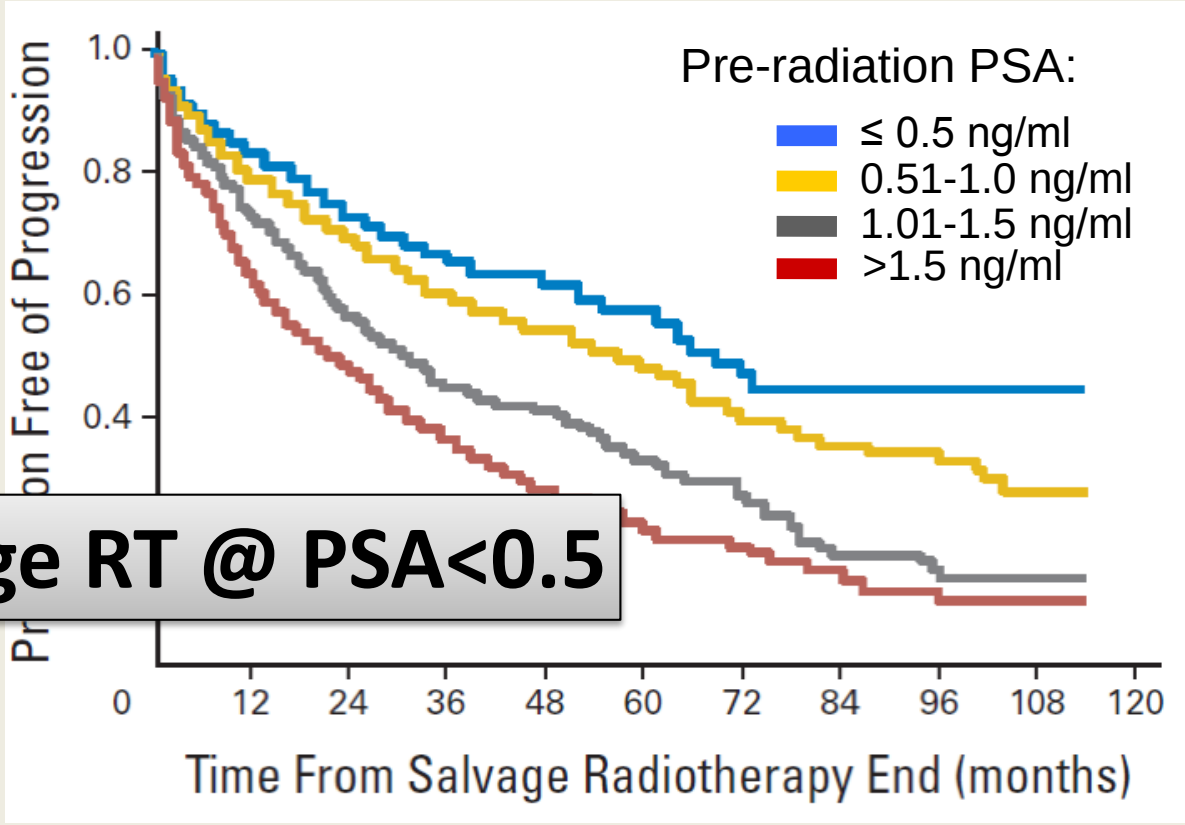
From end of RT



Στο σκέλος της ΑΚΘ διάσωσης η έναρξη θεραπείας σε τιμές **PSA >1ng/ml**

Αναδρομική Πολυκεντρική μελέτη 2299 (192) pts

ΑΚΘ ΔΙΑΣΩΣΗΣ:
ΣΗΜΑΣΙΑ PSA πριν την ΑΚΘ



Salvage RT @ PSA<0.5

BFS 48%

BFS 18%

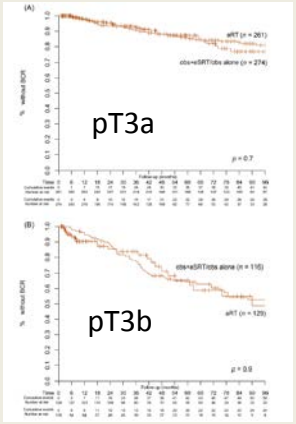
6-year progression-free probability decreased from 48% (**PSA<0.5 ng**) to 18% (PSA >1.5 ng/ml)

