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Natural History of Patients Presenting Biochemical Recurrence After Radical Prostatectomy: Some Good News?

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In this issue of *European Urology*, Boorjian et al [1] report the “natural history” of patients presenting biochemical recurrence (BCR) after radical prostatectomy (RP). We all have experienced the worries of these patients when prostate-specific antigen (PSA) starts rising after a procedure that was supposed to cure their prostate cancer (PCa).

This study analyzes an impressive 2500-patient cohort of about 10 400 patients (24%) from the Mayo Clinic database, followed up for a median time of 11.5 yr after RP and 6.6 yr after their BCR. There is a lot to be learned from this report, and we thank the authors for sharing their findings with us. Indeed, there is a lot of good news.

First, what we call “good risk PCa patients with a BCR” are indeed really good-risk ones. That is, after having excluded the ones who require salvage treatment, either external-beam radiation therapy (EBRT) or androgen-deprivation therapy (ADT), these patients are doing relatively well. They present a BCR within a median time of 3.1 yr (according to the authors’ definition of BCR, ie, PSA > 0.4 ng/ml), and when they do so (about 24% of patients present BCR after RP in this follow-up time), 12% of them present a systemic progression at some point, and 5.8% ultimately die from their PCa (to be compared with 17% who die from another cause).

Good news: When patients do not have adverse risk factors on their prostate specimen, the risk of dying from PCa when they experience a BCR is reassuringly very low, 1.3% within a median time of 11.5 yr.

Second, salvage therapy may be “useless” in term of systemic progression or cancer-specific survival, according to their analysis for this group of patients within this study time.

Good news: If patients do not have adverse risk factors on prostate specimen requiring adjuvant treatment but present a BCR and are not too anxious about PSA rise, they possibly do not have to endure the side effects of EBRT or ADT.

Third, when patients do not have adverse risk factors on prostate specimen requiring adjuvant treatment but present a BCR, the time between RP and BCR is not an adverse prognostic factor. The lack of prognostic value for systemic progression and specific survival of the delay between prostatectomy and BCR is in discordance with the other main previous large series reporting on the natural history of patients with BCR, namely that from the Johns Hopkins group [2]. These patients with BCR were treated differently at the two institutions (salvage treatment was considered in the Mayo Clinic experience versus surveillance only at Hopkins), and selection bias (exclusion of patients with initial high-risk features treated with androgen suppression) might well be the explanation for this apparent discordance.

For the rest, the data just reinforce what we already knew—except patients’ age, where does that come from?—that having a poor prognosis PCa is bad, in terms of both progression and death from PCa, that is, high Gleason score, higher clinical stage, and rapid PSA doubling time.

We are not far from a truism but far from the real question: Were we correct to operate on these patients? In the light of the randomized studies comparing the benefits/disadvantages for population who are screened versus not screened for PCa [3,4], the conclusion is dubious.

But after the fact, it is always too easy to criticize and offer lessons. What we urgently need is a good way to predict the final pathology preoperatively.

This article brings a stone to supporters of the active surveillance attitude. Maybe it is the ultimate good news for our future patients?
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References


