PROSTATE CANCER

No need to rush for men with low-risk disease

Men with low-risk prostate cancer can delay radical prostatectomy by up to 12 months without increasing their risk of adverse pathology, according to a new paper in *Urologic Oncology*.

Active surveillance as a form of conservative disease management has recently been recommended in several guidelines as an option for patients with low-risk prostate cancer. However, results from studies examining the safety and short-term outcomes of delayed radical prostatectomy are contradictory. In addition, the number of patients opting for active surveillance has traditionally been low, although this management option might reduce potential morbidity associated with other forms of therapy.

“One consideration that affects men choosing whether to elect for active surveillance is the anxiety associated with potentially harbouring a more aggressive disease than shown on biopsy,” explains lead author Adam Weiner

from the University of Chicago Medical Centre. “In our population-based study, we attempted to answer the following question: does an initial delay in definitive treatment of low-risk prostate cancer lead to adverse pathological findings at prostatectomy associated with worse cancer-specific outcomes?”

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The team extracted data from 2010–2011 stored in the US National Cancer Database, analysing the numbers of patients with low-risk disease (Gleason score = 3 + 3, cT1–T2 and PSA level <10 ng/ml) and how many of these had Gleason upgrading, upstaging, nodal metastases and positive surgical margins at radical prostatectomy. They then used multivariate logistic regression analysis to determine which factors influenced the incidence of these outcomes.

Their final cohort of 17,943 men with available biopsy details was stratified according to the time from diagnosis to radical prostatectomy; 93.7%, 5.0%, 0.9% and 0.3% had undergone the procedure within 6 months, at 6–9 months, at 9–12 months or later than 12 months after diagnosis, respectively. At prostatectomy, 42.9% of patients had upgrading to Gleason score >6, 9.3% had upstaging to pT3–4,

positive surgical margins were found in 15.8% and nodal metastases in 0.3% of patients.

Upon multivariate analysis, increased age, black race, >1 comorbidity, high PSA, >2 positive biopsy cores and >34% positive cores were associated with an increased probability of ≥1 adverse pathological outcome (upstaging, upgrading or nodal metastases) at radical prostatectomy. A delay of 6–9 months or 9–12 months did not affect the risk of adverse pathology (95% CI 0.99–1.32 and 0.75–1.41, respectively).

“This finding suggests men diagnosed with low-risk prostate cancer can usually safely take the time following their biopsy to think about all management options and consider a restaging evaluation before entering an active surveillance protocol,” summarizes Weiner. “Because of its large cohort size and population-based design, our study overcomes shortcomings of several previous reports that were limited by small cohorts largely from academic institutions. Thus, our findings are probably more generalizable to the average low-risk prostate cancer population in the USA.”

Clemens Thoma

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