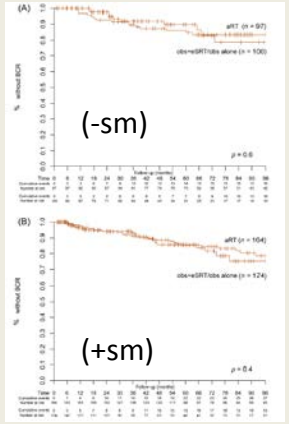
Stephenson et al. J. Clin Oncol 2007

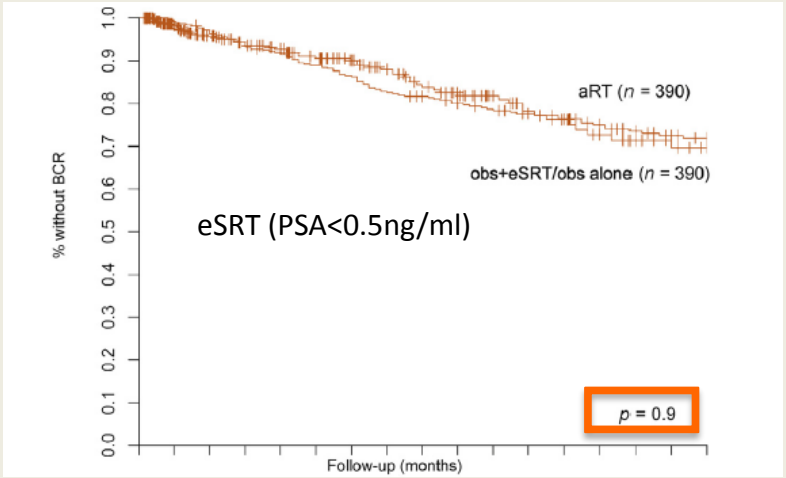
ΕΠΙΚΟΥΡΙΚΗ ΑΚΘ VS ΠΡΩΙΜΗ ΑΚΘ ΔΙΑΣΩΣΗΣ

Early Salvage Radiation Therapy Does Not Compromise Cancer Control in Patients with pT3N0 Prostate Cancer After Radical Prostatectomy: Results of a Match-controlled Multi-institutional Analysis

Alberto Briganti [a,†,], Thomas Wiegel [b,†], Steven Joniau [c], Cesare Cozzarini [d], Marco Bianchi [a,e], Maxine Sun [e], Bertrand Tombal [f], Karin Haustermans [g], Tom Budiharto [g], Wolfgang Hinkelbein [h], Nadia Di Muzio [d], Pierre I. Karakiewicz [e], Francesco Montorsi [a], Hein Van Poppel [c]*







BFS	aRT	Ob+eSRT	p
2y	91.4%	92.8%	NS
5y	78.4%	81.8%	NS

Conclusions: The current study suggests that timely administration of eSRT is comparable to aRT in improving BCR-free survival in the majority of pT3pN0 PCa patients. Therefore, eSRT may not compromise cancer control but significantly reduces overtreatment associated with aRT.

Prostate Cancer–Specific Survival Following Salvage Radiotherapy vs Observation in Men With Biochemical Recurrence After Radical Prostatectomy

Bruce J. Trock, PhD
Misop Han, MD
Stephen J. Freedland, MD
Elizabeth B. Humphreys, MS
Theodore L. DeWeese, MD
Alan W. Partin, MD, PhD
Patrick C. Walsh, MD

Context Biochemical disease recurrence after radical prostatectomy often prompts salvage radiotherapy, but no studies to date have had sufficient numbers of patients or follow-up to determine whether radiotherapy improves survival, and if so, the subgroup of men most likely to benefit.

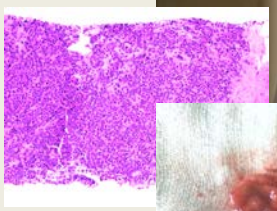
Objectives To quantify the relative improvement in prostate cancer–specific survival of salvage radiotherapy vs no therapy after biochemical recurrence following prostatectomy, and to identify subgroups for whom salvage treatment is most beneficial.

