



ORIGINAL ARTICLE

Our experience in the management of prostate cancer in renal transplant recipients[☆]



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KEYWORDS

Renal transplant;
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Abstract

Introduction and objectives: The management of prostate cancer (PCa) in renal transplant recipients (RTRs) is challenging and remain controversial. Currently there is no consensus about this condition. The aim of the study was to analyze our experience in the diagnosis and management of PCa in RTR.

Method: Retrospective monocentric study of a prospective and consecutive database from 2003 to 2017. Inclusion of RTR diagnosed of PCa. Staging and treatment in agreement with the contemporary guidelines. The main outcome measures included clinical staging, type of treatment, oncological outcomes and follow-up.

Results: 1330 renal transplants were performed (787 males), diagnosed of PCa in 33 RTR (4.2%), mean age 66 years \pm 6.3 (51–78). Median PSA was 8.8 ng/ml and PSA ratio 0.19. Mean time between renal transplantation and PCa diagnosis 130 months \pm 90 (2–236). Treatments: radical prostatectomy (RP) ($n=22$; 66.7%), radiation therapy (RT) with androgen deprivation therapy (ADT) ($n=7$; 21.2%), active surveillance ($n=3$; 9.1%), and ADT ($n=1$; 3%). No graft loss neither impaired renal function due to PCa treatment was reported. After RP two patients (9.1%) presented biochemical recurrence treated with RT. Remission of the 100%. Mean follow-up was 61 months \pm 37 (6–132).

Conclusions: PCa in renal transplant patients can be managed with the same therapeutic options as in the general population. Active surveillance should also be provided in RTR despite being under immunosuppressive therapy.

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PALABRAS CLAVE

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Cáncer de próstata;
Prostatectomía
radical;
Vigilancia activa;
Recidiva bioquímica

Nuestra experiencia en el manejo del cáncer de próstata en pacientes trasplantados renales

Resumen

Introducción y objetivos: El manejo del cáncer de próstata (CP) en receptores de trasplante renal (RTR) es un reto y muchos aspectos siguen siendo controvertidos. Actualmente no hay consensos sobre el manejo de esta enfermedad. El objetivo del estudio fue analizar nuestra experiencia en el diagnóstico y tratamiento del CP en RTR.

Método: Estudio monocéntrico retrospectivo de una base de datos prospectiva y consecutiva del 2003-2017. Inclusión de RTR diagnosticados de CP. Estadificación y tratamiento según guías contemporáneas. Los principales parámetros evaluados incluyeron estadificación clínica, tipo de tratamiento, resultados oncológicos y seguimiento.

Resultados: De 1.330 trasplantes renales (787 varones), se diagnosticó CP en 33 RTR (4,2%), con una edad media de 66 años \pm 6,3 (51-78). La media de PSA fue de 8,8 ng/ml y PSA ratio de 0,19. El tiempo medio entre el trasplante renal y el diagnóstico de CP fue de 130 meses \pm 90 (2-236). Tratamiento: prostatectomía radical (PR) (n = 22; 66,7%), radioterapia (RT) más terapia de privación androgénica (TDA) (n = 7; 21,2%), vigilancia activa (n = 3; 9,1%) y TDA (n = 1; 3%). No se reportaron pérdidas del injerto ni deterioro de la función renal atribuibles al tratamiento del CP. Tras PR, 2 pacientes (9,1%) presentaron recurrencia bioquímica, tratados con RT. La remisión fue del 100% y el seguimiento medio, de 61 meses \pm 37 (6-132).

Conclusiones: El CP en trasplantados renales puede ser manejado con las mismas opciones terapéuticas que en la población general. La vigilancia activa debería también considerarse en los RTR a pesar de estar bajo tratamiento inmunosupresor.

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Introduction

Cancer is a major adverse outcome of solid organ transplantation, with a 2–3-fold elevated risk of tumors than the general population, especially skin cancer and post-transplant lymphoproliferative disorder.¹

The presence of neoplasms is a major threat and cause of morbidity in renal transplant recipients (RTRs). In this population, the most common solid organ diseases reported have been lymphoproliferative diseases, followed by lung cancer and genitourinary malignancies.²

Nowadays, morbidity and mortality of RTR are still mainly of cardiovascular origin, but it has been suggested that within the next 20 years death due to tumor development will be the principal cause of death in this patient category.³

Among urogenital tumors in RTR, a highly increased incidence rate of renal cell carcinoma (15-fold), bladder (3-fold), testicular (3-fold), and prostate (2-fold) have been estimated compared with the general population.^{1–3} Of these, urologic tumors, renal cell carcinoma, and prostate cancer (PCa) have been reported as the most common genitourinary cancers after solid organ transplantation.^{4–7}

PCa is the most common tumor in men, with an estimated age-standardized incidence of 82.27 cases per 100,000 men.⁸ This pathology in RTR has not been widely studied, its incidence remains variable reported 2–5 times more than the general population, ranging from 0.3 to 1.9%, especially in series where systematic screening is performed by prostate specific antigen (PSA) and digital rectal examination (DRE) in all male RTRs over 50 years old with a life expectancy of at least 10 years.^{9,10} However, there are series in which the incidence is similar or even lower than the general population. Likewise, the prevalence increases

with the age of the recipient due to increased allograft survival, recipient age, and if intensive systematic screening is performed.^{11–18}

The treatment modalities that have been used for RTR with PCa include radical prostatectomy (RP), radiation therapy (RT), hormonal therapy, and active surveillance (AS).¹⁹ In RTR, there are a number of important considerations so that the management of this disease is challenging. It is believed that RTRs under immunosuppressive therapy may have increased postoperative morbidity and higher rate of tumor progression given their vulnerability to infection due to immunodeficiency and the oncogenic status of immunosuppressive treatments. Additionally, the surgery in RTR is complicated due to several factors, including the distortion of normal tissue planes, the pelvic location of the transplant kidney with difficulty to perform bilateral lymphadenectomy.²⁰

Nonetheless, radical prostatectomy (RP) remains the preferential option, being that several published series have demonstrated its feasibility via open radical retroperitoneal prostatectomy (RRP), perineal radical prostatectomy (PRP), laparoscopic radical prostatectomy (LRP), and robot-assisted laparoscopic radical prostatectomy (RARP).^{20,21}

Another aspect is the radiation therapy (RT) that is often avoided due to risks of allograft injury, ureteral injury, and urethral strictures. Conversely, some experts maintain that RT is a safe and viable option in RTR as doses delivered to the graft are typically below thresholds reported to induce complications.^{22,23}

Currently, there are not standardized guidelines, consensus, or randomized studies for screening or management of this condition in these complex patients.

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