Management of advanced prostate cancer

We read with interest the report from the St Gallen Advanced Prostate Cancer Consensus Conference (APCCC) March 2015 [1]. The report represents eight specialities but not nuclear medicine and laboratory medicine. Therefore, we add some comments.

Many European hospitals have a practice of functional imaging of PC with multiparametric MRI and PET/CT. The imaging often points to the locoregional site of the recurrence for patients with PSA recurrence [2]. These patients often have a reduced PSA after treatment targeting the sites identified with functional imaging. APCCC gave priority for CT and bone scans, and did not recommend functional imaging. But it may influence treatment and outcome.

APCCC stated that there were no solid data on PET/CT with a tracer based on prostate-specific membrane antigen (PSMA). Nevertheless, a study has published solid data with PSMA PET/CT [3]. The study was published on line 20 November 2015 and evaluated the diagnostic accuracy of the PET/CT for 319 patients. PSMA PET/CT had a detection rate of 56% for patients with PSA of 0.2–1.0, rising to 89% for patients with PSA >1.0 ng/ml. Thus, PSMA PET/CT allows treatment decisions for patients with PSA recurrence guided by awareness of the site of the recurrence early in the clinical course. Also radiolabeled choline PET/CT shows the site for recurrence for most patients with a PSA >2. Further, the PET/CT is positive for most intermediate- and high-risk patients with a PSA >0.5 ng/ml. In contrast, a bone scan usually only detects the site of recurrence for PSA >20 ng/ml [1]. So PET/CT is better for restaging than CT and bone scans. PET/CT may show that patients have a local, regional, or distant site of recurrence [2]. APCCC argued that patients with PSA recurrence should be treated with ADT. However, ADT is not the best treatment of patients with a loco-regional recurrence.

APCCC also claimed that early initiation of treatment of PSA recurrence has not been shown to be associated with patient benefit. However, early initiation of salvage radiotherapy for patients with PSA recurrence improves PSA recurrence-free survival. It was highest if the salvage radiotherapy was started while PSA is <0.5 ng/ml [4].

APCCC is skeptical for radiotherapy of oligometastatic prostate cancer. Oligometastatic disease is defined as few metastases in lymph node or bones [1]. But CT and bone scans are not optimal for detecting lymph node metastases. APCCC acknowledged studies that showed better detection of bone metastases with MRI than with bone scans. So physicians need the sensitive imaging methods to identify these patients. A study evaluated radiotherapy for patients with oligometastatic prostate cancer and found they had nearly 80% 3-year overall survival [5]. For comparison, overall survival was worse for patients with advanced prostate cancer treated with abiraterone or enzalutamide. Median overall survival was 15–20 months. So physicians should examine patients for oligometastatic prostate cancer. They should be informed of ongoing trials that further evaluate radiotherapy for the oligometastatic sites.

Thus, the right imaging may add to the right treatment of the right patient at the right time.

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Reply to the letter to the editor ‘Management of patients with advanced prostate cancer: recommendations of the St Gallen Advanced Prostate Cancer Consensus Conference (APCCC) 2015’ by Gillessen et al.

We thank von Eyben et al. for their interest in our recent article by Gillessen et al. [1]. They make five comments: first, at the Advanced Prostate Cancer Consensus Conference (APCCC), nuclear medicine was not represented; second, APCCC did not recommend functional imaging in patients with PSA recurrence after local treatment; third, APCCC stated that there were no solid data on PSMA PET/CT; fourth, APCCC did not appreciate the value of early treatment for men with PSA recurrence after local treatment and fifth, the panel was critical about the role of...