Design, Setting, and Patients Retrospective analysis of a cohort of 635 US men undergoing prostatectomy from 1982-2004, followed up through December 28, 2007,

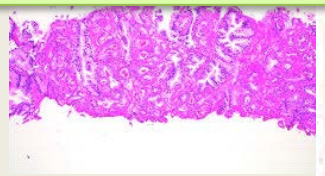
Salvage XBRT better in pt with

- **PSA DT<6mt**

ΕΞΑΤΟΜΙΚΕΥΣΗ ΘΕΡΑΠΕΙΑΣ



Salvage vs adjuvant



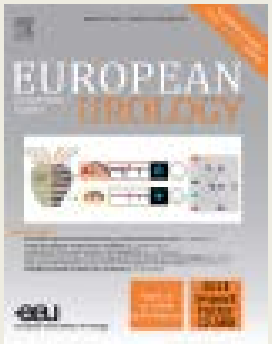
Platinum Priority – Prostate Cancer

Editorial by Alberto Bossi, Thomas Wiegel and Mack Roach on pp. 775–776 of this issue

Declining Use of Radiotherapy for Adverse Features After Radical Prostatectomy: Results From the National Cancer Data Base

Helmneh M. Sineshaw [a,†,], Phillip J. Gray [b,†], Jason A. Efstathiou [b,‡], Ahmedin Jemal [a,‡]*

[a] American Cancer Society, 250 Williams Street NW, Atlanta, GA, USA; [b] Department of Radiation Oncology, Massachusetts General Hospital, Boston, MA, USA



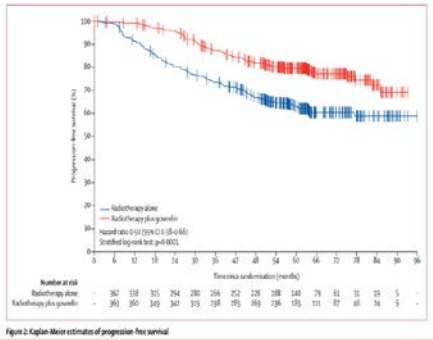
100.000 ασθενείς

ΑΚΘ ΔΙΑΣΩΣΗΣ
ΡΟΛΟΣ ΤΗΣ ΟΡΜΟΝΟΘΕΡΑΠΕΙΑΣ

Salvage radiotherapy with or without short-term hormone therapy for rising prostate-specific antigen concentration after radical prostatectomy (GETUG-AFU 16): a randomised, multicentre, open-label phase 3 trial

Christian Carrie, Ali Hasbini, Guy de Laroche, Pierre Richaud, Stéphane Guerif, Igor Latorzeff, Stéphane Supiot, Mathieu Bosset, Jean-Léon Lagrange, Véronique Beckendorf, François Lesaunier, Bernard Dubray, Jean-Philippe Wagner, Tan Dat N'Guyen, Jean-Philippe Suchaud, Gilles Créhange, Nicolas Barbier, Muriel Habibian, Céline Ferlay, Philippe Fourneret, Alain Ruffion, Sophie Dussart

