

Prostate Cancer Treatment: What's Best for You

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Introduction

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Thank you, Virgil and the sponsors, for inviting me to talk today. I am in charge of the prostate medical oncology program here in Jacksonville. Hopefully, I will enlighten you as far as what type of treatments should we offer to our patients. I will give the introduction; the other two speakers will go in-depth about the other treatment options for prostate cancer such as surgery or radiation.

About five to ten years, we saw patients with metastatic disease lying down in bed with severe pain and close to being in a coma, not able to talk to their patient, with spinal cord compression and with urinary and bowel incontinence. Hopefully, we can avoid that by early diagnosis. I know there is a lot of controversy in screening, but I think the most important message that I would convey today in one sentence is that we should screen men who want to be screened for prostate cancer.

Prostate cancer is the most common cancer in men, and unfortunately, 30,000 men each year still die of prostate cancer because of late diagnosis and maybe because of aggressive disease. There is a lot of variability in the disease, and it is important hopefully with the different things that we discussed this morning, including looking at biomarkers, looking at certain genes, that we will be able to better stratify these patients and try to know which patient will have aggressive disease in the long run or not. On top of what we know from today, the Gleason score, the grade of the disease, whether there is perineural [phonetic] involvement, or whether there is extension beyond the capsule, we should go beyond that, and that is why this kind of conference is important. When you go to the urologist and your PSA gets high enough, at least you would do a biopsy.

Diagnosis is important, and we talk about PSA. Gleason score is important, and staging is important, whether it is localized in the prostate, or has gone beyond the bounds of the prostate, which is known as extracapsular extension, and whether the patients have metastasis or not. There is a lot still to be done as far as screening for metastasis because we do not have the perfect tool to detect a small bone metastasis. Unfortunately, bone scans, MRIs, and all those things are very inaccurate.

So our options as far as treatment of prostate cancer includes surgery, and Dave Thiel from the urology department will talk about the permutations about radical prostatectomy. There is the robot helping the surgeon do the surgery; there is what we call laparoscopic surgery, less invasive, less blood loss. We have external beam radiation, the proton machine, and IMRT, seed implant, and of course, for high risk disease, there is the combination of radiation, seed, and sometimes hormonal therapy. The other spectrum of the disease is observation: who are the patients that need to be

observed as far as prostate cancer is concerned? So radical prostatectomy, you have a full pathology. You look at the extent of the disease, you look at whether there is seminal vesicle involvement, perineural involvement; however, there is a risk of going through anesthesia, blood loss, urinary incontinence, and definitely morbidity from surgery, and impotence. Now for many years, Patrick Walsh has looked at a way of doing nerve-sparing prostatectomy, at least in those low risk patients to spare this man impotence.

What has not been studied in prostate cancer extensively is how do these procedures, including prostatectomy, affect quality of life? How do they affect men as they live their lives and do their work?

External beam radiation is important. There are complications from it which I will not go through. We have brachytherapy, low risk but it is not for everybody; we have to mention specifically that brachytherapy, or seed implant, should not be offered to high risk patients, and Dr. Ko will discuss that.

Which patients are appropriate for observation? Elderly patients, most patients that have ten years to live, who are we to judge who can live ten years or less, but at least if they have significant comorbidities, significant heart disease, strokes, or other cancers, maybe those are patients that ought not to be treated, patients with low Gleason score, and in the U.S., those patients who want to be screened and tested and biopsied most of the time would not agree to observation. In Scandinavia, most of the patients are, because they have a different health care system; they are observed and monitored, and actually, most of those patients can outlive prostate cancer. It is important to mention that there are certainly a group or subset of patients that can survive or outlive their prostate cancer.

So options are obviously not equal, and each patient, in a careful discussion with their physician, has to make a decision on what they want to do, either surgery, radiation, or observation. It is very important that you talk to a team; this is a team approach. Unfortunately, in the real world, it is a one-team approach, meaning when you go to the radiation oncologist, they are going to irradiate you; if you go to the surgeon, they are going to do surgery on you. Fortunately, not that I am selling myself, medical oncologists, they would not give chemo to you obviously for early disease, so we do not have a vested interest there. So joking aside, it is very important for you to talk to each one of these players, and at least in our institution, we have what we call a multidisciplinary approach to these patients, so all of us talk to them and give them an objective opinion on how to go about their treatment.

The choice is yours: if you have a diagnosis of localized prostate cancer, it is not your doctor that makes the decision; it is you. However, your doctors have to be very good in informing you about the choices, and specifically the risks and the benefits. You are in charge, and that is why you are here, because you want to know what is important in prostate cancer. Just another important thing, and Dr. Heath here, and the rest of you, would probably agree that it is very important that we participate in clinical trials. Prostate cancer will be the same ten years from now, 20 years from now, 100 years from now, maybe when all of us are gone, hopefully some of you will be still here, but what I mean is that we need to improve, improve upon, where we are today, and the only way we can change the treatment and the prognosis and the outcome of those 30,000 men who are dying each year is clinical trials.

