Prostate Cancer Treatment: What's Best for You?

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Daniel Petrylak, MD

I. Medical Oncologist

When patients come into my office, their question is what is the best treatment? For local disease, the major reason that patients come to me is they see the surgeon, the surgeon recommends surgery, the radiation oncologist recommends radiation therapy, and I supposedly have the unbiased opinion. We have more of a role in high-risk disease, and the question for a patient who is undergoing a prostatectomy is should they have chemotherapy or should they have hormone therapy added? We don't have good evidence one way or the other, and this is where we would like to enter patients into clinical trials. Finally, the third situation is when patients come to see us with metastatic disease. When do we start hormone therapy, and what is the initiation of second-line hormone therapy, chemotherapy and radiation therapy?

II. High-Risk Prostate Cancer: The Options

The treatment options must be tailored to what the patient has as far as risks are concerned, but in terms of surgery there is the standard radical prostatectomy with wide/extended resection based on the extent of disease. Neoadjuvant hormone therapy is generally not recommended for patients with surgery. Androgen blockade afterwards is useful certainly if a patient has high-risk disease, and adjuvant radiation therapy now is coming into play. A lot of patients will come to me after they have had a prostatectomy and they have high-risk pathology and ask what do we do? Chemotherapy is not considered to be standard of care for those patients who have localized prostate cancer. Until additional data are published, we really don't have a guide as to how to use chemotherapy in this situation.

Generally, we do recommend for a high-risk patient that radiation therapy be combined with hormone therapy. The duration of the hormone therapy is not really clear, but there are other studies in the RTOG that are looking at giving chemotherapy after the radiation therapy is complete. With all of these modalities, it is important to assess the medical condition of the patient and to determine what the odds are of the patient dying from other causes before their prostate cancer actually could potentially metastasize.

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Questions

I. Robotic surgery is all over the media. How does a patient who is considering this technology go about choosing where to go?

Ihor Sawczuk, MD

Choosing a physician comes down to word of mouth and groups such as Prostate Net that have experience with physicians. There are outcomes that physicians have based on true data, and it comes down to picking an individual who has a good experience.

II. There is a lot of advertising regarding CyberKnife treatment. Could you explain what that means?

Andrew Salner, MD

CyberKnife is a stereotactic, very precise linear accelerator. The basis of the CyberKnife experience is that the treatment can be given in a small number of treatments. With conventional IMRT, we usually will treat the patient daily five days a week over eight weeks. CyberKnife gives prostate cancer treatment in five days. It has now been done for about three years, but there is no long-term data yet showing the efficacy or potential toxicity.

III. For the patient who has very advanced prostate cancer who now is not responding to hormone therapy, what are the options?

Daniel Petrylak, MD

You have to assess how quickly a patient is progressing, and what we have been finding is despite the fact that a patient may have a castration level of testosterone in their blood stream, if you take tissue from the prostate or the metastases, there are detectable testosterone levels in the tissue, which is the basis for this concept of androgen-independent or castration-resistant prostate cancer. They are resistant to their primary form of castration, and probably what we should say is failing primary hormone therapy. We can see patients who respond to going on flutamide or Casodex afterwards. Abiraterone has undergone a randomized trial after patients fail chemotherapy, and we are awaiting the results of that study. Another drug is called MDV3100, which actually antagonizes or prevents the testosterone androgen receptor complex from going into the nucleus, causing gene expression and causing cancer cells to grow. Interestingly, Taxotere chemotherapy will do the same thing. The decision to institute chemotherapy is complex. It absolutely should be done for somebody who has symptomatic disease. Giving it earlier is a little bit more controversial.

IV. HIFU is a hot topic right now. What do you think about it?

Daniel Petrylak, MD

We are part of the clinical trial of HIFU at Hackensack University Medical Center, and we do have a HIFU unit but only as part of a clinical trial. It is a new technology that should be available in the United States for use in localized prostate cancer in selected patients. It is like radiation therapy in that very intense ultrasound waves generate heat, and it kills the cells by heat transmission.

V. How do you manage someone who is young whose pathology is such that they have had a radical prostatectomy, have a Gleason's 9, and a positive lymph node. The PSA right after three months was 1.5 or 2.

Daniel Petrylak, MD

The issue is what do we have evidence for, and what can we accomplish in the long-term with these particular patients? The question is when should you institute androgen blockade, and since he has positive lymph nodes we generally will do it right off the bat. There is data that clearly show that earlier androgen blockade in the adjuvant setting after the prostate is out is better than waiting until the patient develops a clinical relapse. The flip side of that is the median PSA at which patients started hormone therapy was 14. There is no evidence at this point that immediate versus waiting until the first PSA rise is any better or worse. In fact, the other complicating issue is should we give hormone therapy intermittently or continuously, and there will be data coming out from a randomized trial next year looking at that issue. Right now the standard answer is to go with immediate androgen blockade based on lymph nodes. The other more interesting question should be when do you institute hormone therapy for a rising PSA? There is no answer for that. We are also identifying more and more that hormone therapy has serious complications, the most published of which is osteoporosis. You have to use clinical judgment.

VI. What patient is a candidate for radiation after radical prostatectomy with rising PSA?

Andrew Salner, MD

Patients who don't have a rising PSA but who have stage 3 disease we might contemplate for adjuvant therapy depending on the pathology findings, and those patients with a rising PSA where we think the disease is highly likely to be just local, we would consider for radiation therapy.

Participant

What is the recurrence rate after primary therapy?

Andrew Salner, MD

It very much depends on the stage of the disease, the Gleason grade and all of the other pathology factors. There is no single answer.