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LETTER TO THE EDITOR

Upfront metastasis-directed therapy in oligorecurrent prostate cancer does not decrease the time from initiation of androgen deprivation therapy to castration resistance: in response to Onal's letter to the editor

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Dear editor,

We read with very interest the letter to the editor by Onal et al. [1] regarding our paper evaluating upfront metastasis-directed therapy (MDT) for oligorecurrent prostate cancer (PC) [2].

As the authors properly mentioned, the doses used for MDT have a significant impact on local control (LC) in this setting. More specifically, better LC is expected when biological effective doses (BED) of 100 Gy (using α/β ratio of 3 Gy) or higher are delivered. Several MDT schedules are used in our series (according to different Institutional prescription habits), ranging from 25 Gy/5 fractions (BED = 67 Gy) to 48 Gy/4 fractions (BED = 240 Gy).

Nevertheless, in our series 5-year LC reached more than 90%, which is in line with our expectations and with the current literature. Such acceptable results in terms of LC persuade us that no further analyses in terms of radiation therapy doses and disease control were needed.

Concerning the potential weaknesses of our article, we are conscious that it represents a hypothesis generating for well-designed randomized trial. Nevertheless, the current article represents a real-life experience attesting that MDT favorably impacts on the natural history of metastatic PC.

As we previously mentioned, BED of 100 Gy or higher ensures better LC: yet, no potential impact of BED in terms of distant-progression free survival has been demonstrated. This last endpoint represents the focus of the current article.

On the other hand, in a previous article, we demonstrated that in the case of oligorecurrent castration-sensitive PC, PSMA-PET-guided SBRT produced a higher rate of ADT-free patients when compared with the 18F-choline-PET cohort [3].

Finally, we strongly believe that proper patient selection is more important than dose prescription when performing MDT in this setting. Hence, in our opinion the mainstay of the treatment decision should be based on the biological characteristics of the disease.

Moreover, as the authors properly mentioned, the introduction of several tracers in metabolic imaging has changed the decision-making process in PC [3].

Last, we underline that the time to castration-resistance phase is not associated with the modality of detection of the metastasis in the castration-sensitive phase. On the contrary, the main purpose of this series is exactly to suggest that MDT does not decrease the time to castration-resistance phase, regardless of whether PET-tracer is used in the castration-sensitive phase.

Declarations

Conflict of interest All authors declare no conflicts of interest related to this article.

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