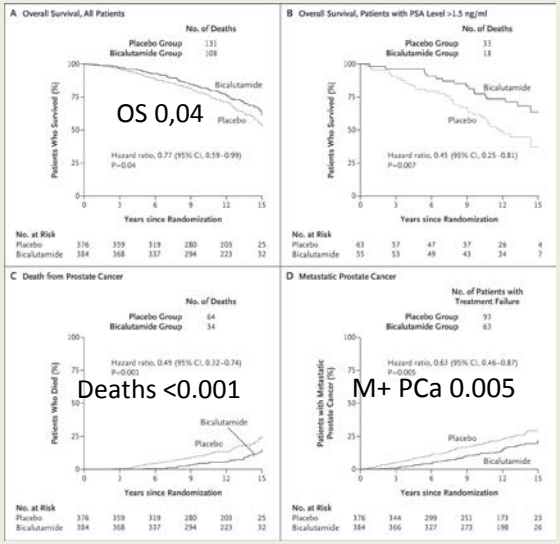
THE LANCET



XBRT + ADT vs **XBRT** only

- OS ⟶ NS
- BFR ⟶ SS

SRT + Gosereline for 6 mo



Original Article

Radiation with or without Antiandrogen Therapy in Recurrent Prostate Cancer

William U. Shipley, M.D., Wendy Seiferheld, M.S., Himanshu R. Lukka, M.D., Pierre P. Major, M.D., Niall M. ley, M.D., David J. Grignon, M.D., Oliver Sartor, M.D., Maltibehn P. Patel, M.D., Jean-Paul Bahary, M.D., hony L. Zietman, M.D., Thomas M. Pisansky, M.D., Kenneth L. Zeitzer, M.D., Colleen A.F. Lawton, M.D., Felix Y. M.D., Richard D. Lovett, M.D., Alexander G. Balogh, M.D., Luis Souhami, M , M.D., James J. Dignam, Ph.D., Stephanie L. Pugh, Ph.D., and Howard M.

SRT + placebo vs SRT + Bicalutamide 150mg for 24mo

ΟΡΜΟΝΟΘΕΡΑΠΕΙΑ ΩΣ ΜΟΝΟΘΕΡΑΠΕΙΑ ΜΕΤΑ ΑΠΟ ΒΥ

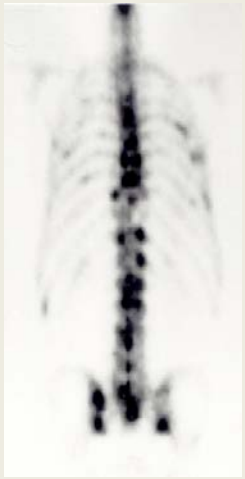
Role of Hormonal Treatment in Prostate Cancer Patients with Nonmetastatic Disease Recurrence After Local Curative Treatment: A Systematic Review

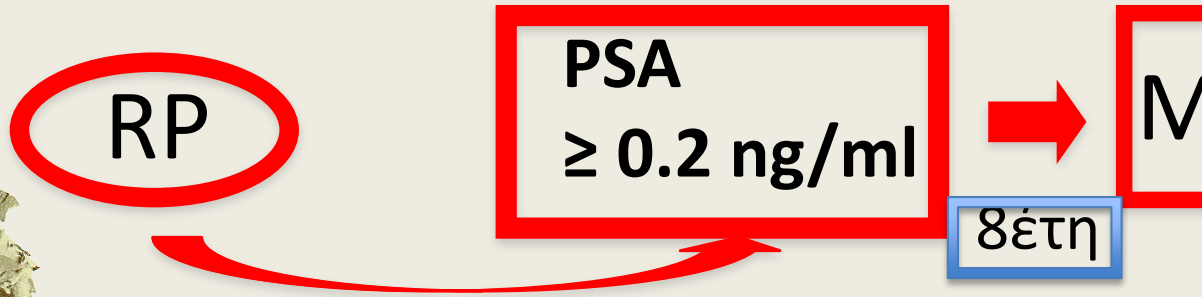
Roderick C.N. van den Bergh [a], Niels J. van Casteren [b], Thomas van den Broeck [c], Eve R. Fordyce [...], William K.M. Gietzmann [e], Fiona Stewart [d], Steven MacLennan [d], Saeed Dabestani [f], Joaquim Bellmunt [g], Michel Bolla [h], Erik Briers [i], Philip Cornford [j], Steven Joniau [k], Malcolm D. Mason [l], Vsevolod Matveev [m], Henk G. van der Poel [n], Theo H. van der Kwast [o], Olivier Rouvière [p], Thomas Wiegel [q], Thomas B. Lam [d,e], Nicolas Mottet [r,]*

- Studies with **conflicting results**
- HT has **side effects**
- HT in this setting should be **reserved** for pt at **highest risk of progression**
  - Short PSA DT at relapse
  - GS>7
  - Long life expectancy

