ΡΙΖΙΚΗ ΑΝΤΙΜΕΤΩΠΙΣΗ ΚΑΡΚΙΝΟΥ ΤΟΥ ΠΡΟΣΤΑΤΗ

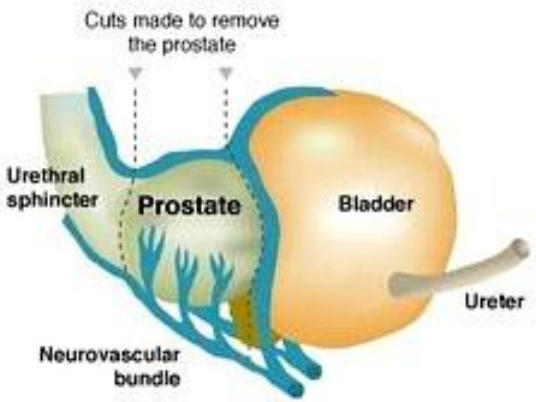
ΙΩΑΝΝΗΣ ΒΑΡΚΑΡΑΚΗΣ
ΑΝΑΠΛΗΡΩΤΗΣ ΚΑΘΗΓΗΤΗΣ
ΕΘΝΙΚΟ & ΚΑΠΟΔΙΣΤΡΙΑΚΟ ΠΑΝΕΠΙΣΤΗΜΙΟ ΑΘΗΝΩΝ
ΣΙΣΜΑΝΟΓΛΕΙΟ Γ.Ν

Dept. Urology, Athens Medical School

ΡΙΖΙΚΗ ΠΡΟΣΤΑΤΕΚΤΟΜΗ

RISK STRATIFICATION

	Low-risk	Intermediate-risk	High-risk	
Definition	PSA < 10 ng / mL and GS < 7 and cT1-2a	PSA 10-20 ng /mL or GS 7 or cT2b	PSA > 20 ng / mL or GS > 7 or cT2c	any PSA any GS cT3-4 or cN+
	Localised			**Locally advanced**



ΡΙΖΙΚΗ ΠΡΟΣΤΑΤΕΚΤΟΜΗ

EAU GUIDELINES - INDICATIONS FOR RP

In patients with low- and intermediate-risk PCa and a life expectancy > 10 years, RP should be offered.	1b	A
In patients with high-risk localised PCa and a life expectancy of > 10 years, RP should be offered in a multimodality setting.	2a	A
In selected patients with locally advanced (cT3a) PCa, and a life expectancy > 10 years, RP may be offered in a multimodality setting.	2b	B

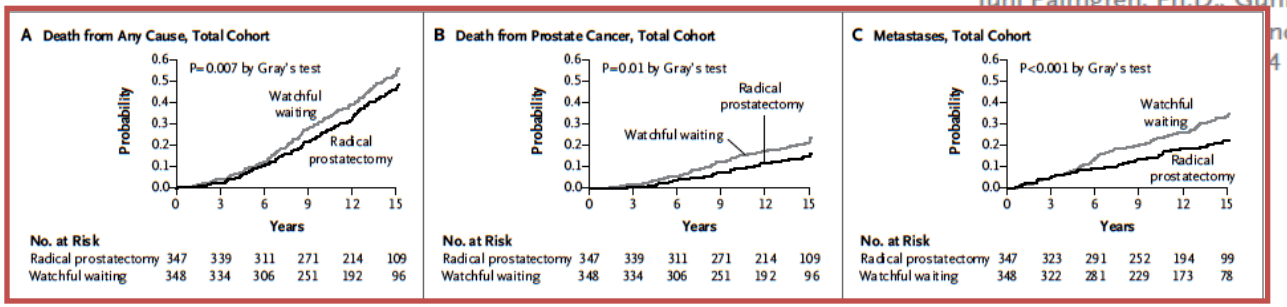
- Προσδόκιμο επιβίωσης (>10 έτη)
  - Ηλικία
  - Συνοσηρότητα

In highly selected patients with locally advanced PCa (cT3b-T4 N0 or any T N1), RP may be offered in a multimodality setting.	3	C

benefit for OS & CSS & risk of M+

Radical Prostatectomy versus Watchful Waiting in Early Prostate Cancer

Anna Bill-Axelson, M.D., Ph.D., Lars Holmberg, M.D., Ph.D., Mirja Ruutu, M.D., Ph.D., Hans Garmo, Ph.D., Jennifer R. Stark, Sc.D., Christer Busch, M.D., Ph.D., Stig Nordling, M.D., Ph.D., Michael Häggman, M.D., Ph.D., Swen-Olof Andersson, M.D., Ph.D., Stefan Bratell, M.D., Ph.D., Anders Spångberg, M.D., Ph.D., Juni Palmgren, Ph.D., Gunnar Steineck, M.D., Ph.D., nd Jan-Erik Johansson, M.D., Ph.D., 4 Investigators*



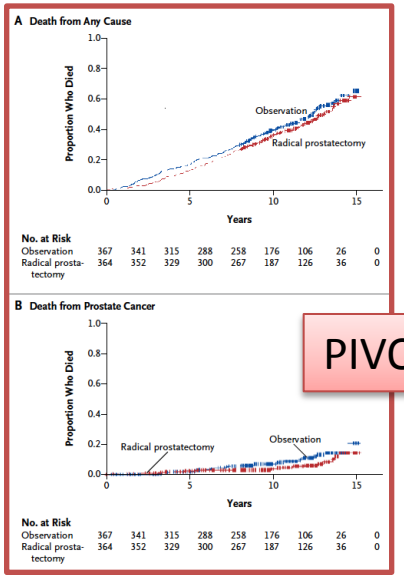
SPCG-4

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 JULY 19, 2012 VOL. 367 NO. 3

Radical Prostatectomy versus Observation for Localized Prostate Cancer

Timothy J. Wilt, M.D., M.P.H., Michael K. Brawer, M.D., Karen M. Jones, M.S., Michael J. Barry, M.D., William J. Aronson, M.D., Steven Fox, M.D., M.P.H., Jeffrey R. Gingrich, M.D., John T. Wei, M.D., Patricia Gilhooly, M.D., B. Mayer Grob, M.D., Imad Nsouli, M.D., Padmini Iyer, M.D., Ruben Cartagena, M.D., Glenn Snider, M.D., Claus Roehrborn, M.D., Ph.D., Roohollah Sharifi, M.D., William Blank, M.D., Parikshit Pandya, M.D., Gerald L. Andriole, M.D., Daniel Culkin, M.D., and Thomas Wheeler, M.D., for the Prostate Cancer Intervention versus Observation Trial (PIVOT) Study Group



