Re: The Relationship between the Extent of Extraprostatic Extension and Survival following Radical Prostatectomy


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Abstract for this article http://dx.doi.org/10.1016/j.juro.2015.03.044 available at http://jurology.com/

Editorial Comment: This study reveals differences in cancer specific outcomes among men with extraprostatic extension (EPE) identified on final prostatectomy pathology. The authors demonstrate that the extent of EPE (focal vs nonfocal) is predictive of risk of recurrence but not cancer specific or overall survival. This finding is a bit confusing, given the level I evidence showing improved survival among men with EPE undergoing adjuvant radiotherapy. In those studies of adjuvant therapy decreased risk of recurrence translated to improved survival. The disconnect may relate to the study population, more specifically the prevalence of adverse pathological features that predict metastatic progression, or it may relate to the use of adjuvant or salvage therapies, although the reported rate of secondary treatment is low. The article importantly illustrates that for the majority of men with EPE the risk of mortality from prostate cancer following surgery remains exceedingly low.

Samir S. Taneja, MD

Suggested Reading


Re: Patterns of Declining Use and the Adverse Effect of Primary Androgen Deprivation on All-Cause Mortality in Elderly Men with Prostate Cancer


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Editorial Comment: The use of androgen deprivation therapy (ADT) as a means of treatment in elderly patients with localized prostate cancer has previously been shown in meta-analysis to decrease overall survival. As the therapy is largely noncurative and results in substantial short and long-term toxicity, its use has been generally discouraged in this setting.

This study evaluates trends in the use of ADT in the setting of localized disease without curative intent. Men with nonmetastatic prostate cancer within the SEER (Surveillance, Epidemiology and End Results) program registry who did not undergo surgery or radiotherapy were included, and outcomes of those who were observed and those who received ADT were evaluated. During 2004 to 2009 the use of primary ADT decreased by approximately a third as compared to 1992 to 2004. Those most likely to undergo ADT were men with shorter estimated life expectancy. Importantly the study demonstrated worsened all cause mortality for men in the ADT group. While this observation should be considered with caution due to the absence of clinical parameters for risk stratification, it is provocative in view of previous findings. The continued use of ADT in the setting of localized cancer calls for further physician education in this regard, although its use may partly be related to
symptoms from localized disease and the planned use of concomitant radiotherapy subsequent to ADT administration.

Suggested Reading


Re: Intense Androgen-Deprivation Therapy with Abiraterone Acetate plus Leuprolide Acetate in Patients with Localized High-Risk Prostate Cancer: Results of a Randomized Phase II Neoadjuvant Study


Dana-Farber Cancer Institute, Beth Israel Deaconess Medical Center, and Brigham and Women’s Hospital, Harvard Medical School, Boston, Massachusetts, University of Washington, Geriatric Research, Education and Clinical Center, Veterans’ Affairs Puget Sound Health Care System and Fred Hutchinson Cancer Research Center, Seattle, Washington, University of Texas M. D. Anderson Cancer Center, Houston, Texas, Emory University School of Medicine, Atlanta, Georgia, Perelman School of Medicine, University of Pennsylvania, Philadelphia, Pennsylvania, Janssen Research and Development, Los Angeles, California, and King’s College London, London, United Kingdom


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Editorial Comment: The use of androgen deprivation therapy in the neoadjuvant setting before radical prostatectomy has previously been shown to decrease positive surgical margins and the prevalence of extraprostatic disease at radical prostatectomy. However, it has never been demonstrated to reduce the risk of biochemical relapse. Recent studies are testing whether prolongation of treatment interval from 3 to 8 months could result in improved outcomes.

In this study the investigators appear to hypothesize that the degree of androgen suppression may be a factor in the efficacy of androgen suppression in the neoadjuvant setting. Men were randomized to receive 12 weeks of neoadjuvant luteinizing hormone-releasing hormone (LHRH) agonist alone or in combination with abiraterone acetate, an inhibitor of androgen synthesis. Men receiving combination therapy had decreased levels of testosterone and dihydrotestosterone in tissue sampled on biopsy after 12 weeks of treatment compared to men on LHRH agonist alone. After the randomization phase all men were converted to an additional 12 weeks of combination therapy before prostatectomy. On final pathological evaluation maximal suppression of tissue androgens was noted in all patients. Final pathology demonstrated decrease in tumor burden, with complete response in 10% of men and minimal tumor burden (less than 0.5 cc) in 62% of men on combination therapy. The impact of this treatment strategy on eventual oncologic outcome obviously needs to be determined through additional followup. However, it remains extremely provocative in view of the substantial reduction in tumor burden and suppression of tissue androgens.

Suggested Reading