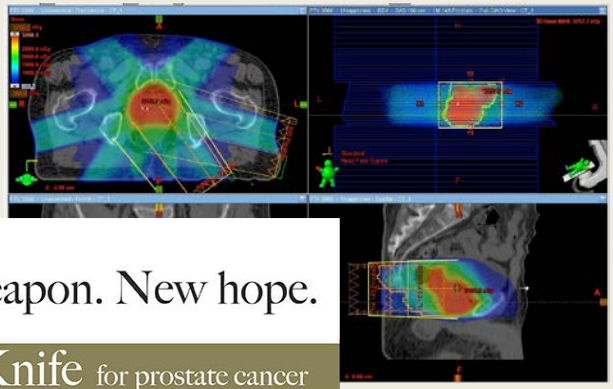
ΠΑΡΑΚΟΛΟΥΘΗΣΗ ΜΕΤΑ ΑΠΟ ΒΥ

- Παρακολούθηση μετά την ΒΥ **μέχρι** να γίνει έκδηλη η **μεταστατική** νόσος
- Σε ασθενείς **χαμηλού κινδύνου** για εξέλιξη
  - PSADT>12mo
  - Time to BCR>3y
  - GS<7
  - Stage<T3a
  - Life expectancy <10y
  - Unfit or unwilling



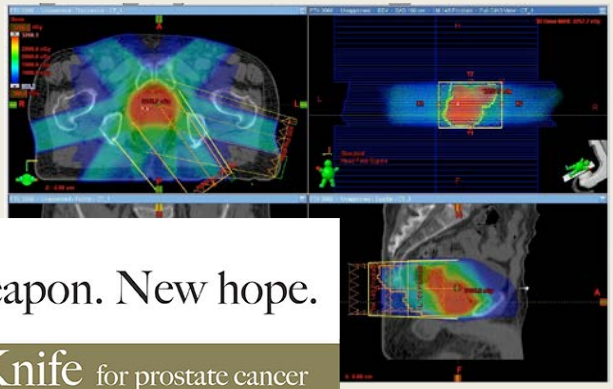


XBRT



- **70-74 GY**
  - ✓ **± Εκτεταμένο πεδίο** και χρήση **ανδρογονικού** αποκλεισμού
- **PSA nadir** σε **18 μήνες**
  - ✓ Περιπλέκει ο ανδρογονικός αποκλεισμός
  - ✓ 10-30% PSA "**bounce**" 12-18 μήνες μετά
  - ✓ Β.Υ= συνήθως **τοπικά προχωρημένη νόσο**

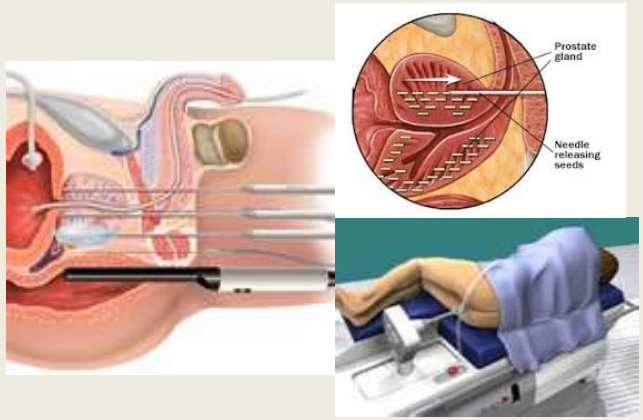
XBRT



- Αντιμετώπιση ΒΥ μετά από ΑΚΘ
  - Μόνο μετά από επιβεβαίωση με **βιοψία**
    - Bx @ 24 μήνες (έμπειρος **Παθ/ος**)
  - Μόνο σε ασθενείς με **προσδόκιμο επιβίωσης**
    - Καλύτεροι υποψήφιοι
      - » PSA <10ng/ml
      - » PSADT>10
      - » GS<8
      - » cT1c/T2, N0M0

ΑΝΤΙΜΕΤΩΠΙΣΗ ΒΥ ΜΕΤΑ ΑΚΘ

- **ΘΕΡΑΠΕΥΤΙΚΕΣ ΕΠΙΛΟΓΕΣ**
  - Salvage **RP**
  - Salvage **Cryo**
  - Salvage **BRT**
  - Salvage **HIFU**



6.9.6 ***Management of PSA failures after radiation therapy***

Therapeutic options in these patients are ADT or local procedures such as SRP, cryotherapy, interstitial brachytherapy and HIFU [691-700]. Strong recommendations regarding the choice of any of these techniques cannot be made as the available evidence for these treatment options is of (very) low quality. The following is an overview of the most important findings regarding each of these techniques with a proposal for their indications.