PIVOT trial

Results not reproduced

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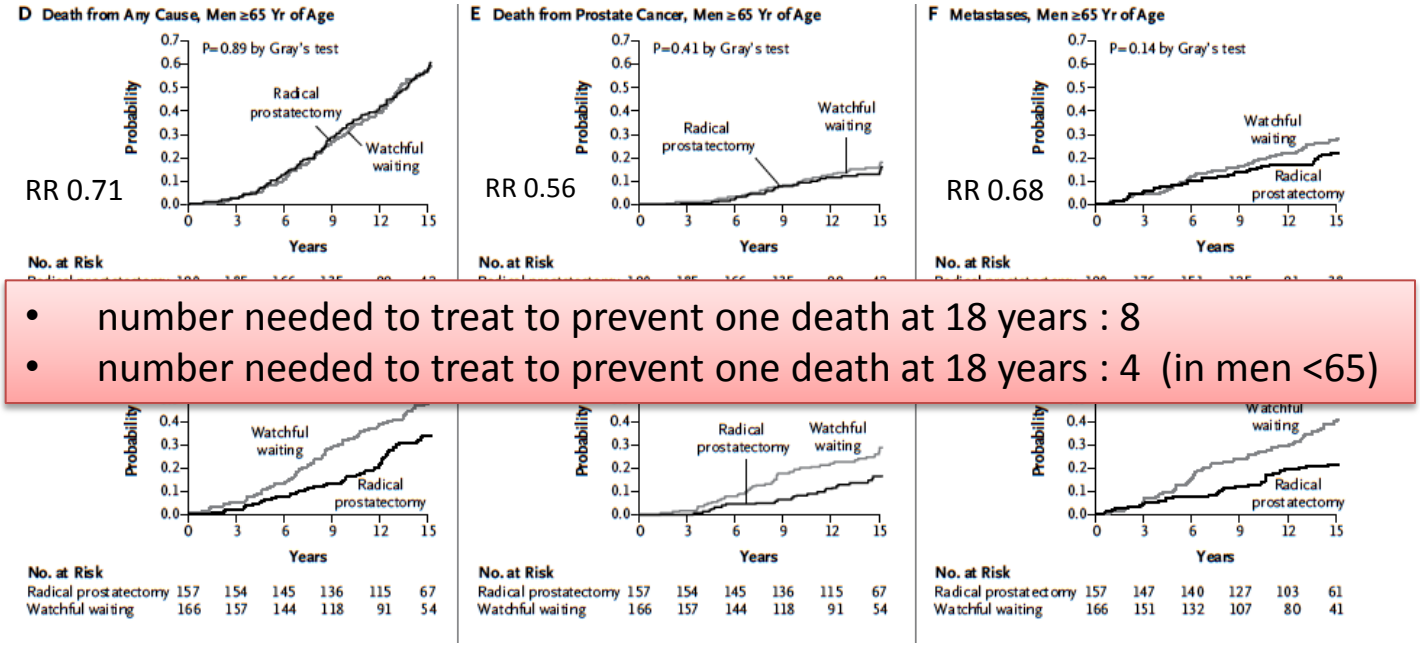
LOW RISK PCa

Radical Prostatectomy versus Watchful Waiting in Early Prostate Cancer

Anna Bill-Axelson, M.D., Ph.D., Lars Holmberg, M.D., Ph.D., Mirja Ruutu, M.D., Ph.D., Hans Garmo, Ph.D., Jennifer R. Stark, Sc.D., Christer Busch, M.D., Ph.D., Stig Nordling, M.D., Ph.D., Michael Häggman, M.D., Ph.D., Swen-Olof Andersson, M.D., Ph.D., Stefan Bratell, M.D., Ph.D., Anders Spångberg, M.D., Ph.D., Juni Palmgren, Ph.D., Gunnar Steineck, M.D., Ph.D., Hans-Olov Adami, M.D., Ph.D., and Jan-Erik Johansson, M.D., Ph.D., for the SPCG-4 Investigators*



>65

<65

- number needed to treat to prevent one death at 18 years : 8
- number needed to treat to prevent one death at 18 years : 4 (in men <65)

LOW RISK PCa

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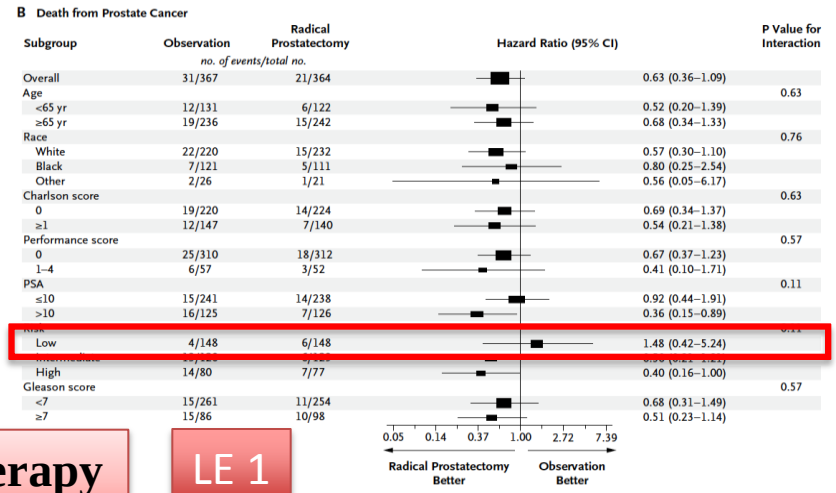


Lack of benefit in low risk Dx from radical therapy

LE 1

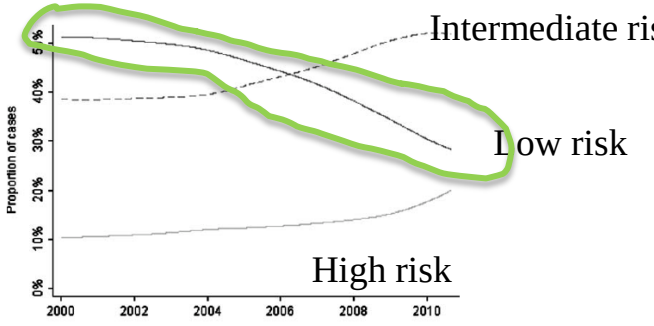
Cancer

Less low risk Pt undergoing RRP

Reverse Stage Shift at a Tertiary Care Center

Escalating Risk in Men Undergoing Radical Prostatectomy

Jonathan L. Silberstein, MD[1]; Andrew J. Vickers, PhD[2]; Nicholas E. Power, MD[1]; Samson W. Fine, MD[3]; Peter T. Scardino, MD[1]; James A. Eastham, MD[1]; and Vincent P. Laudone, MD[1]



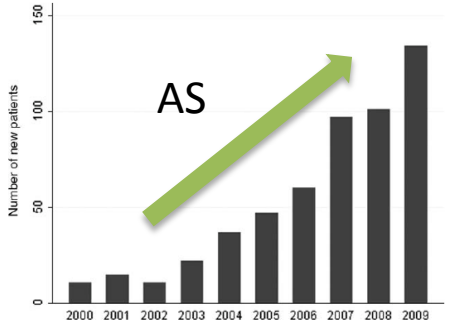


Figure 5. This bar chart illustrates the number of patients enrolled in active surveillance by year.

