GU toxicity was observed in 16 patients (19.0%) and 2 patients (2.4%) had grade 3–4 GU adverse effects. Grade 1–2 late GI toxicities were presented in 6 patients (7.1%) and no patient had grade 3–4 late GU toxicity. After a median follow-up of 70-months, the median BPF and 5-year BPFS in the groups treated with aIMRT and sIMRT were 114-months/88% and not-reached/80%, respectively.

Conclusion. The profile of acute and late adverse effects in prostatectomy patients treated with aIMRT or sIMRT is compared favorably with 3D CRT series. Further follow-up and the inclusion of a greater number of patients are needed to assess the definitive effect of aIMRT or sIMRT in late toxicity, biochemical failure and overall survival.

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Postoperative radiotherapy in localized prostate cancer: Referral criteria from urology departments
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Purpose/objective. To review the criteria followed by urology departments to refer patients to postoperative External Beam Radiotherapy (EBRT) for localized prostate cancer (PCa) after Radical Prostatectomy (RP).

Material/methods. Data from 159 consecutive patients referred from 4 different urology departments, were collected between 2007 and 2012. Clinical and pathological data were analyzed, including a double risk-group classification before and after PR, postoperative EBRT criteria, time from indication to EBRT and pre-EBRT PSA.

Results. The mean age of our series was 60.9 years (SD: 6.5). In a not negligible percentage of patients, the risk group and other clinical and/or pathological factors could not be determined due to lack of data from referral reports. Before RP, 17.6%, 43.4%, 17% and 22% of patients were classified into low, intermediate, high or undetermined risk-group, respectively. After RP, 3.1%, 17% and 22% of patients were classified into low, intermediate, high or undetermined risk-group, respectively. 62.9% of patients had pre-EBRT PSA ≥0.10 ng/ml was present in 42.8% (unknown: 10%). Referral and corrected EBRT intention were adjuvant (28.9% and 11.9%, respectively) and salvage (71.1% and 88.1%; patients with a PD-PSA were classified in salvage-EBRT intention group). Median time from BF to EBRT was 5 months (range: 0–145) and 35.2% had a pre-EBRT PSA ≥1 ng/ml (unknown: 11.9%).

Conclusions. A majority of patients were referred for salvage-EBRT, although most of them met established criteria for adjuvant-EBRT (pT3a/b/T4 and/or positive margins). In salvage setting, attention should be paid to avoid undue delay in the time from indication to EBRT referral, not to exceed PSA pre-EBRT described limit of 1 ng/ml. High quality data are desirable to a better decision-making process in this setting.

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Primary mucin-producing prostate adenocarcinoma presenting as a gluteal mass. A case report and review of the literature
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Aim. To report a rare case of primary mucin-producing prostate adenocarcinoma that arise as right pararectal mass and discuss the clinical diagnosis, treatment and prognosis of the mucin-producing carcinoma of the prostate from a review of published reports.

Materials and methods. We describe a case of a 74-year-old patient who had 2-month history of urinary frequency and dysuria that in the last month noticed a gluteal mass without pain. Was initially suspected neoplasm of rectal origin, so various tests was performed both clinically and immunohistochemically to confirm its origin.

Results. After discarding a neoplasm of rectal origin, this case was diagnosed as a high risk locally advanced prostatic mucin-producing adenocarcinoma with elevated PSA presenting as a gluteal mass, which was pending to begin long-terms androgen suppression therapy (2–3 years) plus resection of the mass and external beam radiation therapy. Reviewing the literature, there is no case with a gluteal mass presentation. Comparing our case with the literature, the primary mucin-producing adenocarcinoma is a variant of high–grade adenocarcinoma of the prostate with high rate of prostate-specific antigen elevation.

Conclusions. Mucin-producing adenocarcinoma of the prostate is extremely rare and is a first case with a gluteal mass presentation. Its differential diagnosis mainly includes conventional prostatic adenocarcinoma with mucin production urothelial-type and secondary adenocarcinoma. The diagnosis and treatment of this disease should be further investigated. Although it has been suggested that mucinous carcinoma is a variant of high–grade adenocarcinoma of the prostate, and their prognoses are very poor.

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