ΘΕΡΑΠΕΙΕΣ ΔΙΑΣΩΣΗΣ ΣΕ Β.Υ ΜΕΤΑ ΑΠΟ ΑΚΘ «ΟΓΚΟΛΟΓΙΚΑ ΑΠΟΤΕΛΕΣΜΑΤΑ»

	Nb pt	FU (mt)	bDFS % @ 5years	bDFS % @ 10 years
Salvage RP	40-138	35-92	47-71	30-43
Salvage CRYO	18-279	12-39	44-73	
Salvage BRT	13-49	19-64	34-87	
Salvage HIFU	32-167 (3)	7-14	53 (3)	

ΘΕΡΑΠΕΙΕΣ ΔΙΑΣΩΣΗΣ ΣΕ Β.Υ ΜΕΤΑ ΑΠΟ ΑΚΘ «ΕΠΙΠΛΟΚΕΣ»

	Ακράτεια %	Στένωμα %	Συρίγγιο/κάκωση ορθού %	Στυτική Δυσλειτουργία %
Salvage RP	20-68	9-32	0-15	72-84
Salvage CRYO 3rd	4-40	0-20	0-2	86
Salvage BRT	GU (G 3-4) 14-47		GI (G 3-4) 2-24	NA
Salvage HIFU	7-50	8-36	3-7	72

ΠΑΡΑΚΟΛΟΥΘΗΣΗ ΜΟΝΟ ΣΕ ΒΥ ΜΕΤΑ ΑΠΟ ΑΚΘ

Validation of a Treatment Policy for Patients with Prostate Specific Antigen Failure after Three-Dimensional Conformal Prostate Radiation Therapy

Wayne H. Pinover, D.O.[1]
Eric M. Horwitz, M.D.[1]
Alexandra L. Hanlon, Ph.D.[1]
Robert G. Uzzo, M.D.[2]
Gerald E. Hanks, M.D.[1]

[1] Department of Radiation Oncology, Fox Chase Cancer Center, Philadelphia, Pennsylvania.

[2] Department of Urologic Oncology, Fox Chase Cancer Center, Philadelphia, Pennsylvania.

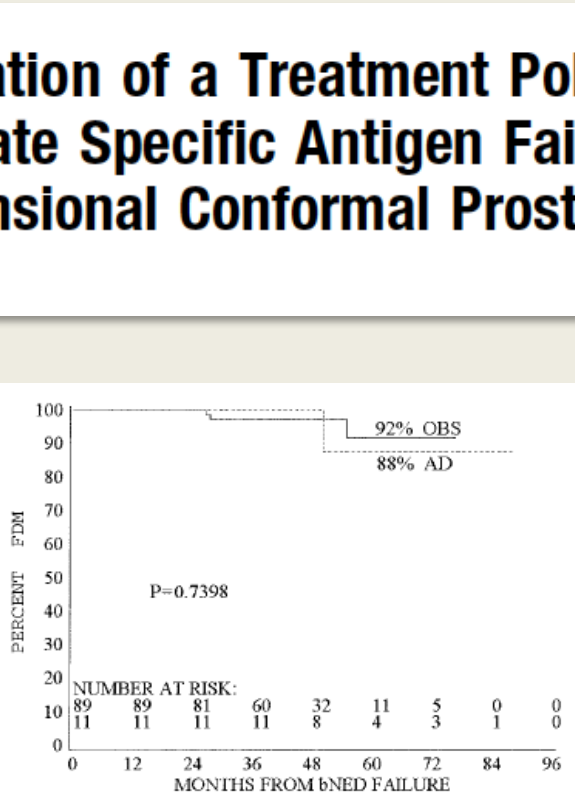


FIGURE 4. Freedom from distant metastasis (FDM) for patients with a prostate specific antigen doubling time (PSADT) ≥ 12 months. AD: androgen deprivation; OBS: observation; bNED: biochemical no evidence of disease.