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INTERMEDIATE RISK PCa

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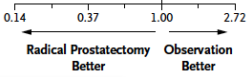
Radical Prostatectomy versus Observation for Localized Prostate Cancer

Timothy J. Wilt, M.D., M.P.H., Michael K. Brawer, M.D., Karen M. Jones, M.S., Michael J. Barry, M.D., William J. Aronson, M.D., Steven Fox, M.D., M.P.H., Jeffrey R. Gingrich, M.D., John T. Wei, M.D., Patricia Gilhooly, M.D., B. Mayer Grob, M.D., Imad Nsouli, M.D., Padmini Iyer, M.D., Ruben Cartagena, M.D., Glenn Snider, M.D., Claus Roehrborn, M.D., Ph.D., Roohollah Sharifi, M.D., William Blank, M.D., Parikshit Pandya, M.D., Gerald L. Andriole, M.D., Daniel Culkin, M.D., and Thomas Wheeler, M.D., for the Prostate Cancer Intervention versus Observation Trial (PIVOT) Study Group

PIVOT

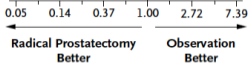
A Death from Any Cause

Subgroup	Observation	Radical Prostatectomy	Hazard Ratio (95% CI)	P Value for Interaction
	no. of events/total no.			
Overall	183/367	171/364	0.88 (0.71–1.08)	
Age				0.85
<65 yr	50/131	43/122	0.89 (0.59–1.34)	
≥65 yr	133/236	128/242	0.84 (0.63–1.08)	
Race				0.81
White	119/220	117/232	0.84 (0.65–1.08)	
Black	53/121	46/111	0.93 (0.62–1.38)	
Other	11/26	8/21	0.85 (0.34–2.11)	
Charlson score				0.79
0	86/220	82/224	0.90 (0.66–1.21)	
≥1	97/147	89/140	0.84 (0.63–1.13)	
Performance score				0.66
0	146/310	139/312	0.89 (0.71–1.13)	
1–4	37/57	32/52	0.82 (0.51–1.31)	
PSA				0.04
≤10	101/241	110/238	1.03 (0.79–1.35)	
>10	77/125	61/126	0.67 (0.48–0.94)	
Risk				0.07
Low	54/148	62/148	1.13 (0.80–1.60)	
Intermediate	70/120	59/129	0.69 (0.49–0.98)	
High	43/86	42/77	0.74 (0.49–1.13)	
Gleason score				0.87
<7	125/261	113/254	0.86 (0.67–1.12)	
≥7	47/86	50/98	0.84 (0.56–1.25)	



B Death from Prostate Cancer

Subgroup	Observation	Radical Prostatectomy	Hazard Ratio (95% CI)	P Value for Interaction
	no. of events/total no.			
Overall	31/367	21/364	0.63 (0.36–1.09)	
Age				0.63
<65 yr	12/131	6/122	0.52 (0.20–1.39)	
≥65 yr	19/236	15/242	0.68 (0.34–1.33)	
Race				0.76
White	22/220	15/232	0.57 (0.30–1.10)	
Black	7/121	5/111	0.80 (0.25–2.54)	
Other	2/26	1/21	0.56 (0.05–6.17)	
Charlson score				0.63
0	19/220	14/224	0.69 (0.34–1.37)	
≥1	12/147	7/140	0.54 (0.21–1.38)	
Performance score				0.57
0	25/310	18/312	0.67 (0.37–1.23)	
1–4	6/57	3/52	0.41 (0.10–1.71)	
PSA				0.11
≤10	15/241	14/238	0.92 (0.44–1.91)	
>10	16/125	7/126	0.36 (0.15–0.89)	
Risk				0.11
Low	4/148	6/148	1.48 (0.42–5.24)	
Intermediate	13/120	6/129	0.50 (0.21–1.21)	
High	2/86	1/77	0.48 (0.04–5.30)	
Gleason score				0.57
<7	15/261	11/254	0.68 (0.31–1.49)	
≥7	15/86	10/98	0.51 (0.23–1.14)	



OS RR 0.71

+LNs 3.7-20.1%
eLND performed if risk >5%

CSS RR 0.56

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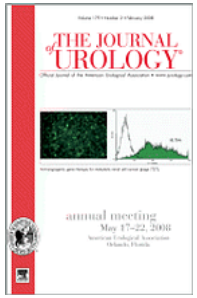
HIGH RISK PCa



Radical Prostatectomy for Clinically Localized, High Risk Prostate Cancer: Critical Analysis of Risk Assessment Methods

Ofer Yossepowitch, Scott E. Eggener, Fernando J. Bianco Jr., Brett S. Carver, Angel Serio, Peter T. Scardino, James A. Eastham.
Urology Service, Department of Surgery, Memorial Sloan-Kettering Cancer Center, New York, New York

- There is **no consensus** regarding the optimal treatment
- **Not all** high-risk PCa patients have a uniformly **poor prognosis after RP**

	OS	5y CSS	10y CSS	15y CSS
GS 8-10	29%	96%	86%	66%
PSA>20ng/ml		50%	30%	25%

- Provided the tumor is **not fixed RP is a reasonable first step** in selected patients with a low tumour volume
- **e-LND** should be performed **in all cases** (risk +LN 15-40%)

LOCALLY ADVANCED PCa

- RP **traditionally discouraged** because increased risk of +sm, + LN, distant relapse.
- **Renewed interest** in RP part of **multimodality** setting assuming LN (-)

Results of radical prostatectomy in men with locally advanced prostate cancer: multi-institutional pooled analysis.
Gerber GS1, Thisted RA, Chodak GW, Schroder FH, Frohmuller HG, Scardino PT, Paulson DF, Middleton AW Jr, Rukstalis DB, Smith JA Jr, Ohori M, Theiss M, Schellhammer PF.

cT3	5years	10years
CSS	90-99%	85-92%
OS	90-96%	76-77%
BFS	45-62%	43-51%

Predicting prostate cancer-specific outcome after radical prostatectomy among men with very high-risk cT3b/4 PCa: a multi-institutional outcome study of 266 patients
F Moltzahn, J Karnes, P Gontero, B Kneitz, B Tombal, P Bader, A Briganti, F Montorsi, H Van Poppel, S Joniau and M Spahn

CT3b-T4	5years	10 years
CSS	88-92%	87-92%
OS	73-88%	65-71%

- Due to limited evidence, **local treatment of cN+** patients, should be discussed on **individual** basis.

