Prostate cancer has been singled out as a litmus test for US health care reform with a lack of consensus regarding optimal treatment strategies [1]. Up to 21–37% of men experience biochemical recurrence (BCR) after radical prostatectomy [2]. Radiotherapy after prostatectomy improves prostate cancer–specific survival [3] and significantly decreases overall mortality when used in the adjuvant [4] or salvage setting in selected men with high-risk disease [5]. In the current issue, Briganti et al. provide a novel tool to predict BCR following early salvage radiotherapy (eSRT) after radical prostatectomy (RP) [6]. Prior studies have assessed risk factors for BCR following post-RP adjuvant RT and identified men most likely to benefit from early radiotherapy [4,7]. The current study provides a nomogram to identify men at greater risk for BCR following eSRT.

It has been suggested that self-referral patterns may lead to increased utilization and costs of medical care [8,9]. With regard to primary RT for prostate cancer, consultation with radiation oncologists and regional variation has a significant impact on the utilization of RT treatment options [10]. The magnitude of RT utilization is significantly increased with the integration of urology and radiation oncology practices into prostate cancer center groups [10]. Furthermore, companies that sell turnkey intensity-modulated radiation treatment (IMRT) programs to US urology practices market the potential for increased IMRT revenue to replace lost earnings from androgen-deprivation therapy, for which reimbursement decreased sharply as part of the 2003 Medicare Modernization Act [10,11].

The utilization of advanced treatment technologies including IMRT has increased with limited data to suggest superiority over less costly treatment options [12]. Further comparative effectiveness research separating the diagnosis and treatment of prostate cancer are needed to limit overtreatment when comorbidities and competing risks outweigh the survival benefits from secondary treatments [13,14]. Therefore, eSRT following RP must be offered judiciously based on expected overall survival [15,16].

Briganti et al. [6] provide a novel tool in identifying men most suitable for secondary radiotherapy (ie, BCR following eSRT after RP), and the authors should be applauded for their efforts. Further research is needed to examine patient and provider factors influencing treatment decisions and its effect on overtreatment and health care costs. Socioeconomic and clinical outcomes must be balanced when considering health care reform initiatives to improve quality of care.

Conflicts of interest: The authors have nothing to disclose.

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