

Prostate Cancer

A Contemporary Approach to Treatment and Outcomes

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KEYWORDS

- Prostatic neoplasm • Therapeutics • Treatment outcomes • Surgical procedures
- Operative • Radiotherapy • Watchful waiting

KEY POINTS

- It is imperative for primary care providers to understand the different treatment options for prostate cancer given the high incidence and need for shared-decision making before screening.
- The mainstays of prostate cancer treatment include observation, surgery, and radiotherapy for localized disease; and androgen deprivation therapy and chemotherapy for metastatic disease.
- Active surveillance for low-risk prostate cancer may minimize unnecessary treatment without compromising survival and is the preferred management approach.
- Radical prostatectomy and radiotherapy with or without androgen deprivation therapy, are used to treat localized prostate cancer and have similar cancer-specific outcomes but different adverse effects.
- Androgen deprivation therapy has a variety of adverse effects that require monitoring and preventive measures.

INTRODUCTION

Prostate cancer will be diagnosed in more than 160,000 men and claim the lives of more than 25,000 men in 2017.¹ Over the past decade, the diagnosis of prostate cancer using prostate-specific antigen (PSA)-directed screening has been scrutinized with concerns that it may lead to overtreatment of low-grade disease that may never have become symptomatic in a patient's lifetime or result in death from prostate cancer. In 2012, the US Preventive Services Task Force (USPSTF) recommended against routine prostate cancer screening, citing that the benefits of screening were outweighed by the potential harms associated with diagnosis and treatment.²

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It is notable that recent trends in the approach to managing low-grade prostate cancer have moved more toward a risk-adaptive approach, including active surveillance, when appropriate, in the hopes of reducing overtreatment.^{3,4} (See William J. Catalona's article, "Prostate Cancer Screening," in this issue.) In addition, data from large trials have supported that early screening and subsequent treatment may prevent progression to metastatic disease.⁵ These trends have influenced the USPSTF to recently recommend screening for prostate cancer after discussion with a clinician about the potential harms and benefits of screening.⁶ Therefore, it is imperative that, as the first point of contact, primary care providers are knowledgeable on the topic of prostate cancer management if they are going to advise patients about screening.

The traditional paradigm of treatment of adenocarcinoma of the prostate (which will henceforth be implied when referring to prostate cancer) includes observation, radical prostatectomy, and radiotherapy with or without androgen deprivation therapy (ADT) for localized, nonmetastatic prostate cancer. Systemic treatment alone, such as ADT and chemotherapy, are generally reserved for men with metastatic disease. Each of these management approaches has a unique combination of indications, advantages, disadvantages, adverse effects, and surveillance schedules.

The goal of this article is to serve as a reference for primary care providers who are counseling their patients on screening for and management of prostate cancer. It covers the standard approaches to the initial management of prostate cancer, post-treatment surveillance, and the adverse effects of each management approach. It also briefly reviews the management options following cancer recurrence and current areas of research interest.

OBSERVATION

Observation can be categorized into 2 subsets: watchful waiting and active surveillance. Both were developed as a means of reducing overtreatment in prostate cancer and have been increasingly implemented in recent years.^{3,4}

Watchful Waiting: Treatment Only for Symptomatic Relief

Watchful waiting implies a passive monitoring of symptoms without treatment in the absence of clinical symptoms or extreme elevations in PSA (>100 ng/mL).⁷ Development of symptoms associated with prostate cancer progression or extremely high PSA values (which may portend imminent symptoms) would trigger treatment intervention with intentions to palliate symptoms. Patients electing watchful waiting can expect possible blood tests and physical examinations no more frequently than every 6 months. Palliative measures may include ADT (see later discussion) or radiotherapy directed at painful bony metastases. In the largest randomized controlled trial comparing radical prostatectomy to watchful waiting, surgery was able to reduce the rate of developing metastatic disease for men aged 65 years and younger from 45% to 28%, but differences between the 2 treatment arms were minimal before 10 years of follow-up.⁸ Thus, in general, patients who qualify as watchful waiting candidates have less than 5 years life expectancy or have low-risk or intermediate-risk disease according to the National Comprehensive Cancer Network (NCCN) standards (Table 1) and a life expectancy of less than 10 years.⁷

The rationale to pursue watchful waiting is aimed at minimizing the adverse effects associated with treatment of patients who may derive minimal survival benefit from definitive local therapy, such as surgery or radiation. One important factor in enrolling a man into watchful waiting is his age, which serves a surrogate for life expectancy.

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