RP with cN0 ⟶ pN1

Immediate versus deferred androgen deprivation treatment in patients with node-positive prostate cancer after radical prostatectomy and pelvic lymphadenectomy

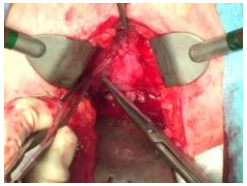
Edward M Messing, Judith Manola, Jorge Yao, Maureen Kiernan, David Crawford, George Wilding, Anthony di'Sant Agnese, Donald Trump, on behalf of the Eastern Cooperative Oncology Group study EST 3886

- Dramatic **improvement** in CSS and OS **in favour of completed RP** vs. abandoned RP in patients who were found to be **N+ at the time of surgery**.

After surgery in pN1 PCa	5years	10 years	15 years
CSS	84-95%	51-86%	45%
OS	79-85%	36-69%	42%

- **Frozen sections** of LN intraoperatively **no longer** recommended

ROBOT VS OPEN VS LAP



In patients who are surgical candidates for radical prostatectomy, all approaches (i.e. open, laparoscopic or robotic) are acceptable because none has clearly shown superiority in terms of functional or oncological results.	1a	A

Platinum Priority – Prostate Cancer

Editorial by Thomas E. Ahlering on pp. 226–227 of this issue

Urinary Incontinence and Erectile Dysfunction After Robotic Versus Open Radical Prostatectomy: A Prospective, Controlled, Nonrandomised Trial

Eva Haglind [a,], Stefan Carlsson [b], Johan Stranne [c], Anna V... Thordis Thorsteinsdottir [d,e], Mikael Lagerkvist [f], Jan-Erik L... Jonas Hugosson [c], Peter Wiklund [b], Gunnar Steineck [d,h], on behalf of the LAPPRO steering committee[†]*

[a] Department of Surgery, Institute of Clinical Sciences, Sahlgrenska Academy at the University o... Sweden; [b] Department of Molecular Medicine and Surgery, Section of Urology, Karolinska Institu... Clinical Sciences, Sahlgrenska Academy at the University of Gothenburg, Sahlgrenska Univers... Epidemiology, Department of Oncology, Institute of Clinical Sciences, Sahlgrenska Academy at ... Nursing, School of Health Sciences, University of Iceland, Reykjavik, Iceland; [f] UroClinic, Stockholm, Sweden; [g] Department of Urology, Skåne University Hospital, Lund University, Malmö, Sweden; [h] Department of Oncology and Pathology, Division of Clinical Cancer Epidemiology, Karolinska Institutet, Stockholm, Sweden

Conclusions: In a Swedish setting, RALP for prostate cancer was modestly beneficial in preserving erectile function compared with RRP, without a statistically significant difference regarding urinary incontinence or surgical margins.

Trifecta differences NS

Collaborative Review – Prostate Cancer

A Systematic Review of the Volume–Outcome Relationship for Radical Prostatectomy

Quoc-Dien Trinh [a,b,c,], Anders Bjartell [d], Stephen J. Freedland [e], Brent K. Hollenbeck [f], Jim C. Hu [g], Shahrokh F. Shariat [h], Maxine Sun [b], Andrew J. Vickers [i]*

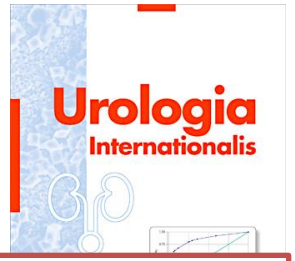
[a] CRCHUM, Centre Hospitalier de l'Université de Montréal, Montreal, Canada; [b] Cancer Prognostics ... l'Université de Montréal, Montreal, Canada; [c] Vattikuti Urology Institute, Henry Ford Health System, ... University Hospital, Malmö, Sweden; [e] Section of Urology, Durham VA Medical Center, Durham, NC, U... Surgery, Departments of Surgery and Pathology, Duke University School of Medicine, Durham, NC, USA; ... Outcomes and Policy, University of Michigan, Ann Arbor, MI, USA; [g] Department of Urology, David Geffe... [h] Department of Urology, Weill Medical College of Cornell University, New York, NY, USA; [i] Department ... Kettering Cancer Center, New York, NY, USA

Conclusions: Undeniable evidence suggests that increasing volume improves outcomes. Although it would seem reasonable to refer RP patients to high-volume centers, such regionalization may not be entirely practical. As such, the implications of such a shift in practice have yet to be fully determined and warrant further exploration.

High volume surgeon

ΕΠΙΠΛΟΚΕΣ RP

Complication	Incidence (%)
Per-operative death	0-2
Major bleeding	1-11.5
Rectal injury	0-5.4
DVT	0-8.3
PE	0.8-7.7
Lymphocele	1-3
Urine leak, fistula	0.3-15.4
Stress incontinence	4-50 / 0-15.4
Impotence	29-100
Bladder neck obstruction	0.5-14.6
Ureteral obstruction	0-0.7
Urethral stricture	2-9



Retropubic, Laparoscopic, and Robot-Assisted Radical Prostatectomy: Surgical, Oncological, and Functional Outcomes: A Systematic Review

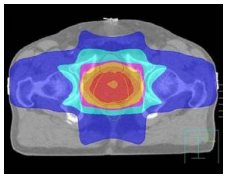
Francesco De Carlo[a] Francesco Celestino[b] Cristian Verri[a] Francesco Masedu[c] Emanuele Liberati[b] Savino Mauro Di Stasi[a]

