EDITORIAL

clinical

The relative impact of lymph-node metastasis and seminal vesical invasion on oncologic outcomes following radical prostatectomy

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In their manuscript Rodrigues Pessoa and colleagues present the long-term oncological results of a large cohort of prostate cancer (PCa) patients with seminal vesicle invasion (SVI) at radical prostatectomy (RP) [1]. The study includes 2043 SVI cases with a median follow-up of 12 years. Thus, it represents the largest published retrospective series investigating the progression and survival outcomes of this high-risk condition to date. The authors have to be congratulated for their work. As expected, reported metastasis-free (MFS) (77%), cancer-specific (CSS) (87%) and overall survival (OS) (74%) at 10 years were significantly worse compared to patients without SVI. However, among patients with SVI, the presence of a single metastatic pelvic node was not associated with worse oncological outcomes contrary to patients with ≥ 2 positive nodes. Although patients mostly underwent RP before the times of modern staging (mpMRI and molecular imaging (MI)) and decisions for adjuvant and/or salvage therapy were made in an unstandardized manner up to the treating physician discretion, there are some important findings we can translate into the modern days.

First, increasing use of MI leads to a stage migration, with more N1 disease being detected before primary treatment. The proPSMA trial has reported a more than doubled detection of pelvic node disease using PSMA PET instead of conventional imaging (20% vs 9%) [2]. We still do not fully understand how to integrate these findings into clinical practice: current guidelines recommend caution when redefining the primary treatment strategy on a MI-basis, lacking long-term data. However, the paradigm is already changing on the thrust of a more tailored approach. Rodrigues Pessoa et al. give us a good rationale for keep on performing radical surgical treatment in high-risk patients, despite the presence of a low-density N1 disease. Likewise, we know from the STAMPEDE trial that prostate radiotherapy did improve overall survival in those with low metastatic burden and is favored in the subgroup of cN1, further strengthening that these patients should not automatically be denied local therapy [3].

Second, we still debate if and when to apply adjuvant or salvage therapy in patients with high risk features. In the presented paper, adjuvant RT (aRT) and adjuvant HT (aHT) were administered in 13 and 45% of the cases, with a benefit in MFS survival for both and in CSS for aHT, in multivariable models. These data are supported by Tilki et al. [4] demonstrating in a large retrospective cohort that aRT should be still considered in men with pN1 or pGleason score 8 to 10 and pT3/4 PCa given the possibility that a significant reduction in all cause mortality exists. In the study by Rodrigues Pessoa et al. salvage RT and salvage HT were administered in 27 and 44%, but indications and timings are not reported, preventing us from drawing sound conclusions. In this regard the analysis of a large multinational RP cohort has found that an early-sRT approach (below a PSA level of 0.25 ng/ml) is not affecting the OS, also in patients with high-risk characteristics [5].

Third, the current recommendations concerning systemic treatment suggest an observant management for RP patients with ≤ 2 positive nodes, undetectable PSA and favorable accompanying characteristics [6]. Differently, in the setting of primary RT within STAMPEDE trial, N1 disease *tout-court* was adopted as a selection criteria for testing an intensified HT regimen, regardless of nodal burden [7]. The presented results endorse the idea that not all N1 diseases are equal and that a minimal nodal involvement may not per se affect the patient outcome and management, in a high-risk context. Moreover, from a speculative standpoint, they speak in favor of a possible curative role of lymph node dissection in selected, low-burden N1 patients, although evidence in the overall high risk population is lacking [8, 9].

In summary, these data strengthen the role for local surgical treatment in minimal N1 disease; moreover, a single positive node at RP may not be enough to opt in favor of adjuvant HT, when careful observant management may be considered.

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AUTHOR CONTRIBUTIONS

CK and GC wrote the article; critical revision by GP.

COMPETING INTERESTS

The authors declare no competing interests.