Conference Abstract

Role of radical localised treatment in patients with metastatic prostate cancer

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It is well known that the maximum reduction of tumour burden in malignancies such as ovarian cancer, colon cancer and renal cell carcinoma, can improve survival and increase response to systemic therapy. Androgen-deprivation therapy (ADT) is considered the standard therapy for patients with metastatic disease at the time of diagnosis, while definitive local therapy such as radical prostatectomy (RP) and radical radiation are often reserved for patients with organ-confined disease. However, the optimal treatment for metastatic prostate cancer (mPC) remains inconclusive.

Recently, a growing number of research suggest that the effective local management of mPC may help suppress systemic disease progression and improve patients’ survival. Antwi et al reviewed the records of 7858 mPC patients, including 222 with RP, 120 with brachytherapy (BT) and 7516 with no definitive local therapy (NDLT).1 Patients who underwent RP or BT were significantly less likely to die from prostate cancer (PC) compared to NDLT. In a multivariable survival model, RP was associated with a 73% lower risk of death from all causes and 72% lower risk of death from PC compared to NDLT. In another SEER database based study, Culp et al reported that the 5-year overall survival (OS) was significantly higher in patients undergoing either RP (67.4%) or BT (52.6%) compared with patients who had no surgery or underwent radiation therapy (22.5%) (p<0.001).2 A Munich Cancer Registry (MCR) based research showed a similar result. mPC patients in the RP group had a higher 5-year OS rate than the non-RP group (55% vs. 21%; p<0.01).3 Fossati et al, in their aim to identify optimal candidates for local treatment (LT) among mPC patients, found that for patients with a predicted cancer-specific mortality (CSM) risk of <40%, the local treatment of the primary tumour conferred a higher CSM-free survival rate than patients with no local treatment.4 When the predicted CSM risk exceeded 50%, LT did not provide a survival benefit. In a case control study, Heidenreich et al revealed that RP patients followed by ADT experienced significantly better clinical progression-free survival and cancer specific survival than control group patients (on ADT only).5 There are several potential mechanisms by which treatment of the primary tumour can decrease disease progression. These include eliminating the source of future metastatic sites, blocking the delivery of tumor cells into circulation and improving the response of metastatic sites to subsequent systemic therapy.

Although the available data are encouraging, RP should not be performed for patients with metastatic disease except of clinical trials due to limitations of the data. There are several ongoing clinical trials, aimed at evaluating the benefit of treating primary tumor in mPC patients, including a randomised trial at the MD Anderson Cancer Center (NCT01751438) and the STAMPEDE trial (NCT00268476) in the UK. With initial experience and data from these ongoing clinical trials, we may have the opportunity to advance the care of a previously under-treated population of patients.

Conflicts of interest

None declared.

References