Predicted probability of event	RALP	Laparoscopic RP	RRP
Bladder neck contracture	0.010	0.021	0.049
Anastomotic leak	0.010	0.044	0.033
Infection	0.008	0.011	0.048
Organ injury	0.004	0.029	0.008
Ileus	0.011	0.024	0.009
Deep-vein thrombosis	0.006	0.002	0.014
Predicted rates of event	**RALP (%)**	**Laparoscopic RP (%)**	**RRP (%)**
Clavien I	2.1	4.1	4.2
Clavien II	3.9	7.2	17.5
Clavien IIIa	0.5	2.3	1.8
Clavien IIIb	0.9	3.6	2.5
Clavien IVa	0.6	0.8	2.1
Clavien V	< 0.1	0.2	0.2

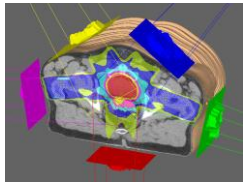
ΕΠΙΠΛΟΚΕΣ ΣΕ ΕΞΕΙΔΙΚΕΥΜΕΝΟ ΚΕΝΤΡΟ

ΕΓΚΡΑΤΕΙΑ & ΣΤΥΤΙΚΗ ΛΕΙΤΟΥΡΓΙΑ ΜΕΤΑ ΑΠΟ ΡΠ στο Johns Hopkins				
	3 μήνες	6 μήνες	12 μήνες	18 μήνες
Στυτική λειτουργία				
Ικανός	38%	54%	73%	86%
Καθόλου ή μικρό πρόβλημα	49%	64%	76%	84%
Εγκράτεια				
Καμία πάνα	79%	88%	98%	

ΑΚΤΙΝΟΘΕΡΑΠΕΙΑ



- **3D CRT**
- **IMRT**
- **TOMOTHERAPY**

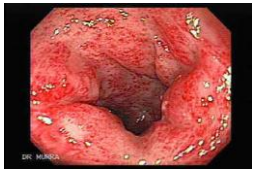


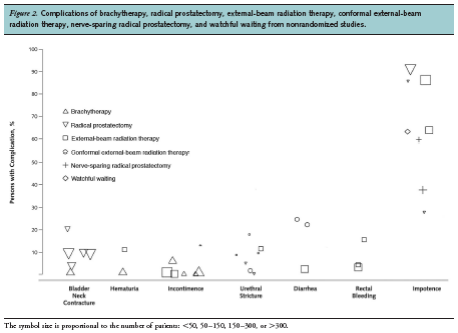
- **Intensity-modulated radiotherapy (IMRT)**, with or without image-guided radiotherapy (IGRT), is the **gold standard** for EBRT.

- **Dose escalation (range 74-80Gy)**:
  - ➢ No trials showing OS benefit with dose escalation, however consistent improvements in freedom from **biochemical progression** are reported.

- **Hypofractionation (1.8-2Gy)**

- **Complications**





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XBRT INDICATIONS

Radiotherapy	In low-risk PCa the total dose should be 74 to 78 Gy.	A

Radiotherapy	In intermediate-risk PCa, the total dose should be 76-78 Gy in combination with short-term ADT (4-6 mo).	A

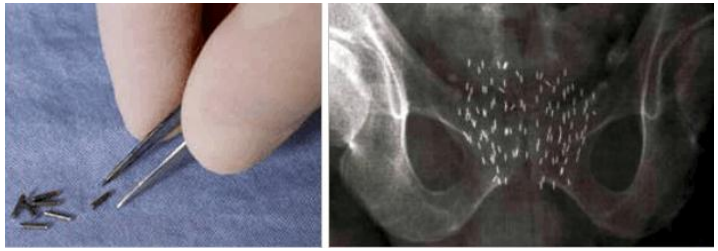
Radiotherapy	In patients with high-risk localised PCa, the total dose is 76-78 Gy in combination with long-term ADT (2-3 yr is recommended).	A
	In patients with **locally advanced cN0** PCa, radiotherapy must be given in combination with long-term ADT (2-3 yr is recommended).	A

GUIDELINES

European Association of Urology

ΒΡΑΧΥΘΕΡΑΠΕΙΑ

In patients with low-risk PCa, without a previous TURP and with a good IPSS and a prostate volume < 50 mL, LDR brachytherapy is a treatment option.	A



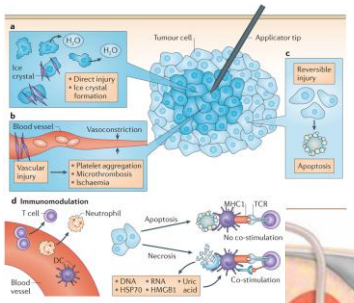
Low risk	5year	10 year
RFS	71-93%	65-85%

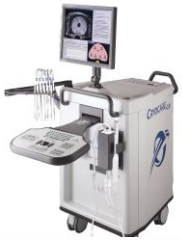
Complications
Urinary retention 1.5-22% (TURP 9%)
Incontinence 0-19%
ED 40%

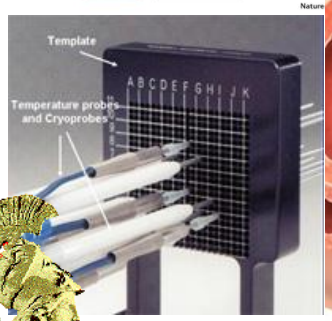
	Differences in prostate brachytherapy techniques
Low Dose Rate (LDR)	Permanent seeds Uses I-125, Pd-103 or Cs-131 isotopes Radiation delivered over weeks and months Acute side effects resolve over months Radiation protection issues for patient and carers
High Dose Rate (HDR)	Temporary implantation Ir-192 isotope introduced through implanted needles or catheters Radiation dose delivered in minutes Acute side effects resolve over weeks No radiation protection issues for patient or carers

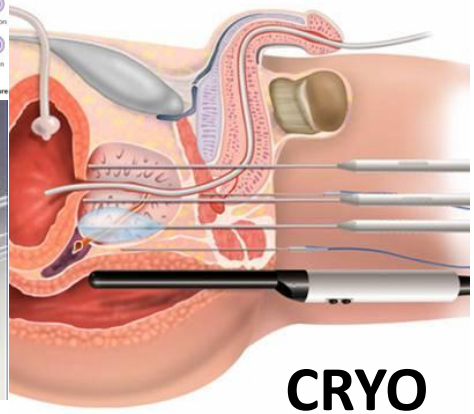
OTHER FORMS OF RADICAL THERAPY

Cryotherapy, HIFU	In patients who are unfit for surgery or radiotherapy, cryotherapy or HIFU might be an alternative treatment for PCa. The lack of long-term efficacy compared to standard modality should be discussed with patients.	C