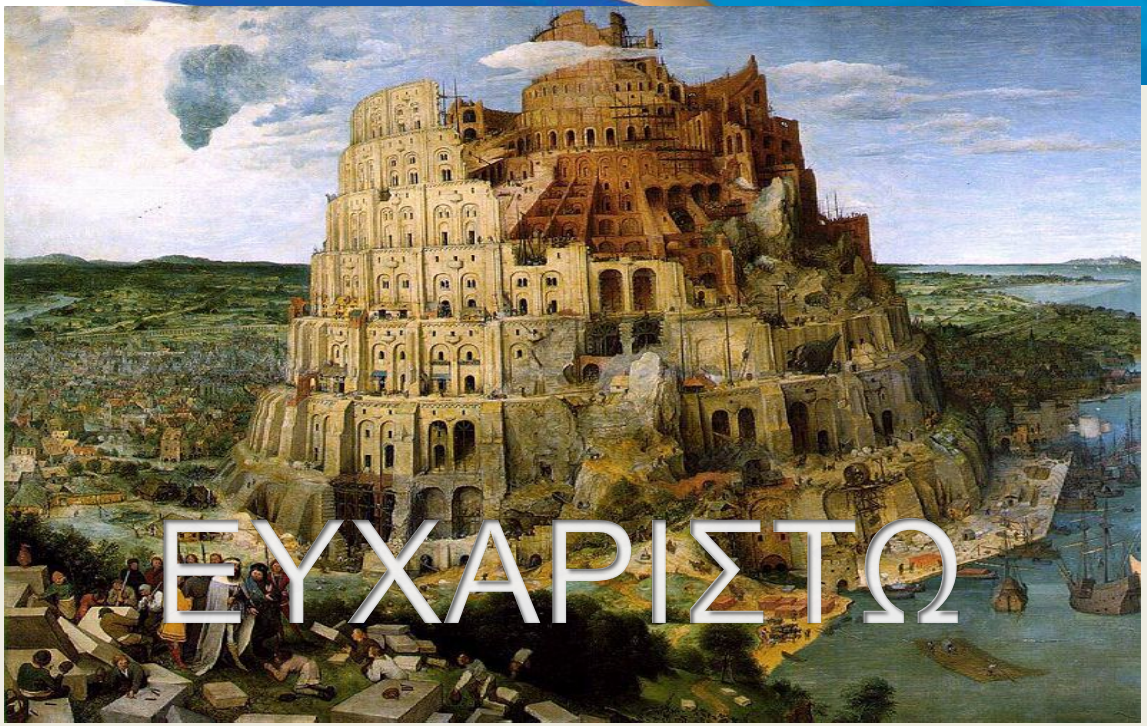
- 248 ασθενείς AD vs OS
- Στην υποομάδα **PSADT>12mo** καμμία διαφορά

Η **παρακολούθηση** αποτελεί επιλογή σε **ασθενείς χαμηλού κινδύνου** με οψιμη τοπική υποτροπή και αργή άνοδο του PSA που δεν θελουν παρέμβαση.

ΣΥΜΠΕΡΑΣΜΑΤΑ

- **Πρόβλεψη Βιοχημικής Υποτροπής**
  - Ομάδες Κινδύνου (Κλινικά στοιχεία, Παθ/κή εξέταση)
- **Επικουρική ΑΚΘ**
  - Καλύτερα αποτελέσματα όσον αφορά την ΒΥ
  - Αυξημένη νοσηρότητα
- **ΑΚΘ Διάσωσης**
  - PSA<0.5ng/ml
- **Θεραπείες διάσωσης μετά από ΑΚΘ**
  - Πολλές επιπλοκές
  - Μέτρια αποτελέσματα

13η Εκπαιδευτική Εβδομάδα
Ελλήνων Ειδικευομένων Ουρολόγων
12-16 Φεβρουαρίου 2018
Αθήνα • Crowne Plaza Hotel



Dept. Urology, Athens Medical School, J. Varkarakis