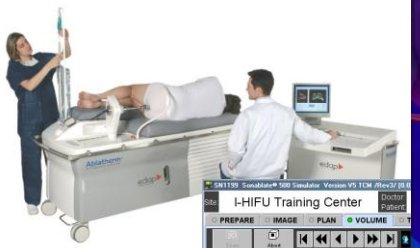


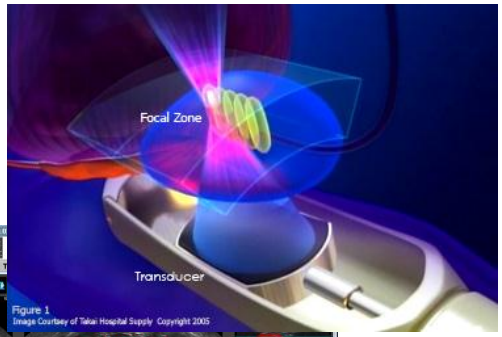


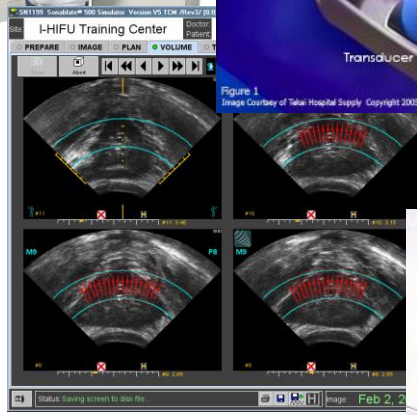


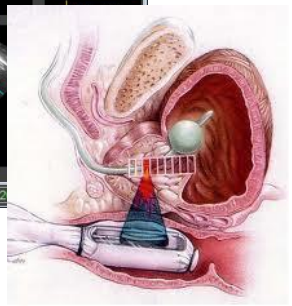
CRYO

HIFU









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ΑΝΤΙΜΕΤΩΠΙΣΗ ΡΙΖΙΚΗΣ ΠΡΟΣΤΑΤΕΚΤΟΜΗΣ ΜΕ ΑΥΞΗΜΕΝΟ ΚΙΝΔΥΝΟ ΓΙΑ ΥΠΟΤΡΟΠΗ

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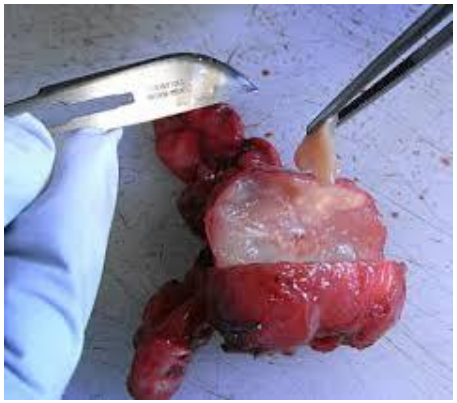
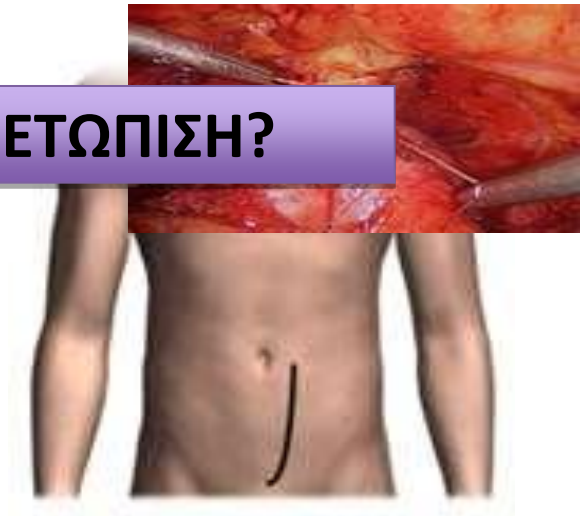
ΡΙΖΙΚΗ ΠΡΟΣΤΑΤΕΚΤΟΜΗ

ΚΑΚΑ ΠΡΟΓΝΩΣΤΙΚΑ ΣΗΜΕΙΑ ΜΕΤΑ ΡΠ

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



ΑΝΤΙΜΕΤΩΠΙΣΗ?



Κινδυνος

- ΒΥ
- Παραμονή υψηλού PSA

ΑΚΤΙΝΟΘΕΡΑΠΕΙΑ

ΠΟΤΕ ΚΑΤΑΛΛΗΛΟ TIMING?

ΕΠΙΚΟΥΡΙΚΗ XBRT

"adjuvant"

RP

+sm
+Sv
+cap
GS8

60-64GY

1.5-4.5 mt

BY

XBRT ΔΙΑΣΩΣΗΣ

"salvage"

ΥΠΕΡΘΕΡΑΠΕΙΑ

ΤΟΞΙΚΟΤΗΤΑ

ΑΠΩΛΕΙΑ ΘΕΡΑΠΕΥΤΙΚΟΥ ΠΑΡΑΘΥΡΟΥ

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ΕΠΙΚΟΥΡΙΚΗ ΑΚΘ vs. ΠΑΡΑΚΟΛΟΥΘΗΣΗ

3 προοπτικά τυχαιοποιημένες μελέτες – LEVEL 1b

Study	N	Median FU	**Biochemical PFS**	Mets	Death (%)
EORTC 22911 Bolla et al	**Van Popel 2011 EAU Vienna** FU>10years MF NS **OS NS**				
SWOG 8794 Thompson et al	**Thompson et al J Urol 2009** 12.6 years MF p<0.016 **OS p<0.023**				
ARO 96-02 Wiegel et a					

GUIDELINE STATEMENT 2013 (ASTRO & AUA)

ADJUVANT XBRT IN PT WITH ADVERSE PATHOLOGIC FEATURES

- **SV**
- **+SM**
- **EPE**

AUA GUIDELINES

W 2009

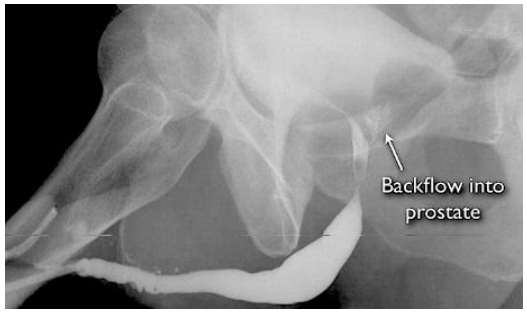
ΜΕΙΟΝΕΚΤΗΜΑΤΑ ΕΠΙΚΟΥΡΙΚΗΣ ΑΚΘ: ΤΟΞΙΚΟΤΗΤΑ

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	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	3.7	0	0	
Small bowel obstruction	0.2	0.2	0	
Leg oedema	1.5%	0%	0%	1.5%
Erectile dysfunction				
Secondary malignancy				

10%

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

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: ΚΙΝΔΥΝΟΣ ΥΠΕΡΘΕΡΑΠΕΙΑΣ

- Κέρδος ΚΥΡΙΩΣ σε ασθενείς με (+) ΧΟ
- Β.Υ όχι σίγουρη σε (+) ΧΟ

ΤΙ ΓΙΝΕΤΑΙ (-) ΧΟ & ΕΡΕ

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%

Porter CR et al BJU 2009

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**

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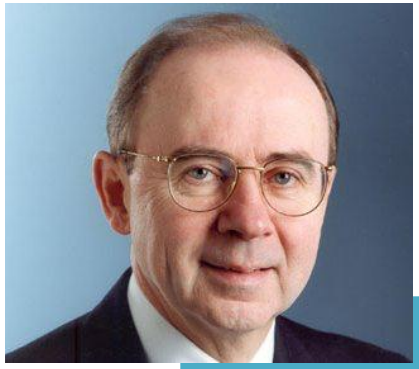
Platinum Priority – Prostate Cancer

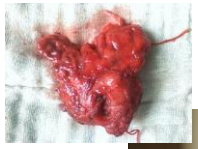
Editorial by Alberto Bossi, Thomas Wiegel and Mack Roach on pp. 775–776 of this issue

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

ΕΞΑΤΟΜΙΚΕΥΣΗ ΘΕΡΑΠΕΙΑΣ

ADJUVANT XBRT : WHO SCHOULD RECEIVE IT

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

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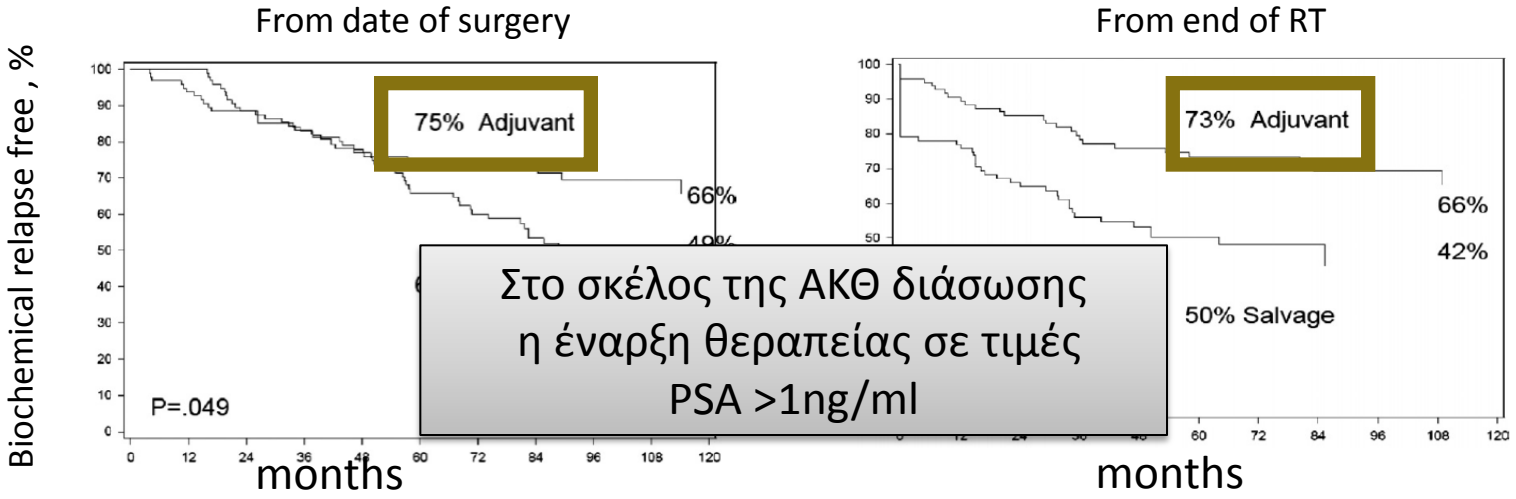
ΕΠΙΚΟΥΡΙΚΗ ΑΚΘ vs. ΑΚΘ ΔΙΑΣΩΣΗΣ

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



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

Αναδρομική Πολυκεντρική μελέτη 2299 (192) pts

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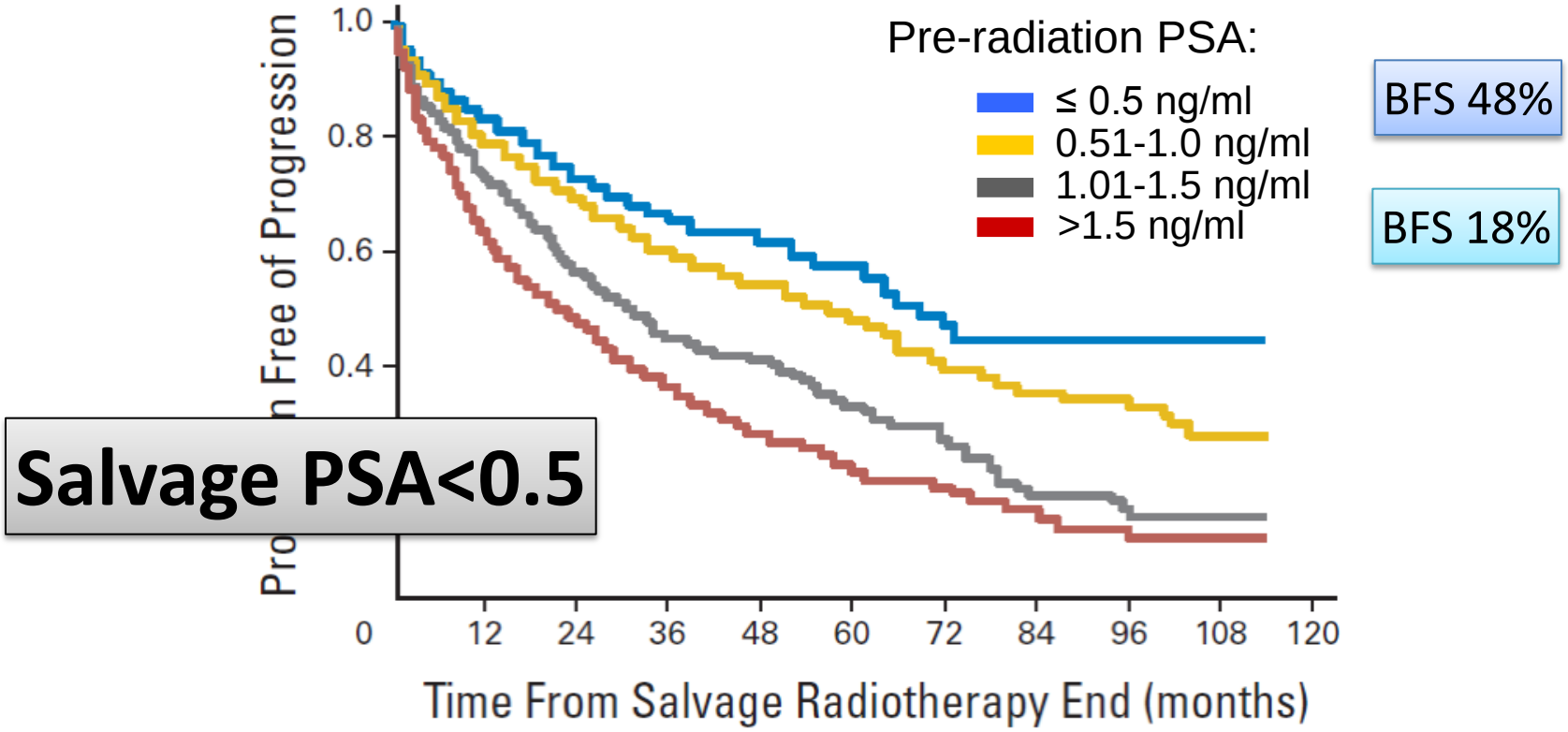
ΑΚΘ ΔΙΑΣΩΣΗΣ
Σημασία PSA προ ΑΚΘ



BFS 48%

BFS 18%

Salvage PSA<0.5

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

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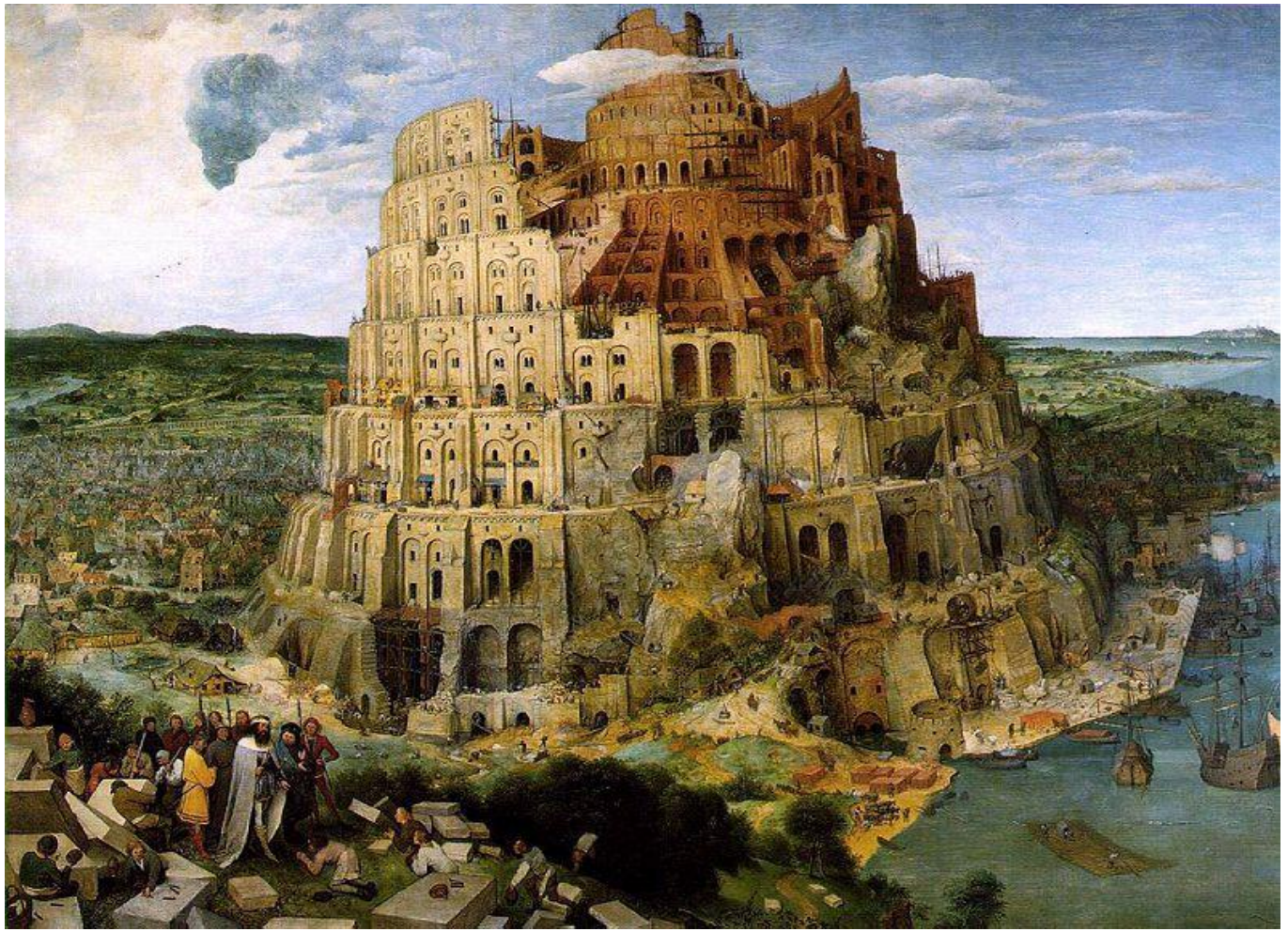
Stephenson et al. J. Clin Oncol 2007

ΣΥΜΠΕΡΑΣΜΑΤΑ

- **Πρόβλεψη Βιοχημικής Υποτροπής**
  - Ομάδες Κινδύνου (Κλινικά στοιχεία, Παθ/κή εξέταση)
- **Επικουρική ΑΚΘ**
  - Καλύτερα αποτελέσματα όσον αφορά την ΒΥ κυρίως σε ασθενείς με (+) ΧΟ & HIGH GRADE νόσο
  - Αυξημένη νοσηρότητα
- **ΑΚΘ Διάσωσης**
  - PSA<0.5ng/ml



ΕΥΧΑΡΙΣΤΩ

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